Southeastern Pennsylvania

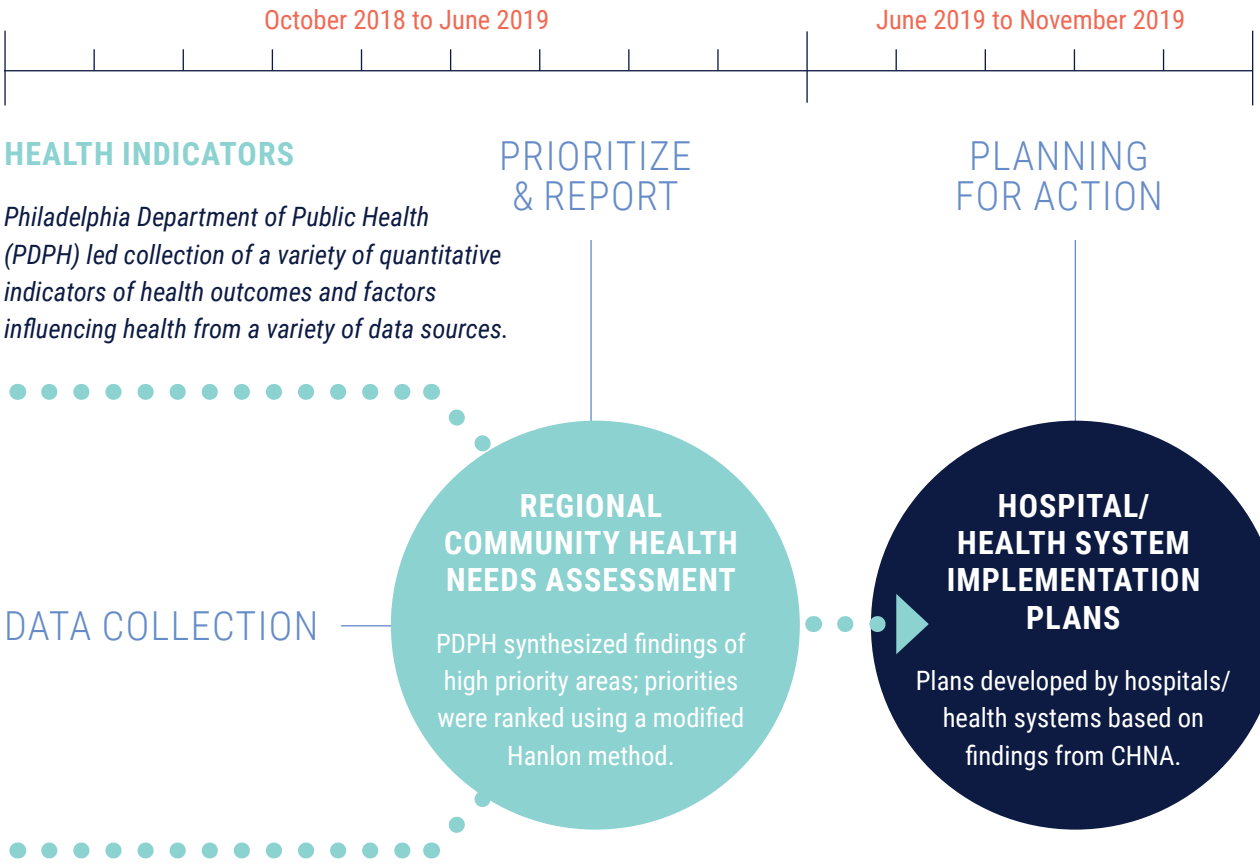
Community HEALTH

NEEDS ASSESSMENT

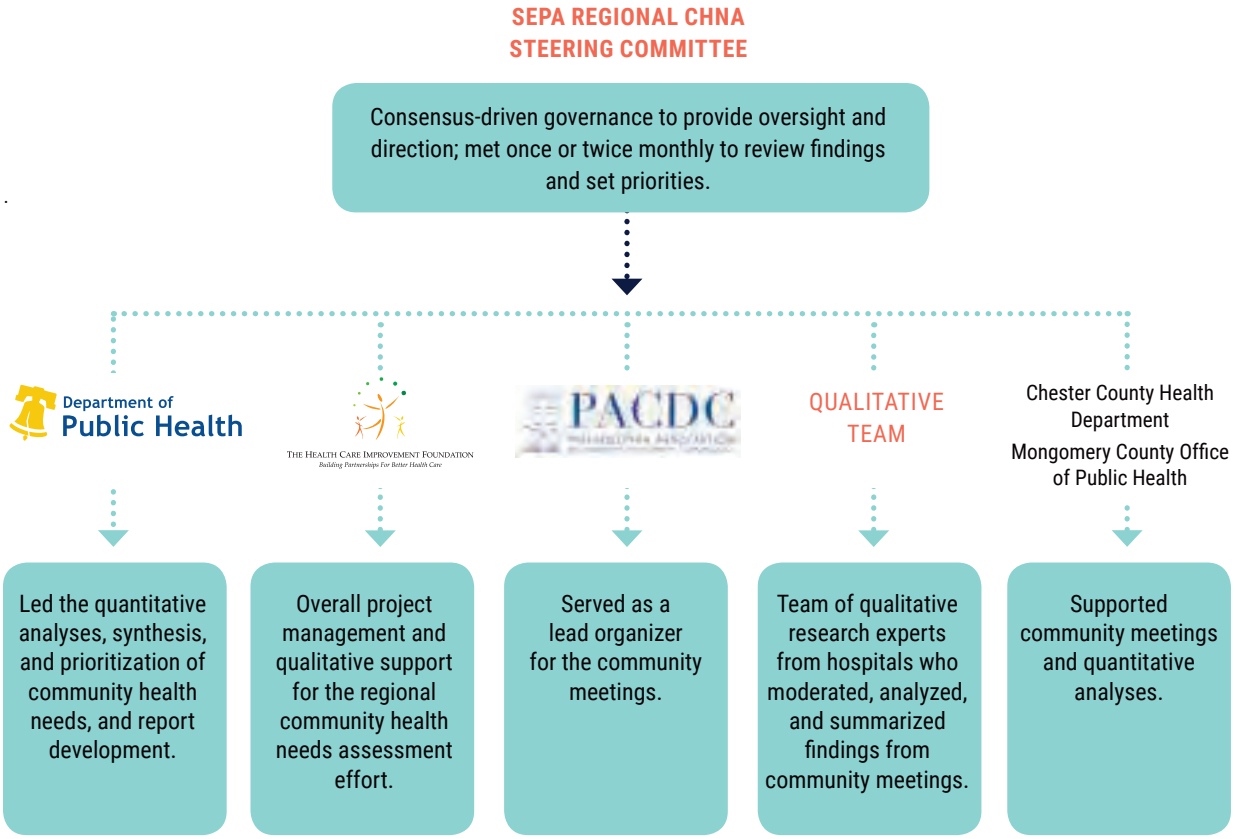
June 2019

OUR COLLABORATIVE APPROACH

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



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



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

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

HCIF coordinated the qualitative components of the assessment which included:

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

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

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

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

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

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

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

COMMUNITY HEALTH PRIORITIES

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

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
3. **ACCESS TO AFFORDABLE PRIMARY/ PREVENTIVE CARE**	» High supply of primary care providers across the region, but long wait times in some areas and Medicaid acceptance variable » Low access to primary care providers for some vulnerable populations and communities due to: • Lack of providers • Affordability: Uninsured (no safety net providers) and low-income with high co-payments/ deductibles • Language/cultural accessibility for immigrant/non-English speaking communities » **Vulnerable populations:** uninsured people, individuals/ families with low income, immigrants	» Expand primary care locations in neighborhoods with low access » Support transportation assistance » Expand appointment availability and hours in low access areas » Develop health promotion campaigns and initiatives to raise awareness » Provide samples/discounts on medications and enroll patients in prescription assistance programs » Use technology/telehealth to increase access to health information
4. **HEALTHCARE AND HEALTH RESOURCES NAVIGATION**	» Navigating healthcare services and other health resources, like enrollment in public benefits and programs, remains a challenge due to: • General lack of awareness • Fragmented systems • Resource restraints » Financial costs and logistics associated with transportation can be a barrier to accessing healthcare and health resources » **Vulnerable populations:** individuals/families with low income, uninsured people, persons with disabilities	» Increase access to healthcare navigators, community health workers and patient advocates » Develop community health resource directories, bulletins or newsletters » Create permanent social service hubs and resource fairs » Encourage bi-directional integration of data between health and community-based organizations » Develop school-based health and health resources navigation, like Community Schools » Provide information regarding available transportation services and facilitate the process for accessing these services » Create accessible healthcare offices and access to preventive care and health screening for persons with disabilities

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

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

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

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

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
15. NEIGHBORHOOD CONDITIONS (E.G. BLIGHT, GREENSPACE, PARKS/ RECREATION, ETC.)	» Access to safe outdoor and recreational spaces for physical activity and active transit (e.g. walking and biking) is a significant health priority, particularly for youth and young adults » Extreme neighborhood blight, including abandoned homes, vacant lots and extreme amounts of litter and trash, impacts communities socially and has been associated with poorer overall health and increased violence » Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards	» Develop new affordable housing units » Support neighborhood remediation and clean-up activities » Invest in infrastructure improvements to support active transit near hospitals » Improve vacant lots by developing gardens and spaces for socialization and physical activity
16. HOMELESSNESS	» Individuals experiencing homelessness are more likely to: • Be racial/ethnic minorities • Have mental health and substance use disorders • Seek care at emergency departments/hospitals and be high-utilizers • Experience discrimination and bias in healthcare settings » Inadequate temporary shelters, transitional housing, and affordable housing options exist for individuals experiencing homelessness throughout the region	» Create medical respites for individuals in urgent need of transitional housing » Develop medical-legal partnerships » Develop new affordable housing units » Co-locate health and social services

INTRODUCTION

The Affordable Care Act (ACA) mandates that, every three years, tax-exempt hospitals must conduct a Community Health Needs Assessment (CHNA) and implement strategies to address priority needs. Federal requirements for the CHNA include:

- A definition of the community served by the hospital 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 determining and examining the service needs and gaps in a community, an organization can develop responses to address them in implementation plans also mandated by the ACA.

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 2019 Community Health Needs Assessment (CHNA) for the Southeastern PA (SEPA) region, with specific focus on **Bucks, Chester, Montgomery, and Philadelphia** counties. While some local hospitals/health systems have worked collaboratively on some components of previous CHNA implementation plans, they previously produced independent CHNAs. Based on service area definitions from previous CHNAs, many hospitals/health systems mutually serve residents of communities within the SEPA region. In contrast to health systems conducting independent CHNAs, a collaborative CHNA offered:

- Increased collaboration among local hospitals/health systems serving this region
- Reduced duplication of activities and community burden from participation in multiple community meetings
- Reduced hospital/health system costs in CHNA report development
- Opportunities for shared learning
- Establishment of a strong foundation for coordinated efforts to address highest priority community needs

MISSION

We Improve Lives.

VISION

Reimagining health, education and discovery to create unparalleled value.

Abington Hospital, a regional referral center and teaching hospital located in Abington, Montgomery County, has served the residents of Bucks and Montgomery Counties for over 100 years. In FY18, Abington Hospital celebrated the fourth anniversary of its merging with Jefferson Health. This collaboration continues to enhance Abington's ability to improve lives by providing high quality care at lower costs, allowing the facility to serve more people when and where needed.

In July 2018 the partnership achieved its most important strategic initiative of the year with the opening of the Asplundh Cancer Pavilion, an 86,000-square-foot modern outpatient center which serves as home to the Sidney Kimmel Cancer Center at Abington-Jefferson Health. Conveniently located just off the Pennsylvania Turnpike's Willow Grove interchange, this exceptional facility sets a new standard for providing comprehensive outpatient cancer care in a soothing and convenient setting.

In addition to the 31 Abington oncologic specialists based at Asplundh, patients will be able to schedule appointments with 15 Center City-based oncologic specialists who will travel to Asplundh to see patients in the new facility. In addition to the phase II and phase III trials previously offered by Abington Hospital, the new center offers phase I clinical trials, a major step forward for the region.

In addition to its collaboration with Jefferson Health, Abington Hospital also maintains associations with Drexel University College of Medicine, Philadelphia College of Osteopathic Medicine, and Sidney Kimmel Medical College at Thomas Jefferson University.

In FY18, Abington Hospital received numerous awards and accolades, including Joint Commission certification in advanced Ventricular Assist Device, advanced heart failure, advanced hip and knee, and palliative care services. Additionally, Abington's Diamond Stroke Center received re-certification as a comprehensive stroke center from the American Heart Association/American Stroke Association. In 2013, Abington was one of the first comprehensive stroke centers designated in the Delaware Valley and is currently one of only eight stroke centers in Pennsylvania to achieve this status. The most recent certification is Abington Hospital's third.

VALUES

Jefferson'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

Abington Hospital earned chest pain center accreditation from the American College of Cardiology and the Mission: Lifeline Gold Award from the American Heart Association. These awards recognize staff members' demonstrated expertise and commitment to treating patients with chest pain and the implementation of specific quality improvement measures for the treatment of severe heart attacks, respectively.

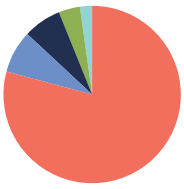
For the fourth year running, Abington Hospital received magnet recognition from the American Nurses Credentialing Center, the nation's highest honor for professional nursing practice. This honor bestows on the Hospital an elite national status.

In FY18, Abington Hospital was ranked seventh in the Philadelphia region and thirteenth in the state by U.S. News & World Report. Abington scored high-performing in six of nine categories: heart bypass surgery, hip and knee replacement, COPD, congestive heart failure, and colon cancer surgery.

BEDS	EMPLOYEES	ADVANCED PRACTICE PROFESSIONALS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
665	5,708	303	30,346	566,850	95,488

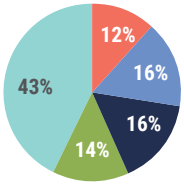
demographics

RACIAL COMPOSITION



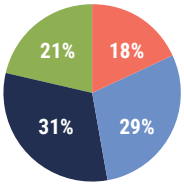
2% | Other
4% | Hispanic/Latino
7% | Black
8% | Asian
80% | White

INCOME DISTRIBUTION



$100,000+
$75,000-$99,999
$50,000-$74,999
$25,000-$49,999
<$25,000

AGE DISTRIBUTION



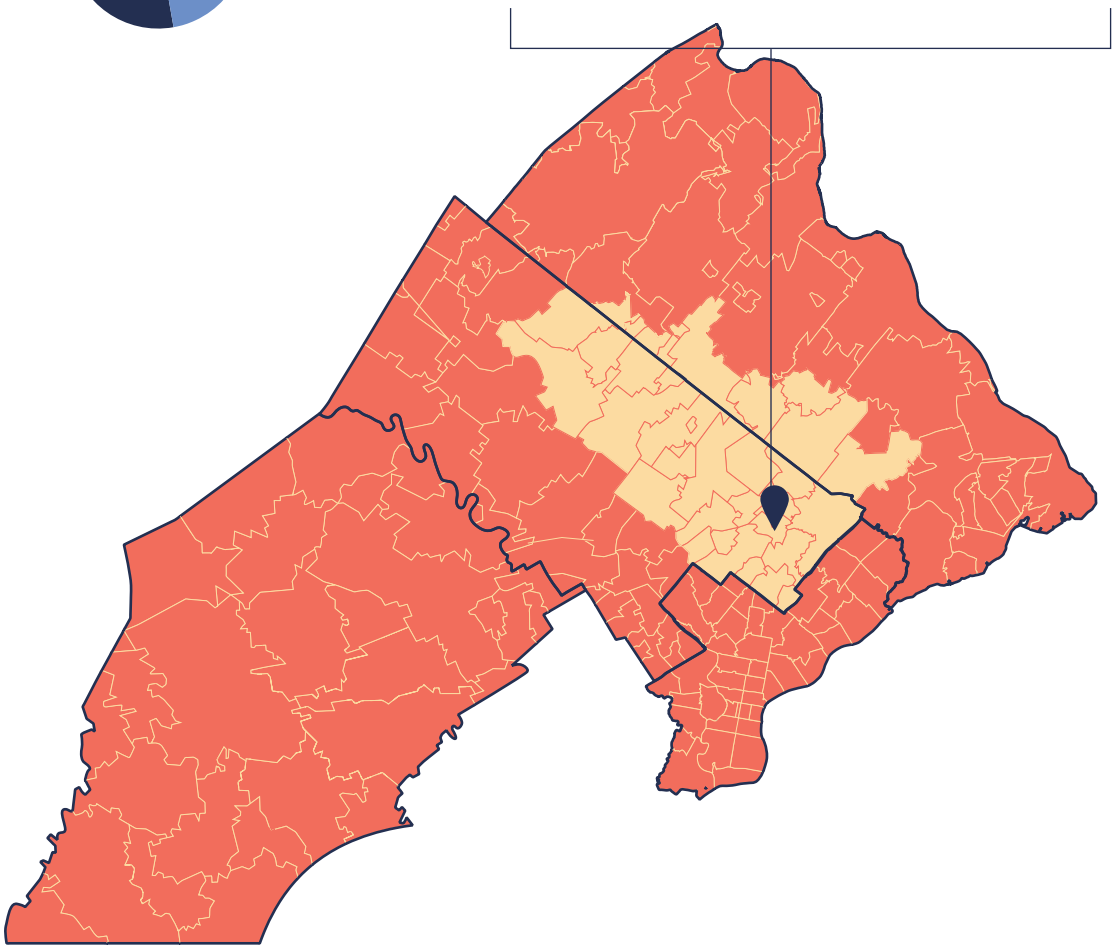
0-17
18-44
45-64
65+

Targeted Service Area for Community Health Improvement

Abington Hospital defines its targeted service area as the following ZIP codes in Bucks and Montgomery Counties. These areas represent areas proximate to the hospital where 70% of inpatients reside and a total population of 543,386.

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

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



Impact of Prior Community Health Needs Assessment and Implementation

Abington Hospital and its parent organization, Abington – Jefferson Health (AJH), are non-profit 501(c)3 organizations with a strong mission of community service and outreach, aligning with the Mission of Abington –Jefferson Health: We Improve Lives. Abington – Jefferson Health works to create the healthiest possible community by orchestrating targeted outreach for maximum community benefit while reducing health disparities. AJH completed its first CHNA in 2013 and concluded work on the identified needs through related implementation plans in June of 2016. In March 2016, AJH completed and published the 2016-19 Community Health Needs Assessment.

A three-year implementation plan was completed and approved in June 2016, and addresses the following most important priority health needs for the population of the Abington Community Benefit areas:

- Mental Health Services
- Obesity
- Social and Health Care Needs of Older Adults
- Alcohol/Substance Abuse
- Women's Cancer
- Chronic Disease Management (diabetes, heart disease and hypertension, stroke, asthma)
- Colon Cancer
- Health Education, Social Services and Regular Source of Care

Full copies of the 2013 and 2016 Needs Assessments and related implementation plans are available at JeffersonHealth.org/Abington.

Abington Jefferson Health®

MISSION

We Improve Lives.

VISION

Reimagining health, education and discovery to create unparalleled value.

Located in Lansdale, Montgomery County, Abington-Lansdale Hospital provides a broad range of clinical services to the surrounding area. Like Abington Hospital, Abington-Lansdale Hospital was combined with Jefferson Health in 2015 and is dedicated to Jefferson Health's mission to improve lives and reimagine health, education, and discovery to create unparalleled value. This commitment is evidenced by the Hospital's receipt of the Healthgrades Experience Award, ranking in the top five percent in the nation, and the Healthgrades Outstanding Patient Experience Award in 2018.

Abington-Lansdale Hospital's renowned stroke program was recognized by the American Heart Association, earning both the Get with the Guidelines® Stroke Gold Plus award and the Target 2018 Stroke Elite Award in FY18. Abington-Lansdale was also named an Advanced Primary Stroke Center. The Hospital also earned The Joint Commission's advanced hip and knee certification, and received a Pathway to Excellence designation from the American Nurses Credentialing Center in recognition of its professional nursing practice. Abington-Lansdale Hospital has also earned chest pain center accreditation from the American College of Cardiology for staff members' demonstrated expertise in treating patients with chest pain. Additionally, the Gift of Life donor program and Hospital and Healthsystem Association of Pennsylvania has honored Abington-Lansdale Hospital with their Platinum Award.

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

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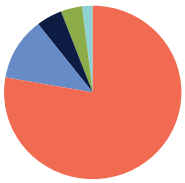
BEDS	EMPLOYEES	PHYSICIANS	ADVANCED PRACTICE PROFESSIONALS	INPATENT ADMISSIONS	OUTPATIENT REGISTRATIONS	EMERGENCY DEPT. VISITS
140	575	383	115	5,864	78,345	27,925

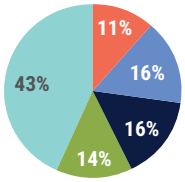
demographics

RACIAL COMPOSITION



1.9% | Other
4.0% | Hispanic/Latino
4.5% | Black
11.8% | Asian
78.0% | White

INCOME DISTRIBUTION



$100,000+
$75,000-$99,999
$50,000-$74,999
$25,000-$49,999
<$25,000

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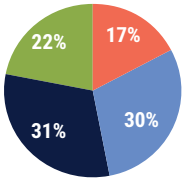

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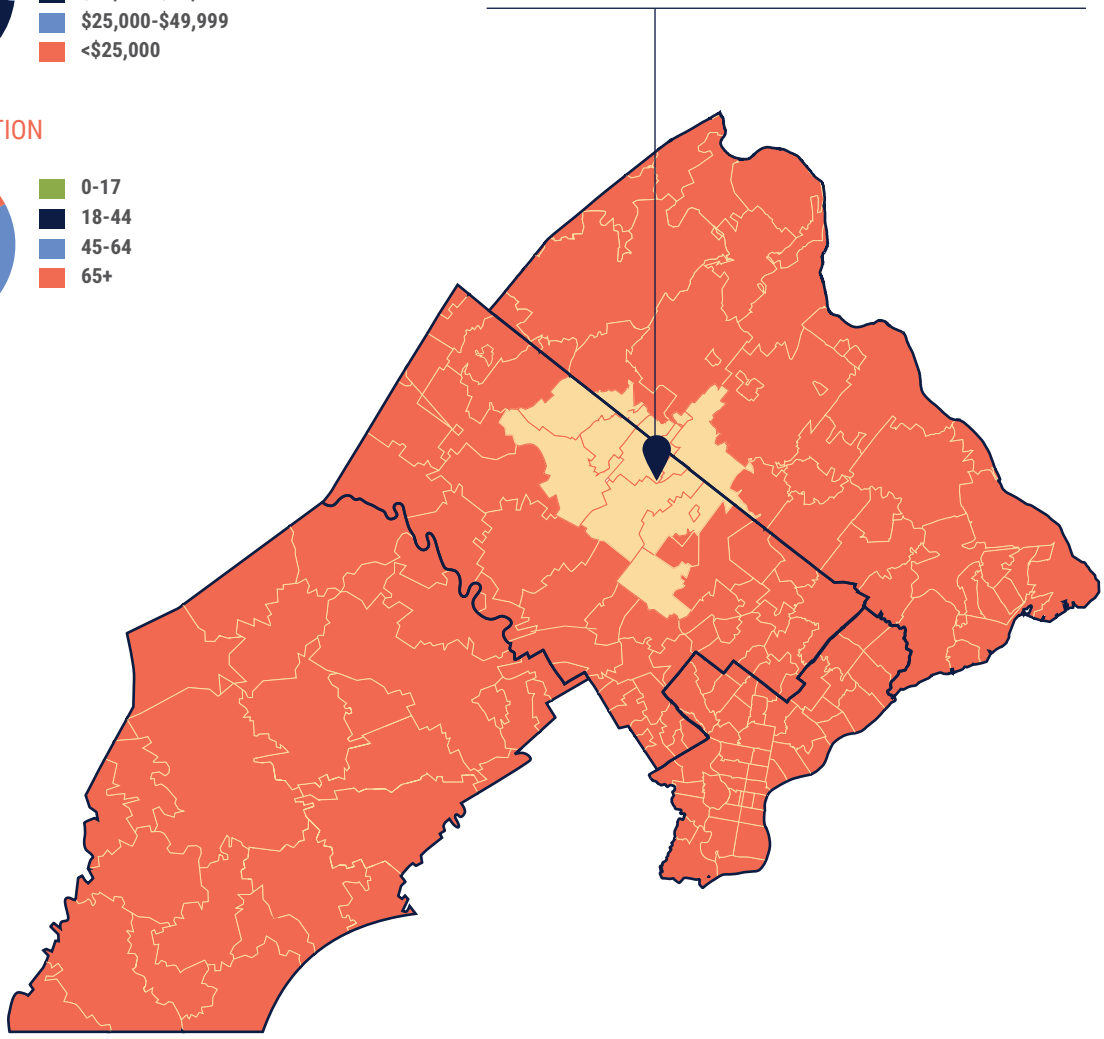
Bucks County: 18914, 18932



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MISSION

ICARE: Innovation, Collaboration, Accountability, Respect, Excellence

Chester County Hospital, part of Penn Medicine, is dedicated to the health and well-being of the people in Chester County, Pennsylvania, and the surrounding areas. The hospital is located in West Chester with outpatient services extending 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.

In 2013, Chester County Hospital joined the University of Pennsylvania Health System as part of its ongoing effort to provide the most progressive services available. The hospital also has clinical affiliations with Children's Hospital of Philadelphia for pediatrics and neonatology and maintains numerous teaching affiliations with colleges and universities throughout the Delaware Valley.

Chester County Hospital offers an array of inpatient and outpatient medical and surgical services, including interventional heart and vascular services, open heart surgery, advanced spine surgery, general, orthopedic and oncological surgery, oncology, radiation oncology and comprehensive maternal/infant health services.

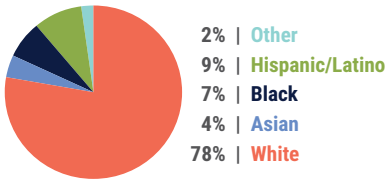
The hospital also offers home health and hospice care; occupational and employee health care; professional and technical education; outpatient laboratory; radiology and physical therapy services; prenatal care and gynecological care for all women, including the underserved; and cardiopulmonary rehabilitation.

True to its commitment to providing ways for people to maintain a healthy life, Chester County Hospital offers a broad scope of high quality health education programs to the community, including physician lectures about important health concerns; a wide variety of wellness programs and services that address specific life cycle needs and chronic health conditions; cardiovascular, cancer, blood pressure, osteoporosis and other screenings to identify risk at an early stage; and support groups. Chester County Hospital's diabetes education program is accredited by the American Association of Diabetes Educators. The hospital has also achieved full recognition status from the Centers for Disease Control for the National Diabetes Prevention Program, and is also enrolled as a Medicare provider for this service. The hospital achieved this singular designation because of its successful track-record for serving the community and its dedication to reducing the prevalence of diabetes in Pennsylvania.

BEDS	EMPLOYEES	PHYSICIANS	INPATENT ADMISSIONS	OUTPATIENT TESTS & PROCEDURES	EMERGENCY DEPT. VISITS	BIRTHS
248	2,518	705	13,821	451,530	45,161	2,845

demographics

RACIAL COMPOSITION



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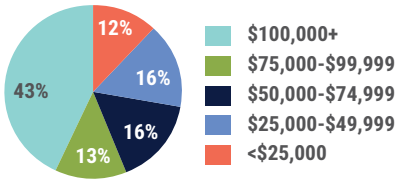

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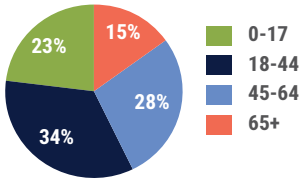
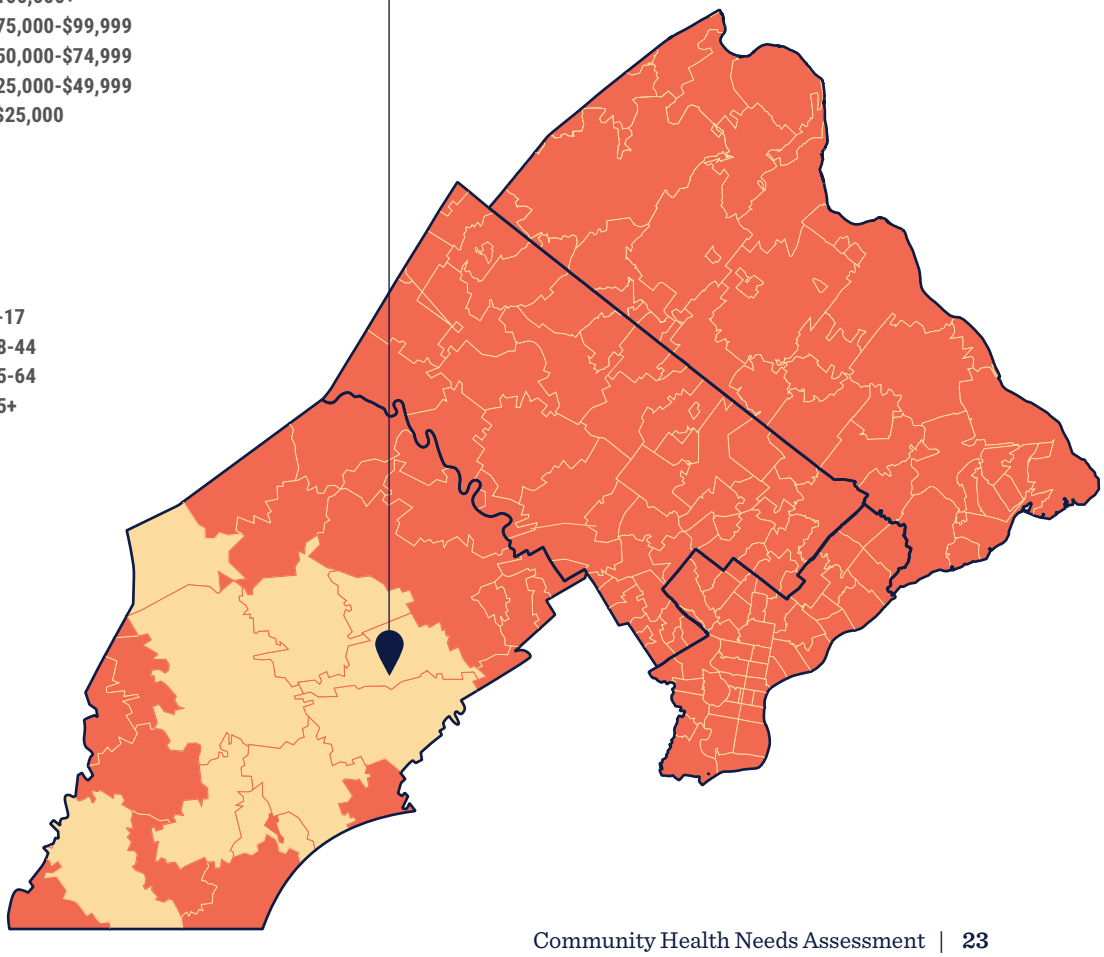


Targeted Service Area for Community Health Improvement

Chester County Hospital defines its targeted service area to include the following ZIP codes in Chester County. These areas represent 75% of inpatient admissions and a total population of 300,806.

Chester County:
19311, 19320, 19335, 19341, 19344, 19348, 19363, 19380, 19382, 19390



Chester County Hospital's vision is to be the leading provider of care in the region and a national model for quality, service excellence, and fiscal stewardship. Progress toward those aims is reflected in the numerous awards bestowed on the hospital in recent years. Among many other acknowledgments, in 2017 the Centers for Medicare and Medicaid Services awarded Chester County Hospital a five star rating — the highest possible score — for the second year in a row. The hospital was also named among the 100 Top U.S. Hospitals by IBM Watson Health™. Additionally, Chester County Hospital's nursing staff has been recognized by the American Nurses Credentialing Center's Magnet Recognition Program for its excellence in patient care.

The hospital's heart and vascular programs have received a number of accolades, including the American Heart Association's Mission: Lifeline® Silver Receiving Quality Achievement Award and Heart Failure Quality Achievement Award and the Blue Distinction® Centers for Cardiac Care in 2018.

In 2017, the hospital received full reaccreditation as a Chest Pain Center with Primary PCI and Resuscitation from the American College of Cardiology. Both the Breast Health Program and the Cancer Program also recently received accreditation from the National Accreditation Program for Breast Cancers and the Commission on Cancer of the American College of Surgeons, respectively. The Cancer Program's accreditation is for three years and was received with commendation. Chester County Hospital has also been certified as a Primary Stroke Center by The Joint Commission.

Impact of Prior Community Health Needs Assessment and Implementation

The 2016 Community Health Needs Assessment and resulting three-year implementation plan identified multiple actions to address the priority health needs affecting our community. Highlights of the impact of this plan include the following:

- Over the last three years, an average of 397 wellness and health education programs that targeted chronic disease prevention and injury avoidance were delivered to 9,568 individuals each year.
- The prenatal clinic achieved and sustained a rate of 5.3% low infant birth rate, surpassing the Healthy People 2020 goal.
- Prenatal clinic patients are screened for food insecurity and provided with emergency prenatal food boxes prepared by the Chester County Food Bank.
- Free glucose testing supplies were provided to prenatal clinic patients with gestational diabetes.
- A total of 27 bilingual lifestyle coaches from partner agencies were trained to deliver the Diabetes Prevention Program in Spanish increasing access for the Hispanic community.
- Four Diabetes Prevention Programs (three in English and one is Spanish) were offered through the outpatient diabetes department.
- Over 1,000 individuals were trained in Hands Only CPR and AED use.
- Two Linda Creed breast cancer screenings were offered to under or uninsured women over 40.
- A contract with the Pennsylvania HealthyWoman Program was finalized increasing access to breast and cervical screening for low income women.
- All Childbirth Classes were offered at no charge to under or uninsured patients.
- After rigorous preparation by labor, delivery, and maternity, the Hospital received the "Baby Friendly" designation.
- 160 flu vaccinations were given at homeless shelters.

Details on the full impact of the 2016 implementation plan can be found at https://www.chestercountyhospital.org/about/community-health-needs-assessment.

Children's Hospital of Philadelphia®

MISSION

Children's Hospital of Philadelphia (CHOP), 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.

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 community benefit target 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, New Jersey, and New York.

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 houses the world's leading pediatric research enterprise, the CHOP Research Institute (the "Institute"), and one of the top pediatric graduate medical education programs in the nation. As part of the residency program, CHOP also offers the Community Pediatrics and Advocacy Program (CPAP). This longitudinal curriculum prepares medical residents to be child and family advocates and work with community partners towards creating prevention and population health programs. The Institute reflects the Hospital's deep and long-standing commitment to improve child health. With a research staff in the thousands, the Institute carries out groundbreaking research on the science, policy, and treatment of childhood illnesses, including spina bifida, autism, cancer, diabetes, hemophilia, pediatric heart disease, cystic fibrosis, nutrition disorders, hypercholesterolemia, mental retardation, AIDS, sickle cell disease, Friedreich's Ataxia and numerous other diseases and disorders.

BEDS	EMPLOYEES	PHYSICIANS/ DENTISTS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS	RESEARCH STAFF
546	13,868	1,667	29,313	1,379,199	88,569	2,000+

VISION

We will distinguish ourselves as the #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.

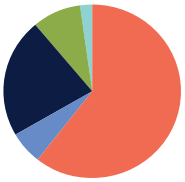
We will be "high touch" and "high tech," and will be digitally accessible to patients around the world and in our backyard.

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.

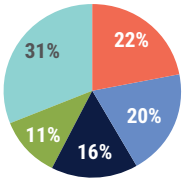
demographics

RACIAL COMPOSITION



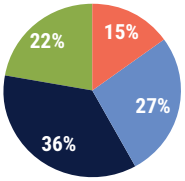
2% | Other
9% | Hispanic/Latino
22% | Black
6% | Asian
60% | White

INCOME DISTRIBUTION



$100,000+
$75,000-$99,999
$50,000-$74,999
$25,000-$49,999
<$25,000

AGE DISTRIBUTION



0-17
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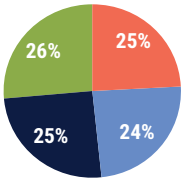
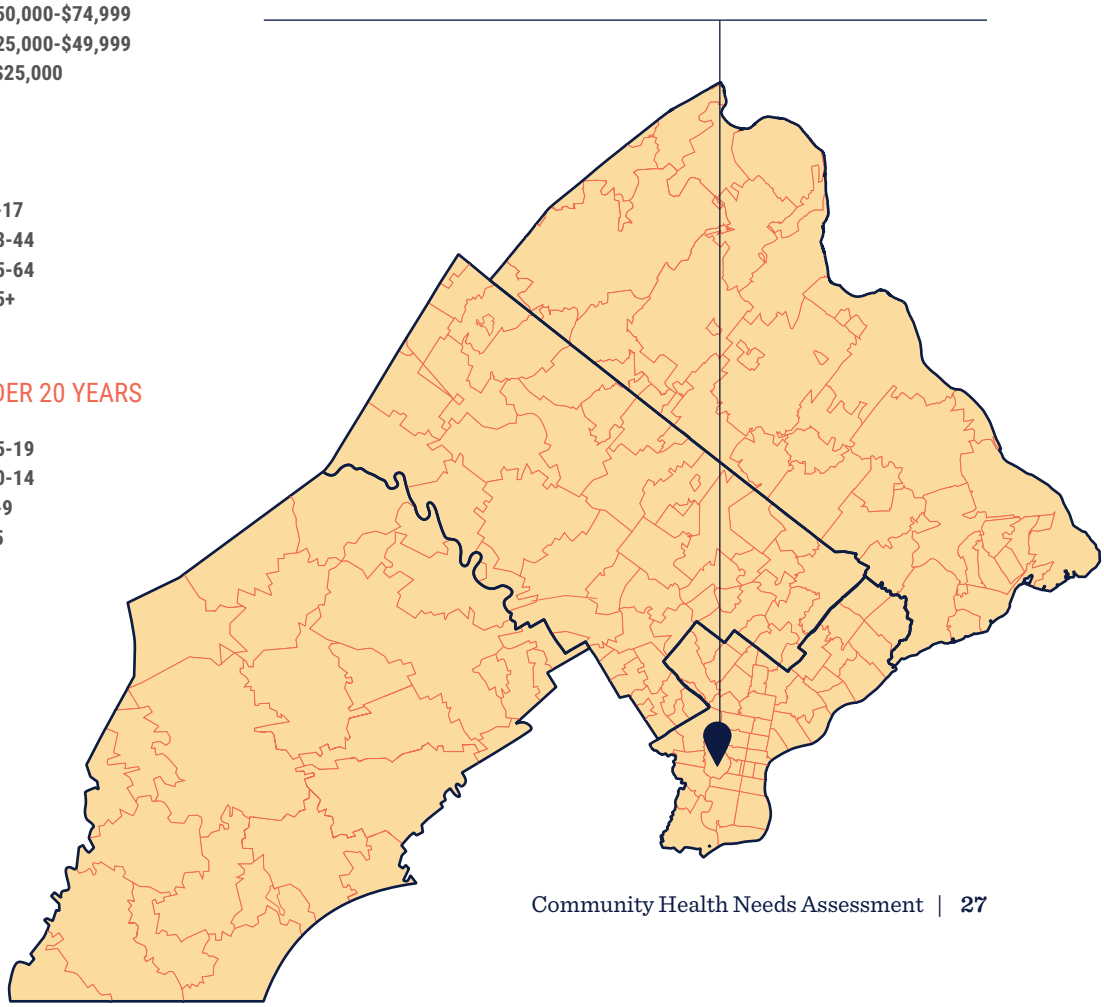
AGE DISTRIBUTION, UNDER 20 YEARS



15-19
10-14
5-9
<5

Targeted Service Area for Community Health Improvement

CHOP defines its targeted service area for community benefit as all ZIP codes in the Greater Philadelphia four-county region. While the Greater Philadelphia region is CHOP's primary target area, as a globally recognized children's hospital, CHOP has also served patients from 72 countries as well as 50 states and the District of Columbia. CHOP also provides primary patient care beyond the four-county Greater Philadelphia region within 14 counties of Southeastern Pennsylvania, including a large share of Delaware County, PA, Northern Delaware, and Southern New Jersey.



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 community benefit target area. 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. Grantees of the program must specifically address needs identified in the CHNA. The Philadelphia Inquirer awarded CHOP with its award for charitable volunteerism, recognizing the CHOP Cares Community Grant Program specifically, at the 2018 Corporate Philanthropy Conference.

Among many of CHOP's community engagement initiatives, a few notable programs include the Karabots Community Garden, the Community Asthma Prevention Program (CAPP), the Homeless Health Initiative (HHI), and the Violence Prevention Initiative (VPI).

- The Karabots Community Garden opened in 2016, donating produce to the West Philadelphia Community through a partnership with The Enterprise Center and hosting cooking demonstrations and educational events throughout the year.
- CAPP conducts community service and education projects, community-based asthma research, and asthma interventions to improve the lives of children in Philadelphia communities most affected by asthma.
- 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.
- VPI was created in 2013 and continues as a CHOP-wide effort to reduce exposure to and impact of violence among children and families. Guided by trauma-informed practices, principles of social justice and equity, and community-based participatory research, the VPI conducts research and implements innovative, evidence-based programs in clinical, school, and neighborhood settings.

CHOP has more than 100 community benefit programs that strive to ensure that all children, especially the most vulnerable, experience the wonders of childhood. Our dedication to addressing community needs was recognized when the Association of American Medical Colleges presented us with the 2015 Spencer Foreman Award for Outstanding Community Service.

More recently, CHOP was named one of the 20 most innovative children's hospitals by Parents magazine, specifically for significant contributions to the development of a new treatment for a certain pediatric leukemia, and efforts to help other hospitals offer this therapy to patients.

Impact of Prior Community Health Needs Assessment and Implementation

In CHOP's 2016 CHNA, seven core areas of focus were identified:

1. Access to primary and preventative care for vulnerable children;
2. Increased access to education, primary care and other health services for families who speak English as a second language;
3. Access to healthy food, opportunities for physical activity and wellness education;
4. Access to sex education, sexual health services and OB/GYN services for adolescents;
5. Access to mental health, behavioral health, and substance abuse screening, education and services;
6. Increased collaboration and communication to create a more seamless approach between services;
7. Access to dental, vision and specialty care for children.

CHOP developed numerous strategies to address these community needs, including some of the initiatives aforementioned. For example, the opening of the Karabots Community Garden helped to increase access to healthy food (priority 3) for residents of West Philadelphia through distributing over 1,500 pounds of produce and engaging over 1,200 residents at educational events. To better address mental and behavioral health needs (priority 5), the Violence Prevention Initiative (VPI) has created new programs and expanded existing ones. In the 2017-2018 school year, approximately 500 students received VPI's school-based aggression and bullying prevention programs, and close to 70% of the students improved on two or more outcomes. Furthermore, CHOP has implemented several changes to hospital systems that are helping patients and families to better navigate the healthcare system.

More detail on CHOP's progress towards addressing these needs can be found in a supplement (https://media.chop.edu/data/files/pdfs/2016-19-chna-implementation-plan.pdf) that is posted alongside this report on CHOP's website.

Einstein
MEDICAL CENTER MONTGOMERY

More than Medicine

Einstein Medical Center Montgomery (Einstein Montgomery) is a tertiary care medical center located in East Norriton, Montgomery County. Einstein Montgomery opened in August 2012 and is part of the Einstein Healthcare Network, a private, non-profit healthcare organization. Einstein Healthcare Network is also comprised of Einstein Medical Center Philadelphia, the largest independent academic medical center in the Philadelphia region; Einstein Medical Center Elkins Park; MossRehab, a provider of comprehensive rehabilitation services; and Willowcrest, a skilled nursing facility.

Einstein Montgomery offers a wide range of healthcare programs and services, from community education programs and preventive medicine to complex care requiring advanced technology and expertise. 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 keeping with this mission, Einstein Montgomery received the HealthyWoman designation by the PA Department of Health to provide free cervical and mammogram screenings to uninsured and underinsured patients.

In addition to its affiliation with Thomas Jefferson University, Einstein Healthcare Network also has academic associations with a number of 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.

Einstein Montgomery operates one of the most experienced labor and delivery programs in the region, with more than 2,200 babies born at the facility each year. 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.

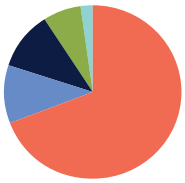
Einstein Montgomery also operates the Nurse-Family Partnership, a nationally recognized, evidence-based program that provides home visits by specially trained nurses to first time pregnant moms through the child's second birthday. The program provides skills and resources to the client for optimum prenatal care and a healthy birth outcome.

MISSION

With humanity, humility and honor, to heal by providing exceptionally intelligent and responsive healthcare and education for as many as we can reach.

DEMOGRAPHICS

RACIAL COMPOSITION



2% | Other
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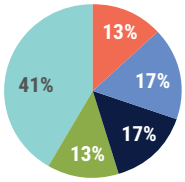
11% | Black
11% | Asian
70% | White

INCOME DISTRIBUTION



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$75,000-$99,999
$50,000-$74,999
$25,000-$49,999
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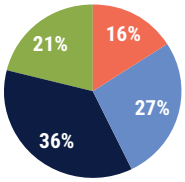

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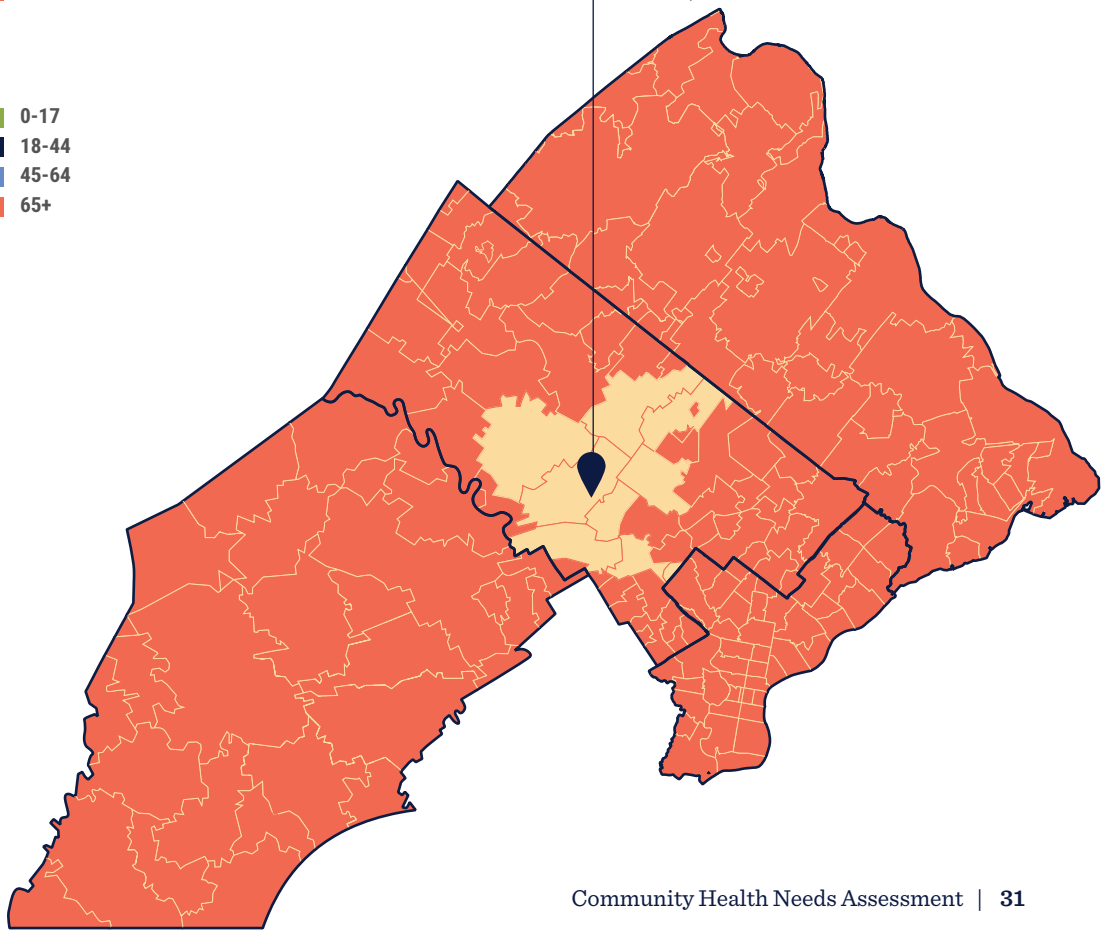
65+

Targeted Service Area for Community Health Improvement

Einstein Medical Center Montgomery defines its targeted service area as the following ZIP codes in Montgomery County. These areas represent 75% of Einstein Montgomery's inpatient admissions and a total population of 278,830.

Montgomery County: 19401, 19403, 19405, 19406, 19422, 19426, 19428, 19446, 19454



BEDS	EMPLOYEES	PHYSICIANS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
171	1,377	426	12,459	209,632	43,016

Einstein Montgomery has been the recipient of many awards and accolades. For stroke care, EMCM was awarded the American Heart Association/American Stroke Association's Get with the Guidelines®-Stroke Bronze Quality Achievement Award and The Joint Commission Advanced Certification as Primary Stroke Center. The Joint Commission also awarded their Gold Seal of Approval® to Einstein Medical Center Montgomery's Hip and Knee Joint Replacement Program. Einstein Montgomery is a Certified Chest Pain Center by the Society of Cardiovascular Patient Care with the American College of Cardiology and is also designated as a Center of Excellence in Bariatric Surgery by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program

The Breast Health Program at Einstein Montgomery also received recognition, earning accreditation from the National Accreditation Program for Breast Centers, a program of the American College of Surgeons.

The three-year accreditation is given to those centers that have voluntarily committed to provide the highest level of quality breast care and that undergo a rigorous evaluation process and review of their performance. Einstein Montgomery's Breast Health Program is also an accredited Breast Imaging Center of Excellence by the American College of Radiology.

For cancer care, Einstein Montgomery's Department of Radiation Oncology earned full three-year Accreditation from the American College of Radiology. This ACR accreditation signifies that the radiation treatment received by cancer patients meets the highest standards for quality and safety. Additionally, the hospital's Cancer Program earned three-year national accreditation from the Commission on Cancer of the American College of Surgeons.

COMMUNITY BENEFIT STATEMENT

Einstein Montgomery continues to address the unmet health needs in its service area by increasing access to care and expanding its reach in the community. As a result of the FY16 Community Health Needs Assessment, we strategically focused on the following priority areas:

- **Primary and specialty care** – Outpatient care was expanded to include primary, pediatric and specialty care offices in King of Prussia, Collegeville, Lansdale and Blue Bell.
- **Prenatal Care** – Having a disproportionatly high infant mortality rate, we are committed to improving birth outcomes for our most vulnerable population in Norristown. Here, Einstein Montgomery offers the CenteringPregnancy program which incorporates the excellence of Einstein care with a peer-support focus to develop an innovative group care model that reduces healthcare disparities and provides health promotion to improve pregnancy outcomes and reduce infant mortality. To increase our reach and better meet the health needs of our communities, the Genuardi Family Foundation Maternal Health Center recently began offering services at Einstein's Women's Associates for Healthcare OB/GYN office in Collegeville. We also implemented the Nurse-Family Partnership program, a nationally recognized and evidence-based program that provides one on one nurse care to low income, first time pregnant mothers from pregnancy up to the child's second birthday. In addition to personal home visits, the program also promotes pregnancy planning, strengthening family protective factors and enhancing early childhood development.
- **Mental Health Services** – Behavioral health counselors are available in our primary care, OB/GYN and pediatric offices on a rotating basis to allow for direct access to care. In addition, a Certified Recovery Specialist has been added to the Emergency Department to provide counseling services to those presenting with drug and alcohol addiction problems.
- **Cultural Outreach and Wellness program initiatives** – This includes community education and wellness initiatives for Korean, Latino and Asian/Pacific Islander populations that includes free health screenings and chronic disease management.

Einstein Montgomery works collaboratively to strengthen community partnerships that leverage resources and address the social determinants of health that impact a population. Current initiatives include addressing food insecurity and access to healthy food through an onsite garden that provides fresh produce and nutrition education to patients in Norristown. In addition, Einstein Montgomery and Montgomery County Department of Health and Human Services initiated a campaign to promote safe housing that includes the Cribs for Kids program and home safety for aging adults.

MISSION

With humanity, humility and honor, to heal by providing exceptionally intelligent and responsive healthcare and education for as many as we can reach.

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 has now grown to become Einstein Healthcare Network (EHN), a leading private, 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.

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

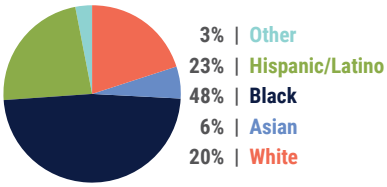
BEDS	EMPLOYEES	PHYSICIANS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
794	6,676	783	26,118	392,956	119,734

EMCP is a tertiary care teaching hospital with a Level One Trauma Center providing training for more physicians than any independent academic medical center in Philadelphia. EMCP serves more than 400 residents in 30 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. As a whole, EHN trains more than 3,500 health professional students each year.

demographics

RACIAL COMPOSITION



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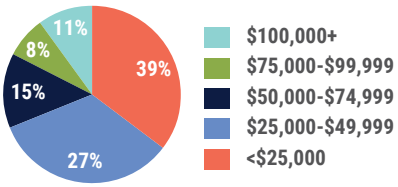

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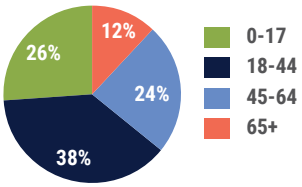


Targeted Service Area for Community Health Improvement

EMCP/EMCEP define their targeted service area as the following ZIP codes in Philadelphia. These areas represent 75% of EMCP/EMCEP's inpatient admissions and a total population of 562,122.

Philadelphia County: 19111, 19119, 19120, 19124, 19126, 19134, 19138, 19140, 19141, 19144, 19149, 19150

As one of the six hospitals providing obstetrical care in Philadelphia, EHN handles many of the area's deliveries, averaging more than 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 the three major components of care, health assessment, education, and support, into unified programs in group settings. 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 and as a Baby-Friendly birth facility (2019-2023) by the World Health Organization and the United National Fund.

Families Understanding Nutrition (FUN) is a collaborative partnership between Einstein and more than 45 agencies, including the School District of Philadelphia, Pottstown School District, and the Montgomery County Family Services, 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. Seventy-eight percent of PA SNAP-Ed preschool participants are located in a major urban area. The majority of programming (82%) is provided by Einstein Medical Center Philadelphia in Philadelphia and Montgomery Counties.

MossRehab is a national and international leader in rehabilitation medicine, ranked the number one rehabilitation hospital in Pennsylvania and number ten in the nation by U.S. News and World Report.

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.

Among many other accolades EMCP has achieved, the Department of Radiation Oncology received accreditation from the American College of Radiology and 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 has been recognized by the American Heart Association and the American Stroke Association with the Get With the Guidelines® Heart Failure Gold Plus Quality Achievement Award and the Stroke Gold Plus Quality Achievement Award for adherence to standards of care for heart failure and stroke patients.

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 CHNA was performed in the fall of 2015 to determine the health status and health care needs of residents of Einstein Healthcare Network, Einstein Medical Center Philadelphia's service area. As a result of this CHNA, EMCP/EMCEP adopted strategies to address the following needs:

- Early prenatal care through implementation of CenteringPregnancy® and a CenteringParenting® programs and Baby Friendly Designation to reduce infant mortality.
- 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.

GVH 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 particular expertise in bariatrics, cancer care, cardiology, orthopedics, surgery, women's & children's health, and post-acute care.

The hospital's cardiology program received the American Heart/American Stroke Association's Get With The Guidelines®-Heart Failure Gold Plus Quality Achievement Award in 2018, while the stroke care program was awarded Primary Stroke Center Certification from The Joint Commission and Gold Seal of Approval™ from the American Heart Association and the American Stroke Association.

MISSION

Leading our community to a healthier future

Grand View Health has received seven consecutive "A" ratings from Leapfrog Hospital Safety Grade. Grand View Health also operates several outpatient locations in Bucks and Montgomery Counties, many of which offer early morning, evening, and weekend hours, making care convenient and highly accessible. Furthermore, HomeCare Elite has named Grand View Health a top-rated Home Care agency for the past seven years running.

In 2018, Grand View Health joined the Penn Cancer Network, part of Penn Medicine, to allow patients in the Grand View Health service area to access subspecialty and expert cancer care. With the formation of a strategic alliance, Grand View Health and Penn Medicine work jointly to develop innovative programs and initiatives to improve patient care in the community.

VISION Recognized for excellence— chosen for caring

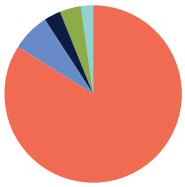
BEDS	EMPLOYEES	PHYSICIANS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
175	1,700+	380	10,316	105,039	30,200

Additionally, with the creation of CHOP Pediatric Care at Grand View Health, a CHOP pediatrician is available on-site at Grand View's main campus at all times, allowing for access to high quality pediatric and neonatal care.

Grand View Health also hosts students from various nursing and radiology programs throughout Southeastern Pennsylvania.

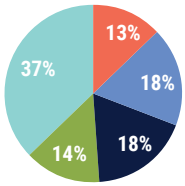
demographics

RACIAL COMPOSITION



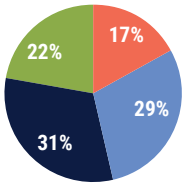
2% | Other
4% | Hispanic/Latino
3% | Black
7% | Asian
84% | White

INCOME DISTRIBUTION



$100,000+
$75,000-$99,999
$50,000-$74,999
$25,000-$49,999
<$25,000

AGE DISTRIBUTION



0-17
18-44
45-64
65+

Targeted Service Area for Community Health Improvement

Grand View Health defines its targeted service area as the following ZIP codes in Bucks and Montgomery Counties. These areas represent 75% of Grand View's inpatient admissions and a total population of 212,326.

Bucks County:

18944, 18951, 18960

Montgomery County:

18073, 18964, 18969, 19440, 19438, 19446

Impact of Prior Community Health Needs Assessment and Implementation

Grand View Health's 2016 Community Health Needs Assessment identified the following health issues in the community:

1. Obesity in adults and children
2. Diabetes in adults and children
3. Cardiovascular health
4. Lung disease
5. Cancer prevention, screenings and services
6. Behavioral health

The first three issues are dependent on individuals' active lifestyles and dietary choices, and action plans involved eating and exercise education programs. Grand View programs range from a bariatric surgery program and support group to online "Grand New You" nutritional counseling. An exercise group called "Get Fit with a Doc" was initiated to encourage activity.

Action plans for lung disease and cancer prevention focused on smoking cessation programs. Grand View Medical Practices have been proactive in reminding their patients to schedule cancer screenings annually. Most recently, Grand View Health joined the Penn Cancer Network, part of Penn Medicine, to allow patients in the Grand View Health service area to access subspecialty and expert cancer care.

Behavioral health has been addressed in our Emergency Room (ER) with crisis workers from 7 a.m. to 11 p.m. for ER admissions. Our practices have begun to integrate with a behavioral health group to address issues in the community. We will continue to create new action plans around this health issue as it has moved up the rankings in our recent assessment.

Overall community engagement has been strong. Nearly 700 persons have participated in a bariatric info session or support group, 200 in a lung health or smoking cessation class and up to 50 participate in the walking program twice a month from spring through fall each year.

With an emphasis on providing a continuum of care, Holy Redeemer Health System remains true to the mission to care, comfort, and heal that its sponsors, the Sisters of the Redeemer, began in our region in 1924 – to provide high quality, compassionate care.

Today, Holy Redeemer 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 active living community, a transitional housing program for homeless families, and a home for independent, intellectually disabled adults. With corporate offices in Huntingdon Valley, PA, Holy Redeemer Health System is a Catholic healthcare provider, serving southeastern Pennsylvania and 12 counties in New Jersey, from Union County south to Cape May County.

Among its wide array of clinical services, Holy Redeemer Hospital places a particular focus on Women's Health and Older Adult Health. The hospital has highly regarded programs in obstetrics and gynecology, overseeing 2,659 deliveries in FY18; high risk maternal-fetal medicine; neonatal intensive care; breast and heart health; gynecologic oncology; and natural women's health. Holy Redeemer Hospital is a recipient of the Independence Blue Cross Distinction for Maternity Care and has received accreditation with the Commission on Cancer and with the National Accreditation Program for Breast Centers.

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.

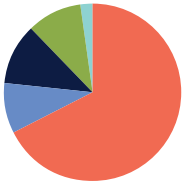
INPATIENT BEDS	EMPLOYEES	PHYSICIANS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
239 plus 21 in hospital-based skilled nursing facility	**4,879**	**661**	**9,806**	**155,828**	**29,642**

Holy Redeemer Hospital also maintains a cardiovascular center, a 24-bed inpatient senior behavioral health unit, a transitional care unit, a wound care center, and a cancer center to address the needs of the community it serves. In recognition of these efforts, the hospital has been designated as an Aetna Institute of Quality in Spine/ Orthopedics and an Independence Blue Cross Blue Distinction Center for Knee and Hip Replacement. Holy Redeemer Hospital has also been awarded the Get with the Guidelines® Stroke Gold Plus Award and the Mission Lifeline Gold Award STEMI, both from the American Heart Association; DNV GL certification as a primary stroke center; and Accreditation for Cardiovascular Excellence. The hospital's cardiovascular program maintains a partnership with Doylestown Health.

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.

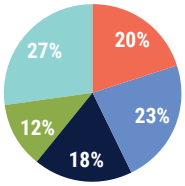
demographics

RACIAL COMPOSITION



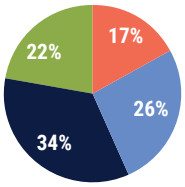
2% | Other
10% | Hispanic/Latino
11% | Black
9% | Asian
67% | White

INCOME DISTRIBUTION



$100,000+
$75,000-$99,999
$50,000-$74,999
$25,000-$49,999
<$25,000

AGE DISTRIBUTION



0-17
18-44
45-64
65+

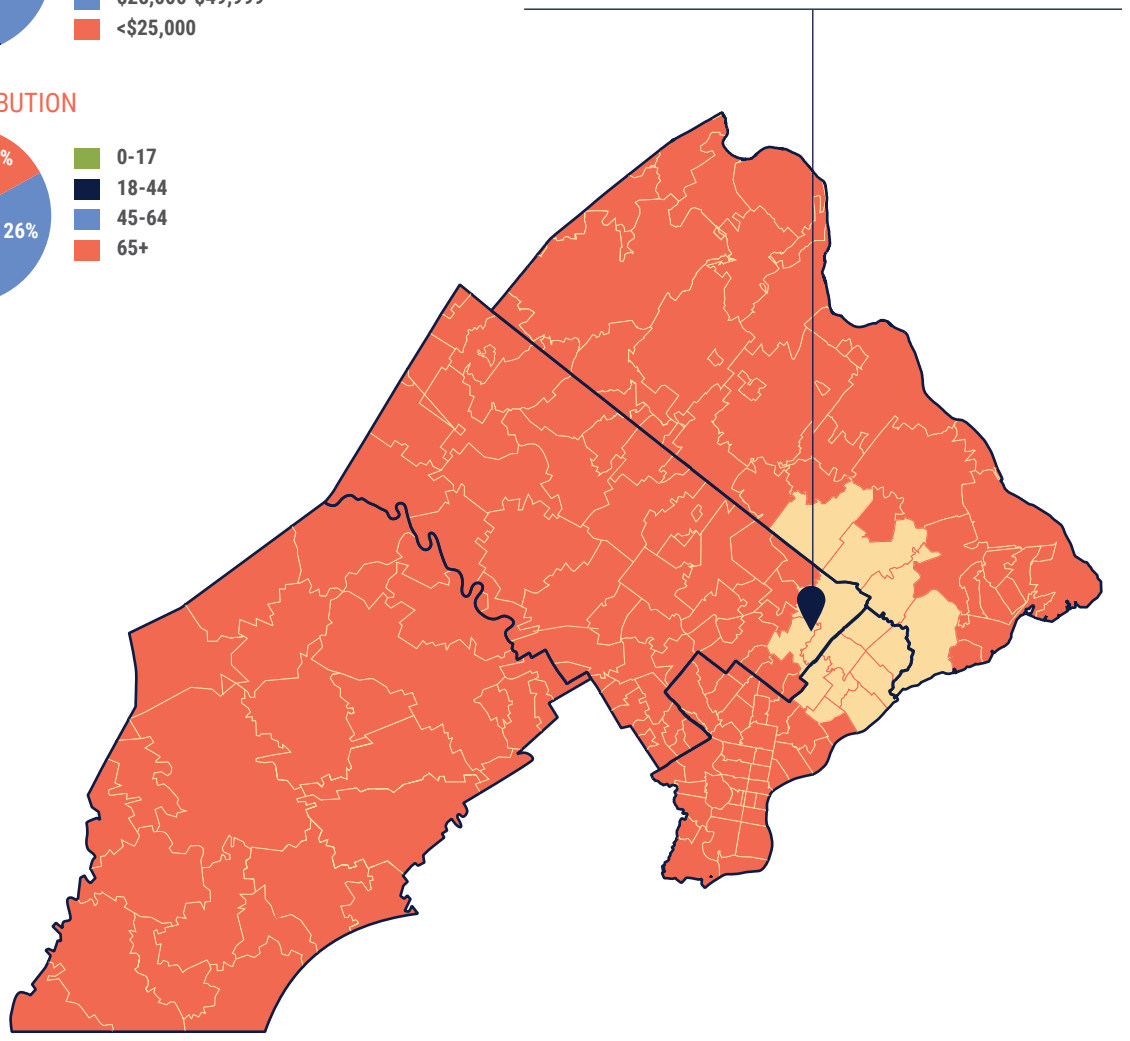
Targeted Service Area for Community Health Improvement

Holy Redeemer Hospital defines its targeted service area as the following ZIP codes in Bucks, Montgomery, and Philadelphia Counties. These areas represent 75% of Holy Redeemer's inpatient admissions plus nearby areas and a total population of 531,546.

Bucks County: 18966, 18974, 19020, 19053

Montgomery County: 19006, 19009, 19046

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



Impact of Prior Community Health Needs Assessment and Implementation

Holy Redeemer's 2016 priorities were based on three criteria: problem magnitude; strategic plan alignment; and resource availability. Ranked needs and actions include the following:

- **Prenatal Care** — Activities included Holy Redeemer's obstetrical and family practice physicians focus on early access to prenatal care with all patients, Medicaid sign ups to ensure insurance access, and education throughout social media and hospital publications.

- **Mental Health, including behavioral and substance abuse** — Activities included integrating behavioral health specialists into primary care practices, implementing depression screenings, working collaboratively with hospitals and mental health organizations on improving access and services in Montgomery County, and identifying a hospital location for the disposal of controlled substances.

- **Healthy Living** including nutrition, exercise, screenings, smoking cessation, etc. to have an impact on prevention, identification and management of health conditions. Activities included biannual Healthy Kids run, smoking cessation classes, lung cancer screenings, healthy drink and food options on campus, free mammogram and cervical screenings, community garden, community events, local elementary school partnerships in gardening and healthy eating, food pantries, food insecurity screening and referral in collaboration with other regional partners, among other activities.

- **Access to care, focused on access to medications and literacy** – Activities included new outpatient pharmacy allowing patients to acquire medications before discharge, including bedside delivery, analyzinginsurance and medicationsfor the cheapest alternative possible even if it directs to other providers, working with a regional health literacy coalition to address health literacy needs and improving understanding.

JEFFERSON HEALTH – NORTHEAST

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Health – Northeast, comprised of Jefferson Bucks Hospital, Jefferson Frankford Hospital, and Jefferson Torresdale Hospital, is a part of Jefferson Health serving Northeast Philadelphia and eastern Bucks County. All three Jefferson Health – Northeast hospitals are in the top 5% in the nation for overall clinical excellence, as designated by Healthgrades America's 250 Best Hospital™.

MISSION

We Improve Lives.

VISION

Reimagining health, education and discovery to create unparalleled value.

In recent years, Jefferson Health – Northeast has endeavored to improve access to and convenience of care by streamlining their scheduling system. The health system added a dedicated Scheduling Advocate Program and successfully built and operationalized online appointment scheduling functionality for all employed Northeast primary care physicians and specialists. Additionally, Jefferson Health – Northeast's Central Scheduling Department was redesigned to vastly improve average answer times and abandonment rates. Improved access has provided the opportunity to expand outpatient testing hours at multiple sites and introduce a same-day mammography appointment initiative. Jefferson Torresdale Hospital has also taken strides to enhance patient experience by improving communication with nurses and providing education and resources to staff regarding communication about medications. All of these efforts are in keeping with JH-NE's value of service-mindedness and putting people first.

VALUES

Jefferson'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

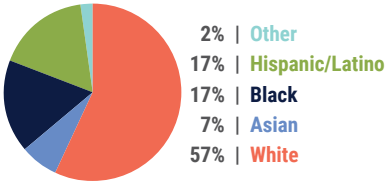
Jefferson Health – Northeast also successfully implemented a functional status initiative aimed to improve patient outcomes. The Boston-Ampac functional assessment tool replaced nursing admission and daily assessment in an effort to decrease length of stay, complications, skilled nursing facility utilization, and unnecessary physical therapy and occupational therapy consultations to improve prioritization and patient experience. A collaborative effort to include physician, physical medicine and rehabilitation, and nursing engagement, along with hands-on education, was essential to the successful launch.

This year the American Heart Association honored Jefferson Health – Northeast facilities with several awards, including the Get with the Guidelines® – Coronary Artery Disease Mission: Lifeline Gold Plus award, the Plus Measure for Mission: Lifeline award, the Target Stroke Honor Roll-Elite Plus award, and the Gold Plus Quality Award. Jefferson Bucks Hospital also recently successfully planned and implemented expanded cardiovascular services, including a STEMI Program, in close partnership with Bucks County EMS. Additionally, Jefferson Health – Northeast sits in the top decile in the nation for observed over expected mortality.

BEDS	EMPLOYEES	PHYSICIANS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
464	4,000	687	23,489	114,200	128,829
Torresdale: 253 **Frankford: 115** **Bucks: 96**					

demographics

RACIAL COMPOSITION



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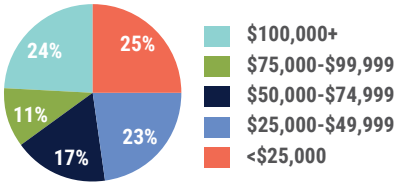

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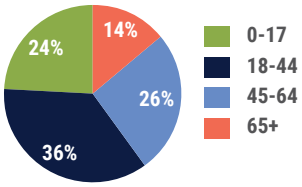


Targeted Service Area for Community Health Improvement

Jefferson Health – Northeast defines its targeted service area as the following ZIP codes in Bucks and Philadelphia Counties. These areas represent 70% of inpatient admissions and a total population of 1,042,189.

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

Philadelphia County: 19111, 19114, 19115, 19116, 19120, 19124, 19125, 19134, 19135, 19136, 19137, 19140, 19149, 19152, 19154

Impact of Prior Community Health Needs Assessment and Implementation

At Jefferson, we recognize that by providing quality health care to our patients, and education and outreach to our neighbors, we are also enriching the lives and future of our surrounding community. Our work extends beyond the bedside. By partnering with our community, Jefferson Health 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 completed and published its second Community Health Needs Assessment and three-year Implementation Plan in 2016, 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)
- **Alcohol/Substance Abuse**
- **Smoking Cessation**
- **Access to Healthy Affordable Food and Nutrition Education and Food Security**
- **Health Education, Social Services and Regular Source of Care**
- **Social and Health Care Needs of Older Adults**
- **Women's Cancer**

In FY 2018, Thomas Jefferson Northeast provided $28,693,538 of services to individuals in our community seeking care or information. This community benefit is delivered 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

Full copies of the 2018 Community Health Needs Assessment and related implementation plan are available at https://www.ariahealth.org/community-health/community-health-dashboard.

MISSION

We Improve Lives.

VISION

Reimagining health, education and discovery to create unparalleled value.

Jefferson Health locations in Center City have major programs in a wide range of clinical specialties. Services are provided at five primary locations. Three are highlighted here: Thomas Jefferson University Hospital (TJUH), the main hospital facility, established in 1825 and located in Center City Philadelphia; Jefferson Hospital for Neuroscience (JHN), also located in Center City; and Jefferson Methodist Hospital (JMH), in South Philadelphia. Services are also provided at Jefferson at the Navy Yard, in South Philadelphia, and Jefferson at Voorhees in South Jersey.

Jefferson Health is associated with Jefferson (Philadelphia University + Thomas Jefferson University), a comprehensive university focused on transdisciplinary, experiential professional education that is designed to deliver high-impact education and value. The University envisions and creates new fields for the 21st century, crossing traditional discipline boundaries and focusing on emerging professions.

Affordability and employability are pivotal value propositions for students and their families. Jefferson draws upon concepts like the continuum of education, bridging the undergraduate/graduate divide, co-curricular innovation, and lifelong learning. The University emphasizes impactful programmatic, clinical and applied research that embraces the benefits of an integrated approach.

TJUH continues to top the list of hospitals in Pennsylvania (3rd) and the Philadelphia metro area (2nd) in the 2018-2019 U.S. News & World Report's annual listing of the best hospitals and specialties. Along with JHN and JMH, TJUH is Magnet® Designated. Additionally, TJUH and JMH have received Leapfrog "A" ratings for six and five of the past eight rating periods, respectively. In 2018 TJUH was also recognized with the 2018 HealthGrades Distinguished Hospital Award for Clinical Excellence,™ as one of HealthGrades's America's 100 Best Hospitals,™ and was named as one of Becker's 100 Great Hospitals in America.

Several clinical programs at TJUH have also been recognized for outstanding performance. The Sidney Kimmel Cancer Center is one of only 70 designated National Cancer Institute (NCI) Centers and one of only eight NCI-designated Prostate Centers of Excellence. 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.

VALUES

Jefferson'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:

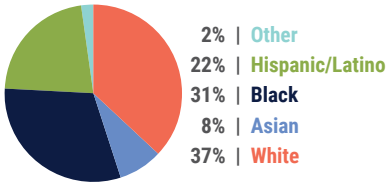
Put People First:
Service-Minded, Respectful & Embraces Diversity

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

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

demographics

RACIAL COMPOSITION



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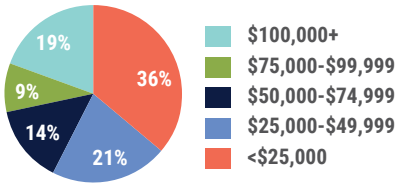

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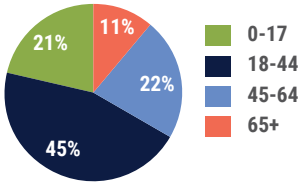


Targeted Service Area for Community Health Improvement

Jefferson Health defines its targeted service area as the following zip codes in Philadelphia. These ZIP codes are the most geographically proximate to TJUH, JHN and JMH campuses. The focus within these zip codes is on communities with a poverty rate >20% and where health disparities are more prevalent. These areas represent a total population of 592,693.

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

BEDS	EMPLOYEES	PHYSICIANS	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS
908	9,059	933	39,969	1,374,545	116,381

TJUH's transplant program received a five-star rating from the Scientific Registry of Transplant Recipients for Kidney & Liver transplant 1 year survival rates and is recognized as a Blue Distinction Center for liver, pancreas, and bone marrow/stem cell transplants. TJUH is also an Aetna Institute of Excellence™ Transplant Facility for bone marrow, heart, kidney, pancreas, and liver transplants.

TJUH also earned recognition as a HealthGrades 100 Best Hospitals for Cardiac Care™ (2018-2019) and Coronary Intervention™ (2016-2019) and as a Blue Distinction Center Plus in cardiac care. The heart and vascular program also received Aetna Institute of Quality® Designation for Cardiac Medical Intervention and Cardiac Rhythm and the American Heart Association Stroke Gold Plus, Target: Stroke Elite Plus Honor Roll, and the American Heart Association/American Stroke Association/The Joint Commission Comprehensive Stroke Center Certification. The Joint Commission also awarded the Ventricular Assist Device Therapy Facility Advanced Certification.

The Rothman Institute at TJUH is currently ranked #4 by US News and World Report and has been seated in the top 20 for 15 years running. The Rothman Institute at Jefferson was the first hospital to earn the advanced Joint Commission certification for Total Hip & Total Knee Replacement and has been named one of HealthGrades 100 Best Hospitals for Joint Replacement™ from 2016-2018. The Institute is also a Blue Distinction Center for Spine Surgery and performs approximately 25,000 procedures annually.

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 earned recognition as a HealthGrades 100 Best Hospitals for Neurosciences Excellence™ (2017-2019) and also received the HealthGrades Stroke Care Award™ (2016-2019).

The Institute is also home to the first and only center in Philadelphia dedicated solely to ALS research, the Frances & Joseph Weinberg Research Unit in the Jefferson Weinberg ALS Center, and is one of the nation's 14 federally designated Model Spinal Cord Injury (SCI) Centers.

Jefferson Health also stands out as among the best in several other specialty areas, receiving national rankings for ear, nose & throat; gastroenterology & GI surgery; nephrology; ophthalmology; geriatrics; and urology programs.

Impact of Prior Community Health Needs Assessment and Implementation

At Jefferson, we recognize that by providing quality health care to our patients, and education and outreach to our neighbors, we are also enriching the lives and future of our surrounding community. Our work extends beyond the bedside. By partnering with our community, Jefferson Health 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 completed and published its second Community Health Needs Assessment and three-year Implementation Plan in 2016, which addresses the following priority health needs for the population of Jefferson's Community Benefit area:

- **Access to Care –** Workforce Development and pipeline programs, Health Insurance, Culturally Competent Care and Language Access, Hospital and Emergency Department (ED) Utilization, Regular Source of Care
- **Chronic Disease Prevention and Management –** Obesity, Heart Disease, Hypertension, Diabetes and Stroke
- **Health Screening and Early Detection –** Colon Cancer, Women's Cancer
- **Social and Health Care Needs of Older Adults**

In FY 2018, Thomas Jefferson University Hospitals provided $133,883,582 of services to more than 114,000 individuals in our community seeking care or information from Jefferson. This community benefit is delivered 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 as well as programs that address social determinants of health such as homelessness, food access/security and health literacy

Full copies of the 2013 and 2016 Community Health Needs Assessments, related implementation plans, and evaluation are available at https://hospitals.jefferson.edu/about-us/in-the-community/community-health-needs-assessment.html.

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 $7.8 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 2018 fiscal year, Penn Medicine provided more than $500 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 $810 million in annual sponsored research and is consistently among the nation's top recipients of funding from the National Institutes of Health, with $425 million awarded in the 2018 fiscal year. The School of Medicine has more than 750 M.D. students, 1,300 residents and fellows, and 2,600 full-time faculty members. In the City of Philadelphia, UPHS' patient care facilities include: The Hospital of the University of Pennsylvania, Penn Presbyterian Medical Center, and Pennsylvania Hospital. With 1,655 licensed hospital beds in Philadelphia, UPHS is a valued health care resource in the community.

» 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 University of Pennsylvania's medical school, the Perelman School of Medicine. Today, it has 18 clinical departments and provides training in more than 40 clinical specialties. HUP's 3.7 million-square foot campus is a hub for innovative medical care. Major areas of clinical focus 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.

BEDS	RESIDENTS AND FELLOWS	FULL-TIME FACULTY	INPATENT ADMISSIONS	OUTPATIENT VISITS	EMERGENCY DEPT. VISITS	BIRTHS
1,655	1,344	2,624	71,852	2.4M	147,495	9,652

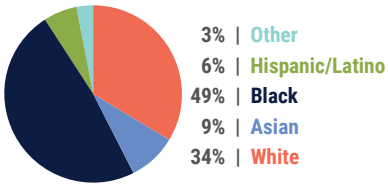
- Penn Presbyterian Medical Center (PPMC) is consistently recognized as a center of excellence for cardiac care, ophthalmology, neurosciences, and the Musculoskeletal Center's outpatient facility – Penn Medicine University City. PPMC is also home to Penn Medicine's Level 1 Trauma Center, which operates around the clock to care for patients who have been critically injured in car accidents, falls, and through blunt and penetrating traumas. Each year the Penn Medicine Trauma Center cares for more than 2,000 patients, several hundred of whom are transferred from other hospitals.

- 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 260 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.

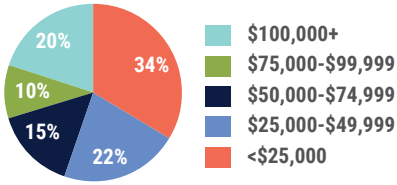
In keeping with its charitable purpose, UPHS accepts patients in serious need of medical care regardless of their financial status. UPHS also provides care to patients who do not have health insurance or meet the criteria to qualify for its charity care policy. In fiscal year 2018, Penn Medicine provided $279.7 million in charity and underfunded care for Medicaid families. UPHS operates emergency rooms open to the public 24 hours a day, 7 days a week; maintains research facilities for the study of disease and injuries; provides facilities for teaching and training various students and medical personnel; facilitates the advancement of medical and surgical education; provides various community services. These include providing basic medical care for the homeless; treating of chronic disease for low-income residents; providing women's health services to uninsured and low-income women of all ages; conducting screenings for the detection of breast, colorectal, and skin cancer; and facilitating cancer support groups and health education classes. UPHS also partners with many entities, including local government, foundations, and fellow non-profit organizations to extend the reach of its services in the community.

demographics

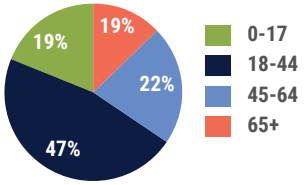
RACIAL COMPOSITION



INCOME DISTRIBUTION

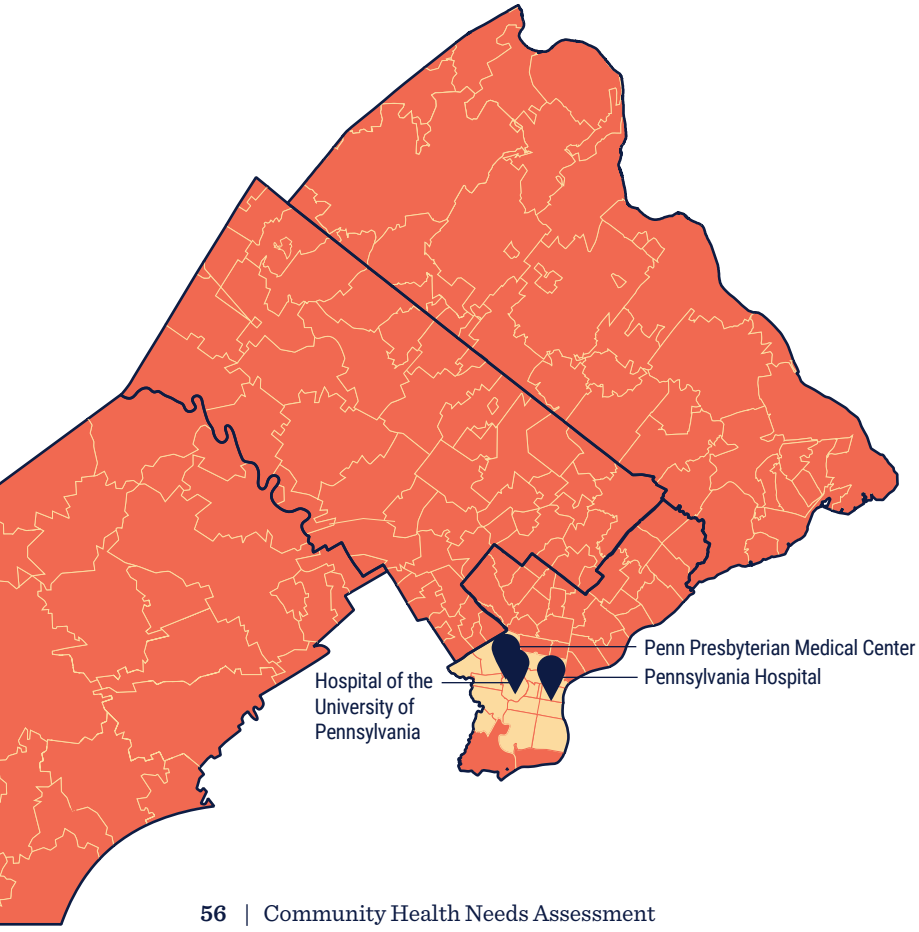


AGE DISTRIBUTION



Impact of Prior Community Health Needs Assessment and Implementation

Penn Medicine faculty, staff, and students throughout the organization donate their time and expertise to provide countless hours of work to improve the health and well-being of the communities we serve. Propelled by our missions of patient care, education and research, Penn Medicine works with its surrounding communities to foster change by cultivating and growing roots within them. A few of Penn Medicine's signature programs, developed in response to community needs, include supporting a robust network of free safety-net clinics such as Puentes de Salud and Prevention Point Philadelphia; the Penn Medicine Educational Pipeline and Penn Medicine Academy High School Pipeline programs which aim to give underserved students a better chance at pursuing a career in science, medicine, and health care; and Penn Medicine's Mobile CPR Project and Stop the Bleed Program which aim to make a dent in the city's poor survival rates from cardiac arrest and traumatic injuries, respectively.



Targeted Service Area for Community Health Improvement

For purposes of the Community Health Needs Assessment, the targeted service area of Penn Medicine's Philadelphia-based hospitals includes 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 and represents a total population of 577,970. Philadelphia County:

19102, 19103, 19104, 19106, 19107, 19109, 19121, 19123, 19130, 19131, 19139, 19142, 19143, 19145, 19146, 19147, 19148, 19151

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 460 community projects. More information about the CAREs Grant program and our Community Benefit programs can be found here: https://www.pennmedicine.org/about/serving-our-community/reports

In response to community needs identified in 2016, Penn Medicine has developed a number of programs including, but not limited to:

- **Primary Care Service Line.** Launched in July 2017, the Primary Care Service Line was implemented as a strategy to create a unified Penn Primary Care across the region's largest primary care network with 88 practices and over 500 providers.
- **Behavioral Health Integration.** The Collaborative Care Behavioral Health (CCBH) initiative was launched in January of 2018 to integrate behavioral health care in the primary care setting. CCBH works to proactively identify patients who have unmet behavioral health care needs, and provides assessment and treatment as needed during primary care appointments.
- **Women's Health.** Penn Medicine provides prenatal care at Federally Qualified Health Centers (FQHCs) in Philadelphia through the departments of Family Medicine and Community Health, and Obstetrics and Gynecology. Additionally, at Pennsylvania Hospital, The Ludmir Center and Latina Community Health Services (LCHS) provide quality medical care as well as social work support and health education to all patients, regardless of their ability to pay. Developed to serve Hispanic, undocumented women through ongoing and high-risk obstetric and gynecological care, prenatal diagnostic testing (ultrasound, biophysical profiles, non-stress tests), laboratory testing, contraceptives, cervical cancer screening, and medications to treat sexually transmitted diseases (STDs), LCHS has served the healthcare needs of over 1,000 women.
- **Coordinated Health Improvement & Education.** Penn Medicine has a partnership with Puentes de Salud to promote the health and wellness of South Philadelphia's rapidly growing Latino immigrant population through high-quality health care, innovative educational programs, and community building. Additionally, for 2018, Penn Medicine partnered with the American Heart Association and the Philadelphia Housing Authority (PHA) to provide a series of events aimed to reach the more than 80,000 residents of PHA. The events take place in the community, at PHA buildings and complexes and offer blood pressure screenings, education on health, nutrition, and exercise, as well as opportunities to link to primary care. Finally, Penn's IMPaCT (Individualized Management for Patient-Centered Targets) program continues to not only guide outreach in the Philadelphia area but also across the country. IMPaCT trains community health workers (CHWs) to help high-risk patients navigate the healthcare system and address key health barriers, such as housing stability, trauma, or food insecurity.
- **Cancer Screening and Prevention.** The Penn Medicine Colorectal Cancer Screening Navigation Program offers personalized access to navigators from the first phone call to the completion of the screening to assist with colonoscopy scheduling, translator services, prep materials, and SEPTA transportation.

In addition to the participating hospitals and health systems, the organizations below provided support to the CHNA process.

Chester County Health Department (CCHD)

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, services, and programs to Chester County residents. The Health Department embraces the public health principle of "community as client," promoting the health of families, groups, and communities through coordinated efforts across the Bureau of Administrative and Support Services, the Bureau of Personal Health Services, the Bureau of Environmental Health Protection, and the Division of 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; health education; and much more. Chester County Health Department also leads Chester County's Community Health Improvement Planning Partnership, working with partners to assess health status, identify community health priorities, and advocate for policies and practices that promote health and wellness throughout Chester County.

Chester County Health Department supported Chester County Hospital in conducting community meetings and assisted the Philadelphia Department of Public Health with data requests.

Health Care Improvement Foundation (HCIF)

The Health Care Improvement Foundation (HCIF) is an independent nonprofit organization based in Philadelphia that drives high-value health care through stakeholder collaboration and targeted quality improvement initiatives. HCIF is dedicated to the vision of a responsive, coordinated health care delivery system that fulfills the needs of patients and consumers, and achieves better health. Using skills in program design, coaching, facilitation, measurement, and evaluation, HCIF's team of experts convenes stakeholders around common goals for healthcare improvement. HCIF's approach engages multi-stakeholder resources 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 Philadelphia. Through COACH and other initiatives, HCIF builds system capacity and cross-sector partnership opportunities to more effectively address social determinants of health in the five-county southeastern Pennsylvania region.

HCIF provided project management and qualitative support for the regional community health needs assessment effort.

Montgomery County Office of Public Health (OPH)

In 2018, the Pennsylvania Department of Health approved the name change of Montgomery County Health Department to Montgomery County Office of Public Health (OPH). As the Office of Public Health continues to integrate with Montgomery County Health and Human Services, public health programs will have many touchpoints with County human services, particularly Aging & Adult Services, Children & Youth, Drug & Alcohol, Mental Health and more.

It is the Mission of the Montgomery County Office of Public Health 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 Montgomery County Office of Public Health 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 meetings in Montgomery County and assisted the Philadelphia Department of Public Health with data requests.

Philadelphia Association of Community Development Corporations (PACDC)

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 $300 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 served as the lead organizer for the community meetings.

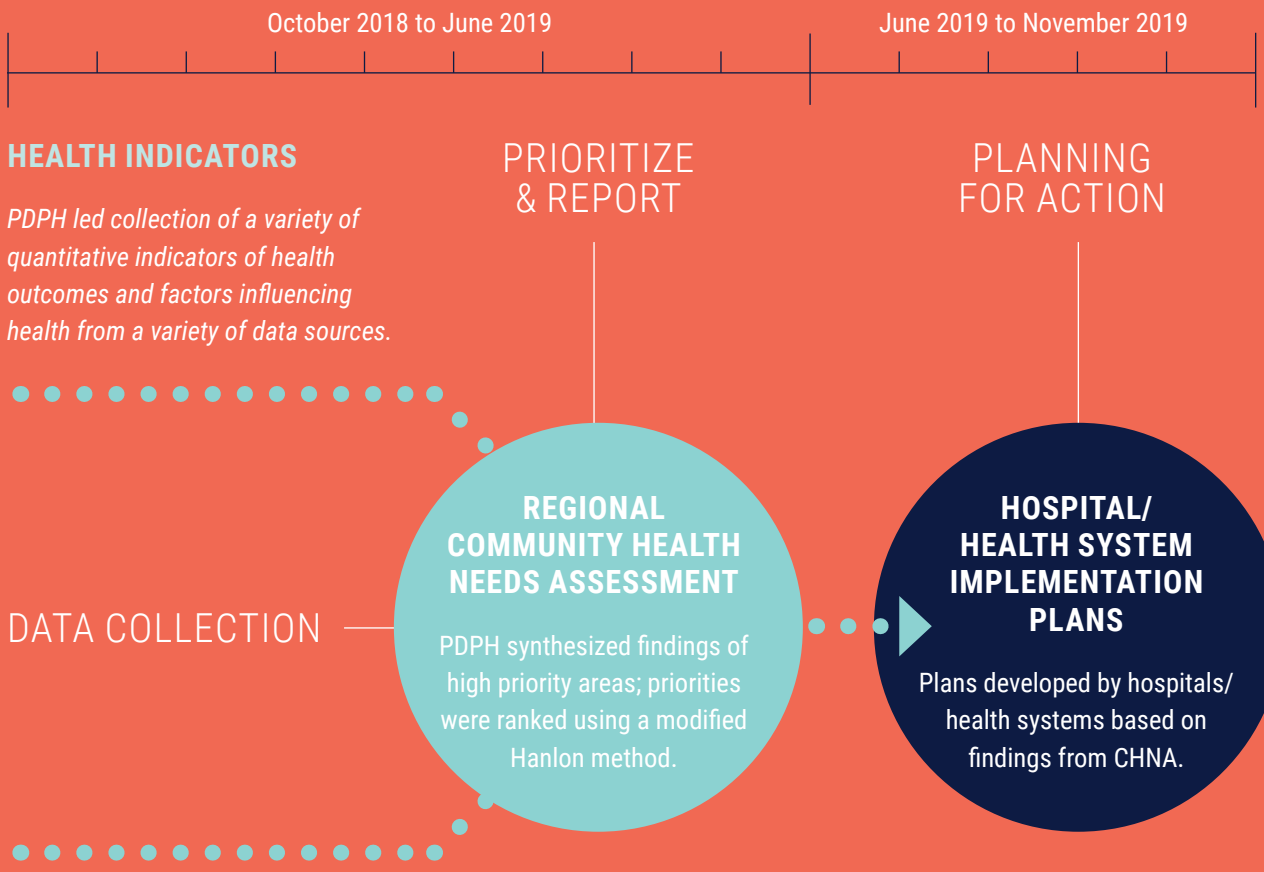
Philadelphia Department of Public Health (PDPH)

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 quantitative analyses, synthesis and prioritization of community health needs, and report development.

OUR COLLABORATIVE APPROACH

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



Governance

A Steering Committee, composed of representatives from participating hospitals and health systems, was formed to guide the development of the CHNA. The Steering Committee met once or twice each month starting in October 2018 to plan, reach consensus on key decisions, review findings and set priorities. Supporting partners also participated in Steering Committee meetings.

Steering Committee Members

Marianna Calabrese, MA	Manager, Community Benefit	Abington – Jefferson Health
Kathy McCarter, MSHA, RN, CCP	Director, Community Health	Abington – Jefferson Health
Jeanne Casner, MPH, PMP	County Health Director	Chester County Health Department
Ashley Orr, MPH	Population Health Supervisor	Chester County Health Department
Julie Funk, MS, RD, CDE, LDN	Director, Community Health & Wellness Services	Chester County Hospital
Sarah Gibbons, MSS, MLSP	Director, Community Relations	Children's Hospital of Philadelphia
Amanda Evans, MPH	Program Specialist	Children's Hospital of Philadelphia
Joan Boyce	Senior Director, Government Relations & Public Affairs	Einstein Healthcare Network
Leroy Howell	Manager, Constituency Relations	Einstein Healthcare Network
Brandi Chawaga, M.Ed	Director, Community Wellness	Einstein Medical Center Montgomery
Jo Ann Hart	Senior Director, Strategic Marketing & Communications	Grand View Health
Cynthia Westphal, MSN, RN, NE-BC	Senior Director, Nursing	Grand View Health
Susan Choi, PhD	Senior Director, Population Health	Health Care Improvement Foundation
Kelsey Salazar, MPH	Project Manager	Health Care Improvement Foundation
Barbara Tantum, MBA, MHA	Director, Planning	Holy Redeemer Health System
Maria Cerceo Slade, BA, MHA	Vice President, Marketing	Jefferson Health - Northeast
Karen Sobczak	Clinical Associate Executive Director	Jefferson Health - Northeast
Rickie Brawer, PhD, MPH, MCHES	Co-Director, Center for Urban Health	Jefferson Health
Abby Cabrera, MPH	Community Benefits Coordinator	Jefferson Health
Robert Motley, MD, MHCDS	Vice Chair, Community Medicine	Thomas Jefferson University & Sidney Kimmel Medical College
Patrice Penrose, MPH	Epidemiology Research Associate	Montgomery County Office of Public Health
Brenda Weis, MSPH, PhD	Health Administrator	Montgomery County Office of Public Health
Garrett O'Dwyer	Health Programs & Special Projects Manager	Philadelphia Association of Community Development Corporations
Heather Klusaritz, PhD, MSW	Director of Community Engagement, Penn Center for Public Health Initiatives; Associate Director, Center for Community & Population Health, DFMCH	University of Pennsylvania
Laura Lombardo	Manager, Penn Center Community Relations	Penn Medicine
Courtney Summers, MSW	Associate Director, Center for Public Health Initiatives; Senior Research Project Manager, DFMCH	University of Pennsylvania
Jessica Whitley, MPH	Health Equity Fellow	Philadelphia Department of Public Health
Raynard Washington, PhD, MPH	Chief Epidemiologist	Philadelphia Department of Public Health

Health Indicators

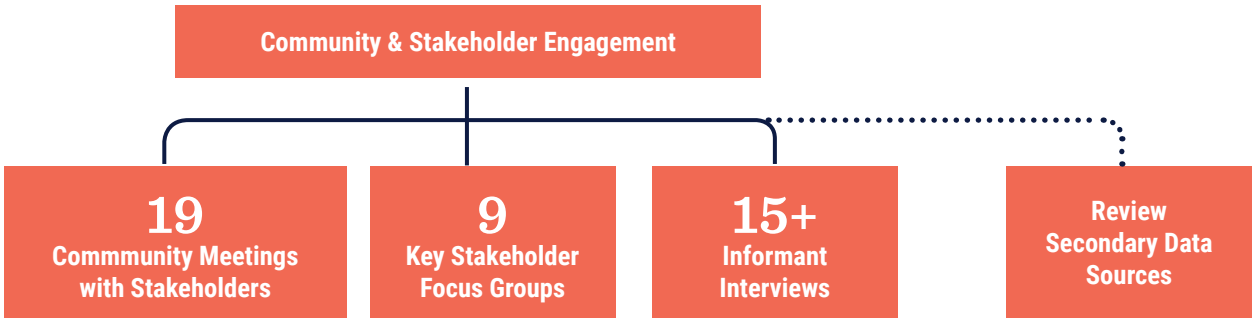
The PDPH team, which included experts in epidemiologist and geospatial analyses, produced and aggregated over 40 health indicators from primary and secondary data sources for the CHNA. Health indicators were collected by county and by zip code, wherever possible. The table below outlines each of the major health indicators and data sources. More details can be found in Appendix A.

Indicator	Data Source
Population Demographics (e.g. age, race, nation of origin, and language)	2013-2017 American Community Survey, Census Bureau
HEALTH OUTCOMES	
All-cause mortality	2015-2017 Vital Statistics
Premature deaths	2019 RWJF County Health Rankings
Premature cardiovascular disease mortality	2015-2017 Vital Statistics
Obesity, >17 years	2015 US News Healthiest Communities
Diabetes-related hospitalizations	2017 PA Health Care Cost Containment Council
Hypertension-related hospitalizations	2017 PA Health Care Cost Containment Council
Cancer mortality	2015-2017 Vital Statistics
Infant mortality	2015-2017 Vital Statistics
Preterm and low birth weight births	2015-2017 Vital Statistics
Late or inadequate prenatal care	2015-2017 Vital Statistics
Lead poisoning, 0-6 years	2017 PA Childhood Lead Surveillance
Asthma-related hospitalizations, 2 to 14 years	2017 PA Health Care Cost Containment Council
Homicide mortality	2015-2017 Vital Statistics
Drug overdose mortality	2015-2017 Vital Statistics
Suicide mortality	2015-2017 Vital Statistics
Pedestrian and bicycle crashes	2017 PennDOT
Hospitalizations for falls, >64 years	2017 PA Health Care Cost Containment Council
Emergency department utilization	2018 HealthShare Exchange
Emergency department high-utilizers	2018 HealthShare Exchange
HEALTH FACTORS	
Insurance coverage, <18 years	2013-2017 American Community Survey, Census Bureau
Insurance coverage, 18 to 64 years	2013-2017 American Community Survey, Census Bureau
Mammography screening	2015-2018 PHMC SEPA Household Survey
Colorectal cancer screening	2015-2018 PHMC SEPA Household Survey
Smoking, >17 years	US News Healthiest Communities
Binge drinking, >17 years	2015-2018 PHMC SEPA Household Survey
Poverty	2013-2017 American Community Survey, Census Bureau
Community need index score	2016 Truven Health Analytics
Excessive housing cost	2013-2017 American Community Survey, Census Bureau
Housing with potential lead risk	2013-2017 American Community Survey, Census Bureau
Households receiving food assistance	2013-2017 American Community Survey, Census Bureau
Food insecurity	2018 PHMC SEPA Household Survey

NOTABLE Statistically significant differences between communities and county level statistics are highlighted throughout the report.

Gathering Community & Stakeholder Input

The Steering Committee recognized that there are many communities in the area with unique experiences and specific needs, and that no single data collection effort can comprehensively reflect the needs of all communities. As such input on priority health needs was collected from community members and other key health care and health resources stakeholders via a series of community meetings, focus groups, and key informant interviews. HCIF, in partnership with PACDC, coordinated the community engagement component.



19 community meetings with groups of community leaders and residents were held throughout the region. Communities were selected based on inclusion in hospitals'/health systems' targeted service areas for community benefit and included meetings in each county: Bucks (1), Chester (2), Montgomery (5), and Philadelphia (11).

PACDC worked closely with community leaders and organizations to secure meeting locations, plan logistics, and recruit community residents to participate in community meetings.

HCIF coordinated a team of experienced qualitative researchers from CHOP PolicyLab, Jefferson Health, and Penn Medicine to lead efforts to develop meeting guides, moderate meetings, code and analyze meeting transcripts, and summarize meeting findings. Representatives from Holy Redeemer Health System, Grand View Health, and Chester County Hospital took the lead in moderating meetings in communities in their service area, supported by representatives from Abington – Jefferson Health, Chester County Health Department, and Einstein Medical Center Montgomery.

Qualitative Team Members:

Marianna Calabrese, MA	Abington – Jefferson Health
Kathy McCarter, MSHA, RN, CCP	Abington – Jefferson Health
Erin Brown	Chester County Health Department
Ashley Orr, MPH	Chester County Health Department
Julie Funk, MS, RD, CDE, LDN	Chester County Hospital
Susan Pizzi, RN, MS	Chester County Hospital
Judy Suska, MBA, FHFMA	Chester County Hospital
Sonja Dahl	Children's Hospital of Philadelphia
Amanda Evans, MPH	Children's Hospital of Philadelphia
Samantha Stalford	Children's Hospital of Philadelphia
Eda Akpek	Children's Hospital of Philadelphia, PolicyLab
Siobhan Costanzo, MPH, M.Ed	Children's Hospital of Philadelphia, PolicyLab
Stephanie Garcia, MPH	Children's Hospital of Philadelphia, PolicyLab
Doug Strane, MPH	Children's Hospital of Philadelphia, PolicyLab
Emmy Stup, MPA	Children's Hospital of Philadelphia, PolicyLab
Kavya Sundar	Children's Hospital of Philadelphia, PolicyLab
Diana Worsley, MPH	Children's Hospital of Philadelphia, PolicyLab
Brandi Chawaga, M.Ed	Einstein Medical Center Montgomery
Jo Ann Hart	Grand View Health
Susan Choi, PhD	Health Care Improvement Foundation
Kelsey Salazar, MPH	Health Care Improvement Foundation
Barbara Tantum, MBA, MHA	Holy Redeemer Health System
Andrea Bilger, MPH	Penn Medicine
Natalie Czekai	Penn Medicine
Heather Klusaritz, PhD, MSW	Penn Medicine
Arnav Shah	Penn Medicine
Courtney Summers, MSW	Penn Medicine
Rickie Brawer, PhD, MPH, MCHES	Thomas Jefferson University Hospitals
Abby Cabrera, MPH	Thomas Jefferson University Hospitals
Caleb Dafilou, MPH	Thomas Jefferson University Hospitals
Drew Harris, DPM, MPH	Thomas Jefferson University Hospitals

KEY STAKEHOLDER FOCUS GROUPS

» Several populations of special interest were identified by the Steering Committee as priority populations for identifying and addressing health inequities in the region. Based on a consensus vote informed by the magnitude of the special populations, availability of existing data sources and capacity, six of these populations were selected for primary data collection:

- Individuals living with behavioral/mental health conditions
- Hispanic/Latino communities
- African-American communities
- Individuals experiencing housing insecurity
- Individuals experiencing homelessness
- Prenatal/postpartum women

» The HCIF team organized, facilitated and summarized findings for nine focus groups with key stakeholders. Four county-level meetings were conducted for the focus on behavioral health and a regional meeting for each of the other populations. Stakeholders representing a wide range of disciplines from more than 50 health care, public health, governmental, and community organizations participated in the focus groups. A full list of participating organizations can be found in Appendix B.

KEY INFORMANT INTERVIEWS

» Additional interviews were conducted with key informants throughout the region; these included:

- The Health Federation of Philadelphia conducted targeted interviews with leaders from five community health center organizations in the region.
- Several participating institutions conducted interviews with hospital/health system staff, patients and partners.

» Findings were all summarized independently by the respective institutions, reviewed and integrated with other CHNA findings, and considered during the prioritization of community health needs.

SECONDARY DATA SOURCES

» Reports and summaries from other community and stakeholder engagement efforts for other initiatives in the region were reviewed and included in the CHNA. A full list of reports is included in the "Resources" section.

Some notable reports included:

- Foundation for the Future: Developing Philadelphia's Housing Action Plan
- PA State LGBT Health Needs Assessment
- Philadelphia Assessment of Fair Housing
- Philadelphia Community Health Improvement Plan
- Philadelphia Region of Pennsylvania LGBTQA Community Health Needs Assessment
- Philadelphia Youth Homelessness Needs Assessment
- Philadelphia Department of Public Health Death Review Reports (e.g. Maternal, Homeless, and Child)
- Philadelphia Roadmap for Safer Communities
- Refugee Health Collaborative Needs Assessment

Determining and Prioritizing Community Health Needs

- The PDPH team synthesized a full list of community health needs based on the health indicators and findings from the community and stakeholder engagement components. Related community health needs were consolidated to produce the final list of 16 high priority community health needs.
- The PDPH team presented the community health needs and highlights of supporting data to the Steering Committee for discussion and to inform the prioritization process. After initial review and discussion, minor adjustments were made to some descriptions.
- A modified Hanlon rating method was used to prioritize the community health needs.
- PDPH epidemiologists assigned scores for "Criterion 1: Size of the Health Problem" based on available health indicators and for "Criterion 2: Importance to Community" based on how frequently the community health need was reported in community and stakeholder engagement components.
- Each participating hospital/health system scored the remaining criteria using the below ranking guidance with input from other internal stakeholders. The percentage below each criterion represents the weight assigned to it.

		1	2	3	4	5
		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 and stakeholder input (30%)	**CAPACITY TO ADDRESS** Availability of effective/feasible interventions (30%)	**ALIGNMENT WITH HOSPITAL/HEALTH SYSTEM MISSION/ VISION** (15%)	**EXISTING COLLABORATIONS/ INTERVENTIONS** (10%)
RANKING GUIDANCE	9 or 10	Greater than 25%	40+	High effectiveness/ High feasibility	Very consistent with mission AND strategic direction	Yes, strong existing partnerships AND initiatives
	7 or 8	15 to 25%	30 - 39	High effectiveness/ Moderate feasibility	Relatively consistent with mission AND strategic direction	Yes, existing partnerships AND initiatives
	5 or 6	5 to 14.9%	20 - 29	Effective/Feasible	Consistent with mission AND strategic direction	Yes, existing partnerships OR initiatives
	3 or 4	1 to 4.9%	10 - 19	Low Effectiveness/ Low Feasibility	Relatively consistent with mission NOT strategic direction	Yes, existing partnerships, no current initiatives
	1 or 2	0.1 up to 1.0%	1 - 9	Low Effectiveness/ Not Feasible	Consistent with mission NOT strategic direction	Weak, existing partnerships OR initiatives
	0	<0.1%	0	Not Effective/Not Feasible	Not consistent with mission OR strategic direction	No, existing initiatives or partnerships
COMMUNITY HEALTH NEEDS	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

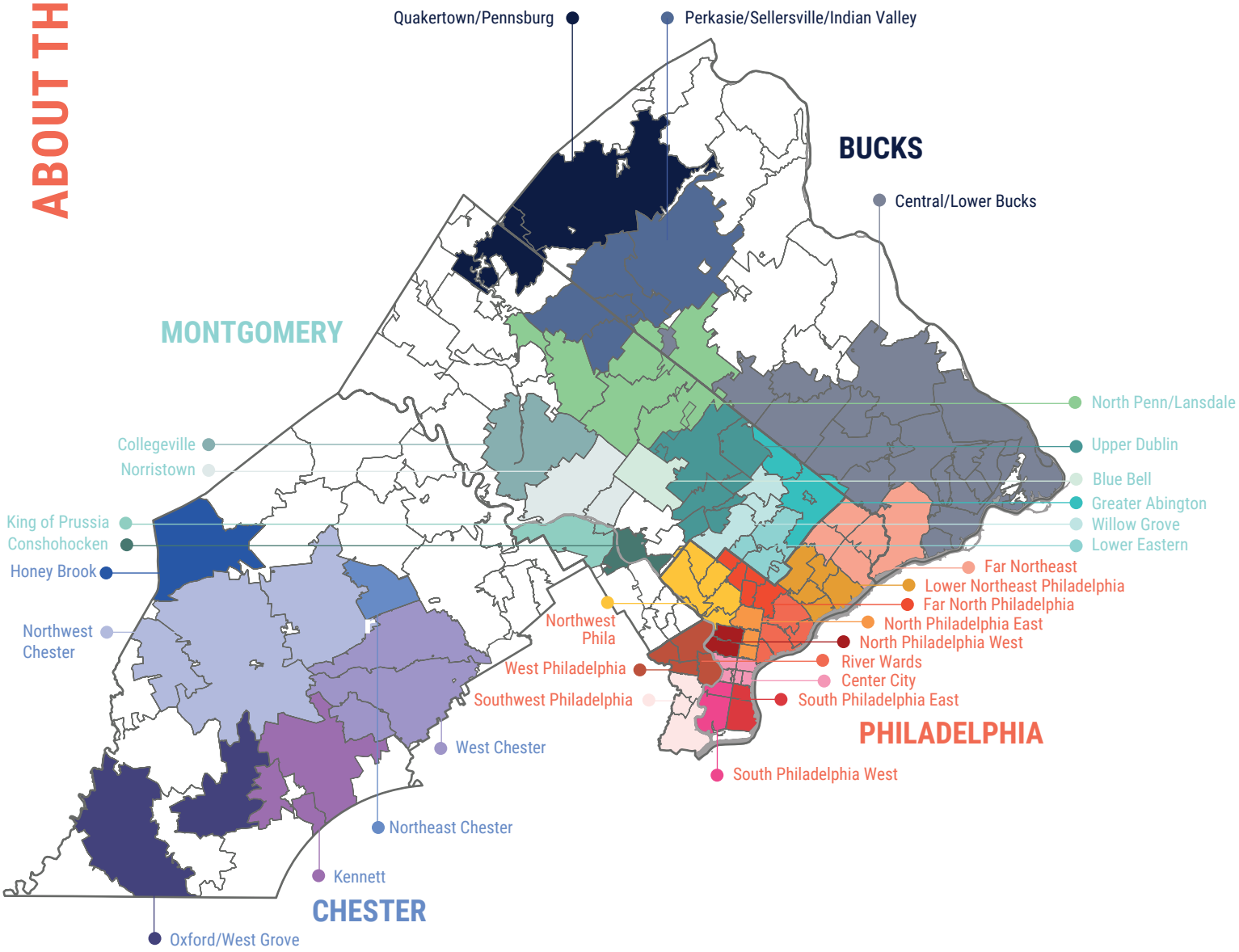
- Once community health needs were rated using the modified Hanlon rating method, the 'PEARL' Test was applied to screen out any community health needs that did not meet the following feasibility factors:
  - **P**ROPRIETY – Is a program for the health problem suitable?
  - **E**CONOMICS – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
  - **A**CCEPTABILITY – Will a community accept the program? Is it wanted?
  - **R**ESOURCES – Is funding available or potentially available for a program?
  - **L**EGALITY – Do current laws allow program activities to be implemented?
- Final rankings for each community health need were calculated as a simple average of ratings across all participating hospitals/health systems.

Final CHNA Report

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

ABOUT THE SERVICE AREA

The overall service area includes four counties, Bucks, Chester, Montgomery, and Philadelphia and represents a diverse population of **3,540,678** people. Clusters of populated zip codes across the four counties were assigned to well-established communities as shown below. These communities represent the target areas for community benefit for all of the participating hospitals and health systems and the residential zip codes of at least 75 percent of the hospitals' and health systems' inpatient admissions.

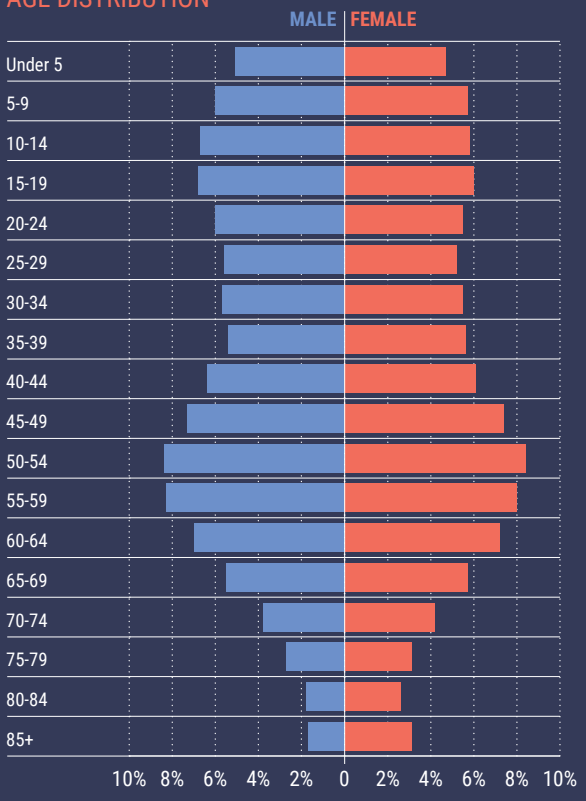


BUCKS COUNTY

HOSPITAL HEALTH CENTER

There are 10 hospitals and no health centers in Bucks County, which has an estimated population of 626,486.

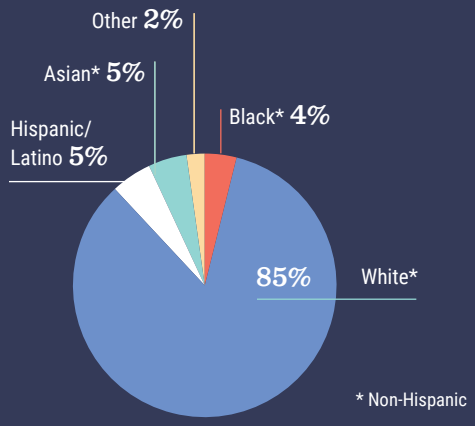
AGE DISTRIBUTION



FOREIGN BORN: **8.8%**

NOT FLUENT IN ENGLISH: **3.9%**

Adults ages 50 to 59 comprise the largest portion of the population.



White, non-Hispanic individuals make up 85 percent of Bucks County's residents.

Approximately 9 percent of the residents of Bucks County were born in a foreign country. Slightly less than 4 percent of residents speak English less than "very well."

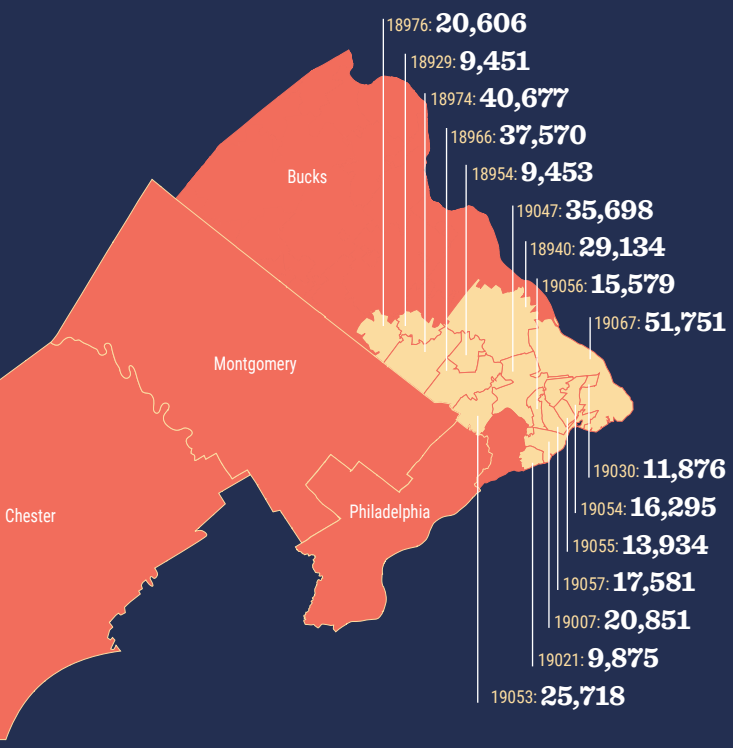
CENTRAL/ LOWER BUCKS

This community is served by:

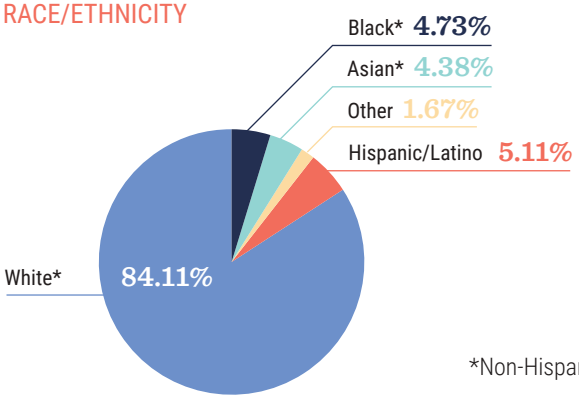
- Abington Hospital
- Abington–Lansdale Hospital
- Children's Hospital of Philadelphia
- Holy Redeemer Hospital
- Jefferson Health Northeast

demographics

POPULATION

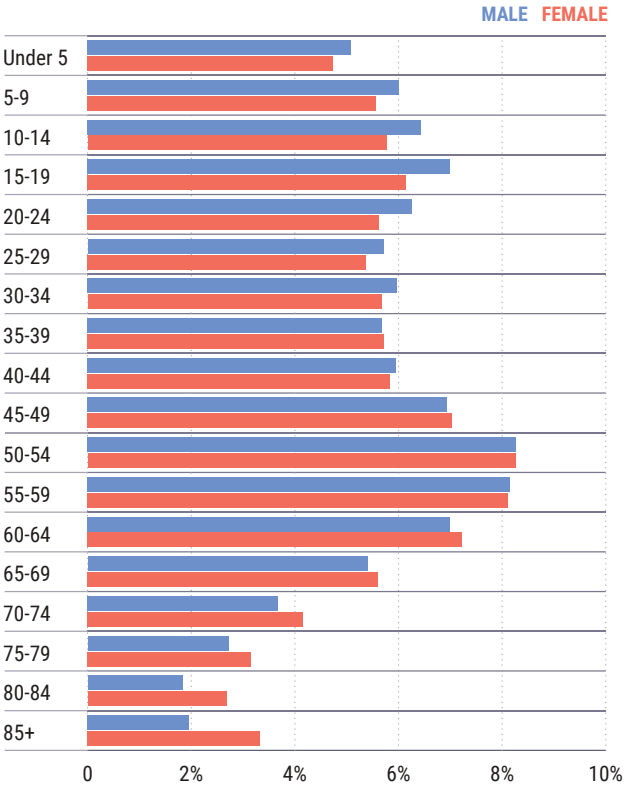


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Central/ Lower Bucks	Bucks County
Chronic Disease & Smoking	Death rate (per 100,000 people)	757.7	734.8
	Premature CVD deaths (per 100,000 people)	38.1	35.7
	Diabetes hospitalizations (per 100,000 people)	204.6	183.7
	Adult obesity	30.0%	25.1%
	Hypertension hospitalizations (per 100,000 people)	403.0	358.0
	Cancer deaths (per 100,000 people)	75.3	72.2
	Mammography screening	76.4%	75.2%
	Colorectal screening	68.9%	68.2%
	Adult smoking	15.4%	14.0%
	Adult binge drinking	33.5%	17.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	4.0	3.3
	Percent of preterm or low birth weight births	12.2%	11.2%
	Late or inadequate prenatal care	31.1%	28.9%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	77.4	88.8
Injuries	Homicide mortality rate (per 100,000 people)	2.3	1.9
	Drug overdose mortality rate (per 100,000 people)	35.3	31.1
	Suicide mortality rate (per 100,000 people)	11.6	11.3
	Pedestrian and cyclist crash rate (per 100,000 people)	28.1	24.1
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,837.0	2,481.0
Access to Care	Adults 19-64 without insurance	6.4%	6.6%
	Children <19 without insurance	2.4%	2.6%
	Adults 19-64 with Medicaid	6.8%	6.5%
	Children <19 with public insurance	19.5%	19.3%
	Emergency department utilization (per 100,000 people)	23,956.3	20,620.3
	Emergency department high-utilizers (per 100,000 people)	470.4	380.1
Social & Economic Determinants	Percent in poverty	5.8%	6.1%
	Community need index score	2.0	2.0
	Excessive housing cost	31.6%	32.5%
	Housing with potential lead risk	33.8%	32.1%
	Households receiving food assistance	5.6%	5.5%
	Food insecurity	11.1%	10.5%
	Speak English less than "very well"	4.0%	4.0%

COMMUNITY PERSPECTIVES

"...it's cheaper to go to McDonald's and get a meal than it is to get a healthy meal at a supermarket."

"People need dental care. Medicare doesn't pay for it, you have to get your own insurance, the kids need it and the parents don't take them because they don't have the money. There was a truck that used to come around years and years ago, free dental care. They don't do that anymore, but that was a really needed service for anybody."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on March 6, 2019 at Abington Health Center Warminster. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Access to quality education, healthcare and other social services.
- Abundance of colleges and great school districts.
- Home to some of the best health systems in the world calling it "a hub for healthcare," including access to specialty services such as cancer care.
- Easy access to assets such as libraries, shopping, community events for various age groups, the YMCA, and youth athletics.
- Lower tax rate, affordable housing, and Bensalem being recognized as one of the ten best communities.
- Bucks County Transport provides shared ride transportation services at a free to low-range cost for all Bucks county residents.

Priority Health Issues

BEHAVIORAL HEALTH	» **Behavioral health issues** including substance use/addiction, depression and suicide, smoking and alcohol are impacting community. » Lack of adequate **medical-legal partnerships** and **substance use treatment**.
ACCESS TO CARE	» **Long wait times** to get an appointment with specialists and at times with primary care physicians. » Fragmented healthcare system leaves individuals **confused about how health insurance works**. » Access to and affordability of **dental care** for insured and uninsured people. » Growing **out of pocket costs** for prescriptions.
ENVIRONMENTAL CONDITIONS	» **Environmental factors** in the community that can potentially affect health conditions, such as air and water pollution; ranked high for air pollution.
CHRONIC DISEASE	» **Cancer incidence and mortality** as well as neurological, respiratory, and autoimmune diseases. » **Nutrition barriers** include high cost, lack of education, and lack of time.
CHILDREN AND YOUTH	» Insufficient **support for parenting**. » For young children, **lack of affordable daycare, early education, up-to-date immunizations, autism care**. » **Bullying and cyberbullying** among children, youth and young adults. » Fear of violent acts faced by teenagers such as **school shootings**. » **Financial stress** due to college-related loans. » **Among young adults**, suicide, depression, drug overdose, peer pressure, workforce development, and gender identity as key social and health issues.
OLDER ADULTS	» Need for better **coordination and navigation of healthcare** for the **older adult** population. » Need for more **high-quality nursing homes**. » **Transportation barriers** impact older adults' ability to pick-up their medication, attend medical appointments and access other resources.

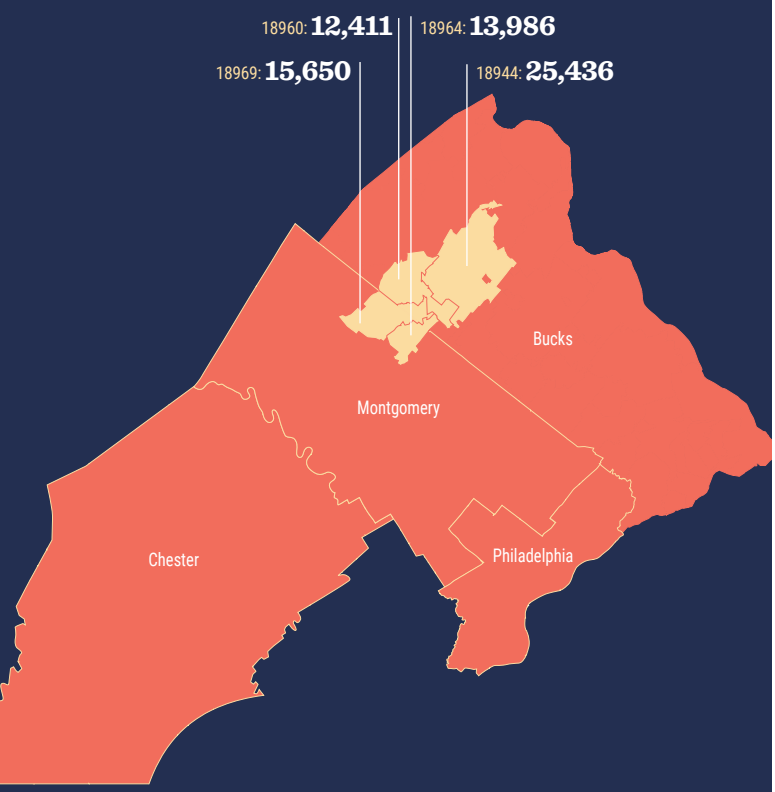
PERKASIE/ SELLERSVILLE/ INDIAN VALLEY

This community is served by:

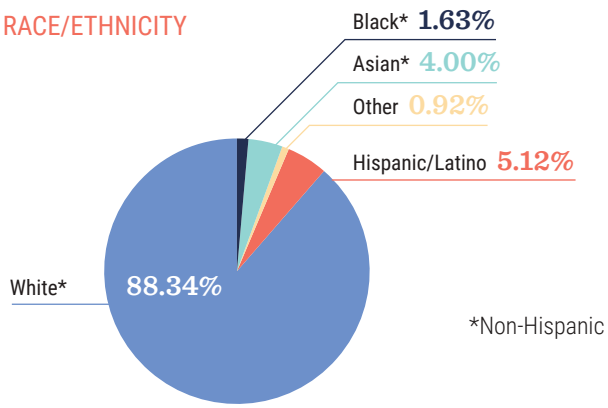
- Abington Hospital
- Abington–Lansdale Hospital
- Children's Hospital of Philadelphia
- Grand View Health

demographics

POPULATION



RACE/ETHNICITY



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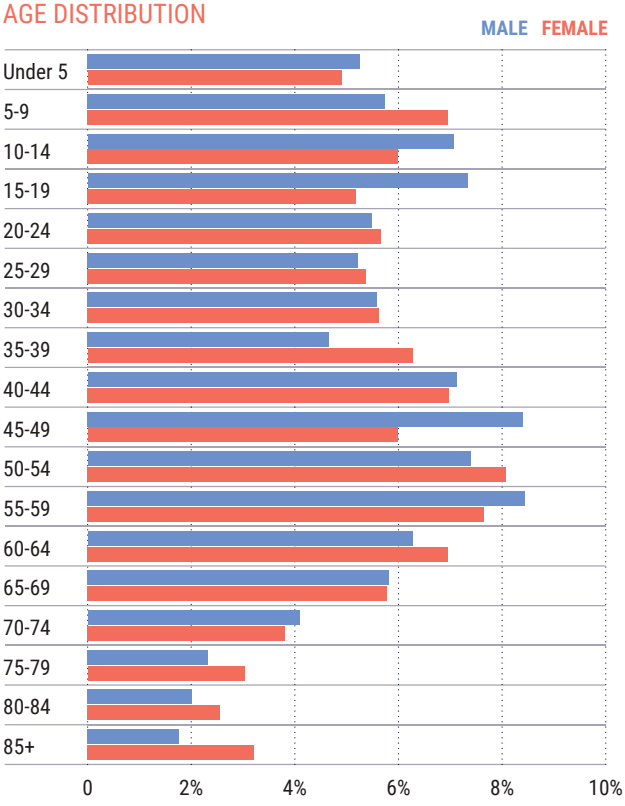


summary health measures

NOTABLE

		Perkasie/ Sellersville/ Indian Valley	Bucks County
Chronic Disease & Smoking	Death rate (per 100,000 people)	697.5	734.8
	Premature CVD deaths (per 100,000 people)	34.7	35.7
	Diabetes hospitalizations (per 100,000 people)	163.0	183.7
	Adult obesity	26.9%	25.1%
	Hypertension hospitalizations (per 100,000 people)	243.0	358.0
	Cancer deaths (per 100,000 people)	61.6	72.2
	Mammography screening	80.0%	75.2%
	Colorectal screening	63.4%	68.2%
	Adult smoking	13.1%	14.0%
	Adult binge drinking	20.0%	17.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	2.5	3.3
	Percent of preterm or low birth weight births	9.6%	11.2%
	Late or inadequate prenatal care	20.5%	28.9%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	223.3	88.8
Injuries	Homicide mortality rate (per 100,000 people)	1.8	1.9
	Drug overdose mortality rate (per 100,000 people)	27.6	31.1
	Suicide mortality rate (per 100,000 people)	10.0	11.3
	Pedestrian and cyclist crash rate (per 100,000 people)	17.8	24.1
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	1,832.3	2,481.0
Access to Care	Adults 19-64 without insurance	7.3%	6.6%
	Children <19 without insurance	4.0%	2.6%
	Adults 19-64 with Medicaid	6.0%	6.5%
	Children <19 with public insurance	21.3%	19.3%
	Emergency department utilization (per 100,000 people)	27,119.4	20,620.3
	Emergency department high-utilizers (per 100,000 people)	398.6	380.1
Social & Economic Determinants	Percent in poverty	6.7%	6.1%
	Community need index score	2.1	2.0
	Excessive housing cost	30.7%	32.5%
	Housing with potential lead risk	34.0%	32.1%
	Households receiving food assistance	4.7%	5.5%
	Food insecurity	10.0%	10.5%
	Speak English less than "very well"	3.4%	4.0%

COMMUNITY PERSPECTIVES

"[New residents receive] welcome neighbor envelopes when you first move in, that's got coupons, and they tell you what's in the neighborhood."

"you have to have a pretty severe [developmental] delay to be eligible for therapy when they're young. You can see the warning signs and you just have to wait and watch your child fall farther and farther behind, so that you're playing catch up..."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on March 6, 2019 at Abington Health Center Warminster. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- **Accessibility** for individuals with physical disabilities.
- Community caters to older adult population and offers quality resources such as assisted living facilities.
- **Community organizations**, like churches, stores, movie theaters, and health care facilities.
- Good schools and proximity to open lands and parks.
- Low crime and generally feels safe.
- Diverse and accepting of the diversity.

Priority Health Issues

BEHAVIORAL HEALTH	» Limited number of **behavioral health providers** in the area and long wait times once an appointment is scheduled. » One large behavioral health organization has high turn-over rate with their psychiatrists. » Inadequate resources to provide for psychiatric emergencies, such as inpatient services. » Nurse care managers and a mobile crisis van are facilitators to accessing behavioral health and specialty wrap-around services. » **Difficult to find behavioral health** providers for children, which delays identification of behavioral health and developmental issues. » Limited substance use disorder service providers; in-patient detox facilities do not provide ample supports after discharge and many patients return to drug use thereafter.
ACCESS TO CARE	» **Long wait times** for specialty care. » **Lack of on-site medications** at urgent care facilities. » Providers **not accepting insurance coverage** is a barrier to accessing health care. » Online patient portals are often difficult to navigate, and patients go without necessary health information due to **technology limitations.**
CHRONIC DISEASE	» Rates of diabetes seem to be increasing and there is **no diabetic education center** with nutrition lectures and trainings. » Limited **free or low-cost activities for children & youth** to keep them active and healthy.
SOCIAL AND ECONOMIC DETERMINANTS	» **Lack of awareness of food resources**, as well as stigma surrounding people who utilize them. » **Limited resources** for support with transportation needs, especially for older adults and persons with disabilities.

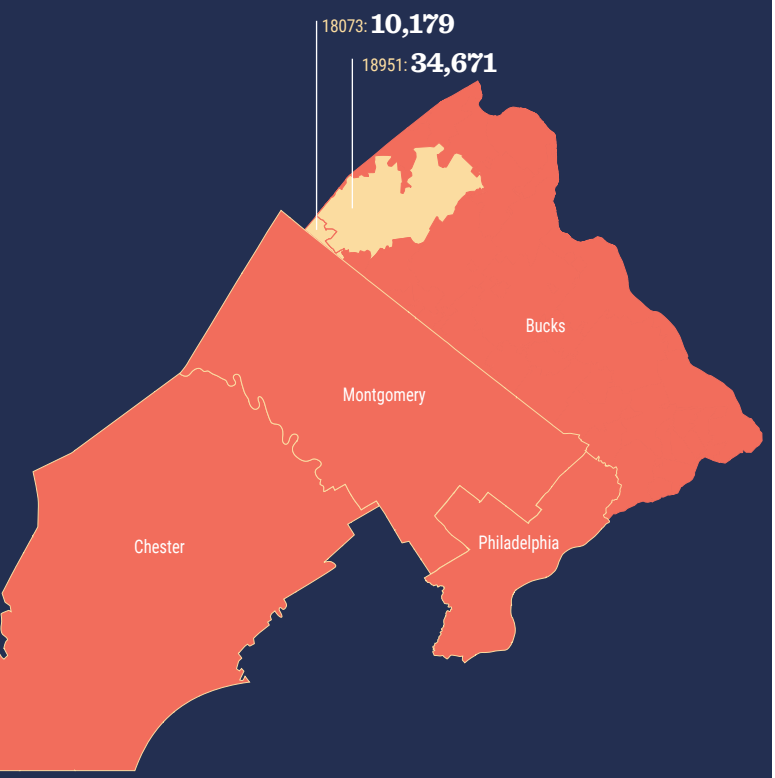
QUAKERTOWN/ PENNSBURG

This community is served by:

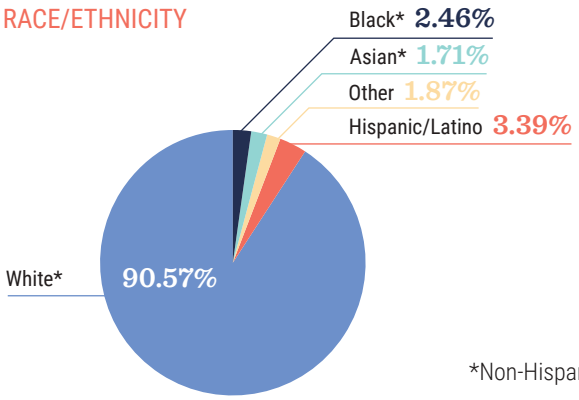
- Children's Hospital of Philadelphia
- Grand View Health

demographics

POPULATION

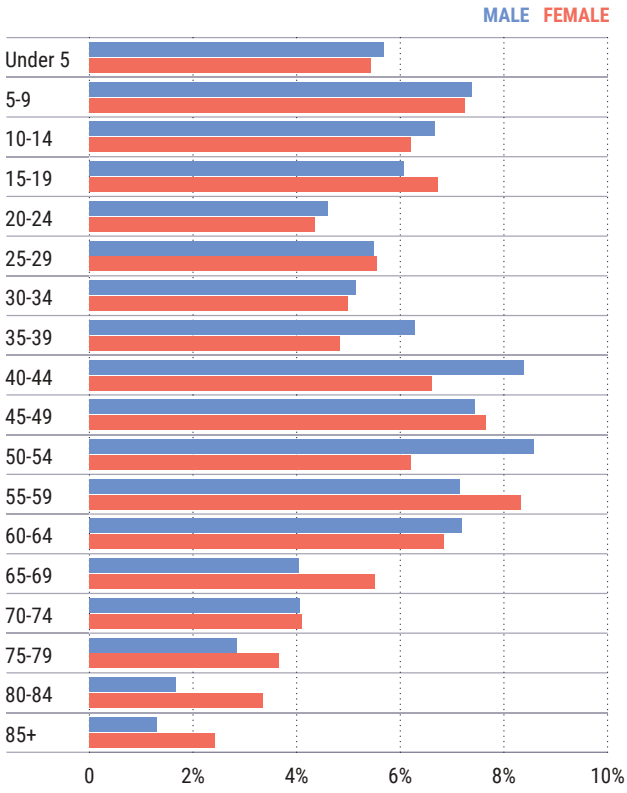


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION

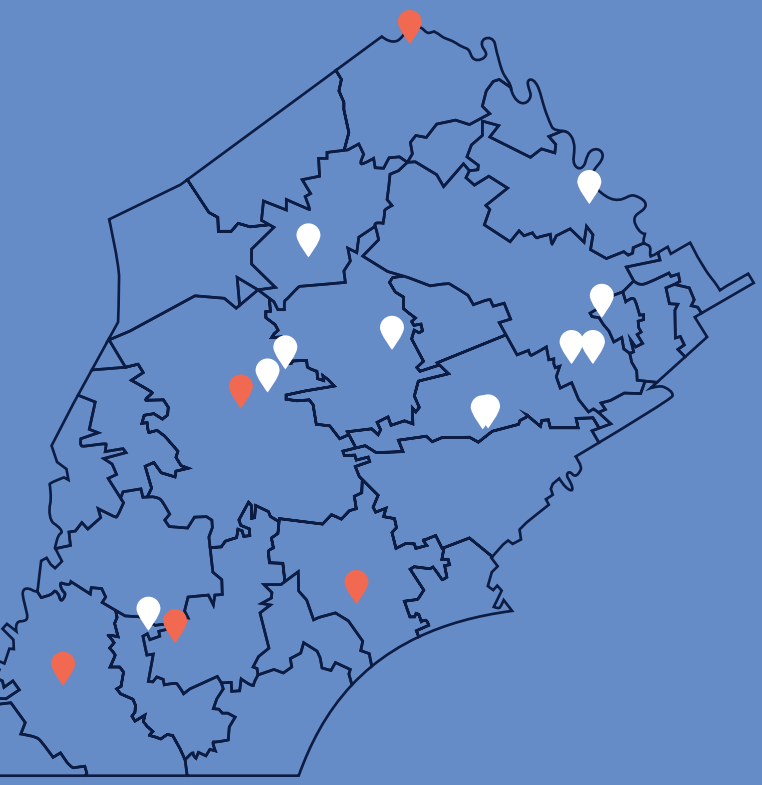


summary health measures

NOTABLE

		Quakertown and Pennsburg	Bucks County
Chronic Disease & Smoking	Death rate (per 100,000 people)	854.8	734.8
	Premature CVD deaths (per 100,000 people)	44.6	35.7
	Diabetes hospitalizations (per 100,000 people)	142.7	183.7
	Adult obesity	33.4%	25.1%
	Hypertension hospitalizations (per 100,000 people)	312.2	358.0
	Cancer deaths (per 100,000 people)	66.9	72.2
	Mammography screening	80.2%	75.2%
	Colorectal screening	70.6%	68.2%
	Adult smoking	23.7%	14.0%
	Adult binge drinking	8.0%	17.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	4.8	3.3
	Percent of preterm or low birth weight births	12.0%	11.2%
	Late or inadequate prenatal care	22.9%	28.9%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	91.3	88.8
Injuries	Homicide mortality rate (per 100,000 people)	1.2	1.9
	Drug overdose mortality rate (per 100,000 people)	32.5	31.1
	Suicide mortality rate (per 100,000 people)	11.6	11.3
	Pedestrian and cyclist crash rate (per 100,000 people)	20.1	24.1
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	1,308.5	2,481.0
Access to Care	Adults 19-64 without insurance	7.0%	6.6%
	Children <19 without insurance	3.5%	2.6%
	Adults 19-64 with Medicaid	6.6%	6.5%
	Children <19 with public insurance	21.6%	19.3%
	Emergency department utilization (per 100,000 people)	13,638.8	20,620.3
	Emergency department high-utilizers (per 100,000 people)	176.1	380.1
Social & Economic Determinants	Percent in poverty	7.5%	6.1%
	Community need index score	2.3	2.0
	Excessive housing cost	32.9%	32.5%
	Housing with potential lead risk	33.0%	32.1%
	Households receiving food assistance	5.1%	5.5%
	Food insecurity	10.0%	10.5%
	Speak English less than "very well"	1.8%	4.0%

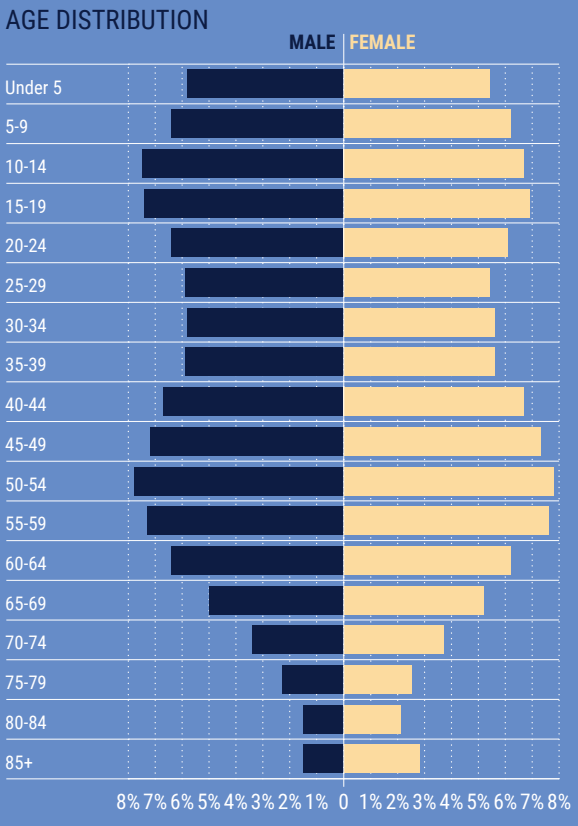
CHESTER COUNTY

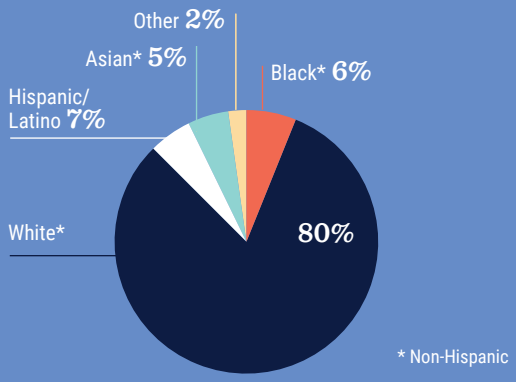


HOSPITAL HEALTH CENTER

Chester County has 11 hospitals and 5 health centers. These health centers serve over 32,000 patients each year.

Chester County's population totals 514,652 individuals. Many residents fall between the ages of 45 and 59, with a similarly large proportion between the ages of 10 and 19.





Eighty percent of Chester County's residents are non-Hispanic White.

Foreign-born individuals make up approximately 9 percent of Chester County's population. Nearly 5 percent speak English less than "very well."

FOREIGN BORN: 9.4%

NOT FLUENT IN ENGLISH: 4.5%

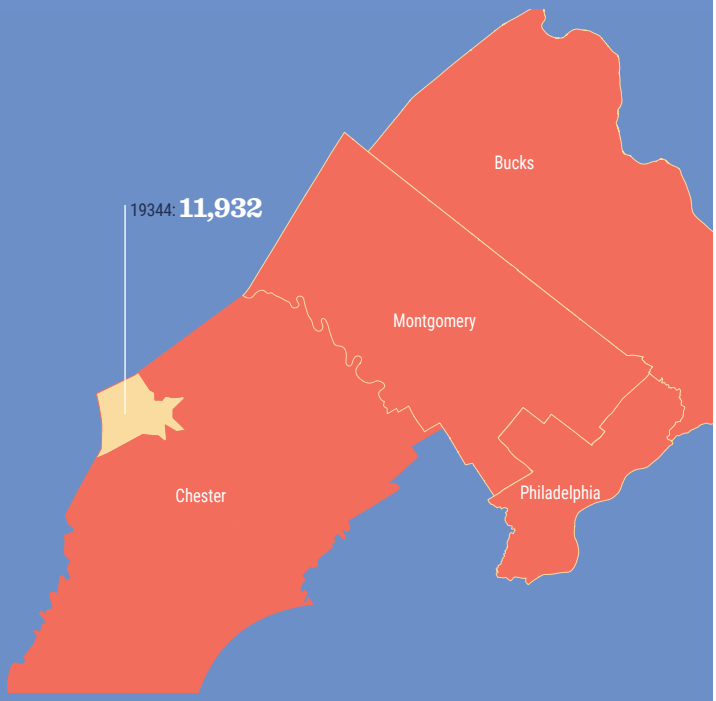
HONEY BROOK

This community is served by:

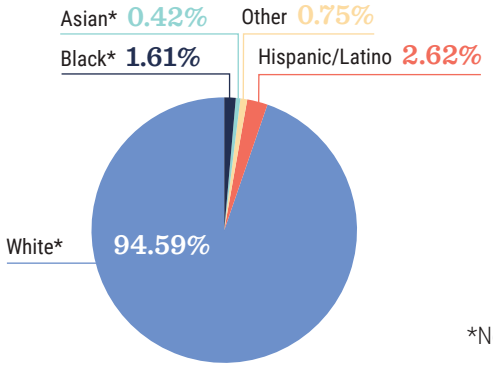
- Chester County Hospital
- Children's Hospital of Philadelphia

demographics

POPULATION

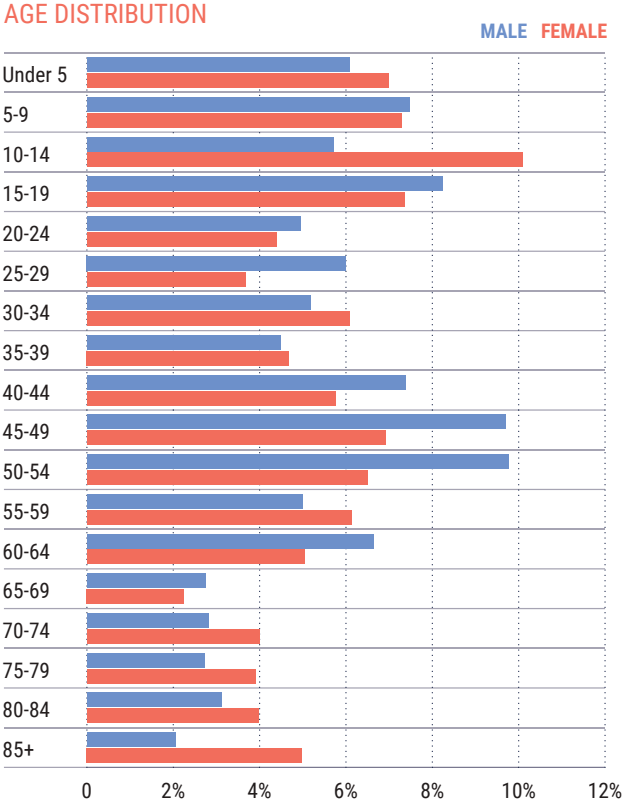


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Honey Brook	Chester County
Chronic Disease & Smoking	Death rate (per 100,000 people)	897.0	651.6
	Premature CVD deaths (per 100,000 people)	86.8	36.5
	Diabetes hospitalizations (per 100,000 people)	150.9	114.3
	Adult obesity	--	22.3%
	Hypertension hospitalizations (per 100,000 people)	293.3	257.7
	Cancer deaths (per 100,000 people)	89.0	65.1
	Mammography screening	--	79.9%
	Colorectal screening	--	71.1%
	Adult smoking	--	15.3%
	Adult binge drinking	--	19.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	8.7	4.3
	Percent of preterm or low birth weight births	9.1%	11.2%
	Late or inadequate prenatal care	58.0%	31.8%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	43.6	62.4
Injuries	Homicide mortality rate (per 100,000 people)	0.0	1.9
	Drug overdose mortality rate (per 100,000 people)	43.1	22.3
	Suicide mortality rate (per 100,000 people)	13.5	12.0
	Pedestrian and cyclist crash rate (per 100,000 people)	8.4	15.0
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	3,030.3	2,412.6
Access to Care	Adults 19-64 without insurance	19.8%	8.3%
	Children <19 without insurance	20.2%	5.0%
	Adults 19-64 with Medicaid	6.0%	5.8%
	Children <19 with public insurance	21.4%	18.7%
	Emergency department utilization (per 100,000 people)	7,634.9	9,992.6
	Emergency department high-utilizers (per 100,000 people)	67.1	98.9
Social & Economic Determinants	Percent in poverty	11.7%	6.8%
	Community need index score	2.4	2.2
	Excessive housing cost	34.81%	30.1%
	Housing with potential lead risk	22.1%	29.2%
	Households receiving food assistance	7.2%	4.9%
	Food insecurity	--	7.6%
	Speak English less than "very well"	3.1%	4.5%

"—" Estimates are not available or unreliable due to low sample size within community.

COMMUNITY PERSPECTIVES

"Doctors need to slow down, spend less time on computers, and build a relationship with us. Be more patient."

"The youth have been hit hard with the opioid crisis, too, because they suffer sports injuries and are then given prescription drugs, so they've been hit hard with that."

"Seniors are living longer than expected, so the money we planned to retire with is running out. Now some of us have to choose between medication and food."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on March 5, 2019 at Honey Brook Presbyterian Church. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Ample access to libraries, parks, churches, community green spaces, health care services, and engaged community organizations.
- Unique geographic location of Honey Brook as having both positive and negative implications for the community, as it sits on the border of three counties: Chester, Lancaster, and Berks. This provides access to many amenities; however, community members are often unaware of what is offered in neighboring counties because "the community has naturally become insular."

Priority Health Issues

BEHAVIORAL HEALTH	» Growing **behavioral health and substance use needs** in the community, especially considering the opioid epidemic's impact on youth in the area.
YOUTH	» Children and youth have a lack of consistent **food options** when school is out of session in the summer, as well as a general lack of food adequacy in the area. » Youth also experiencing **high rates of suicide**, unmet **mental health needs**, **bullying, obesity, and vaping**.
OLDER ADULTS	» Growing **aging population** in the community and need to focus resources and efforts on supporting these members. » Loneliness and social isolation are unmet behavioral health needs among older adults. » Lack of **quality and access** to aging-in-place services for seniors, as well as an adequate stock of senior living facilities. » Challenges **navigating the changing health care landscape**, specifically, using technology for ordering of prescriptions and access to medical records. » Need to adapt advances in technology to meet the needs of seniors and their cognitive and physical abilities (self-checkout kiosks at grocery stores, the airport, gas stations, etc.).
SOCIAL AND ECONOMIC DETERMINANTS	» Growing **costs of housing and utilities**, compounded by flat rates of income growth and social security payments, creates financial stressors for many community members. » Stigma prevents families from access necessary services.
ENVIRONMENTAL CONDITIONS	» **Built environment** in Honey Brook is not safe or accessible for people using wheelchairs.
ACCESS TO CARE	» Limited **quality and access** to preventative health services, occupational medicine, and urgent care centers. » Lack of **insurance affordability and costs of health care**, especially for seniors with fixed income.

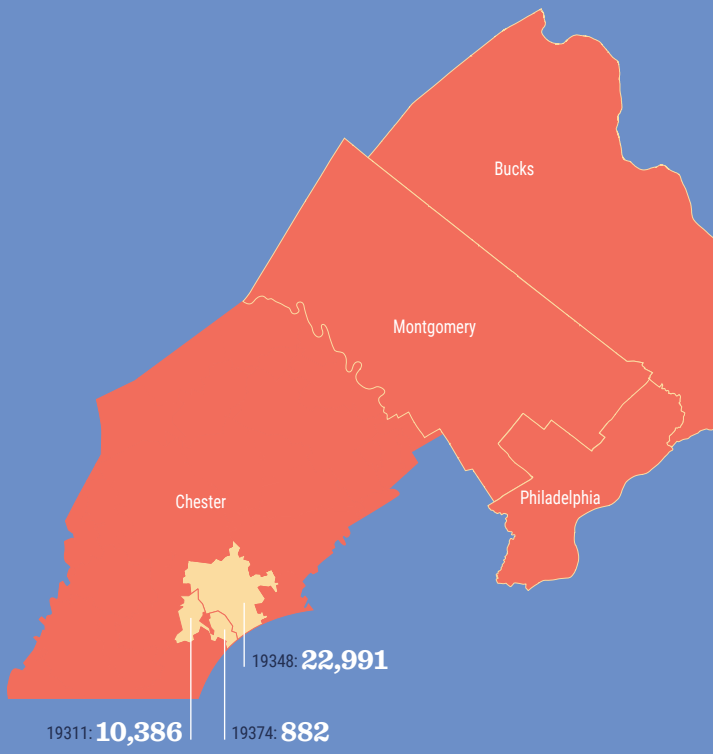
KENNETT

This community is served by:

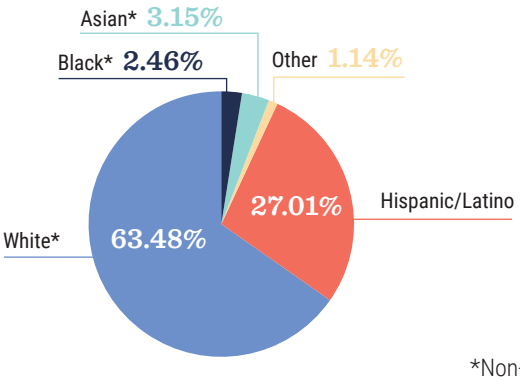
- Chester County Hospital
- Children's Hospital of Philadelphia

demographics

POPULATION

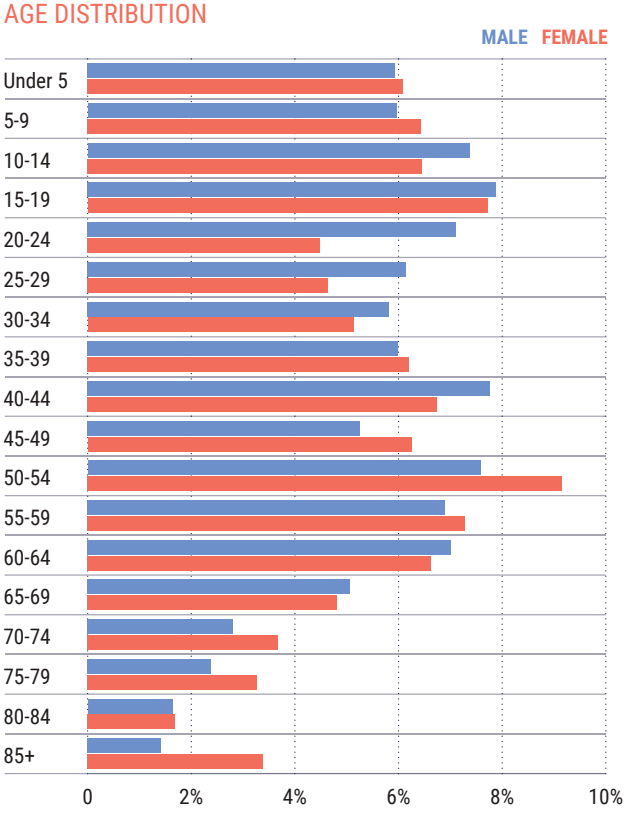


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Kennett	Chester County
Chronic Disease & Smoking	Death rate (per 100,000 people)	510.2	651.6
	Premature CVD deaths (per 100,000 people)	17.9	36.5
	Diabetes hospitalizations (per 100,000 people)	84.7	114.3
	Adult obesity	12.8%	22.3%
	Hypertension hospitalizations (per 100,000 people)	143.0	257.7
	Cancer deaths (per 100,000 people)	39.9	65.1
	Mammography screening	96.9%	79.9%
	Colorectal screening	75.2%	71.1%
	Adult smoking	22.1%	15.3%
	Adult binge drinking	45.0%	19.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	0.0	4.3
	Percent of preterm or low birth weight births	9.2%	11.2%
	Late or inadequate prenatal care	39.9%	31.8%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	53.8	62.4
Injuries	Homicide mortality rate (per 100,000 people)	0.0	1.9
	Drug overdose mortality rate (per 100,000 people)	7.6	22.3
	Suicide mortality rate (per 100,000 people)	11.8	12.0
	Pedestrian and cyclist crash rate (per 100,000 people)	12.0	15.0
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	1,830.9	2,412.6
Access to Care	Adults 19-64 without insurance	20.7%	8.3%
	Children <19 without insurance	8.1%	5.0%
	Adults 19-64 with Medicaid	5.5%	5.8%
	Children <19 with public insurance	27.0%	18.7%
	Emergency department utilization (per 100,000 people)	6,852.0	9,992.6
	Emergency department high-utilizers (per 100,000 people)	50.9	98.9
Social & Economic Determinants	Percent in poverty	7.2%	6.8%
	Community need index score	2.9	2.2
	Excessive housing cost	30.9	30.1%
	Housing with potential lead risk	29.0%	29.2%
	Households receiving food assistance	2.2%	4.9%
	Food insecurity	5.5%	7.6%
	Speak English less than "very well"	15.5%	4.5%

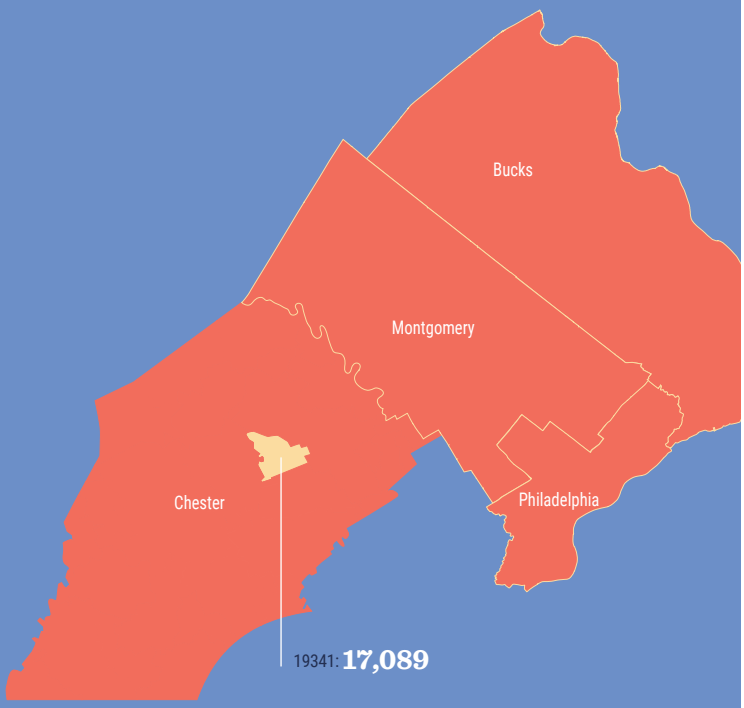
NORTHEAST CHESTER

This community is served by:

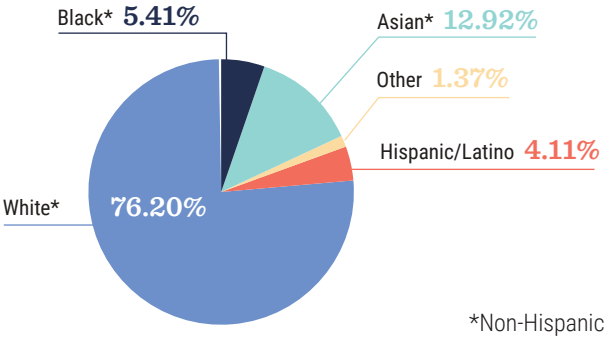
- Chester County Hospital
- Children's Hospital of Philadelphia

demographics

POPULATION

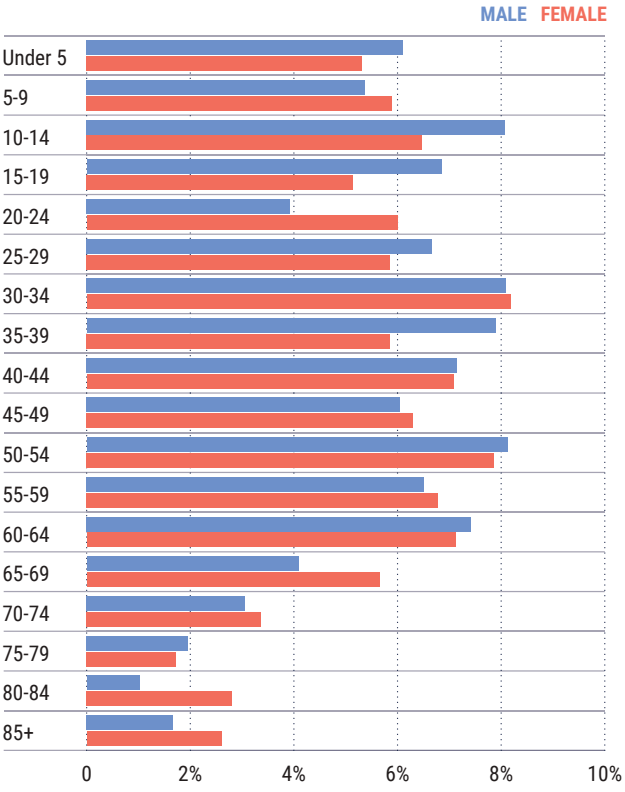


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Northeast Chester	Chester County
Chronic Disease & Smoking	Death rate (per 100,000 people)	667.6	651.6
	Premature CVD deaths (per 100,000 people)	28.9	36.5
	Diabetes hospitalizations (per 100,000 people)	152.1	114.3
	Adult obesity	--	22.3%
	Hypertension hospitalizations (per 100,000 people)	234.1	257.7
	Cancer deaths (per 100,000 people)	67.6	65.1
	Mammography screening	--	79.9%
	Colorectal screening	--	71.1%
	Adult smoking	--	15.3%
	Adult binge drinking	--	19.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	6.6	4.3
	Percent of preterm or low birth weight births	11.7%	11.2%
	Late or inadequate prenatal care	23.3%	31.8%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	179.6	62.4
Injuries	Homicide mortality rate (per 100,000 people)	2.5	1.9
	Drug overdose mortality rate (per 100,000 people)	23.6	22.3
	Suicide mortality rate (per 100,000 people)	12.2	12.0
	Pedestrian and cyclist crash rate (per 100,000 people)	11.7	15.0
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	4,083.3	2,412.6
Access to Care	Adults 19-64 without insurance	5.3%	8.3%
	Children <19 without insurance	3.6%	5.0%
	Adults 19-64 with Medicaid	4.3%	5.8%
	Children <19 with public insurance	9.5%	18.7%
	Emergency department utilization (per 100,000 people)	15,068.2	9,992.6
	Emergency department high-utilizers (per 100,000 people)	193.1	98.9
Social & Economic Determinants	Percent in poverty	4.4%	6.8%
	Community need index score	2.4	2.2
	Excessive housing cost	25.1%	30.1%
	Housing with potential lead risk	17.9%	29.2%
	Households receiving food assistance	3.0%	4.9%
	Food insecurity	--	7.6%
	Speak English less than "very well"	4.9%	4.5%

"—" Estimates are not available or unreliable due to low sample size within community.

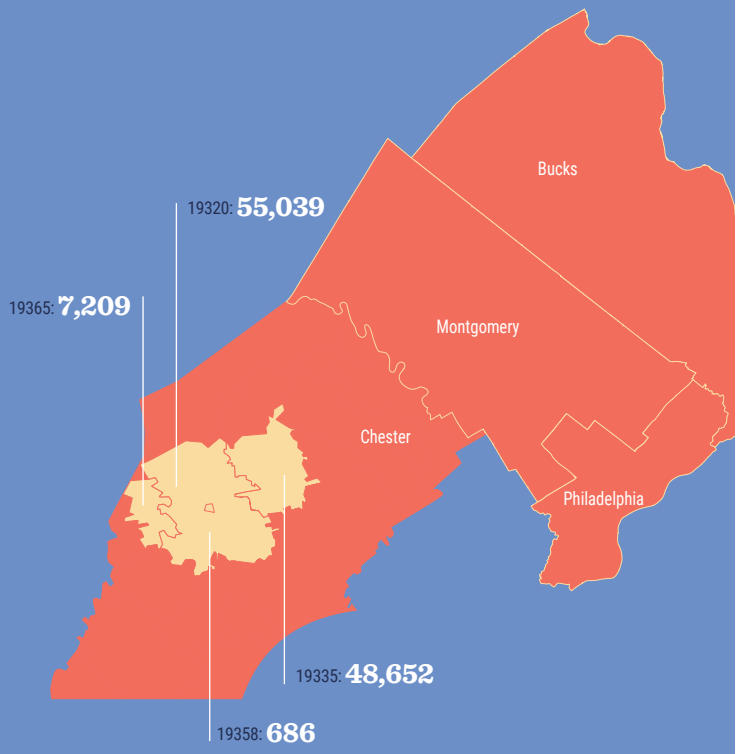
NORTHWEST CHESTER

This community is served by:

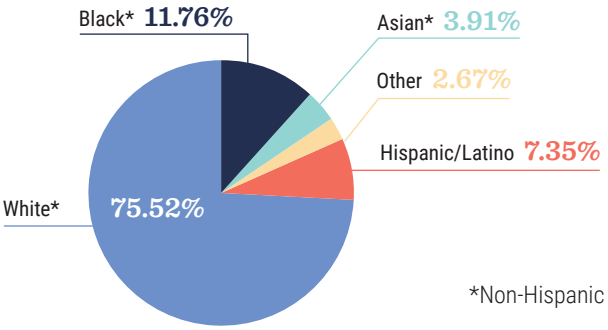
- Chester County Hospital
- Children's Hospital of Philadelphia

demographics

POPULATION



RACE/ETHNICITY



*Non-Hispanic

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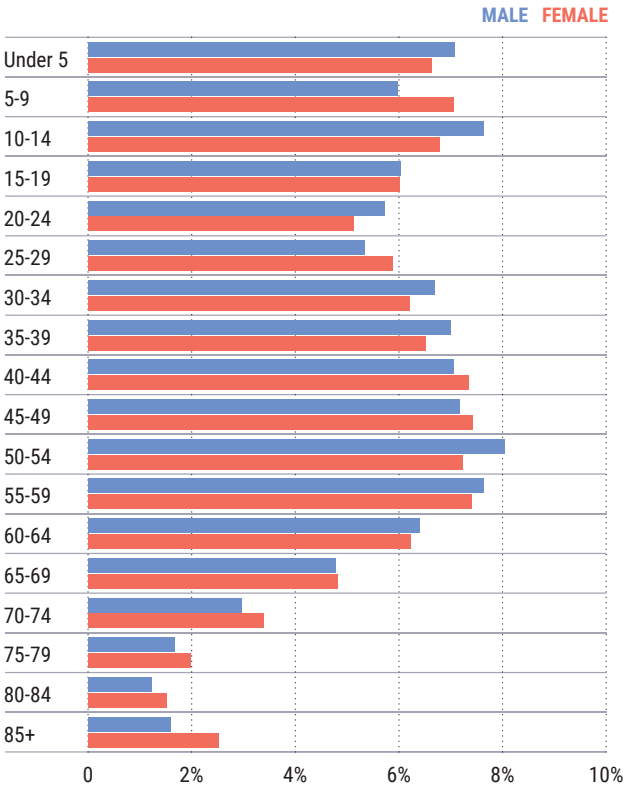


summary health measures

NOTABLE

		Northwest Chester	Chester County
Chronic Disease & Smoking	Death rate (per 100,000 people)	749.2	651.6
	Premature CVD deaths (per 100,000 people)	58.1	36.5
	Diabetes hospitalizations (per 100,000 people)	146.7	114.3
	Adult obesity	27.9%	22.3%
	Hypertension hospitalizations (per 100,000 people)	329.2	257.7
	Cancer deaths (per 100,000 people)	77.3	65.1
	Mammography screening	75.5%	79.9%
	Colorectal screening	73.0%	71.1%
	Adult smoking	20.3%	15.3%
	Adult binge drinking	36.4%	19.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	4.6	4.3
	Percent of preterm or low birth weight births	12.8%	11.2%
	Late or inadequate prenatal care	36.2%	31.8%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	80.9	62.4
Injuries	Homicide mortality rate (per 100,000 people)	4.0	1.9
	Drug overdose mortality rate (per 100,000 people)	26.4	22.3
	Suicide mortality rate (per 100,000 people)	12.2	12.0
	Pedestrian and cyclist crash rate (per 100,000 people)	16.2	15.0
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,299.7	2,412.6
Access to Care	Adults 19-64 without insurance	9.1%	8.3%
	Children <19 without insurance	5.2%	5.0%
	Adults 19-64 with Medicaid	8.3%	5.8%
	Children <19 with public insurance	27.3%	18.7%
	Emergency department utilization (per 100,000 people)	11,392.4	9,992.6
	Emergency department high-utilizers (per 100,000 people)	109.2	98.9
Social & Economic Determinants	Percent in poverty	8.3%	6.8%
	Community need index score	2.4	2.2
	Excessive housing cost	32.3%	30.1%
	Housing with potential lead risk	28.6%	29.2%
	Households receiving food assistance	8.6%	4.9%
	Food insecurity	10.1%	7.6%
	Speak English less than "very well"	3.5%	4.5%

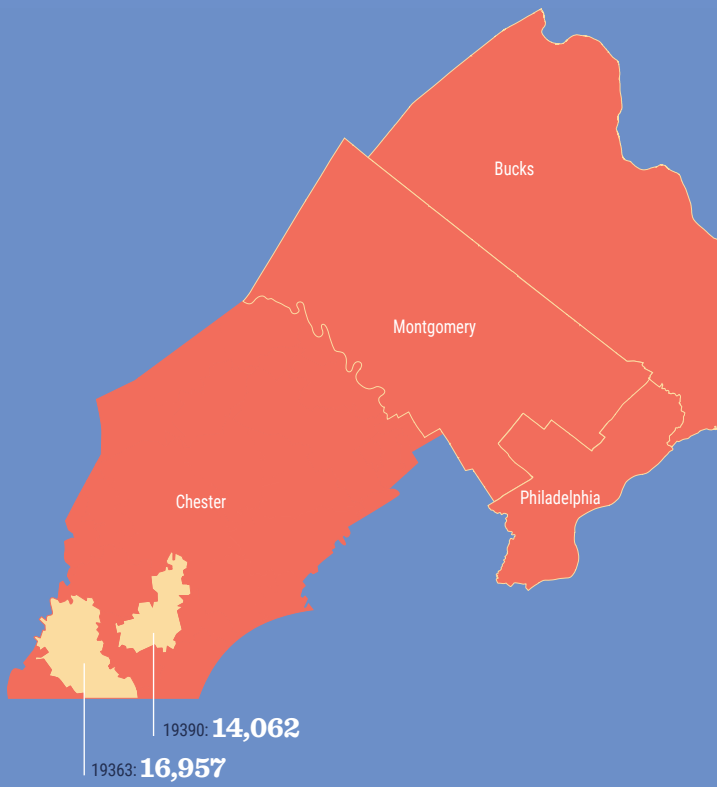
OXFORD AND WEST GROVE

This community is served by:

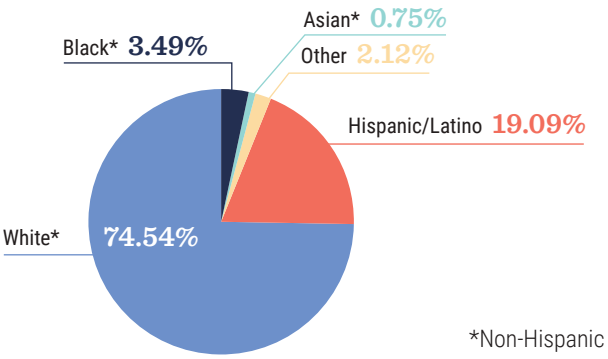
- Chester County Hospital
- Children's Hospital of Philadelphia

demographics

POPULATION

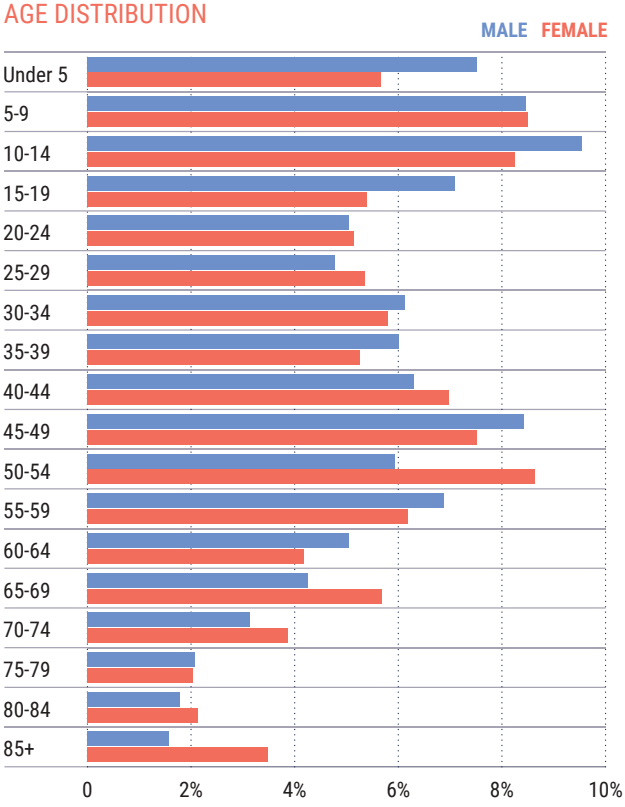


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Oxford & West Grove	Chester County
Chronic Disease & Smoking	Death rate (per 100,000 people)	717.5	651.6
	Premature CVD deaths (per 100,000 people)	37.2	36.5
	Diabetes hospitalizations (per 100,000 people)	145.1	114.3
	Adult obesity	30.2%	22.3%
	Hypertension hospitalizations (per 100,000 people)	306.3	257.7
	Cancer deaths (per 100,000 people)	71.9	65.1
	Mammography screening	81.1%	79.9%
	Colorectal screening	63.7%	71.1%
	Adult smoking	20.2%	15.3%
	Adult binge drinking	42.3%	19.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	6.3	4.3
	Percent of preterm or low birth weight births	8.7%	11.2%
	Late or inadequate prenatal care	45.9%	31.8%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	30.3	62.4
Injuries	Homicide mortality rate (per 100,000 people)	0.0	1.9
	Drug overdose mortality rate (per 100,000 people)	30.4	22.3
	Suicide mortality rate (per 100,000 people)	10.1	12.0
	Pedestrian and cyclist crash rate (per 100,000 people)	9.7	15.0
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	17,34.9	2,412.6
Access to Care	Adults 19-64 without insurance	14.9%	8.3%
	Children <19 without insurance	10.8%	5.0%
	Adults 19-64 with Medicaid	6.6%	5.8%
	Children <19 with public insurance	28.0%	18.7%
	Emergency department utilization (per 100,000 people)	3,933.1	9,992.6
	Emergency department high-utilizers (per 100,000 people)	16.1	98.9
Social & Economic Determinants	Percent in poverty	8.6%	6.8%
	Community need index score	3.1	2.2
	Excessive housing cost	32.4%	30.1%
	Housing with potential lead risk	25.2%	29.2%
	Households receiving food assistance	6.9%	4.9%
	Food insecurity	6.1%	7.6%
	Speak English less than "very well"	9.1%	4.5%

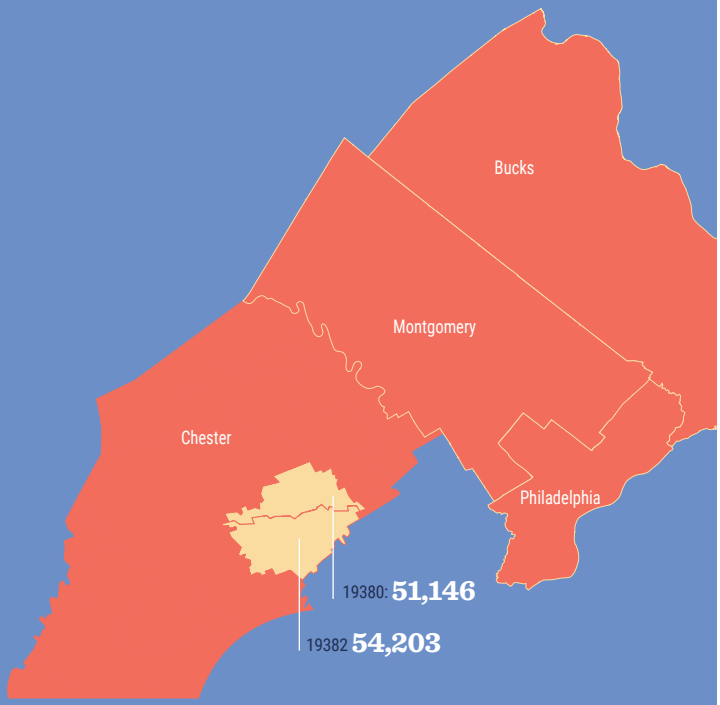
WEST CHESTER

This community is served by:

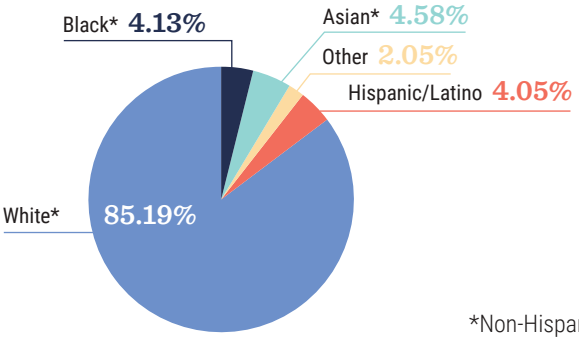
- Chester County Hospital
- Children's Hospital of Philadelphia

demographics

POPULATION

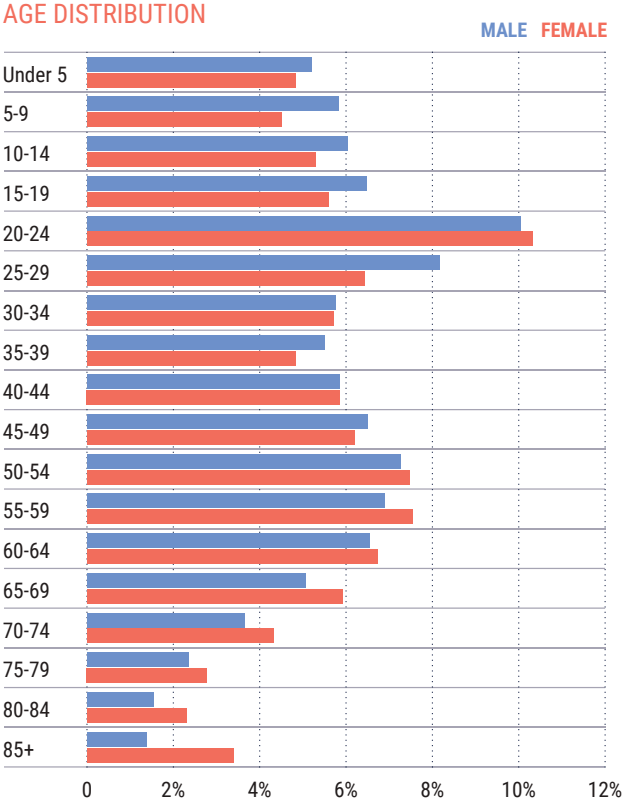


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		West Chester	Chester County
Chronic Disease & Smoking	Death rate (per 100,000 people)	637.9	651.6
	Premature CVD deaths (per 100,000 people)	29.4	36.5
	Diabetes hospitalizations (per 100,000 people)	92.0	114.3
	Adult obesity	21.5%	22.3%
	Hypertension hospitalizations (per 100,000 people)	254.2	257.7
	Cancer deaths (per 100,000 people)	62.4	65.1
	Mammography screening	81.0%	79.9%
	Colorectal screening	81.8%	71.1%
	Adult smoking	11.3%	15.3%
	Adult binge drinking	18.4%	19.8%
Infant & Child Health	Infant mortality (per 1,000 live births)	4.3	4.3
	Percent of preterm or low birth weight births	9.7%	11.2%
	Late or inadequate prenatal care	26.3%	31.8%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	68.6	62.4
Injuries	Homicide mortality rate (per 100,000 people)	1.3	1.9
	Drug overdose mortality rate (per 100,000 people)	17.5	22.3
	Suicide mortality rate (per 100,000 people)	10.1	12.0
	Pedestrian and cyclist crash rate (per 100,000 people)	27.5	15.0
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,747.5	2,412.6
Access to Care	Adults 19-64 without insurance	5.9%	8.3%
	Children <19 without insurance	2.4%	5.0%
	Adults 19-64 with Medicaid	4.2%	5.8%
	Children <19 with public insurance	11.5%	18.7%
	Emergency department utilization (per 100,000 people)	15,252.4	9,992.6
	Emergency department high-utilizers (per 100,000 people)	147.0	98.9
Social & Economic Determinants	Percent in poverty	8.1%	6.8%
	Community need index score	2.0	2.2
	Excessive housing cost	30.6%	30.1%
	Housing with potential lead risk	27.3%	29.2%
	Households receiving food assistance	2.3%	4.9%
	Food insecurity	4.0%	7.6%
	Speak English less than "very well"	3.0%	4.5%

COMMUNITY PERSPECTIVES

"I feel inadequate to counsel them sometimes, because it is so complex. I would say that the ease of understanding our own healthcare in this country for seniors is lacking."

"I think a lot of folks who have made it to the senior population are not used to questioning authority or asking [questions]. If the doctor says, 'take the drug that costs $20,000 a month', well that must be the drug I have to take, [as opposed to saying] 'I can't afford this, isn't there something else I can do?"

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on March 6, 2019 at West Chester Area Senior Center. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Availability of parks and recreation areas.
- High quality public schools.
- New urgent care centers that have recently opened in the area where providers spend more quality time with patients.

"You feel as though they're looking after you, they're not just out for the money part, they are helping you because you're going there because you're sick and you're telling them, so they're going to listen and help you. I know my doctor gets sick of me."

Priority Health Issues

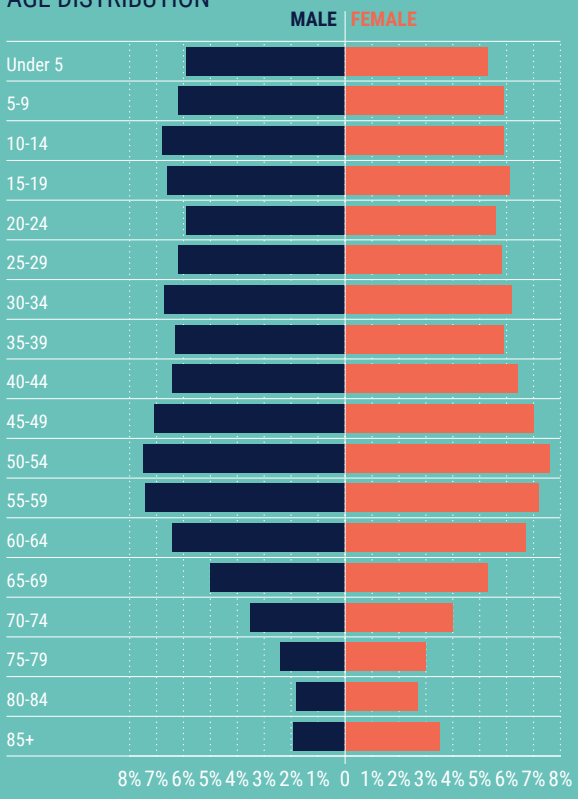
BEHAVIORAL HEALTH	» The opioid epidemic is impacting all of West Chester — all ages, races and neighborhoods — and most participants noted personal experiences.
ACCESS TO CARE	» Barriers to **access to quality** providers and health care services were discussed by participants, citing that most providers/services were located in Philadelphia, which is further away and harder to get to. » Challenges **navigating health systems as a senior citizen**, specifically in terms of awareness of health options, self-advocacy, and having the necessary knowledge to ensure quality and affordability of health services. » Need for price transparency for medications and medical services. For example, several participants provided personal examples of when they had been prescribed an expensive medication by their doctor and were unaware that cheaper versions were available. » Lack of understanding or preparation to manage **chronic diseases** and navigate health care systems, strong need for education and explicit training on how to self-advocate.
OLDER ADULTS	» Lack of a clear understanding of Medicare coverages. » **Lack of supply and financial constraints** are barriers to hiring in-home caretakers for seniors in the community; without affordable options, many are having to move to nursing homes or assisted living communities. » Knowledge gaps and a lack of comfort with technology are specific transportation barriers; a participant stated that "the senior population isn't really familiar" or "comfortable" with utilizing ride share platforms as an alternative. » **Existing stigma** around asking for help as well as participating or living in a senior center. » With a scarcity of senior living centers, price of real estate and moving, and the expense of in-home care, individuals in the community are feeling stuck and unsure about next steps.
SOCIAL AND ECONOMIC DETERMINANTS	» Limited forms of available, affordable, and timely **transportation**; services like Rover Community Transport can be unreliable for meeting medical appointment times. » Adequate and affordable **housing** for low income. » **Gentrification** has led to challenges for many long-term residents of the area, especially when it comes to moving within the community, as new housing developments are unaffordable. » Student loan debt was discussed as a prevalent and underlying concern for **young adults**; recent college graduates frequently need to move home because they cannot afford to live on their own, which can hinder or delay retirement for older adults.
YOUTH	» Youth spending too much time using technology as opposed to other extracurricular activities. » Limited access to affordable afterschool programs that provide additional supervision and structure for younger children.

MONTGOMERY COUNTY

Montgomery County houses 15 hospitals and 4 health centers. These health centers serve a combined 66,000 patients each year.

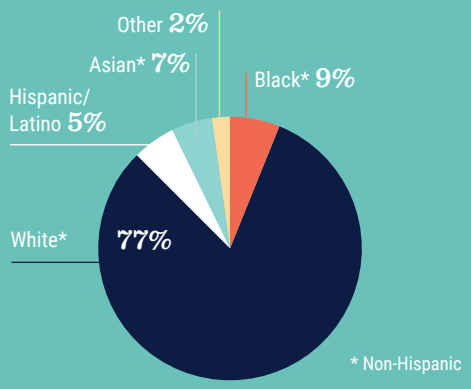
Montgomery County has an estimated population of 818,677. The largest proportion of residents is between the ages of 45 and 59.

AGE DISTRIBUTION



FOREIGN BORN: **10.7%**

NOT FLUENT IN ENGLISH: **4.4%**



Seventy-seven percent of the residents of Montgomery County are non-Hispanic White. Non-Hispanic Black residents make the next largest population, comprising 9 percent of Montgomery County's residents.

Nearly 11 percent of Montgomery County residents are foreign-born, and about 4 percent speak English less than "very well."

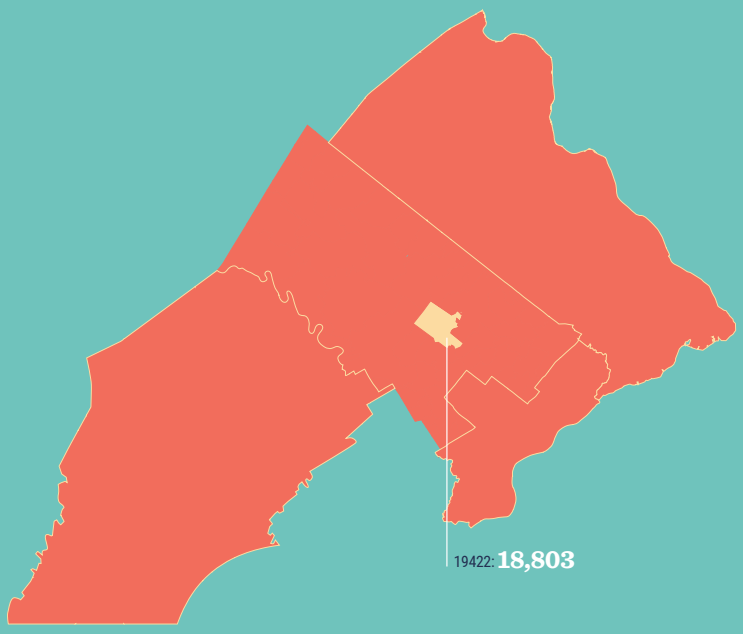
BLUE BELL

This community is served by:

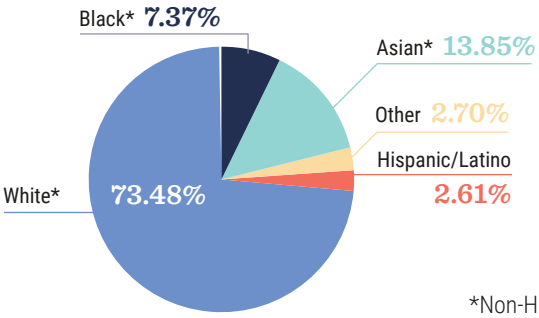
- Abington Hospital
- Abington-Lansdale Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery

demographics

POPULATION

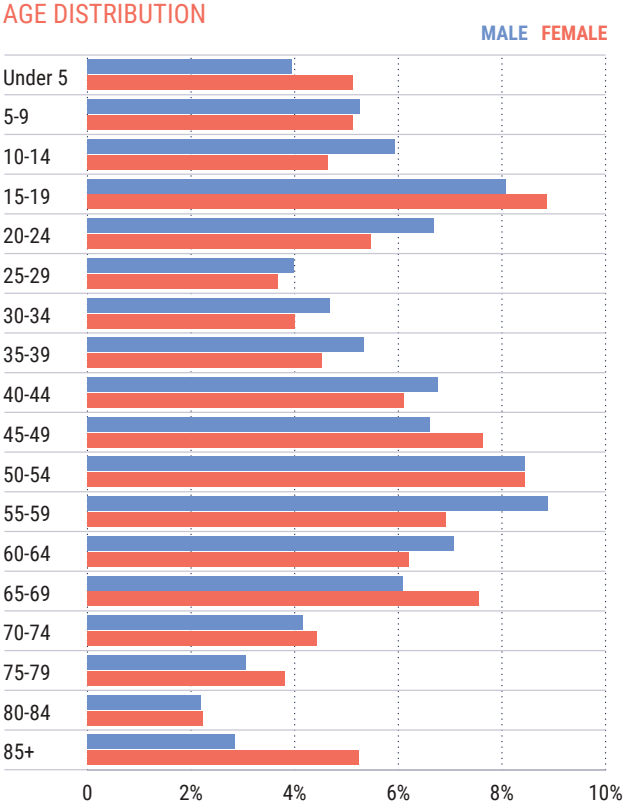


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Blue Bell	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	581.3	700.2
	Premature CVD deaths (per 100,000 people)	18.1	46.9
	Diabetes hospitalizations (per 100,000 people)	58.5	155.1
	Adult obesity	--	24.2%
	Hypertension hospitalizations (per 100,000 people)	250.0	323.6
	Cancer deaths (per 100,000 people)	61.3	70.5
	Mammography screening	--	82.1%
	Colorectal screening	--	73.5%
	Adult smoking	--	12.8%
	Adult binge drinking	--	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	1.8	4.2
	Percent of preterm or low birth weight births	9.7%	10.5%
	Late or inadequate prenatal care	23.2%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	40.3	107.1
Injuries	Homicide mortality rate (per 100,000 people)	1.9	1.7
	Drug overdose mortality rate (per 100,000 people)	22.5	23.5
	Suicide mortality rate (per 100,000 people)	13.3	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	31.9	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,418.5	2,544.6
Access to Care	Adults 19-64 without insurance	4.1%	6.5%
	Children <19 without insurance	4.1%	2.7%
	Adults 19-64 with Medicaid	4.0%	6.9%
	Children <19 with public insurance	12.6%	20.6%
	Emergency department utilization (per 100,000 people)	20,300.0	19,925.6
	Emergency department high-utilizers (per 100,000 people)	430.8	385.1
Social & Economic Determinants	Percent in poverty	3.6%	6.5%
	Community need index score	2.2	2.2
	Excessive housing cost	24.3%	30.6%
	Housing with potential lead risk	24.0%	39.1%
	Households receiving food assistance	2.0%	6.0%
	Food insecurity	--	9.3%
	Speak English less than "very well"	6.4%	4.4%

"—" Estimates are not available or unreliable due to low sample size within community.

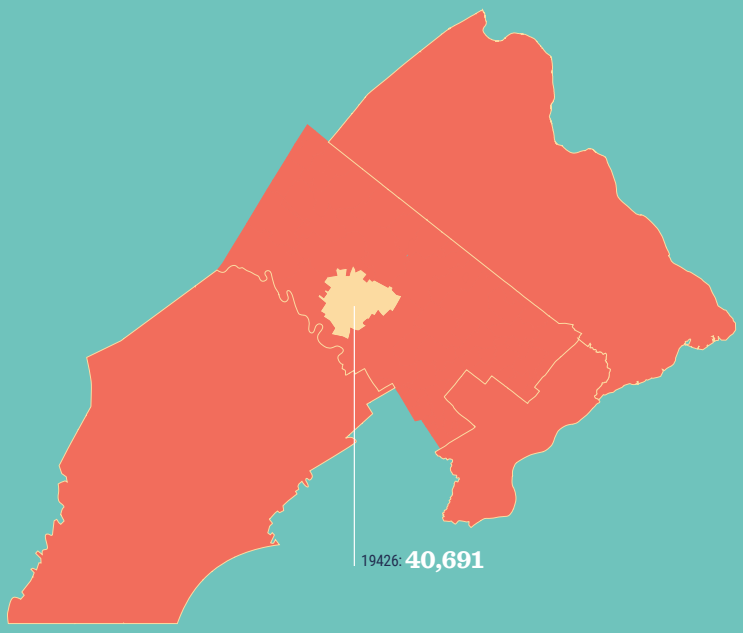
COLLEGEVILLE

This community is served by:

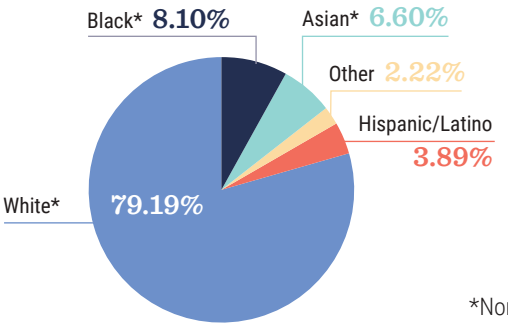
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery

demographics

POPULATION

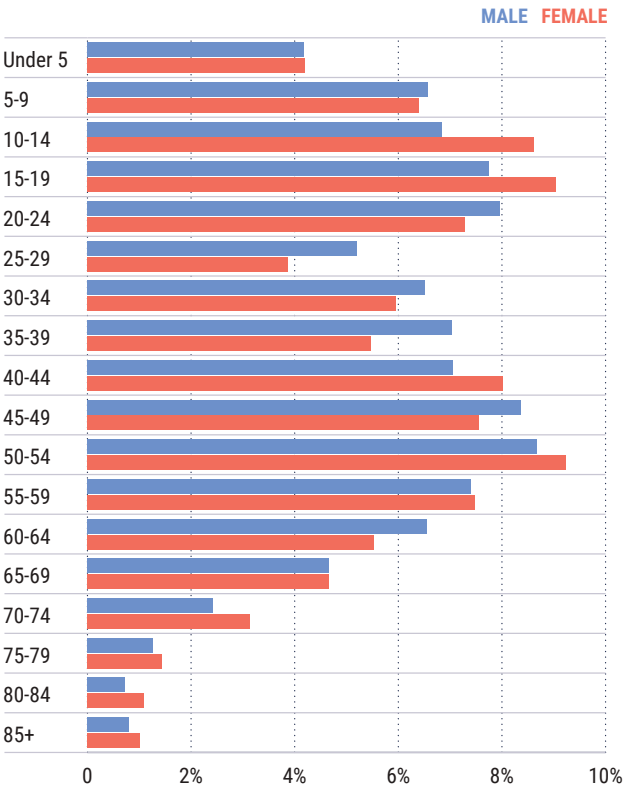


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Collegeville	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	698.6	700.2
	Premature CVD deaths (per 100,000 people)	33.8	46.9
	Diabetes hospitalizations (per 100,000 people)	95.8	155.1
	Adult obesity	--	24.2%
	Hypertension hospitalizations (per 100,000 people)	154.8	323.6
	Cancer deaths (per 100,000 people)	72.0	70.5
	Mammography screening	--	82.1%
	Colorectal screening	--	73.5%
	Adult smoking	--	12.8%
	Adult binge drinking	--	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	5.1	4.2
	Percent of preterm or low birth weight births	10.0%	10.5%
	Late or inadequate prenatal care	17.8%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	59.0	107.1
Injuries	Homicide mortality rate (per 100,000 people)	0.0	1.7
	Drug overdose mortality rate (per 100,000 people)	15.1	23.5
	Suicide mortality rate (per 100,000 people)	13.1	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	7.4	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	1,884.6	2,544.6
Access to Care	Adults 19-64 without insurance	4.1%	6.5%
	Children <19 without insurance	2.1%	2.7%
	Adults 19-64 with Medicaid	4.2%	6.9%
	Children <19 with public insurance	9.9%	20.6%
	Emergency department utilization (per 100,000 people)	13,071.7	19,925.6
	Emergency department high-utilizers (per 100,000 people)	235.9	385.1
Social & Economic Determinants	Percent in poverty	3.4%	6.5%
	Community need index score	1.6	2.2
	Excessive housing cost	25.6%	30.6%
	Housing with potential lead risk	20.9%	39.1%
	Households receiving food assistance	3.1%	6.0%
	Food insecurity	--	9.3%
	Speak English less than "very well"	3.4%	4.4%

"—" Estimates are not available or unreliable due to low sample size within community.

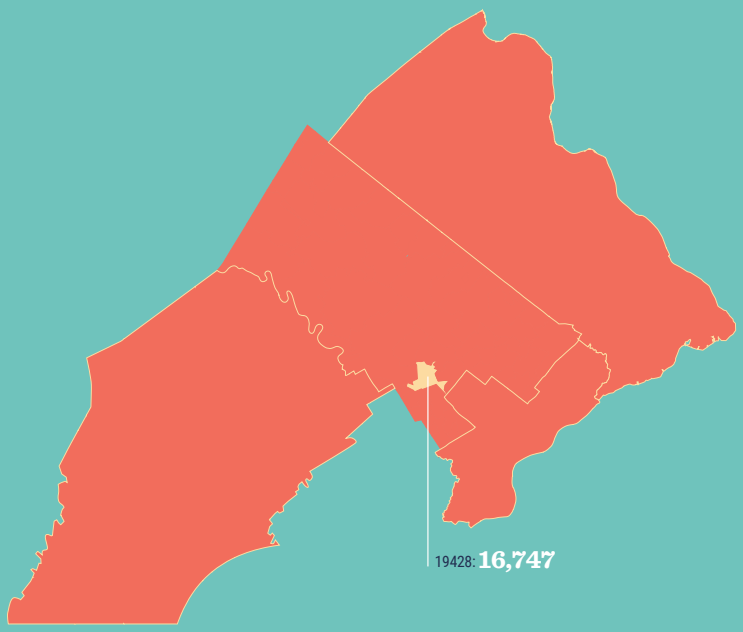
CONSHOHOCKEN

This community is served by:

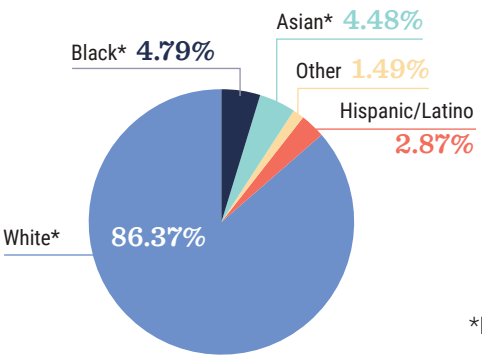
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery

demographics

POPULATION

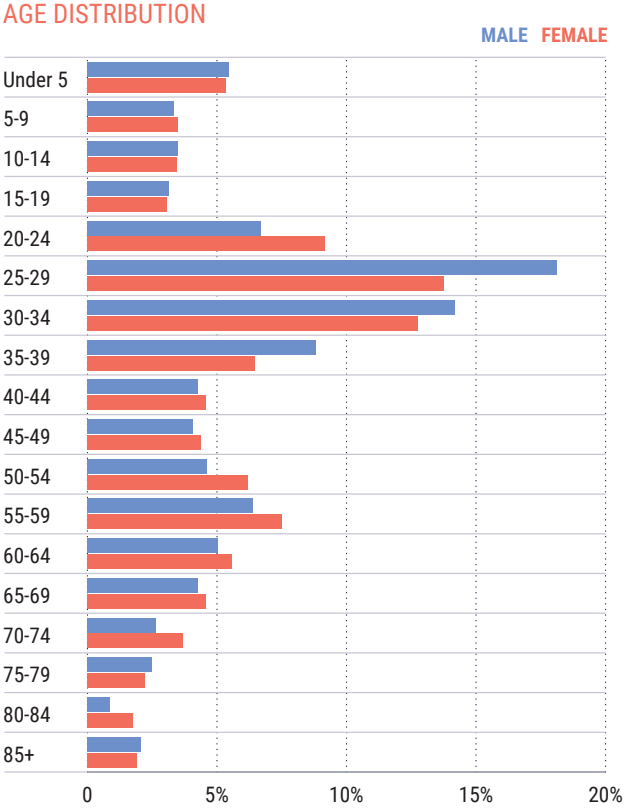


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Conshohocken	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	790.6	700.2
	Premature CVD deaths (per 100,000 people)	67.7	46.9
	Diabetes hospitalizations (per 100,000 people)	83.6	155.1
	Adult obesity	--	24.2%
	Hypertension hospitalizations (per 100,000 people)	364.2	323.6
	Cancer deaths (per 100,000 people)	94.8	70.5
	Mammography screening	--	82.1%
	Colorectal screening	--	73.5%
	Adult smoking	--	12.8%
	Adult binge drinking	--	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	8.0	4.2
	Percent of preterm or low birth weight births	9.5%	10.5%
	Late or inadequate prenatal care	23.5%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	--	107.1
Injuries	Homicide mortality rate (per 100,000 people)	2.0	1.7
	Drug overdose mortality rate (per 100,000 people)	34.2	23.5
	Suicide mortality rate (per 100,000 people)	19.4	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	35.8	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,169.0	2,544.6
Access to Care	Adults 19-64 without insurance	4.6%	6.5%
	Children <19 without insurance	0.9%	2.7%
	Adults 19-64 with Medicaid	4.6%	6.9%
	Children <19 with public insurance	16.2%	20.6%
	Emergency department utilization (per 100,000 people)	20,182.7	19,925.6
	Emergency department high-utilizers (per 100,000 people)	406.0	385.1
Social & Economic Determinants	Percent in poverty	7.1%	6.5%
	Community need index score	2.4	2.2
	Excessive housing cost	29.5%	30.6%
	Housing with potential lead risk	44.3%	39.1%
	Households receiving food assistance	5.2%	6.0%
	Food insecurity	--	9.3%
	Speak English less than "very well"	1.8%	4.4%

"—" Estimates are not available or unreliable due to low sample size within community.

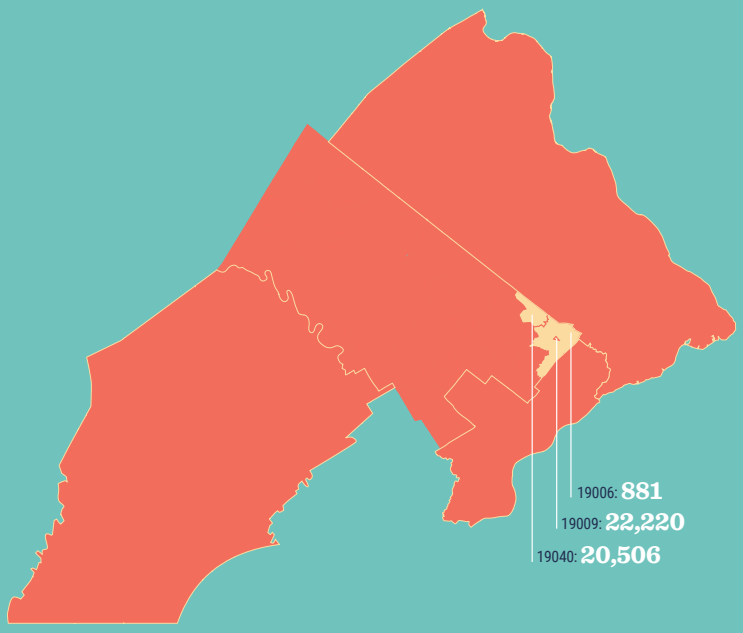
GREATER ABINGTON

This community is served by:

- Abington Hospital
- Children's Hospital of Philadelphia
- Holy Redeemer Hospital

demographics

POPULATION



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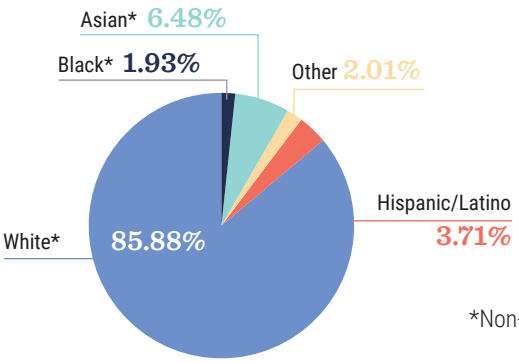
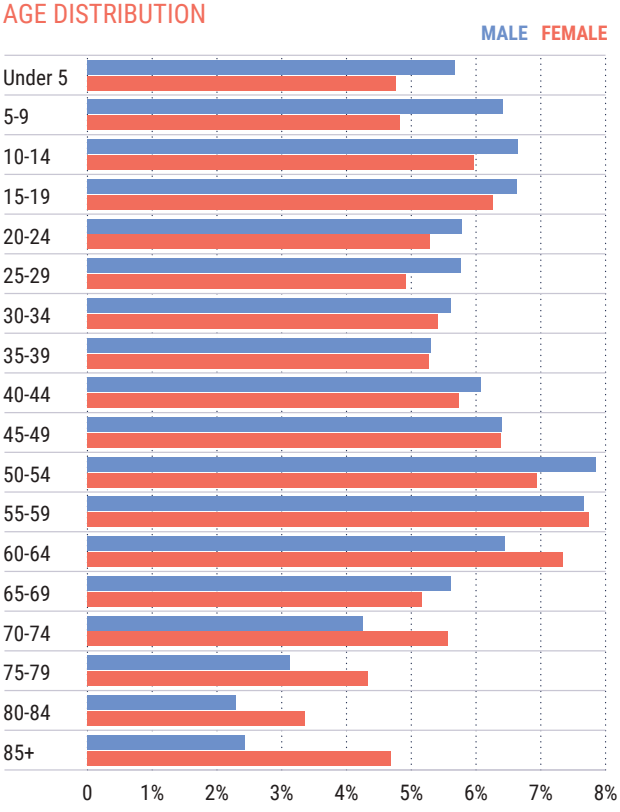


*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Greater Abington	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	652.4	700.2
	Premature CVD deaths (per 100,000 people)	39.3	46.9
	Diabetes hospitalizations (per 100,000 people)	142.2	155.1
	Adult obesity	28.8%	24.2%
	Hypertension hospitalizations (per 100,000 people)	314.2	323.6
	Cancer deaths (per 100,000 people)	79.4	70.5
	Mammography screening	77.1%	82.1%
	Colorectal screening	74.1%	73.5%
	Adult smoking	13.4%	12.8%
	Adult binge drinking	39.9%	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	6.8	4.2
	Percent of preterm or low birth weight births	12.1%	10.5%
	Late or inadequate prenatal care	23.3%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	76.4	107.1
Injuries	Homicide mortality rate (per 100,000 people)	0.8	1.7
	Drug overdose mortality rate (per 100,000 people)	25.3	23.5
	Suicide mortality rate (per 100,000 people)	18.0	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	16.1	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,784.0	2,544.6
Access to Care	Adults 19-64 without insurance	5.2%	6.5%
	Children <19 without insurance	1.5%	2.7%
	Adults 19-64 with Medicaid	5.9%	6.9%
	Children <19 with public insurance	18.7%	20.6%
	Emergency department utilization (per 100,000 people)	20,950.8	19,925.6
	Emergency department high-utilizers (per 100,000 people)	256.8	385.1
Social & Economic Determinants	Percent in poverty	4.1%	6.5%
	Community need index score	1.9	2.2
	Excessive housing cost	32.9%	30.6%
	Housing with potential lead risk	41.7%	39.1%
	Households receiving food assistance	4.7%	6.0%
	Food insecurity	12.2%	9.3%
	Speak English less than "very well"	5.2%	4.4%

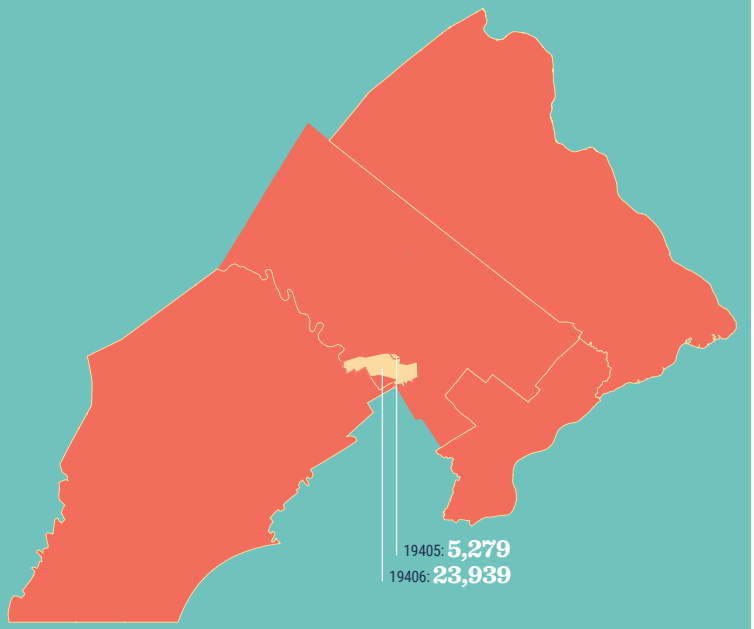
KING OF PRUSSIA

This community is served by:

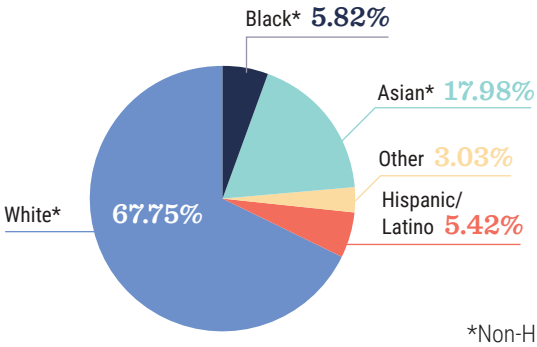
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery

demographics

POPULATION

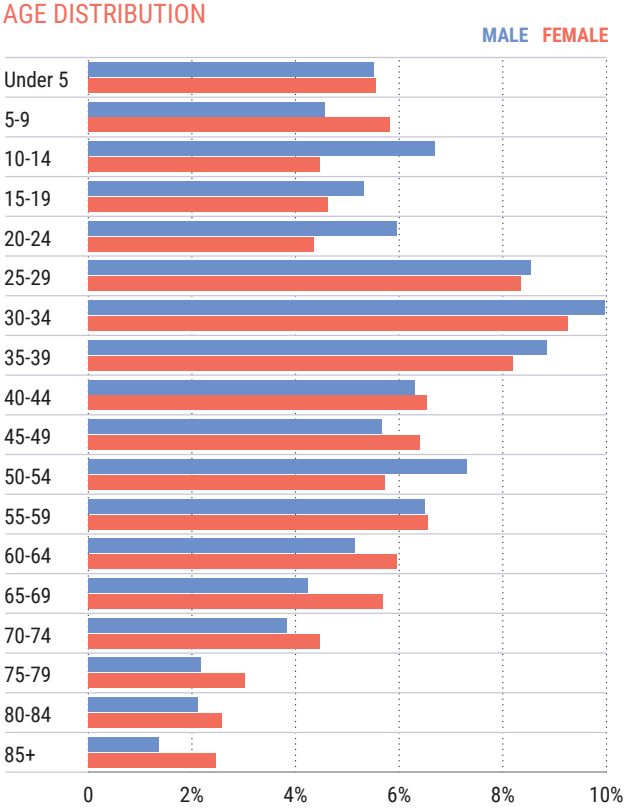


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		King of Prussia	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	626.7	700.2
	Premature CVD deaths (per 100,000 people)	49.1	46.9
	Diabetes hospitalizations (per 100,000 people)	102.5	155.1
	Adult obesity	24.6%	24.2%
	Hypertension hospitalizations (per 100,000 people)	283.7	323.6
	Cancer deaths (per 100,000 people)	72.0	70.5
	Mammography screening	66.5%	82.1%
	Colorectal screening	66.6%	73.5%
	Adult smoking	8.4%	12.8%
	Adult binge drinking	30.8%	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	2.9	4.2
	Percent of preterm or low birth weight births	12.6%	10.5%
	Late or inadequate prenatal care	27.7%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	97.1	107.1
Injuries	Homicide mortality rate (per 100,000 people)	0.0	1.7
	Drug overdose mortality rate (per 100,000 people)	24.5	23.5
	Suicide mortality rate (per 100,000 people)	9.7	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	30.8	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,841.9	2,544.6
Access to Care	Adults 19-64 without insurance	6.6%	6.5%
	Children <19 without insurance	1.5%	2.7%
	Adults 19-64 with Medicaid	4.9%	6.9%
	Children <19 with public insurance	19.6%	20.6%
	Emergency department utilization (per 100,000 people)	21,173.7	19,925.6
	Emergency department high-utilizers (per 100,000 people)	451.2	385.1
Social & Economic Determinants	Percent in poverty	6.0%	6.5%
	Community need index score	2.4	2.2
	Excessive housing cost	29.2%	30.6%
	Housing with potential lead risk	38.1%	39.1%
	Households receiving food assistance	4.3%	6.0%
	Food insecurity	7.4%	9.3%
	Speak English less than "very well"	8.9%	4.4%

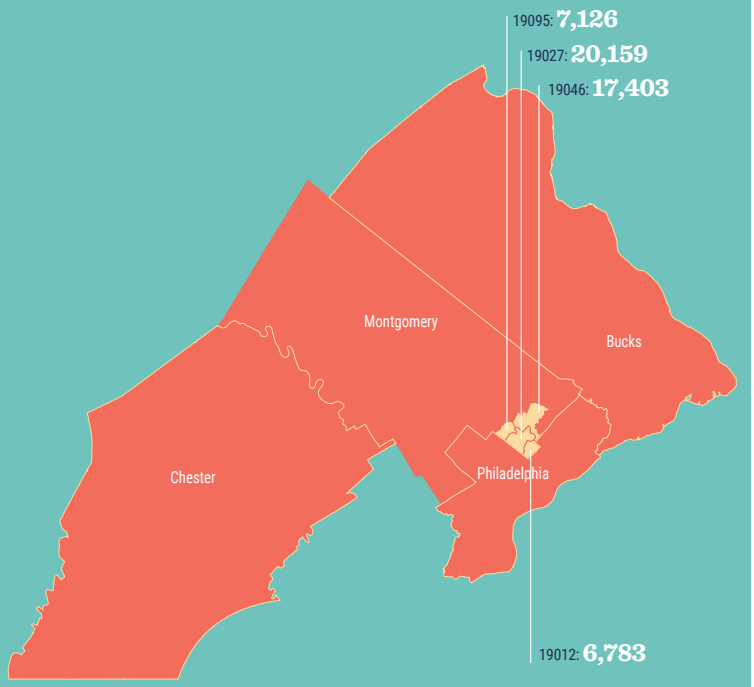
LOWER EASTERN MONTGOMERY

This community is served by:

- Abington Hospital
- Children's Hospital of Philadelphia
- Holy Redeemer Hospital

demographics

POPULATION



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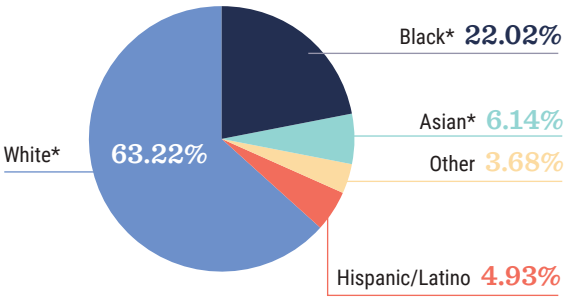
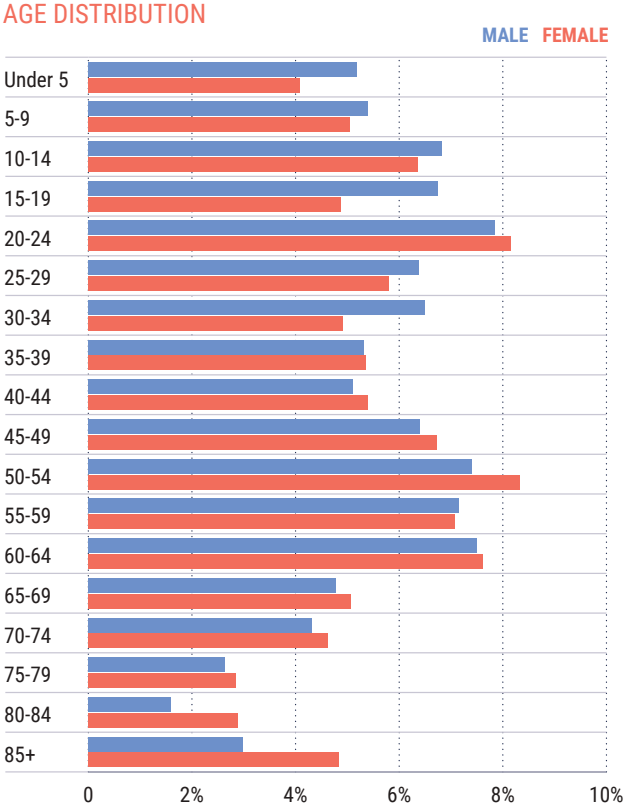


*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Lower Eastern Montgomery	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	711.2	700.2
	Premature CVD deaths (per 100,000 people)	46.6	46.9
	Diabetes hospitalizations (per 100,000 people)	155.4	155.1
	Adult obesity	30.3%	24.2%
	Hypertension hospitalizations (per 100,000 people)	392.5	323.6
	Cancer deaths (per 100,000 people)	62.2	70.5
	Mammography screening	79.4%	82.1%
	Colorectal screening	73.9%	73.5%
	Adult smoking	12.5%	12.8%
	Adult binge drinking	30.8%	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	7.7	4.2
	Percent of preterm or low birth weight births	11.9%	10.5%
	Late or inadequate prenatal care	28.4%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	120.2	107.1
Injuries	Homicide mortality rate (per 100,000 people)	3.3	1.7
	Drug overdose mortality rate (per 100,000 people)	17.4	23.5
	Suicide mortality rate (per 100,000 people)	13.6	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	48.6	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,904.5	2,544.6
Access to Care	Adults 19-64 without insurance	7.9%	6.5%
	Children <19 without insurance	3.3%	2.7%
	Adults 19-64 with Medicaid	7.0%	6.9%
	Children <19 with public insurance	19.0%	20.6%
	Emergency department utilization (per 100,000 people)	27,092.9	19,925.6
	Emergency department high-utilizers (per 100,000 people)	592.6	385.1
Social & Economic Determinants	Percent in poverty	7.2%	6.5%
	Community need index score	2.4	2.2
	Excessive housing cost	34.0%	30.6%
	Housing with potential lead risk	55.5%	39.1%
	Households receiving food assistance	6.0%	6.0%
	Food insecurity	7.5%	9.3%
	Speak English less than "very well"	3.3%	4.4%

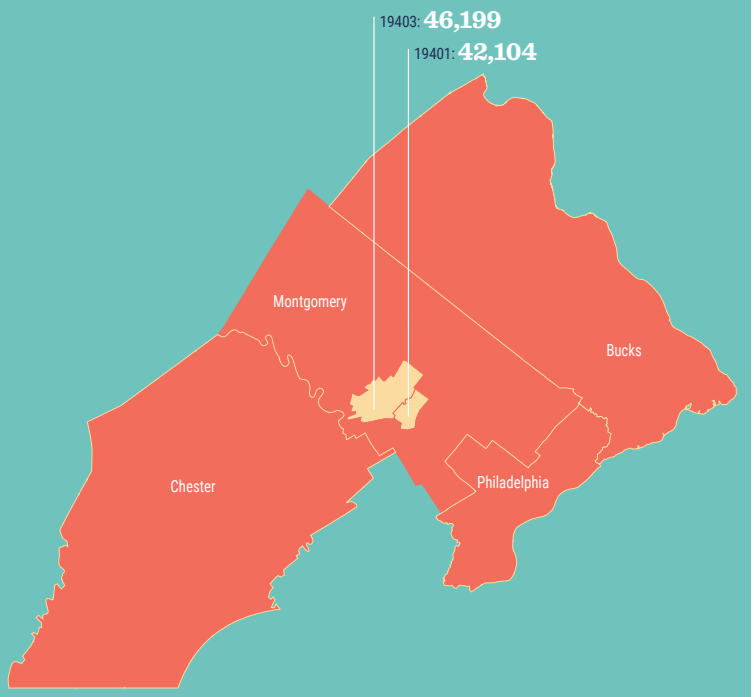
NORRISTOWN

This community is served by:

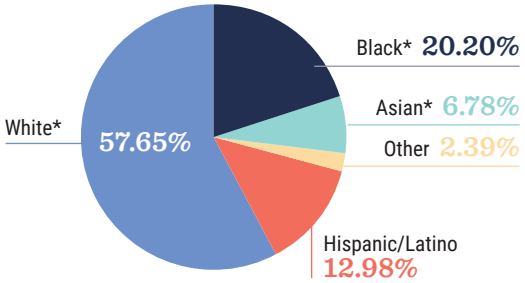
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery

demographics

POPULATION

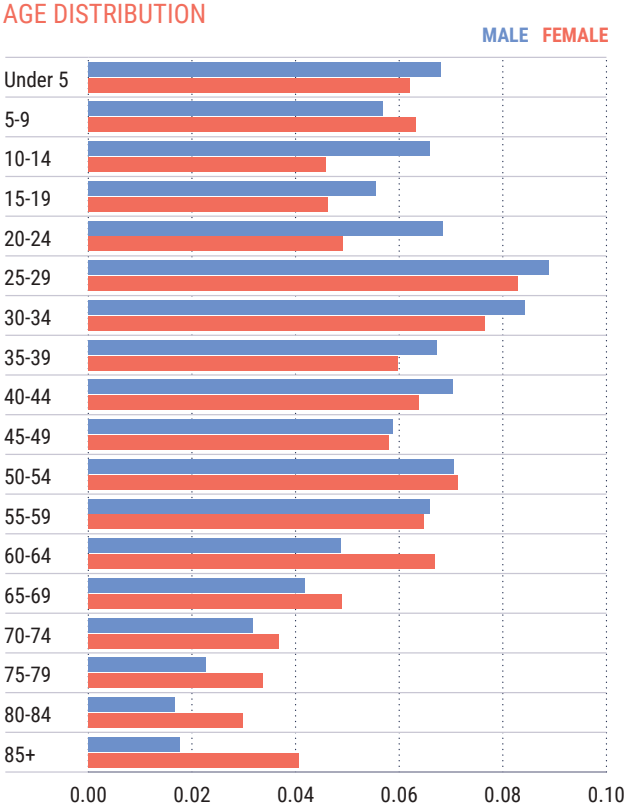


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Norristown	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	764.4	700.2
	Premature CVD deaths (per 100,000 people)	76.7	46.9
	Diabetes hospitalizations (per 100,000 people)	266.1	155.1
	Adult obesity	33.7%	24.2%
	Hypertension hospitalizations (per 100,000 people)	518.7	323.6
	Cancer deaths (per 100,000 people)	78.8	70.5
	Mammography screening	80.5%	82.1%
	Colorectal screening	63.1%	73.5%
	Adult smoking	18.5%	12.8%
	Adult binge drinking	21.8%	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	5.2	4.2
	Percent of preterm or low birth weight births	12.1%	10.5%
	Late or inadequate prenatal care	37.8%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	160.8	107.1
Injuries	Homicide mortality rate (per 100,000 people)	3.3	1.7
	Drug overdose mortality rate (per 100,000 people)	33.1	23.5
	Suicide mortality rate (per 100,000 people)	10.5	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	53.2	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,790.5	2,544.6
Access to Care	Adults 19-64 without insurance	13.1%	6.5%
	Children <19 without insurance	3.5%	2.7%
	Adults 19-64 with Medicaid	11.9%	6.9%
	Children <19 with public insurance	40.0%	20.6%
	Emergency department utilization (per 100,000 people)	34,364.6	19,925.6
	Emergency department high-utilizers (per 100,000 people)	1,082.6	385.1
Social & Economic Determinants	Percent in poverty	11.8%	6.5%
	Community need index score	3.0	2.2
	Excessive housing cost	35.3%	30.6%
	Housing with potential lead risk	40.6%	39.1%
	Households receiving food assistance	12.4%	6.0%
	Food insecurity	11.9%	9.3%
	Speak English less than "very well"	8.3%	4.4%

COMMUNITY PERSPECTIVES

"I was going to say with talking to families with children like in mental health services, there's a big language barrier for the Latino community because the parents don't speak English and the children need services. They're having to relay all this information to a child that then has to – that's the biggest problem, so then they're not going because there is that language barrier."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 26, 2019 at Norristown Library. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Accessability and availability of food resources and the library.
- A welcoming environment compared to large metropolitan areas and a strong sense of community.
- Many **community organizations** that offer services to low-income people or people experiencing homelessness; geographic proximity of these resources creates easier access for community members.

"There was a particular young lady who was couch surfing with her child and that wasn't good. Because the person who she was couch surfing [with] was a little bit — it wasn't physically abusive but was more like mentally and emotionally abusive to her and the kid."

Priority Health Issues

BEHAVIORAL HEALTH	» Challenges of depression and Post-Traumatic Stress Disorder, particularly in the **homeless** community. » High prevalence of **behavioral health needs** including substance use. » Need for greater **continuity of care**, particularly for mental health; improvements needed to discharge processes from mental health hospitals and coordinating patient needs. » **Care coordination** for people receiving treatment for multiple conditions, particularly increased communication between providers for substance use treatment, mental health, and physical health.
HOMELESSNESS AND HOUSING INSECURITY	» LGBTQ youth encounter mental health difficulties and homelessness more frequently; geographic and social isolation of Norristown make LGBTQ youth feel unwelcome. » Homelessness for children - whether couch surfing or in shelters - and the extent to which it places them in potentially traumatizing or dangerous situations. » Adolescent boys may be split up from their mothers in homeless shelters due to policies that don't allow males above a certain age to stay in the same quarters as women. » Need for **affordable, safe, and clean housing**; a specific example of housing's impact on health includes the effects of mold, cockroaches, and bedbugs on asthma. » Greater accessibility of unhealthy food compared to healthy food. » Food insecurity due to summer recess and holidays was a concern for school-aged children.
ENVIRONMENTAL CONDITIONS	» Substance use needs of the community have a significant impact on **neighborhood safety** and the **environment**. » Unused public spaces because of **public substance use**, intoxication, **trash and litter**. » **Hispanic community** may face unique vulnerability related to slumlords and quality housing.
ACCESS TO CARE	» Concerns regarding **quality and access to health services** were raised during the Norristown focus group. » Language barriers for Asian and Latino community members.
OLDER ADULTS	» Challenges for adult children in the community **caring for their elderly parents**; resources, if available, were not widely known. » Challenges for **older adults whose adult children with disabilities** live with them and are in need of medical and social support services. » **Transportation** for older adults and persons with disabilities is a substantial gap in community resources and results in social isolation for older adults.
YOUTH	» Community **lacks activities** for children such as a YMCA. » Youth spending too much time playing video games and on electronic devices.

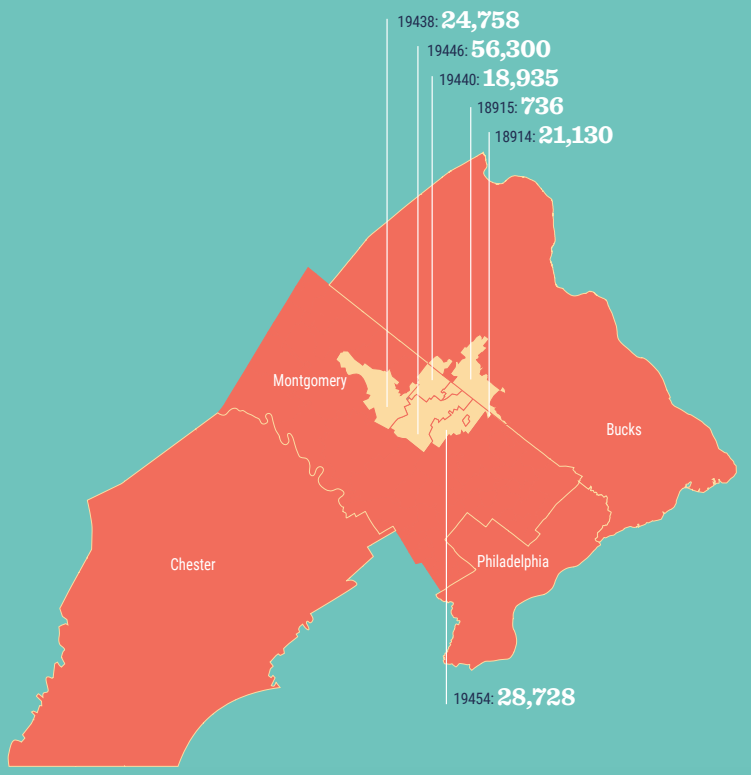
NORTH PENN AND LANSDALE

This community is served by:

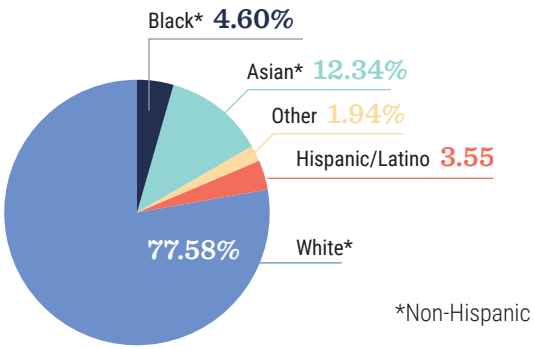
- Abington Hospital
- Abington-Lansdale Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Grand View Health

demographics

POPULATION

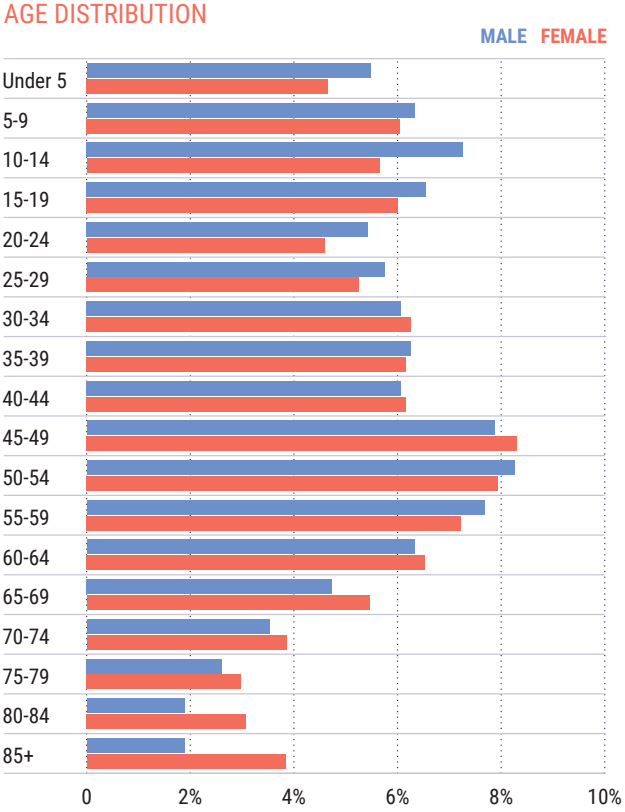


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		North Penn and Lansdale	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	665.0	700.2
	Premature CVD deaths (per 100,000 people)	35.1	46.9
	Diabetes hospitalizations (per 100,000 people)	142.8	155.1
	Adult obesity	25.1%	24.2%
	Hypertension hospitalizations (per 100,000 people)	243.7	323.6
	Cancer deaths (per 100,000 people)	70.1	70.5
	Mammography screening	78.2%	82.1%
	Colorectal screening	69.9%	73.5%
	Adult smoking	7.8%	12.8%
	Adult binge drinking	31.1%	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	1.7	4.2
	Percent of preterm or low birth weight births	10.9%	10.5%
	Late or inadequate prenatal care	23.3%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	106.0	107.1
Injuries	Homicide mortality rate (per 100,000 people)	1.7	1.7
	Drug overdose mortality rate (per 100,000 people)	18.7	23.5
	Suicide mortality rate (per 100,000 people)	10.9	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	23.9	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,235.3	2,544.6
Access to Care	Adults 19-64 without insurance	5.5%	6.5%
	Children <19 without insurance	1.9%	2.7%
	Adults 19-64 with Medicaid	5.1%	6.9%
	Children <19 with public insurance	14.8%	20.6%
	Emergency department utilization (per 100,000 people)	23,716.5	19,925.6
	Emergency department high-utilizers (per 100,000 people)	309.5	385.1
Social & Economic Determinants	Percent in poverty	4.8%	6.5%
	Community need index score	2.0	2.2
	Excessive housing cost	29.1%	30.6%
	Housing with potential lead risk	25.2%	39.1%
	Households receiving food assistance	3.9%	6.0%
	Food insecurity	9.9%	9.3%
	Speak English less than "very well"	5.4%	4.4%

COMMUNITY PERSPECTIVES

"With minimum wage, you know, it's nearly impossible, I think, to afford good daycare. And a lot of daycares are open during normal work hours, and a lot of parents are not necessarily working during those normal hours."

"They were so afraid of calling 911 because of the cost of the ambulance, knowing that insurance may not pay for it, the only way they pay for it is if you check in the hospital."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 2, 2019 at North Penn Commons. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Community organizations, spiritual organizations, community parks, and local government.
- Organizations like MANNA, the PEAK center, and the YMCA are partners that make the community stronger.
- Many options in Lansdale for good access to healthy food and fresh produce via the farmer's market, grocers, and accessible transportation.
- Neighborhood's accessibility, racial and cultural diversity, and public events such as concerts.
- Montgomery County OPH is a key asset to health in the community.
- Strong local school district.

Priority Health Issues

YOUTH	» Stressors for children in the school environment, like bullying, and addressing mental health needs in schools. » Lack of engagement in activities outside of home and school settings; need for funding and transportation assistance to after school programs.
BEHAVIORAL HEALTH	» **Behavioral health and substance use**, particularly among young people, is a key problem in the community. » Substance use treatment is available but not frequently accessed by the target population. » Long wait times are a barrier and frustration when accessing mental health services.
ENVIRONMENTAL CONDITIONS	» Impact of substance use and homelessness on perceived safety in the community.
ACCESS TO CARE	» **Accessibility** of health care services in Lansdale is often limited by financial and employment constraints. » **Rising out of pocket costs of health care**.
OLDER ADULTS	» Social isolation and lack of self-efficacy, especially regarding challenges that seniors face in knowing what resources are available to them in the community.

"Bullying as well. I mean, the schools are great at doing as much as they can, but they are overwhelmed. The counselors are overwhelmed. The issues of trauma leading up to this is significant, and I'm fearful. I'm fearful for the future of their health as adults, because they've been through so much stress and anxiety during their teenage years."

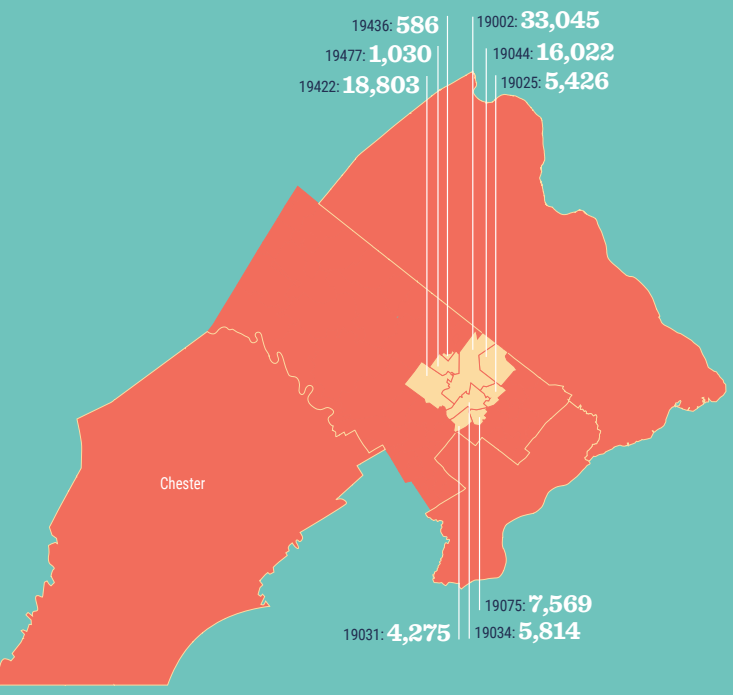
UPPER DUBLIN

This community is served by:

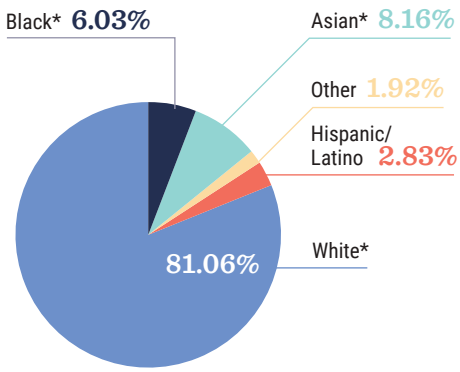
- Abington Hospital
- Abington-Lansdale Hospital
- Children's Hospital of Philadelphia
- Einstein Medical Center Montgomery

demographics

POPULATION

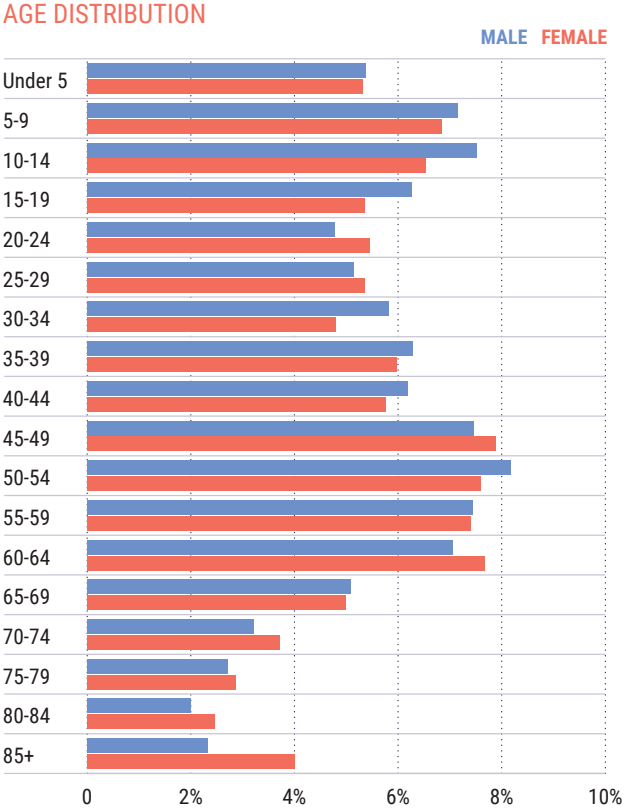


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Upper Dublin	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	689.8	700.2
	Premature CVD deaths (per 100,000 people)	38.8	46.9
	Diabetes hospitalizations (per 100,000 people)	129.1	155.1
	Adult obesity	22.9%	24.2%
	Hypertension hospitalizations (per 100,000 people)	271.7	323.6
	Cancer deaths (per 100,000 people)	68.7	70.5
	Mammography screening	88.2%	82.1%
	Colorectal screening	74.1%	73.5%
	Adult smoking	10.6%	12.8%
	Adult binge drinking	37.5%	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	2.0	4.2
	Percent of preterm or low birth weight births	9.6%	10.5%
	Late or inadequate prenatal care	22.7%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	46.9	107.1
Injuries	Homicide mortality rate (per 100,000 people)	1.9	1.7
	Drug overdose mortality rate (per 100,000 people)	22.1	23.5
	Suicide mortality rate (per 100,000 people)	8.6	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	20.2	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,812.4	2,544.6
Access to Care	Adults 19-64 without insurance	5.7%	6.5%
	Children <19 without insurance	3.2%	2.7%
	Adults 19-64 with Medicaid	4.6%	6.9%
	Children <19 with public insurance	15.1%	20.6%
	Emergency department utilization (per 100,000 people)	15,991.0	19,925.6
	Emergency department high-utilizers (per 100,000 people)	238.1	385.1
Social & Economic Determinants	Percent in poverty	4.1%	6.5%
	Community need index score	1.9	2.2
	Excessive housing cost	27.9%	30.6%
	Housing with potential lead risk	35.5%	39.1%
	Households receiving food assistance	3.4%	6.0%
	Food insecurity	8.9%	9.3%
	Speak English less than "very well"	3.7%	4.4%

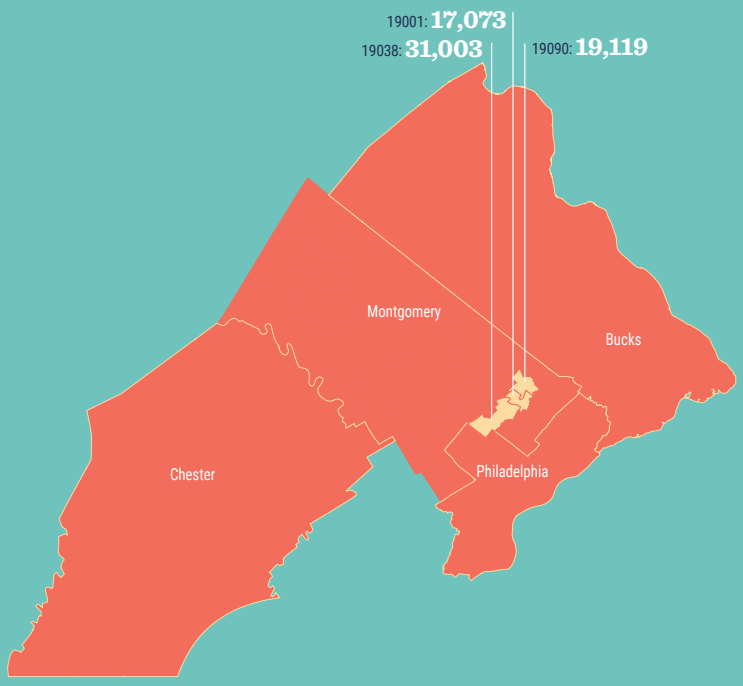
WILLOW GROVE

This community is served by:

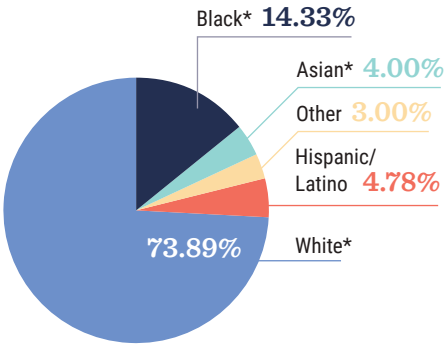
- Abington Hospital
- Children's Hospital of Philadelphia

demographics

POPULATION



RACE/ETHNICITY



*Non-Hispanic

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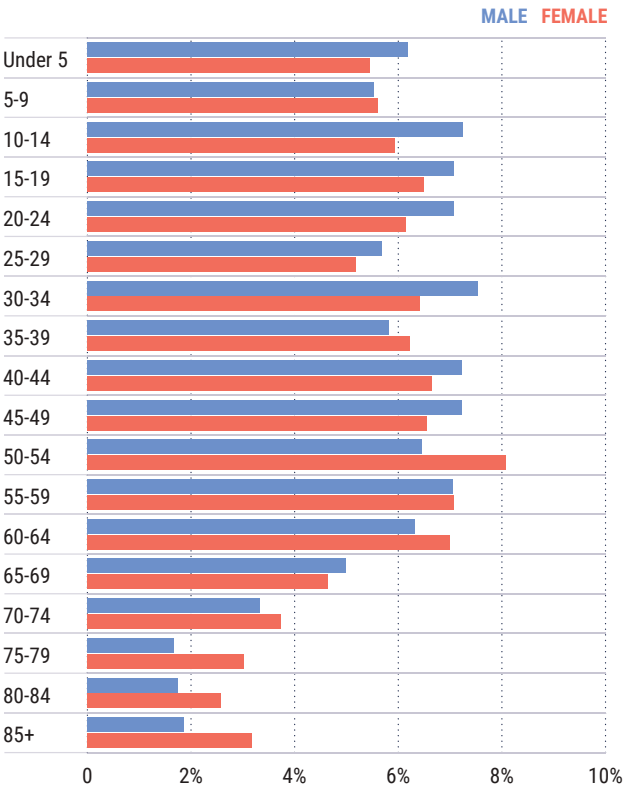


summary health measures

NOTABLE

		Willow Grove	Montgomery County
Chronic Disease & Smoking	Death rate (per 100,000 people)	744.3	700.2
	Premature CVD deaths (per 100,000 people)	56.7	46.9
	Diabetes hospitalizations (per 100,000 people)	184.5	155.1
	Adult obesity	29.7%	24.2%
	Hypertension hospitalizations (per 100,000 people)	331.9	323.6
	Cancer deaths (per 100,000 people)	77.2	70.5
	Mammography screening	78.0%	82.1%
	Colorectal screening	72.3%	73.5%
	Adult smoking	13.7%	12.8%
	Adult binge drinking	16.9%	16.6%
Infant & Child Health	Infant mortality (per 1,000 live births)	3.3	4.2
	Percent of preterm or low birth weight births	10.5%	10.5%
	Late or inadequate prenatal care	24.0%	26.2%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	123.9	107.1
Injuries	Homicide mortality rate (per 100,000 people)	1.4	1.7
	Drug overdose mortality rate (per 100,000 people)	22.6	23.5
	Suicide mortality rate (per 100,000 people)	10.4	12.4
	Pedestrian and cyclist crash rate (per 100,000 people)	38.7	30.9
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,505.5	2,544.6
Access to Care	Adults 19-64 without insurance	5.2%	6.5%
	Children <19 without insurance	2.6%	2.7%
	Adults 19-64 with Medicaid	8.3%	6.9%
	Children <19 with public insurance	22.4%	20.6%
	Emergency department utilization (per 100,000 people)	22,900.5	19,925.6
	Emergency department high-utilizers (per 100,000 people)	382.5	385.1
Social & Economic Determinants	Percent in poverty	6.4%	6.5%
	Community need index score	2.2	2.2
	Excessive housing cost	32.0%	30.6%
	Housing with potential lead risk	57.6%	39.1%
	Households receiving food assistance	7.4%	6.0%
	Food insecurity	5.9%	9.3%
	Speak English less than "very well"	2.7%	4.4%

COMMUNITY PERSPECTIVES

"In the Moreland School District, we have 33 percent that are on a free or reduced [meal] program. Despite the awareness of this issue, there are still barriers to utilizing and disseminating this resource because not every school is eligible for participation and there is still an onus on parents to fill out the paperwork."

"There's a bunch of people that don't quite make enough money to be able to afford affordable housing. [Single, working moms] employed, making money, but not enough money to be financially independent."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 6, 2019 at GIANT Community Center. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Transportation-related benefits of living in this area, including **accessibility** to major highways and living within walking distance of various train stations that connect to regional rail lines with widespread destinations.
- Consistent and reliable clearing of snow and trash within neighborhoods.
- Accessibility and availability of "safe, clean, and affordable" **community organizations**, resources, and activities within close proximity to home, including malls, banks, culturally diverse restaurants, social services, and health clinics.
- The Annex Courthouse or meetings held by the Abington Township Police Department for sources of community-based resources and information.
- School districts and quality of **education** as being "some of the best in the state."
- Availability of extracurricular activities, including the music and theater programs.
- Programs such as SNAP, H.A.T. (Helping Around Town) Packs in Hatboro, and summer meal programs as some of the ways the community and government is currently providing **more nutritious foods to food insecure families**.

Priority Health Issues

GENERAL

- Challenges related to knowledge of and access to community-based services that provide additional support for those with chronic disease.
- Widespread misconception of the community's financial makeup and how that affects availability and allocation of resources within the Willow Grove area.
- Homelessness, food insecurity, and unavailability of affordable and high-quality healthcare were continually depicted as "not obvious" and thereby not receiving the same levels of funding or attention as compared to other suburbs where these concerns are "very visible."
- **Affordable housing** and issues related to **homelessness**.
- Housing programs such as Section 8 Voucher, Your Way Home, and The Ambler Interfaith, may result in only being able to "stay for a month" or short term.
- Inequitable **access to quality and affordable healthcare** for many middle-class families in the area.
- **Navigating the health systems**, insurance coverage and available services is challenging.
- Affordability of dental care for both insured and uninsured individuals.
- Longer emergency department wait-times and lower levels of satisfaction after merger of Abington and Jefferson Hospitals.

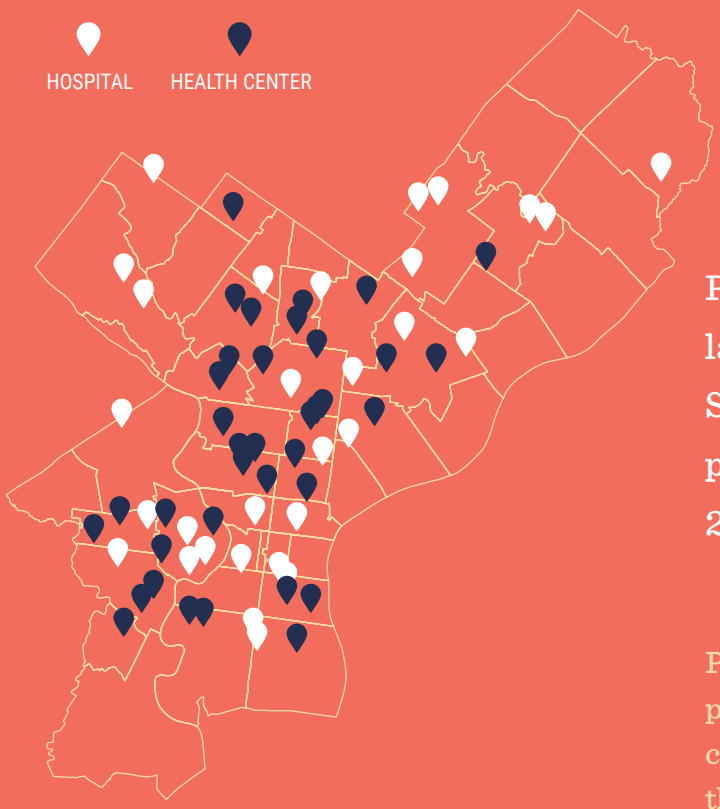
YOUTH

- Exposure to social media, increased technology use.
- Increase in food allergies for unknown reasons.
- **Childhood obesity and access to nutritious foods**; despite several programs providing kids with school lunches and families with daily meals, there are still challenges when it comes to eligibility for services.
- Mental health challenges in school, specifically for girls, often related to social conflicts and bullying on social media platforms.
- High obesity rates linked with high availability of fast food and lack of physical activity.
- Lack of awareness of eligibility for food programs like school lunches and daily meals.

OLDER ADULTS

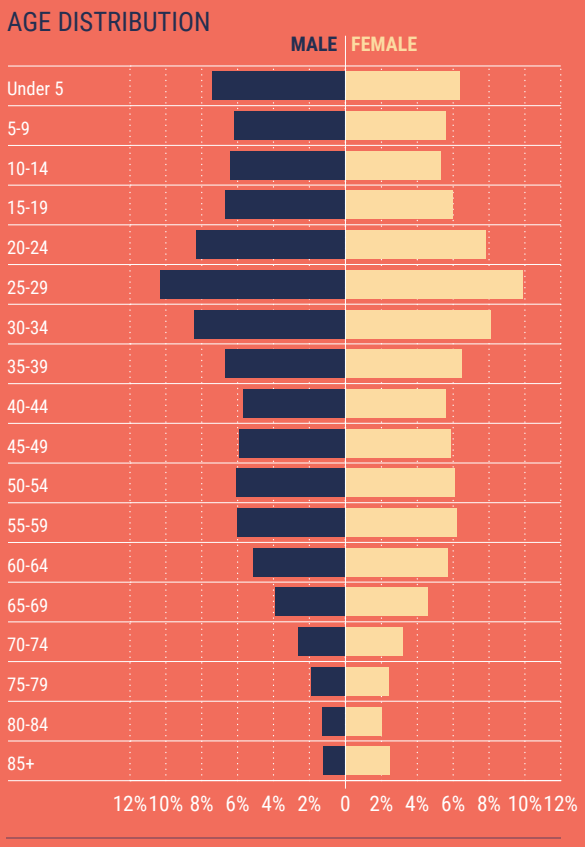
- Affordable housing, loneliness, increased healthcare costs and copays, and lack of technological skills.
- Lack of social activities and peers.

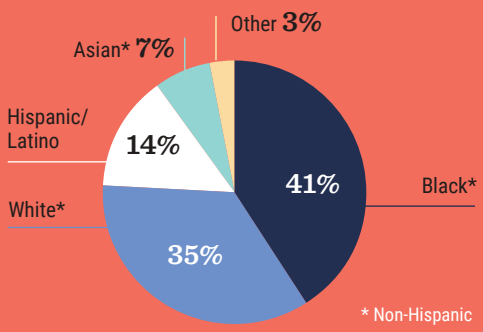
PHILADELPHIA COUNTY



Philadelphia is the sixth largest city in the United States, with an estimated population of 1,580,863 in 2017.

Philadelphia's young adult population (ages 20 to 34 years) continues to grow and represents the largest portion of the population.





Philadelphia's population is racially and ethnically diverse. Forty-one percent of the population is non-Hispanic black, 35 percent is non-Hispanic white, 14 percent is Hispanic/Latino, and 7 percent is Asian.

Thirteen percent of Philadelphia's residents were born outside of the United States. About 11 percent speak English less than "very well."

FOREIGN BORN: **13.4%**

NOT FLUENT IN ENGLISH: **10.6%**

summary health measures

NOTABLE

		Center City	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	672.3	927.4
	Premature CVD deaths (per 100,000 people)	67.3	104.8
	Diabetes hospitalizations (per 100,000 people)	252.3	371.9
	Adult obesity	17.4%	29.8%
	Hypertension hospitalizations (per 100,000 people)	358.5	649.2
	Cancer deaths (per 100,000 people)	65.3	97.6
	Mammography screening	84.4%	82.9%
	Colorectal screening	78.3%	70.8%
	Adult smoking	11.0%	19.5%
	Adult binge drinking	28.3%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	3.8	8.2
	Percent of preterm or low birth weight births	11.0%	14.2%
	Late or inadequate prenatal care	42.5%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	178.6	727.3
Injuries	Homicide mortality rate (per 100,000 people)	4.3	17.6
	Drug overdose mortality rate (per 100,000 people)	22.4	48.3
	Suicide mortality rate (per 100,000 people)	12.2	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	292.2	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,771.1	2,363.1
Access to Care	Adults 19-64 without insurance	5.1%	14.9%
	Children <19 without insurance	4.4%	4.2%
	Adults 19-64 with Medicaid	7.3%	23.1%
	Children <19 with public insurance	30.1%	58.6%
	Emergency department utilization (per 100,000 people)	41,207.5	55,382.0
	Emergency department high-utilizers (per 100,000 people)	1,278.3	1,716.9
Social & Economic Determinants	Percent in poverty	15.3%	25.8%
	Community need index score	3.0	4.0
	Excessive housing cost	35.5%	38.9%
	Housing with potential lead risk	53.2%	61.1%
	Households receiving food assistance	6.7%	24.5%
	Food insecurity	11.9%	19.0%
	Speak English less than "very well"	5.0%	10.6%

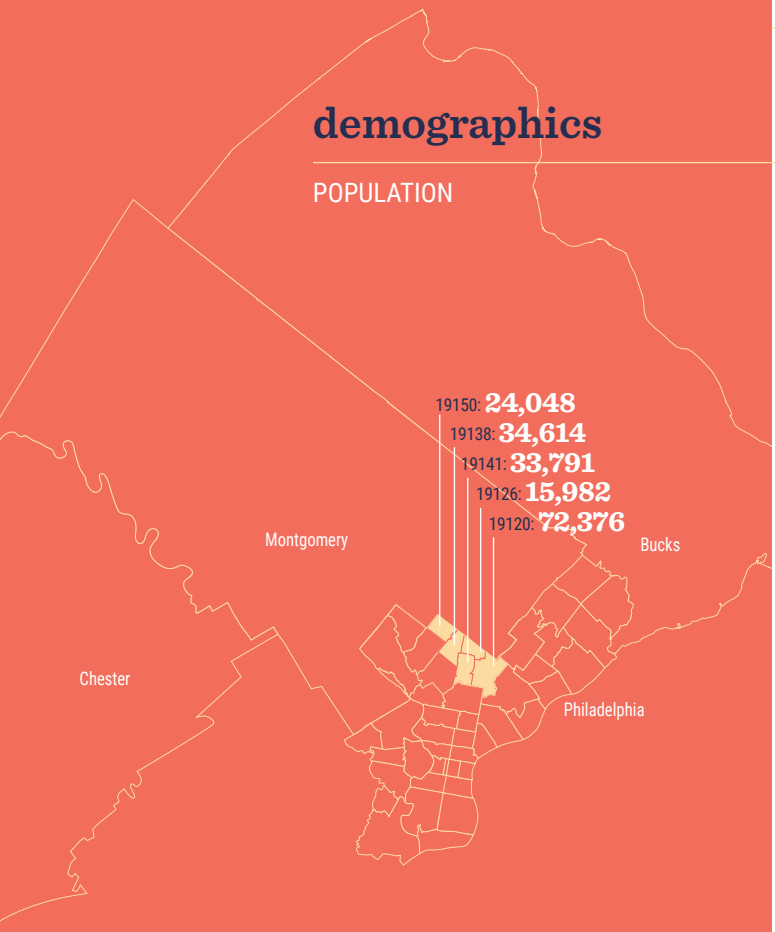
FAR NORTH PHILADELPHIA

This community is served by:

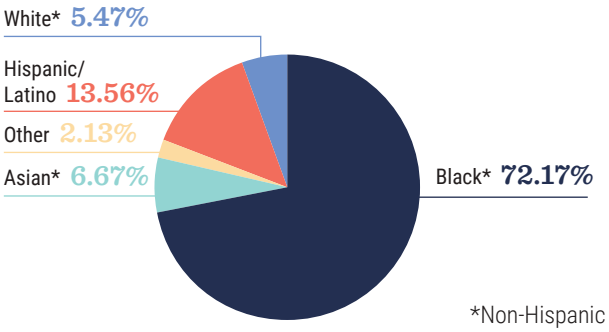
- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Jefferson Health – Northeast

demographics

POPULATION

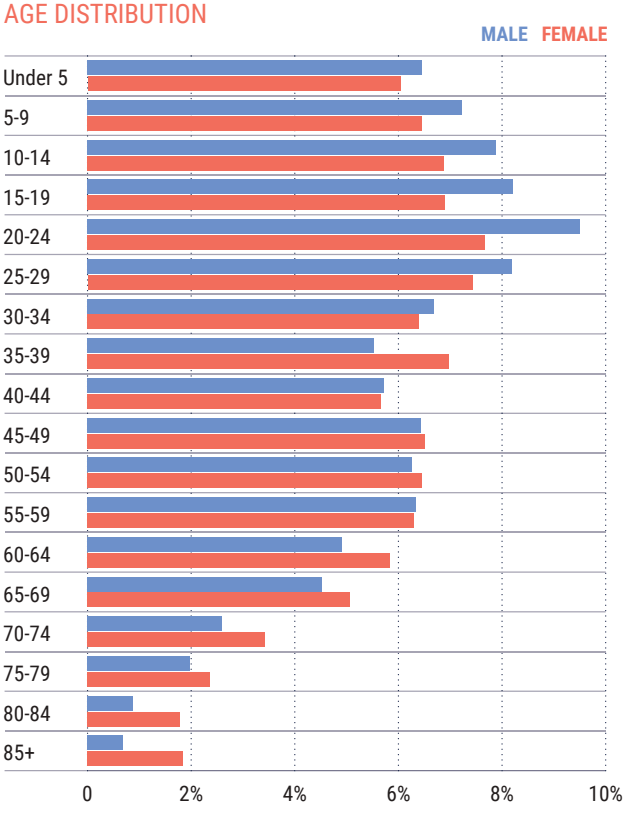


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Far North Philadelphia	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	928.7	927.4
	Premature CVD deaths (per 100,000 people)	110.8	104.8
	Diabetes hospitalizations (per 100,000 people)	442.5	371.9
	Adult obesity	37.5%	29.8%
	Hypertension hospitalizations (per 100,000 people)	805.3	649.2
	Cancer deaths (per 100,000 people)	105.6	97.6
	Mammography screening	88.7%	82.9%
	Colorectal screening	76.2%	70.8%
	Adult smoking	19.9%	19.5%
	Adult binge drinking	16.8%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	10.5	8.2
	Percent of preterm or low birth weight births	17.0%	14.2%
	Late or inadequate prenatal care	46.0%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	773.5	727.3
Injuries	Homicide mortality rate (per 100,000 people)	21.9	17.6
	Drug overdose mortality rate (per 100,000 people)	25.5	48.3
	Suicide mortality rate (per 100,000 people)	6.1	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	89.0	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	1,558.2	2,363.1
Access to Care	Adults 19-64 without insurance	17.6%	14.9%
	Children <19 without insurance	6.3%	4.2%
	Adults 19-64 with Medicaid	26.1%	23.1%
	Children <19 with public insurance	61.9%	58.6%
	Emergency department utilization (per 100,000 people)	67,322.2	55,382.0
	Emergency department high-utilizers (per 100,000 people)	2,497.1	1,716.9
Social & Economic Determinants	Percent in poverty	25.8%	25.8%
	Community need index score	4.2	4.0
	Excessive housing cost	40.7%	38.9%
	Housing with potential lead risk	67.2%	61.1%
	Households receiving food assistance	28.9%	24.5%
	Food insecurity	23.1%	19.0%
	Speak English less than "very well"	10.5%	10.6%

COMMUNITY PERSPECTIVES

"The quality of service you get on Medicaid is highly lacking. They sort you and can send you to certain places. So for mental health, the places are already overrun and underfunded... you can't really get what you need. You have to really, really advocate for yourself. You have to be your own caseworker, because you won't get what you need, nine times out of 10, because they're overrun."

"In some ways, the adolescent population has lost faith in the adult population... I had to work with teens who sold drugs because that was how the family survived...But it becomes a lifestyle that you get so steeped in, and for the child who is doing that and appears successful, he attracts others who see that you got money, you got clothes, you got girls. What's to think about? And when they see maybe their parents are working and struggling and still not able to provide, they lose faith in the system."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 13, 2019 at St. Paul's Evangelical Lutheran Church. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Convenient transportation, affordable housing, a strong business community and access to diverse community organizations such as the library, churches, hospitals (Einstein Healthcare Network) and schools and universities (La Salle University).
- Neighborhood is clean and well maintained by residents.
- Diverse, informed, and responsible citizens who work collaboratively.
- Programs like Mental Health First Aid for Teens course offered by the Department of Behavioral Health and Intellectual Disabilities.

"We talk about the 5th Street corridor and the businesses, thriving businesses, but there are a lot of like pizza, cheesesteak, restaurants. If I don't have a vehicle, if I don't have transportation and this is the food that I have access to on a daily basis, as opposed to it being a weekend treat, that affects your health."

Priority Health Issues

BEHAVIORAL HEALTH	» Substance use and the opioid epidemic further strain **limited access to and the quality of behavioral health** services. » Lack of mental health providers and cost of behavioral health services. » The behavioral health system was described as underfunded and overworked. » Social isolation, depression and substance use among older adults; need for more safe, affordable activities for older adults.
CHRONIC DISEASE	» **Chronic diseases** such as diabetes, obesity and asthma impact children and adults.
ACCESS TO CARE	» Limited to no access to urgent care centers. » Financial barriers to care including health insurance issues and out of pocket costs. » Low access to health and behavioral services for the **persons with disabilities**. » **Communication** with healthcare providers due to inadequate time with providers and use of difficult-to-understand terminology.
ENVIRONMENTAL CONDITIONS	» Safety concerns limit "kids being able to play outside" and as a result youth spend more time on sedentary activities that involve "too much screen time." » Inequity in terms of **access to healthy, affordable food**; clear differences in food quality among various grocers and the quality and cost of food varies depending on which community you live in. » Preponderance of inexpensive fast food and lack of physical activity in schools were identified as risk factors for obesity. » **Community transportation** to food stores requires a car or using the "hack-man" (unofficial cars that provide taxi services), as public transportation does not go to supermarkets. » Healthier food choices are more expensive and the sugar beverage tax was cited as limiting access to soda and other beverages.
YOUTH	» Many youth experience multiple sources trauma including: community violence, bullying, absent fathers and male role models, parental abandonment, out-of-home placement, and parental drug use. » Exposure to adverse childhood experiences can create barriers to building intergenerational relationships, which are essential for communities to thrive. » Need to create learning environments geared to children with special needs. » Children with ADHD or behavioral issues often stigmatized and over medicated.

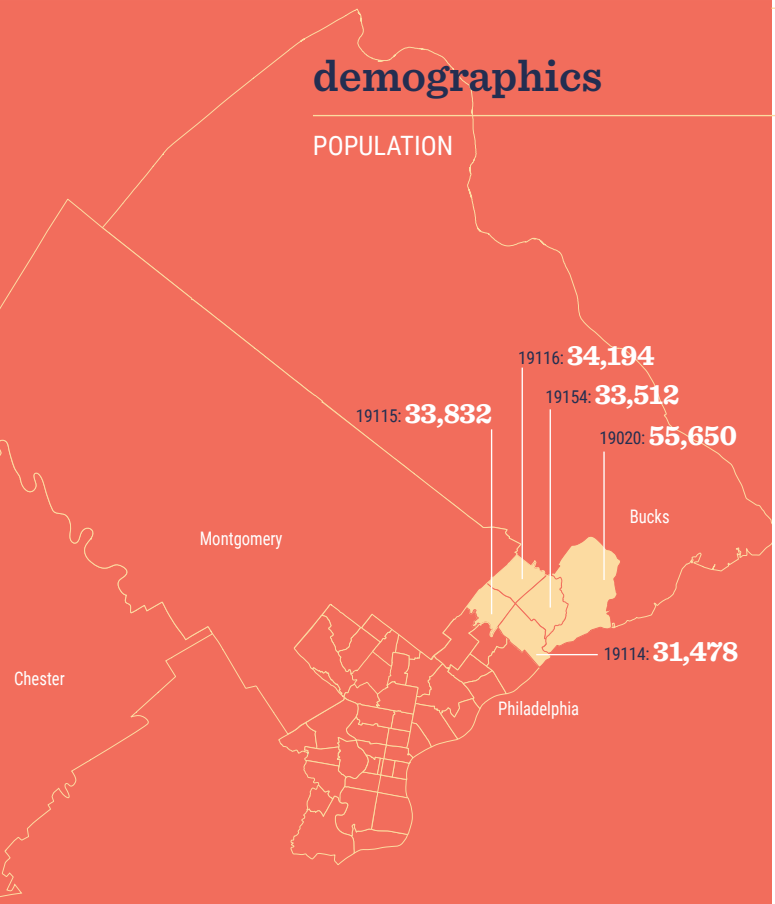
FAR NORTHEAST PHILADELPHIA

This community is served by:

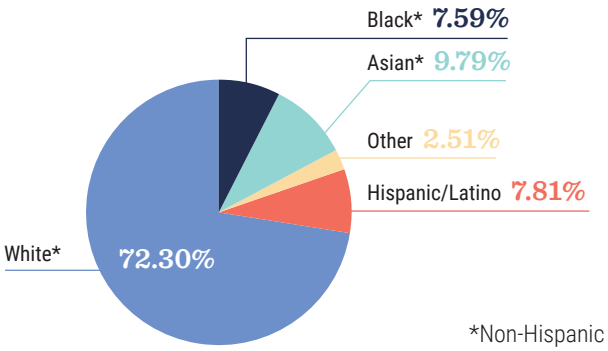
- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia/ Elkins Park
- Holy Redeemer Health System
- Jefferson Health – Northeast

demographics

POPULATION

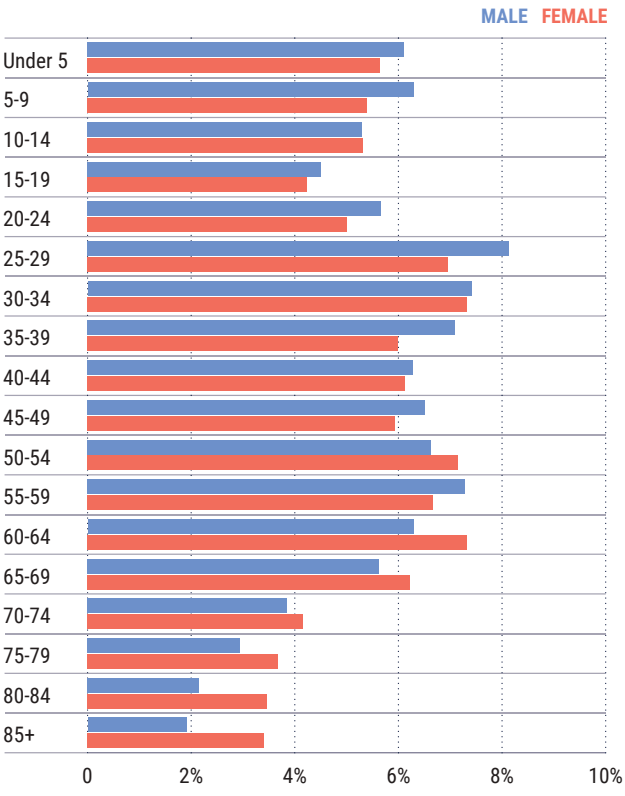


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Far Northeast Philadelphia	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	886.5	927.4
	Premature CVD deaths (per 100,000 people)	70.8	104.8
	Diabetes hospitalizations (per 100,000 people)	238.5	371.9
	Adult obesity	30.2%	29.8%
	Hypertension hospitalizations (per 100,000 people)	538.0	649.2
	Cancer deaths (per 100,000 people)	84.4	97.6
	Mammography screening	81.3%	82.9%
	Colorectal screening	65.3%	70.8%
	Adult smoking	17.0%	19.5%
	Adult binge drinking	23.7%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	3.4	8.2
	Percent of preterm or low birth weight births	11.4%	14.2%
	Late or inadequate prenatal care	35.0%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	155.6	727.3
Injuries	Homicide mortality rate (per 100,000 people)	3.0	17.6
	Drug overdose mortality rate (per 100,000 people)	49.2	48.3
	Suicide mortality rate (per 100,000 people)	14.2	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	46.6	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,637.2	2,363.1
Access to Care	Adults 19-64 without insurance	10.8%	14.9%
	Children <19 without insurance	3.9%	4.2%
	Adults 19-64 with Medicaid	11.8%	23.1%
	Children <19 with public insurance	36.3%	58.6%
	Emergency department utilization (per 100,000 people)	31,667.6	55,382.0
	Emergency department high-utilizers (per 100,000 people)	580.4	1,716.9
Social & Economic Determinants	Percent in poverty	10.6%	25.8%
	Community need index score	2.9	4.0
	Excessive housing cost	36.4%	38.9%
	Housing with potential lead risk	31.4%	61.1%
	Households receiving food assistance	12.7%	24.5%
	Food insecurity	14.5%	19.0%
	Speak English less than "very well"	13.5%	10.6%

COMMUNITY PERSPECTIVES

"So, once they go to the rehab, there's nothing that keeps them on that straight path. Say they go away for 60 days or 30 days, when they get out, there's nothing for them."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 25, 2019 at Northeast Philadelphia Chamber of Commerce. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Accessibility, including walkability; ample public transportation.
- Presence of ample health care resources such as doctors, dentists, and hospitals.
- Availability of employment and education opportunities.
- Community members' civic engagement and willingness to take part in **community organizations**.

Priority Health Issues

BEHAVIORAL HEALTH	» Substance use and drug overdoses highlighted the community's most pressing **behavioral health concerns**. » Perceived barriers to therapy and medication to address these needs. » High prevalence of anxiety and depression, both among children and adults; barriers to therapy and medication. » Suicide perceived as common and possibly related to bullying in schools and drug addiction.
ACCESS TO CARE	» Health care **quality and access** for low-income populations who have to travel farther to obtain affordable medical care. » Lack of an emergency department (ED). » Difficulty scheduling appointments with primary care doctors resulting in use of urgent care facilities. » Many people earning too much to qualify for public insurance, but not enough to afford private health insurance. » Difficulty understanding the cost of **health insurance** and limited transparency in health care costs. » High deductibles for health insurance create a financial burden such that it is "almost not worth it" to have private health insurance. » Difficulty finding doctors that are trusted who also accept their health insurance and who are local.
SOCIAL AND ECONOMIC DETERMINANTS	» Some local services intended to provide preventive care to low-income populations have challenges engaging with parents whose children may benefit from those services. » Perceived lack of social cohesion among some community members; particularly new residents who are renting homes. » Public schools in the area have declined in quality and seen as unsafe, even for parents.
ENVIRONMENTAL CONDITIONS	» Car and motorcycle accidents were perceived as a common event, creating a dangerous everyday **environment** for both vehicles and pedestrians. » Many parks are lacking trees to provide coverage for pedestrians, especially during warmer months.
CHRONIC CONDITIONS	» Cancer – particularly breast cancer – as a **chronic disease** priority. » Rising rates of diabetes and cardiovascular disease as conditions are also having a significant impact.

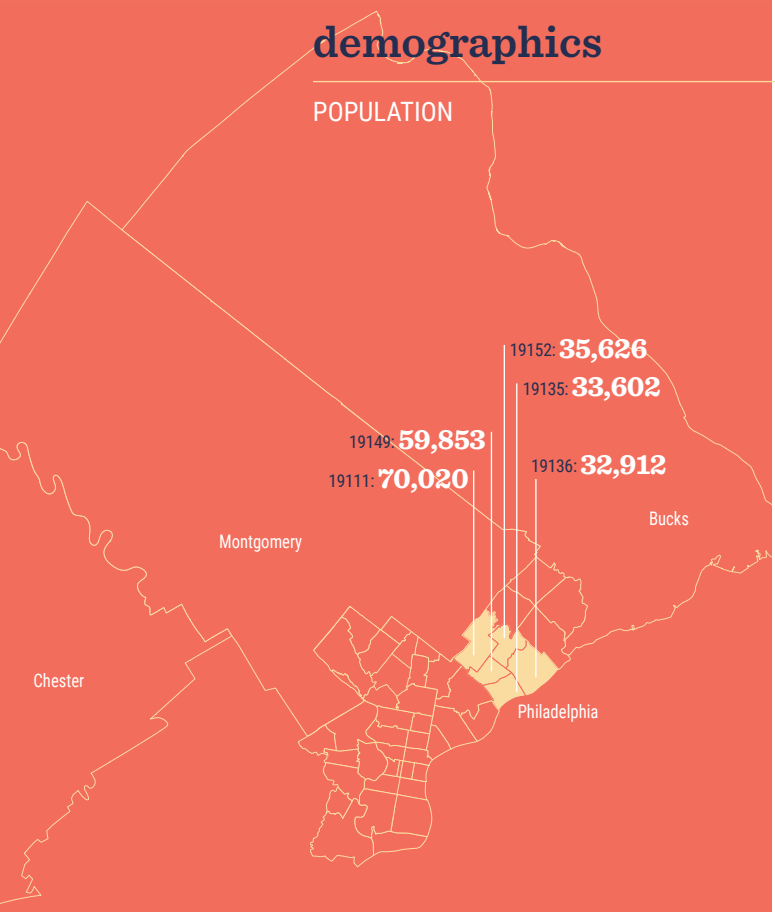
LOWER NORTHEAST PHILADELPHIA

This community is served by:

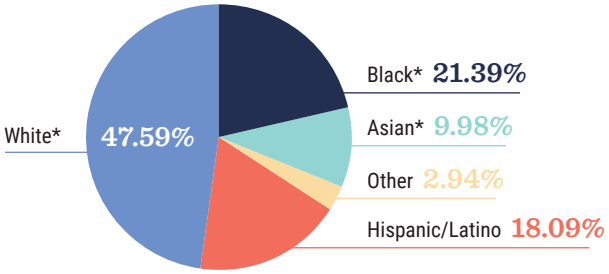
- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia/ Elkins Park
- Holy Redeemer Health System
- Jefferson Health – Northeast

demographics

POPULATION



RACE/ETHNICITY



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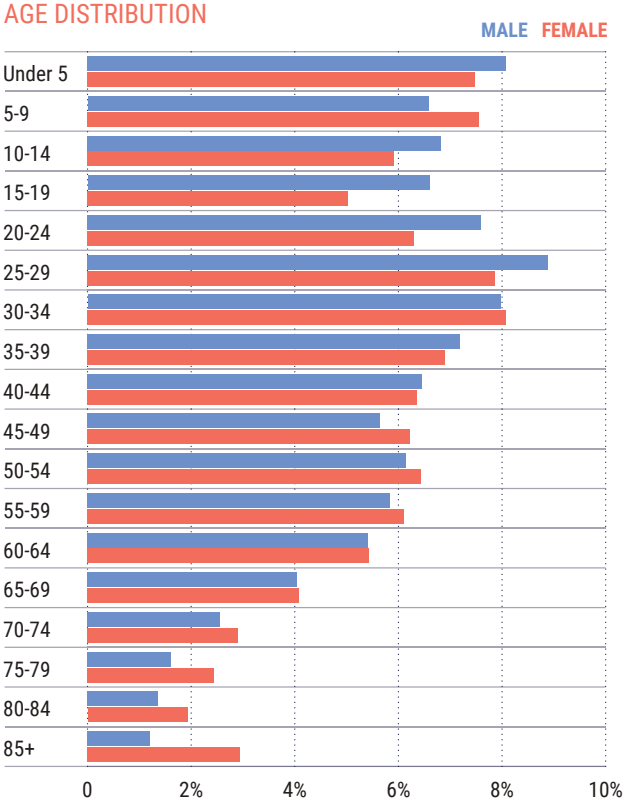


summary health measures

NOTABLE

		Lower Northeast Philadelphia	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	908.3	927.4
	Premature CVD deaths (per 100,000 people)	87.8	104.8
	Diabetes hospitalizations (per 100,000 people)	269.3	371.9
	Adult obesity	33.8%	29.8%
	Hypertension hospitalizations (per 100,000 people)	455.6	649.2
	Cancer deaths (per 100,000 people)	89.9	97.6
	Mammography screening	75.8%	82.9%
	Colorectal screening	67.2%	70.8%
	Adult smoking	22.3%	19.5%
	Adult binge drinking	19.7%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	6.5	8.2
	Percent of preterm or low birth weight births	12.5%	14.2%
	Late or inadequate prenatal care	44.5%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	495.4	727.3
Injuries	Homicide mortality rate (per 100,000 people)	8.9	17.6
	Drug overdose mortality rate (per 100,000 people)	55.8	48.3
	Suicide mortality rate (per 100,000 people)	13.0	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	74.6	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,795.7	2,363.1
Access to Care	Adults 19-64 without insurance	18.4%	14.9%
	Children <19 without insurance	5.4%	4.2%
	Adults 19-64 with Medicaid	20.6%	23.1%
	Children <19 with public insurance	55.6%	58.6%
	Emergency department utilization (per 100,000 people)	45,847.0	55,382.0
	Emergency department high-utilizers (per 100,000 people)	1,039.2	1,716.9
Social & Economic Determinants	Percent in poverty	19.9%	25.8%
	Community need index score	3.7	4.0
	Excessive housing cost	38.9%	38.9%
	Housing with potential lead risk	56.6%	61.1%
	Households receiving food assistance	21.3%	24.5%
	Food insecurity	13.9%	19.0%
	Speak English less than "very well"	17.0%	10.6%

COMMUNITY PERSPECTIVES

"There's more parks than bars... I used to live on 52nd and Girard and everywhere you go on each corner there's a bar; but up here, you go around every four blocks, it's a park."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 4, 2019 at Tacony Library. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Shared belief that people in the community support one another.
- Accessibility of transportation as a strength of the Lower Northeast community.
- Access to parks and recreational facilities.

"Well, when folks get older and they can't pay the bills or handle the property, they want to transition to either federal housing or assisted living facilities and so access and knowing what your options are, and then the cost factor, I think they are community issues that are definitely something all seniors have to face."

Priority Health Issues

YOUTH	» **Use and availability of drugs**, especially among middle and high school students. » Key youth and young adult health issues include asthma, bullying, and lack of physical activity. » Youth are seen as spending too much time on their phones, tablets, and social media. » Lack of affordable activities such as sports and safety concerns contributing to physical inactivity. » Unmet educational needs in public schools, for example, class sizes are too large, special-needs students lack support in the classroom, and there needs to be improvement in teaching reading, spelling and math; teachers are facing too much stress in the classroom.
ENVIRONMENTAL CONDITIONS	» **Lack of nutritional, affordable food options**; more pizza and other fast foods than supermarkets.
ACCESS TO CARE	» **Access and affordability of healthcare** and difficulty navigating services – long wait times for primary care appointments and physicians not accepting new patients. » Although individuals may have insurance, high out of pocket medication costs. » Medicare, Medicaid, and their cost not well understood among community members. » Limited resources to assist individuals with Medicaid/Medicare enrollment.
OLDER ADULTS	» Social and health wellbeing concerns include social isolation, lack of outreach, fear of getting help, lack of access to dental care, eye care, and mobility. » Lack of awareness of options available and costs of housing transitions as one ages is a concern among older adults.

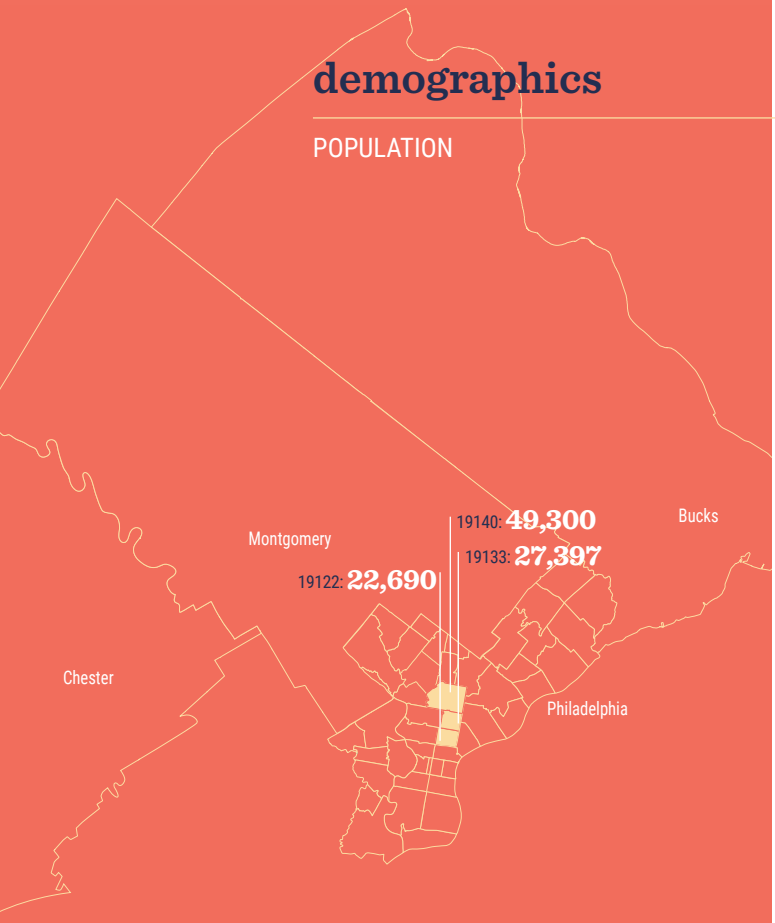
NORTH PHILADELPHIA–EAST

This community is served by:

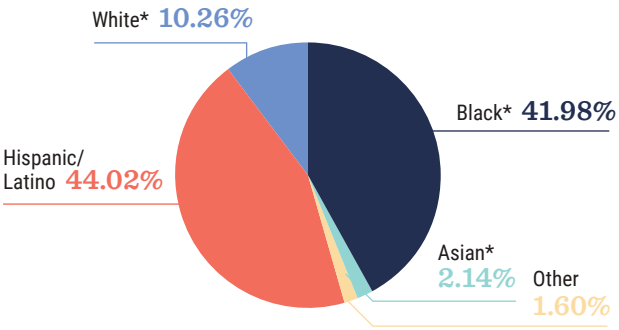
- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia/ Elkins Park
- Jefferson Health – Northeast
- Jefferson Health

demographics

POPULATION

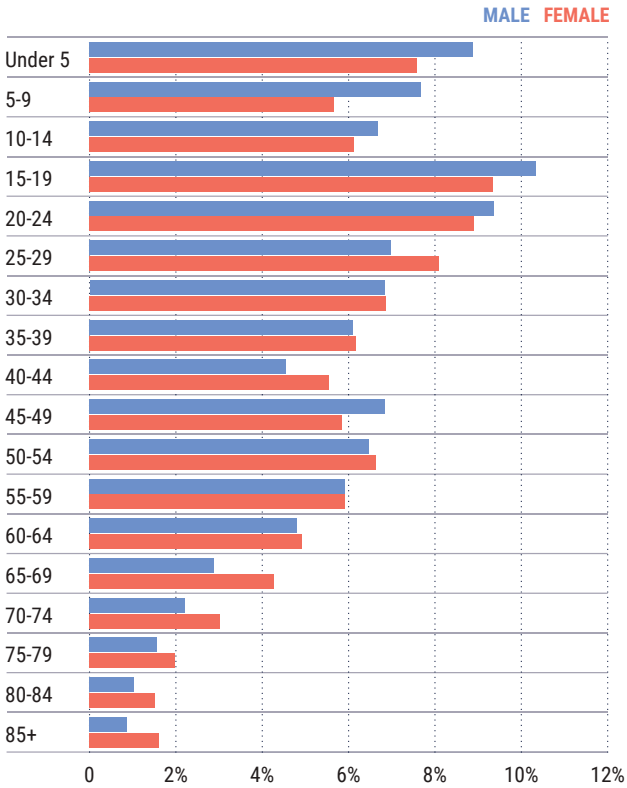


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		North Philadelphia East	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	1,136.4	927.4
	Premature CVD deaths (per 100,000 people)	152.2	104.8
	Diabetes hospitalizations (per 100,000 people)	529.2	371.9
	Adult obesity	39.3%	29.8%
	Hypertension hospitalizations (per 100,000 people)	956.9	649.2
	Cancer deaths (per 100,000 people)	106.1	97.6
	Mammography screening	84.7%	82.9%
	Colorectal screening	56.1%	70.8%
	Adult smoking	28.8%	19.5%
	Adult binge drinking	21.7%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	11.1	8.2
	Percent of preterm or low birth weight births	16.0%	14.2%
	Late or inadequate prenatal care	51.9%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	1,424.2	727.3
Injuries	Homicide mortality rate (per 100,000 people)	38.4	17.6
	Drug overdose mortality rate (per 100,000 people)	71.7	48.3
	Suicide mortality rate (per 100,000 people)	8.7	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	204.3	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	1,937.8	2,363.1
Access to Care	Adults 19-64 without insurance	19.0%	14.9%
	Children <19 without insurance	3.6%	4.2%
	Adults 19-64 with Medicaid	39.6%	23.1%
	Children <19 with public insurance	73.3%	58.6%
	Emergency department utilization (per 100,000 people)	90,768.4	55,382.0
	Emergency department high-utilizers (per 100,000 people)	3,148.3	1,716.9
Social & Economic Determinants	Percent in poverty	47.1%	25.8%
	Community need index score	4.7	4.0
	Excessive housing cost	41.8%	38.9%
	Housing with potential lead risk	64.6%	61.1%
	Households receiving food assistance	43.1%	24.5%
	Food insecurity	27.9%	19.0%
	Speak English less than "very well"	17.5%	10.6%

COMMUNITY PERSPECTIVES

"It's hard to find a doctor that knows what the disabled adult would need or how to get equipment for your adult child"

"...the media (influences) parents who are refusing certain vaccinations, certain medications for their children and there isn't enough public awareness and education about that."

"They don't know how to deal with conflict resolution, because they are so into what is going on in social media — they are ready to fight because of social media."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 11, 2019 at Paseo Verde South Apartments. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Community organizations that provide programs and services to youth and older adults as well as those that assist with housing, food access and other social needs.
- Community organizations, such as the Lighthouse, were valued for their outreach to youth, particularly afterschool programs that provide structured activities.
- Community organizations serving older adults providing socialization opportunities for those who might otherwise be isolated.
- Community Development Corporations help residents with housing information.
- Faith-based institutions aid with food, clothing and school supplies.
- Community leaders and residents such as block captains and teachers.

Priority Health Issues

BEHAVIORAL HEALTH	» Exposure of adults and children to chronic stress and trauma.	» Lack of community awareness about how to assist someone with a mental health problem and the lack of available community resources and services.
ACCESS TO CARE	» More primary care providers are needed to reduce wait times for appointments and hours should be extended to provide for individuals working multiple jobs.	» Few urgent care centers are available and they are expensive.
YOUTH	» Autism rates among young children. » Children experiencing trauma resulting from environmental exposures including drugs/violence. » Other priorities include bullying, teen pregnancy, tobacco and drug use, poor nutrition and lack of affordable, safe opportunities for physical activity.	» Childhood immunization awareness and education for parents needed. » Transition period from pediatric to adult care for children with disabilities is a concern. Finding a doctor who is knowledgeable about this transitioning period for individuals with disabilities can be difficult.
OLDER ADULTS	» Key priorities for older adults include elder abuse, support services and resources for grandparents raising their grandchildren, quality of home healthcare agencies' employees, loneliness and social isolation, financial insecurity, and support for people dealing with loss and grief. » Sometimes families must relinquish caregiving responsibilities to home healthcare agencies due to competing responsibilities.	» Some family members may be reluctant to report negligent caregiver employees to healthcare agencies. » Many grandparents are "raising grandchildren because their parents are in prison or on drugs" and "grandparents need more support services because they can't always take them (grandchildren) to the doctors for health and get the things they need."
ENVIRONMENTAL CONDITIONS	» Impact of air quality on respiratory illness such as asthma and COPD. » High crime rates related to addiction and homicide and community appearance, particularly trash and short-dumping, impact walkability and use of parks and playgrounds.	» Community beautification efforts can't be maintained due to animals and people ripping open bags, lack of garbage cans throughout the community, and ticketing for trash cans put in front or side yards of properties. » **Lack of access to healthy, affordable food**; local supermarket recently closed resulting in a "food desert."
SOCIAL AND ECONOMIC CONDITIONS	» Educational inequities persist including quality and safety concerns, unmet student needs, lack of resources and services. » Financial concerns can result in older adults going without needed health care.	» In terms of preschool, safety and other concerns were raised associated with housing children aged 3-6 in the same building as eighth graders.

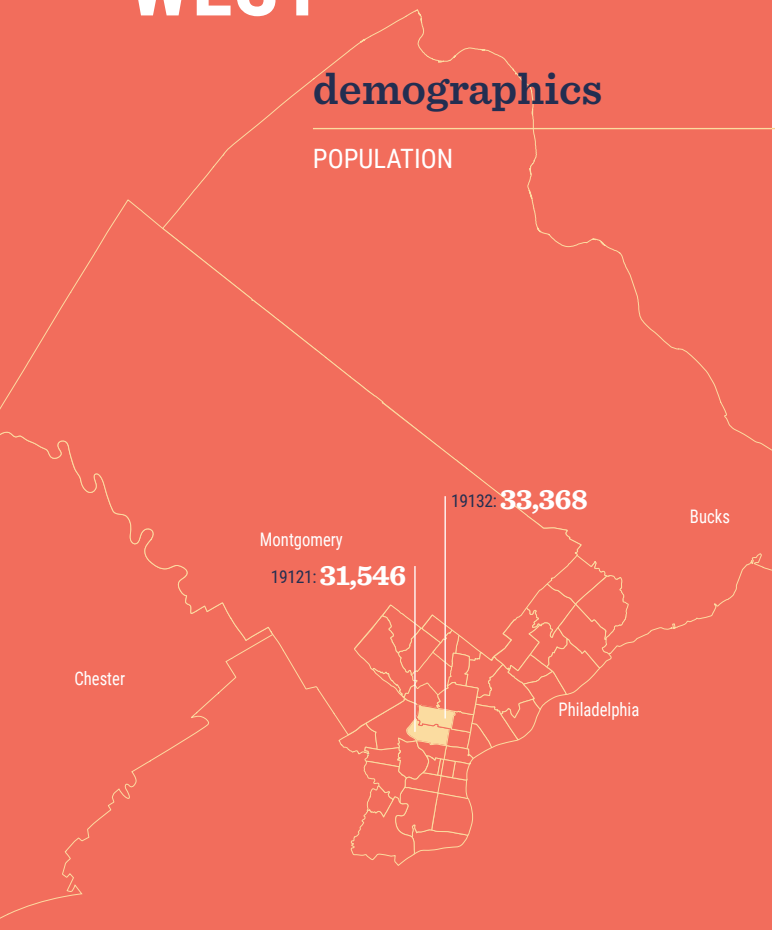
NORTH PHILADELPHIA–WEST

This community is served by:

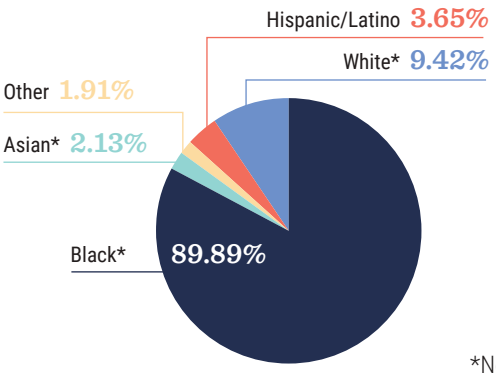
- Children's Hospital of Philadelphia
- Jefferson Health
- Penn Medicine

demographics

POPULATION



RACE/ETHNICITY



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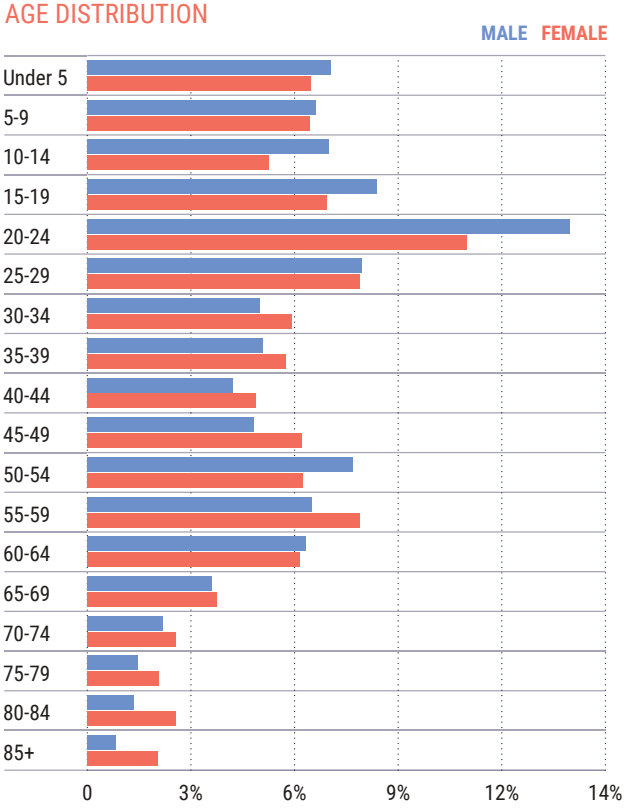
AGE DISTRIBUTION



summary health measures

NOTABLE

		North Philadelphia West	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	1309.3	927.4
	Premature CVD deaths (per 100,000 people)	165.2	104.8
	Diabetes hospitalizations (per 100,000 people)	776.4	371.9
	Adult obesity	31.9%	29.8%
	Hypertension hospitalizations (per 100,000 people)	1,278.6	649.2
	Cancer deaths (per 100,000 people)	148.3	97.6
	Mammography screening	81.6%	82.9%
	Colorectal screening	69.6%	70.8%
	Adult smoking	28.8%	19.5%
	Adult binge drinking	20.8%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	13.3	8.2
	Percent of preterm or low birth weight births	19.2%	14.2%
	Late or inadequate prenatal care	56.1%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	1,484.0	727.3
Injuries	Homicide mortality rate (per 100,000 people)	48.5	17.6
	Drug overdose mortality rate (per 100,000 people)	78.5	48.3
	Suicide mortality rate (per 100,000 people)	5.5	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	1,92.6	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,359.3	2,363.1
Access to Care	Adults 19-64 without insurance	16.0%	14.9%
	Children <19 without insurance	4.0%	4.2%
	Adults 19-64 with Medicaid	36.8%	23.1%
	Children <19 with public insurance	74.7%	58.6%
	Emergency department utilization (per 100,000 people)	107,010.8	55,382.0
	Emergency department high-utilizers (per 100,000 people)	4,079.2	1,716.9
Social & Economic Determinants	Percent in poverty	45.5%	25.8%
	Community need index score	4.7	4.0
	Excessive housing cost	41.3%	38.9%
	Housing with potential lead risk	67.7%	61.1%
	Households receiving food assistance	37.2%	24.5%
	Food insecurity	17.9%	19.0%
	Speak English less than “very well”	2.8%	10.6%

COMMUNITY PERSPECTIVES

"Shootings, murders, stabbings, all kinds of violence has become nothing extraordinary to our children. You see some kind of upheaval and you see children running to it instead of running away from it because they're attracted to that kind of commotion and violence. The whole mental health aspect of this."

"We as people really don't think that we have mental health issues. We don't believe in going to therapy and stuff like that so it's hard to break through and make people understand that there's nothing wrong with talking to a counselor."

"Kids brains are so preoccupied with being an adult and actually being the parent that they can't be kids, they can't go to school and learn because their mind is so mumbo-jumbo with worrying about if they're going to have any lights when they come home or if there's going to be any food on the table, you know what I mean? It's like the roles have reversed."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on March 6, 2019 at Mander Recreation Center. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Accessibility, the built environment, community organizations, the people and history of the community.
- Public transportation (SEPTA) as well as access to major interstates and highways and the Indego bike share program are highlights of community accessibility.
- Vacant land represents development opportunity.
- Community organizations such as the Dell Music Center and religious institutions are strengths for the Strawberry Mansion neighborhood.
- Proud history of high home ownership, employment and the potential for upward mobility.
- An example of this community strength is that small food business owners, unlike supermarket chains, sometimes provide temporary credit to help parents buy food for their families.
- Strawberry Mansion historical reputation for social protest, especially civil rights protests – intent to leverage assets to oppose gentrification and its negative outcomes.

Priority Health Issues

BEHAVIORAL HEALTH	» Multi-generational challenges with substance use; beyond opioids, crack and synthetic marijuana are emerging issues. » Gun violence and homicides in the community are traumatic for adults and children.	» Stigma among African-American community regarding accessing behavioral health services.
ENVIRONMENTAL CONDITIONS	» Older housing in disrepair is a major risk factor for lead poisoning, asthma complications and injuries among children. » An aging population unable to afford needed repairs for their homes. » Stress due to trauma as well as **homelessness**, lack of access to healthy affordable food and lack of opportunities for physical activity.	» Access to healthy affordable food and safe, affordable places for physical activity; need functional, safe recreational facilites. » Difficult to improve nutrition if only corner stores and bodegas with unhealthy food options are the only options within walking distance. » High rates of **chronic diseases** like diabetes, hypertension, cholesterol, and heart disease contribute significantly to poor health.
YOUTH	» Tobacco and other substance use. » Youth are being compelled to take on adult responsibilities in order to survive. » Transient housing for young children.	» **Homelessness** among youth may not be readily apparent due to couch surfing. » Runaway youth may be tied to child abuse, disagreement with parents, and may lead to sex trafficking.
SOCIAL AND ECONOMIC CONDITIONS	» **Low quality of the public schools** and the potential closing of the local high school threaten education opportunity. » Inadequate housing and food support for students in college. » Affordable, structured activities, particularly during summer months, is needed for youth.	» Quality early childhood education is needed. Children may be labeled as having behavioral or learning problems when they actually need better access to speech, hearing and vision services as well as nutritious food. Early identification of these needs is key to educational attainment of children.
ACCESS TO CARE	» Access to health care coverage for working poor and immigrants. » Availability of timely appointments and the ability to obtain care from private health care practices.	» Difficulty navigating the health insurance exchange website. » Even with insurance, community members experienced long waits at health centers and the VA — sometimes two to three months — to get an appointment.
OLDER ADULTS	» As older adults transfer to Medicare the need for supplemental insurance arises and often there is confusion about what is actually covered. » Living on a fixed income often forces choices of whether to pay for food, rent, utilities, health insurance, or medications.	» Older adults are also raising their grandchildren according to several focus group participants, which is straining their limited income. » Concerns about elder abuse.

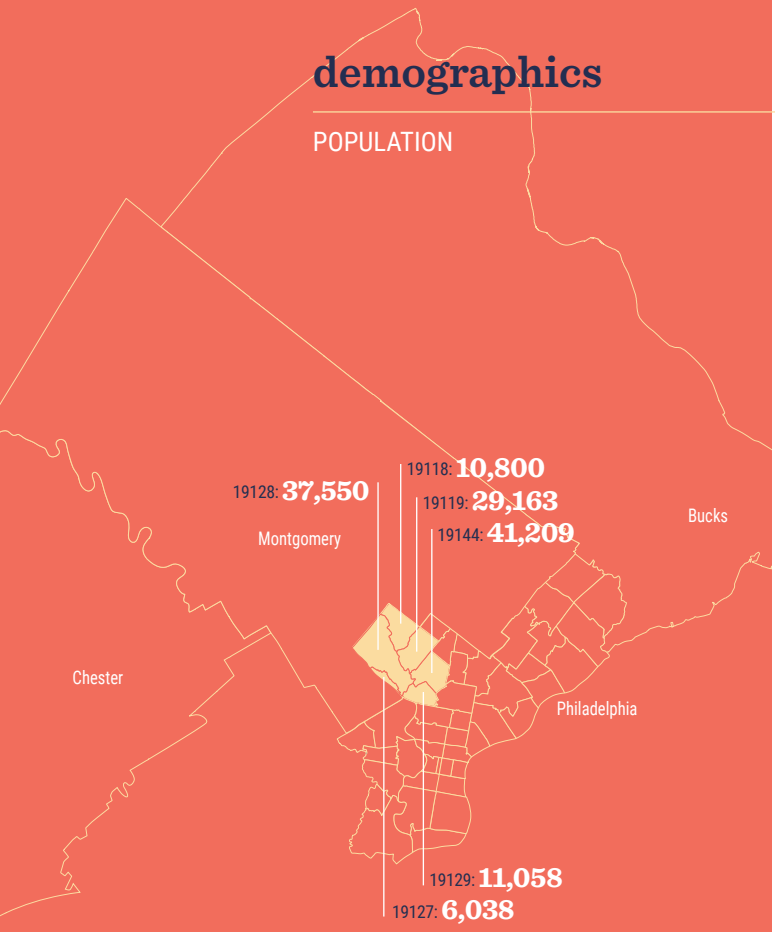
NORTHWEST PHILADELPHIA

This community is served by:

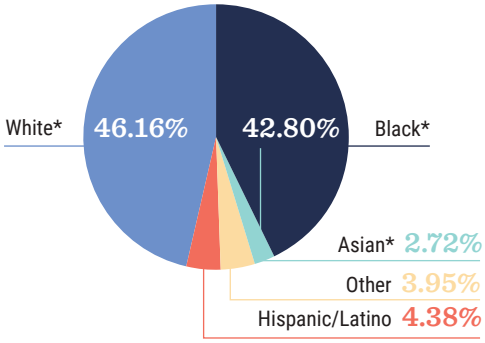
- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia/ Elkins Park

demographics

POPULATION

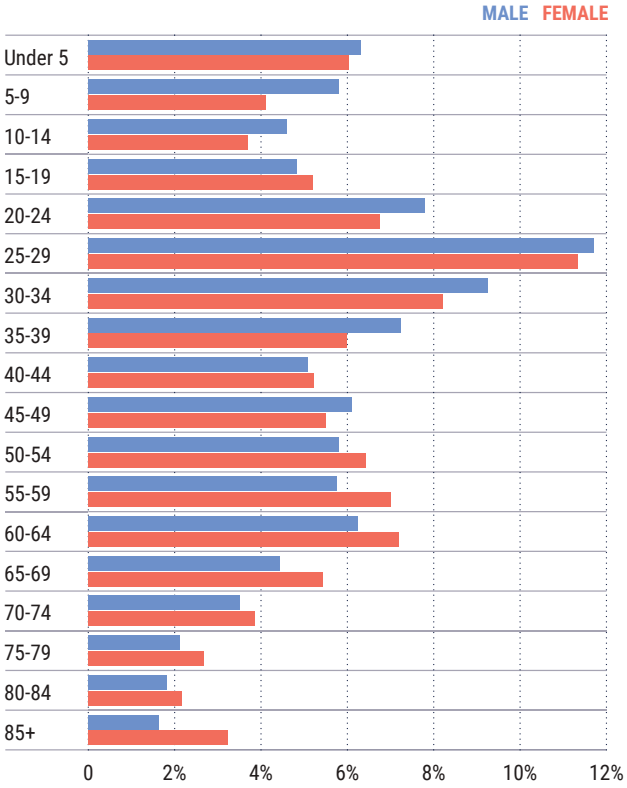


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		Northwest Philadelphia	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	822.8	927.4
	Premature CVD deaths (per 100,000 people)	93.7	104.8
	Diabetes hospitalizations (per 100,000 people)	317.3	371.9
	Adult obesity	32.9%	29.8%
	Hypertension hospitalizations (per 100,000 people)	684.7	649.2
	Cancer deaths (per 100,000 people)	90.0	97.6
	Mammography screening	87.5%	82.9%
	Colorectal screening	76.5%	70.8%
	Adult smoking	17.4%	19.5%
	Adult binge drinking	15.8%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	9.7	8.2
	Percent of preterm or low birth weight births	12.6%	14.2%
	Late or inadequate prenatal care	39.6%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	550.1	727.3
Injuries	Homicide mortality rate (per 100,000 people)	11.4	17.6
	Drug overdose mortality rate (per 100,000 people)	33.1	48.3
	Suicide mortality rate (per 100,000 people)	9.3	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	95.7	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,243.9	2,363.1
Access to Care	Adults 19-64 without insurance	10.0%	14.9%
	Children <19 without insurance	2.4%	4.2%
	Adults 19-64 with Medicaid	15.8%	23.1%
	Children <19 with public insurance	41.8%	58.6%
	Emergency department utilization (per 100,000 people)	37,009.8	55,382.0
	Emergency department high-utilizers (per 100,000 people)	1,186.2	1,716.9
Social & Economic Determinants	Percent in poverty	19.0%	25.8%
	Community need index score	3.3	4.0
	Excessive housing cost	36.8%	38.9%
	Housing with potential lead risk	62.9%	61.1%
	Households receiving food assistance	16.8%	24.5%
	Food insecurity	18.22%	19.0%
	Speak English less than "very well"	2.2%	10.6%

COMMUNITY PERSPECTIVES

"I do think that there is an assumption that in urban, poor, black communities or brown communities that people aren't going to eat healthy, and so they saturate [the area] with what they think people are going to eat. If we can start making healthier food options convenient, we might see it move a little bit."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 26, 2019 at LIFE Center. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Access to transportation and a robust housing stock that is good quality and affordable.
- Ample shops, religious organizations, a business district, and recreation centers.

"African Americans, in this particular culture, we don't like to accept the fact that we have mental health issues. There's a stigma with seeing the psychiatrist. Some people are just not comfortable speaking to someone else about their problems because with African Americans, there's this trust factor."

Priority Health Issues

BEHAVIORAL HEALTH	» Lack of local **behavioral health care providers**; existing services are too heavily located in Center City Philadelphia and should be spread amongst the larger community to provide medication, housing, and services that support people living with mental health needs. » Residential programs for people with mental health needs are saturated because the housing is unaffordable. » Loneliness leading to depression. » Perceived stigma regarding race and mental health.
ACCESS TO CARE	» Desire for racial concordance between providers and the population. » Despite there being many federally qualified health centers in the immediate area, wait times for services create access issues. » Need for more **family-focused support services**, for example, trainings to deescalate household conflict and support families with children that have behavioral and mental health needs.
YOUTH	» Obesity among children related to a lack of recreational activities and limited availability of healthy food.
ENVIRONMENTAL CONDITIONS	» A high saturation of fast food restaurants in the area but a limited access to healthy food outlets. » Despite having proximity to green space at Wissahickon Park, recreational activities for children are limited.
SOCIAL AND ECONOMIC CONDITIONS	» The "antiquated" **educational** system that currently lacks opportunities for innovation (science and technology) and physical activity. » Thriving private school system and worsening conditions in the public school system. » Lack of job readiness programs for trade jobs like welding, plumbing, and electrical work. » Limited **employment** opportunities in the immediate area, aside from few cashier and stocker positions at supermarkets.

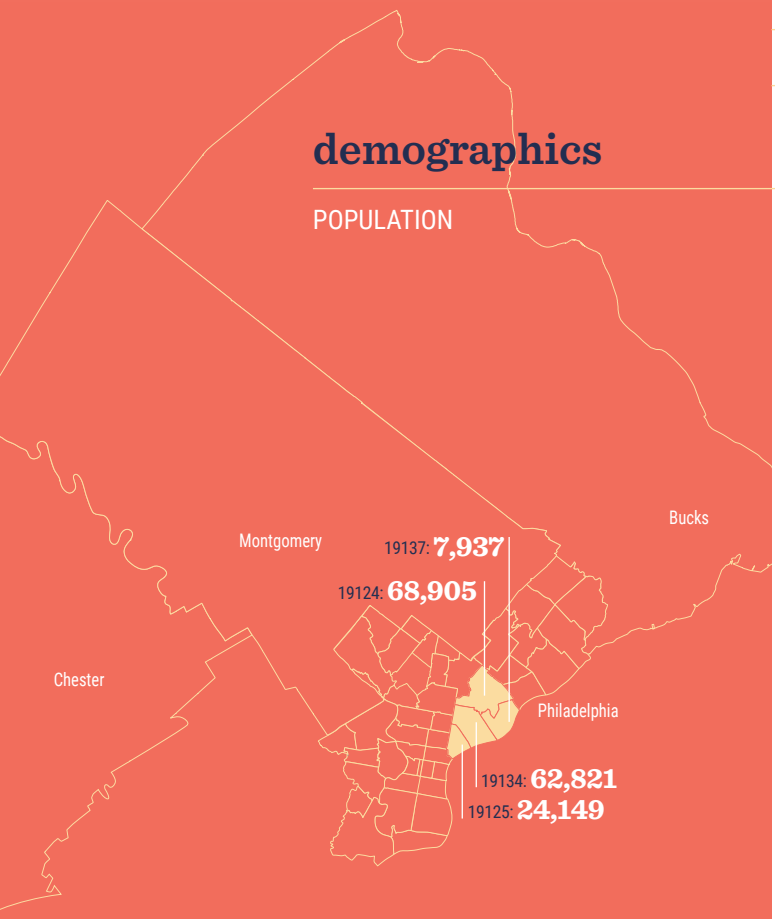
RIVER WARDS

This community is served by:

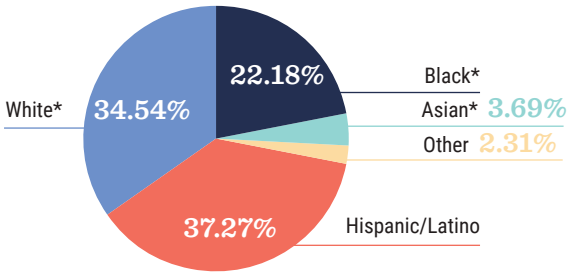
- Children's Hospital of Philadelphia
- Einstein Medical Center Philadelphia/ Elkins Park
- Jefferson Health – Northeast
- Jefferson Health

demographics

POPULATION



RACE/ETHNICITY



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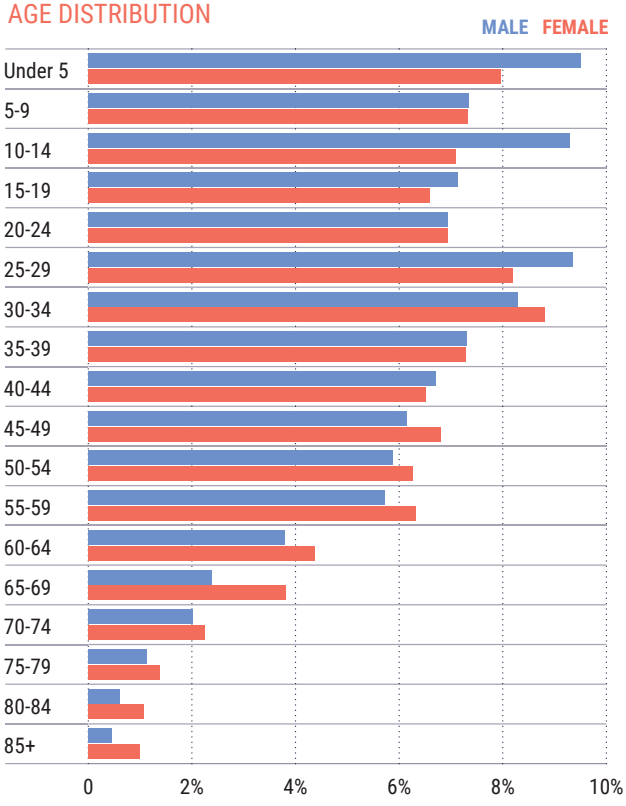


summary health measures

NOTABLE

		River Wards	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	1,186.5	927.4
	Premature CVD deaths (per 100,000 people)	128.6	104.8
	Diabetes hospitalizations (per 100,000 people)	354.6	371.9
	Adult obesity	38.5%	29.8%
	Hypertension hospitalizations (per 100,000 people)	448.6	649.2
	Cancer deaths (per 100,000 people)	115.8	97.6
	Mammography screening	77.7%	82.9%
	Colorectal screening	59.4%	70.8%
	Adult smoking	26.1%	19.5%
	Adult binge drinking	14.3%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	7.3	8.2
	Percent of preterm or low birth weight births	13.6%	14.2%
	Late or inadequate prenatal care	48.8%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	986.9	727.3
Injuries	Homicide mortality rate (per 100,000 people)	24.8	17.6
	Drug overdose mortality rate (per 100,000 people)	85.4	48.3
	Suicide mortality rate (per 100,000 people)	12.1	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	130.6	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,463.7	2,363.1
Access to Care	Adults 19-64 without insurance	18.1%	14.9%
	Children <19 without insurance	3.3%	4.2%
	Adults 19-64 with Medicaid	35.1%	23.1%
	Children <19 with public insurance	74.7%	58.6%
	Emergency department utilization (per 100,000 people)	64,512.5	55,382.0
	Emergency department high-utilizers (per 100,000 people)	2,078.7	1,716.9
Social & Economic Determinants	Percent in poverty	34.0%	25.8%
	Community need index score	4.7	4.0
	Excessive housing cost	42.7%	38.9%
	Housing with potential lead risk	69.1%	61.1%
	Households receiving food assistance	36.9%	24.5%
	Food insecurity	19.7%	19.0%
	Speak English less than "very well"	16.1%	10.6%

COMMUNITY PERSPECTIVES

"Everybody's like really determined in this neighborhood."

"I was sick; had called into my primary doctor. They sent me to urgent care 'cause they didn't have any appointments coming in and that's like the third time that's happened when I've been sick."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on January 8, 2019 at Visitation Community Center. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Active participation and involvement of community members and availability of community organizations such as Impact Services, New Kensington Community Development Corporation (NKCDC), HACE, Somerset, Prevention Point and Penn Medicine's mobile unit health screenings.
- Access to local businesses, corner stores, churches, schools, libraries, parks, events at community centers, urban gardening, health centers, and the presence of an opioid taskforce.
- Community businesses support the community through various charity events like coat drives and food donations at events.
- Family-oriented neighborhood and there is a willingness to get involved, neighborhood clean-ups and tree planting events are examples of residents invested in the community.

Priority Health Issues

GENERAL	» Strong emphasis that **community health needs** are being overshadowed by the opioid epidemic. » Based on a Somerset Neighborhood Survey: • 53.8% reporting a need for information on how to stretch money/food stamps • 56.4% reporting a need for employment/job training • 33.3% view depression as a health issue • 35.9% reporting a need for assistance with improving parenting skills • 33.3% are concerned with child/elder abuse
BEHAVIORAL HEALTH	» Lack of parental care, guidance, and accountability in the home environment. » Need for more attention on families with drug addiction and an increase of awareness of services and assistance navigating the behavioral health system.
ACCESS TO CARE	» **Access to healthcare** and concerns regarding high cost of health care even if you have insurance and limited coverage of insurance. » Lack of timely, convenient appointments to see primary care and specialty physicians. » Lack of awareness of the services available at Urgent Care centers which contributes to overutilization of the Emergency Department. » Lack of understanding and transparency of healthcare benefits and insurance plans, which could be mediated by increasing access to healthcare navigators.
YOUTH	» Many social and health concerns for the **children, youth and young adults** of the River Wards community such as trauma, mental health, hunger among children, physical and sexual abuse, high teenage pregnancy rates, suicide, and bullying due to peer pressure.
SOCIAL AND ECONOMIC CONDITIONS	» Increase in high school dropouts and a lack of employment opportunities and underemployment wages in the neighborhood. » Need for workforce and vocational skills, mentoring, tutoring, structured activities and parenting education.
ENVIRONMENTAL CONDITIONS	» **Lack of access to fresh food and supermarkets**. » Numerous **environmental** health concerns such as the presence of lead, mold and asbestos, trash and human feces, dumping in the water system and sewers leading to water pollution, poor air quality, bedbugs, pests and more. » Paraphernalia and community blight related to opioid epidemic, particularly used needle exposure. » Lead exposure among young children due to old housing stock. » **Safety issues in the neighborhood** due to sidewalks kept in poor condition and a lack of speed bumps to prevent speeding and reckless drivers.
OLDER ADULTS	» **Lack of transportation** access and options for older adults. » Social isolation, mental health, elder abuse, lack of affordable and safe housing, the need for neighborhood collaboration and social capital to look out for one another, transportation, access to technology/internet, and the need to raise awareness to prevent being scammed.

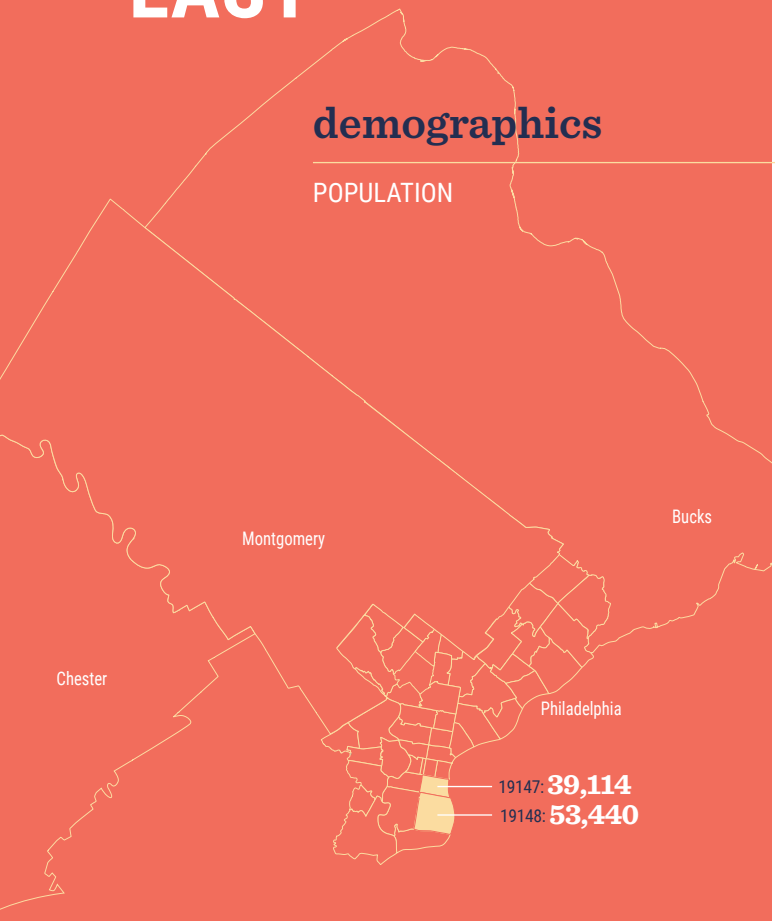
SOUTH PHILADELPHIA–EAST

This community is served by:

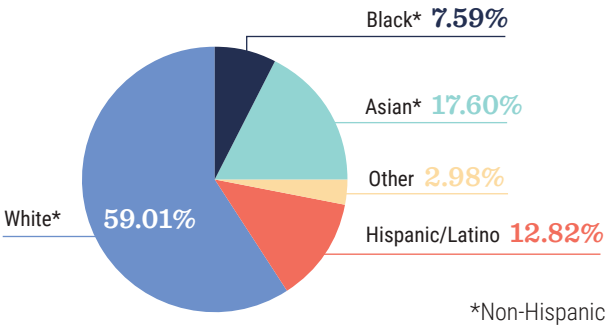
- Children's Hospital of Philadelphia
- Jefferson Health
- Penn Medicine

demographics

POPULATION



RACE/ETHNICITY



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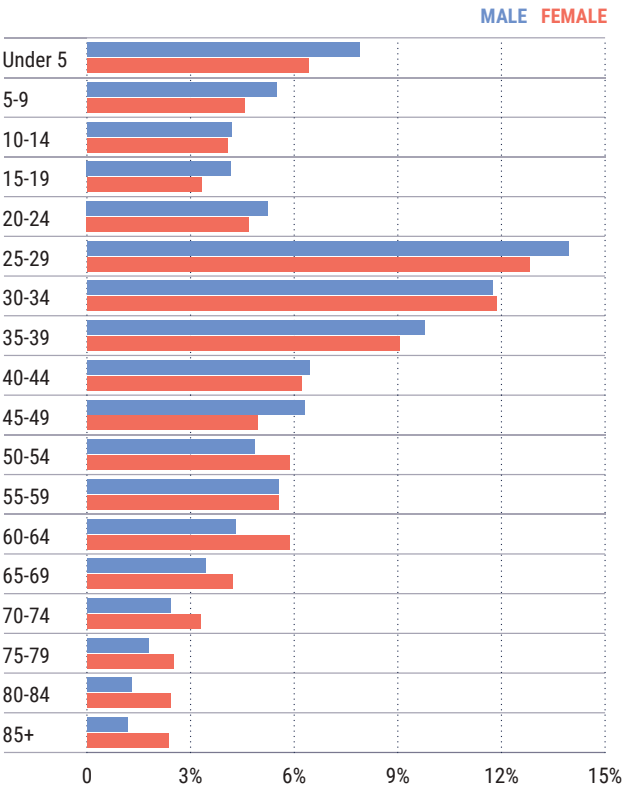


summary health measures

NOTABLE

		South Philadelphia East	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	848.0	927.4
	Premature CVD deaths (per 100,000 people)	90.9	104.8
	Diabetes hospitalizations (per 100,000 people)	268.0	371.9
	Adult obesity	22.4%	29.8%
	Hypertension hospitalizations (per 100,000 people)	373.8	649.2
	Cancer deaths (per 100,000 people)	96.7	97.6
	Mammography screening	73.0%	82.9%
	Colorectal screening	72.6%	70.8%
	Adult smoking	16.0%	19.5%
	Adult binge drinking	17.6%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	4.5	8.2
	Percent of preterm or low birth weight births	10.3%	14.2%
	Late or inadequate prenatal care	47.6%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	257.3	727.3
Injuries	Homicide mortality rate (per 100,000 people)	6.0	17.6
	Drug overdose mortality rate (per 100,000 people)	57.0	48.3
	Suicide mortality rate (per 100,000 people)	12.2	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	131.82	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,572.8	2,363.1
Access to Care	Adults 19-64 without insurance	18.8%	14.9%
	Children <19 without insurance	4.7%	4.2%
	Adults 19-64 with Medicaid	15.1%	23.1%
	Children <19 with public insurance	48.0%	58.6%
	Emergency department utilization (per 100,000 people)	30,675.1	55,382.0
	Emergency department high-utilizers (per 100,000 people)	689.3	1,716.9
Social & Economic Determinants	Percent in poverty	17.1%	25.8%
	Community need index score	3.8	4.0
	Excessive housing cost	33.1%	38.9%
	Housing with potential lead risk	68.3%	61.1%
	Households receiving food assistance	17.2%	24.5%
	Food insecurity	21.5%	19.0%
	Speak English less than “very well”	17.3%	10.6%

COMMUNITY PERSPECTIVES

"The infrastructure that does exist for bikes is poorly maintained. The bike lanes are almost invisible. I used to bike to work and I stopped because I was concerned about getting hurt and had too many close calls."

"[Education] is a really serious health issue because if someone is in poverty, they'll stay in poverty forever without access to a good education system."

"It's broken glass, hygiene products, food waste, food containers, drug paraphernalia, animal waste. And of course, that's running off and getting into the whole region's water supply. It creates an unhealthy environment."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on March 5, 2019 at Bok School. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Transportation, walkability, and the recent movement to repurpose vacant lots into green spaces.
- A variety of shops and restaurants create culture and community.
- A diverse composition of community members, and friendly, caring neighbors.
- Ample availability of physical health care services, including primary care, specialty care and pharmacies.

"There's so much new construction and with a 10-year tax abatement, people are moving into the neighborhood and they're not contributing to the school system."

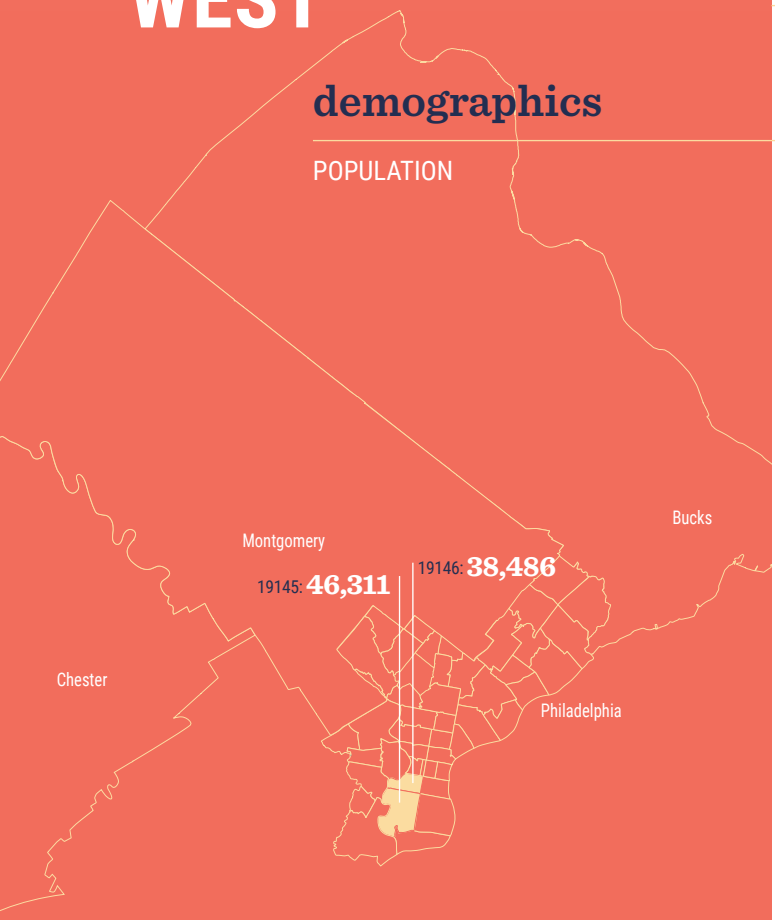
Priority Health Issues

ENVIRONMENTAL CONDITIONS	» Despite having access to a main artery of public transportation, the Broad Street Line, **accessibility** issues with other modes of public transportation, such as buses and trolleys, specifically due to tricky navigation and unreliable bus schedules. » Poor road conditions cause bus routes to be rerouted. » Limited transportation options create lack of accessibility to healthy food sources; food options in walking distance for many are expensive and low quality. » Areas of improvement regarding the **built environment** including light pollution from all of the businesses along the streets in the neighborhood, poor air quality from all of the traffic, and unsafe sidewalks for pedestrians. » Need for protected bike lanes and universal regulations/education for bicyclists and drivers. » Green spaces in the community, parks and playgrounds often feel segregated by race and ethnicity. » **Neighborhood appearance** is a pain point, specifically regarding the amount of litter and trash along the streets and green spaces. » Unsafe conditions for children playing in the streets or pedestrians walking on the sidewalk. » Housing stock is old and the quality is diminishing, leading to some health-related issues, such as asthma, lung and heart disease. » **Affordability of housing** is a concern, as many houses that have been in families for generations are being flipped and resold for unaffordable prices.
BEHAVIORAL HEALTH	» **Limited access to behavioral health care services** to treat childhood behavioral conditions, substance use, and depression. » Community is suffering from **chronic stress** due to community violence, death, poverty, and the opioid crisis. » Shame and bias that go along with addiction leads to an unwillingness to bring residential rehabilitation programs to the community, cited as an **unmet health need**. » Need to increase access to Medication-Assisted treatment.
ACCESS TO CARE	» **Insurance coverage and affordability**, in part, due to the fact that many Philadelphians work in New Jersey and Delaware, so employer-sponsored health insurance plans don't often cover many services in the local community where they reside and, if they do, the services are typically out-of-network and more expensive to receive. » Low access to affordable options, like Urgent Care centers. » Lack of vaccination among community members, leading to increase in infectious diseases.
SOCIAL AND ECONOMIC CONDITIONS	» The **quality of public education** in the area was of notable concern; some attributed the issue of **unmet educational needs** to **persistent gentrification**.

SOUTH PHILADELPHIA–WEST

demographics

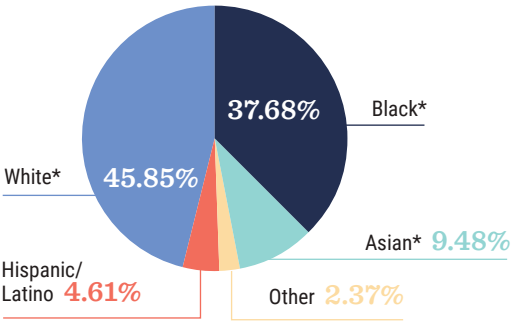
POPULATION



This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Health
- Penn Medicine

RACE/ETHNICITY



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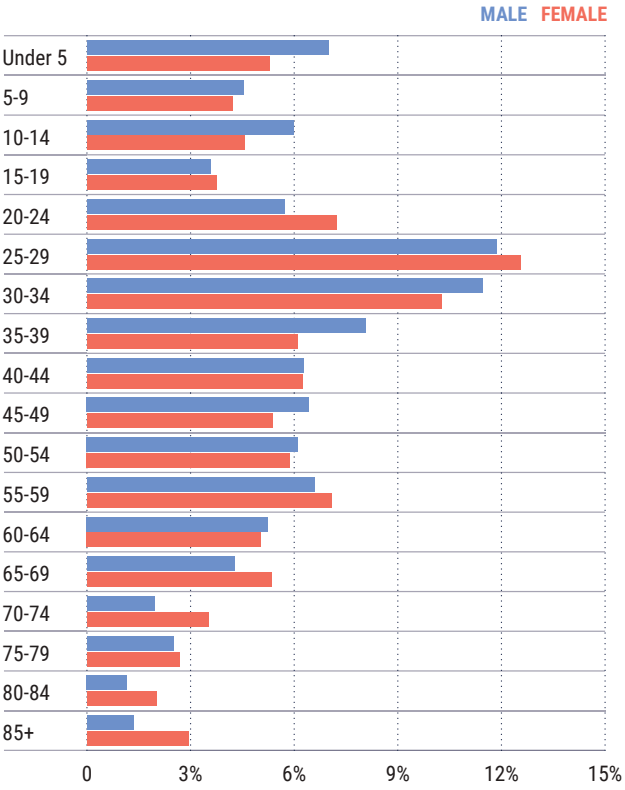
AGE DISTRIBUTION



summary health measures

NOTABLE

		South Philadelphia West	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	869.3	927.4
	Premature CVD deaths (per 100,000 people)	99.9	104.8
	Diabetes hospitalizations (per 100,000 people)	402.1	371.9
	Adult obesity	29.9%	29.8%
	Hypertension hospitalizations (per 100,000 people)	651.0	649.2
	Cancer deaths (per 100,000 people)	102.2	97.6
	Mammography screening	85.6%	82.9%
	Colorectal screening	73.1%	70.8%
	Adult smoking	22.5%	19.5%
	Adult binge drinking	28.5%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	6.7	8.2
	Percent of preterm or low birth weight births	12.2%	14.2%
	Late or inadequate prenatal care	45.6%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	561.0	727.3
Injuries	Homicide mortality rate (per 100,000 people)	17.2	17.6
	Drug overdose mortality rate (per 100,000 people)	44.0	48.3
	Suicide mortality rate (per 100,000 people)	8.4	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	88.5	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,410.7	2,363.1
Access to Care	Adults 19-64 without insurance	12.4%	14.9%
	Children <19 without insurance	2.7%	4.2%
	Adults 19-64 with Medicaid	19.5%	23.1%
	Children <19 with public insurance	52.3%	58.6%
	Emergency department utilization (per 100,000 people)	44,702.1	55,382.0
	Emergency department high-utilizers (per 100,000 people)	1,169.9	1,716.9
Social & Economic Determinants	Percent in poverty	20.9%	25.8%
	Community need index score	4.0	4.0
	Excessive housing cost	36.2%	38.9%
	Housing with potential lead risk	65.9%	61.1%
	Households receiving food assistance	21.4%	24.5%
	Food insecurity	20.2%	19.0%
	Speak English less than "very well"	7.6%	10.6%

COMMUNITY PERSPECTIVES

"When I think of basic things that children should get, I'm thinking of things at school and at home. We have kids being raped. We have kids pregnant. We have kids being killed. Basic school things or vision, hearing, they don't even do stuff like that anymore. Nobody is talking to the kids about mental health. Nobody is talking to children about what they're feeling mentally. Nobody is talking to children about what's bothering them. So when I hear the word, basic health care, it really frustrates me because it's like, how basic?"

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on March 7, 2019 at D. Finnegan Recreation Center. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Access to transportation and green space; yet spaces lack inclusive or accessibility for everyone in the community, primarily due to "racial policies and traditions."
- Strong bonds among neighbors.

"The Philadelphia Energy Solutions Oil refinery is poisoning us to a much larger degree than anywhere else in the city in terms of cancer and respiratory illness. But people are so disempowered by having to deal with all of these stressors and violence, worry about losing their homes, not having access to basic care: food, water, shelter, whatever. There is no time or space to take on the kind of fight [with the energy company] where there's long-term health effects."

"I think hopelessness is a huge health problem in this area. How are you supposed to care about anything when there's so much neglect from so many services and institutions and from the City? These people haven't been listening for a long time."

Priority Health Issues

SOCIAL AND ECONOMIC CONDITIONS	» Wide-spread **gentrification** in the neighborhood leads to rising costs of housing and threats of landlords selling properties that some community members have occupied for multiple generations. » Trauma and grief due to violence in the community; lack of support systems to help individuals cope with trauma resulting in a cycle of violence. » **Accessibility of housing** is exacerbated by a crumbling infrastructure in the existing stock, mold, and indoor air quality issues that cause asthma. » Diminishing resources at local public schools have eliminated positions for school nurses and social workers, and have created pay disparities between various teacher positions. » **Limited assets** in terms of economic opportunity; lack of financial institutions, banks, ATMS, and credit unions; the community "stays poor." » Need for more economic opportunity for people to have meaningful work with dignity, and pipelines for entrepreneurs in the neighborhood to become small business owners.
ACCESS TO CARE	» Basic health care (mental and physical) for children, and prenatal care for young women. » A mistrust of local institutions and organizations. » Participants stated knowing, second-hand, of programs that the University of Pennsylvania offers but expressed that little communication is shared with the surrounding neighborhoods.
ENVIRONMENTAL CONDITIONS	» Public health initiatives in the community, like Healthy Corridors, have highlighted the **environmental stressors** on health in the Grays Ferry area, specifically high rates of asthma and cancer. » **Air quality** is a specific concern due to proximity to the interstate, a waste management refinery, and an oil refinery. » Neighborhood safety and appearance, trash and sanitation are all concerns.
YOUTH	» Bullying and tense student-teacher relationships in schools that lead to depression and other poor outcomes.

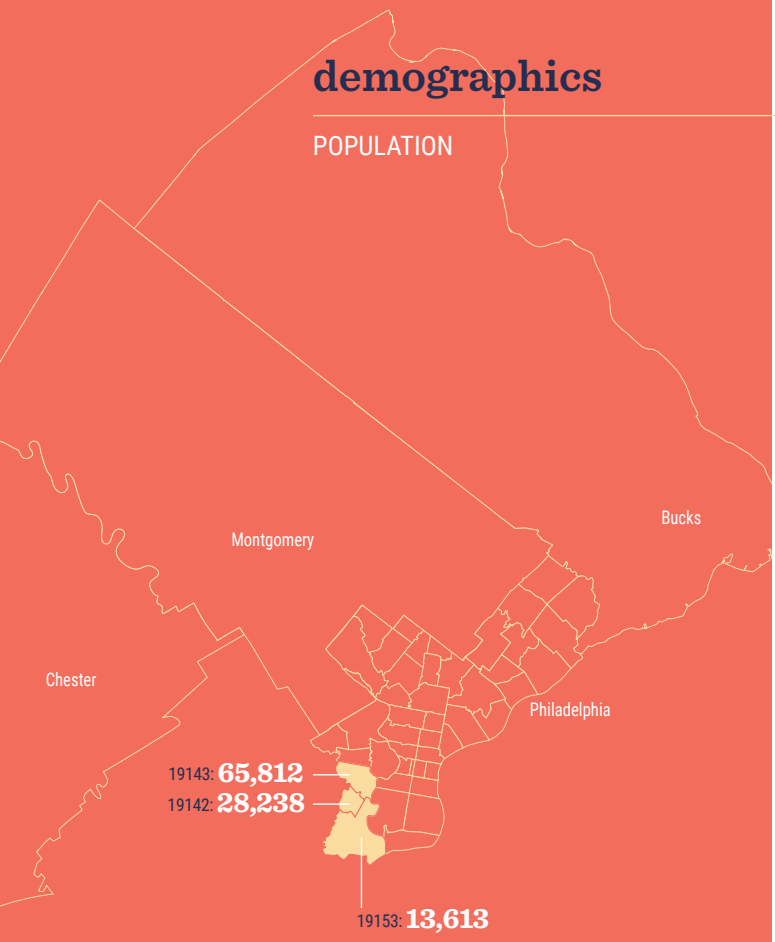
SOUTHWEST PHILADELPHIA

This community is served by:

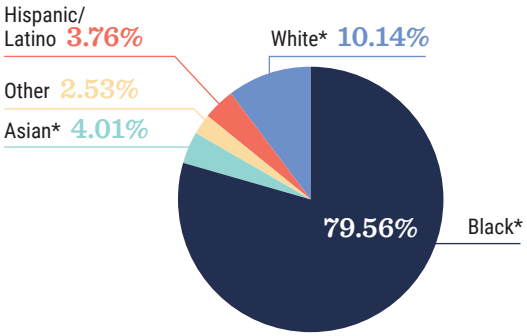
- Children's Hospital of Philadelphia
- Penn Medicine

demographics

POPULATION



RACE/ETHNICITY



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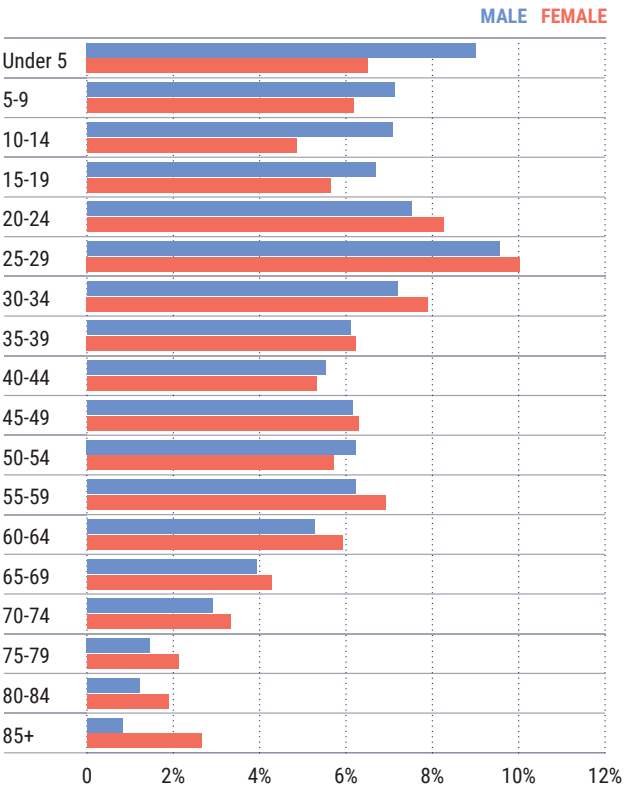


summary health measures

NOTABLE

		Southwest Philadelphia	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	979.3	927.4
	Premature CVD deaths (per 100,000 people)	115.5	104.8
	Diabetes hospitalizations (per 100,000 people)	529.4	371.9
	Adult obesity	34.8%	29.8%
	Hypertension hospitalizations (per 100,000 people)	835.9	649.2
	Cancer deaths (per 100,000 people)	112.8	97.6
	Mammography screening	84.7%	82.9%
	Colorectal screening	73.9%	70.8%
	Adult smoking	20.8%	19.5%
	Adult binge drinking	18.3%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	11.9	8.2
	Percent of preterm or low birth weight births	16.3%	14.2%
	Late or inadequate prenatal care	54.0%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	919.0	727.3
Injuries	Homicide mortality rate (per 100,000 people)	32.9	17.6
	Drug overdose mortality rate (per 100,000 people)	35.2	48.3
	Suicide mortality rate (per 100,000 people)	9.6	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	119.8	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,184.9	2,363.1
Access to Care	Adults 19-64 without insurance	16.5%	14.9%
	Children <19 without insurance	4.7%	4.2%
	Adults 19-64 with Medicaid	31.3%	23.1%
	Children <19 with public insurance	66.3%	58.6%
	Emergency department utilization (per 100,000 people)	65,975.3	55,382.0
	Emergency department high-utilizers (per 100,000 people)	2,011.8	1,716.9
Social & Economic Determinants	Percent in poverty	30.6%	25.8%
	Community need index score	4.4	4.0
	Excessive housing cost	41.4%	38.9%
	Housing with potential lead risk	67.2%	61.1%
	Households receiving food assistance	32.5%	24.5%
	Food insecurity	26.4%	19.0%
	Speak English less than "very well"	5.8%	10.6%

COMMUNITY PERSPECTIVES

"You have students that take medication, and there is no health professional on-site to help administer that. So, you have regular teachers or the receptionist that giving out medication."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on January 29, 2019 at Southwest Community Development Corporation. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- The built environment, specifically ample green space at Bartram's Garden's and the John Heinz National Wildlife Refuge, and walkability.
- Easy access to public transportation is available in the community, but recent updates to the SEPTA Key card have made transferring lines of transit very expensive and hard to maintain for people who do not have access to the internet.
- Limited resources, like transitional housing and employment opportunities, specifically for women with children who are experiencing homelessness, are available.
- Several **community organizations**, including the Southwest Community Development Corporation whose list of services include housing assistance and career development programs.
- The Neighborhood Advisory Subcommittee initiative to move neighbors from relying on payday loan services to establishing bank accounts, and their campaign to eliminate dumping in their community.
- Close relationships with police officers, small businesses such as corner stores, and local libraries.
- Libraries also offer a cadre of helpful services like job fairs, community events, movie nights, volunteer opportunities, tax preparation services, and computer skills classes, among others.

"People are more depressed, they're more oppressed, and they're not getting help. They're not talking through frustrations and anxiety."

Priority Health Issues

BEHAVIORAL HEALTH	» Several behavioral health issues were listed as priorities, including: substance use, suicide, depression, anxiety, trauma caused by high murder rates in the community.
CHRONIC DISEASE	» Treatment and prevention of obesity, hypertension, and diabetes among vulnerable populations, like people living in poverty.
YOUTH	» Childhood diabetes and asthma.
ENVIRONMENTAL CONDITIONS	» **Environmental** health issues like lead exposure and air pollution in schools and at home, and behavioral health issues such as anxiety and chronic stress.
ACCESS TO CARE	» Affordability concerns were attributed to poor **insurance coverage**, particularly for participants churning on and off Medicaid; prescription drug costs; and costs of deductibles. » Limited access to specialty care services; particularly, issues with unaffordable copays, navigating the referral process, and costs of prescriptions. » Limited availability of affordable dental care.
SOCIAL AND ECONOMIC CONDITIONS	» Lack of financial health due to **unlivable minimum wages**, rising costs of living and utilities, and costs of medical care. » **Unmet educational needs** echoed widely, including a lack of resources and programming for adults with cognitive delays who have aged out of school-based programs. » Replacing cuts to programs and schools including school nurses and social workers. » Access to exercise options and high-quality, **affordable food**.

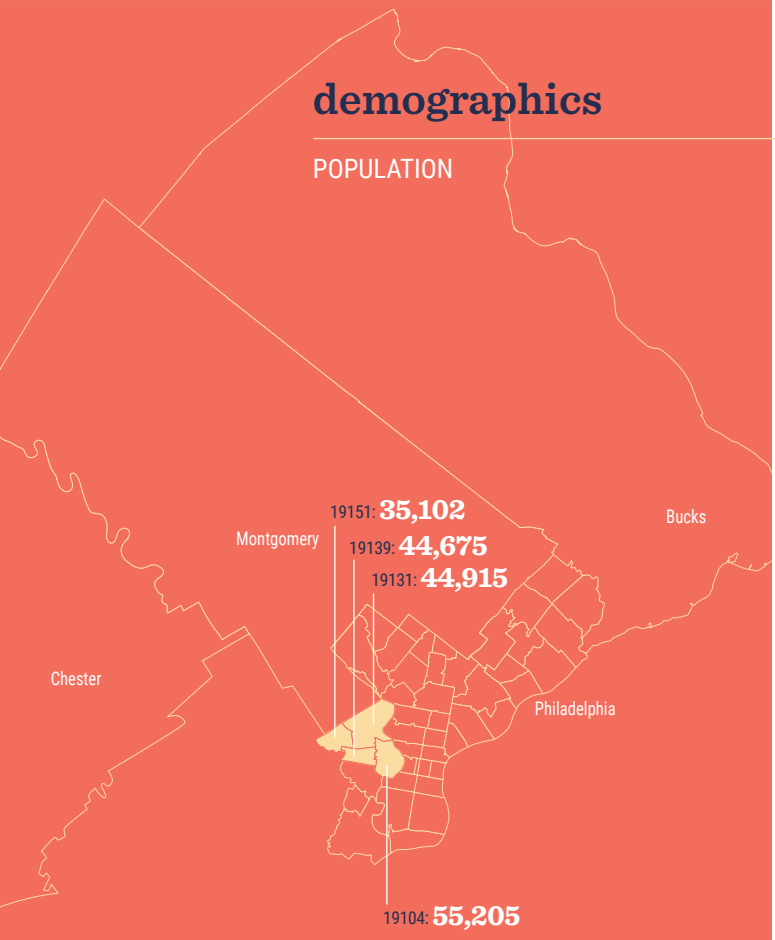
WEST PHILADELPHIA

This community is served by:

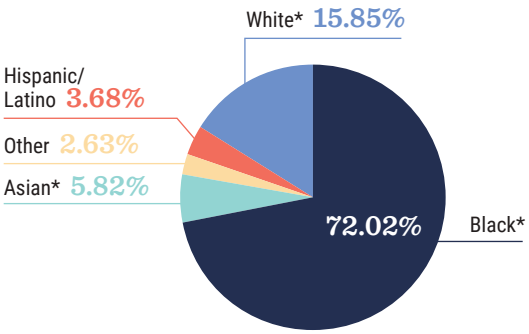
- Children's Hospital of Philadelphia
- Penn Medicine

demographics

POPULATION

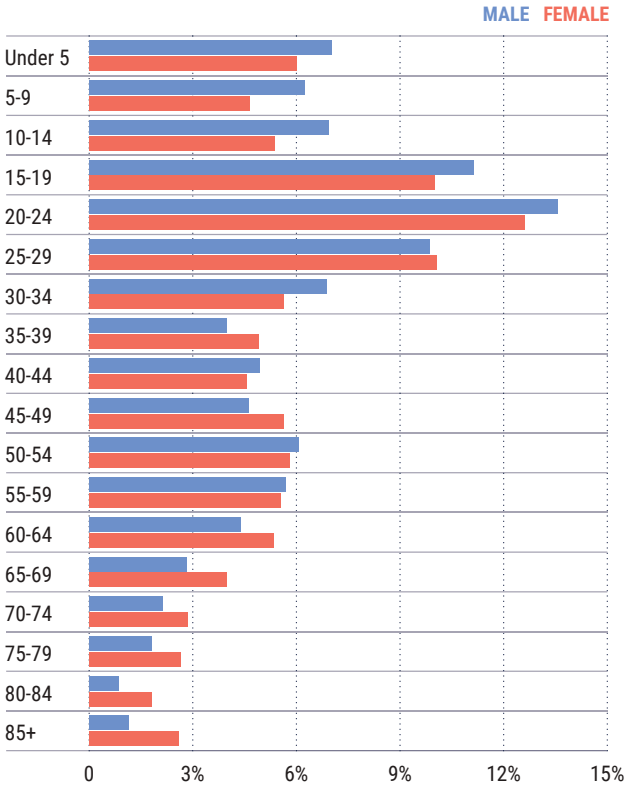


RACE/ETHNICITY



*Non-Hispanic

AGE DISTRIBUTION



summary health measures

NOTABLE

		West Philadelphia	Philadelphia County
Chronic Disease & Smoking	Death rate (per 100,000 people)	947.8	927.4
	Premature CVD deaths (per 100,000 people)	123.7	104.8
	Diabetes hospitalizations (per 100,000 people)	376.9	371.9
	Adult obesity	36.3%	29.8%
	Hypertension hospitalizations (per 100,000 people)	751.5	649.2
	Cancer deaths (per 100,000 people)	101.6	97.6
	Mammography screening	84.4%	82.9%
	Colorectal screening	77.1%	70.8%
	Adult smoking	20.8%	19.5%
	Adult binge drinking	16.5%	18.9%
Infant & Child Health	Infant mortality (per 1,000 live births)	12.0	8.2
	Percent of preterm or low birth weight births	18.0%	14.2%
	Late or inadequate prenatal care	49.7%	46.5%
	Asthma hospitalization rate, ages 2-14 (per 100,000 children 2-14)	721.5	727.3
Injuries	Homicide mortality rate (per 100,000 people)	18.9	17.6
	Drug overdose mortality rate (per 100,000 people)	39.2	48.3
	Suicide mortality rate (per 100,000 people)	6.8	9.9
	Pedestrian and cyclist crash rate (per 100,000 people)	154.5	125.2
	Fall hospitalization rate, ages 65+ (per 100,000 people 65+)	2,341.3	2,363.1
Access to Care	Adults 19-64 without insurance	13.2%	14.9%
	Children <19 without insurance	3.3%	4.2%
	Adults 19-64 with Medicaid	23.1%	23.1%
	Children <19 with public insurance	56.6%	58.6%
	Emergency department utilization (per 100,000 people)	59,288.9	55,382.0
	Emergency department high-utilizers (per 100,000 people)	1,932.2	1,716.9
Social & Economic Determinants	Percent in poverty	33.7%	25.8%
	Community need index score	4.2	4.0
	Excessive housing cost	42.0%	38.9%
	Housing with potential lead risk	63.1%	61.1%
	Households receiving food assistance	28.5%	24.5%
	Food insecurity	16.4%	19.0%
	Speak English less than "very well"	3.9%	10.6%

COMMUNITY PERSPECTIVES

"I grew up in 19104 in the 60s and 70s and we didn't always have a good relationship with the college. Back then, colleges were trying to push us out and there was no meeting, there was no cooperation, but now we have a very good working relationship and they have a lot of programs in our neighborhood and our community. That's been very good."

FINDINGS FROM COMMUNITY MEETINGS

Below is a summary of community assets and priority health needs as reported by community members who participated in a facilitated focus-group style discussion on February 11, 2019 at ACHIEVEability. The full text of the meeting can be found in the Appendix.

Notable Community Assets

- Strong network of community organizations and anchor institutions, as well as the diversity of religious beliefs and institutions, including Oak Tree Health Service, Sayre Health Center (for uninsured), the CHOP Karabots Pediatric Care Center, a robust faith-based community, youth programs, and services for veterans, among others.
- **Accessibility** is a community asset, including community-based health care, walkability, and proximity to public transportation.
- Safety net providers, like Sayre Health Center, are great for people who "don't have insurance," and the CHOP Karabots Center is helpful because people don't have to "travel outside of the neighborhood" to get care for their children.
- Strengthened relationship with the local colleges in the neighborhood.
- Diverse religious organizations coexisting together are a part of the richness of the West Philadelphia community.

"We have so many high school students who are in 10th and 11th grade who are literally reading at a third grade level. Literacy is a huge problem, our high school kids are in trouble."

Priority Health Issues

BEHAVIORAL HEALTH	» **Barriers to accessing behavioral and mental health** including the cost of care, and the stigma associated with the diagnosis of a behavioral health need. » Overprescribing and diagnosis of ADD/ADHD. » High rates of opioid use/abuse. » High rates of **maternal mortality** related to mental health and substance abuse.
ACCESS TO CARE	» Negative perception of the **quality and access of health care** due to high copays, providers and hospitals that do not accept certain types of insurance plans, and trouble navigating health care systems (finding a provider, getting an appointment, transportation, health literacy). » **Lack of trust in health care**, from mistrust of insurance companies, health care systems, and providers. » Lack of respect from healthcare providers due to **racism**.
YOUTH	» STDs and sex education among youth. » Lack of strong relationships with their neighbors among young people. » Declining quality of educational and unmet need of students, teachers, and educational infrastructure. This includes the physical condition of school bathrooms, cafeterias, and classrooms, as well as lack of teachers or teacher absences, leading to an influx of substitutes.
CHRONIC DISEASE	» Strokes, cancer, sleeping disorders and sickle cell disease were notable chronic conditions.
SOCIAL AND ECONOMIC CONDITIONS	» **Limited quality green spaces** for community dwellers to play in and enjoy. » **Lack of affordable housing** with functional utilities, such as plumbing and heat, and lack of shelters result in increased homelessness in the community. » **Nutrition** and access to healthy food was described as another barrier to health in the West Philadelphia community, primarily because of the expense of fresh fruit and limitations of refrigeration, storage, and shelf life that limit corner stores' desire to carry healthy food. » A great deal of **community trauma** from witnessing violence and chronic stress due to issues such as poverty.

A list of eighteen potential populations of special interest were prioritized by the Steering Committee for primary qualitative data collection for this assessment. The Committee recognized that there are many communities in the area with unique experiences and specific needs, and that no single data collection effort can comprehensively reflect the needs of all communities. Prioritization was based on the perceived magnitude of concerns facing communities, how emergent a concern was, and whether data already existed for a given population. The six populations selected for primary data collection through key stakeholder focus groups were: Hispanic and Latino communities, African-American communities, people experiencing homelessness, people experiencing housing insecurity, prenatal and postpartum women, and people living with behavioral health conditions. Where available, findings from other recent primary data collection efforts and reports for other populations of special interest were included. These populations are immigrant and refugee communities, individuals with disabilities, LGBTQ+ communities, and youth and adolescents.

POPULATIONS OF SPECIAL INTEREST

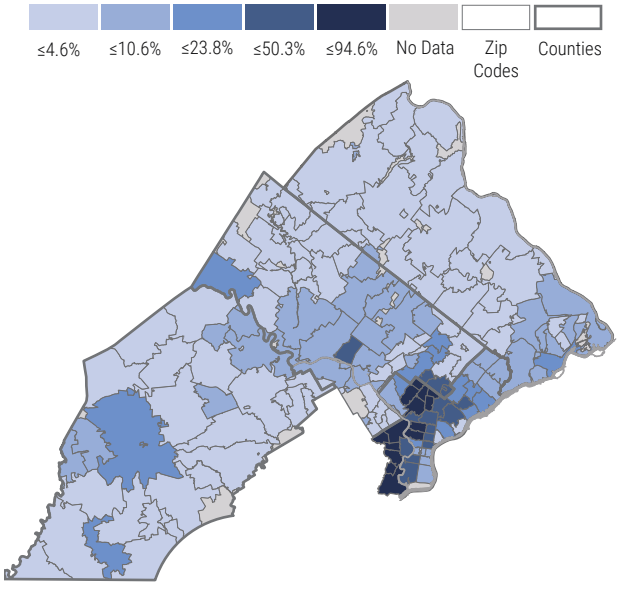
AFRICAN AMERICAN COMMUNITIES

African Americans represent roughly 40 percent of the population in Philadelphia County, and much less in the surrounding counties.

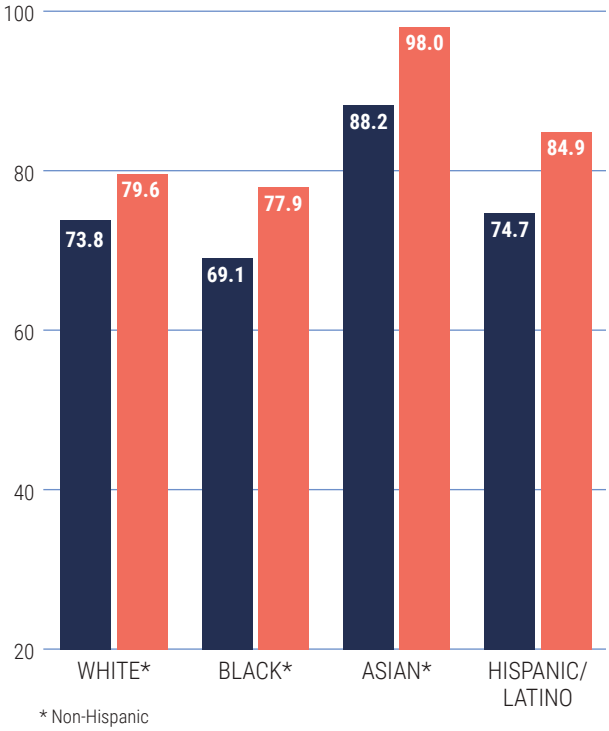
Key health indicators show poorer health outcomes among African Americans as compared to other racial/ethnic groups in the region. Most notably, life expectancy for African Americans is lowest compared to other racial/ethnic groups and lowest for African American men overall. These disparities in outcomes are largely driven by higher rates of poverty and increased exposure to adverse conditions related to poor neighborhood conditions and structural violence.

Additionally, the impact of structural racism and experience of bias in health care and other service settings has and continues to be a significant challenge for these communities and critical to address in order to improve health and achieve health equity in the region.

BLACK NON-HISPANIC POPULATION

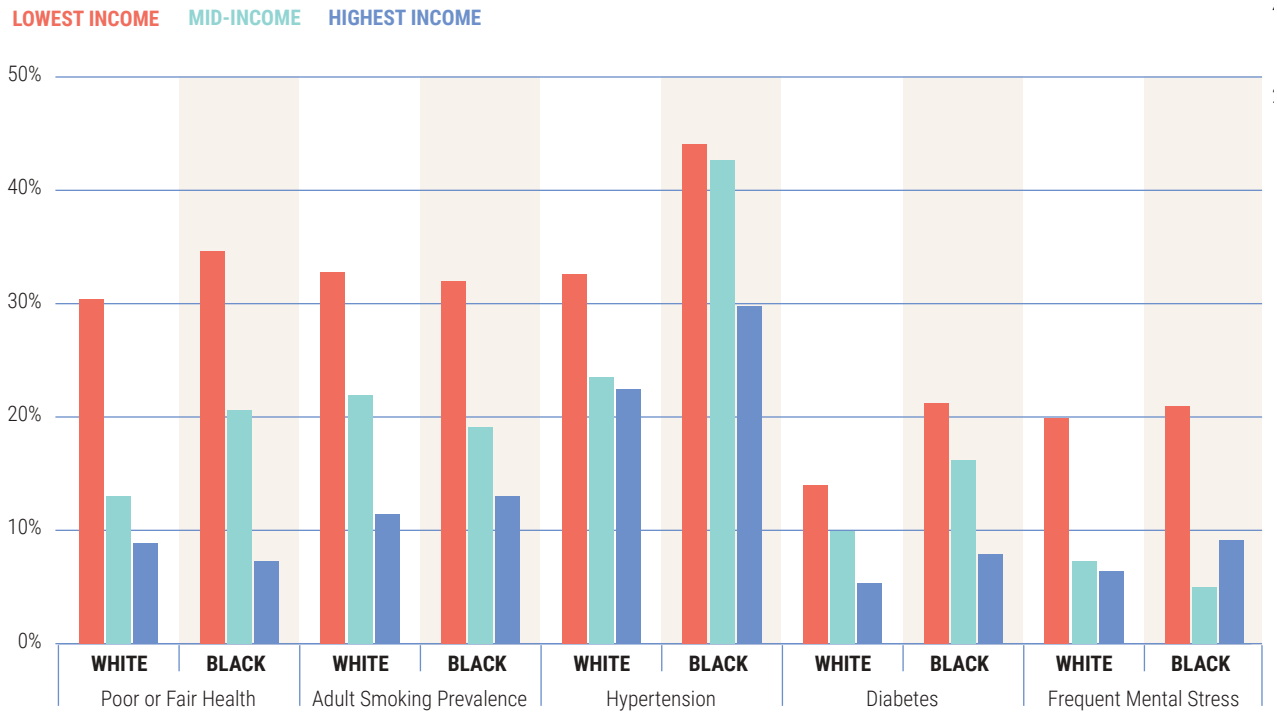


LIFE EXPECTANCY BY RACE AND SEX



* Non-Hispanic

IMPACT OF POVERTY ON BLACK-WHITE HEALTH DISPARITIES, 2015–2017



PHYSICAL HEALTH CONCERNS

- Diabetes, heart disease, stroke, and hypertension were all identified as chronic diseases of concern, with obesity raised as a particularly significant issue. Cancer was also a health concern.
- Place-based determinants and neighborhood environments play a strong role in the development of these health issues. For example, under-resourced communities have too many fast food places and not enough healthy food options.

MENTAL AND BEHAVIORAL HEALTH CONCERNS

- Substance use, including opioid use, is prevalent and respondents noted that "demand is high" and "resources are slim" for treatment options. Treatment is short and insufficient, and sometimes located near places where the substance use originally initiated, which could cause people in recovery to relapse.
- Multiple respondents agreed that African American communities are vulnerable to violence, such as shootings, and resultant trauma. This violence is a result of root causes that create resource disparities and desperation, including intergenerational poverty, limited educational opportunities, limited housing, and issues with crowding.
- Respondents noted "incredible amounts" of depression and anxiety, concurrent with an increase in drugs to offset those conditions. Respondents noted an associated stigma with mental health conditions in some African American communities, which can make the conditions more difficult for providers to address.

POPULATIONS OF SPECIAL INTEREST

AFRICAN AMERICAN COMMUNITIES

Serving African American children

HEALTH CONCERNS

- One respondent reflected on recognizing a child's position in a family. They are "powerless" in that they are subject to an adult's control and bound by their environment, but they also exhibit resilience.
- Parents who struggle with the continual exhaustion of limited income, multiple jobs, and raising multiple children may have limited bandwidth to offer support to their children. As a result, children may not have well-visits and may be late on immunizations.
- Obesity and asthma are significant health concerns for children.
- African American teens may experience depression, anxiety, bullying, and negative effects from exposure to technology. Trauma from exposure to violence or substance use may also have strong effects. Homeless teens may have additional difficulties thriving in school.

SYSTEMS ISSUES

- Accessing mental health services for children is a particularly significant issue; respondents described children in school settings on waiting lists to be screened.
- Respondents identified gaps in knowledge of how to access health care, find insurance, navigate the system, and complete care transition from pediatric to adult care.
- The school system is not set up to encourage education. Students are rushed to move along even if they are not fully prepared. A lack of faculty continuity means a high proportion of substitute teachers. Child illness also contributes to absenteeism, which has implications for future educational and professional opportunities.

Serving African American older adults

- Seniors have fears around safety in their neighborhoods, which present barriers to accessing resources like food, medication, and exercise.
- One respondent noted that as African Americans age and need to see their providers more, the fear of hearing bad news increases, which seems especially prevalent in men.
- Older adults experience worry over their younger family members, especially when circumstances create family structures where grandparents are caretakers of their grandchildren. They may also feel a sense of loss for their adult children.

Access to care

UNDERLYING BARRIERS TO ACCESS

- Providers often converge in a small number of large complexes. This clustering creates areas where other communities have no locally accessible health care.
- Transportation can pose a significant barrier when families need to take several buses or trains to get care.
- Some families cannot afford to miss work, which makes seeking healthcare a challenge.
- Respondents also noted a tendency to seek care from the emergency department rather than seeking primary care. This preference is likely due to interrelated issues of transportation and financial barriers causing delays in care, people not having insurance coverage, and/or a lack of familiarity with navigating the health care system's care options.

NAVIGATION AND SYSTEM CHALLENGES

- Respondents noted that some people within African American communities may lack insurance or, if they have it, they may not be familiar with how to use it.
- Even when people can access health care facilities, respondents noted a reluctance to receive care, because of the biases they experience when interacting with health care providers. Respondents reported that patients feel like "an underclass, subclass, alternative class."
- Respondents noted specialists are difficult to access, with long waitlists and long spans of time waiting for an appointment. Patients find specialist care difficult to navigate successfully and are "sent through insurance roundabouts."
- Respondents also discussed the shortage of psychiatrists, leading to poor mental health care that overmedicates patients who would benefit from therapy.

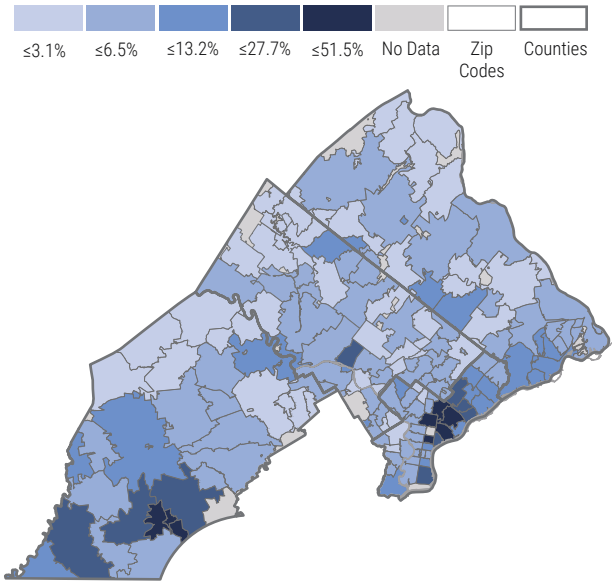
On reluctance to interact with the health care system due to the interpersonal treatment experienced there:

"How long can I go with the pain I'm having to avoid how I feel after I leave this place that is supposed to take care of me?"

POPULATIONS OF SPECIAL INTEREST

HISPANIC AND LATINO COMMUNITIES

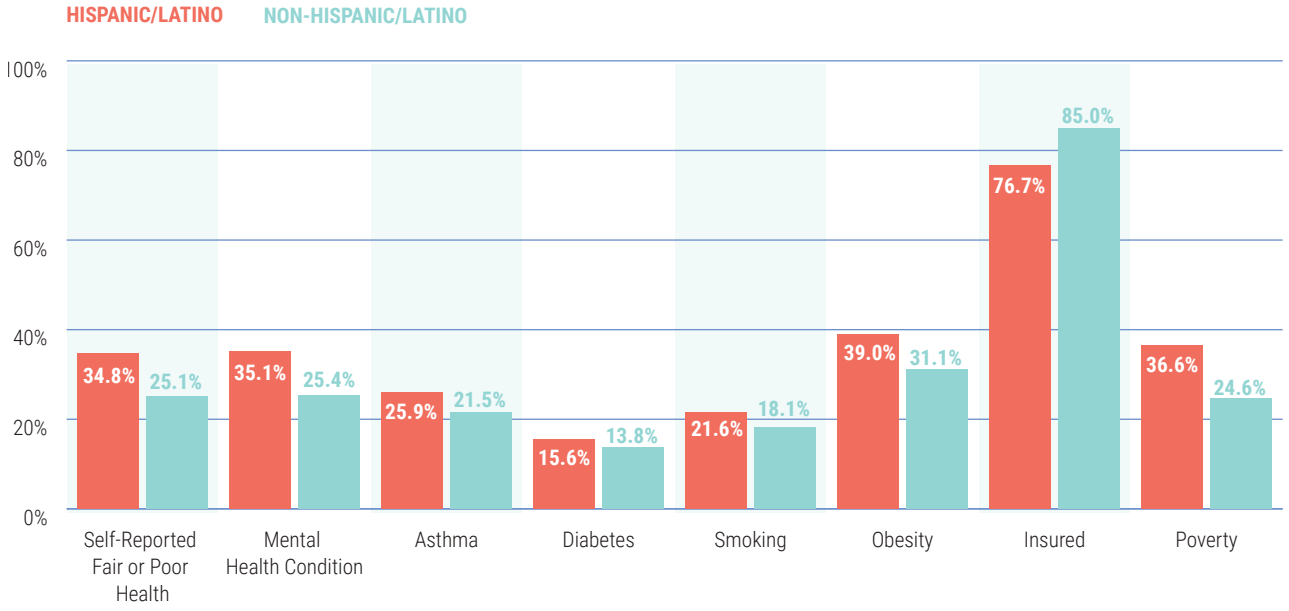
HISPANIC/LATINO POPULATION



Hispanic and Latino communities cluster in the Northeast region of Philadelphia and parts of West Chester, where the population is as high as 50% in some areas. Overall, about 14% of Philadelphia County residents are Hispanic or Latino.

Hispanic and Latino communities continue to experience higher rates of many chronic conditions, particularly mental health conditions, compared to other racial demographic groups in Philadelphia. These higher rates of chronic disease are related to higher rates of unhealthy behaviors, which are both driven by higher rates of poverty and lower access to care.

HISPANIC/LATINO HEALTH MEASURES



Across the region, many members of Hispanic and Latino communities face cultural and linguistic barriers to health that contribute to poor health outcomes. The current political climate associated with immigration poses further barriers that lead to fear, stress, and delays in seeking out needed care and services. To more fully reflect the impact of these barriers, information gained from the CHNA focus group effort and a recent qualitative assessment are shared below.

CULTURE AND CARE

- Multiple respondents emphasized that culturally competent and linguistically appropriate care are critical to addressing the needs of Hispanic and Latino communities.
- Respondents shared that some health systems have not built trust with newly arrived patients or with well-established Latino communities. Unfamiliarity and disengagement with Latino communities creates mistrust and disconnects between providers and the patients they serve.
- Respondents shared that local public health entities are not focused on addressing the prevalence of chronic health conditions in Hispanic and Latino communities. For example, vast majorities of Latino clients in some health and wellness programs have diabetes or pre-diabetes; in some programs the prevalence approaches 90 percent. A lack of prioritization is compounded by a general lack of knowledge about serving the needs of Hispanic/Latino communities.
- Intersections of cultural traditions, acculturation to American norms, and intergenerational differences can affect how Hispanic and Latino families interact with their health. These considerations can affect things like diet, substance use, and managing chronic conditions.
- People who experience chronic homelessness are at higher risk for poorer mental health, physical health, and premature death. In 2018, there were over 16,500 people experiencing homelessness in Philadelphia, of which 8.2% were Latino. A phenomenon called the Latino Homeless Paradox suggests that Latinos are more likely to find alternative forms of housing before going to a shelter due to language barriers and a lack of available beds in their neighborhoods. The reduced proportion of Latinos using shelters prevents them from accessing housing programs that reach many people through shelters. In addition, it likely results in undercounting the number of truly homeless Latinos in Philadelphia and may conceal the severity of the housing crisis in Latino communities.

"There is poor communication between English speaking providers and English speaking patients, and that communication is even worse when they do not speak the same language."

POPULATIONS OF SPECIAL INTEREST

HISPANIC AND LATINO COMMUNITIES

Serving younger Hispanic and Latino children

- Multiple respondents described chronic stress as a result of the modern political climate and an ever-present culture of fear. Respondents described children being affected by exposure to Spanish-speaking media outlets in the home regarding the state of their countries of origin, or children crying in elementary and middle-school classrooms due to stress and uncertainty about how welcome their families and communities are in the United States.
- There is substantial need for dental services, as raised by respondents describing children who are referred by schools and have never seen a dentist. These children have significant oral health issues that necessitate many visits and sometimes surgical procedures.
- Family context can also affect children's health. Parents with limited language or literacy skills may have difficulty understanding requirements such as immunizations or other forms needed for school, and parents with inflexible work schedules or transportation challenges may have trouble taking their children in for visits.

Serving older Hispanic and Latino children

- One respondent also mentioned bullying as a stressor for Latino children. Another mentioned seeing an elevated rate of panic attacks in teenagers.
- In Bucks County, respondents noted how interactions with the school system affected several of these issues. Examples included sexual education not taking place in high school settings and a lack of resources in schools to help bridge language and communication issues.
- In addition, several respondents mentioned the high rate of pregnancy among teenage Latinas as young as 13-15 years old. Contributing factors included high rates among girls who have recently arrived in the United States, several client cases where the teenagers' parents approved of beginning motherhood at a younger age, and a lack of sexual education curricula being offered in high schools.

Serving Hispanic and Latino older adults

- Loneliness, depression, and isolation emerged as key issues facing older adults.
- Stakeholders identified poverty and poor financial health, unstable employment, unstable housing and community trauma as major sources of chronic stress.
- Social determinants of health can play a heightened role in older adults' health. Respondents described older Latinos struggling to afford and manage their medications, pay copayments, and access healthy food. For some seniors, even when participating in food access programs, the food is often not culturally appropriate and does not include fresh, nutritious produce.

"This community, for the most part, has been pushed aside and we haven't been able to build trust. I think that is a fundamental thing."

Access to care

APPROPRIATENESS AND AVAILABILITY

- Multiple respondents strongly emphasized the need for linguistically appropriate care throughout the discussion. They noted that Hispanics and Latinos are not linguistically or culturally monolithic, but come from many different countries and speak many different dialects. Providers must be sensitive to the diverse cultural backgrounds of Hispanic and Latino communities.
- Respondents described significant waitlists for bilingual counseling services.

CULTURE, CLIMATE, AND ROOT CAUSES

- Multiple respondents noted that a lack of health insurance greatly affects access to care. Undocumented community members may also avoid or delay seeking care due to fear of deportation, resulting in emergency department visits.
- Nationally, rhetoric around immigration has had a tremendous effect on Latino communities. One respondent described expectant mothers who are scared of delivering in the hospital out of fear that they will be separated from their baby.
- The following structural barriers and social determinants of health can also affect access:
  - Transportation was identified as a challenge.
  - Missing work to receive care can present a proportionally greater economic risk for people who may not receive paid time off.
  - Affording healthy foods can also be a challenge, as can accessing culturally appropriate foods that a family is familiar with preparing.

"It is a multigenerational cycle — poor living environment, lower education, and low income all lead to poorer health."

POPULATIONS OF SPECIAL INTEREST

IMMIGRANT AND REFUGEE COMMUNITIES

Approximately 12 percent of residents in the region are foreign-born.

These immigrants and refugees come from around the world and most have arrived in our region since 1990. Within this immigrant and refugee population are many recent arrivals with significant vulnerabilities: some seeking asylum or without current status, those with limited English proficiency, and many experiencing health challenges, all of which create barriers to daily functioning. Many of them are deterred from applying for public benefits or programs that provide necessities, such as health care and food, because they are afraid that their application process will divulge information to federal immigration officials about who they are and where they are living, even if they are eligible immigrants. Nearly 40% of the non-citizen immigrant population is uninsured, which is over four times the rate of the general population.

Many refugees 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 status, and are frequently diagnosed with Post-Traumatic Stress Disorder (PTSD) and other mental health conditions. Language barriers are a particular barrier for those in need of behavioral health services. In addition, cultural beliefs about health may not include disease prevention or use of Western medicine to control chronic disease. Some unique needs of among immigrants and refugees were reported and are summarized below.

Women immigrants/refugees

- There is a need for family planning education and increased need for community education about women's rights.
- Women immigrants and refugees may be unfamiliar with or fear the health effects of contraception.
- This population may lack transportation to reach needed health care services and may have limited health literacy.
- There is a need for culturally competent care.

Older adult immigrants/refugees

- Older adult immigrants and refugees may have difficulty managing conditions, limited health literacy, and trouble navigating health care and health insurance.
- Many older immigrants experience decreased social engagement, poor mobility, and resultant lack of activity.
- Language barriers, concerns for family members, and financial uncertainty are major sources of stress for the older immigrant and refugee population. Language barriers may prevent individuals from learning about and accessing programming.
- Organizations serving immigrant populations are providing patient navigation services due to language barriers and complexity of the health care system.

"Health for [many immigrants] is traditionally if you can sleep well, eat well, look a bit fat and walk."

African and Caribbean immigrants/refugees

- The African Family Health Organization (AFAHO) noticed an influx of immigrant, refugee and asylee Caribbean and African youth, specifically in West Philadelphia, and that many of them were not English-proficient, lacked knowledge of reproductive and sexual health and experienced bullying in the school systems.
- More initiatives, like AFAHO's summer programs, are needed for these immigrant youth to help create a safe environment for them to discuss their hardships; improve self-esteem; and educate the youth on sexual and reproductive health, English, and how to adjust to American life while maintaining their ethnic identity.
- Congolese immigrants and refugees may lack the funds to cover basic expenses. Those who access food stamps experience concerns that these benefits are not enough to cover the entire family.
- Congolese immigrants and refugees frequently experience difficulties with follow-up and specialist appointments.

East and Southeast Asian immigrants/refugees

- Among 330,000 Philadelphia area residents who do not speak English very well, 5.8% speak Vietnamese, but that language is spoken by less than 1% of local physicians. This shortage, according to VietLead, a nonprofit community group for Philadelphians of Vietnamese origin, is especially acute among physician specialists and mental health professionals.
- Buddhist centers across the city provide legal aid, tax assistance, soup kitchen document translation, English classes and other services to East/Southeast Asian, African, Latino, and Eastern European populations.

Muslim immigrants/refugees

- There are over 75,000 Muslims who live in Philadelphia, and about 60% of them live in poverty.
- Furthermore, 25% lack health insurance, 30% report cost as a barrier to healthcare access and 20% have no access to healthcare whatsoever.
- Muslim immigrants and refugees lack access to Muslim-run health care facilities.

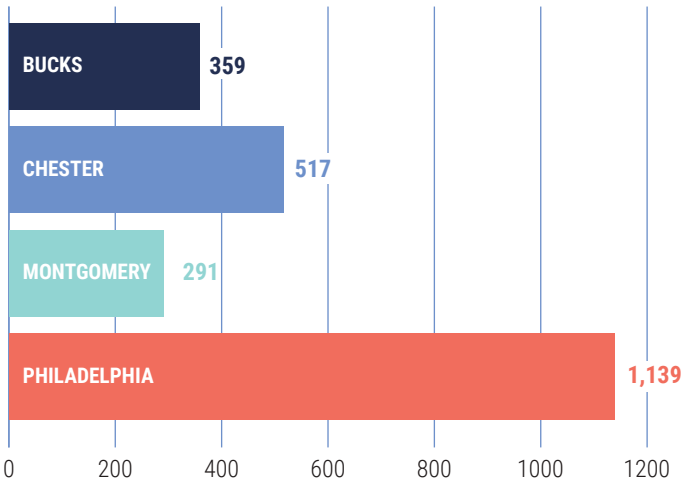
POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS EXPERIENCING HOMELESSNESS

Among the most vulnerable in communities in the region are those individuals experiencing homelessness. Based on the most recent count of unsheltered homeless, there were just over 2,300 homeless individuals in the region, approximately half in Philadelphia County.

These individuals face increased risk of significantly poor physical and mental health because their basic needs are not met and because of their ongoing exposure to adverse environmental conditions. Physical or behavioral health conditions often go undiagnosed or untreated, due to lack of access to care. The challenges associated with homelessness are further exacerbated by the opioid epidemic. Improving and expanding systems of services is essential to significantly meet such acute need.

HOMELESSNESS BY COUNTY



PHYSICAL HEALTH CONCERNS AND ROOT CAUSES

- Far and away, respondents concurred that the greatest need of people experiencing homelessness is safe, stable housing. Poverty and hunger, or a lack of consistent access to food, are also concerns.
- Respondents listed acute physical needs resulting from unsafe and unstable conditions of living without a home, including: exposure, adverse effects of not getting enough quality sleep, exposure to lead, asthma, joint pains, arthritis, problems with mobility and feet, heart disease, hypertension, lung disease, sexual and reproductive health needs, and skin disorders.
- These conditions often go undiagnosed and untreated due to lack of access to care and medication.

MENTAL AND BEHAVIORAL HEALTH CONCERNS

- Respondents stressed the needs of homeless individuals who suffer from concurrent mental or behavioral health conditions that are often untreated. Opioid use is a significant concern.
- Families often have histories of trauma and mental health needs.
- One respondent mentioned the needs of homeless individuals who are survivors of domestic violence. Sometimes a partner has blocked or controlled access to care or medication. Other times, their partner has doled out medication as a reward, or kept the survivor under the influence of substances to make them more controllable.
- This abuse results in longer term health needs, including treatment and rehabilitation for substance use disorders.

Serving children

- For very young children, respondents emphasized promoting breastfeeding among expectant mothers to offer protection against health risks of living in shelters.
- For children of domestic violence survivors, abusive partners blocking access to care affects children as well. Expectant mothers are often denied or blocked from receiving any prenatal care.
- Children, even infants, have experienced or witnessed significant trauma and violence that health care professionals need to be trained to recognize and address. Chronic stress among among pregnant women experiencing homelessness is believed to impact birth outcomes.
- Children with intellectual disabilities have particular challenges with shelter environments.
- Children experiencing homelessness have difficulty accessing health care, including vaccinations and screening. One respondent described a mother trying to make a new patient primary care appointment for her seven-month-old baby and being told there was no availability for over two months.
- Children also present with physical conditions such as asthma, lead poisoning, and significant dental issues. Respondents have seen rotting teeth, including baby teeth, due to poor nutrition and deferred dental care.
- Among older children, key informants noted seeing early pregnancy in client populations.
- Older children are at risk for sex trafficking and victimization in exchange for securing a place to stay. Sexually transmitted diseases and HIV/AIDS are resultant concerns.
- Mental health conditions are a significant concern, including the prevalence of depression, anxiety, stress, trauma, and “a lot of very egregious self-harm.”
- Respondents also described some substance use and substantial failure to thrive academically in school.
- LGBTQ+ youth are over-represented in the population of homeless youth and are at risk for experiencing bigotry, physical violence, and sexual violence.

POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS EXPERIENCING HOMELESSNESS

Serving older adults

- Multiple respondents shared that age itself presents differently in homeless populations. People in their 50s and 60s have all the problems of more advanced age, are considered seniors by people who work with them, and are more likely to die within their 50s-60s than people in the general population.
- Experiencing homelessness may also compound mental and behavioral health conditions, as well as mobility issues, in these older adults.
- A compounding issue is that, despite advanced conditions and multiple hardships, these adults may not yet be eligible for housing and other benefits programs that are reserved for traditional categories of seniors (i.e., ages 65 and older).

Access to care

NAVIGATION

- Despite having health insurance, many people experiencing homelessness may depend on 911 or the emergency department (ED) for routine medical care. ED dependence may be due to transience placing people far from their original primary care office or patients not even knowing primary care is an option.
- Providers also need to be trained to recognize and address trauma, especially among children with mental health needs.
- Respondents noted system gaps when homeless patients leave care. Those who are not sick enough to stay in care, but are too sick to return to the shelter, often have nowhere to go. The burden for planning for these individuals can fall on community-based organizations or public services.
- Shelter services often feel unequipped to address special health care needs. Some people in shelter will delay important care, such as treatment or surgery, because they won't be able to deal with recovery while in shelter.
- Connecting patients to specialists is a challenge. People with significant trauma may have to endure wait times of 6-8 weeks for an initial behavioral health assessment.
- People experience stress, transience, and competing needs that make accessing care difficult. Barriers like not having enough minutes on a pre-paid phone to stay on hold with a provider can delay or prevent access.

BIAS AND STIGMA

- Multiple respondents described system failures related to bias and stigma for clients experiencing homelessness presenting with acute needs or severe injury. Despite case managers advocating for them, these patients were turned away from EDs. These patients were dismissed as bed-seeking or med-seeking.
- In these cases, severe health problems were addressed later than they should have been, and in a few cases the patient died.
- Multiple respondents agreed they had witnessed this occurrence across multiple systems of care, even with veterans eligible for VA medical care. While they cautioned against overgeneralizing, they noted enough cases for it to be considered a serious and persistent issue.
- Patients who visit the ED also face stigma from staff and providers while there.

"When I was in elementary school, the solution to polio was not building more lung machines and giving more kids walkers. We all stood in a line and got a vaccine. And so that was the inoculation.

Well, the inoculation for homelessness is not better shots, it's not better dental care, it's not even better mental health care or substance abuse care, all of which I agree on. The inoculation – the actual treatment – is housing."

POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS LIVING WITH BEHAVIORAL AND MENTAL HEALTH CONDITIONS

Numerous indicators strongly demonstrate the growing behavioral health care need in the region. High rates of behavioral health diagnoses (often co-morbid with chronic conditions), stress associated with unmet non-medical needs arising from poverty, and morbidity and mortality stemming from the opioid epidemic present a clear picture of pressing need. Stakeholder input across four counties was sought to identify strategies for improving systems of care and resources to more effectively address behavioral health needs regionally.

MENTAL AND BEHAVIORAL HEALTH CONCERNS

- The opioid epidemic was identified as a significant crisis, resulting in complex medical needs and deaths by overdose. Issues compounding opioid use include limited availability of treatment resources, insufficient wraparound services to support people in recovery, and a lack of housing that offers a safe environment without the presence of other users, which can precipitate relapse.
- Methamphetamine use was identified as an increasing issue in Montgomery County.
- Patients suffering from significant mental health crisis have comparatively shorter life expectancy, leading respondents to question whether current treatment regimens are really changing the course of patients' lives.
- Respondents noted the prevalence of anxiety disorder and related medical symptoms, including headaches, back pain, neck problems, Irritable Bowel Syndrome, fibromyalgia, and chronic fatigue syndrome.
- Respondents in three of the four counties noted the upward trend of deaths by suicide.

CONCURRENT PHYSICAL HEALTH CONCERNS

- Medical conditions that are exacerbated by smoking, alcohol, or illicit drug use include obesity, pain syndromes (orthopedic issues, arthritis, fibromyalgia, and migraines), cellulitis, skin abscesses, cirrhosis, sexually transmitted disease, tuberculosis, hypertension, hyperlipidemia, diabetes, cancer, COPD, and asthma. Smoking, alcohol use, and illicit drug use also affect the health of pregnant women and their fetuses.
- Hepatitis C was identified as a growing concern in Bucks and Montgomery counties, along with a general need to test for sexually transmitted diseases in populations of people who inject drugs.
- Patients with behavioral health conditions have significant dental needs and often lack preventive care. The physical appearance of poor dental health can also present a barrier for patients seeking employment.
- Psychotropic medications may cause side effects and long-term effects, which may contribute to chronic medical conditions like diabetes.

ROOT CAUSES AND COMPETING ISSUES

- Across the counties, respondents cited multiple barriers related to social determinants of health that create additional challenges for behavioral health patients.
- These determinants include a lack of affordable housing, limited employment opportunities, lack of access to healthy foods and poor nutrition, limited transportation, and low socioeconomic status. Exposure to these conditions creates chronic stress and trauma that result in poorer physical and mental health.
- Respondents stressed the persistence of stigma towards people with mental health conditions and substance use disorder among health care providers. Stigma can lead to providers dismissing patients' concerns or can expose patients to trauma and discrimination within healthcare settings.

Serving children

TRAUMA

- Childhood trauma emerged as a critical issue across all the counties. Although key informants mentioned adult trauma and trauma interacting with the healthcare system, they spoke at length of the effects of adverse childhood experiences (ACES), and the negative behavioral and physical outcomes that can emerge.
- These experiences include the stress of growing up in a single-parent household, a lack of development of healthy attachments, parents who have skill deficits in caregiving, parents who have their own behavioral health issues, homelessness, and the high daily allostatic load of growing up in the context of intergenerational poverty.
- Respondents in Philadelphia and Chester Counties also noted specific risk of harm for LGBTQ+ children if behavioral health providers are not sensitive to their experiences, and if providers wrongly assume sexual and gender identities to be products of past trauma.
- Chester County respondents noted a diversity of cultural backgrounds among youth and emphasized the importance of ensuring access to bilingual, bicultural health care providers who make children from any background feel welcome.

POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS LIVING WITH BEHAVIORAL AND MENTAL HEALTH CONDITIONS

MENTAL HEALTH CONCERNS

- Bullying, in particular through social media, emerged as a concern that affects children at younger and younger ages.
- Respondents noted recent data trends appear to show an increase in adolescent and young adult suicide rates, which may be affected by a drop-off in treatment in high schools.
- Anxiety, depression, and ADHD were all cited as mental health conditions affecting this group.
- Children need support developing skills to encourage social-emotional regulation in order to manage behavioral health conditions, trauma, and other stressors. A Montgomery County respondent noted social-emotional learning programs being placed in preschools and elementary schools.
- In Montgomery and Chester Counties, respondents noted a significant burden of stress and pressure to succeed academically in older children from well-off communities.
- Lack of safe, affordable structured activities (such as opportunities for physical activity), excessive screen time, and exposure to bullying on social media impact behavioral health among children.

SUBSTANCE USE

- Across the counties, respondents expressed concern regarding an increase in youth substance use, including alcohol, opioids, marijuana, cigarettes, and especially e-cigarettes.
- Related concerns included youth being unaware of the carcinogenic effects of alcohol, e-cigarettes being expressly marketed to young people, and a misperception that there is a "healthier" way to smoke.
- A resultant need for in-patient rehabilitative services has emerged for this population.

PHYSICAL HEALTH CONCERNS

- One respondent noted increases in childhood asthma, diabetes, and pre-diabetes.
- These issues may be due to genetics, poor nutrition and eating habits, or the psychotropic medications children take.

BARRIERS TO ACCESS

Barriers to access that specifically affect children include:

- A dearth of child psychiatrists.
- A system that is not built for addressing behavioral health concerns of very young children, resulting in misdiagnoses, delayed identification, and a lack of prevention.
- Long emergency department wait times (as much as a week) before securing inpatient behavioral health placement.
- Misdiagnoses of other vulnerable groups. For example, Philadelphia respondents noted young boys of color may be disproportionately and incorrectly diagnosed with conduct disorder due to racial bias.
- Transitions in care from pediatrics to adult primary care providers can be difficult for children with mental health issues such as autism and their families.

Serving older adults

MENTAL HEALTH CONDITIONS AND SUBSTANCE USE

- Loneliness, grief, depression, and isolation may all affect older adults.
- Key informants noted the use of alcohol, opioids, and benzodiazepines in this population; overdoses as a result of substance use are also a problem.
- Resurgence of past substance use patterns may appear in older adults. Substance use may be a strategy to cope with mental health conditions or may result from pain management of physical conditions.

BARRIERS TO ACCESS

Barriers to access that specifically affect older adults include:

- Limited care coordination and medication management present increased risks to seniors. Respondents reported that caregivers and family do not always know an older family member's medication regimen. Similarly, multiple providers across specialties may not be aware of all prescribed medications, which increases risk for dependence and adverse events.
- A lack of covered services to address hearing and dental issues.
- A lack of in-house geropsychiatric services and expertise in retirement communities, assisted living, and nursing facilities.
- The intersection of advanced age and social determinants of health may compound difficulties for older adults. Limited access to transportation, nutritious food, and affordable housing reduces the ability for older adults to access basic services and resources, let alone comprehensive care.

POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS LIVING WITH BEHAVIORAL AND MENTAL HEALTH CONDITIONS

Access to care

INTEGRATION AND COORDINATION

- Respondents reported a lack of coordination across mental and behavioral health and physical care providers, specialists, and other health care providers.
- As an example, in Chester County, behavioral health counselors have discovered some patients are not disclosing symptoms, concerns, or needs to primary care physicians, resulting in gaps in care.
- Respondents described a resultant "catch-22" effect, where providers in a particular care setting may be reluctant to treat or admit a patient with concurrent behavioral and physical health needs.

  An example provided by Bucks County informants was the case of behavioral health patients with skin abscesses: behavioral health specialists may not want to admit the patient due to an inability to address the wound issue, while general community medical hospitals may not feel equipped to address the behavioral health condition(s).
- A subsequent "sick care system" exists in the behavioral health space. The focus must shift to prevention and early identification, which requires engagement of physical health providers like primary care providers.

INSURANCE AND COST

- Coordination across insurance providers is also a need (for example, between commercial and public payers if a patient has primary and secondary coverage).
- Respondents noted a very limited number of behavioral health providers across the counties accept Medicaid.
- Across multiple types of insurance (Medicare, Medicaid, and private insurance) patients sometimes cannot afford the cost of either psychiatric or physical medications.

NAVIGATION

- Patients do not always know the most appropriate entry point to the health care system for various needs.
- Respondents also noted that, within a "sick care system" framework, the emergency department (ED) is frequently the entry point for patients with significant behavioral health needs. They stressed the importance of ED staff being well-trained in trauma-informed care and committed to reducing stigmatization of this vulnerable and complex patient population.
- Challenges imposed by social determinants of health (such as housing insecurity, food insecurity, transportation, employment, and childcare) affect patients' ability to access and navigate health care services.
- Health literacy is further impacted by changes in vision, hearing, and mobility in older adults.

AVAILABILITY

- Across the counties, respondents cited a dearth of psychiatrists as a key issue, reflecting national trends.
- A lack of reimbursement parity for mental/behavioral health specialists, when compared to physical care, contributes to the paucity of available providers.
- Respondents reported extremely long wait times for accessing care, such as a week of boarding in the emergency department while waiting for inpatient behavioral health care (especially for patients with intellectual disabilities), 6-8 weeks for a psychiatric or therapeutic appointment, or as long as 3-4 months to a year for a physical health specialist appointment.

County-specific characteristics and priorities

BUCKS COUNTY: UNIQUE CHARACTERISTICS AND TOP PRIORITIES

- Bucks County respondents stressed the effects of limited transportation in the county, which can affect patients' ability to work, find affordable housing, and access healthy food.
- There is particular difficulty finding adequate specialists in-network for patients in an accessible geographic location in the county. People have to travel significant distances to see a specialist, which presents a real challenge for patients with public insurance.
- Respondents noted the public behavioral health system in Bucks County is overburdened. A majority of patients who present at public crisis centers are covered by commercial insurers that do not cover crisis. The public system also handles activities like bed searches without commercial insurer involvement, which stretches capacity.

TOP PRIORITIES

- **Care coordination and information exchange across care providers in behavioral, primary, dental, and specialty care to treat the whole person holistically.**
- **Coordination between primary care and behavioral health providers to encourage prevention. Primary care providers were described as the "front door" and the "guard of good health."**
- **Ensuring accountability and integration of commercial insurers to reduce the burden on the public system.**

CHESTER COUNTY: UNIQUE CHARACTERISTICS AND TOP PRIORITIES

- Chester County residents have a wide range of socioeconomic status, which translates to substantial variation in insurance status and health care options. Some populations are uninsured and have competing needs such as housing instability and limited income, but a high percentage of people have private insurance.
- Chester County is fairly spread out and rural, meaning transportation to appointments is difficult, especially for people with limited income with few options for affordable housing across the county.
- Affordable housing can be particularly limited for older adults, whose incomes may be fixed and who are concomitantly affected by food, nutrition, and transportation issues. Navigating the health care system is also a notable issue for older adults.
- Chester County informants noted that people who are resource-poor in wealthier counties can be even more disproportionately affected by limited affordable housing options.
- Chester County respondents voiced the longest appointment wait times for physical care specialists. Some care managers have started taking patients into Philadelphia to see specialists, which results in high quality care but presents an even greater transportation barrier.
- Engagement of bilingual, bicultural health care workers to serve children of diverse cultural backgrounds in any health care setting was particularly notable for Latino communities in Chester County.

TOP PRIORITIES

- **Expand use of telemedicine and mobile care for counseling, therapy and other treatment for behavioral health conditions.**
- **Recognition of childhood trauma across all systems and investment in early identification as a community. One respondent expanded on this to include screening for mental health conditions such as depression, suicide, and trauma.**
- **Addressing problems with substance use disorder.**
- **Identifying and addressing social determinants of health, particularly transportation and access/connection to resources and services.**

MONTGOMERY COUNTY: UNIQUE CHARACTERISTICS AND TOP PRIORITIES

- Montgomery County respondents expressed particular concern regarding substance use in the county. They noted increases in related or concurrent conditions like cirrhosis, HIV, sexually transmitted diseases, and tuberculosis. They also emphasized drug-related mortality, noting that organ donation has actually increased due to young, otherwise healthy individuals dying of overdose.
- System issues affect treatment for substance use in the county. Some providers have been reluctant to acquire waivers to administer medically assisted treatment. Newcomers to the healthcare system, such as urgent care facilities, are not always familiar with local behavioral healthcare entities that provide drug and alcohol services.
- Montgomery County respondents noted that autism diagnoses are increasing, perhaps due to early identification, which creates an increased need for services. One respondent posited that some children receiving an autism diagnosis may actually have Fetal Alcohol Spectrum Disorder.
- Respondents also noted the inter-connected nature of behavioral health, physical health, and social determinants of health. Social determinants are "like the legs of a stool" for "people on the margins" and "if one of the legs is kicked out, it starts to impact the other[s]."

TOP PRIORITIES

- **Preventing people dying from opioid overdose.**
- **Addressing the stigma of behavioral health challenges, especially substance use disorder.**
- **Encouraging trauma-informed care across health care providers and community services.**

PHILADELPHIA COUNTY: UNIQUE CHARACTERISTICS AND TOP PRIORITIES

- Children's mental and behavioral health emerged as a strong priority in this discussion; childhood trauma, while discussed across all behavioral health focus groups, was particularly emphasized in the Philadelphia county group.
- Respondents noted the particular role social determinants of health play in behavioral health in Philadelphia, given the county's poverty level, urban environment, and housing system.
- Philadelphia respondents emphasized the importance of research and evaluation of behavioral health data to assess quality, understand the epidemiology and etiology of behavioral health conditions, and predict future crises so as to proactively address them and mitigate their effects.
- Respondents noted access issues based on proximity of care to neighborhoods, especially for specialized treatments that may exist outside of the immediate neighborhood area.
- Youth violence may be increasing in Philadelphia. Respondents also cautioned how to interpret and discuss violence among youth; perpetration is often precipitated by depression or stressors due to social determinants of health.

TOP PRIORITIES

- **Prevention and mitigation of trauma in children.**
- **Systems-level behavioral and physical health care integration.**
- **A preventive, community-based lens that focuses on wellness, patient activation, and navigation.**
- **Comprehensive and broad-based treatment options that include strength-based and resilience programming.**
- **A data-driven and prevention-focused behavioral health system.**
- **Addressing workforce shortages in behavioral health and human services generally; a fair and living wage for behavioral health care providers that mirrors that of physical providers.**

POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS EXPERIENCING HOUSING INSECURITY

The high cost of housing has a significant impact on the health of communities across the region, particularly on low-income households. These households are often at risk of eviction due to missed rental payments and face difficult tradeoffs between rent or other necessities, including food or medical expenses. Poor housing conditions from aging housing stock that residents cannot afford to maintain increase risk of lead exposure, asthma triggers, and injuries due to electrical and other malfunctions.

GENERAL HEALTH CONCERNS: BASIC NEEDS

- Aging housing stock across all counties contributes to unsuitable living conditions in home environments. These include lack of running water, lack of heat, mold, asthma, lead paint, asbestos, and fire safety concerns.
- People experiencing housing instability are often under-resourced and cost-burdened. They may delay or divert resources that would otherwise go to food and healthcare to cover housing costs.
- The volume of need is increasing. Key informants shared that there are hundreds of people on their waitlists for housing or repairs within each of the counties, with wait times stretching up to five years. In Philadelphia, waitlists are into the thousands and wait times are eight to ten years. Renters with small-scale landlords are increasingly unable to complete effective, quality home repair.
- Families "don't know what they don't know." If housing instability has been the norm, people may not turn to health care institutions for assistance.

GENERAL HEALTH CONCERNS: PHYSICAL, MENTAL, AND BEHAVIORAL HEALTH

- People with housing insecurity are "bowled over by different health issues," including high rates of infection for communicable diseases, HIV, asthma, and hypertension.
- Substance use and mental health issues are rising issues, with key informants noting a precipitous incline in the last five years.
- Poverty, rising rent in appreciating neighborhoods, limited affordable housing, and the stress of evictions all create "a haze of stress" for those who are housing insecure.

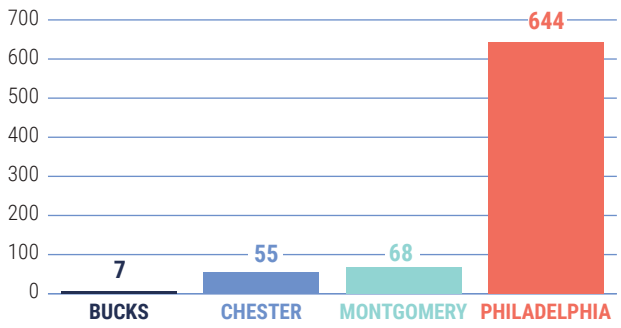
POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS EXPERIENCING HOUSING INSECURITY

Serving children

- Housing and environment-related lead issues, extreme heat and cold, respiratory problems, and asthma all disproportionately affect young children.
- Precarious housing situations and frequent moves can lead to delayed care, like being late on immunizations, or having undiagnosed mental health conditions or learning disabilities.
- Other social determinants of health, such as food insecurity, also affect these children and can lead to conditions like obesity when children can't access produce and healthy foods.
- Sex trafficking and sexual exchanges for places to stay or needed items affects teens and young adults who are housing insecure or homeless in multiple counties. These risks can also lead to sexually transmitted diseases or Post-traumatic stress disorder.

CHILDHOOD LEAD POISONING BY COUNTY



- Mental health, trauma, emotional neglect, limited social cohesion, physical neglect, and school absenteeism are all additional effects of housing instability for children.
- Neighborhood safety was identified as a concern. Teens whose economic situations demand they work one or several part-time jobs, including overnight shifts, was expressed as another concern.

"...Mid-60s-year-old woman with diabetes. The roof leaked, it rotted through the second floor right to the kitchen, so she just kept closing doors in the house, right? She was cooking on a hot plate in the living room.

How do we talk about access to healthcare? No matter what a doctor or nurse practitioner prescribes, she's cooking on a hot plate from the corner store, in a home that is rotted out."

Serving older adults

- More and more seniors live in poor housing stock, nationally and in Philadelphia.
- Many cost-burdened seniors are faced with deteriorating, aging homes which they can't afford to repair. With many multi-story homes in the area, seniors are at risk for falls and injury. If they can't afford a refrigerator, they can't properly store medications like insulin. If they have a disability, they can't make the necessary modifications. Respondents shared stories of older clients returning home from the hospital and not being able to enter or leave the house because there are no front steps.
- Hoarding is a problem with seniors. One key informant shared their organization turns down about 20 percent of repairs because representatives can't access the home. Hoarding leads to other issues such as pests, fall risk, accessibility issues, and building condemnation.
- Respondents have observed seniors deteriorate within institutions, like nursing homes or hospitals, after losing housing and not being financially able to return.
- Competing needs such as transportation, food insecurity, and basic needs like showers can take the place of addressing more chronic issues such as mental health conditions and hypertension. Respondents also noted depression, social isolation, and behavioral health conditions among seniors.
- Gentrification impacts older adults' ability to remain in their homes and age in place. When taxes increase, older individuals on a fixed income may not be able to afford to stay in their homes.

Access to care

- Many people with liminted means turn to the emergency department (ED) for care, rather than urgent or primary care, in some part because patients don't need cash on hand to access the ED.
- A lack of affordable housing forces people into poorer neighborhoods, where it may be harder to access care due to greater distances, safety concerns, or limited transportation.
- One barrier to care is difficulty maintaining health insurance and identification without a stable address. Some shelters offer post office or mailbox systems, but those systems are overwhelmed with need and there are delays in accessing them, meaning people miss deadlines for requirements necessary for obtaining services or do not receive medical results from hospitals and laboratories.
- People can feel mistrust for healthcare providers, or it may not occur to patients to disclose concurrent social challenges, leaving providers in the dark about conditions that are potentially hazardous to their health. Family priorities may also differ significantly from those of housing or healthcare providers, given multiple competing needs they face.

POPULATIONS OF SPECIAL INTEREST

INDIVIDUALS WITH DISABILITIES

An individual can develop a disabling impairment or chronic condition at any point in life. Living with a disability often requires unique health and social supports. Understanding population level needs for individuals with disabilities can be challenging as they are often under-represented in population-based surveys and even efforts like community meetings.

As a part of their CHNA, Magee Rehabilitation Hospital in Philadelphia developed and conducted a survey to assess the needs of their patients and others with disabilities related to physical and mental health, as well as access to and utilization of health and social services. Respondents reside throughout the greater Philadelphia region, including in Bucks, Chester, and Montgomery counties.

About 90 percent of survey respondents were current or former patients at Magee, so responses are biased toward those receiving care at Magee and may not represent the larger community of adults with disabilities. Key findings include:

NEED FOR ADDITIONAL CAREGIVER SUPPORT FOR DAILY ACTIVITIES

- 67% of respondents required personal assistance for major life activities, but 21% of those respondents reported that they were unable to get the help they needed for activities of daily living and driving to doctor appointments.
- 67% of those requiring assistance reported that family members or friends generally provided the care they needed and were unpaid for these services.

OPPORTUNITIES FOR EXERCISE

- 13% reported participating in adaptive sports.
- 34% report exercising 3 or more days per week, and another 24% exercise 2 days per week.
- 29% never exercise, and individuals indicated the following reasons: 16% due to cost, 19% due to lack of capability, 23% due to lack of knowledge about what exercise might be appropriate, 30% due to lack of access to a facility with appropriate equipment.

ACCESSIBLE AND AFFORDABLE HOUSING

- 27% were not able to enter or leave their homes without assistance.
- 16% reported that their housing did not meet their needs.
- 28% reported that the sidewalks, curb cutouts and ramps in their neighborhoods were not in good condition or not present.
- 16% reported a time in the last 12 months that they were not able to pay their mortgage, rent or utility bills.

EMPLOYMENT OPPORTUNITIES

- 28% reported that disability did not limit their employment or ability to work.
- 24% reported wages and earnings as their current source of income.
- 35% received SSDI and 26% received Federal SSI.
- 17% worked full-time, 9% worked part-time, and 25% were retired.

ACCESS TO HEALTH SCREENING AND PREVENTIVE HEALTH SERVICES

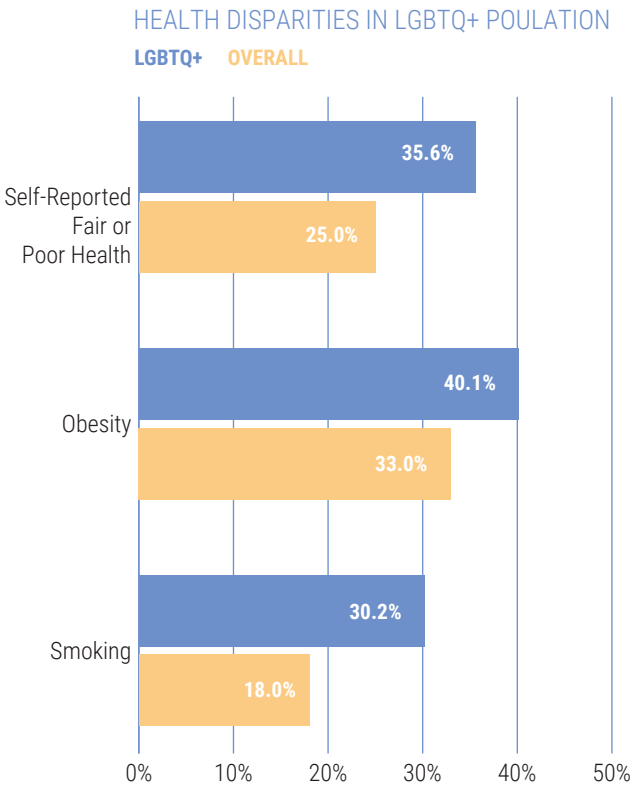
- 32% rated their health as fair or poor compared to 19.2% of adults in Southeastern PA (2018 Public Health Management Corporation Household Health Adult survey (PHMC HHS)).
- 40% report chronic pain.
- 50% had fallen within the past year.
- 16% reported some level of food insecurity.
- All but 4 respondents indicated that they had some form of health insurance (51% had Medicare, 23% had Medicaid, and 40% had access to private health insurance).
- 3% reported that they were not able to get the medications they needed. (44% due to cost, 22% due to transportation issues). This compares favorably with the results from the 2018 PHMC HHS where 13% reported an inability to get medications.
- 25% do not see a dentist at least once per year. (This compares favorably with the results from the 2018 PHMC HHS survey, where 30% reported that they do not see a dentist at least once per year.)
- 22% do not have access to psychological and/or counseling services, if needed.
- 31% reported having been diagnosed with a mental health condition. Of those, 38% were currently receiving treatment.
- 45% had ever been screened for colon cancer compared to 73% of eligible adults in Southeast PA in the past 10 years (2018 PHMC HHS).
- 24% of eligible women had not had a Pap smear within the past 3 years, and another 7% were unsure. (This rate is similar to 2018 PHMC HHS data).
- 26% of eligible women had never had a mammogram, and only 33% had had one in the past two years. According to 2018 PHMC HHS data for Southeastern PA, 5.8% of women had never had a mammogram and 76% had a mammogram in the past two years.
- 33% of eligible men had ever been screened for prostate cancer.

POPULATIONS OF SPECIAL INTEREST

LGBTQ+ COMMUNITIES

Although social acceptance of lesbian, gay, bisexual, transgender, and queer people has been improving, LGBTQ+ individuals continue to face stigma and discrimination. These negative experiences, combined with a lack of access to culturally-affirming and informed health care, result in multiple health disparities for LGBTQ+ populations. Thus, there is an urgent need to provide inclusive, high-quality health services to LGBTQ+ people so that they can achieve the highest possible level of health.

Several local and state efforts to better understand the unique needs of these communities have been occurring; however, a lack of quality data about the health and health needs of LGBTQ+ communities and subgroups remains a challenge.



Based on national data from *Understanding the Health Needs of LGBT People*, some key health disparities among LGBTQ+ communities include:

- Higher rates of HIV and other sexually transmitted infections
- Lower rates of mammography and Pap smear screening
- Higher rates of substance abuse and smoking
- Higher rates of unhealthy weight control/perception
- Higher rates of depression and anxiety
- Higher rates of violence victimization
- Higher rates of discrimination in the healthcare setting

CREATING AN INCLUSIVE HEALTHCARE ENVIRONMENT

- Train medical providers in techniques related to bias, discrimination, and trauma to ensure care delivery is not further discriminating against LGBTQ+ individuals or a barrier to accessing care.
- Design and disseminate LGBTQ+-tailored health materials that help make healthcare settings more LGBTQ+-friendly. For instance, intake forms can be revised to include sexual orientation and gender identity.
- Health care settings should also develop and prominently display non-discrimination policies that include sexual orientation, gender identity, and gender expression.
- All staff members, including receptionists, medical assistants, nurses, and physicians, can be trained to interact respectfully with LGBTQ+ patients, including using patients' preferred names and pronouns.
- Not all clinicians can become experts in LGBTQ+ health, but they should learn to address some of the specific health concerns of this population.

> "When I went to doctor's to get checked up and my doctor asked me who were you having sex with, girls or boys, and I said girls, it's like she looked at me in a certain way and it was like wow, I'm being shamed for liking girls or something like that."

POPULATIONS OF SPECIAL INTEREST

PRENATAL/POSTPARTUM WOMEN

The focus on this population stems from a motivation to positively impact the health of both women and infants in a particularly vulnerable time of life. Ensuring reliable access to prenatal and postpartum care, particularly for those most at risk of maternal morbidity and poor birth outcomes, has the potential to have lasting impact for women and their children. An important priority is to improve services and access to resources for those with risk factors such as low income or behavioral health and chronic physical conditions.

MATERNAL MORBIDITY AND MORTALITY

- Physical conditions such as obesity, hypertension, gestational diabetes, diabetes, and cardiovascular disease were cited as affecting the morbidity and mortality of prenatal and postpartum women.
- Cardiovascular deaths and substance overdoses are contributing to maternal mortality.

ROOT CAUSES AND COMPETING ISSUES: POVERTY, FOOD INSECURITY, HOUSING INSECURITY, BIAS, AND TRAUMA

- Many women are concurrently experiencing issues such as poverty, food insecurity, housing insecurity, or domestic violence during pregnancy.
- These issues are often accompanied by a history of trauma, which may be exacerbated by bias or discrimination within the health care system. Informants said that many providers and other health system staff are not trained in providing trauma-informed care.

ACCESS TO MENTAL AND BEHAVIORAL HEALTH CARE

- Key informants across the counties strongly emphasized that one of the most significant needs for prenatal and postpartum women is timely access to quality mental and behavioral health care.
- Opioid overdoses are contributing to maternal mortality, especially in the fourth trimester period.
- Mental health needs are broader than depression alone and may include anxiety, past trauma, and managing partner relationships.
- Informants shared that many providers are unequipped to provide mental and behavioral health care to women while pregnant. Needs that existed before pregnancy, such as medication regimens for psychological conditions, are not always readdressed after pregnancy.

"Just after giving birth, it's a very vulnerable period. Even if they're not dealing with postpartum depression, they might be much more emotional and the fact of having a newborn baby and maybe other children and getting to that appointment, I think that might definitely be a factor of why we see such a low turnout."

ACCESS TO POSTPARTUM CARE

- Access to postpartum follow-up visits is a significant challenge for women, with many contributing barriers.
- Missed postpartum follow-up visits can lead to missed opportunities to provide continuity of care for women addressing chronic conditions (like cardiovascular health), as well as missed opportunities to arrange family planning and address mental/behavioral health needs.
- If a woman has delivered a healthy child or has already acquired contraception, she may not prioritize follow-up in the face of other competing needs, such as caring for her newborn, arranging childcare, juggling work schedules, and securing transportation.

UNDERLYING BARRIERS TO ACCESS

- Multiple informants said that appointment availability is a significant barrier to all types of care. Women who need referrals are frequently redirected and may encounter significant wait times.
- Respondents agreed that transportation access affects access to care, and sometimes women need to take three modes of transportation to get to a single appointment.
- Chester County and Montgomery County informants stressed that transportation is a significant barrier, with unique challenges due to lack of accessibility by foot or public transit.
- Chester County and Montgomery County informants discussed difficulties in providing linguistically appropriate care for women who speak languages of lesser diffusion. Stress surrounding immigration status, a fear of deportation, and ineligibility for public benefits due to immigration status all contribute to limited access.
- Barriers of language access and transportation can often intersect in these counties, when women who do not speak English are in high-risk prenatal situations and have to be transported to Philadelphia for care.

"Even for my own self with not as many barriers, I'm more apt to do anything if I can just do it when I'm ready. So if I'm calling to do ultrasound, blood work, whatever it is, if it's available and there, you're more apt to just go and do it. If you're waiting for months or getting it put off, you can't get the appointment because of X, Y, and Z, you're just more apt to either not go or not show up when you do make the appointment."

POPULATIONS OF SPECIAL INTEREST

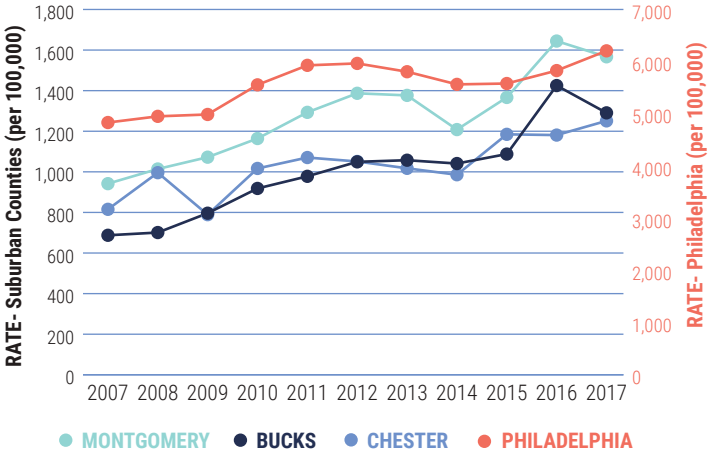
YOUTH AND ADOLESCENTS

Youth ages 13 to 18 are a high priority population for community health improvement as they disproportionately represent preventable health issues, such as sexually transmitted infections and violent crimes; often have undiagnosed or untreated mental and behavior health conditions; and are vulnerable for substance use and abuse. Stakeholder feedback about key health priorities focused on sexual behavior, health education and violence. The below findings are in large part based on a focus group hosted at *The Attic Youth Center* in Philadelphia, PA, an organization that exclusively serves LGBTQ+ youth, and findings are biased toward LGBTQ+ youth needs.

LACK OF SEX EDUCATION

"When it comes to sexual health, it's very vague and they're usually talking about heterosexual sex. But you often need to educate all different types of sex. It's the lack of empathy for us. It's the lack of a home for us in these schools. And it's like we're not learning about our sexual health – one, because it's not there, but two, because we're worried about being teased, being harassed, being messed with, hit on and so many other things that it's like what does it matter?"

SEXUALLY TRANSMITTED INFECTIONS AMONG TEENS



- Youth expressed that sex education was lacking during their time in school and into their early adulthood. Participants noted that sex education provided in schools was heteronormative and limited to the description of female and male anatomy.
- They reported a dearth of information on safe sex practices, especially in the context of the LGBTQ+ community in which they experience different sexual health needs in comparison to their heterosexual counterparts.
- Focus group participants noted that they learned the majority of their health information through peer interactions and the Internet—specifically citing using trusted government sources for their sexual health information. Youth also reported that members of their community use social media and pornography as a resource for learning sexual practices, which could be misleading and cause a further disconnection from healthy behaviors.
- Participants also reported a lack of cultural competency by medical providers (e.g., not respecting preferred pronouns, not being educated on health needs of transgender individuals), which has led to a general mistrust of the medical community.
- Adolescents reported feeling stigmatized by medical providers when disclosing their sexual identity during appointments. As a result, youth have turned to those within their communities to get their health information

as opposed to going to a medical professional.

LACK OF GENERAL HEALTH INFORMATION

- Youth reported they did not receive enough general health information. Adolescents seek the majority of this health education through meetings with peers, the Internet, and by watching YouTube videos on exercise routines and healthy eating.

VIOLENCE AND BULLYING WITHIN COMMUNITIES

- Youth felt that social media is responsible for perpetuating interpersonal conflict and disseminating violent images. The participants stated that it is common to see fights between peers posted on social media, in addition to their peers being violent with others in the community. Youth felt that fighting within social media apps often leads to verbal or physical fights in-person.

"I feel like a lot of that stems into mental health, too, because a lot of the things that we see on social media, like people doing drugs, people overdosing, people getting into fights, fighting and stuff like that – our generation, that's normal to us."

- Youth also commonly see gun violence on social media, as well as within the communities that they live. Some youth reported not feeling safe going outside after a certain time of night and being hyper-aware of the dangers of being a person of color in certain areas of the city at nighttime.
- They shared that they commonly witnessed verbal and physical harassment among youth of color and youth who identify as LGBTQ+ with a lack of response from school administrators or other authority figures. Youth who reported this harassment noted that it could and has led to mental health conditions such as depression and suicidal thoughts.

COMMUNITY HEALTH PRIORITIES

All quantitative and qualitative inputs were organized into 16 community health priorities that were categorized across three domains:

Health Issues

Includes physical and behavioral health issues significantly impacting the overall health and well-being of the region.

Access and Quality of Healthcare and Health Resources

Includes availability, accessibility, and quality of healthcare and other resources to address issues that impact health in communities across the region.

Community Factors

Includes social and economic drivers of health as well as environmental and structural factors that influence opportunity and daily life.

Participating institutions' ratings of the community health priorities were aggregated and are listed below in order of priority:

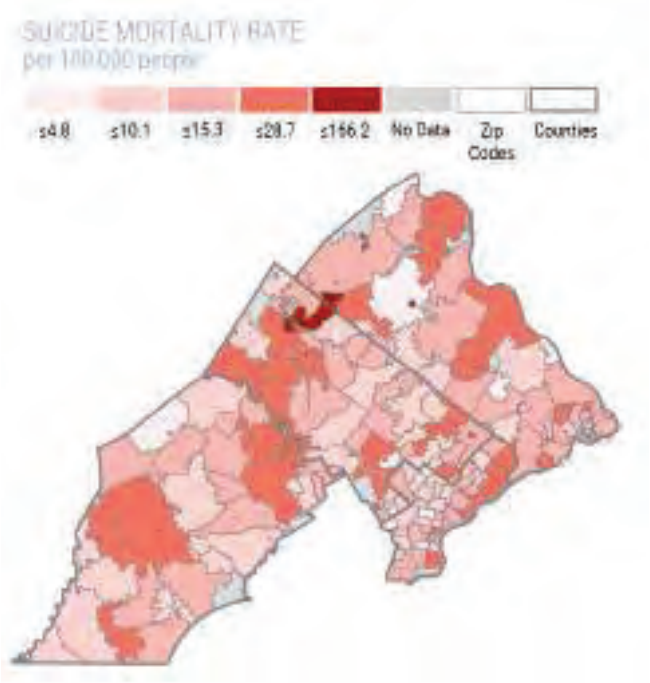
1. Substance/opioid use and abuse
2. Behavioral health diagnosis and treatment (e.g. depression, anxiety, trauma-related conditions, etc.)
3. Access to affordable primary and preventive care
4. Healthcare and health resources navigation
5. Access to affordable specialty care
6. Chronic disease prevention (e.g. obesity, hypertension, diabetes, and CVD)
7. Food access and affordability
8. Affordable and healthy housing
9. Sexual and reproductive health
10. Linguistically- and culturally-appropriate healthcare
11. Maternal morbidity and mortality
12. Socioeconomic disadvantage (income, education, and employment)
13. Community violence
14. Racism and discrimination in healthcare settings
15. Neighborhood conditions (e.g. blight, greenspace, parks/recreation, etc.)
16. Homelessness

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

PRIORITY

2 Behavioral Health Diagnosis and Treatment

- Behavioral and mental health needs continue to impact health in the region. Undiagnosed and untreated conditions like depression, anxiety, and trauma-related conditions result in:
  - High utilization of emergency departments, particularly among youth, for mood and depressive disorders
  - Persisting rates of suicide, particularly among men
  - Substance use and abuse
- Behavioral and mental health needs are especially high among vulnerable populations, including: individuals living in poverty, experiencing homelessness or experiencing housing insecurity; youth and young adults; older adults; racial and ethnic minorities, immigrants and refugees; and LGBTQ+ people.
- There is significant lack of community-based, integrated, and/or mobile behavioral health services.
- While only one, and perhaps the most extreme, indicator of the underlying need for behavioral health services, rates of suicide vary considerably by neighborhood and among sub-groups, and are highest among non-Hispanic White men.



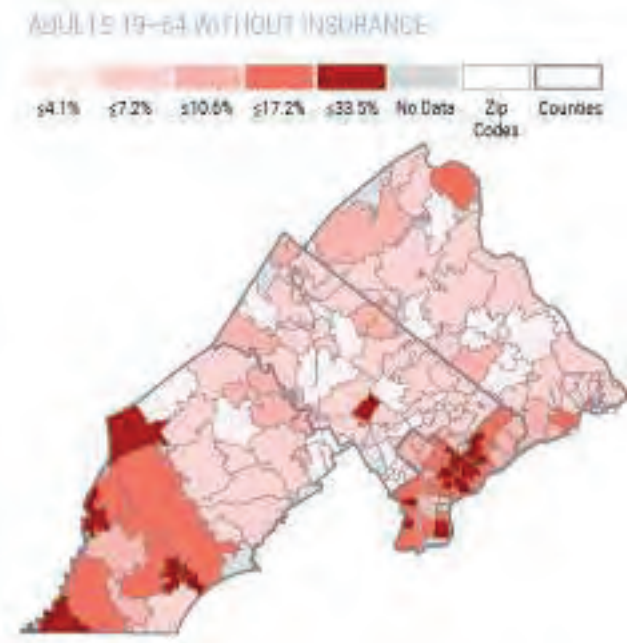
POTENTIAL SOLUTIONS

- **Expand use of telemedicine and mobile care for counseling, therapy and other treatment for behavioral health conditions.**
- **Co-locate physical and behavioral health and social services.**
- **Institute trauma-informed care/counseling training for people working with youth.**

PRIORITY

3 Access to Affordable Primary and Preventive Care

- While there is a high supply of primary care providers across the region, some communities and vulnerable populations continue to experience low access to affordable primary and preventive care. These inequities are driven by:
  - Slow declines in Medicaid acceptance among health providers
  - Lack of providers in their neighborhoods (especially Northeast/Southwest/South Philadelphia, rural neighborhoods in surrounding counties)
  - Affordability: For the uninsured and low-income with high co-payments/deductibles, there are not always safety net providers available
  - Language/cultural accessibility for immigrant/non-English speaking communities
- Rates of uninsurance are down by nearly 50% since ACA Medicaid coverage expansions, however, uninsured rates among populations just above poverty threshold and immigrants are 2 to 4 times higher. As shown on the right, some neighborhoods have uninsured rates above 30%.
- Even for people with insurance, gaps in access to preventive services and health education exist, including:
  - Immunizations for children and youth of low-income, transient, and immigrant families
  - Health screenings and diagnostic testing for vulnerable adults for chronic diseases, sexually transmitted infections, and cancers
  - Health education and promotion for adults at high risk for chronic illness



POTENTIAL SOLUTIONS

- **Expand primary care locations in neighborhoods with low access.**
- **Support transportation assistance.**
- **Expand appointment availability and hours in low access areas.**
- **Develop health promotion campaigns and initiatives to raise awareness.**
- **Provide samples/discounts on medications and enroll patients in prescription assistance programs.**
- **Use technology/telehealth to increase access to health information.**

PRIORITY

4 Healthcare and Health Resources Navigation

- Navigating healthcare services and other health resources, like enrollment in public benefits and programs, remains a challenge due to general lack of awareness, fragmented systems, and resource restraints.
- 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 face significant challenges securing transportation to healthcare and health resources. Financial costs and logistics associated with travel can be a barrier to accessing healthcare and health resources.

POTENTIAL SOLUTIONS

- **Increase access to healthcare navigators, community health workers and patient advocates.**
- **Develop community health resource directories, bulletins or newsletters.**
- **Create permanent social service hubs and resource fairs.**
- **Encourage bi-directional integration of data between health and community-based organizations.**
- **Develop school-based health and health resources navigation, like Community Schools.**
- **Provide information regarding available transportation services and facilitate the process for accessing these services.**
- **Create accessible healthcare offices and access to preventive care and health screening for persons with disabilities.**

PRIORITY

5 Access to Affordable Specialty Care

- Financial and logistical barriers to specialty care exist for uninsured individuals and those with high co-pays and deductibles.
- Linkage to specialty care providers is particularly challenging for safety net providers; health information exchange to facilitate linkage to specialty care is not universal.
- Lack of care coordination, affordability, and appointment availability (e.g. long wait times) result in patients not seeking needed specialty care and use of emergency departments for acute needs.

POTENTIAL SOLUTIONS

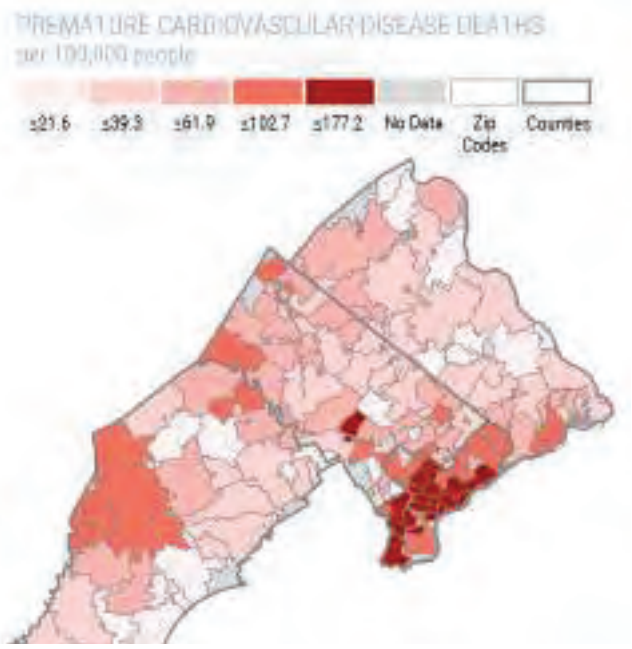
- **Provide telehealth services.**
- **Co-locate primary and specialty care.**
- **Provide care navigation and coordination.**
- **Schedule appointments with outside providers at discharge.**
- **Provide information regarding available transportation services and facilitate the process for accessing these services.**
- **Create accessible healthcare offices for persons with disabilities.**

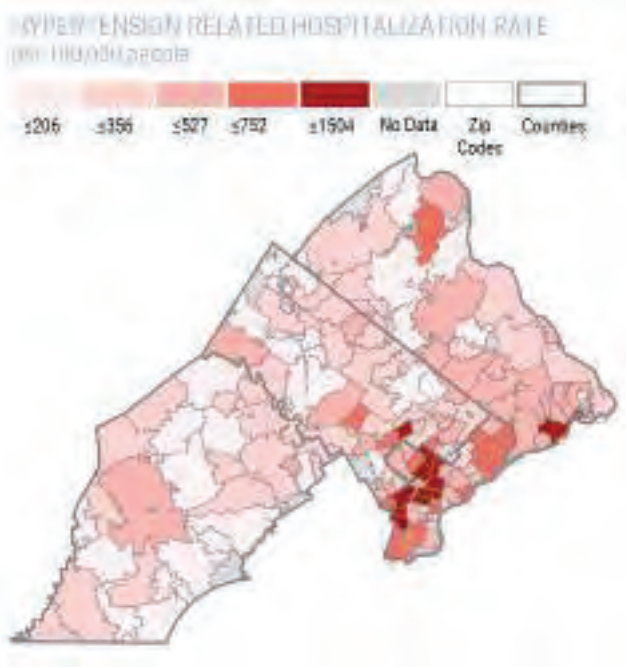
PRIORITY

6 Chronic Disease Prevention

» Overall, rates of cardiovascular disease and its related chronic conditions like obesity, hypertension and diabetes, continue to rise. These conditions continue to be leading causes of premature death, particularly among racial/ethnic minorities, as well as sources of morbidity, including hospitalizations and disability.

» Premature CVD mortality is nearly 2 to 3 times higher in Philadelphia County compared to other counties, which is driven by higher rates of smoking, obesity, hypertension and physical inactivity. These risk factors are all driven by higher rates of social and economic disadvantage.





POTENTIAL SOLUTIONS

» Initiate health education and promotion in natural community hubs, such as beauty salons/barbershops and faith-based institutions.

» Support media campaigns that encourage smoking cessation.

» Create opportunities for physical activity like community walks, group fitness classes, or fitness vouchers.

» Continue expansion and marketing of wellness programs.

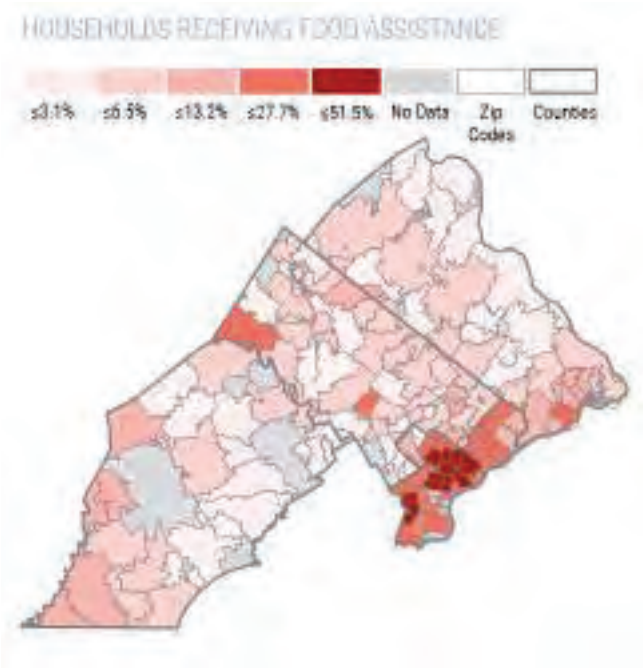
» Centralize health and social services resources information.

» Use technology for health education and support.

PRIORITY

7 Food Access and Affordability

- Lack of access to affordable healthy foods is a driver of poor health in many communities. Low access is largely driven by poor food environments which lack grocery stores or other sources of fresh food and produce, and are saturated with fast food outlets, convenience and corner stores, and other sources of unhealthy, often less expensive, food options.
- Families relying on food assistance need access to a healthy food environment. In communities where food insecurity is highest, the food environment is the poorest – this is particularly true in parts of North, West, and Southwest Philadelphia County.



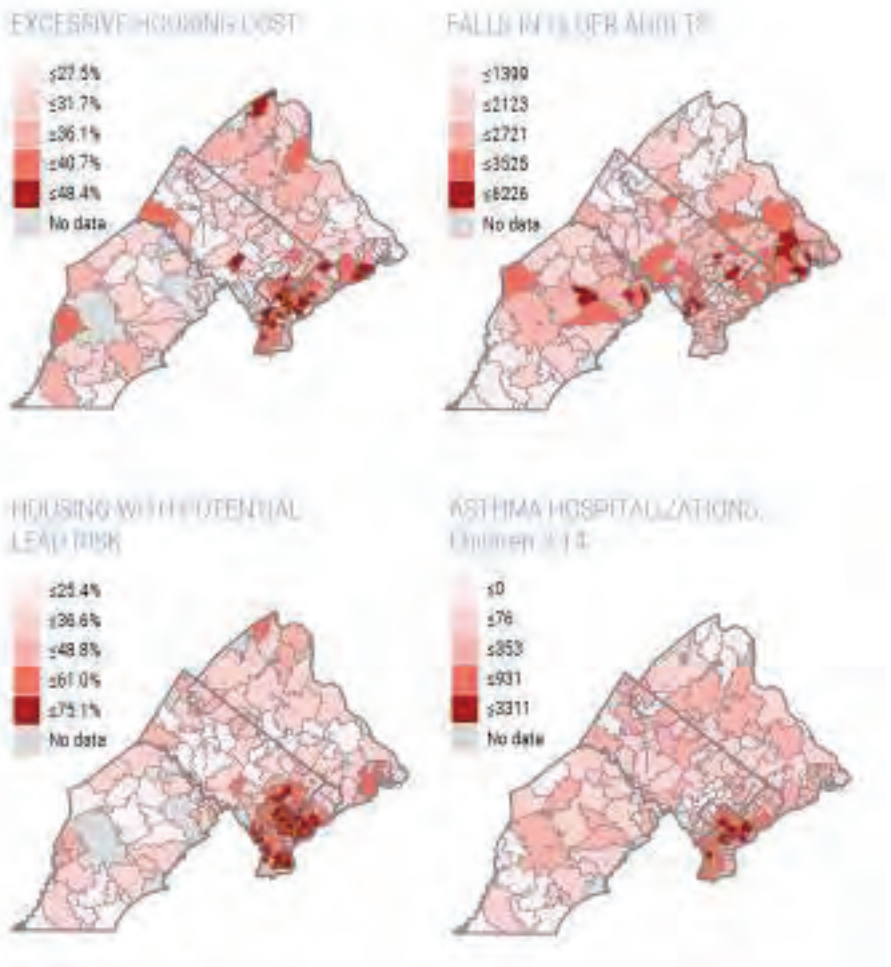
POTENTIAL SOLUTIONS

- **Create additional food access via farmers' markets, summer feeding programs, and food pantries.**
- **Support corner store redesign to accommodate healthier food supply.**
- **Implement screening and referral for food insecurity.**
- **Provide transportation to supermarkets and other food distribution sites.**
- **Provide medical-legal partnership services.**

PRIORITY

8 Affordable and Healthy Housing

- Affordable housing is a major challenge in the region. Rates of excessive housing costs (>30% of income) are as high as 50% in some communities across the region.
- Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity.
- Poor housing conditions like old lead paint, asbestos, poor home hygiene, infestations, lack of running water or HVAC, and damaged infrastructure disproportionately impact low-income populations leading to:
  - Poor childhood health (e.g. lead poisoning, asthma hospitalizations, injuries)
  - Mental distress and trauma
  - Poor older adult health (e.g. falls, disability, nursing home and acute care admissions)
  - Forgoing care, food and other necessities due to financial strain



POTENTIAL SOLUTIONS

- Develop new affordable housing units.
- Invest in cooperative young adult and senior housing.
- Provide home repairs and remediation for high risk youth (e.g. with asthma) and older adults.
- Implement screening for housing insecurity.
- Develop medical-legal partnerships.
- Provide low-cost housing interventions like smoke and carbon monoxide detectors.
- Support rent subsidies.
- Provide assistance in identifying and accessing the waiting lists for accessible housing.
- Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.
- Raise awareness of available resources for housing repair assistance.
- Enforce lead abatement program policies.
- Invest in respite housing.

PRIORITY

9 Sexual and Reproductive Health

- Teen births have declined substantially over the last decade, but are two times higher in Philadelphia and four times higher among Latina women compared to suburban counties and other racial and ethnic groups. There is some indication that this disparity is influenced by cultural norms and lack of sexual education, specifically among 1st generation children of immigrant families.
- Sexually transmitted infection (STI) rates are rising across the region. Several communities are disproportionately impacted by these conditions:
  - HIV: young Men who have Sex with Men (MSM) of color, People who Inject Drugs (PWID), high risk heterosexuals
  - Syphilis: young MSM of color in Philadelphia
  - Gonorrhea/Chlamydia: young females
- Philadelphia overall rate is 6 times higher compared to suburban counties
- Some of the rising rate of STIs among young adults may be associated with the lack of comprehensive sexual education in some public school settings.

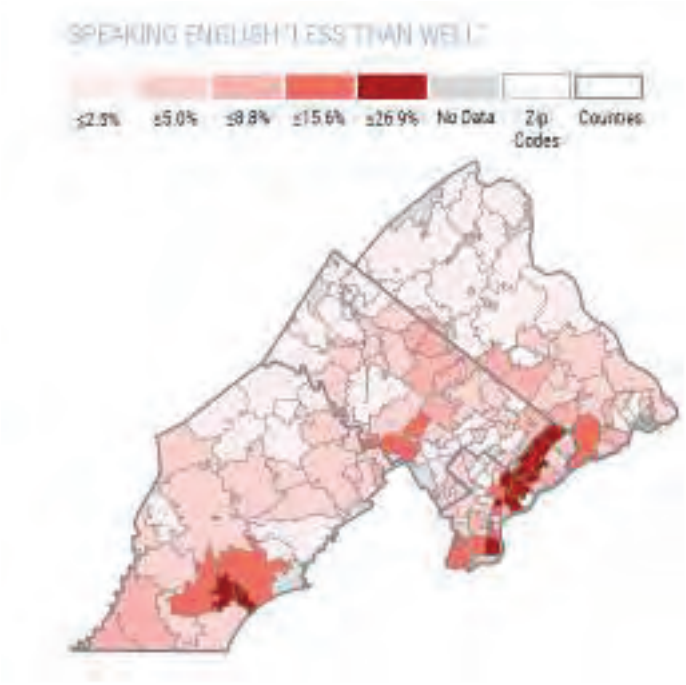
POTENTIAL SOLUTIONS

- **Provide free comprehensive sexual education and family planning services for youth.**

PRIORITY

10 Linguistically- and Culturally-appropriate Healthcare

- About 12 percent of the population across the 4 counties was not born in the U.S. As much as 26 percent of some neighborhoods do not speak English very well.
- Ensuring healthcare services and resources have access to language services is critical for providing care to these communities.
- Beyond language access, cultural and religious norms influence individual beliefs about health. Immigrants migrate to this region from all over the world and must navigate and use health systems that may differ dramatically from their countries of origin.
- Healthcare and health resource providers should have cultural and religious competencies when providing care and services.



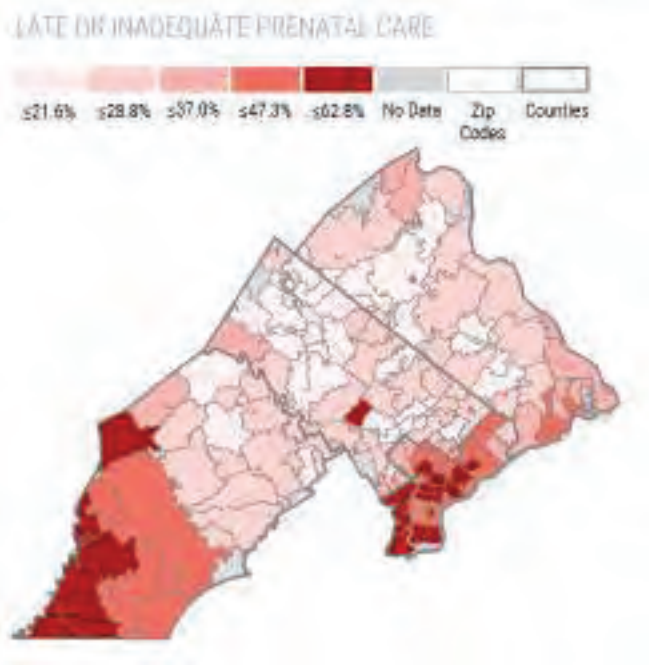
POTENTIAL SOLUTIONS

- **Offer implicit bias, cultural competence, and trauma-informed care competencies for healthcare providers, with focus on care for vulnerable communities like people living in poverty, LGBTQ+ people, individuals experiencing homelessness, and people living with addiction.**
- **Provide multi-lingual health care access.**
- **Recruit and retain a diverse healthcare workforce.**
- **Develop low-literacy, culturally-relevant, multi-lingual health education materials.**

PRIORITY

11 Maternal Morbidity and Mortality

- Late or inadequate access to prenatal care increases risk of maternal morbidity and poor birth outcomes. Late access or inadequate access is 2 times higher in lower-income communities, representing >50% of pregnancies in some communities across the region.
- Maternal morbidity and mortality is often related to pre-existing chronic conditions including obesity, hypertension, diabetes, and CVD.
- African American mothers are 3 times more likely to die from pregnancy-related complications.
- Fatal drug overdoses have caused a spike in maternal deaths not related to pregnancy.



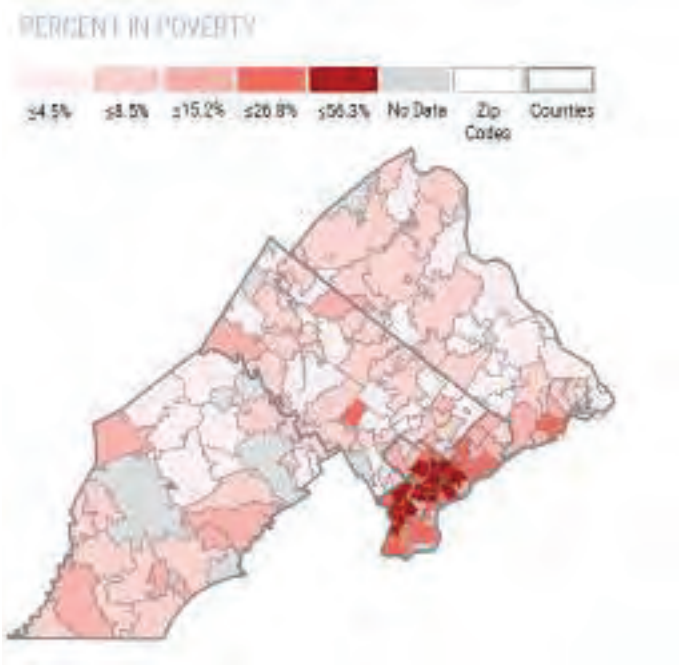
POTENTIAL SOLUTIONS

- Provide prenatal, rather than postpartum, linkages to community-based services.
- Co-locate obstetric, primary, and pediatric care along with lab and imaging services.
- Raise awareness of and increase options for low-cost transportation.
- Create direct linkages to substance use treatment during prenatal and postpartum periods.

PRIORITY

12 Socioeconomic Disadvantage
(income, education, and employment)

- Individuals living at or near poverty levels have higher rates of adverse health behaviors and outcomes.
- Poverty is the underlying determinant for many racial/ethnic health disparities.
- Unemployment and inadequate education and training are key drivers of poverty and result in extreme socioeconomic disadvantage in communities across the region.
- Poverty among children and adults tends to cluster in communities; these communities collectively experience lower life expectancy, lower 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 similar pockets of high poverty cluster in suburban counties.



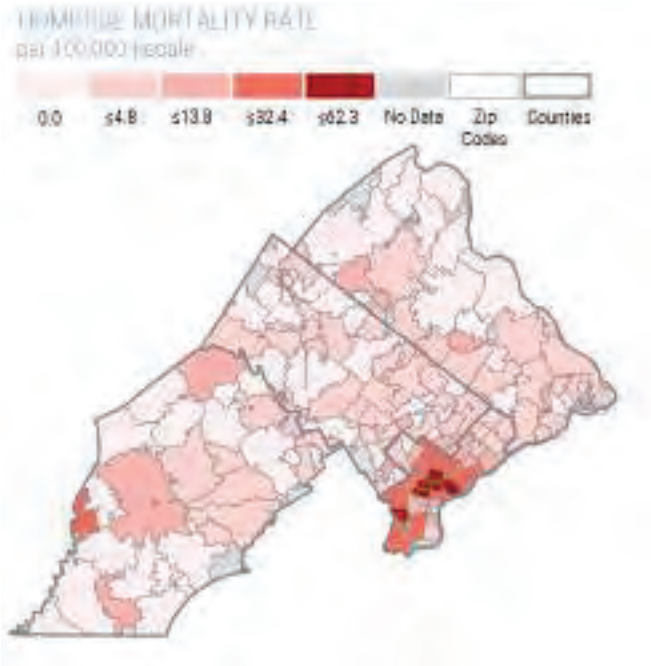
POTENTIAL SOLUTIONS

- **Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs.**
- **Provide education and training opportunities for individuals with low income.**
- **Employ and train returning citizens.**
- **Advocate for improvements to the disability system, so that people with disabilities are able to work without losing the attendant care services.**
- **Provide workforce development/pipeline programs in partnership with schools.**
- **Increase access to STEM education for youth.**

PRIORITY

13 Community Violence

- Community violence is largely driven by community disadvantage and disproportionately impacts Philadelphia County. Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties.
- Gun violence primarily involves young Black males (>75%), many disconnected from school and employment.
- Beyond gun violence, women, immigrant youth, and LGBTQ+ people are at higher risk of other interpersonal violence, including domestic and intimate partner violence, sexual assault, and sex trafficking.
- Negative interactions and bullying prevalent among youth can be a source of community violence and often occurs on social media.



POTENTIAL SOLUTIONS

- **Support and hire returning citizens.**
- **Create school and community-based mentor programs.**
- **Expand gun safety efforts like lock box distribution and provide educational materials.**
- **Provide bullying prevention programs in school and in afterschool programs.**

PRIORITY

14 Racism and Discrimination in Healthcare Settings

- Bias and discrimination experienced by individuals due to their race/ethnicity, immigration status, sexuality, adverse social experiences, and homelessness remain a challenge.
- These experiences result in further mistrust of healthcare providers and institutions and can lead to forgoing care and increased morbidity.

POTENTIAL SOLUTIONS

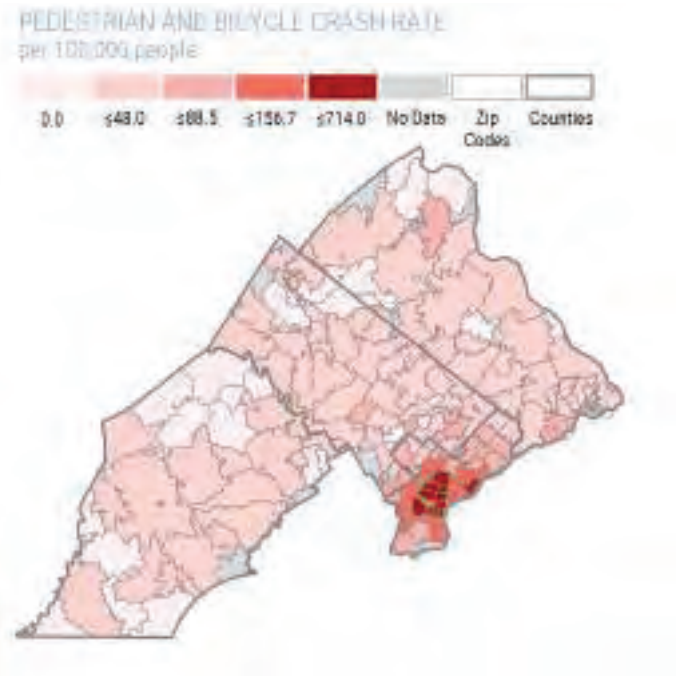
- **Create opportunities for medical professionals and communities to interact outside of the healthcare setting.**
- **Establish systems of ongoing community engagement beyond the CHNA process.**
- **Offer implicit bias, cultural competence, and trauma-informed care competencies for healthcare providers, with focus on care for vulnerable communities like people living in poverty, LGBTQ+ people, individuals experiencing homelessness, and people living with addiction.**
- **Recruit and retain a diverse healthcare workforce.**

PRIORITY

15 Neighborhood Conditions

(e.g. blight, greenspace, parks/recreation, etc.)

- Access to safe outdoor and recreational spaces for physical activity and active transit (e.g. walking and biking) is a significant health priority, particularly for youth and young adults.
- Many communities experience extreme neighborhood blight, including abandoned homes, vacant lots and extreme amounts of litter and trash, which impacts communities socially and has been associated with poorer overall health and increased violence.
- Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards.



POTENTIAL SOLUTIONS

- **Develop new affordable housing units.**
- **Support neighborhood remediation and clean-up activities.**
- **Invest in infrastructure improvements to support active transit near hospitals.**
- **Improve vacant lots by developing gardens and spaces for socialization and physical activity.**

PRIORITY

16 Homelessness

- Homelessness is a health issue.
- Individuals experiencing homelessness are more likely to:
  - Be racial/ethnic minorities
  - Have mental health and substance use disorders
  - Seek care at emergency departments/hospitals and be high-utilizers
  - Experience discrimination and bias in healthcare settings
- Inadequate temporary shelters, transitional housing, and affordable housing options exist for persons living with homelessness throughout the region.

POTENTIAL SOLUTIONS

- **Create medical respites for individuals in urgent need of transitional housing.**
- **Develop medical-legal partnerships.**
- **Develop new affordable housing units.**
- **Co-locate health and social services.**

Local Health Resources and Services

There are many health resources and services addressing the needs of SEPA communities. A list of all organizations in the SEPA region that received at least one referral through the 2-1-1 SEPA Resource Line during the period January 1 - October 31, 2018 was obtained from the United Way of Greater Philadelphia and Southern New Jersey. Organizations serving Bucks, Chester, Montgomery, and Philadelphia counties were coded into categories based on types of services provided. Descriptions of the categories are below and a searchable list of organizations that comprised over 90% of referrals in aggregate with contact information, organized by category and county, is included in the Online Appendix (page 228).

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, and 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 this CHNA.

ORGANIZATION	RESOURCE
African Family Health Organization	African Immigrant Health Needs Assessment
Arab American Development Corporation	Arab-American and Arab Immigrant Health http://www.rroij.com/open-access/philadelphia-arabamerican-and-arab-immigrant-health-needsassessment.pdf
Bucks County Department of Housing Services	Point-in-time Count Data
Chester County Department of Community Development	Point-in-time Count Data
Chinatown Community Development Corporation	Chinatown Health Needs Assessment http://chinatown-pcdc.org/our-community/health-needs-assessment/
City of Philadelphia	Immigration Action Guide https://www.phila.gov/2018-01-08-immigration-policies/
Coalition of African and Caribbean Communities	AFRICOM 2016 http://www.africom-philly.org/AFRICOM%20W%20Crops%20FINAL.pdf
Delaware Valley Regional Planning Commission	Chester County Community Health Improvement Plan https://www.dvrpc.org/health/pdf/2015-02-11_Presentations.pdf
HealthShare Exchange	Hospital Emergency Room Utilization and High-Utilizers
Jefferson Health	Refugee Health Needs Assessment http://philarefugeehealth.org/?page_id=2661
Magee Rehabilitation Hospital	2019 Community Health Needs Assessment https://mageerehab.org/about-us/outcomes/community-needs-assessment-report/
Pennsylvania Department of Health	Birth and Death Records PA Behavioral Risk Factor Surveillance System Childhood Lead Poisoning Surveillance PA 2018 LGBT Health Needs Assessment https://www.livehealthypa.com/docs/default-source/toolkits/lgbt/pennsylvania-2018.pdf?sfvrsn=0&mc_cid=3f3ee7f054&mc_eid=44abda9058
Pennsylvania Department of Transportation	Bike and Pedestrian Crash Data
Pennsylvania Health Care Cost Containment Council	Hospital Inpatient Discharge Data
Pew Charitable Trusts	Philadelphia's Immigrants https://www.pewtrusts.org/-/media/assets/2018/06/pri_philadelphias_immigrants.pdf
Philadelphia Collaborative for Health Equity	East North Philadelphia Latino Community Health Needs Assessment
Philadelphia Department of Planning & Development	Housing Action Plan https://www.phila.gov/media/20190115161305/Housing-Action-Plan-Final-for-Web.pdf

Philadelphia Department of Public Health	Child Death Review Report https://www.phila.gov/media/20190301125634/Philadelphia-Child-Death-Review-Report-2011-17-final.pdf Homeless Death Review Report https://www.phila.gov/media/20180418095811/HDR-Report-2011-2015-Deaths.pdf Maternal Mortality Report https://www.phila.gov/media/20180418095805/MMR-2010-12-Report-final-060115.pdf 2018 Health of the City Report https://www.phila.gov/media/20190110163926/Health_of_City_2018_revise2.pdf Brotherly Love: Health of Black Men and Boys in Philadelphia https://www.phila.gov/media/20190314105459/Brotherly-Love_Health-Of-Black-Men-And-Boys_3_19.pdf Staying Healthy: Access to Primary Care in Philadelphia https://www.phila.gov/media/20181109113640/2018-PrimaryCareReportFINAL.pdf
Philadelphia Office of Homeless Services	Point-in-time Count Data Philadelphia Youth Homelessness Needs Assessment http://philadelphiaofficeofhomelessservices.org/wp-content/uploads/2018/05/philadelphia-youth-homelessness-needs-assessment-april-2018.pdf
Public Health Management Corporation	2015 and 2018 Southeastern PA Household Surveys https://housingalliancepa.org/wp-content/uploads/2016/02/PSH-Needs-Assessment-Final-1-26-16.pdf
Regional Housing Legal Services	Supportive Housing Needs Assessment for PA
Robert Wood Johnson Foundation	County Health Rankings
Truven Health Analytics	Community Need Index Data
US Census Bureau	American Community Survey Data
US News & World Reports	Healthiest Communities Data
William Way LGBT Community Center	LGBTQA Community Health Needs Assessment https://www.livehealthypa.com/docs/default-source/toolkits/lgbt/report---philadelphia---v2.pdf?sfvrsn=2
Your Way Home Montgomery County	Point-in-time Count Data

Online Appendix **An online appendix of resources used to inform and produce this CHNA is available at: http://bit.ly/regional-needs-assessment**