COMMUNITY HEALTH NEEDS

2022 ASSESSMENT

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Phoenixville Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

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TABLE OF CONTENTS

LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Rich Newell, MPT, DPT

President and Chief Executive Officer,
Phoenixville Hospital

Phoenixville Hospital is committed to meeting the changing health needs of our communities while working to develop programs and services that provide our region with high-quality care close to home.

To achieve this goal, we must first identify the community's evolving health needs. Phoenixville Hospital in collaboration with all Tower Health facilities and our community partners completed the 2022 Community Health Needs Assessment (CHNA), which identifies our region's health priorities and determines our collective path forward.

Hospitals are required to conduct a CHNA every three years to retain their nonprofit status. The data for this CHNA was collected regionally and reported for our hospital service area. Working with our strategic and community partners, Phoenixville Hospital will use the results of this assessment as a foundation to develop tactics to address each of the identified regional health priorities: Access to Equitable Care, Behavioral Health, Health Education and Prevention, and Health Equity.

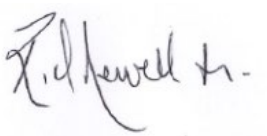
Phoenixville Hospital is committed to advancing health and transforming lives throughout Chester and Montgomery counties. As a leading health care provider, we strive to positively impact the health and well-being of our patients and the broader communities we serve. Many of our programs and services have been developed to address specific regional health needs or overcome barriers to care. These efforts continue to make a difference in the lives of individuals and families. We are grateful for our community partners who worked to help make these programs possible.

The most important aspect of the CHNA process is community partnership and engagement. Resident feedback about the health status of the community is integral to planning and executing interventions, programs, and activities. Each of our community partners brings significant and unique expertise. We look forward to an ongoing partnership to ensure that vulnerable individuals receive the care and services they need. We are much stronger together than we would be individually, and the community benefits from our collaboration.

I would like to offer my sincere thanks to the citizens and stakeholder participants throughout all the Phoenixville Hospital communities who generously volunteered their time and valuable insights during the comprehensive CHNA process.

I am beyond thankful for your ongoing support and continued involvement in the well-being of our communities. By working together, we can continue to change lives across our region.

Sincerely,



Rich Newell, MPT, DPT

President and Chief Executive Officer,
Phoenixville Hospital

Questions or comments
regarding the CHNA can be sent via email to
PhxCommunityHealth@towerhealth.org

ABOUT
THIS REPORT

COMMUNITY HEALTH NEEDS ASSESSMENT INTRODUCTION

A Community Health Needs Assessment (CHNA) is an organized process involving the community to identify and analyze community health needs. The process provides a pathway for communities to identify and prioritize health and social needs and to plan and act upon unmet and prioritized community health needs. The CHNA process undertaken by Phoenixville Hospital included input from those who represent the broad interests of the community. They specifically included representatives served by the hospital facilities, mainly those knowledgeable of public health issues; information related to the vulnerable, underserved, disenfranchised, and hard-to-reach; and representatives of those populations served by each hospital. The CHNA documented what and where the need is along with who is most affected.

In the fall of 2022, Phoenixville Hospital will release our Implementation Strategy Plan (ISP), which includes goals and strategies to address how to solve key findings from the CHNA.

IRS MANDATE

The CHNA report is a complete review of primary and secondary data analyzing demographic, health, and socioeconomic data at the local, state, and national levels. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA), requiring that nonprofit hospitals conduct CHNAs every three years. Phoenixville Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements.

Phoenixville Hospital is proud to present its 2022 CHNA report and its findings to the community.

CONSULTANT INFORMATION

Tower Health contracted with Tripp Umbach, a private health care consulting firm, to complete a CHNA. Tripp Umbach has conducted more than 400 CHNAs and has worked with more than 800 hospitals. Changes introduced by the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts among providers, public health agencies, and community organizations to improve the communities' overall health and ensure access to essential services.

CHNA PROCESS — COMMUNITY ENGAGEMENT

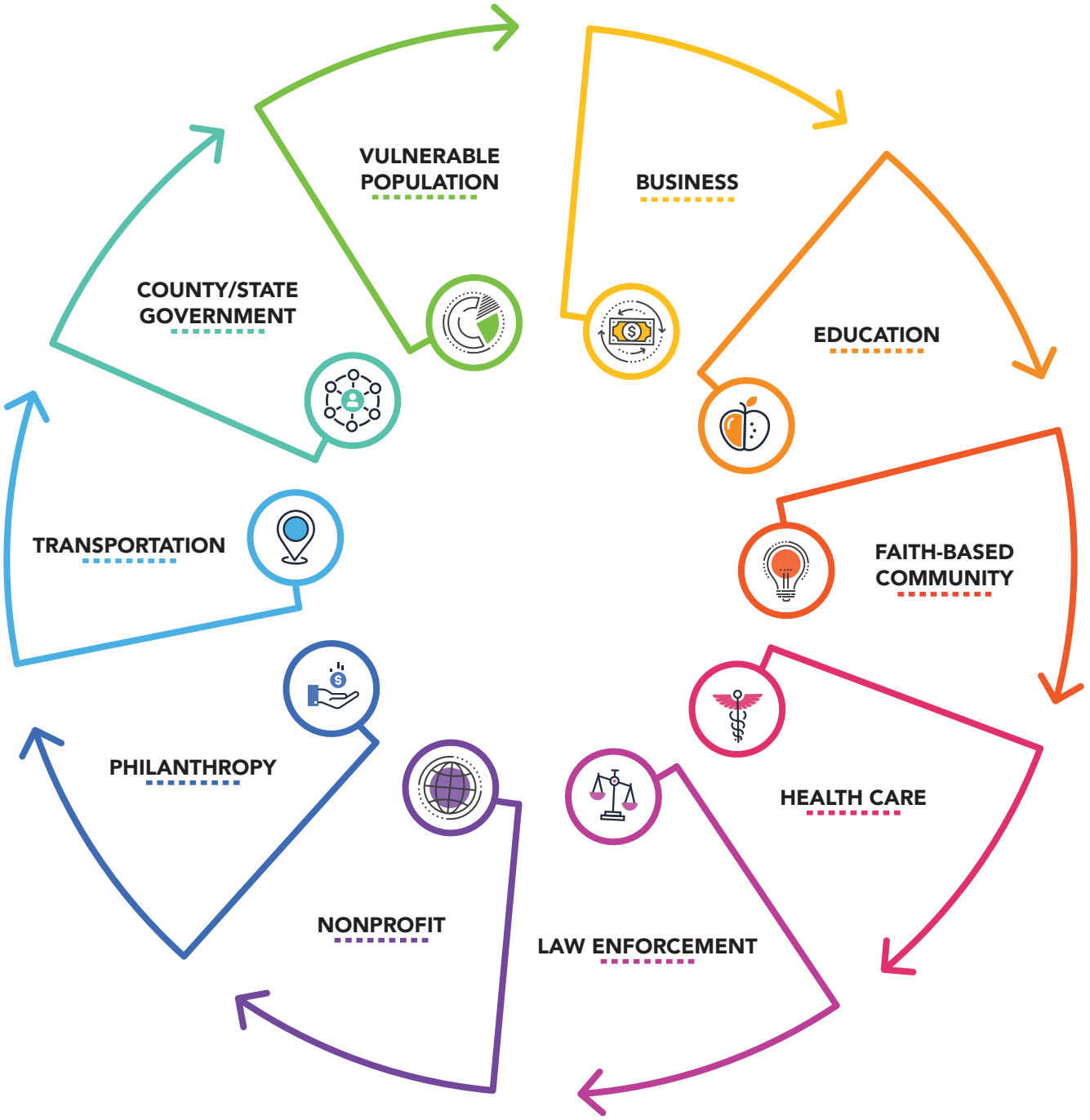
The CHNA process began in February 2021, and the collection of quantitative and qualitative data concluded in September 2021. As part of this needs assessment, a vast number of residents, educators, government and health care professionals, and health and human services leaders in Phoenixville Hospital's service area participated in the study. Information collected from leaders provided a deeper understanding of community matters, health equity factors, and community needs. See Figure 1. Phoenixville Hospital collected community and key informant surveys, community stakeholder interviews, and focus group data to engage and capture the community's perspective.

Various types of data, such as county demographics and chronic disease prevalence, were gathered from local, state, and federal databases to compile secondary data. Community surveys, key informant surveys, and community stakeholder interviews were dispersed to garner participation from all members residing or working in the primary service area. The data collected identified the needs, high-risk behaviors, barriers, societal issues, and concerns of the underserved and vulnerable populations. Information from focus groups with hospital leadership and community partners who provide services and care to the region was also included in the collection phase.

While multiple steps made up the overall CHNA process, Tripp Umbach worked closely with members of the working group[1] to collect, analyze, and identify the results to complete the hospital's assessment.

[1] Members of the working group consisted of Barbara O'Connor, Director of Community Health Education and Outreach, Phoenixville Hospital; Ha T. Pham, Senior Principal, Tripp Umbach; Barbara Terry, Senior Advisor, Tripp Umbach; and Julia Muchow, Project Manager, Tripp Umbach.

Figure 1: Phoenixville Hospital's Community Engagement

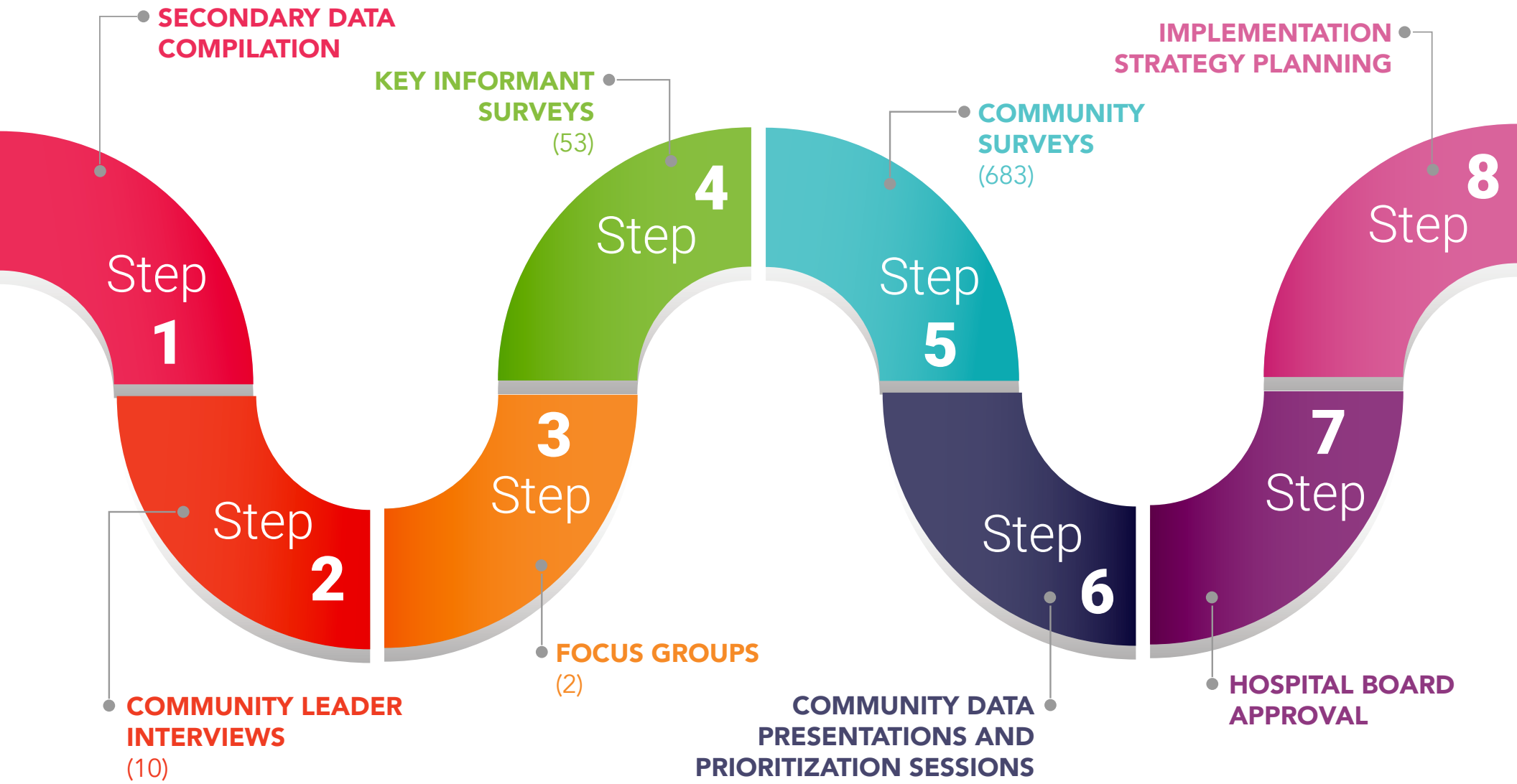


2021-2023 COMMUNITY HEALTH REGIONAL PRIORITIES

The CHNA roadmap was designed to engage all aspects of the community – including community residents, community-based organizations, health and business leaders, educators, policymakers, and health care payers – to identify health care needs and recommend possible solutions to address health issues identified.

Numerous secondary and quantitative data sources were gathered from noted public health sources to establish current health status of the population. Primary data was collected specifically from community stakeholder interviews, key informant surveys, focus groups with health care leaders and community leaders, and a broad-based community survey in English and in Spanish. The primary and secondary data created a framework of current health status as outlined in the CHNA roadmap in Figure 2.

Figure 2: Roadmap for Community Health Needs Assessment at Phoenixville Hospital[2]



[2] It is important to note that data collected for the 2022 CHNA has limitations in information. Secondary data utilized for the report is not specific to the hospital's primary service area but rather provides a scope or picture to a larger geographic region. Data was also limited to the most recent publicly available data years. Primary data obtained through interviews and surveys is also limited in representation of the hospital's service area as information was collected through convenience sampling.

PHOENIXVILLE HOSPITAL

WHO ARE WE?

Phoenixville Hospital is a 144-bed facility that provides comprehensive medical services through emergency room visits, inpatient admissions, outpatient procedures, and community outreach programs. With 25,000 emergency room visits, 8,200 inpatient admissions, and more than 500 community outreach programs, Phoenixville Hospital provides many of top-tier services, including:

- Cancer Care
- Cardiac Rehabilitation
- Hand and Wrist Care
- Heart, Vascular, and Thoracic
- Interventional Radiology
- Joint Replacement
- Neuroscience
- Orthopedic
- Pregnancy and Birth
- Radiology/Imaging
- Rehabilitation
- Robotic Surgery Program
- Surgery
- Women's Health

Phoenixville Hospital's services include an award-winning cardiovascular program, a fully accredited cancer center, NAPBC-accredited breast health center, an acute inpatient rehabilitation center, and a large robotic surgery center. Phoenixville Hospital is accredited by The Joint Commission and has been recognized for its quality outcomes and clinical expertise across services lines that include joint replacement surgery, advanced heart failure care, and the designation as a Primary Stroke Center.


PHOENIXVILLE HOSPITAL

MISSION

The mission of Phoenixville Hospital is to provide compassionate, accessible, high-quality, cost-effective health care to the community; to promote health; to educate health care professionals; and to participate in appropriate clinical research.

VISION

Phoenixville Hospital will be an innovative, leading regional health system dedicated to advancing the health and transforming the lives of the people we serve through excellent clinical quality; accessible, patient-centered, caring service; and unmatched physician and employee commitment.

REPORT SERVICE AREA

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community. Phoenixville Hospital's primary service area includes nine ZIP codes within Chester and Montgomery counties.[3]

Phoenixville Hospital PSA	
ZIP Codes	**Town/Neighborhood**
19403	Norristown
19426	Collegeville
19442	Kimberton
19453	Mont Clare
19460	Phoenixville
19464	Pottstown
19465	Pottstown
19468	Royersford
19475	Spring City
19404	Norristown (NS)
19407	Audubon (NS)
19408	Eagleville (NS)
19409	Norristown (NS)
19415	Norristown (NS)
19423	Cedars (NS)
19456	Oaks (NS)
19481	Valley Forge (NS)
19482	Valley Forge (NS)
19457	Parker Ford (NS)

[3] Note: NS ZIP codes are non-spatial ZIP codes with no population. They are often P.O. boxes.

EVALUATION OF
2019 CHNA IMPLEMENTATION STRATEGY

Phoenixville Hospital has worked over the last three years to develop and implement strategies to address the health needs in the study area and evaluate the effectiveness of the strategy created in terms of meeting goals and combatting health problems in the community.

The evaluation process determines the effectiveness of the previous plan. The working group tackled the problem statements for each past priority and strategy and developed ways to address its effectiveness. The self-assessments on each of the strategies are internal markers to denote how to improve and track each of the goals and strategies within the next three years. The following tables reflect highlights and accomplishments from Phoenixville Hospital. Specific metric information/measurable indicators can be obtained from the hospital's administrative department.

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

Goal 1. Increase access to health care services by community members, particularly those considered vulnerable and/or living in underserved areas.

STRATEGIES	ACTION STEPS
Enhanced and/or expanded telemedicine opportunities	Evaluated opportunity for additional telehealth service. Neurology/Telestroke, Psychiatry, Pediatrics in ED, Virtual ICU, Virtual trauma in ED, Outpatient remote monitoring for Heart Failure, outpatient speech/language pathology
Streamlined the access to care facilities (Tower Access Project)	Opened advanced access center across ambulatory and specialty service lines
Increased cultural awareness, diversity, and inclusion	Staff members attended train-the-trainer session on cultural awareness
	Participated in Diversity and Inclusion Council
Utilized outreach sites to connect vulnerable populations with resources to address unmet health care needs.	Community health nurses provided health information and referrals to resources to vulnerable populations
Hosted Bridging the Gap Medical Interpreter Certification to increase the number of qualified medical interpreters in our community.	BTG training completed in 2019 and 2021

2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH (SDOH)

Goal 1. Identify and address Social Determinants of Health (SDOH).

STRATEGIES	ACTION STEPS
Identified and addressed SDOH in the clinical environment	Screened patients in emergency department and nurse outreach for SDOH in identified clinical areas
Reduced transportation barriers	Implemented Ride Health Program

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

Goal 1. Implement chronic disease prevention and management programs in the primary service area, specifically targeting vulnerable populations.

STRATEGIES	ACTION STEPS
Blood pressure screenings	Blood pressure screenings provided at outreach (low-income housing, food pantry) by Community Health. Made appropriate referrals for follow-up
Provided chronic disease education to target population at nurse-managed outreach sites	Provided chronic disease-specific education to vulnerable populations (Low-income, veterans, and disabled)
	Provided education seminars focused on disease-specific health
Lung cancer screenings	Promoted lung cancer screening at community events
Mammogram screenings	Increased awareness of mammogram screening program through social media campaign
Vaping Cessation Programs	Coordinated and provided student vaping cessation classes
	Coordinated student and parent vaping education in school districts
Tower Wellness Programs	Implemented short- and long-term wellness initiatives
Provided programs that educate the community about diabetes	Promoted diabetes support group meetings
	Partnered with community organizations to provide diabetes programs to at-risk population
Raised awareness of available assistance to food programs	Attended community food coalition meeting

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

Goal 1. Improve access to screening, assessment, treatment, and support for behavioral health.

STRATEGIES	ACTION STEPS
Utilize telemedicine to expand access	Telemedicine utilized for behavioral health
	Warm Handoff

Goal 2. Provide training to hospital staff and community members.

STRATEGIES	ACTION STEPS
Increase provider awareness of suicide ideation	QPR training rescheduled
Equip providers and community members to provide mental health support	Scheduled and hosted youth mental health first aid training
Support providers	Provided resilience/self-care training to staff

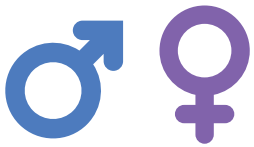
COMMUNITY AT A GLANCE

The health of an individual is largely influenced by the choices we make for ourselves and our families and the available opportunities to make those positive choices. These influences affect our ability to make healthy choices; afford care, housing, and food; and cope with stress factors.

POPULATION

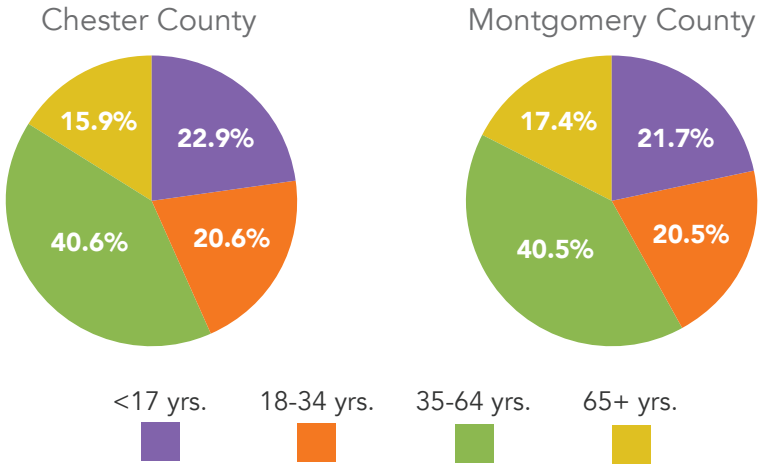
Source: U.S. Census Bureau 2020

GENDER

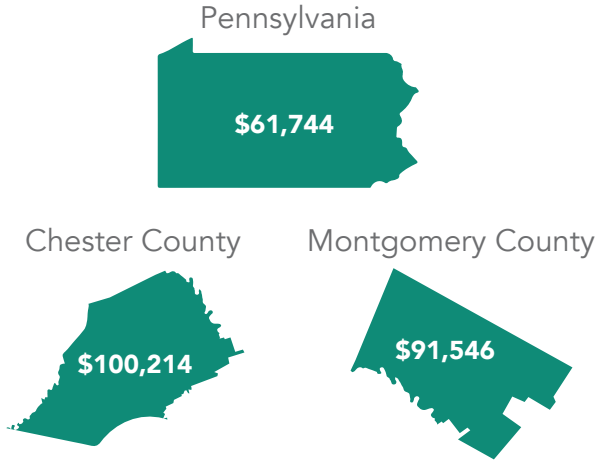


Source: U.S. Census Bureau 2019

AGE DISTRIBUTION



MEDIAN HOUSEHOLD INCOME



Source: U.S. Census Bureau 2019

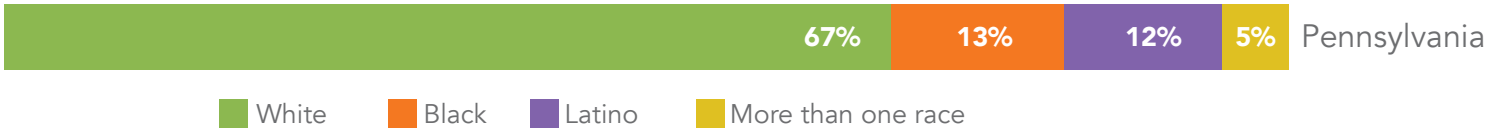
LESBIAN GAY BISEXUAL TRANSGENDER QUEER (LGBTQ) SNAPSHOT IN PENNSYLVANIA

Percent of Adults (18+) Who are LGBTQ	4.1%
Total LGBTQ Population (13+)	490,000
Percent of Workforce That is LGBTQ	5.0%
Total LGBTQ Workers	307,000
Percent of LGBTQ Adults (25+) Raising Children	27.0%

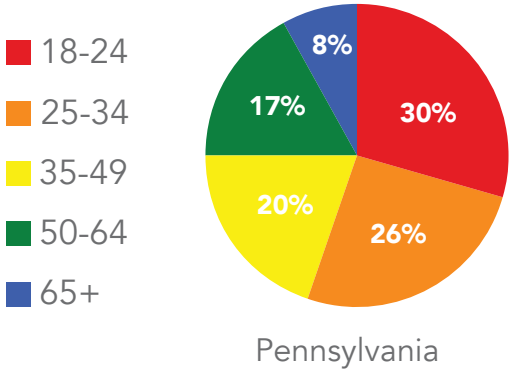
Source: Movement Advancement Project

GENDER OF LGBT POPULATION

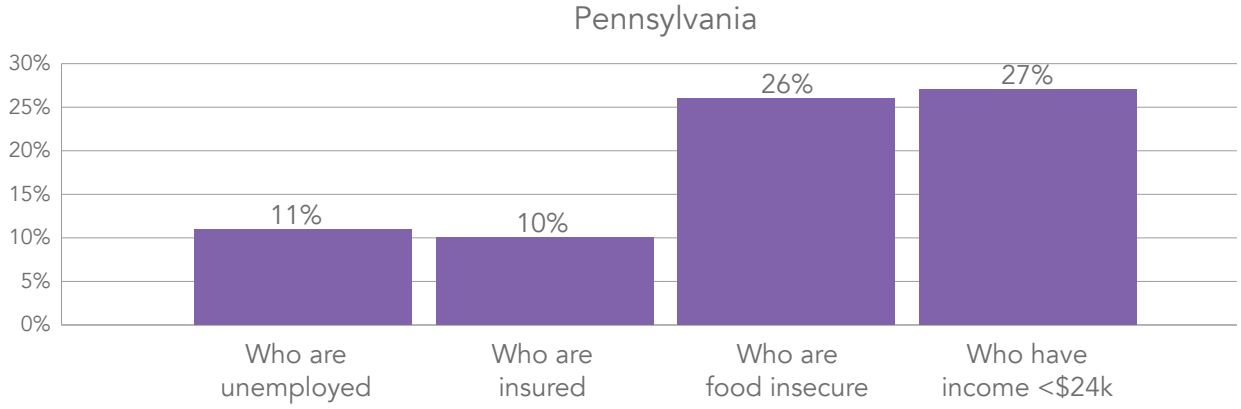
RACE/ETHNICITY OF LGBT POPULATION



AGE OF LGBT POPULATION

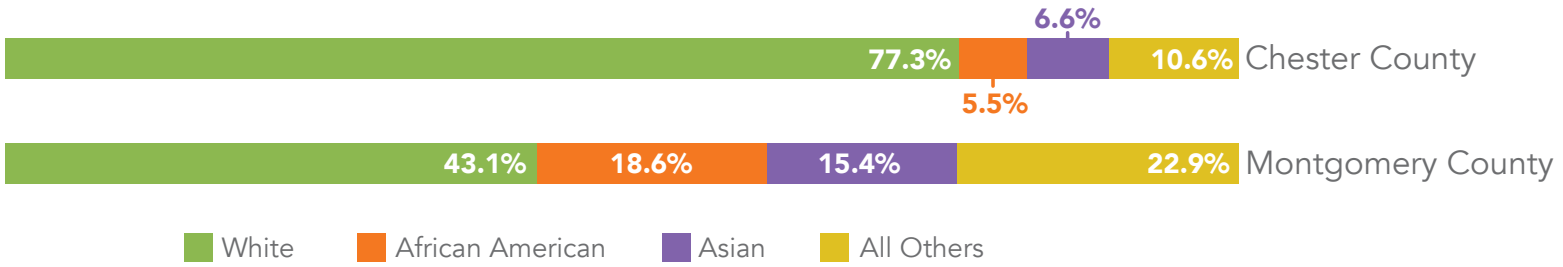


SOCIOECONOMIC FACTORS OF LGBT POPULATION



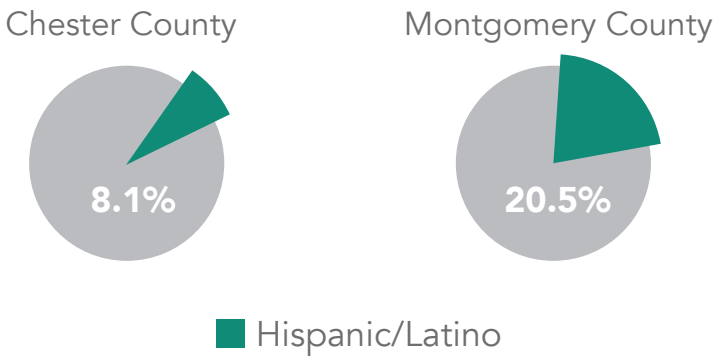
Source: UCLA Williams Institute School of Law

RACE



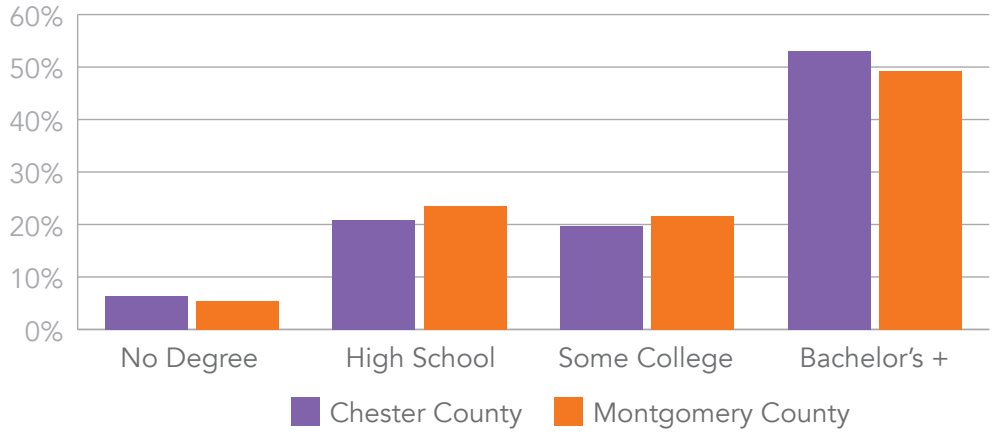
Source: U.S. Census Bureau 2020

ETHNICITY



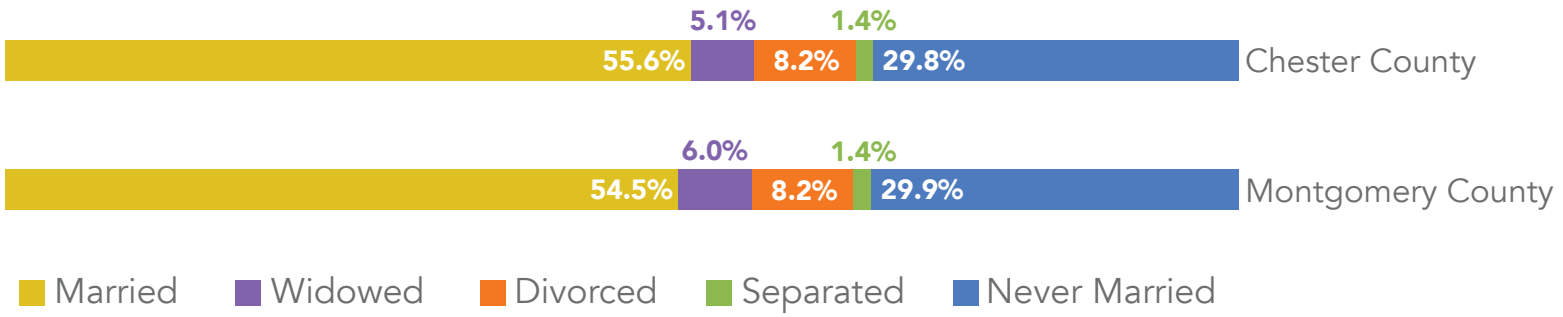
Source: U.S. Census Bureau 2020

EDUCATION



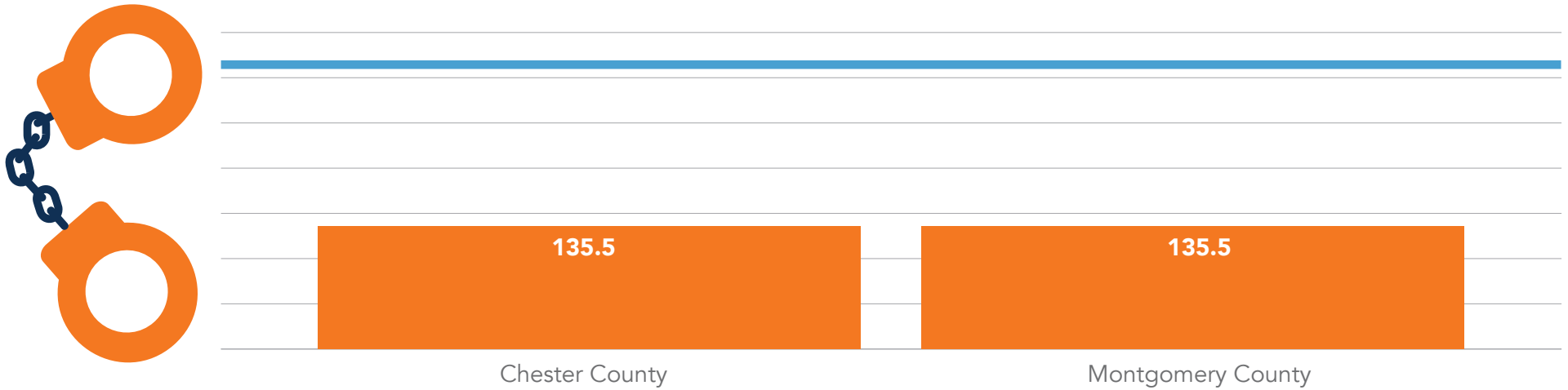
Source: U.S. Census Bureau. American Community Survey 2015-2019

MARITAL STATUS



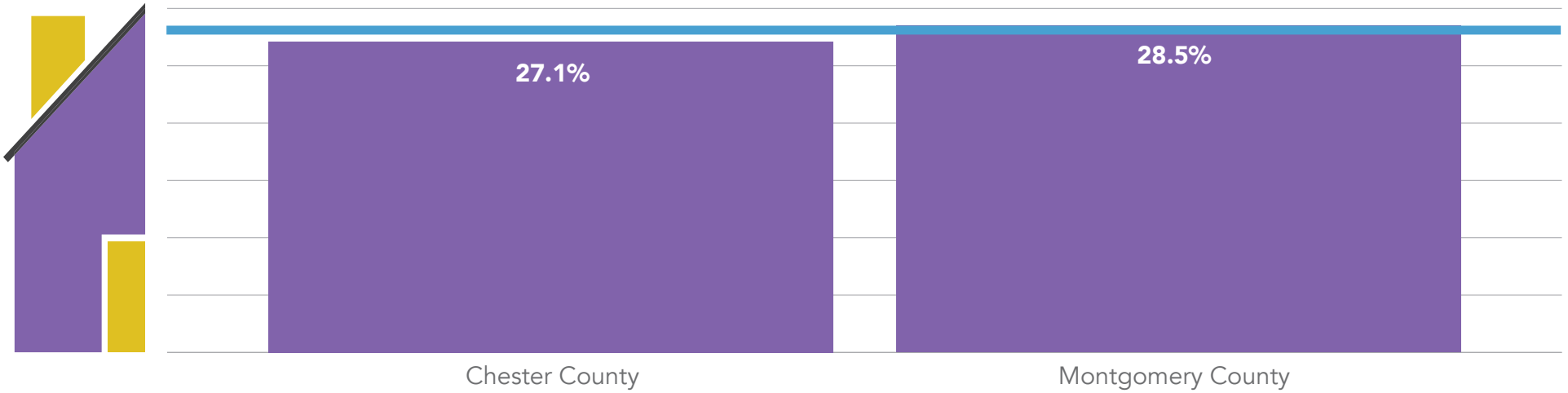
OUR ENVIRONMENT

VIOLENT CRIME
(per 100,000 population)



Note: The blue line indicates the rate in Pennsylvania of 315.6.
Source: FBI Uniform Crime Reports 2020

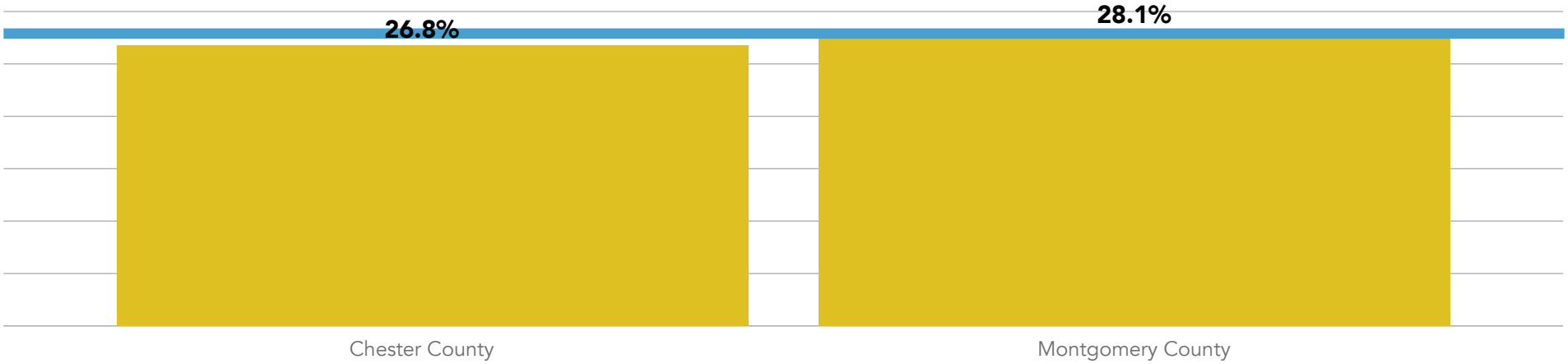
HOUSING COST BURDEN
(Households where housing costs are 30% or more of total household income)



Note: The blue line indicates the percent in Pennsylvania of 28.1%
Source: U.S. Census Bureau 2019

SUBSTANDARD HOUSING

(Units having 1) lack of complete plumbing, 2) lack of complete kitchen, 3) 1+ occupants per room, 4) the percentage of household income greater than 30%, and 5) gross rent of household income greater than 30%)



Note: The blue line indicates the percent in Pennsylvania of 28.1%
Source: U.S. Census Bureau 2019

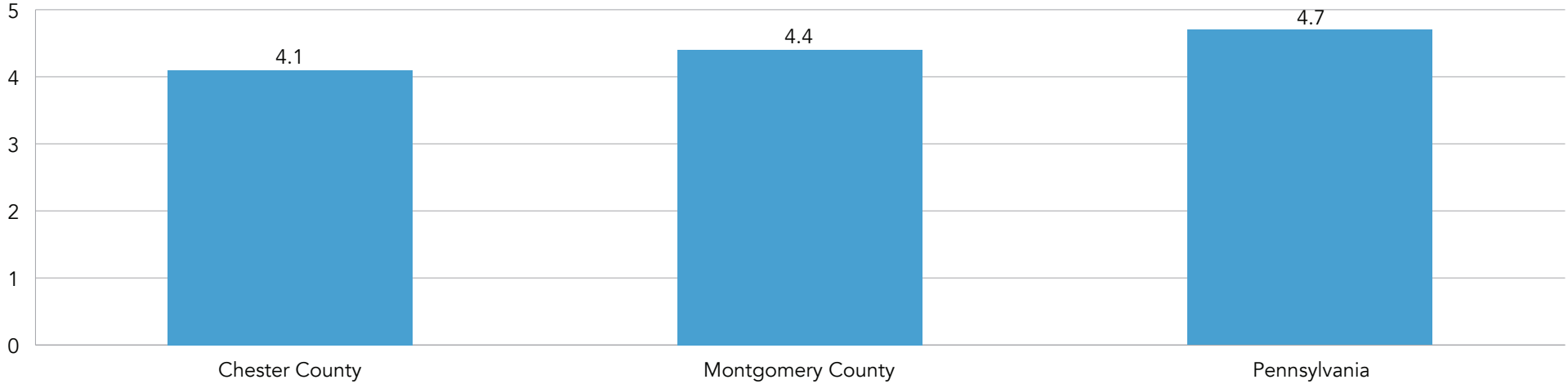
HOUSING OCCUPANCY BY RACE

	Owner Occupied Housing (Percent)		Renter Occupied Housing (Percent)	
	Chester County	Montgomery County	Chester County	Montgomery County
White	77.8	76.0	22.3	24.1
Black	48.0	46.7	52.0	53.3
Asian	67.4	62.8	32.6	37.2
Native American or Alaska Native	64.1	50.2	35.9	49.9
Some other race	25.3	29.7	74.7	70.3
Multiple race	56.6	48.8	43.4	51.2

Source: U.S. Census Bureau 2019

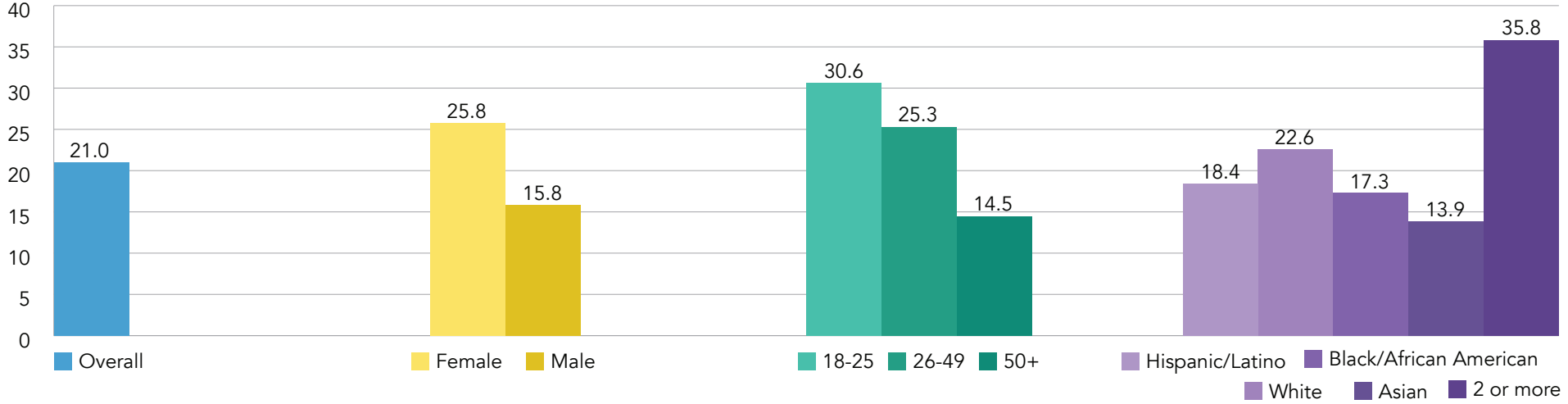
MENTAL HEALTH

The figure reports the average number of mentally unhealthy days reported in the past 30 days (age-adjusted).



Source: County Health Rankings 2018

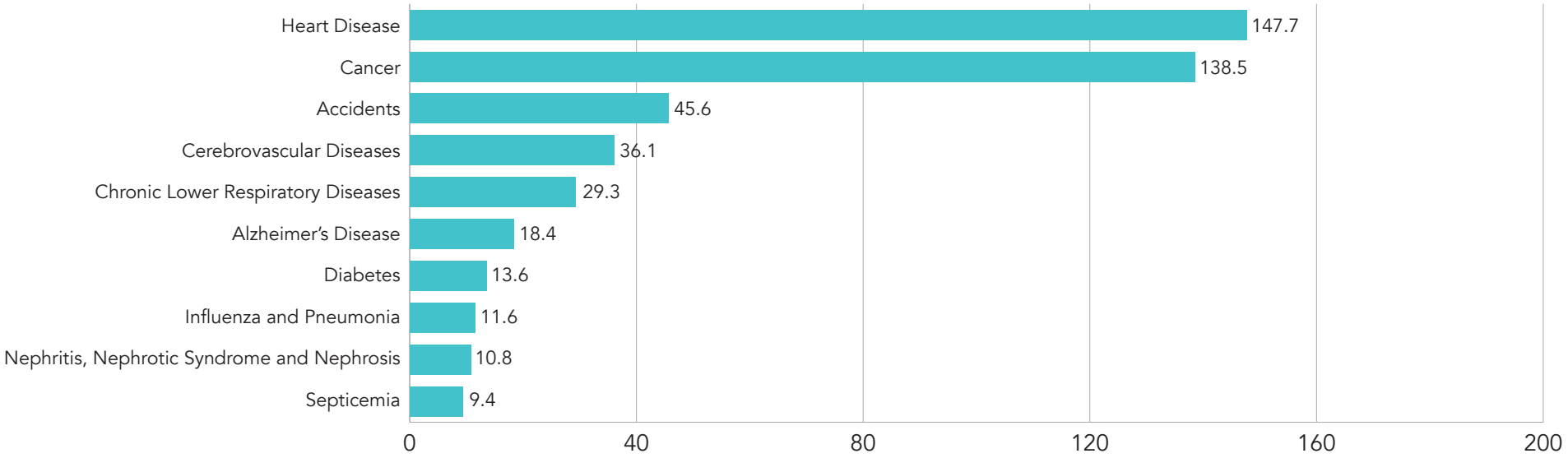
The figure shows the past year's prevalence of any mental illness (AMI) among U.S. adults. In 2020, an estimated 52.9 million adults aged 18 or older in the United States were diagnosed with AMI. This number represented 21.0% of U.S. adults. AMI was more prevalent among females (25.8%) than males (15.8%). Young adults aged 18-25 years had the highest prevalence of AMI (30.6%) compared to adults aged 26-49 years (25.3%) and aged 50 and older (14.5%). The prevalence of AMI was highest among the adults reporting two or more races (35.8%), followed by white adults (22.6%). The prevalence of AMI was lowest among Asian adults (13.9%).



Source: National Institutes of Health

TOP CAUSES OF DEATH IN CHESTER COUNTY

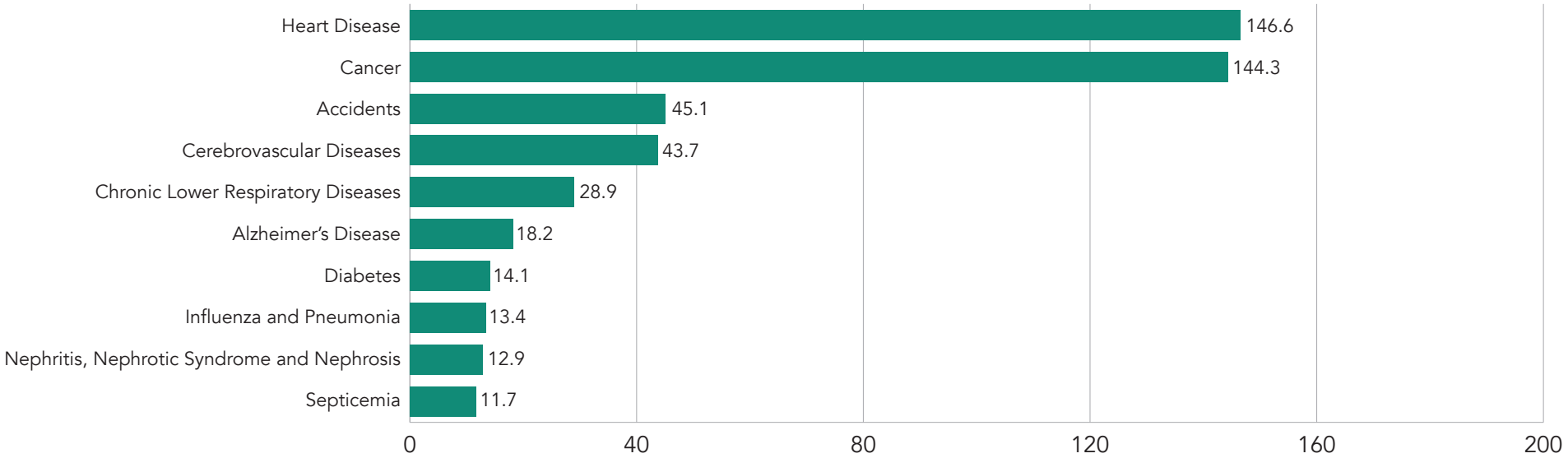
(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

TOP CAUSES OF DEATH IN MONTGOMERY COUNTY

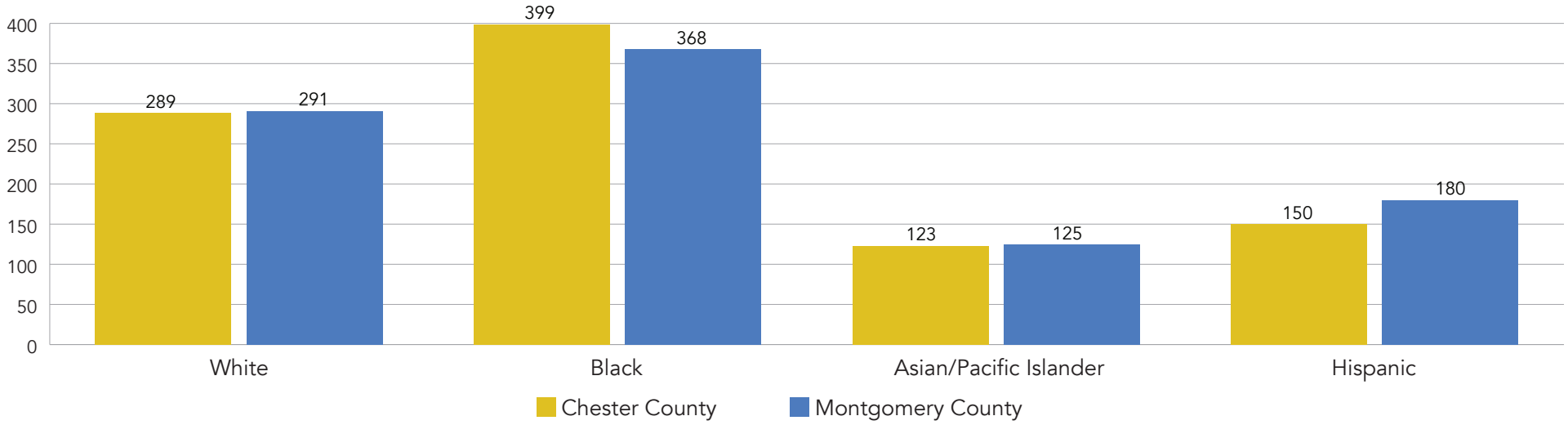
(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

HEART DISEASE DEATHS BY RACE/ETHNICITY BY COUNTY

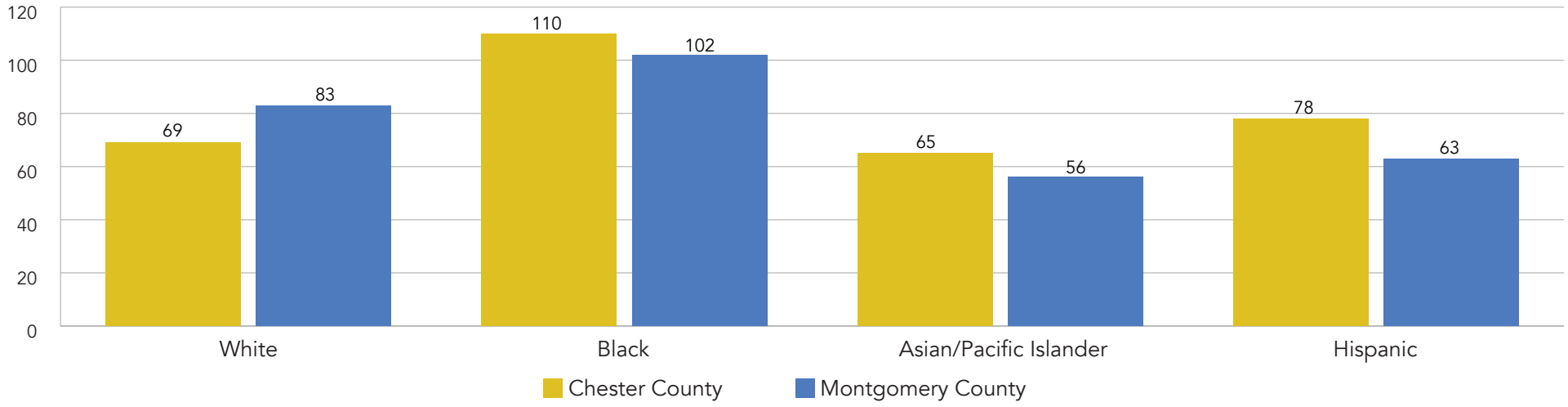
(ages 35 years+ per 100,000 population)



Source: Pennsylvania Department of Health 2019

OVERALL STROKE DEATHS BY RACE/ETHNICITY BY COUNTY

(ages 35 years+ per 100,000 population)

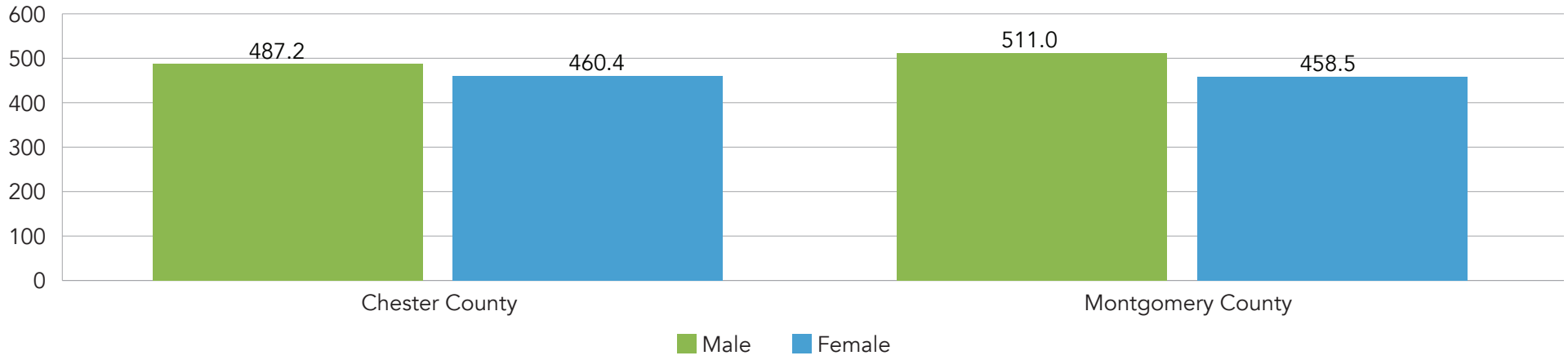


Source: Pennsylvania Department of Health 2019

OVERALL CANCER INCIDENCE

ALL CANCERS INCIDENCE RATES BY GENDER

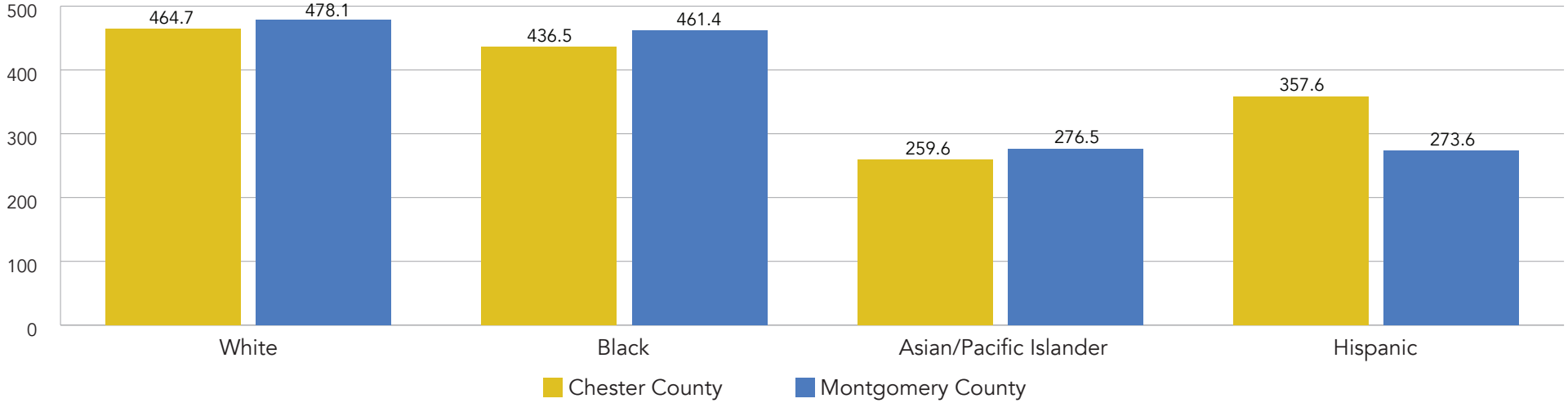
(per 100,000 population)



Source: Pennsylvania State Cancer Profiles 2014-2018

ALL CANCERS INCIDENCE RATES BY RACE/ETHNICITY

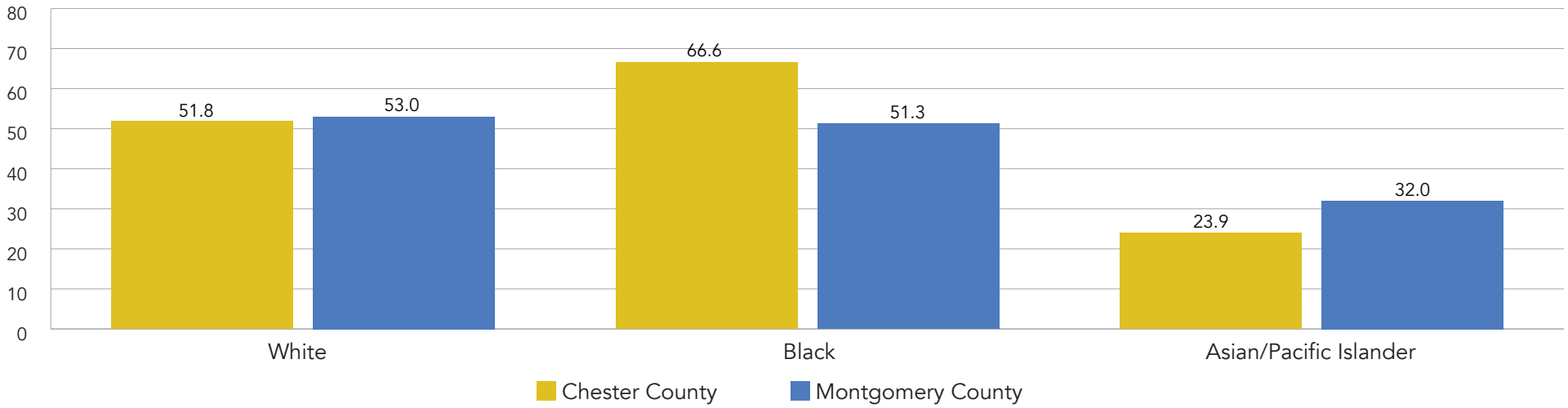
(per 100,000 population)



Source: Pennsylvania State Cancer Profiles 2014-2018

LUNG AND BRONCHUS CANCER INCIDENCE RATES BY RACE

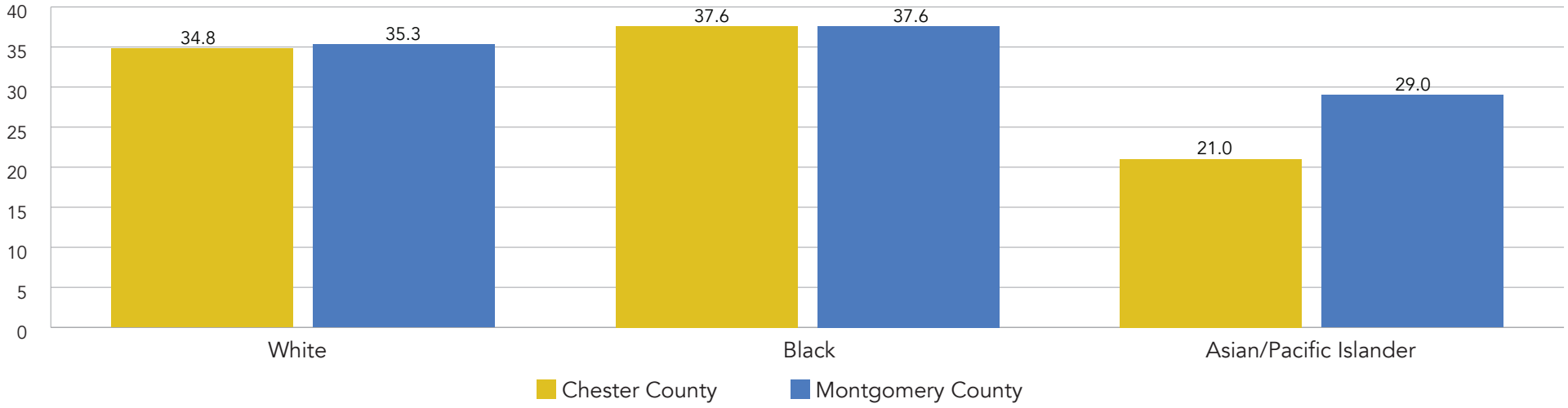
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

COLON AND RECTUM CANCER INCIDENCE RATES BY RACE

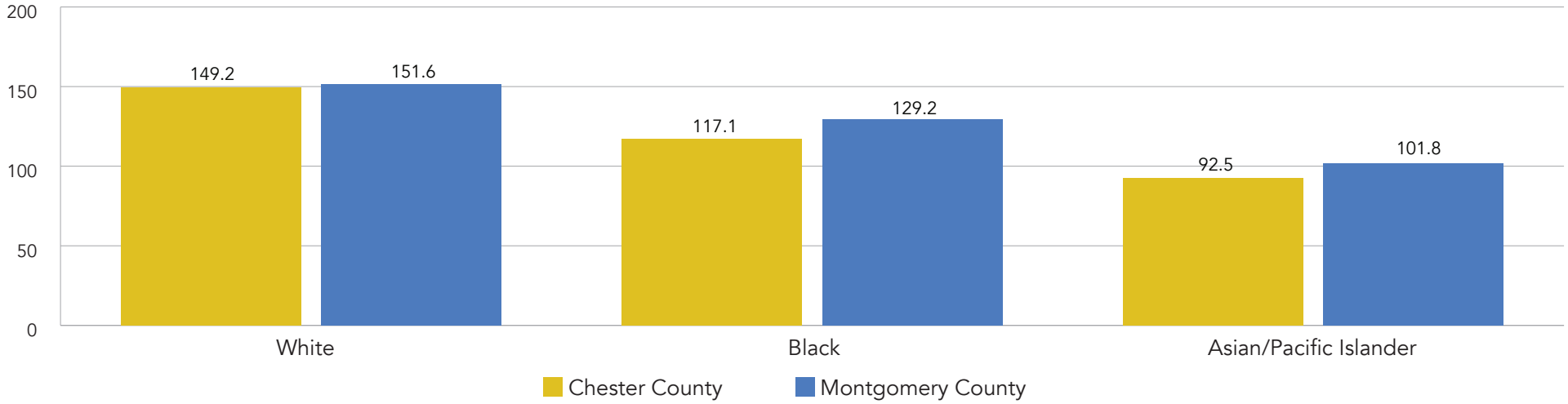
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

FEMALE BREAST CANCER INCIDENCE RATES BY RACE

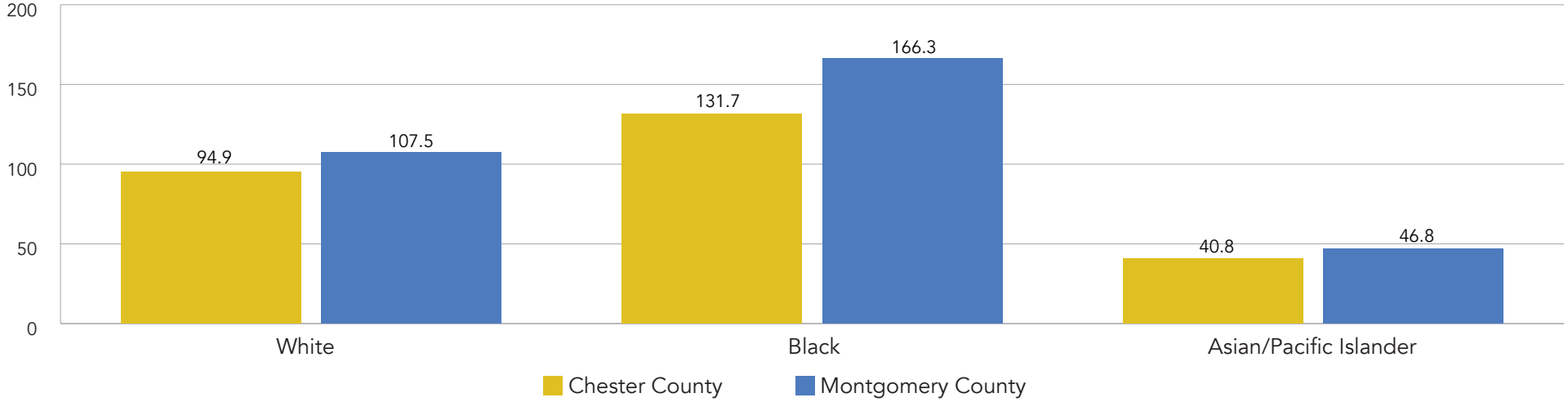
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

MALE PROSTATE CANCER INCIDENCE RATES BY RACE

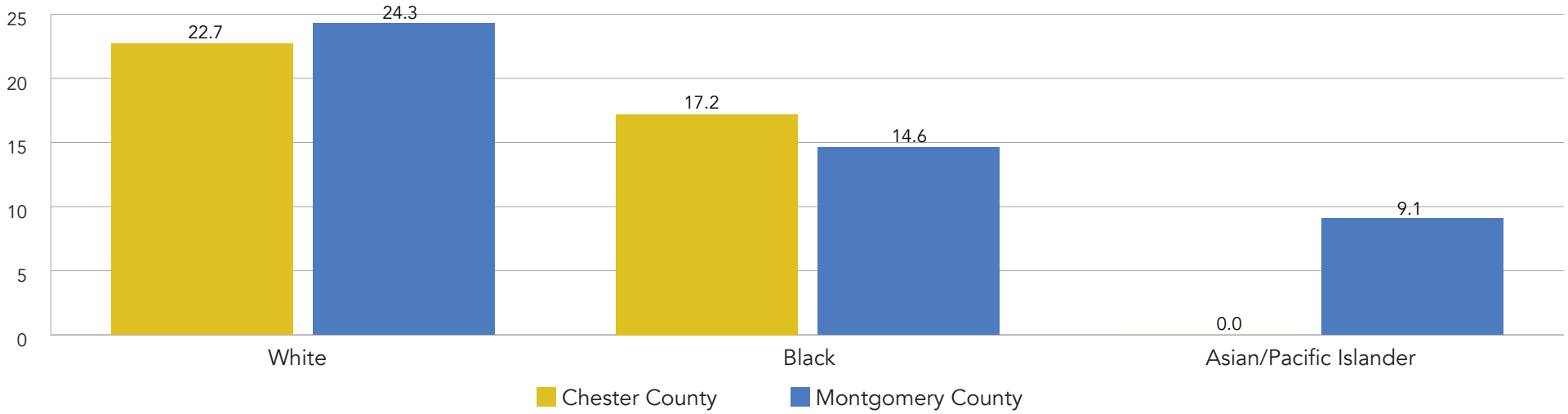
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

BLADDER CANCER INCIDENCE RATES BY RACE

(per 100,000 population)

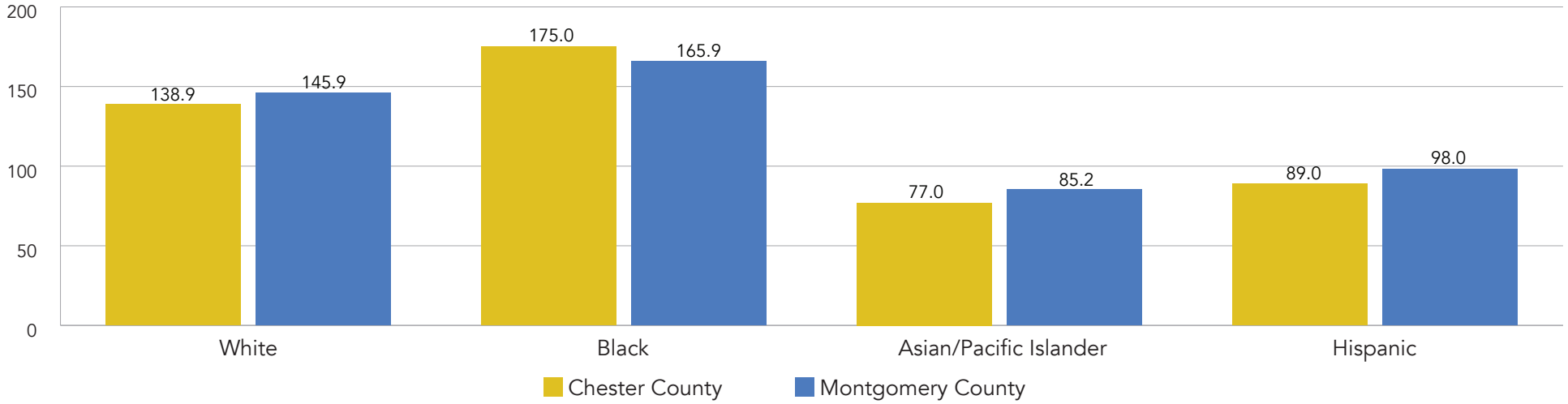


Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

OVERALL CANCER DEATH RATES

ALL CANCER DEATH BY RACE AND ETHNICITY

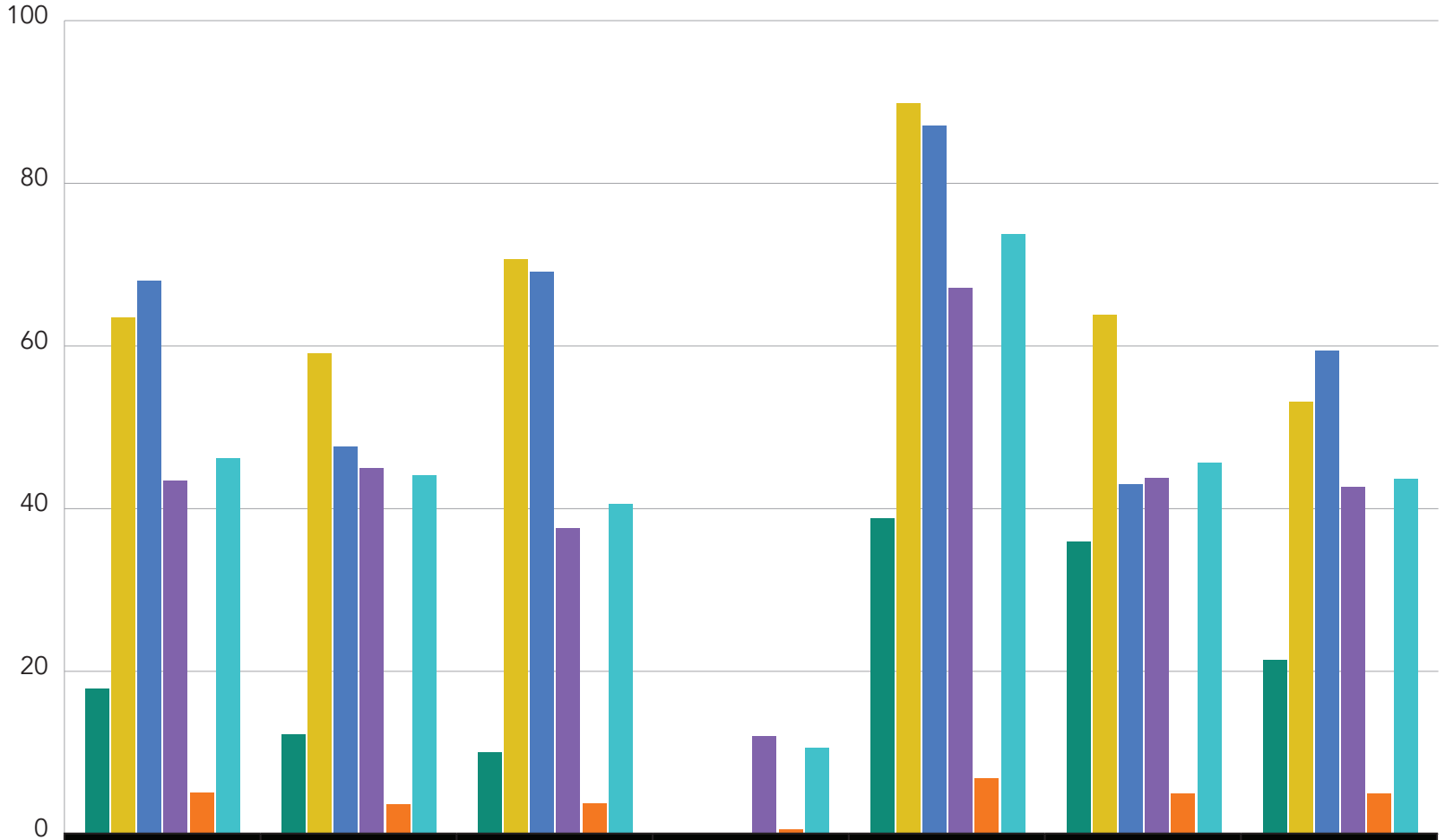
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles. Death data 2015-2019; incidence data 2014-2018.

ADULT EMERGENCY ROOM VISITS PER 1,000/MONTHS ZIP CODE SUMMARY[4]

The figure reports the average number of mentally unhealthy days reported in the past 30 days (age-adjusted).



	19460	19403	19426	19442	19464	19465	19468
Asian	17.9	12.2	10.1	--	38.8	35.9	21.4
Black	**63.5**	**59.1**	**70.7**	--	**89.8**	**63.8**	**53.1**
Hispanic	**68.0**	**47.6**	**69.1**	--	**87.1**	43.0	**59.4**
White	43.4	**45.0**	37.6	**12.0**	67.1	43.8	42.7
Other Race	5.1	3.6	3.8	0.6	6.9	5.0	5.0
All Adults	**46.2**	**44.1**	**40.6**	**10.6**	**73.8**	**45.7**	**43.7**

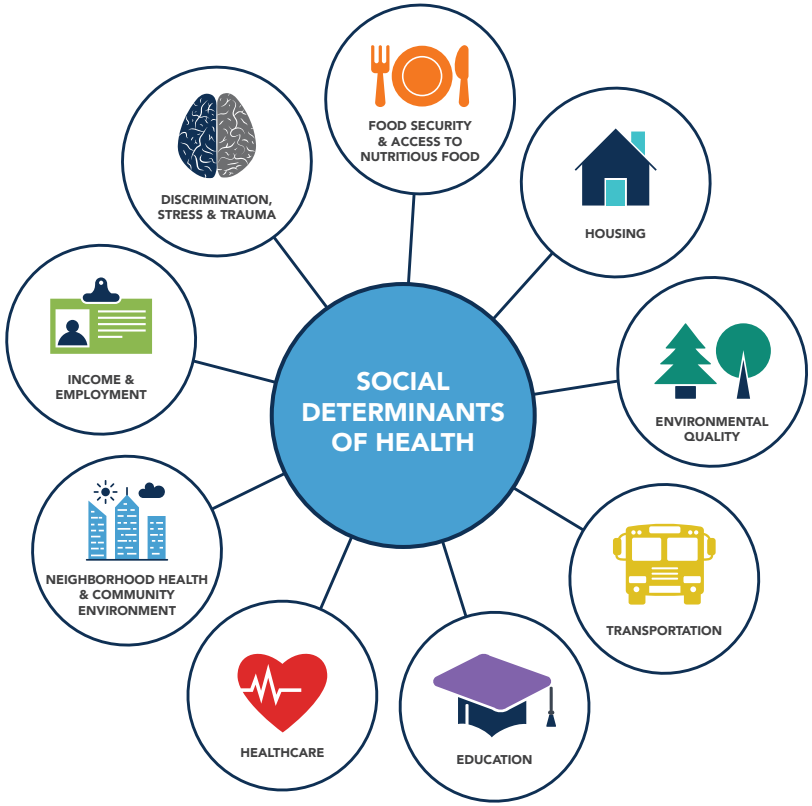
Note: The figures in red indicate high emergency room visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[4] The Department of Human Services (DHS) in collaboration with the Department of Health (DOH) has launched the PA Health Equity Analysis Tool (HEAT). The PA HEAT dashboard is designed to illustrate variation in a variety of health and social determinants of health indicators at the regional, county, ZIP code, and census tract levels.

WHERE WE LIVE, LEARN, WORK, AND PLAY
AND HOW IT AFFECTS OUR LIVES

Figure 3: Influential Factors



Where we live, learn, work, and play are important factors that shape one's overall health standing. Communities that have access to healthy foods, livable-affordable homes, quality education, and a safe/clean environment are healthier compared to their counterparts. Our social and physical environment have strong impacts on our overall health aside from our traditional health care settings. Social and environmental factors include our race, income, education level, and livable home environment (i.e., community).

According to the Robert Wood Johnson Foundation, social inequalities are linked to unhealthy behaviors; however, community investments in proven programs and policy changes can reduce disparities, allowing residents to make it easier to make better healthier choices, thus, reducing illnesses.

FACTORS THAT INFLUENCE OUR HEALTH

Social determinants of health (SDOH) such as safe/clean housing, discrimination, community violence, education, employment, food access, transportation, and language comprehension play a vital role in the overall health and well-being of an individual.

Individual choices play a key role in good health and well-being; however, those choices must be made available to yield a good outcome. SDOH plays a substantial role in providing residents with choices; not everyone has access to the same choices. Providing health equity provides an equal opportunity for individuals to live healthier lives.

Figure 3 Illustrates factors that influence the lives of community residents.

Figure 4: County Health Rankings: Chester and Montgomery Counties
(1-67) (1=Healthiest)

Source: County Health Rankings and Roadmaps 2021

COMMUNITY
HIGHLIGHTS

HEALTHY BABY PROGRAM

The Healthy Baby Program, a partnership between a community hospital and an OB/GYN practice, was developed to improve access to high-quality prenatal, delivery, and post-partum care to uninsured and underinsured women in the primary service area (PSA). While the Healthy Baby Program welcomes all women in need, the primary target group for the Healthy Baby Program is the growing Latino population in the PSA. The goal of the program is to provide equitable and quality access to care to all pregnant women. The program aligns with the Healthy People 2030 Leading Health Indicator (LHI) of maternal, infant, and child health with the objective of increasing the proportion of pregnant women who receive early and adequate prenatal care.

The Healthy Baby Program has been successful in providing prenatal, delivery, and postpartum care to the underserved population. More than 1,300 women have been enrolled in the program with more than 1,200 deliveries to date. Access to early and regular prenatal care improves the chances of a healthy pregnancy. The Healthy Baby Program offers prenatal and other health care services to women who may otherwise not receive them. The program is also making strides toward achieving the Healthy People 2030 goals of improving maternal and child health.

Women who have participated in the Healthy Baby Program report positive experiences and outcomes. Patient testimonials have been collected and shared. One participant stated, “I was so happy that they have staff that speaks my language and can understand me.” Another participant shared, “Learning how to use a car seat was so helpful so I can keep my baby safe.” Another stated, “I was made to feel accepted and comfortable and felt like people truly cared about me and my baby.” The majority of referrals into the Healthy Baby Program are from family or friends who have been a part of the program.

As the Healthy Baby Program has evolved, other opportunities for pregnancy-related health education have been identified.

a. The initial target population was Spanish-speaking women, but as the program has evolved, it was discovered that the Portuguese population in our community also needed care. To meet this need, one of our Spanish navigators also became proficient in Portuguese.

b. Additional birth preparation educational programs have been added to provide women the knowledge and skills necessary to improve maternal and child health. Classes are facilitated by an experienced birth preparation instructor with an interpreter. The first birth preparation class for Spanish-speaking women was piloted in 2018 with 12 women attending. The number of women attending nearly tripled in 2019 and continues to be well attended. Through education, women receive the knowledge and skills necessary to care for themselves during pregnancy, childbirth, and beyond. Feedback indicates that transportation is often the barrier to attending classes, which is an issue being addressed in Healthy People 2030.

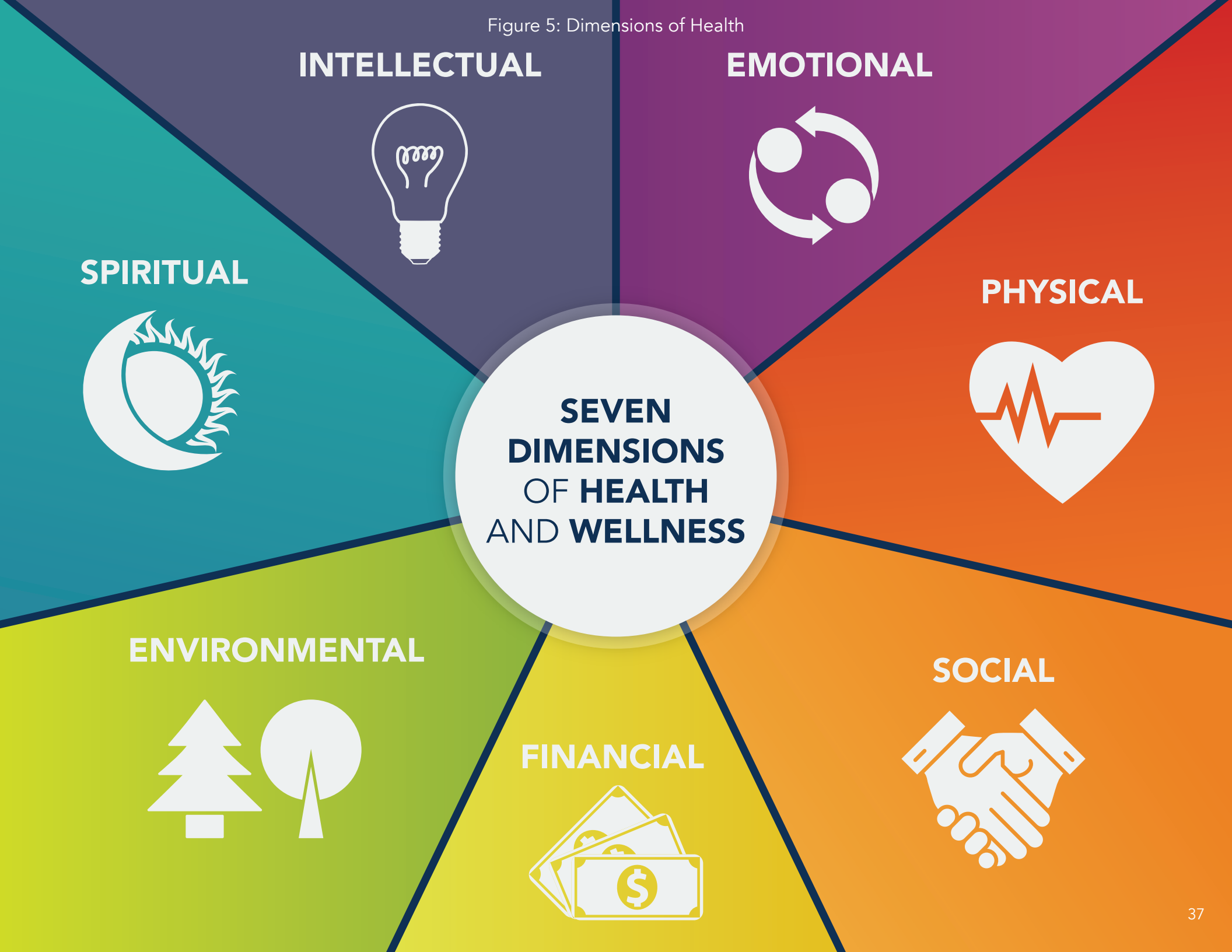
c. The incidence of gestational diabetes mellitus is significant in the Latino population and is reflected in our patient population. Our hospital provides outpatient diabetes education, and a process was developed to provide diabetes education and support to expectant mothers. A registered nurse with diabetes expertise worked closely with a public health student pursuing a master's degree to develop low literacy, culturally appropriate materials for education. To date more than 200 women have received education on gestational diabetes management.

d. Women who enroll in the program also have the opportunity to meet with the financial counselors at the hospital to determine eligibility for insurance or charity care programs. As a result of these meetings, some women have been able to obtain insurance for themselves during their pregnancy. Through quality improvement efforts and careful screening, the number of those who received health benefits increased by 12% from 2018 to 2019.

NURSE OUTREACH

Nursing outreach has been the cornerstone of community health at Phoenixville Hospital for more than 30 years. Registered nurses provide health education to at-risk, underserved, and diverse populations in a variety of settings including subsidized housing, senior housing, food pantries, churches, and other organizations. RNs meet with community members and provide blood pressure screening, weight measurement, chronic disease education, tobacco cessation referrals, medication review, and referrals to community resources. The multiple dimensions of health are addressed.

Figure 5: Dimensions of Health



PULLING IT TOGETHER

Building on the vital work that has been under way, Phoenixville Hospital places an unrelenting focus on actions required to continually improve health and quality of life for its residents. Focus groups with community members and hospital leadership drew similarities in top community health needs.

Figure 6 shows the top community health needs identified by focus groups.

Participants of the CHNA across the various data collection methods emphasized the need to improve access to equitable care and behavioral health and to expand health education and prevention. Inequities such as demographical differences highlight the importance of weaving an equity focus within all areas of health. We can conclude that plans to improve health can be achieved through the following areas of focus:

A) Access to Equitable Care
B) Behavioral Health
C) Health Education and Prevention
D) Health Equity

A) ACCESS TO EQUITABLE CARE

Phoenixville Hospital deploys continuous improvement efforts to better understand the contributing factors that impede access to equitable care and how best to address identified barriers and gaps in the provision of health care and services. Improving an organization's capacity to provide access to equitable care for vulnerable and ethnic populations is a continuous and evolving process.

The pandemic further helped the health system to realize the even wider gaps that resulted as related to accessing care such as the lack of knowledge regarding available health services and programs, the high costs of health care and insurance, the lack of trust, and the limited capacity to provide quality and appropriate care because of a lack of cultural competence among providers and limited language services.

Figure 7 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 7: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Telehealth/internet access is limited for seniors, underrepresented groups, and working poor
- Low-income, poverty, and unemployment
- High co-pays and deductibles
- Lack of trust
- Overall discrimination of the medical community toward minorities, LGBTQ+ groups
- Unavailable language services and bilingual staff
- Fear of COVID-19

"Why are People Treated Differently?"

- Race/ethnicity 50%
- Income 20%
- Not speaking English - 20%
- Insurance coverage 10%

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Affordability
- Lack of transportation
- No Insurance coverage
- Availability of services
- Lack of trust
- Cultural and language barriers

"What are the Barriers to a Quality Life?"

- Cost of health care/meds
- Difficulty getting around
- Economic disparities
- Lack of insurance
- Difficulty navigating health care system

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care?"

- Affordability
- No insurance coverage
- Lack of transportation
- Lack of health care coordination
- Language barriers

"What are the Barriers to a Quality Life?"

- High cost of health care/meds
- Economic disparities
- Lack of insurance coverage
- Availability/lack of transportation
- Difficulty getting around
- Difficulty navigating health care system

COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of affordable health care
- No Insurance/high co-pays
- Lack of affordable housing
- Lack of eldercare options

"What are the Most Important Health Issues?"

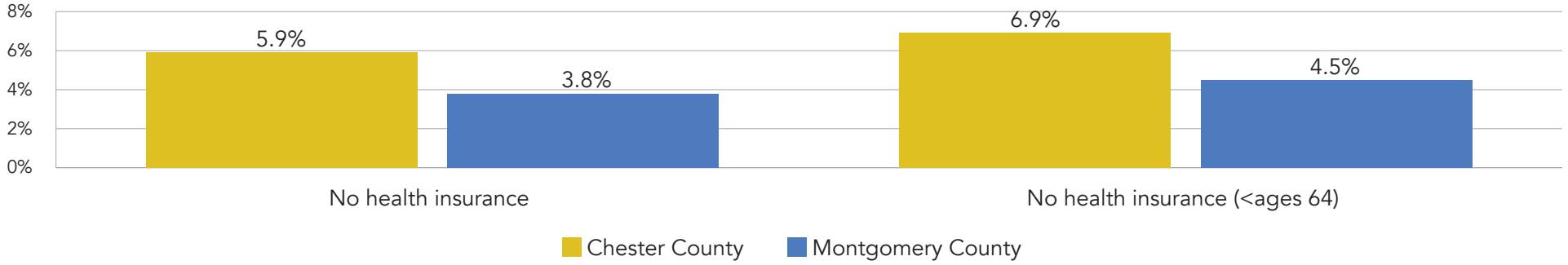
- Behavioral health/mental health
- Aging problems
- Drug/alcohol
- Cancers
- Diabetes

"What are the Barriers to a Quality Life?"

- Easy access to health care
- Low crime/safe neighborhoods
- Good schools
- Good jobs/healthy economy
- Clean environment
- Positive teen activities

Figure 8 shows the percentages of residents in Chester and Montgomery counties who have no health insurance coverage or coverage via Medicare. Over the last few CHNA cycles, we have seen the percentage of insured people steadily rise; however, efforts to improve access to care must continue.

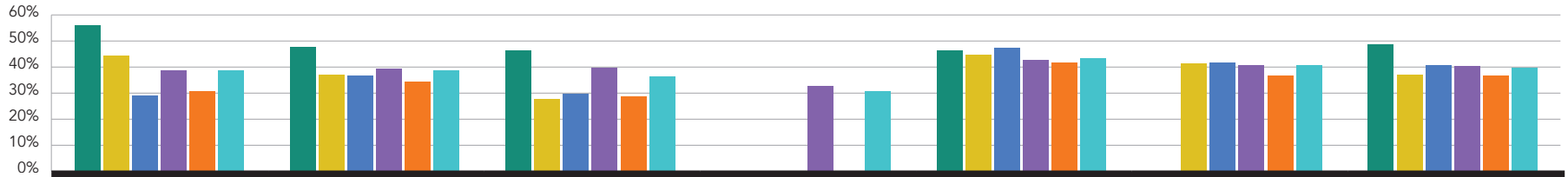
Figure 8: Percentage of Population with No Health Insurance Coverage



Source: The Agency for Healthcare Research and Quality (AHRQ) 2018

The PA Health Equity Analysis Tool (HEAT) provides a geographic perspective at the granular level to areas that have opportunities to improve equity.[5] The below figure depicts ZIP codes within Phoenixville Hospital's service area related to adults who obtain primary care visits.

Figure 9: Percentage of Adults with Primary Care Physician Visits by ZIP Code Summary



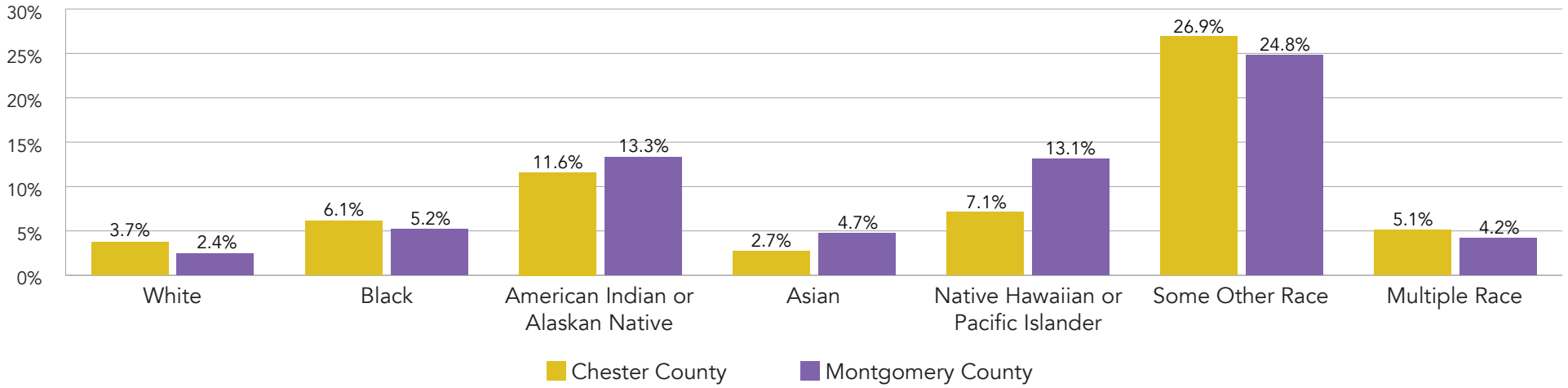
	19460	19403	19426	19442	19464	19465	19468
Asian	55.9	47.8	46.5	--	46.5	--	48.6
Black	44.5	**37.0**	**27.6**	--	44.6	41.5	**37.0**
Hispanic	**29.0**	**36.9**	**29.7**	--	47.5	41.8	40.6
White	**38.8**	39.3	39.8	32.9	**42.8**	40.9	40.3
Other Race	**30.7**	**34.3**	**28.7**	--	**41.8**	**36.9**	**36.9**
All Adults	**38.9**	**38.7**	**36.3**	**30.6**	**43.3**	**40.6**	**39.8**

Note: No data was available for ZIP codes 19453 and 19475. The figures bolded in red indicate low percentages of adults with primary care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.
Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[5] The Department of Human Services (DHS) in collaboration with the Department of Health (DOH) has launched the PA Health Equity Analysis Tool (HEAT). The PA HEAT dashboard is designed to illustrate variation in a variety of health and social determinants of health indicators at the regional, county, ZIP code, and census tract levels.

Although the percentage of uninsured has increased over the past several years, Figure 10 shows more uninsured Blacks, Native Americans or Alaska Natives, Native Hawaiians or Pacific Islanders, and residents of multiple races as compared to whites. The Healthy People 2030 target is to increase the portion of the population covered by health insurance to 92.1% overall. As of 2018, 89.0% of the population under 65 years had medical insurance.

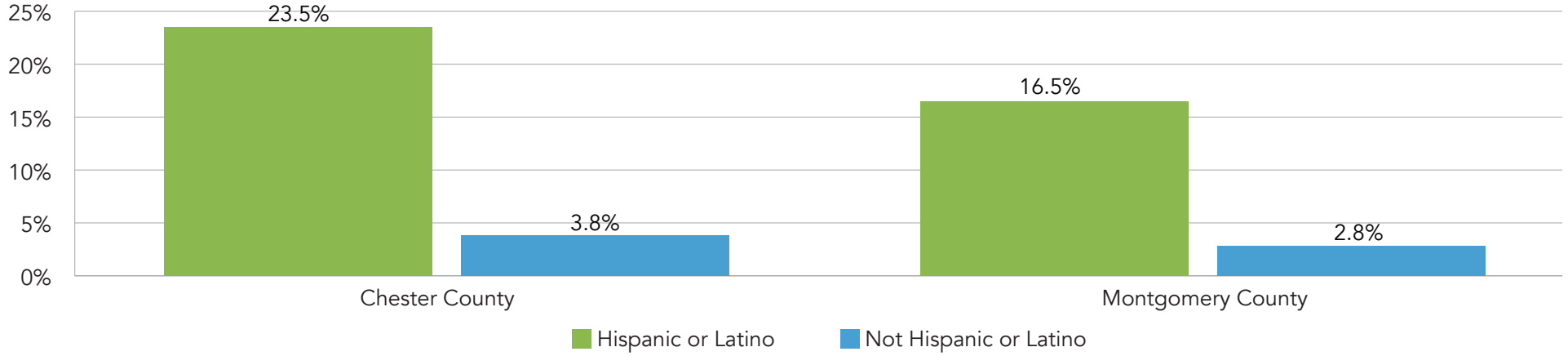
Figure 10: Percentage of Uninsured Population by Race



Source: U.S. Census Bureau, American Community Survey 2019

Figure 11 shows higher uninsured Hispanic or Latinos in the counties.

Figure 11: Percentage of Uninsured Population by Ethnicity

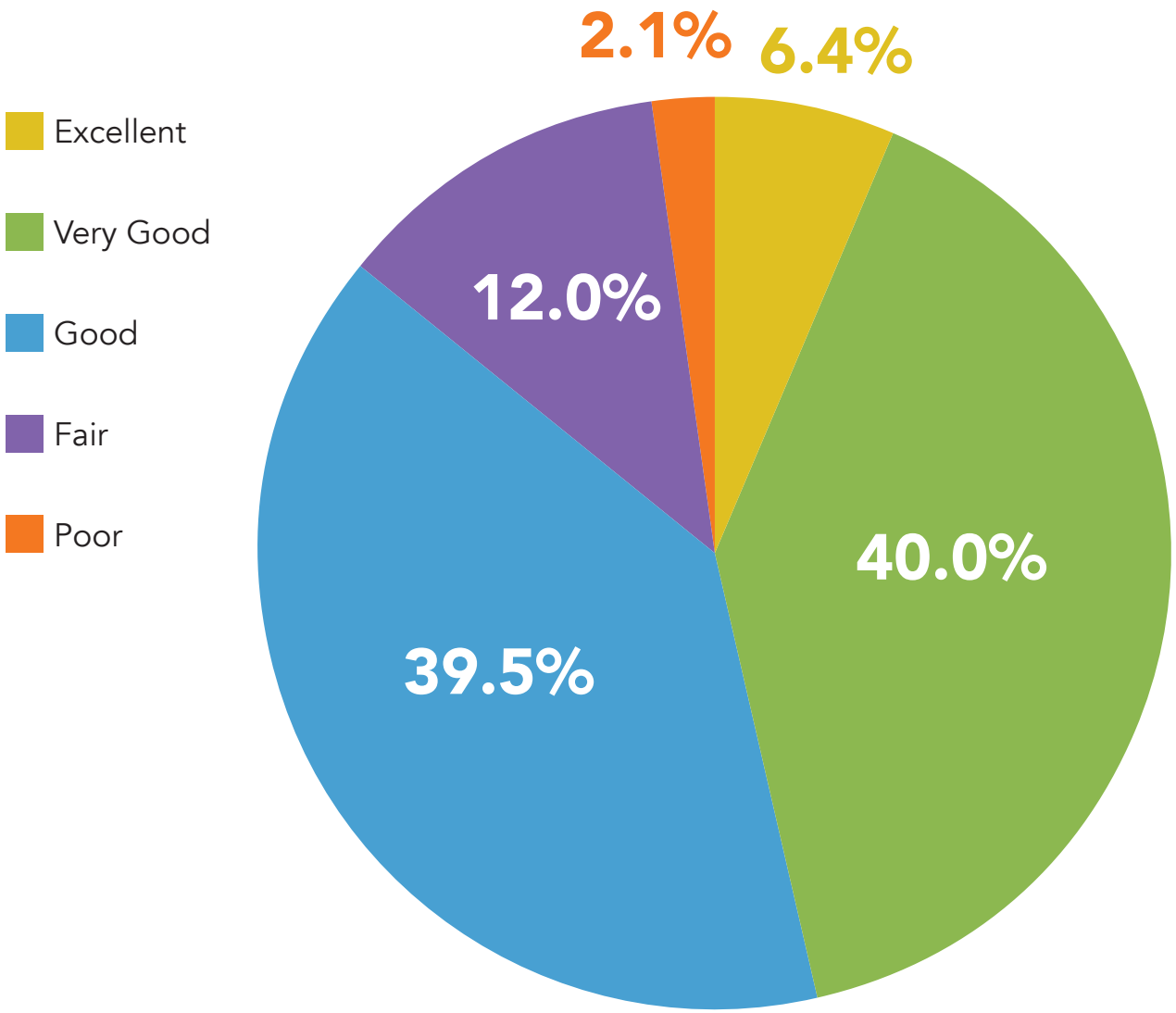


Source: U.S. Census Bureau, American Community Survey 2019

When community residents were asked to rate their health status, 85.9% (n=374) of survey respondents stated good, very good, or excellent health (Figure 12).

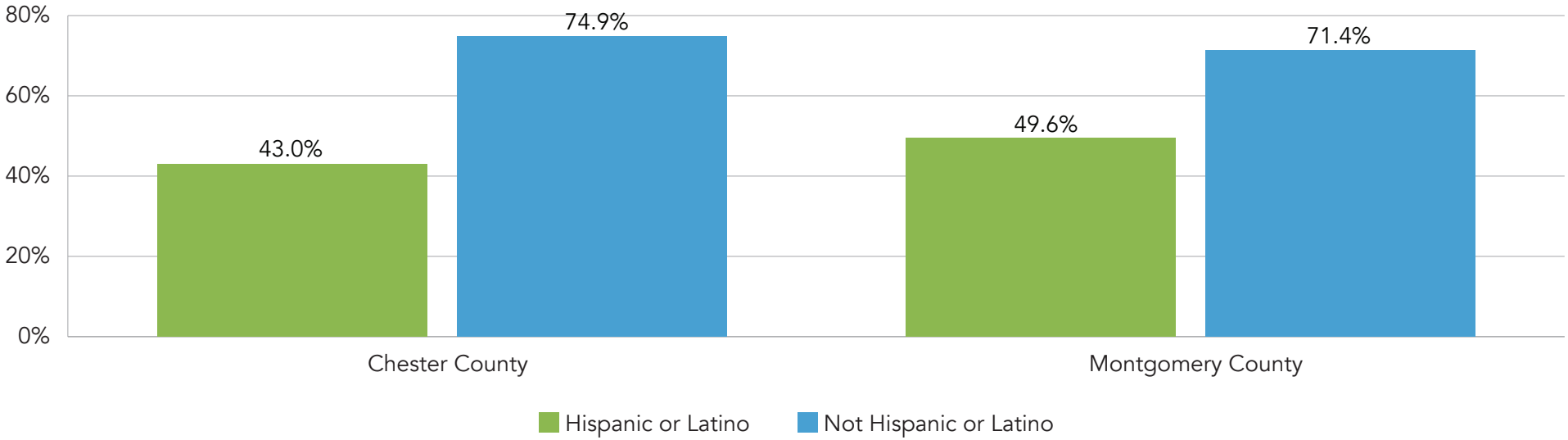
56.7% (n=242) noted the need for blood pressure screenings and 47.3% (n=202) cited the need for cholesterol screenings to keep themselves and their families healthy.

Figure 12: Description of Overall Health



Economic status and income are strongly associated with morbidity and mortality. Income directly influences health and longevity and may perpetuate or exacerbate health disparities. Income inequality has grown substantially over recent decades.

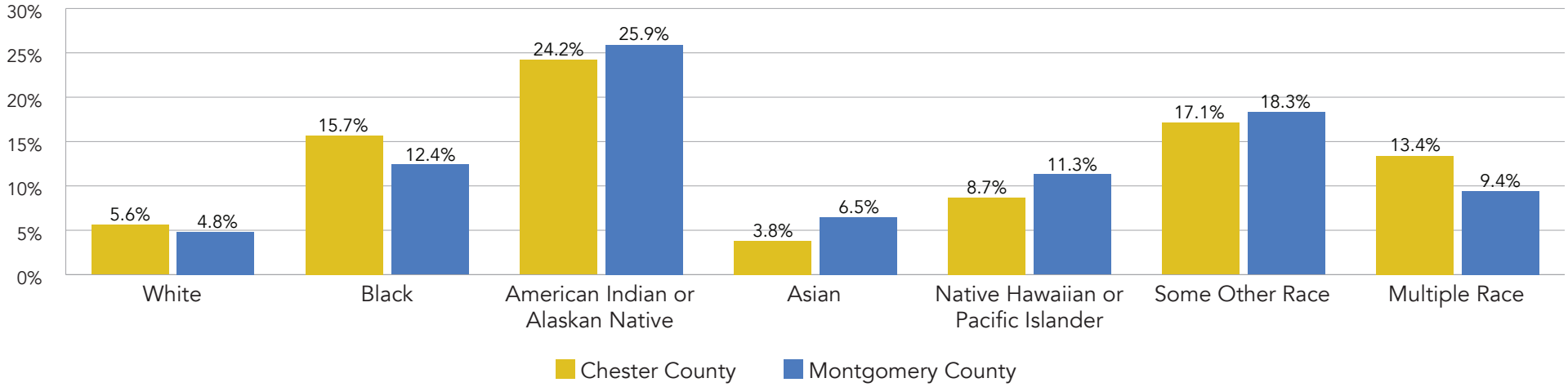
Figure 13: Families Earning More Than $75,000 by Ethnicity



Source: U.S. Census Bureau, American Community Survey 2019

Figure 14 reports the percentage of the population that is below 100% of the federal poverty line (FPL) by race.[6] The Healthy People 2030 target is to reduce the proportion of people living in poverty to 8.0%. In 2018, 11.8% of people lived below the poverty threshold.

Figure 14: Population Below 100% FPL by Race

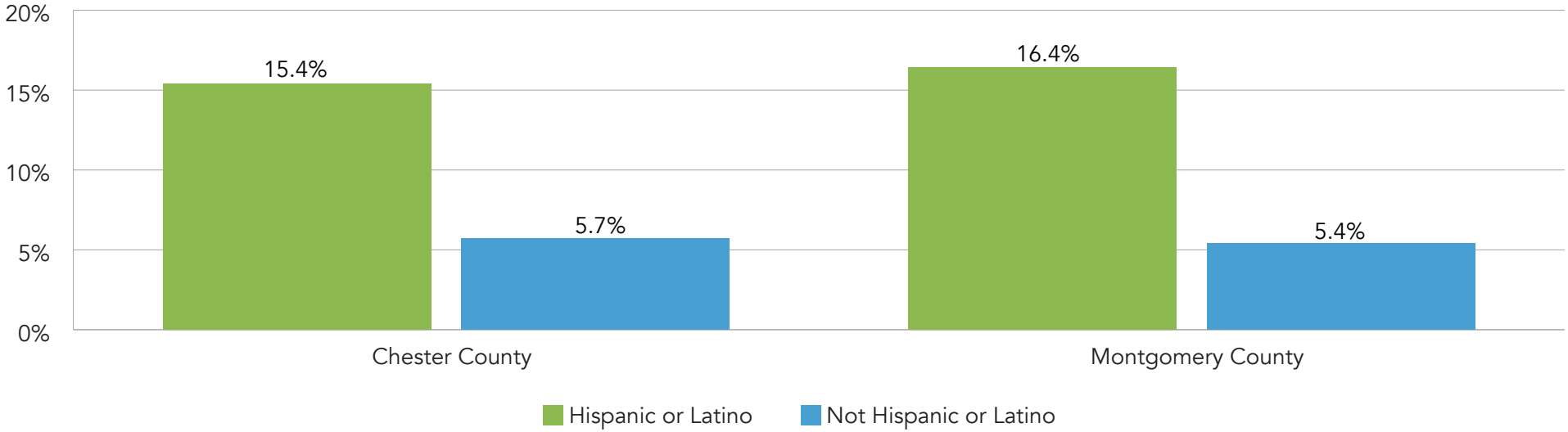


Source: U.S. Census Bureau, American Community Survey 2019

[6] Federal poverty levels (FPL) are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage. For a family or household of four living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2021 is $26,500.

Figure 15 reports the percentage of the population below 100% of the federal poverty line by ethnicity.

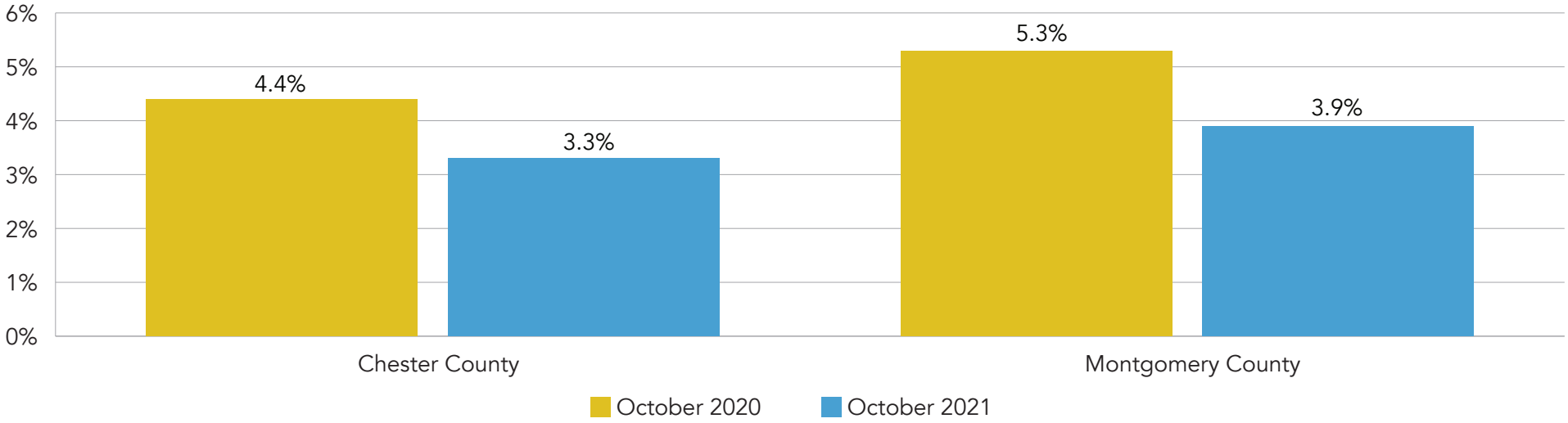
Figure 15: Population Below 100% FPL by Ethnicity



Source: U.S. Census Bureau, American Community Survey 2019

Figure 16 illustrates the unemployment rate in Chester and Montgomery counties.

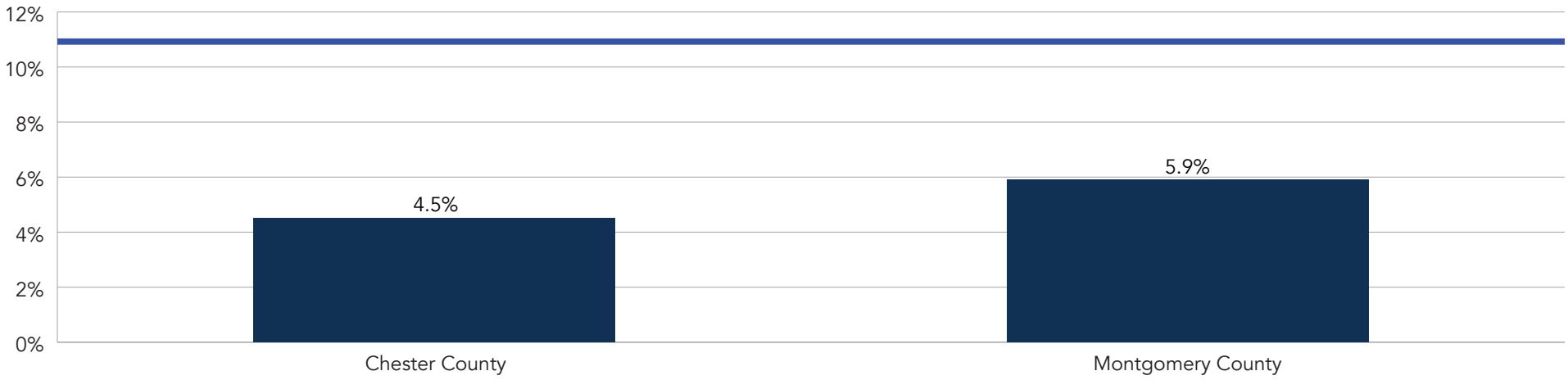
Figure 16: Unemployment Rates



Source: U.S. Census Bureau, American Community Survey 2019

Figure 17 shows a higher rate of Montgomery County residents not having a motor vehicle when compared to those in Chester for the years 2015-2019. Lack of reliable transportation can hinder one's ability to get to and from medical appointments, meetings, work, or things needed for daily living.

Figure 17: Households with No Motor Vehicle

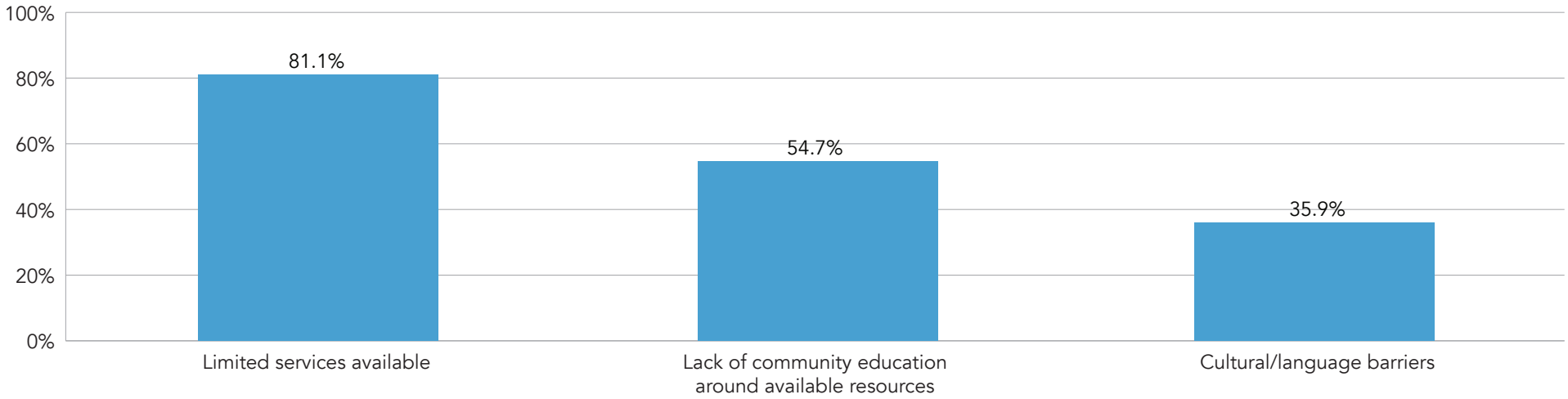


Note: The blue line indicates the rate in Pennsylvania of 10.9%

Source: U.S. Census Bureau, American Community Survey. 2015-19

When key informants for the CHNA were asked what contributes to the transportation issues in their community, the top three responses were limited services 81.1% (n=43), lack of community education around available resources 54.7% (n = 29), and cultural/ language barriers 35.9% (n=19).

Figure 18: Contributors to Transportation Issues in the Community (Top Three Responses)



When community residents for the CHNA were asked to select statements that best applied, the top five responses included: I received or plan to receive the COVID-19 shot, 84.9% (n=355); I receive the flu shot each year, 78.5% (n=328); I use sunscreen or protective clothing for a planned time in the sun, 62.0% (n=259); I exercise at least three times per week, 45.5% (n=190); and I eat at least five servings of fruits and vegetables each day 34.0% (n=142).

Figure 19: Self-Assessment Statements (Top Five)

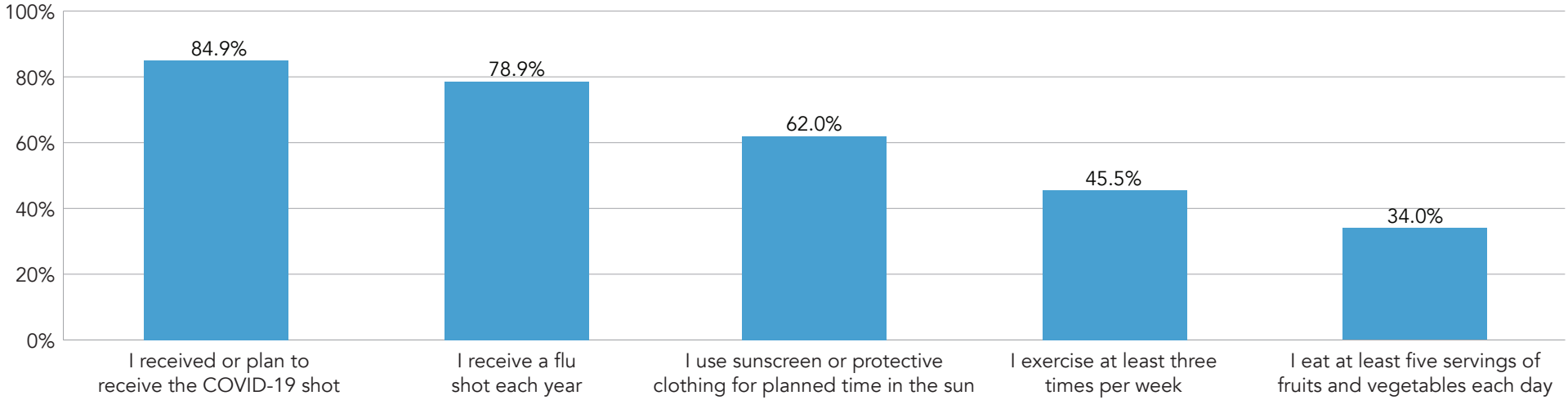
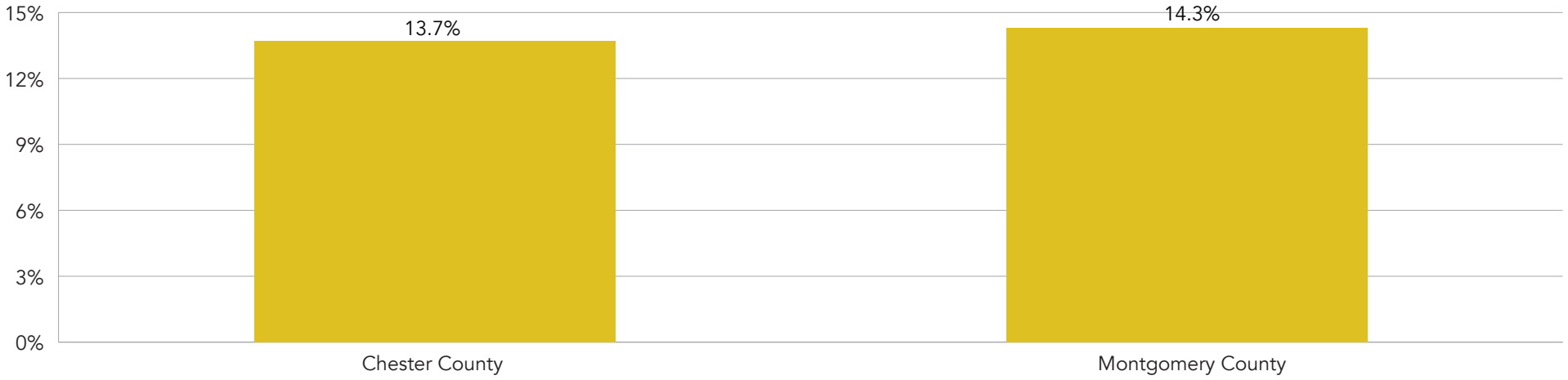


Figure 20 revealed the percentage of residents in Chester and Montgomery counties who reported their health as fair or poor.

Figure 20: Poor or Fair Health – Age-adjusted



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019

B) BEHAVIORAL HEALTH

During the COVID-19 pandemic, the need for access to behavioral health services became even more evident as a result of COVID mandates such as social distancing, wearing masks, mandatory lockdowns, and isolation. Mental health issues and drug and alcohol use have increased significantly as employers and employees worried about the suspension of productive activity, loss of income, and an ever-present "fear of the future" (National Institutes of Health). The impact of COVID-19 on the workplace further resulted in mental health issues such as anxiety, depression, post-traumatic stress disorder (PTSD), and sleep disorders. This impact was especially noted among health care workers, especially those on the front line; migrant workers; and workers in contact with the public.

Phoenixville's CHNA focus groups, stakeholders, key informants, and survey respondents reported "improving access and availability of behavioral health and mental health services and programs" as having a great impact on the overall health of their surrounding communities and a high priority for improving health status.

Figure 21 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 21: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Lack of access/inadequate behavioral health/mental health services

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care?"

- Lack of behavioral health/mental health services
- Substance abuse (drug/alcohol use)

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Limited access to behavioral health/mental health services
- Substance abuse (drug/alcohol use)
- Lack of coordination of health services

COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

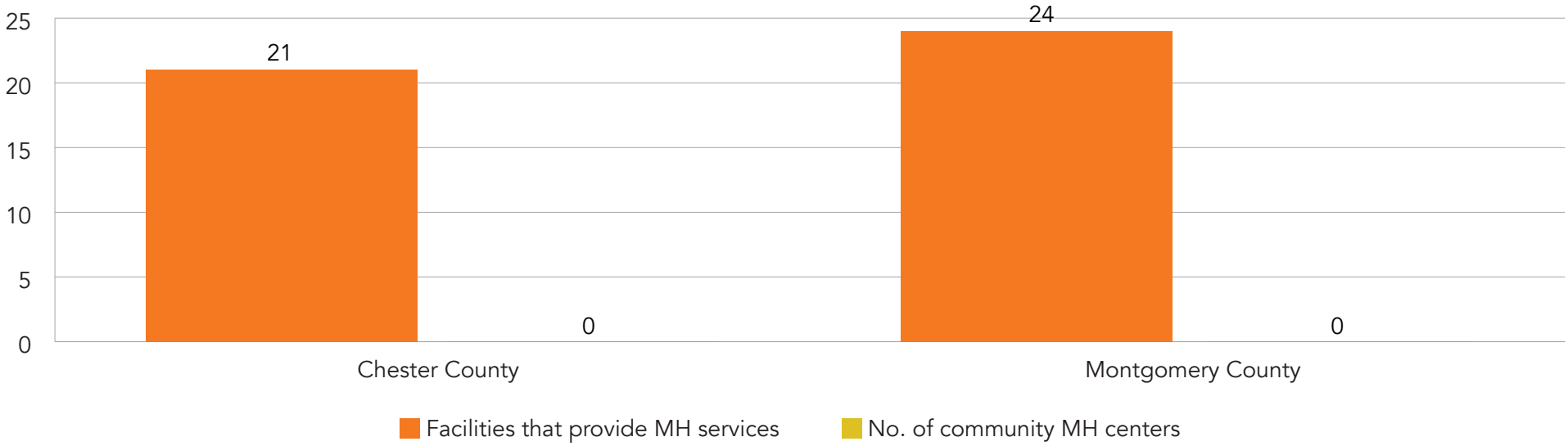
- Inadequate behavioral health/mental health services
- Lack of access to drug/alcohol services
- Lack of access to healthy foods

Figure 22 illustrates the number of facilities that provide mental health services and the number of community mental health centers in Chester County and Montgomery County.

Community mental health centers (CMHC) fill the need for mental health treatment and services throughout the country. CMHCs are community-based organizations providing mental health services, sometimes as an alternative to the care that mental hospitals provide. CMHC represents a basic change in social acceptance and attitudes related to mental health. CMHCs were designed to move mental health care from the traditional hospital or state "custodial" care to the community, where holistic programs, family-centered care, and therapeutic services enhance recovery and restoration.

Community mental health facilities are specific to mental health illnesses. Children, adults, and individuals who are chronically mentally ill or have been discharged from an inpatient mental health facility can be treated at a community mental health center.

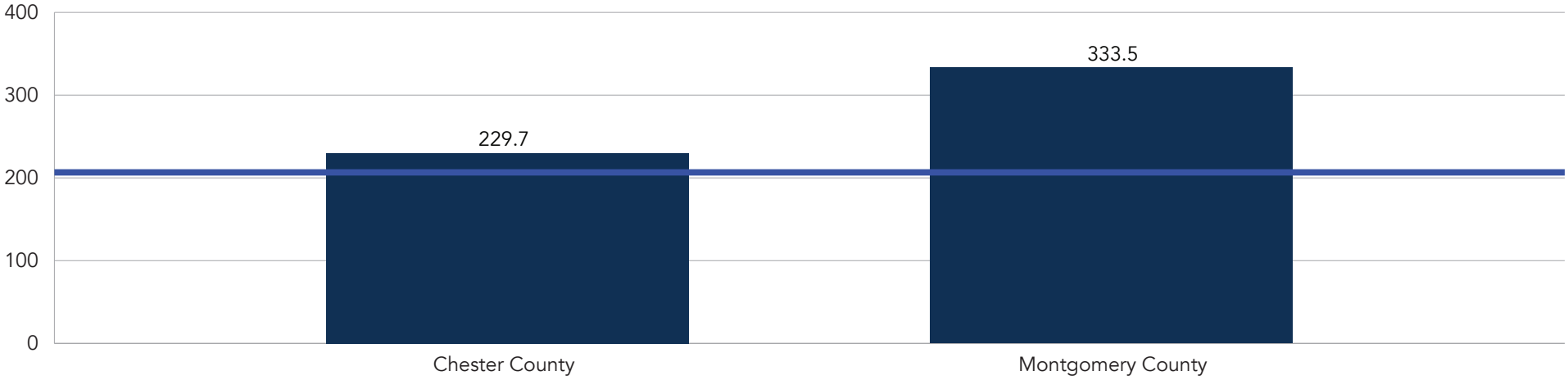
Figure 22: Mental Health Facilities and Centers



Source: The Agency for Healthcare Research and Quality (AHRQ) 2018

Figure 23 illustrates the number of mental health providers (per 100,000 population) in Chester and Montgomery counties.

Figure 23: Mental Health Providers



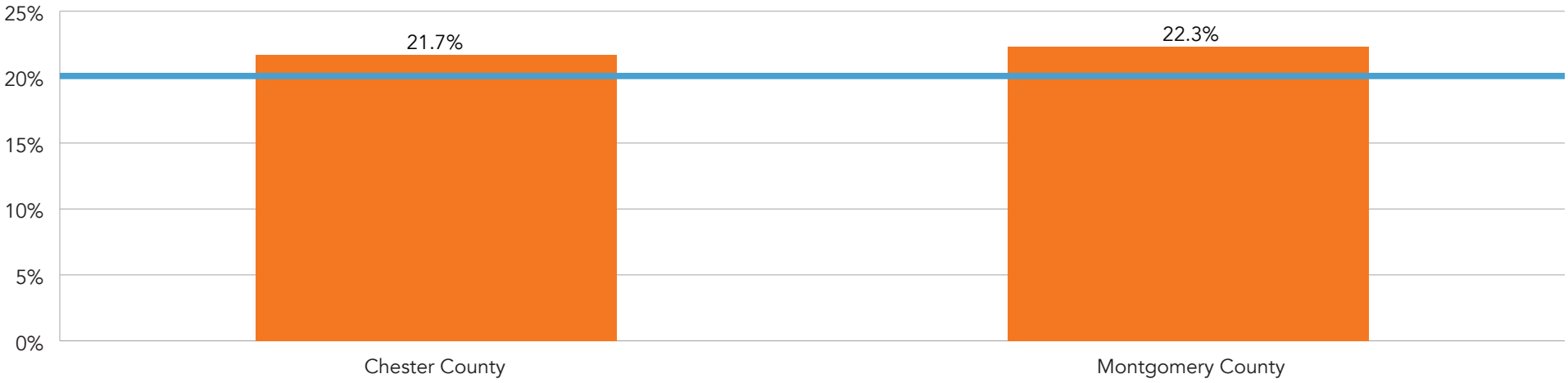
Note: The blue line indicates Pennsylvania at 206.5.

Source: County Health Rankings & Roadmaps 2019

Alcohol and tobacco use are root causes and can exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk when compared to the United States. When analyzing alcohol consumption, rates are worse or the same in Chester County and Montgomery County when compared to the state. Heavy drinking is defined as having more than two drinks per day for men and more than one per day for women, over the past 30 days.

Figure 24 illustrates the percentage of adults who are heavy drinkers in Chester and Montgomery counties.

Figure 24: Alcohol Consumption (18 years and older who are heavy drinkers)

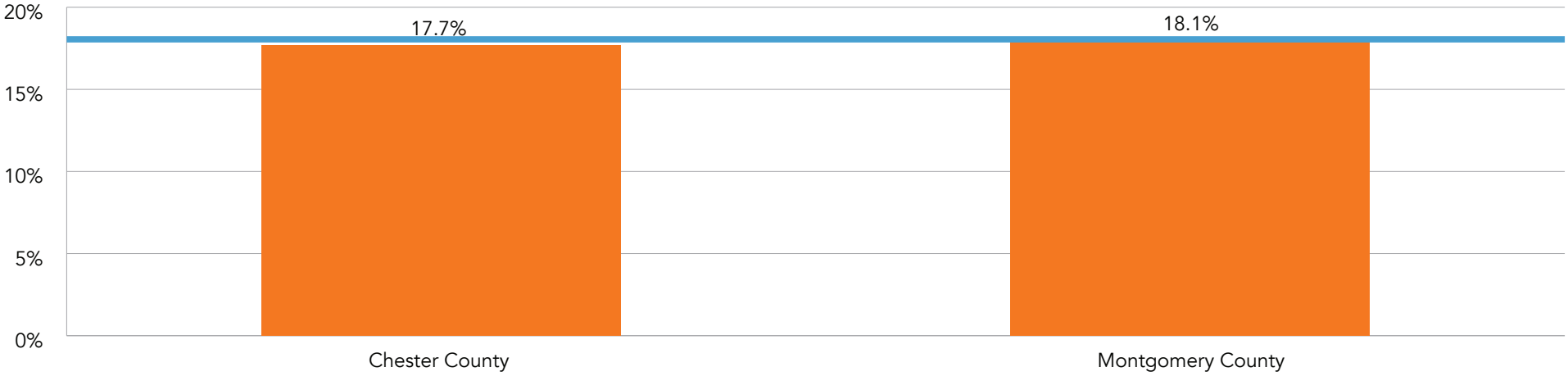


Note: The blue line indicates Pennsylvania at 20.2%.

Source: County Health Rankings & Roadmaps 2018

Figure 25 illustrates the percentage of adults who are binge drinkers in Chester and Montgomery counties. A binge drinker is an adult age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Figure 25: Alcohol Consumption (18 years and Older Who Are Binge Drinkers)

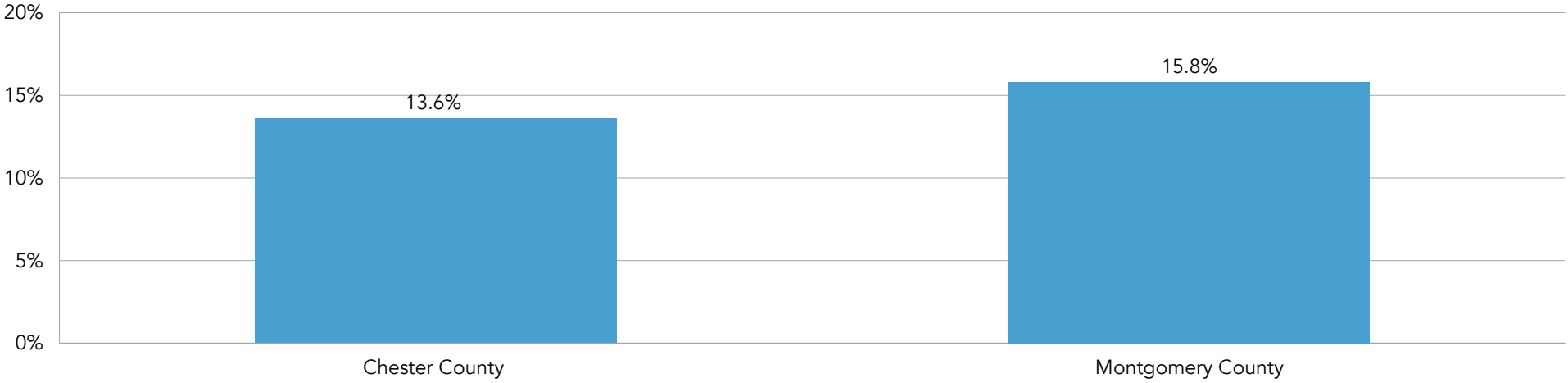


Note: The blue line indicates Pennsylvania at 18.1%.

Source: CDC, Behavioral Risk Factor Surveillance System 2018

Figure 26 shows adults 18 and older who smoke every day or some days in Chester and Montgomery counties. Smokers are adults aged 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

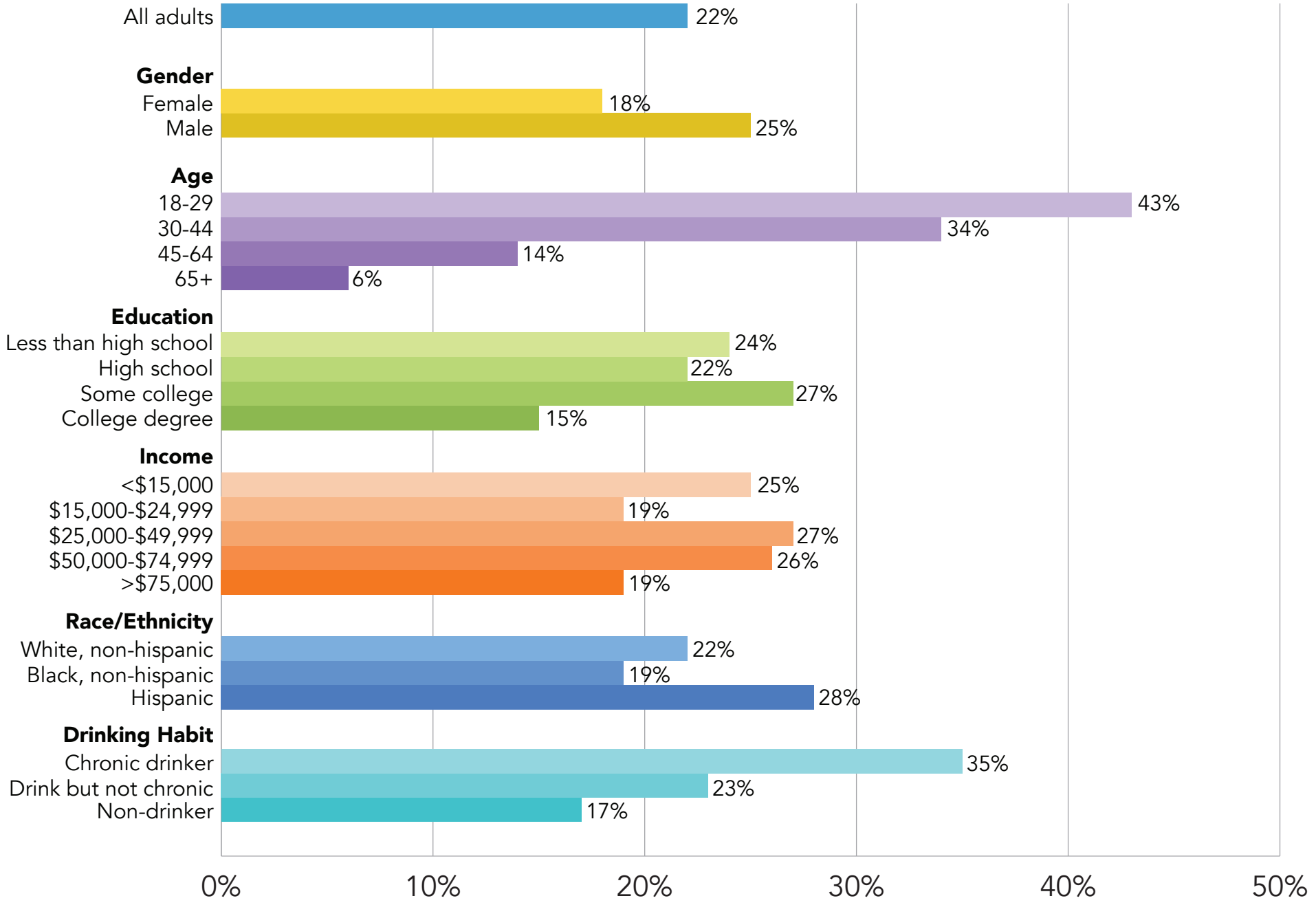
Figure 26: Tobacco Usage — Current Smokers



Source: CDC, Behavioral Risk Factor Surveillance System 2018

Figure 27 shows Pennsylvanians who ever used an e-cigarette or electronic product.

Figure 27: Residents who have ever used an e-cigarette or other electronic vaping product, 2020

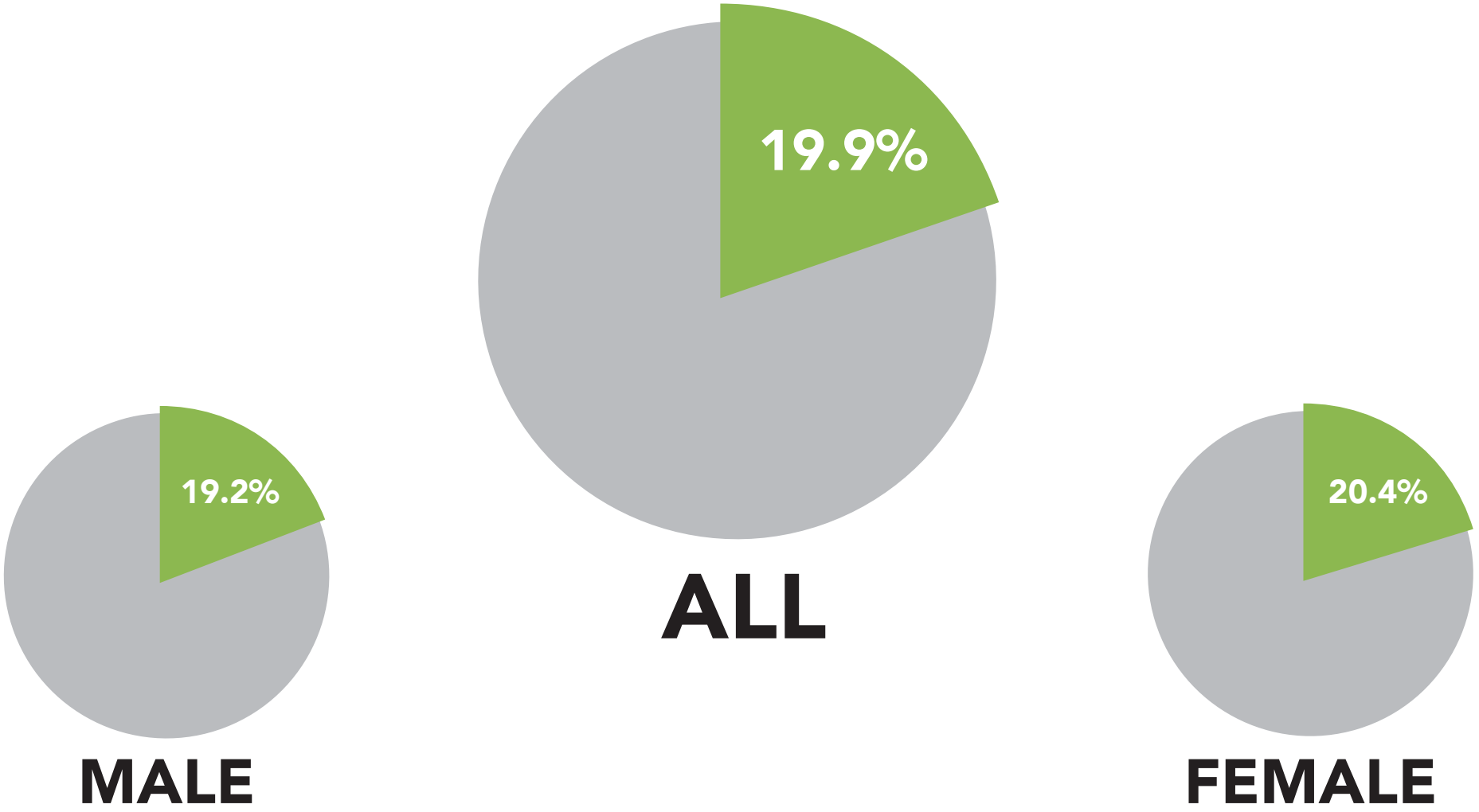


Source: Pennsylvania Department of Health, 2020

Data shows that more than 700,000 high school students are current smokers. Additional information from the CDC shows that 23.6% of high school students reported current use of any tobacco product (cigarettes, electronic cigarettes, cigars, smokeless tobacco, hookah, pipe tobacco, and/or bidis). Figures show that E-cigarettes are the most popular tobacco product among youth as 19.6 % of high school students report current e-cigarette use.

Figure 28 shows the percent of Pennsylvania students using tobacco in grades 6-12.

Figure 28: Tobacco use in Grades 6-12, 2019



Source: Pennsylvania Department of Health, 2019

C) HEALTH EDUCATION AND PREVENTION

Health education programs help people better understand how to manage an existing health condition and how to prevent further illness which is paramount to good health. Phoenixville Hospital's community education and disease prevention programs are designed to engage and empower individuals and communities to practice healthy behaviors that reduce the risk of developing chronic diseases and to improve management for chronic diseases such as heart disease, diabetes, and high blood pressure. According to WHO, "health education enables people to increase control over their own health."

The Phoenixville CHNA process revealed the need for understanding cultural and language barriers to improving health and the need to promote healthy lifestyles and practices. Health education and health literacy empower individuals to make informed health decisions and help them effectively navigate today's complex health care delivery system. Through health education, patients and families can successfully implement treatment plans, manage chronic conditions, and prevent complications and/or hospitalizations. By improving health literacy and education to the broad community, the health organization's paradigm shifts from treating disease to a focus on wellness, healthy behaviors, and positive health outcomes.

Figure 29 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 29: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Health literacy
- Preventive screenings (i.e., mammograms and checkups)
- Language barriers
- Cultural competency

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of health education/literacy
- Language barriers
- Poor/unhealthy eating habits
- Tobacco use
- Lack of exercise/physical activity
- Lack of education

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of health education and literacy
- Cultural/language barriers
- Lack of knowledge on available services
- Poor/unhealthy eating habits
- Lack of exercise/physical activity

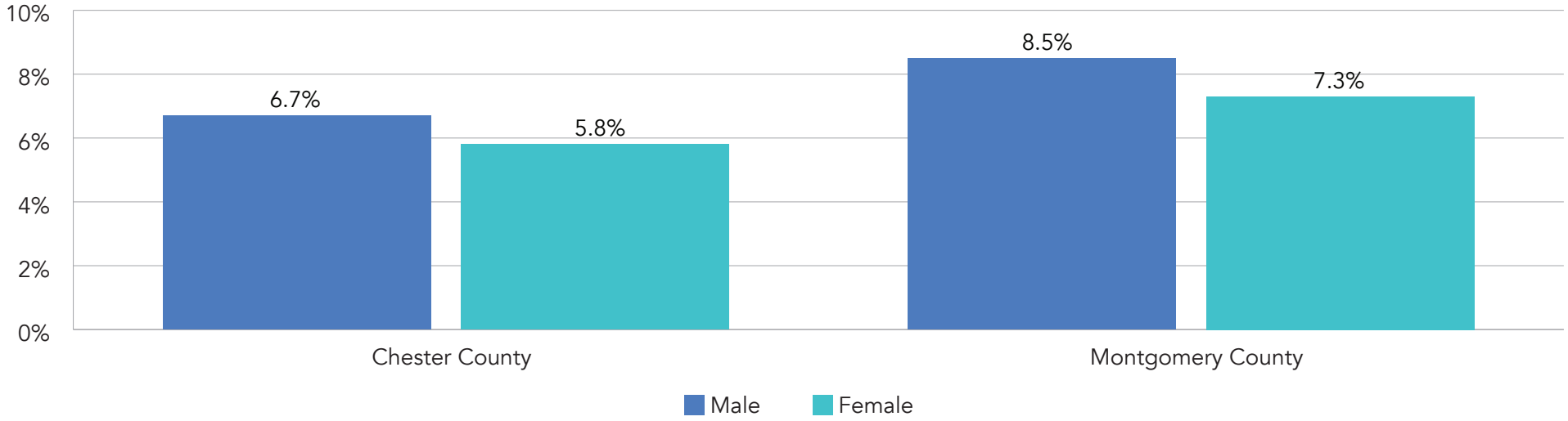
COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of health education
- Cultural/language barriers
- Lack of knowledge where/how to access services
- Lack of exercise/overweight and obesity

Figure 30 shows the percentage of adults aged 20 and older, by gender, who have been told by a doctor that they have diabetes.

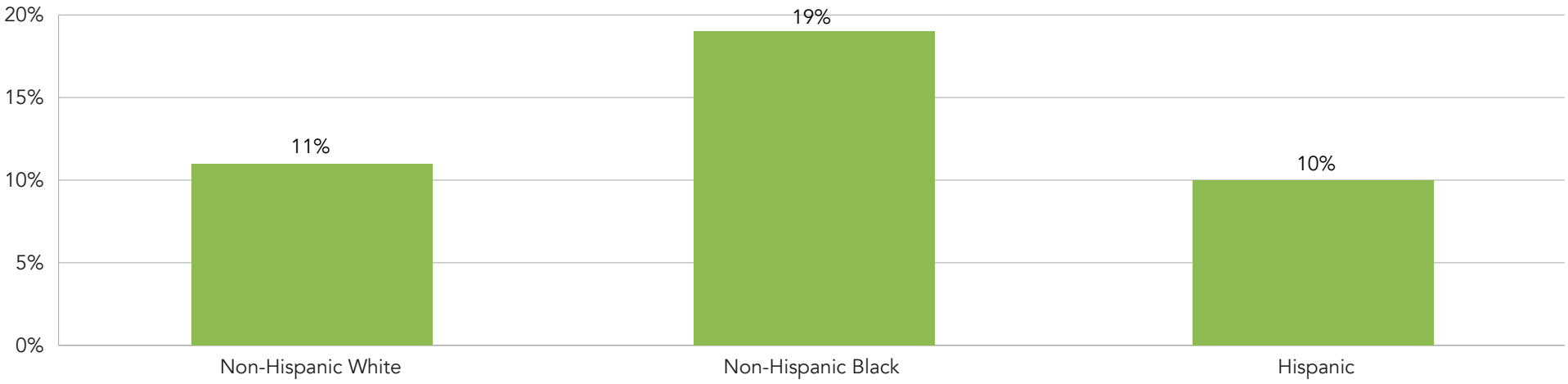
Figure 30: Diabetes by Gender



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion 2019.

Figure 31 shows the percentage of adults by race and ethnicity who have been told by a doctor that they have diabetes.

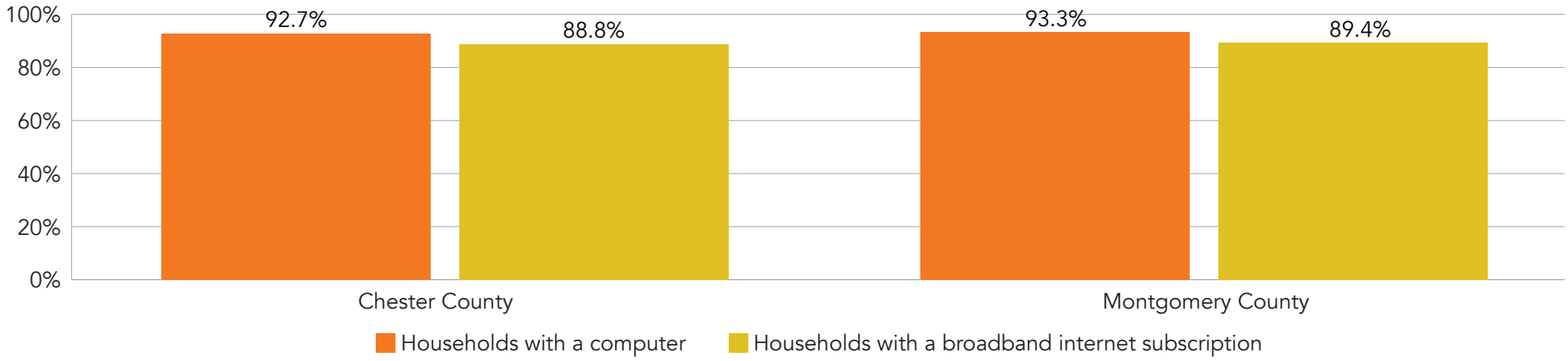
Figure 31: Diabetes by Race/Ethnicity



Source: Pennsylvania Department of Health BRFSS

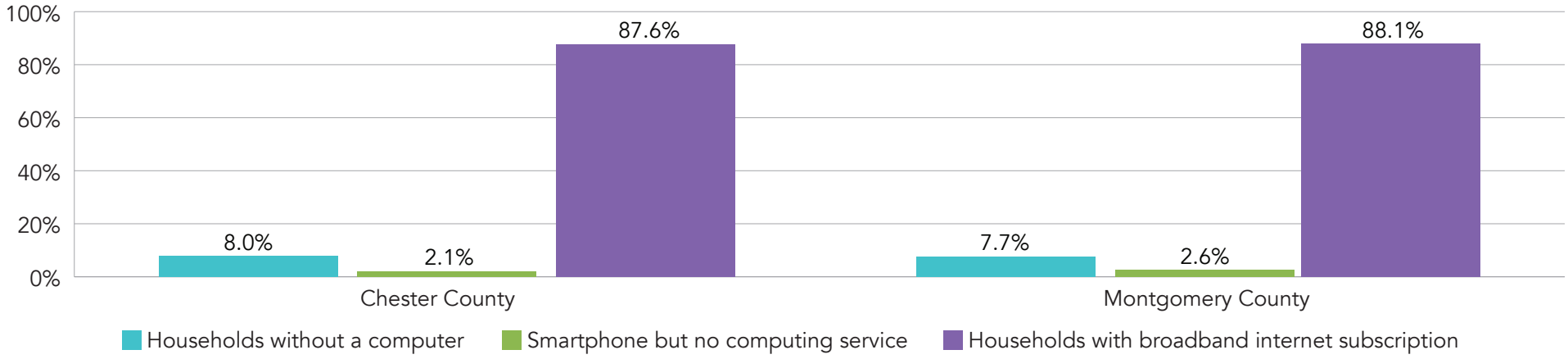
Figure 32 illustrates the percentage of residents in Chester and Montgomery counties with a computing device or internet service. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet as a means of reaching targeted audiences. This avenue allows underserved or disenfranchised populations access to health education.

Figure 32: Percentage of Households with Computer or Internet



Source: U.S. Census Bureau 2019

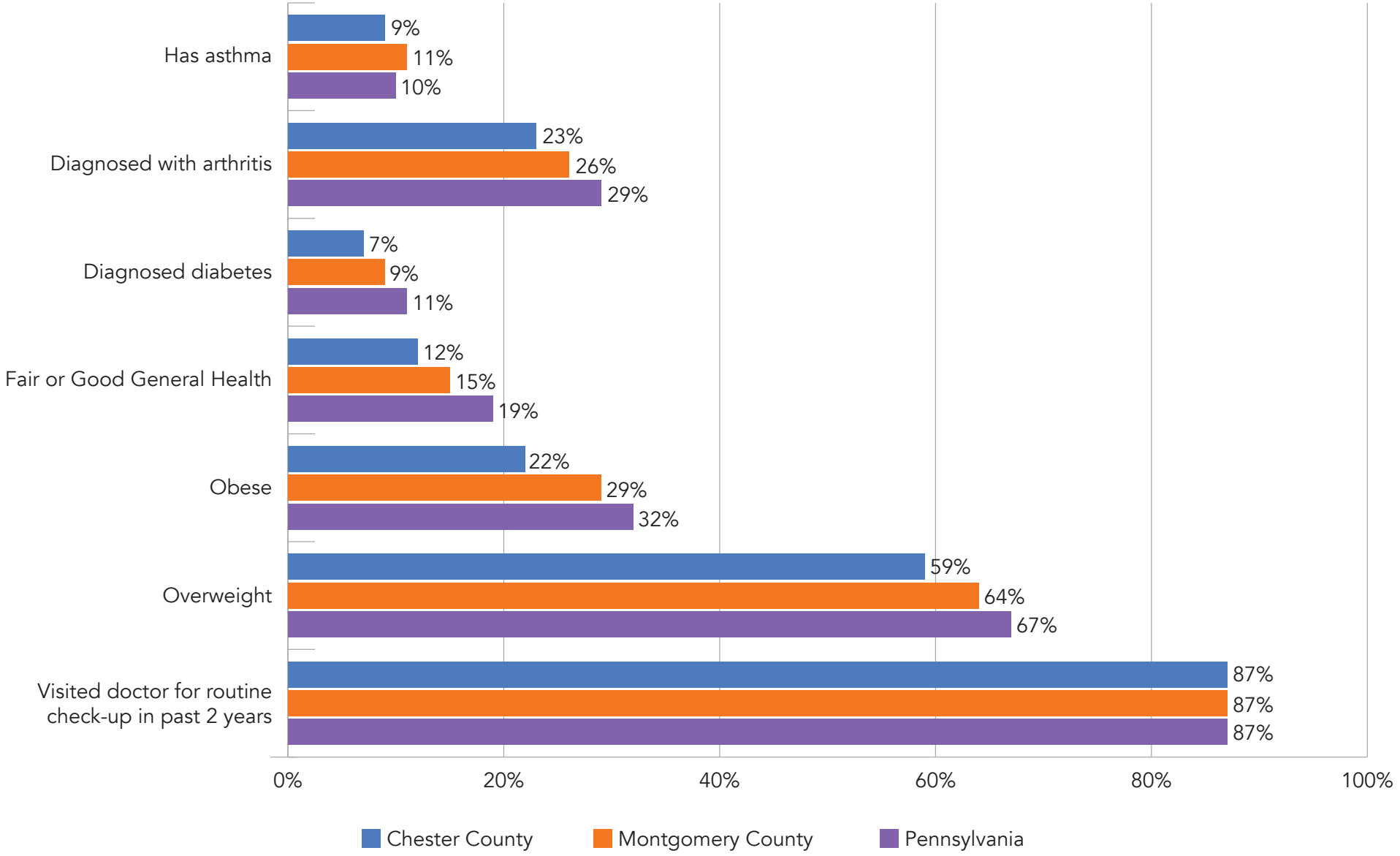
Figure 33: Percentage of Households with Limited Technology



Source: The Agency for Healthcare Research and Quality (AHRQ) 2018

Figure 34 shows adult health risk behaviors, health outcomes, and general health in Chester and Montgomery counties and Pennsylvania. Specifically, the graph depicts that the asthma rate of individuals in Montgomery County has exceeded the state rate.

Figure 34: Overall Adult Health Risks



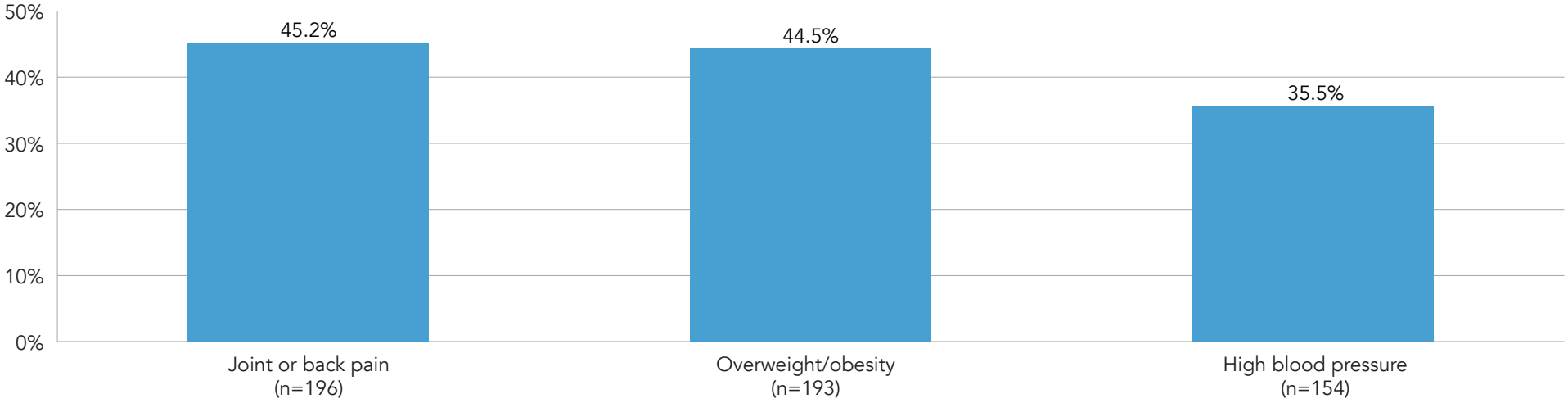
Source: Pennsylvania Department of Health 2017-2019

The USDA refers to food insecurity as the lack of access (periodically) to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. Lack of access to healthy foods impacts chronic diseases such as obesity/ overweight, diabetes, and high blood pressure.

Source: Feeding America 2019

Community health respondents in the Phoenixville service area, when asked about the top challenges faced, reported joint or back pain, overweight/obesity, and high blood pressure.

Figure 35: Top Three Challenges Faced



SM SNAP Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP)[7] reported the following in Berks, Chester, and Montgomery counties:

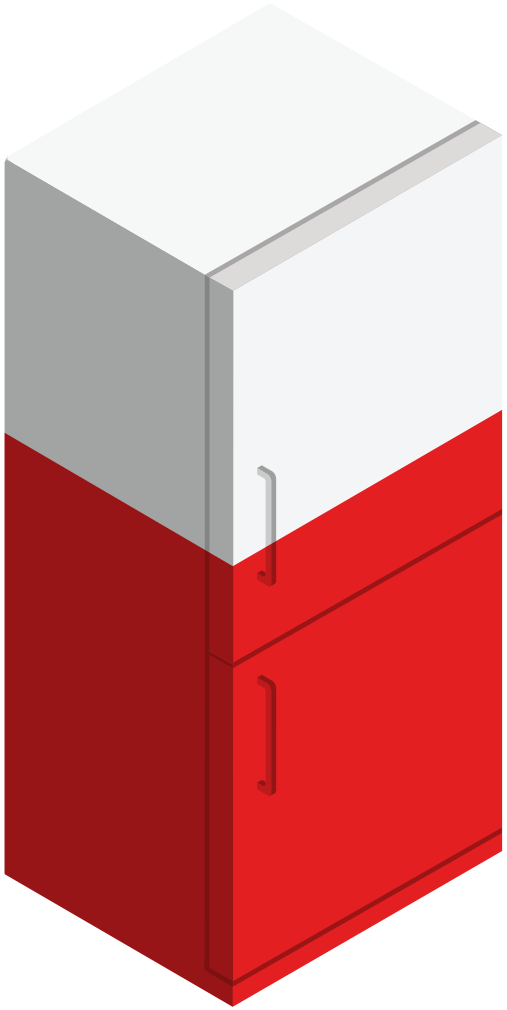
- 24,141 Chester County residents received $2,841,501 in SNAP benefits and 50,742 Montgomery County residents received $6,201,417 in SNAP benefits to help make ends meet in December 2018.
- Low-income SNAP participants spend $1,400, or nearly 25%, less in annual medical costs than low-income adults who don't participate in SNAP.
- SNAP boosts wages for workers who do not earn enough to afford a basic diet and helps those who are between jobs while they search for work.

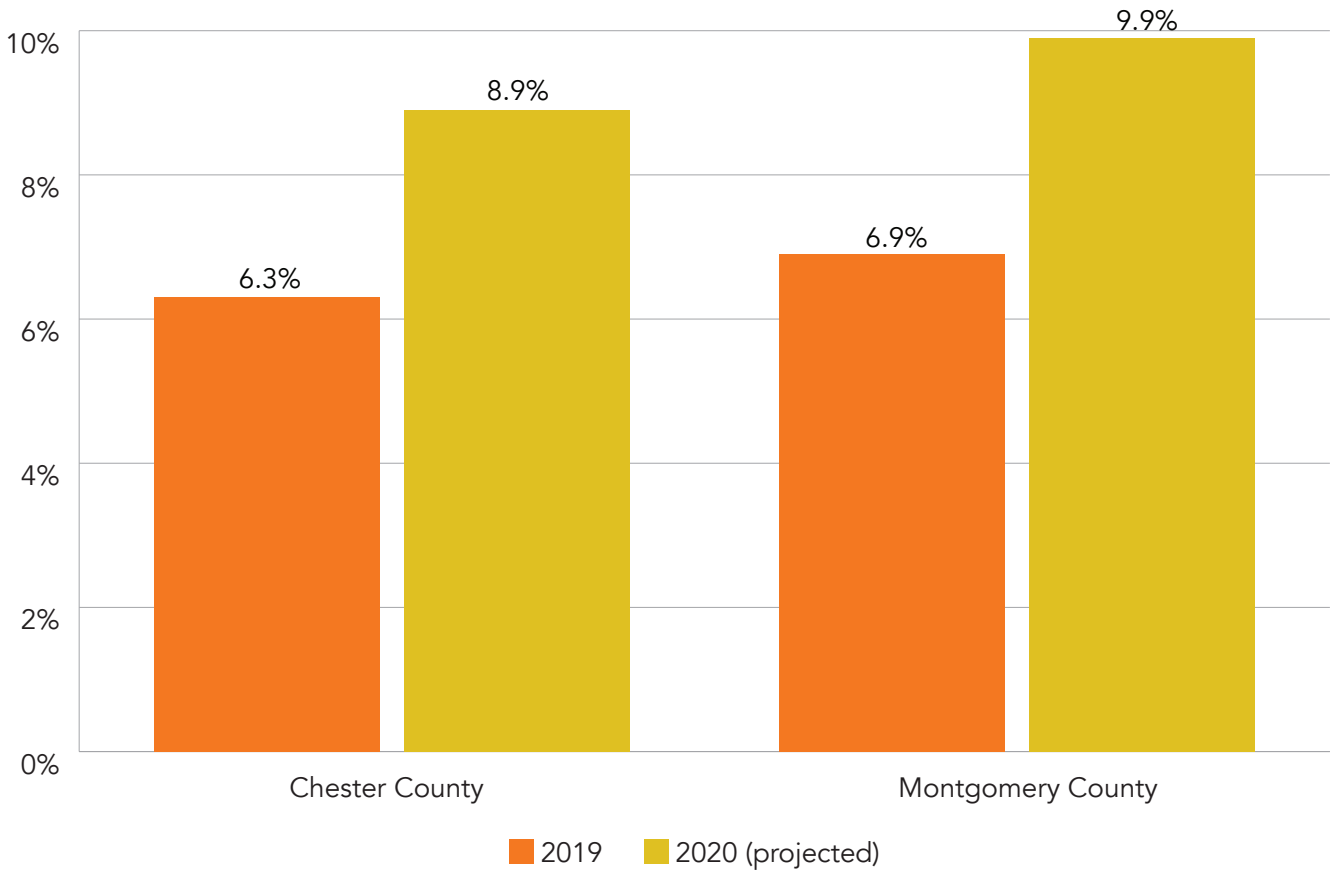
Source: Coalition Against Hunger 2018

[7] SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move toward self-sufficiency.

COVID-19 AND THE IMPACT ON FOOD INSECURITY

In early 2020, COVID-19 spread across the United States, creating an economic recession. The pandemic has negatively impacted millions of people for the first time who are experiencing food insecurity along with those who experienced food insecurity before the COVID-19 crisis.



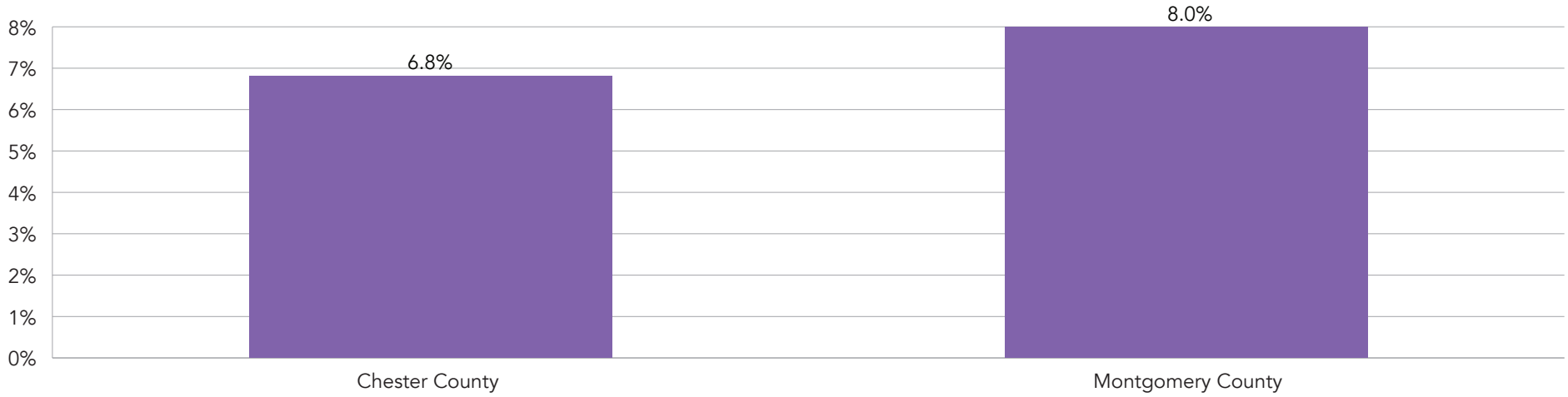


Source: Feeding America 2019

The Phoenixville Area Community Services (PACS) is a model for improving food security filling **45,000** requests for service. "Meeting the growing challenge to provide access to food, in collaboration with other food pantries and meal providers in the Phoenixville community, PACS serves clients with dignity, respect, and healthy, nutritious foods. The need for food has increased by nearly 100% due to the COVID-19 pandemic and PACS has successfully created a food secure community."

Mary Fuller,
Executive Director,
PACS

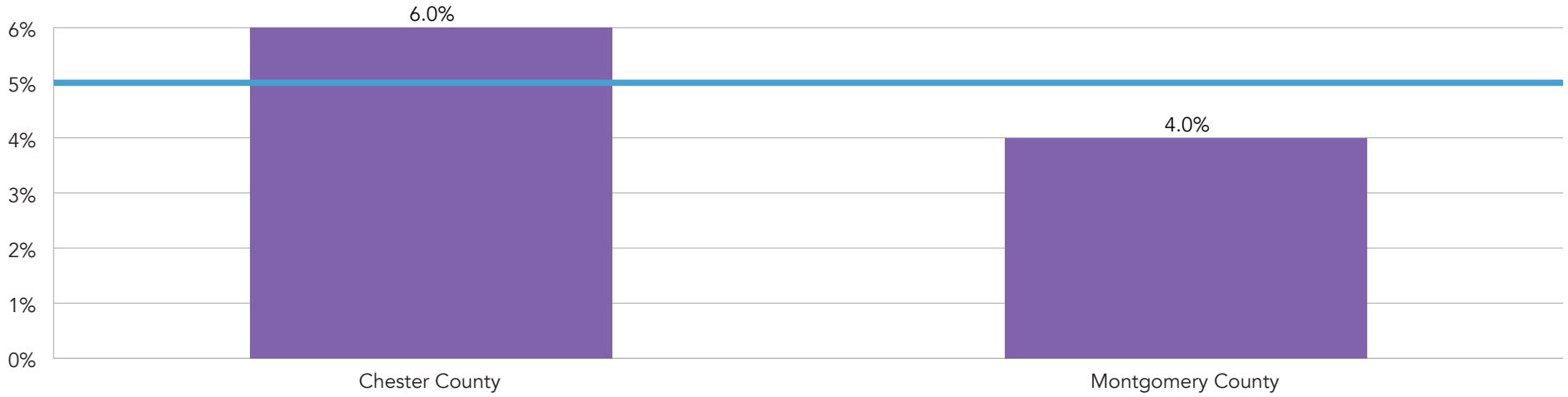
Figure 37: Child Food Insecurity



Source: Feeding America 2019

Figure 38 reports the percentage of the population who are low-income and do not live close to a grocery store.

Figure 38: Limited Access to Healthy Foods



Note: The blue line indicates the overall rate in Pennsylvania of 5.0%.

Source: County Health Rankings & Roadmaps 2015

Figure 39 from the community survey shows health behaviors for which people in the community need more information.

Figure 39: Top Health Behaviors for Which People Need More Information

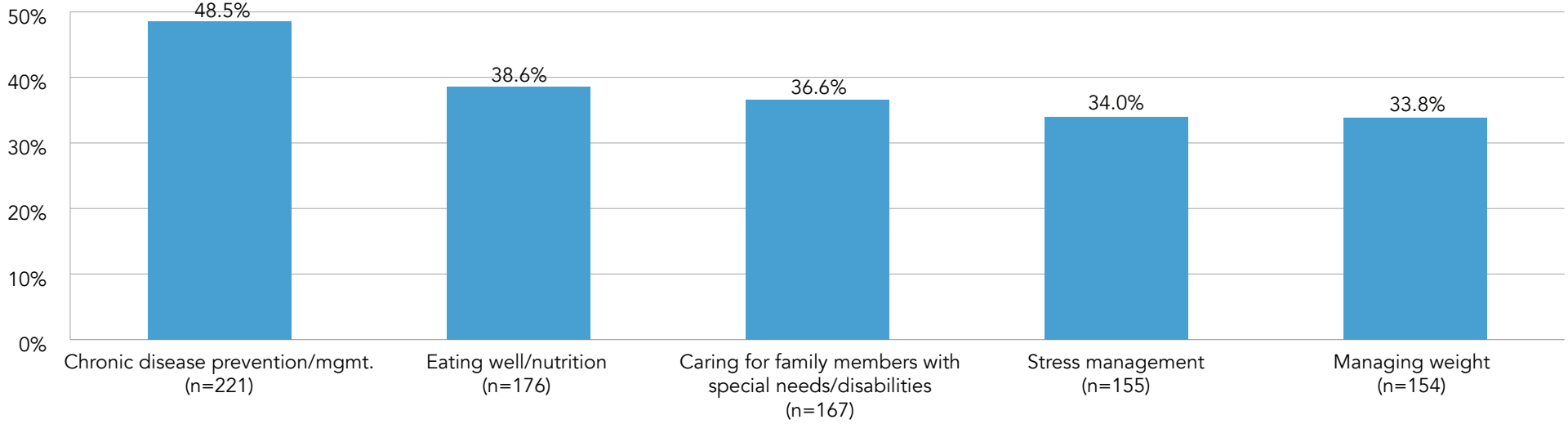
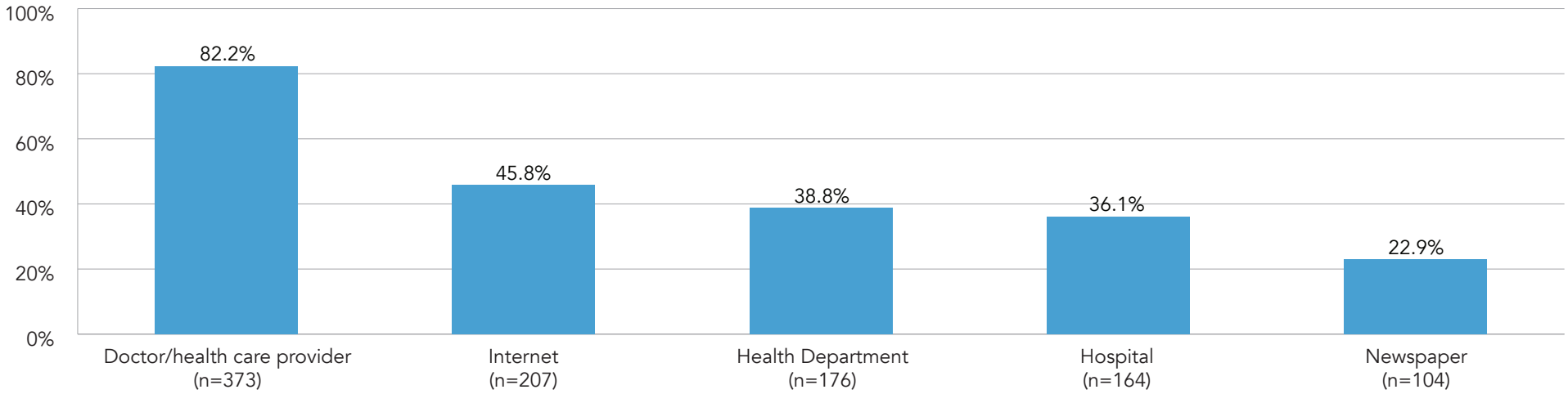


Figure 40 from the community survey reports how the community wants to receive health information.

Figure 40: Top Ways Community Wants to Receive Information



D) HEALTH EQUITY

Understanding and addressing the needs of diverse and disparate populations is a significant challenge for health care organizations. As a critical aspect of improving health equity and decreasing health disparities, there is a continued effort to enhance the provision of culturally competent and linguistically appropriate care to a very diverse service area as defined by racial and ethnic communities with various cultural beliefs and perceptions, health practices, and behaviors as well as a distrust of the health delivery system.

When assessing the diverse and disparate population, many SDOH and barriers to health care access and services were uncovered. Barriers such as a lack of transportation, inadequacy of language and interpretation services, lack of insurance coverage, and cultural bias and discrimination, to name a few, have a very dramatic impact on the capacity to provide quality health care and the quality of life for Phoenixville Hospital's communities. Interventions that improve health equity and reduce disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently.

SYSTEM POLICIES

Health equity is impacted by policies and systems that serve as barriers to equitable care. These policies and systems may favor one group over another, negatively impacting health and quality of life.

LANGUAGE/CULTURE

Meeting the needs of diverse populations through culturally and linguistically appropriate care and patient specific services such as language, literacy, accessibility to interpretation services and targeted outreach to disenfranchised populations can provide health equity.

SOCIAL DETERMINANTS OF HEALTH

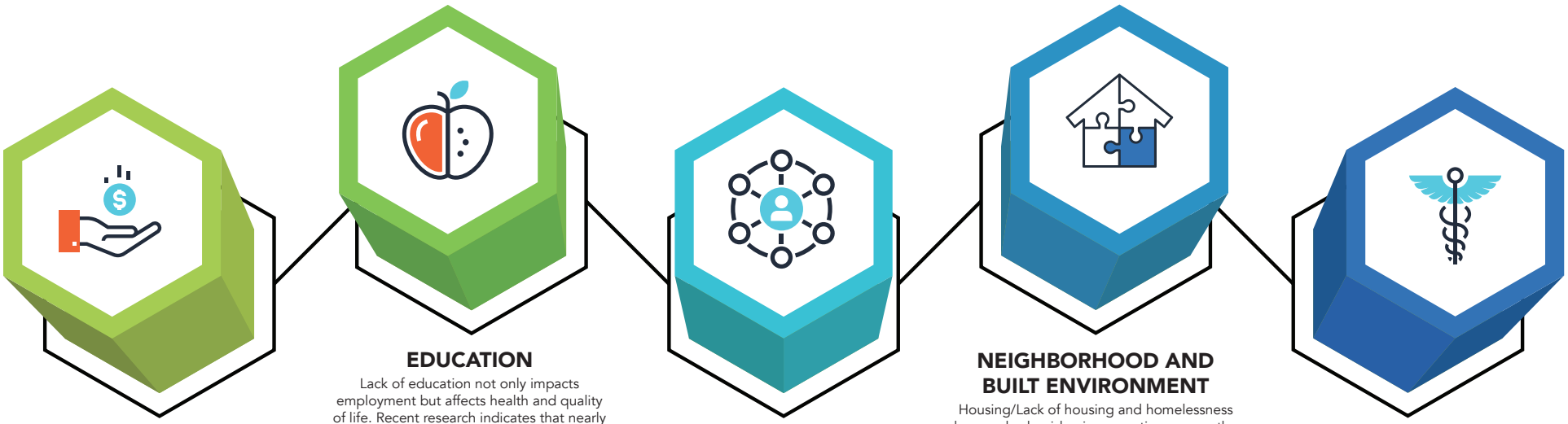
Health equity demands a multi-sectoral approach to engage and mobilize the broad community to address social, economic, educational and environmental factors that influence health, defined as SDOH.

GENERAL OVERVIEW OF SOCIAL DETERMINANTS OF HEALTH

As defined by the World Health Organization (WHO), SDOH are the economic and social conditions that influence individual and group differences in health status. These economic and social conditions under which people and groups live may increase or decrease the risk for a health condition or disease among individuals and populations. Addressing SDOH is paramount to creating a healthier community.

Various domains categorize SDOH; Figure 41 displays five domains as categorized by Healthy People 2030. SDOH domains are also contributors to health disparities and inequities across the nation. Data links determinants and domains to health status, such as the correlation of one's ZIP code resulting in drastically different health statuses for patients with the same/similar health conditions. The literature stresses the need for multi-sector organizations to collaborate in efforts to address social determinants and make positive impacts on overall patient health. In addition, targeting specific populations with specialized interventions is imperative to providing equitable health care.

Figure 41: Understanding SDOH (Healthy People 2030).



ECONOMIC STABILITY

Financial insecurity and poverty are directly related to adverse health outcomes and an important consideration in a country where nearly 28% or 88 million people live under 200% of the federal poverty line.

EDUCATION

Lack of education not only impacts employment but affects health and quality of life. Recent research indicates that nearly 50% of people do not understand information shared when they leave a hospital or doctor's office. We must address patient needs related to at risk patients, racial and ethnic groups, limited/no English-speaking patients, seniors, refugees and others.

SOCIAL AND COMMUNITY CONTEXT

Community involvement and engagement are key to a strong and healthy community. Many recent studies document the impact of racial/ethnic disparities and discrimination on physical, social and mental health.

NEIGHBORHOOD AND BUILT ENVIRONMENT

Housing/Lack of housing and homelessness has reached epidemic proportions across the US as 13,512 are experiencing homelessness on any given day.

The presence of a safe and secure environment, walkable environments, parks, recreation and the quality of housing impacts a person's health. Low-income communities have a poor infrastructure for walking, biking such as sidewalks, street lighting and traffic control features.

HEALTH AND HEALTH CARE

Food Security/Access to healthy food is critical to living a healthy lifestyle. Approx. 11% of households in the US/25.8 million adults are food insecure. Diseases such as heart disease, obesity, diabetes and certain forms of cancer are correlated to food and nutrition. Approx. 30% of households with incomes 130% below poverty are food insecure.

Source: Healthy People 2030

LESSONS LEARNED FROM COVID-19 AND HEALTH EQUITY

The effects of COVID-19 are far-reaching and long-lasting. The Centers for Diseases Control and Prevention (CDC) reported that essential employees (those in health care, food services, and transportation) were much more likely to die than other workers. Hispanics are nearly two times more likely to contract the disease as whites. Blacks have been hospitalized at three times the rate of whites, and American Indian/Alaska Natives have lost loved ones at more than double the rate of whites.

Race and ethnicity are markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

In Pennsylvania, non-Hispanic whites experienced 83.2% of all COVID-19 deaths. However, the impact of looking at the data by age determined multiple, age-specific disparities for Hispanics and non-Hispanic Blacks compared to non-Hispanic whites. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

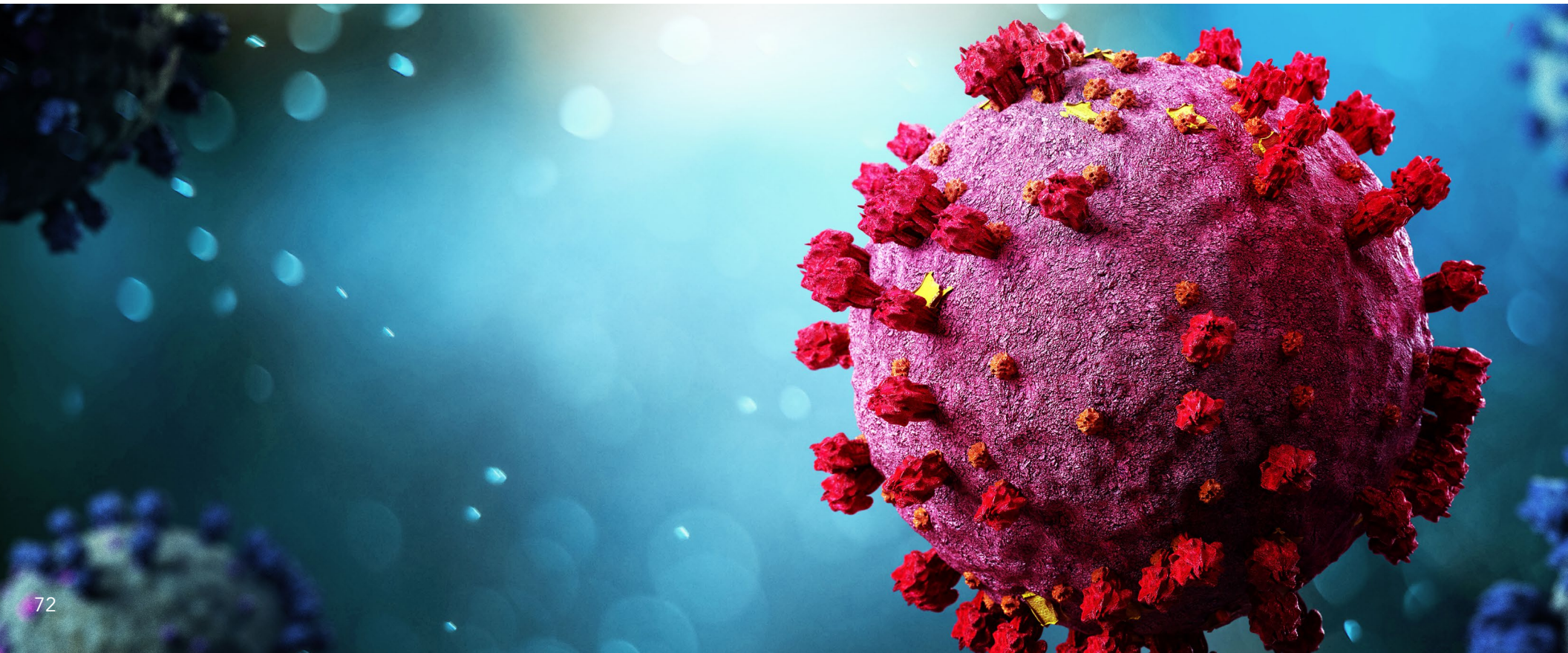
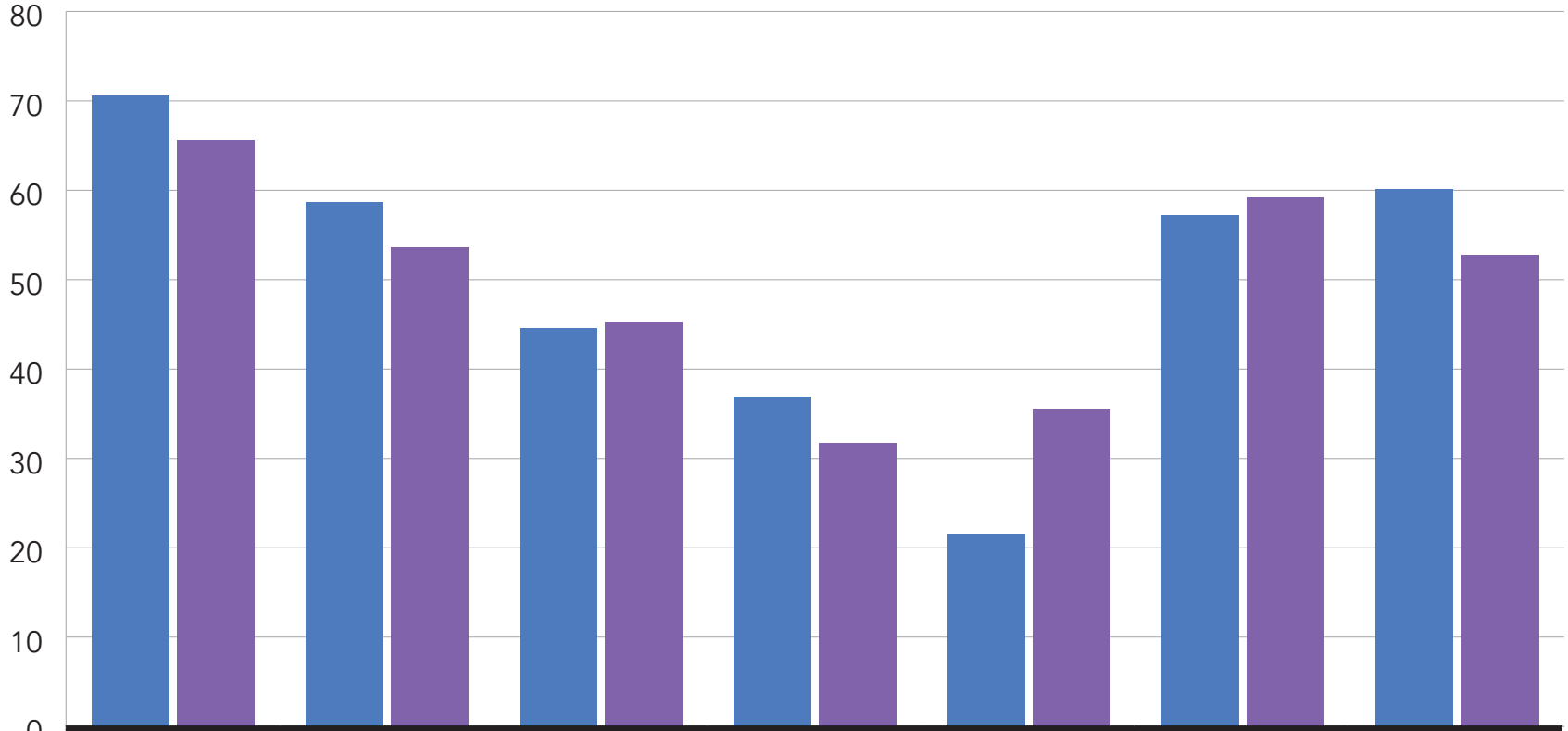


Figure 42: Full Vaccination Coverage for Race/Ethnicity



	All Races/ Ethnicity	White	African American	Asian/Pacific Islander	Native American	Hispanic	Not Hispanic
Chester County	70.6%	58.7%	44.6%	36.9%	21.5%	57.2%	60.1%
Montgomery County	65.6%	53.6%	45.2%	31.7%	35.5%	59.2%	52.8%

Note: Data presented in the above chart was collected in January 2022. Updated information can be obtained from the PA Department of Health.

Source: The PA Department of Health

Reviewing data by demographics such as age, gender, race, and ethnicity are markers for other underlying conditions that affect health. Additional factors such as socioeconomic status, access to health care, and exposure to the virus related to occupation are relevant to uncovering the challenges around vaccination access and acceptance, as well as understanding the impact and providing opportunities to develop mitigation solutions.

DRIVERS OF DISEASE INEQUITIES

Multiple factors continue to contribute to poor health outcomes, including social and health inequalities in marginalized communities. Unfortunately, the COVID-19 pandemic has further exacerbated existing inequalities with many people suffering from chronic illnesses and other conditions that increase their risk of severe illness. Underserved communities continue to feel the brunt, and the lack of investment in addressing barriers to health and productive lives in marginalized communities leads to many other health and social consequences.

Independent drivers of disease inequalities and a multi-sectorial approach are needed to reduce the impact of COVID-19 and other health issues among marginalized, disenfranchised, vulnerable, and underserved communities. (See Figure 43).

DISCRIMINATORY POLICIES

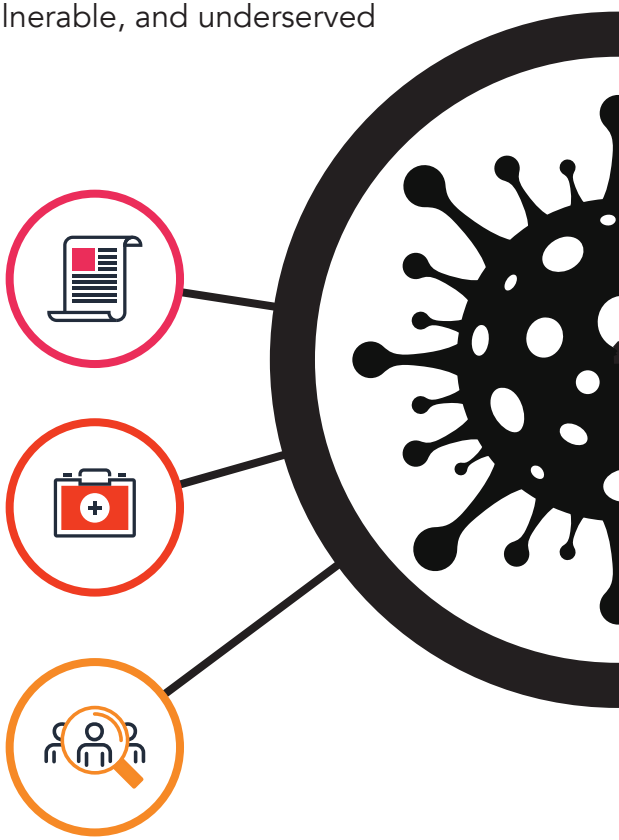
Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare.[8]

LIMITED ACCESS TO ESSENTIAL SERVICES AND RESOURCES

Barriers towards health insurance, childcare, sick leave, paid leave, or access to PPE, make some demographics more prone to COVID-19 inequities.[9]

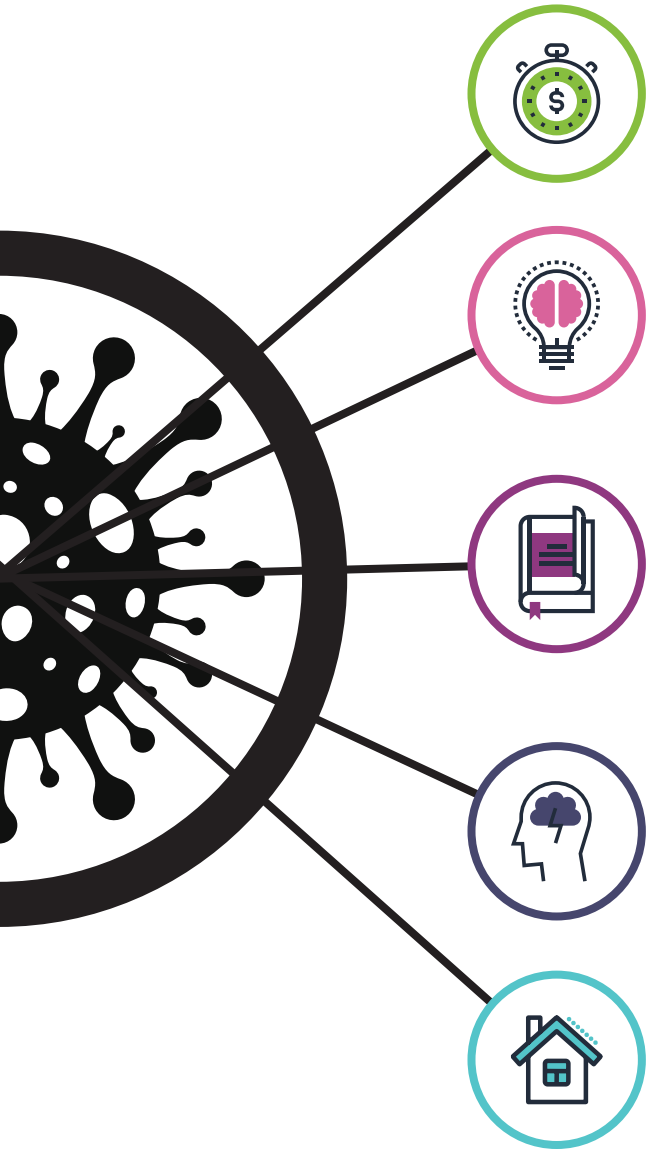
HISTORY OF RACISM & SOCIAL DISCRIMINATION

Systemic racism and other forms of social discrimination have contributed to discriminatory policies, limited investment in community well-being, lack of access to quality healthcare, and a poor sense of trust between communities and health and social systems.[8,10]



[8] CDC, 2020
[9] Pew Research Center, 2020
[10] Health Affairs, 2020
[11] NY Times, 2020
[12] NIMH, 2020
[13] Harvard, 2020
[14] L.C. Cooper and D.C. Crews, 2020
[15] J. Jaiswal, C. LoSchiavo, and D. C. Perlman, 2020
[16] CDC, 2020

Figure 43: COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities (The Health Equality Initiative)



POVERTY

Living in poverty, health is one of many priorities.[16]

MISTRUST

Insufficient community engagement, combined with misinformation or a lack of consistent information as well as a history of discrimination, causes many marginalized communities to lack trust towards health and social services.[14,15]

LOW HEALTH LITERACY & MISINFORMATION

People from ethnically and racially diverse communities didn't have the opportunity to develop skills to identify credible news sources, which has been shown to correlate with low health statuses.[13]

CHRONIC STRESS

Stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications.[12]

OVERCROWDED LIVING CONDITIONS

Many groups live in overcrowded conditions such as multi-generational homes or nursing homes, prisons, homeless shelters, or other kinds of group "homes." This can make it difficult to social distance and increase the risk for COVID-19. Factors such as unemployment can lead to homelessness, and therefore increased vulnerability to COVID-19.[8,11]

Source: The Health Equality Initiative 2020

CONTRIBUTORS TO HEALTH EQUITY

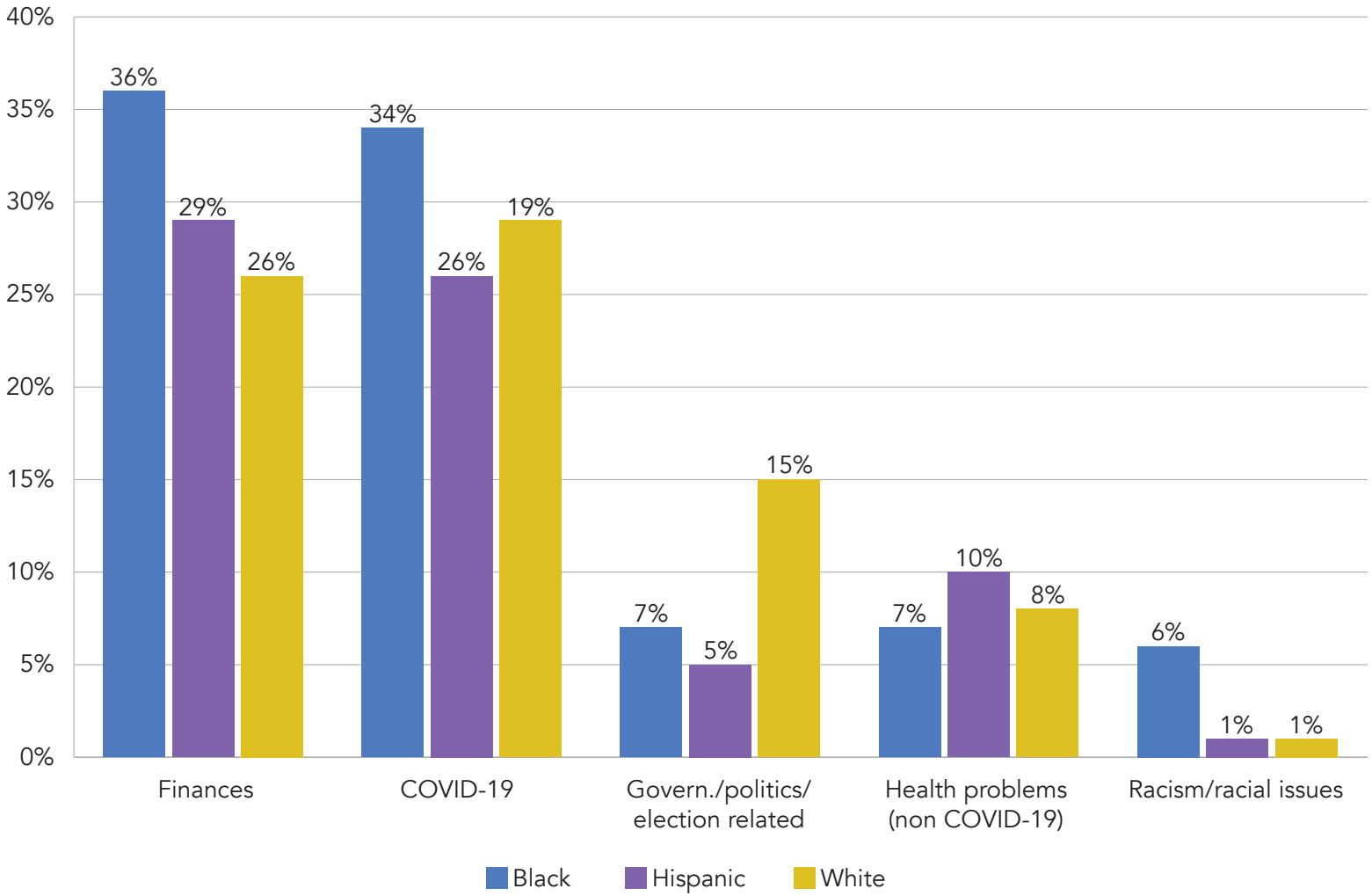
Understanding and addressing the needs of increasingly diverse and disparate populations is a major challenge for health care organizations. As a key aspect of improving health equity and decreasing health disparities, Phoenixville Hospital continues efforts to enhance the provision of culturally competent and linguistically appropriate care to a very diverse service area as defined by racial and ethnic communities with various cultural beliefs and perceptions, health practices, and behaviors as well as a distrust of the health delivery system.

When assessing the diverse and disparate population, a multitude of SDOH and barriers to health care access and services were uncovered. Barriers such as a lack of transportation, inadequacy of language and interpretation services, lack of insurance coverage, and cultural bias and discrimination have a very dramatic impact on the capacity to provide quality health care and the quality of life for Phoenixville Hospital's communities.

Interventions to improve health equity and reduce disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently.

Figure 44 depicts the largest concerns families face, broken down by race/ethnicity. More than one-third of Black adults cite financial issues and a similar share (34%) cite concerns related to the COVID-19 pandemic. These are also the top two concerns mentioned by white and Hispanic adults, though Black adults are 10 percentage points more likely than white adults to name financial challenges among their top concerns (36% vs. 26%). Notably, 6% of Black adults cite issues related to racism as being among their top concerns. Please click here for additional data related to the study conducted by KFF's The Undefeated Survey on Race and Health 2020.

Figure 44: Biggest Concerns Facing Individuals and Families 2020

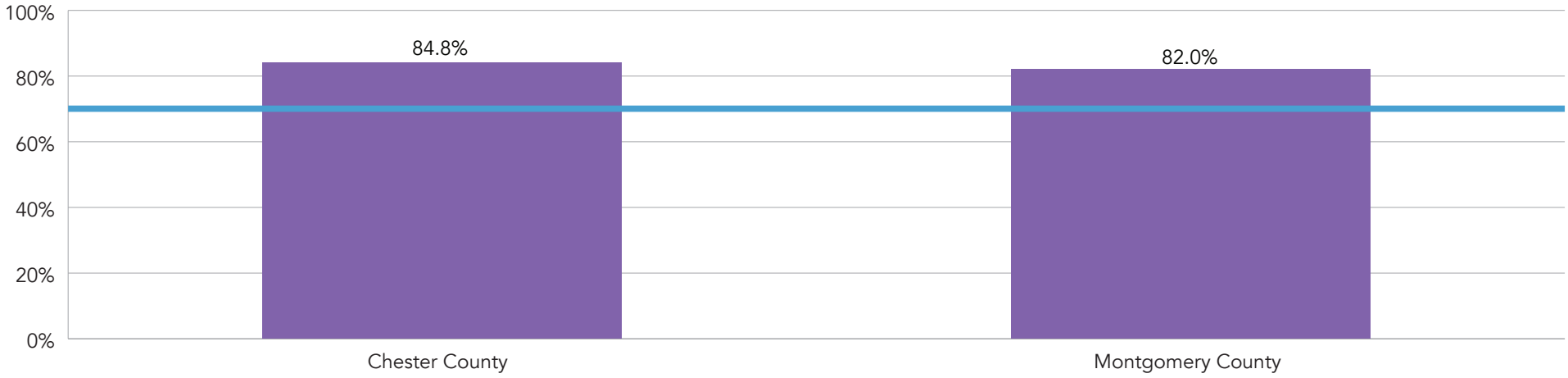


Source: KFF/The Undefeated Survey on Race and Health

A total of 84.8% of Chester County residents and 82.0% of Montgomery County residents are fully vaccinated against COVID-19 as of February 2022, compared to 71.8% in Pennsylvania. Salud America! reported that 59.9% of Latinos in Pennsylvania have received at least one dose of the COVID-19 vaccination.

Residents hesitant against getting the vaccine total 8.5% in Chester County and 8.56% in Montgomery County. This may be because of historical trauma, misinformation, government mistrust, and other factors.

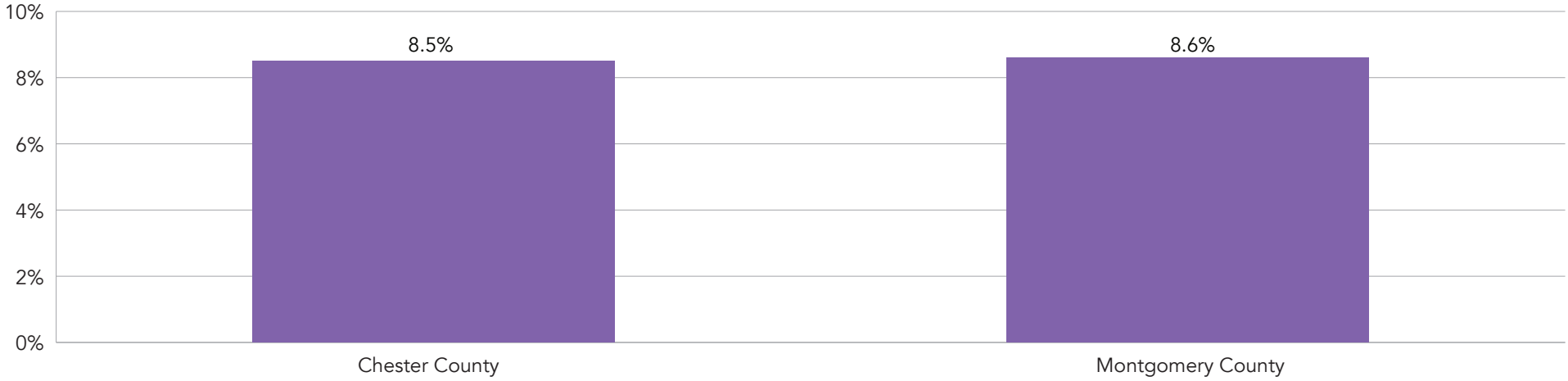
Figure 45: Vaccinated Residents as of February 2022



Note: The blue line indicates the overall rate in Pennsylvania of 71.8%.

Source: Salud America!

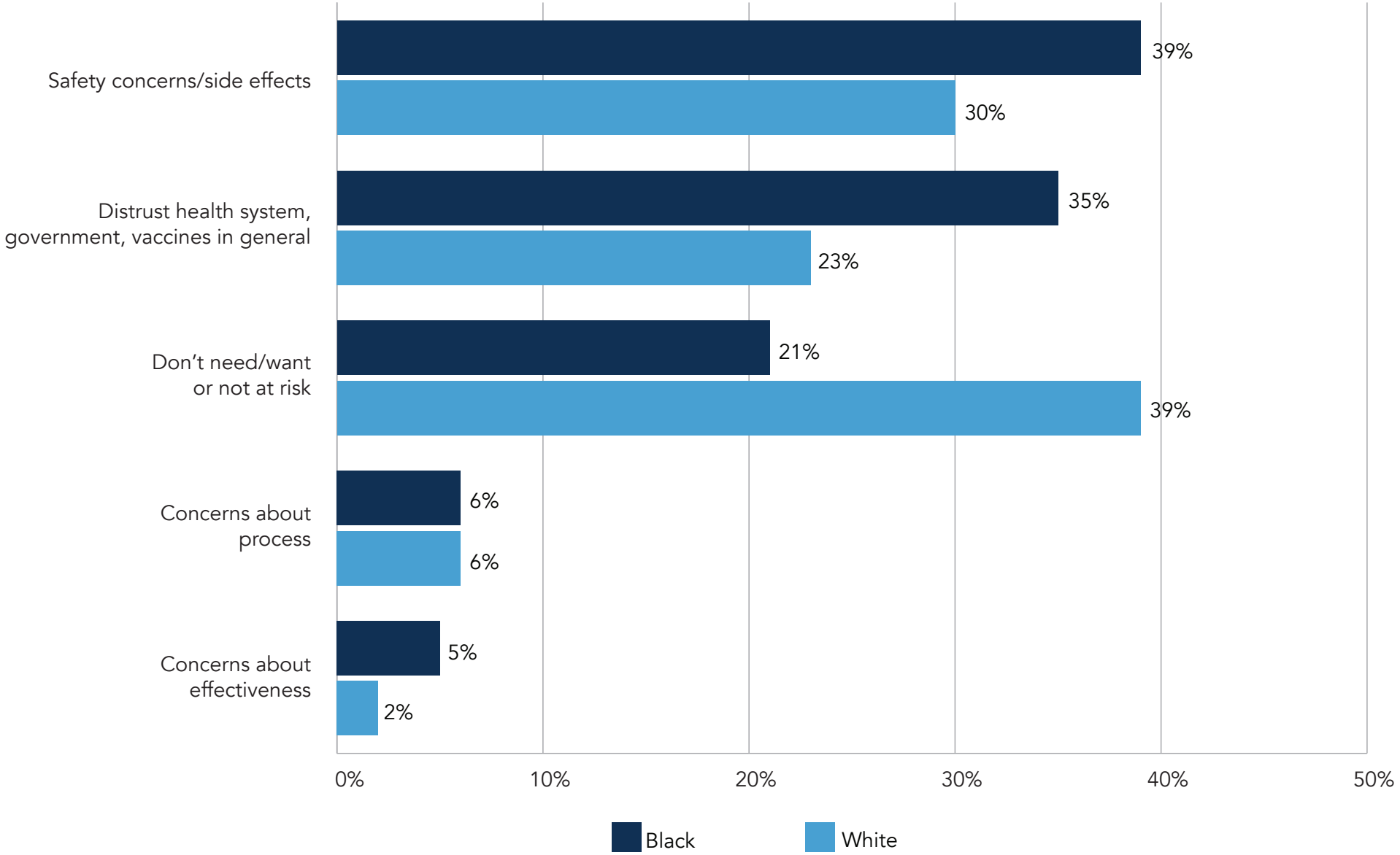
Figure 46: Unvaccinated Residents as of February 2022



Source: Salud America!

Figure 47 reports national data of adults who are vaccine-hesitant. Respondents cite safety concerns and distrust among the top reasons.

Figure 47: Those who say why they would not get a COVID-19 vaccine 2020



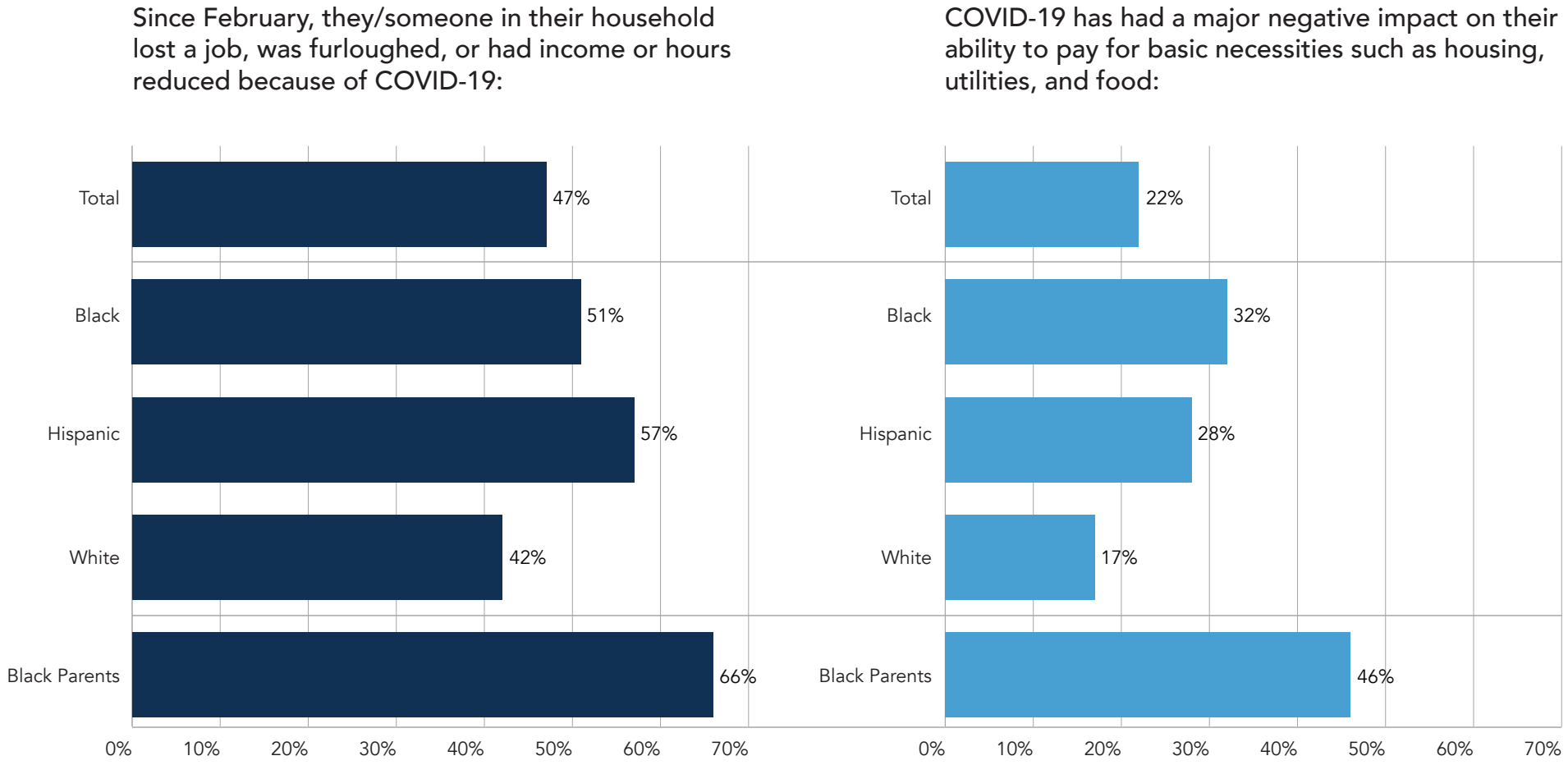
Source: KFF/The Undefeated Survey on Race and Health

Figure 48 reports in 2020 that Black and Hispanic adults were hit harder financially by the pandemic.

Employment disruptions are leading to significant financial struggles. About three in 10 who are Black (32%) or Hispanic (28%) say the pandemic has had a "major negative impact" on their ability to pay for basic necessities like housing, utilities, and food, compared with 17% of white adults.

Disproportionate impacts on the ability to care for children and the family are noted in the below chart.

Figure 48: Pandemic Outcome by Race/Ethnicity 2020



Source: KFF/The Undefeated Survey on Race and Health

COVID-19 is a novel virus, spreading mainly from person-to-person, between people who are in close contact with one another; through respiratory droplets produced when an infected person coughs, sneezes or talks. All guidance recommends frequent hand washing, wearing a mask, practicing social distancing, disinfecting surfaces, avoid going out if sick, and monitor health for symptoms of the virus. These simple practices help stop the spread of the virus.

The below COVID-19 vaccine tables reflect the number of people who are partially and fully vaccinated broke down by race and ethnicity in each county at the time of reporting. Getting vaccinated helps protect the body against the disease.

Table 49: Number of People Vaccinated by County 2/2022

	Partially Covered	Fully Covered	Received Additional Dose since 8/2021
Chester County	86,838	356,434	161,244
Montgomery County	139,476	523,297	238,174
Pennsylvania	8,130,473	7,173,736	3,127,639

Note: Pennsylvania residents who receive a COVID-19 vaccination from a clinic located in Philadelphia County or received vaccination from a federal facility (such as a Veteran Health Administration hospital or a federal prison), or who received a vaccination in another state are not included in this dashboard due to separate reporting requirements.

Source: PA Dept. of Health

Table 50: Percent of People vaccinated by County and Race 2022

	All Races			White			African American		
	Total	Partially Covered	Fully Covered	Total	Partially Covered	Fully Covered	Total	Partially Covered	Fully Covered
Chester County	89.3	17.5	71.8	73.0	13.5	59.5	57.2	11.2	45.9
Montgomery County	84.4	17.8	66.6	67.8	13.7	54.1	61.4	15.0	46.4
Pennsylvania	72.5	10.8	61.6	58.9	8.2	50.7	50.3	9.3	41.0

	Asian/Pacific Islander			Native American		
	Total	Partially Covered	Fully Covered	Total	Partially Covered	Fully Covered
Chester County	62.0	23.2	38.8	37.8	15.2	22.6
Montgomery County	50.8	17.9	32.9	58.8	22.0	36.8
Pennsylvania	55.0	16.6	38.5	29.8	8.9	20.9

Source: PA Dept. of Health

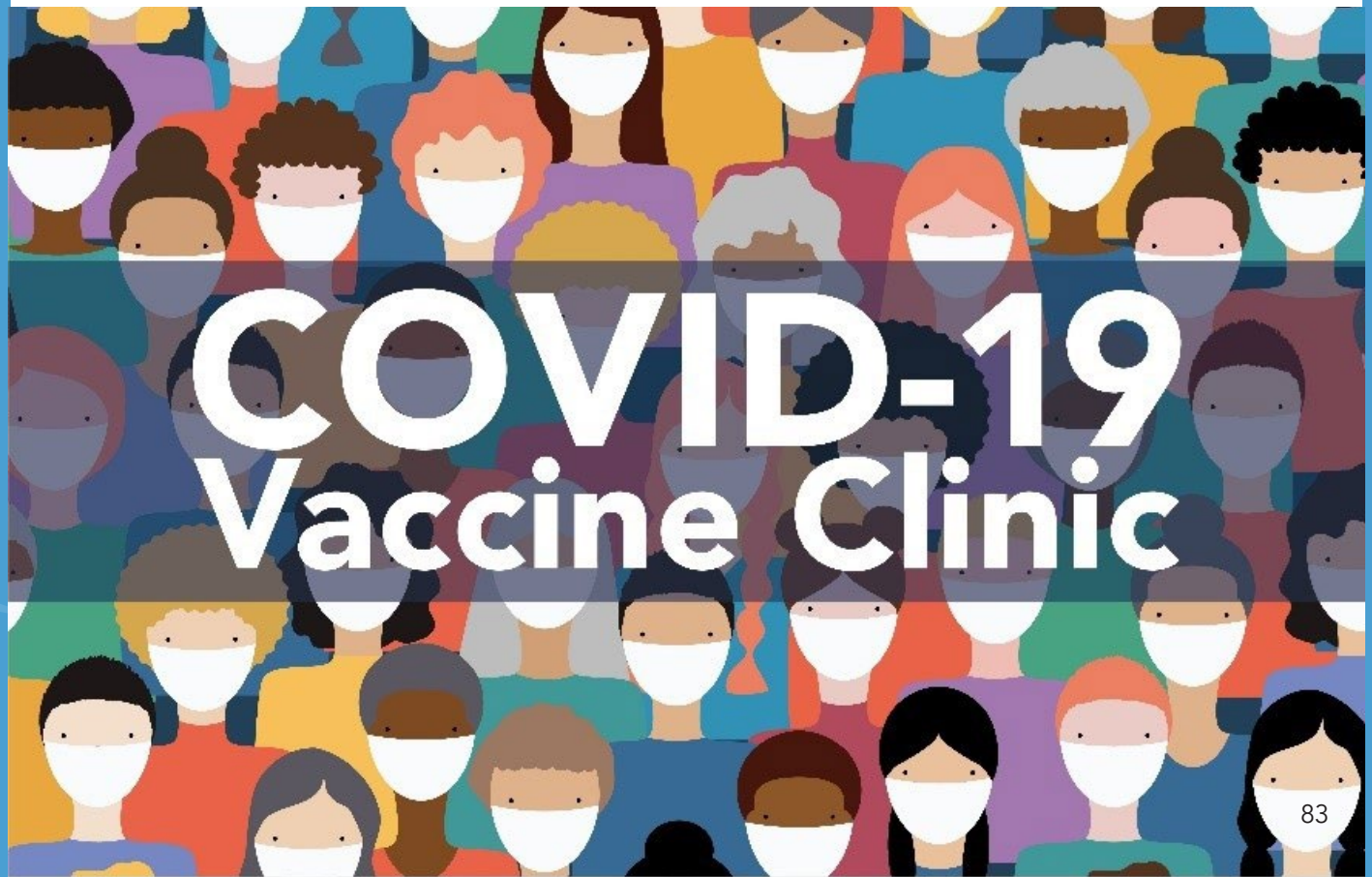
Table 51: Percent of People vaccinated by County and Ethnicity 2022

	All Ethnicities			Hispanic			Not Hispanic		
	Total	Partially Covered	Fully Covered	Total	Partially Covered	Fully Covered	Total	Partially Covered	Fully Covered
Chester County	89.3	17.5	71.8	75.1	15.7	59.4	75.7	14.4	61.2
Montgomery County	84.4	17.8	66.6	81.4	19.8	61.6	68.0	14.3	53.6
Pennsylvania	72.5	10.8	61.6	61.9	11.0	50.9	57.6	8.4	49.2

Source: PA Dept. of Health

RESPONSE TO COVID-19 INEQUITY AND ACCESS

Caring for Our Community – "In this Together" is a community collaborative initiative developed to meet the health needs of our diverse community by providing COVID-19 vaccines to all eligible persons in an accessible location using a mobile clinic. Through our collaborative COVID-19 mobile vaccine clinic, we provided vaccines to seniors, at-risk populations, schools, and other groups. Additionally, the mobile vaccine clinic improves access to care and fosters health equity as we can reach vulnerable and diverse populations. To date, we have provided more than 5,000 COVID-19 vaccinations to our community through the mobile clinic. Our community collaboration has provided us with the knowledge, skills, resources, and expertise to vaccinate persons of all age groups in our community who may have had difficulty accessing care, thus addressing health equity. In addition to the mobile vaccine clinic, Phoenixville Hospital also partnered with Chester County Health Department to provide COVID-19 vaccines at a local community vaccination clinic.



WHAT DID WE LEARN FROM THE COMMUNITY?

Capturing the perspectives and insights from the focus groups, stakeholder interviews, key informants, and community survey respondents, "What we heard from the community on equitable care" is portrayed as follows:

Figure 52: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Fear and lack of trust among vulnerable and minority populations of community and LGBTQ+ groups suffer discrimination by the medical field
- Unavailable language services, bilingual staff, and resources
- Lack of access among underrepresented groups, working poor, and Medicare patients

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care?"

- Language and cultural barriers
- Lack of trust
- Economic disparities
- Lack of educational and employment opportunities
- Lack of housing
- Homelessness
- Strategic focus on SDOH
- Racial inequities

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Language and cultural barriers
- Lack of trust
- Awareness of available services
- Inconvenient bus stop locations
- Economic disparities
- Social justice
- Employment opportunities
- Need to focus on SDOH
- Lack of housing

COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Affordable, quality, and habitable housing
- Affordability/inability to pay for health care
- Culture and language barriers

Figure 53 from the community survey reports how respondents identified the top factors that contribute to a healthy community.

Figure 53: Top Factors that Contribute to a Healthy Community

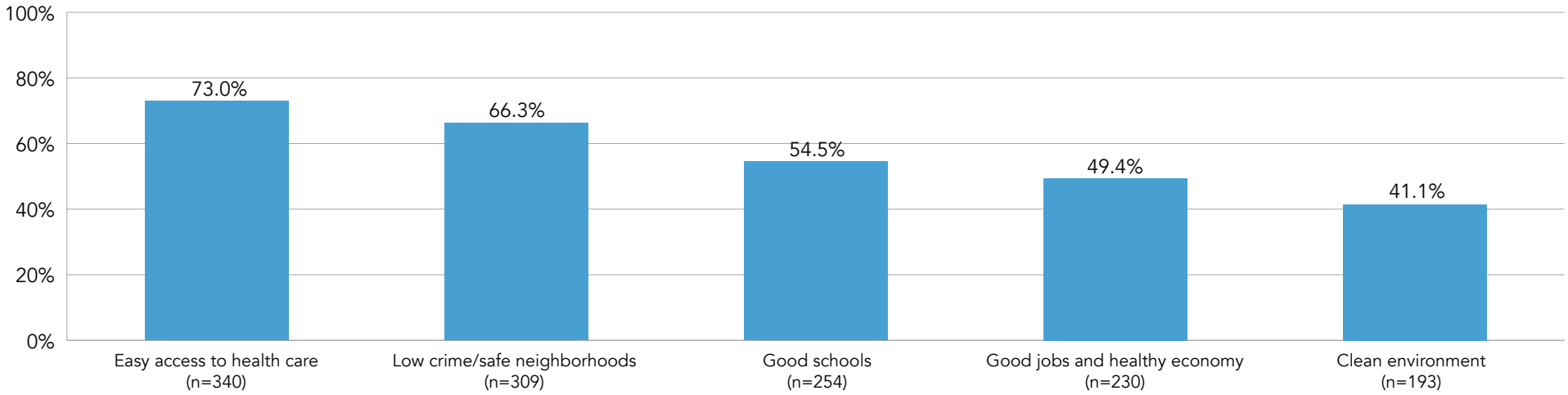


Figure 54 reports the top factors that would improve the quality of life for residents in the community.

Figure 54: Top Factors that Would Improve Life

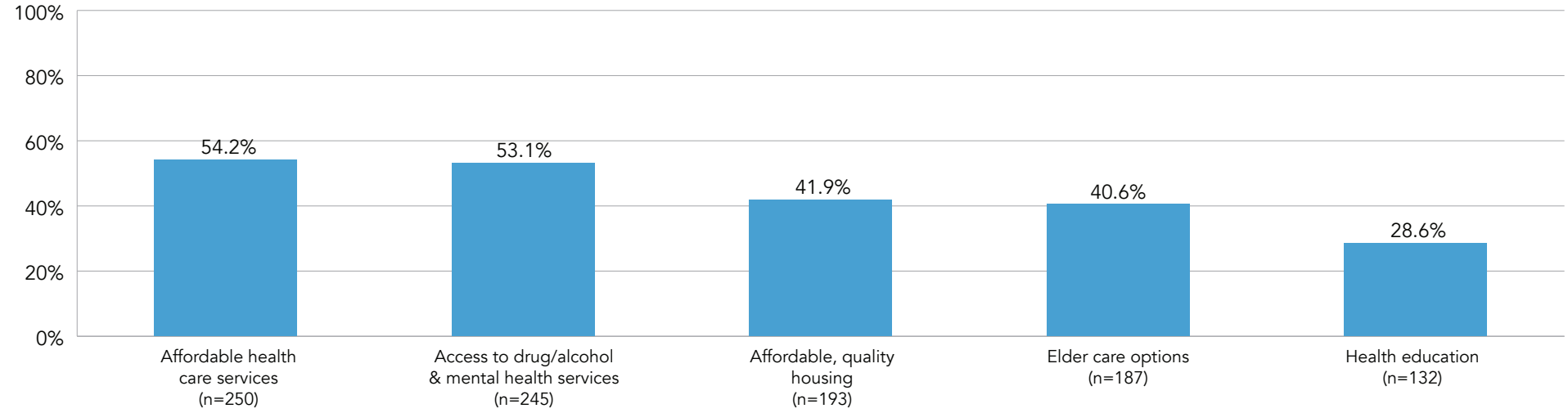


Figure 55 reports the health screenings or services that are needed to keep themselves/family healthy.

Figure 55: Health Screenings Needed to Keep Themselves/Family Healthy

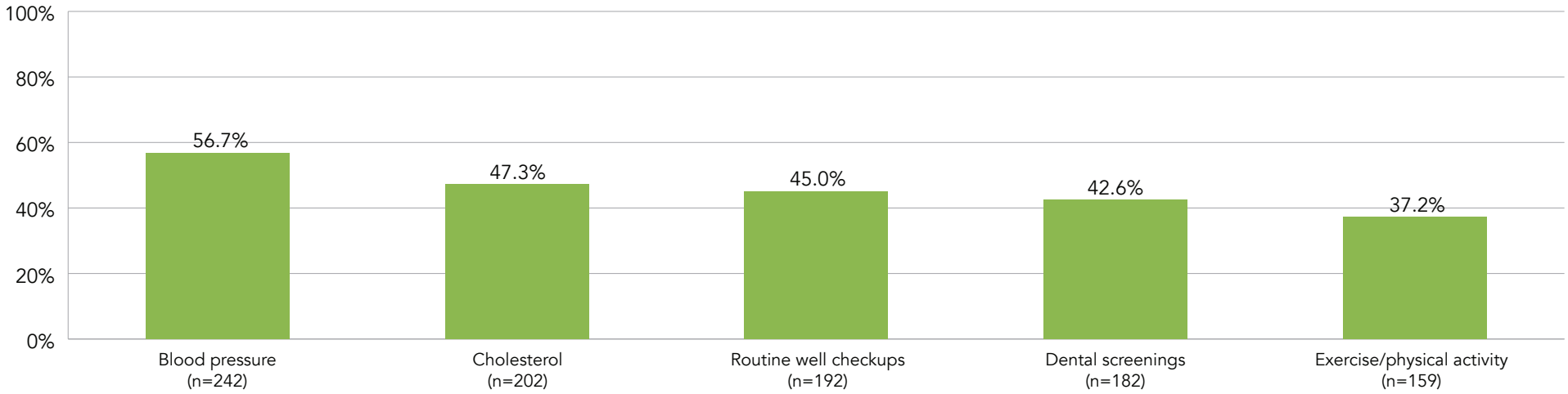


Figure 56 reports survey responses to issues that prevented accessing care.

Figure 56: Issues that Prevented Accessing to Care

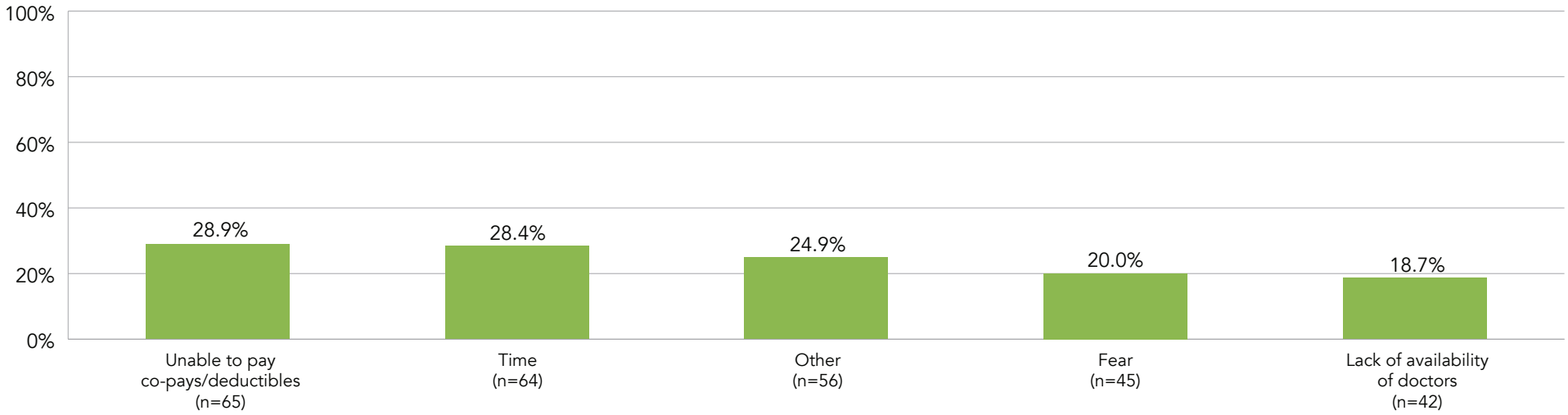
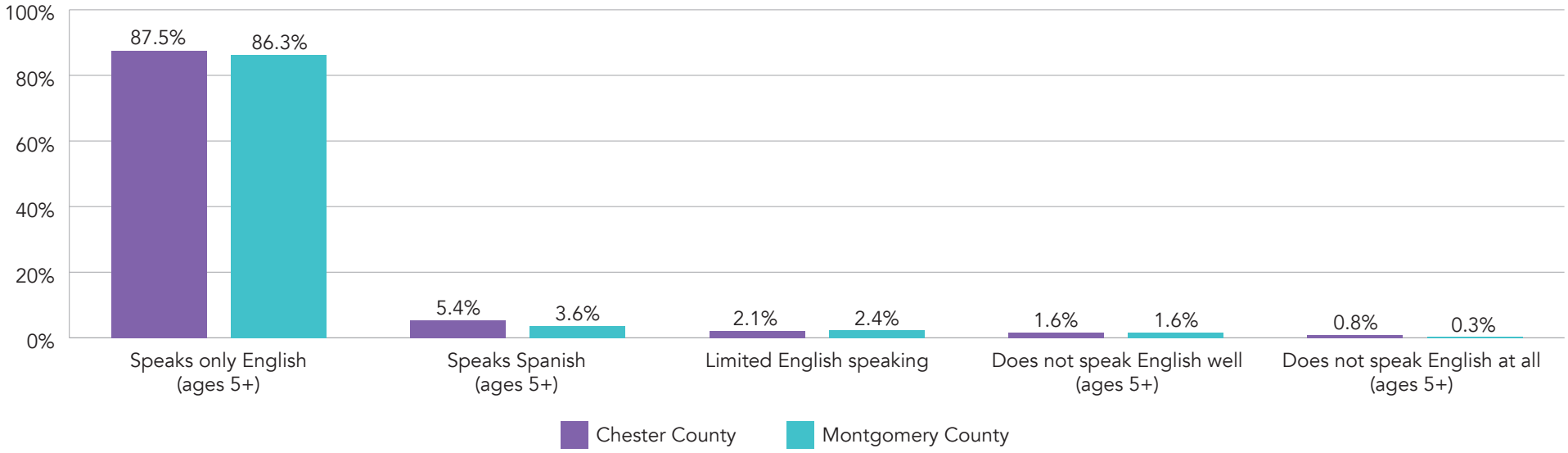


Figure 57 reveals the percentages of residents who speak only English and Spanish and residents who are limited in English-speaking.

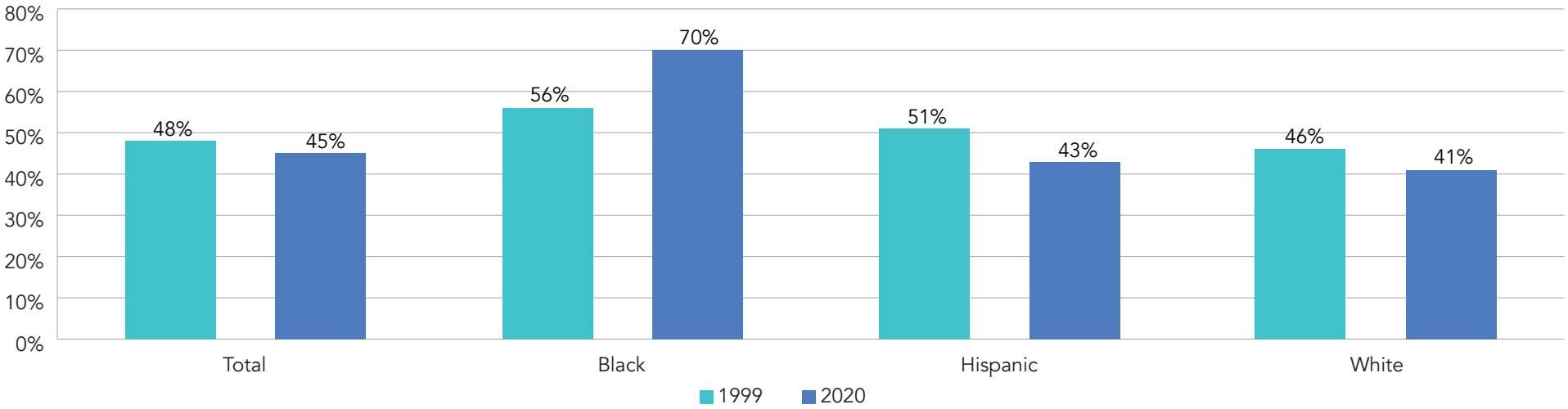
Figure 57: Households with Residents Speaking English Only, Spanish, and Limited English



Source: U.S. Census Bureau, American Community Survey 2018

Figure 58 reveals health care treatment in the years 1999 and 2020. This data highlights disparities in demographics that should be considered when providing health care services.

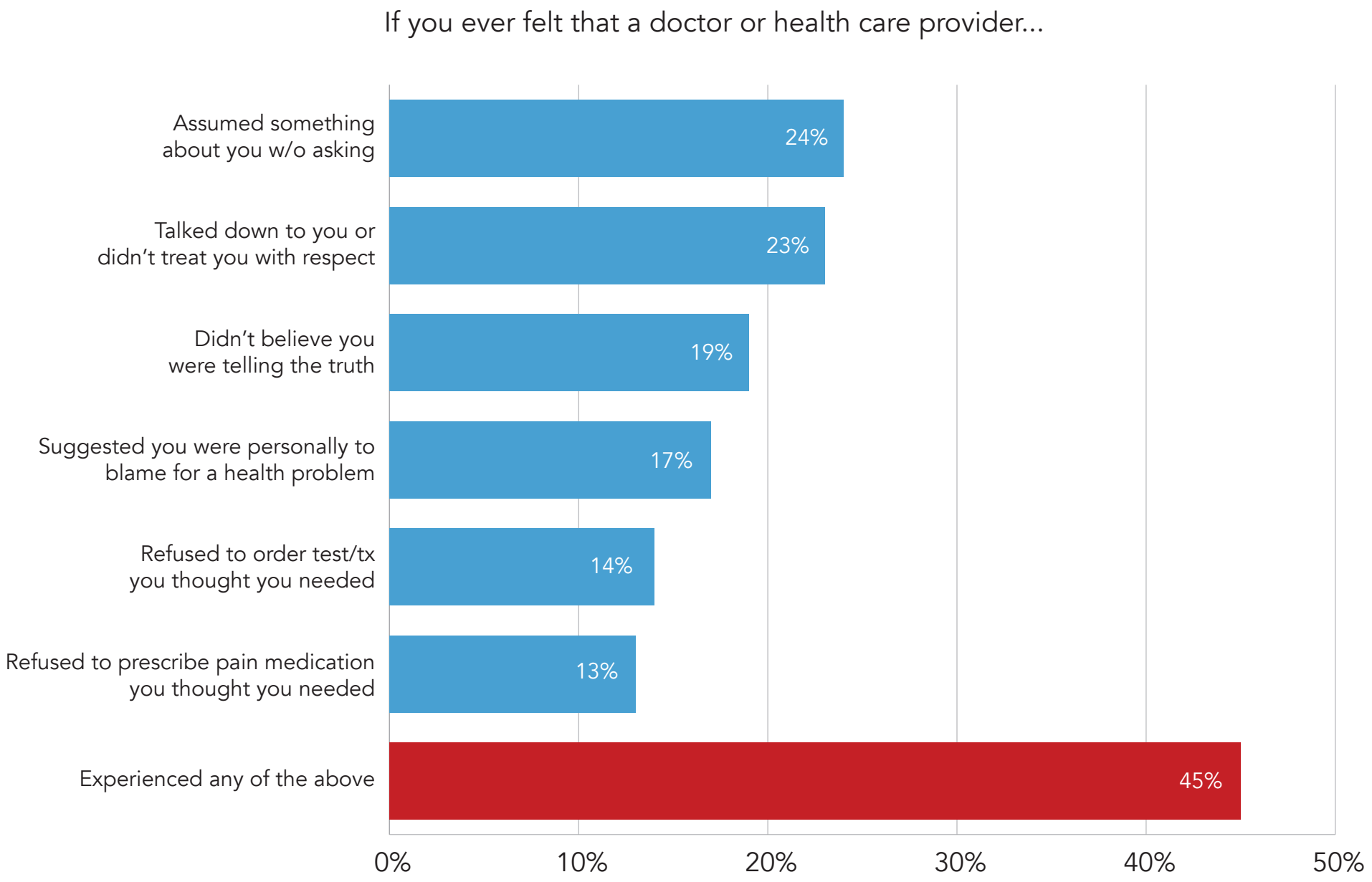
Figure 58: Percentage That Thinks the Health Care System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often



Source: KFF/The Undefeated Survey on Race and Health 2020

Figure 59 reports that nearly half of adults reported one of six negative experiences with health care providers in the last three years.

Figure 59: Percentage Reporting Yes to Negative Experiences With a Doctor or Health Care Provider

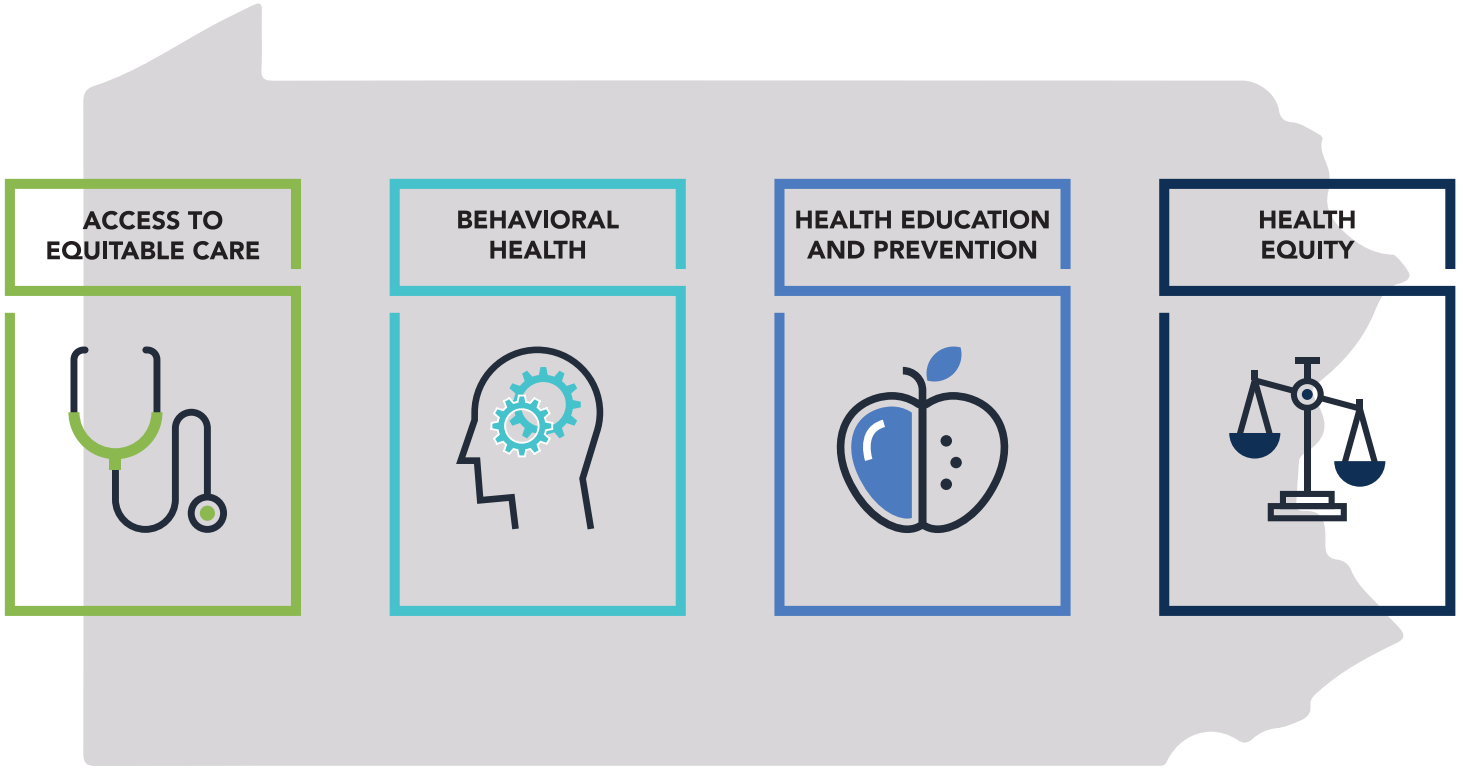


Source: KFF/The Undefeated Survey on Race and Health 2020

CHNA FOCUS AREA FOR
PHOENIXVILLE HOSPITAL 2022

In 2021, key need areas were identified during the CHNA process through the gathering of primary and secondary data such as community stakeholder interviews, leadership and health equity focus groups, key informant surveys, a community survey, and a health provider inventory, which highlights organizations and agencies that serve the community.

Equitable care means delivering care that does not differ in quality according to characteristics of the patient or patient group such as age, gender, geographic location, cultural background, ethnicity, religion, and socioeconomic status. With health equity as an ongoing focus, "access to care" transformed to "access to equitable care" and was strongly emphasized through all aspects of primary data collection. The four identified areas of focus were:



CONCLUSION

WHAT'S NEXT … IT'S COMPLICATED

One of the most challenging aspects of providing quality health care is the difficulty that populations and individuals experience in navigating the health care system. Access to equitable health care becomes more complicated and complex based on geographic factors – where people were born, live, work, and play – and economic, cultural, educational, and social factors. The health system may provide a plethora of recognized physicians, best practice services, and special programs, but access is complicated if residents lack transportation and insurance. The ease of accessing health care and the overall health of a community are directly correlated.

Access is complicated for vulnerable populations such as the elderly, unemployed/underemployed, and low-income. Those factors serve as barriers to care and limit their ability to seek care early, often resulting in a health crisis, emergency visit, or hospitalization for illness and conditions that could be prevented. Access is complicated for ethnic patients with language barriers, limited English-speaking skills, and low levels of education. Culturally competent and appropriate care and treatment are essential to improving health and ensuring good outcomes. Just because we built it does not mean they will come.

Improving health equity is a daunting task as it extends well beyond the walls of the health system, reaches deep into the community sectors, and travels toward local and state government, where health policies and protocols are developed. Recognition across the health care environment that improving health and achieving health equity demands a multi-sectoral approach is increasing. This approach requires the health system to engage and mobilize the broad community to address social, economic, and environmental factors that influence health. For example, the lack of access and availability of public transportation impacts not only access to health care but affects employment, access to affordable healthy food, and many other important drivers of health and wellness.

As the next step, Phoenixville Hospital will advance efforts to align and integrate the many voices and ideas offered from the community as received through the focus groups, a community survey, community stakeholder interviews, and provider interview processes. Phoenixville Hospital will engage and collaborate with our community partners on the development of the CHNA Implementation Strategy Plan.

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