IMPLEMENTATION **STRATEGY**

2022

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

TABLE OF CONTENTS

LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Charles F. Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

Reading Hospital is committed to advancing health and transforming lives throughout Berks County while meeting the changing health needs of our communities through the development of 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. Reading 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. The data for this CHNA was collected regionally and reported for our hospital service area. Working with our strategic and community partners, Reading Hospital has used the results of this assessment as a foundation to develop tactics to address each of the identified health priorities:

- Access to Equitable Care
- Behavioral Health
- Health Education and Prevention
- Health Equity

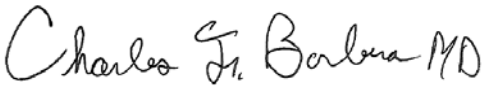
As a leading health care provider, we strive to positively impact the health and well-being of our patients, as well as the broader communities we serve. Many of our programs and services have been developed to address specific regional health needs or overcome barriers to care. These efforts continue to make a difference in the lives of individuals and families. We are grateful for our community partners who work 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 Reading 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,



Charles F. Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

ABOUT
THIS REPORT

IMPLEMENTATION STRATEGY (IS)

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 Reading Hospital incorporated input from participants who represent the broad interests of the community, including those knowledgeable of public health issues and the vulnerable, underserved, disenfranchised, 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.

Reading Hospital's Implementation Strategy (IS) includes goals and strategies on how to address and 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. Reading Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements. Reading Hospital is proud to present its 2022 IS report to the community.

READING
HOSPITAL

WHO ARE WE?

Reading Hospital is a nationally recognized institution that has served the community since 1867 and in its current location since 1926. With a tradition of clinical excellence and a commitment to low patient costs, we perform nearly 19,000 surgical procedures a year. Reading Hospital is home to many of our top-tier specialty care centers, including:

- McGlinn Cancer Institute
- Miller Regional Heart Center
- Reading HealthPlex for Advanced Surgical & Patient Care
- Emergency Services
- Level I Trauma Center
- Beginnings Maternity Center, housing the region's only Level III Neonatal Intensive Care Unit (NICU)

At Reading Hospital, advancing your health and wellness is our mission. When you enter our facilities, you can expect the highest quality health care in the region and access to cutting-edge technology and experienced, caring medical professionals. More than 1,000 physicians and providers across 46 locations offer comprehensive care ranging from prevention, screenings, and education to the latest clinical services and treatments. Our community health programs provide essential resources to residents of Berks County and surrounding areas. Whatever your health care needs, we are committed to meeting them.

MISSION

The mission of Reading 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.

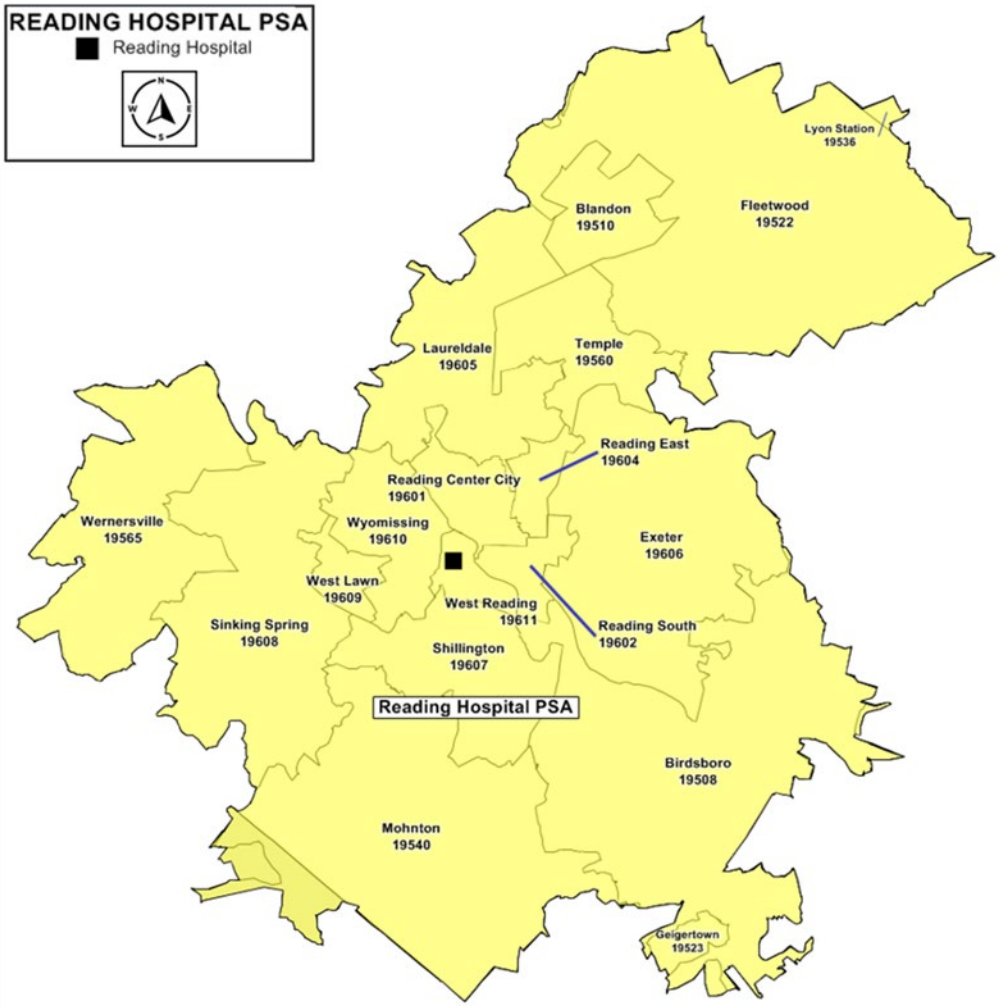
VISION

Reading 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. Reading Hospital's primary service area (PSA) includes 21 ZIP codes within Berks County.[1]

Reading Hospital's Primary Service Area	
ZIP Codes	Town/Neighborhood
19508	Birdsboro
19510	Blandon
19522	Fleetwood
19523	Geigertown
19536	Lyon Station
19540	Mohnton
19560	Temple
19565	Wernersville
19601	Reading Center City
19602	Reading South
19603	Reading (NS)
19604	Reading East
19605	Laureldale
19606	Exeter
19607	Shillington
19608	Sinking Spring
19609	West Lawn
19610	Wyomissing
19611	West Reading
19612	Reading (NS)
19542	Monocacy Station (NS)



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

OUR **FOCUS**

Reading Hospital's 2022 Implementation Strategy (IS) is a key component of the community health needs assessment process as it delineates the strategies and goals designed to meet prioritized needs and sets the stage for action and execution of initiatives that effectively impact health outcomes and sustain improvements in health status across our communities.

Much of today's delivery of health care should acknowledge the social and economic factors that influence health. These factors, called social determinants of health (SDOH), include our race, income, education level, and livable home and community environments. Understanding the strong impact of SDOH requires us to step aside from our traditional health care approaches and to pursue innovative best practices to improve health. Therefore, the 2022 IS was built on accomplishments and lessons learned, as well as the challenges and complexities, of 2019 CHNA and IS efforts.

A DEEPER PERSPECTIVE:
CHNA PRIORITIES

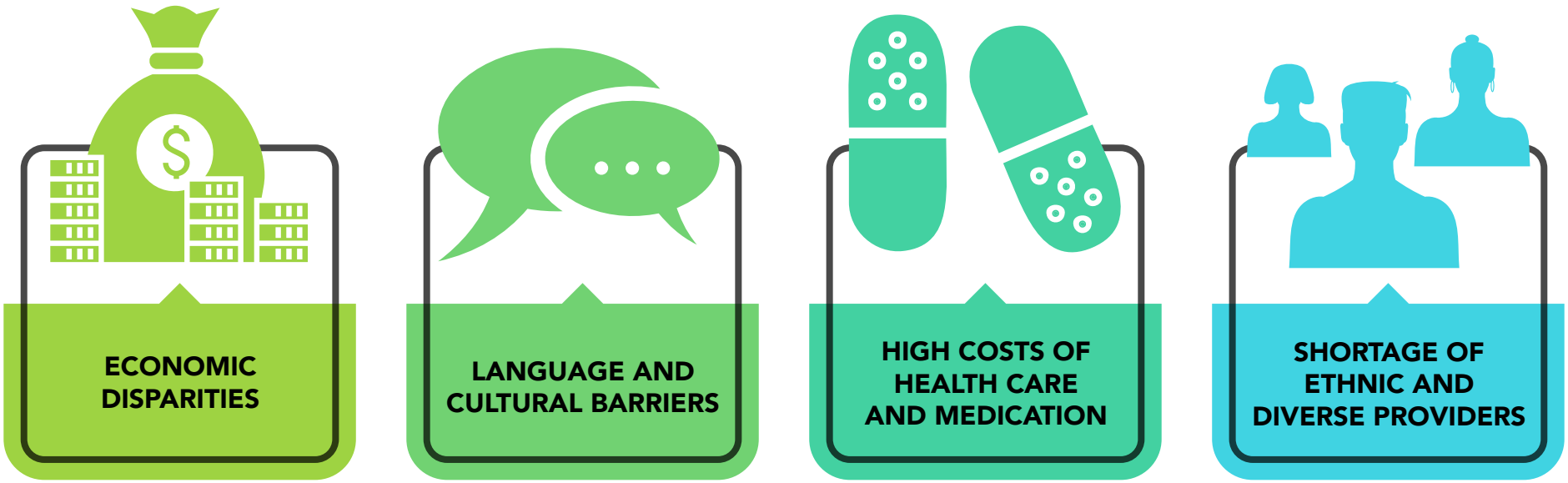
The 2022 IS has a deeper focus on the whole person, is patient- and community-centered, and supports the optimal use of a plethora of health care and human service resources to improve health. Community participants emphasized the need to improve access to equitable care and behavioral health and to expand health education and prevention. Inequities such as demographical differences highlight the importance of weaving an equity focus within all areas of health.

The effectiveness of the 2022 IS is strengthened as we translate our understanding and knowledge of what the community told us into dynamic policies and best practices. Community input guides our efforts to diligently understand past successes and pitfalls in continuously improving the health of our communities through the following areas of focus:

A) ACCESS TO EQUITABLE CARE

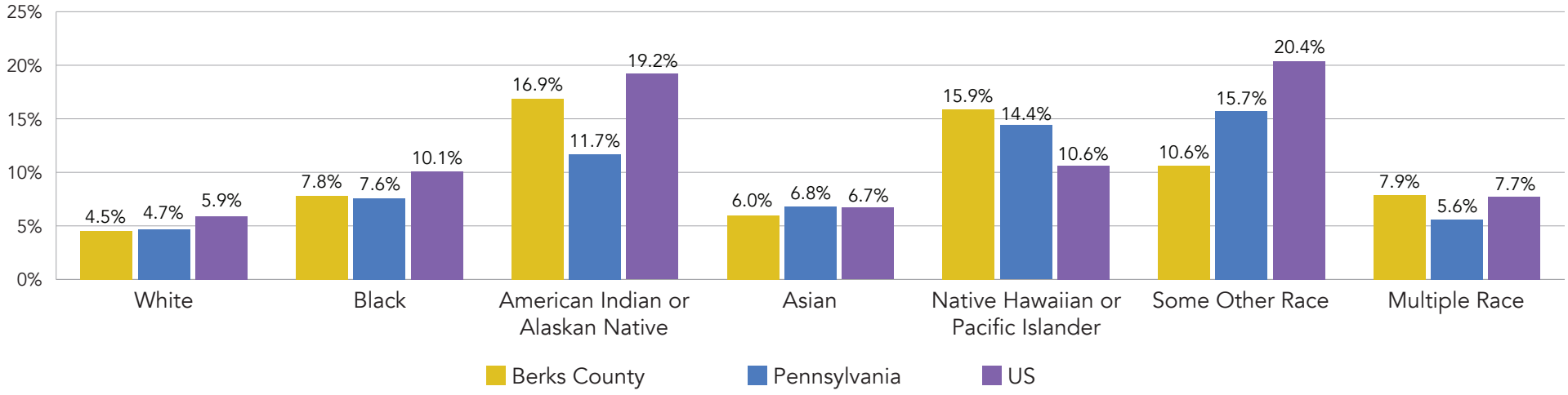
Based on what was heard from community stakeholder interviews, focus groups, and key informant and community survey respondents, solutions for improving access must incorporate better care coordination and integration and alignment of hospital systems and services. Ongoing efforts to address social determinants of health must be continued as those efforts go well beyond medical science alone. Therefore, the 2019 goal to improve access to care is broadened for 2022 to improving access to equitable care.

COMMENTS FROM PRIMARY DATA COLLECTION:



One of the key barriers in accessing care is the availability and adequacy of insurance coverage. In Pennsylvania, 5.8% of residents are uninsured. The following chart depicts uninsured rates by race and ethnicity. For Berks County, there are more uninsured Blacks, Native Americans or Alaska Natives, Native Hawaiians or Pacific Islanders, and residents of multiple races as compared to the state. These are key indicators of racial/ethnic populations experiencing access to care challenges. This data is critical to identifying areas where we can equitably improve access to care.

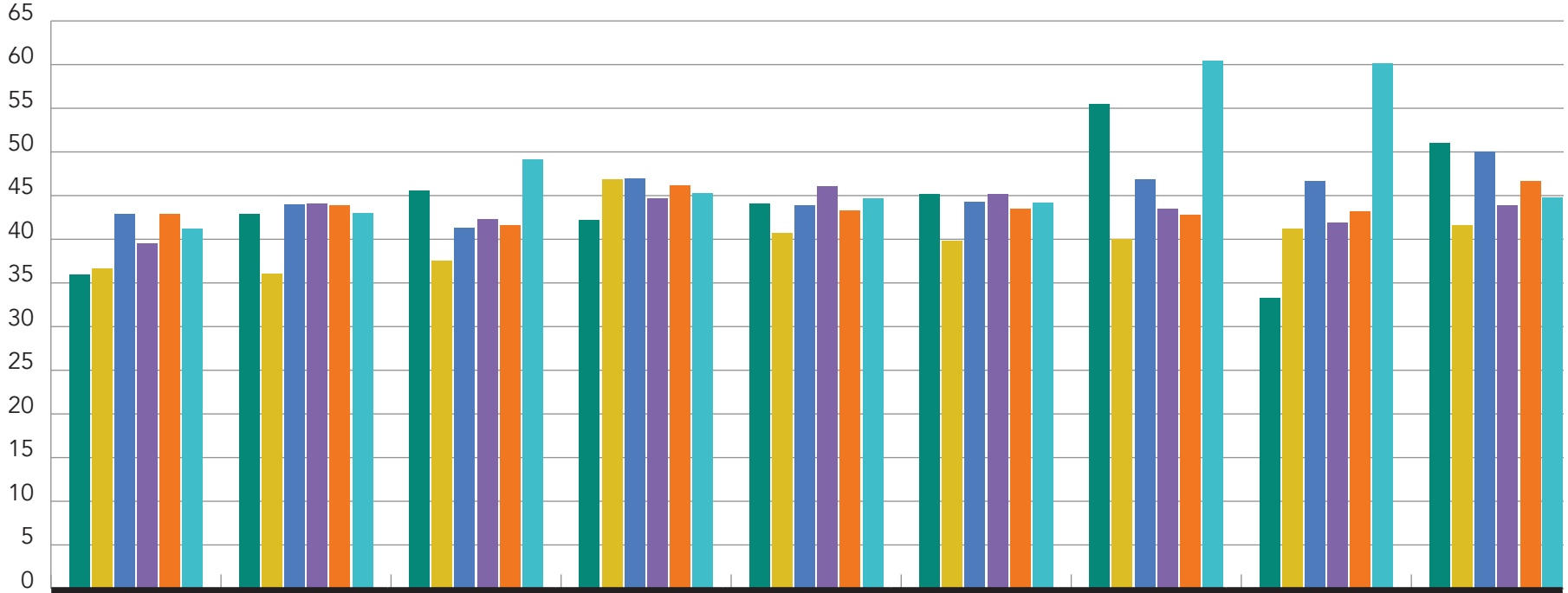
Figure 1: Percentage of Uninsured Population by Race



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

The PA Health Equity Analysis Tool (HEAT) provides a geographic perspective at the granular level to areas that have opportunities to improve equity.[2] Primary-care visits are key to preventative health. The below figure depicts rates of adults by race and ethnicity and by ZIP codes within the City of Reading with primary-care visits. Disparities in rates of primary-care visits for adults can be seen by ZIP code and racial/ethnic populations.

Figure 2: Percentage of Adults with Primary-Care Physician Visits by ZIP Code



	19601	19602	19604	19605	19606	19607	19608	19609	19610
Asian	**35.9**	**42.9**	**45.5**	**42.2**	**44.1**	45.2	**55.5**	**33.3**	51.0
Black	**36.6**	**36.0**	**37.5**	46.8	**40.7**	**39.8**	**40.0**	**41.2**	**41.6**
Hispanic	42.9	44.0	**41.3**	46.9	**43.9**	44.3	**46.8**	**46.6**	50.0
White	**39.5**	44.1	**42.3**	**44.7**	46.0	45.2	**43.5**	**41.9**	**43.9**
Other Race	42.9	43.9	**41.6**	46.1	**43.3**	**43.5**	**42.8**	**43.2**	46.6
All Adults	**41.2**	**43.0**	**59.1**	**45.3**	**44.7**	**44.2**	**60.4**	**60.1**	**44.8**

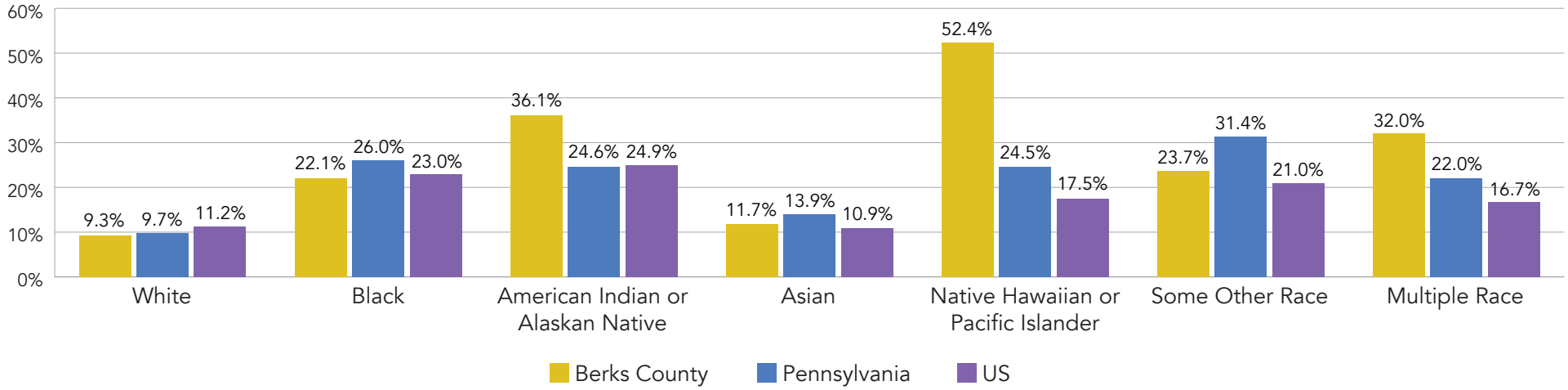
Note: The figures in bold indicate low percentages of adults with primary-care physician visits when compared to the benchmarked data of all adults within the specific ZIP code. Data was unavailable for ZIP codes 19508, 19510, 19522, 19523, 19536, 19540, 19560, 19565, 19611, 19612, and 19542.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

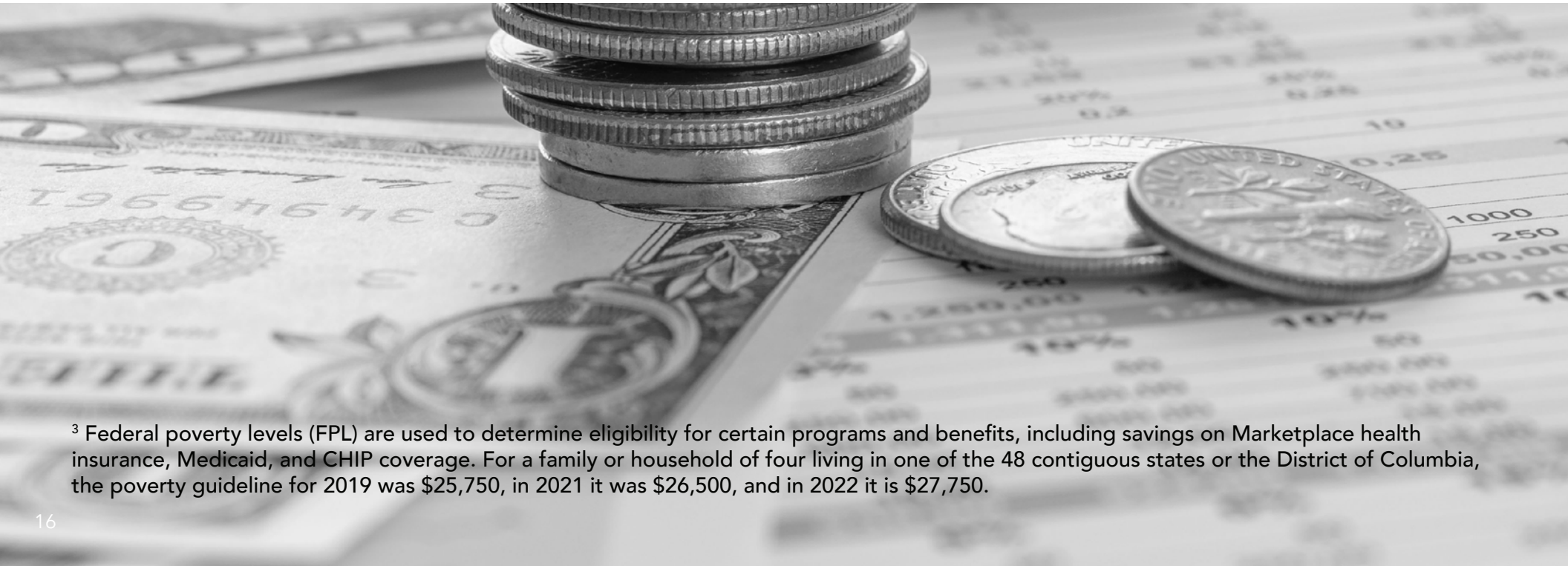
[2] The Department of Human Services (DHS) in collaboration with the Department of Health (DOH) has launched the PA Health Equity Analysis Tool (HEAT). The PA HEAT dashboard is designed to illustrate variation in a variety of health and social determinants of health indicators at the regional, county,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

As reported by focus group attendees and primary data, racial and ethnic populations face severe economic challenges in equitable access to care as depicted in the following graph. Figure 3 reports the percentage of the population below 100% of the federal poverty line (FPL) by race.[3]

Figure 3: Population Below 100% FPL by Race



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

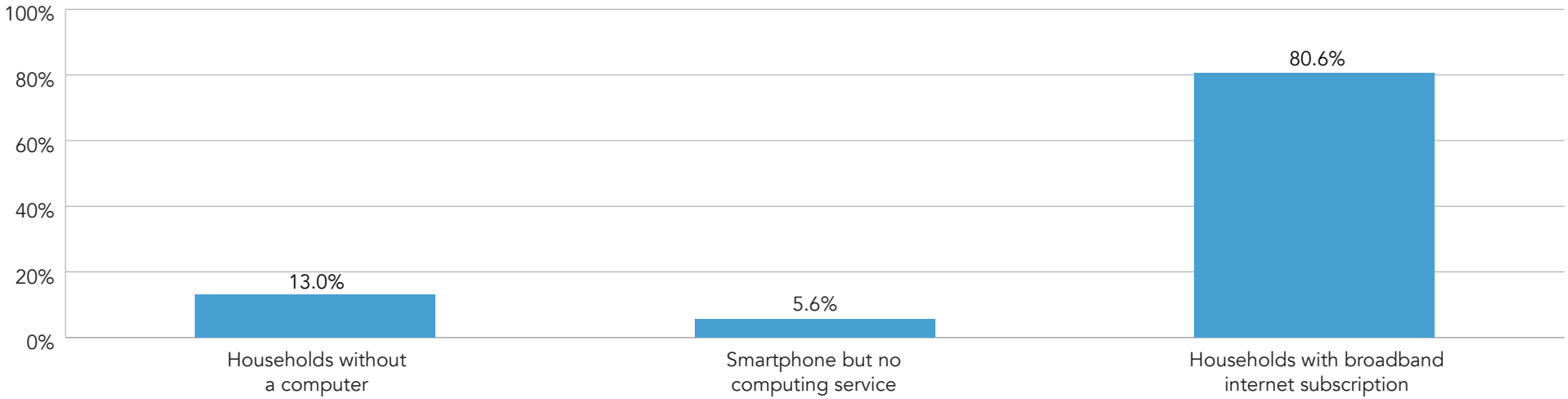


[3] Federal poverty levels (FPL) are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage. For a family or household of four living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2019 was $25,750, in 2021 it was $26,500, and in 2022 it is $27,750.

As a result of COVID, the use of virtual applications (e.g., telehealth) to reach patients and the community has increased significantly. This avenue of providing care creates disparities in populations who demonstrate a lack of access to technology, primarily among minorities and seniors, as seen in primary data collection. Closing the digital divide is necessary to ensure that all individuals and communities, including the most disadvantaged, have access to and use of information and communication technologies. Digital inclusion will enrich the lives of residents and communities, ensuring no one is left behind.

Figure 4 illustrates the percentage of residents in Berks County with limited technology.

Figure 4: Percentage of Households in Berks County with Limited Technology

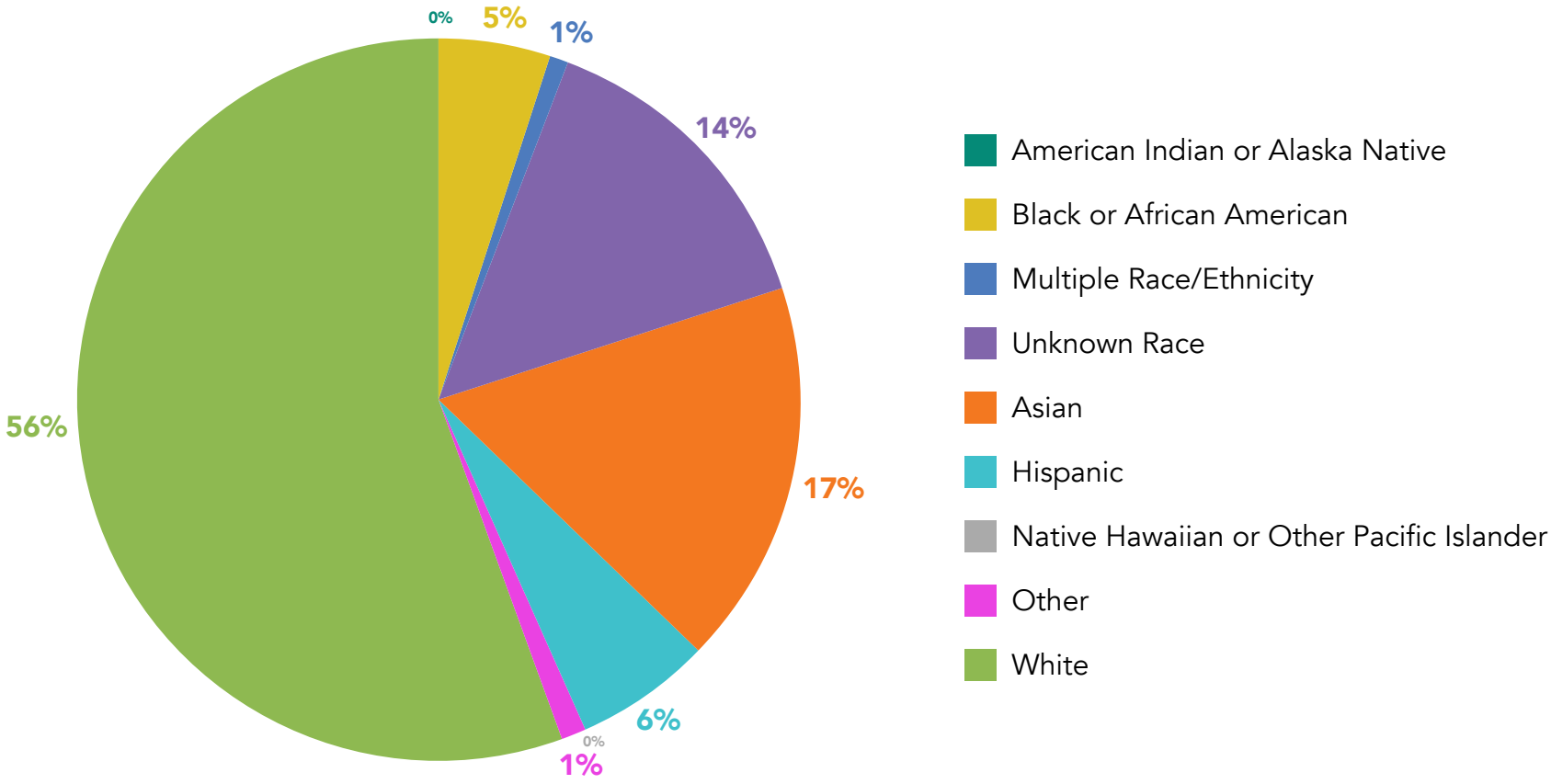


Source: The Agency for Healthcare Research and Quality (AHRQ) 2018

Diversity among physicians is limited. This lack of diversity often leads to mistrust in doctor-patient relationships. National studies have shown that Black patients have better health outcomes when seen by physicians of the same race. Increasing the supply of minority physicians has been proposed as an intervention that might help to enrich differences in health status.[4]

Figure 5 shows the national percentage of active physicians by race/ethnicity. Among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8% identified as Hispanic, and 5.0% identified as Black or African American. Note that the race of 13.7% of active physicians is Unknown, making that the largest subgroup after White and Asian.

Figure 5: Percentage of all Active Physicians by Race and Ethnicity, 2018



Source: Association of American Medical Colleges

[4] National Library of Medicine

GOAL:

Increase access to equitable care by community members, particularly those considered disparate and vulnerable populations.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Street Medicine	Provide primary and preventative care and referrals to vulnerable patients	X	X	X	1,500 patients seen per year	City Light Hope Rescue Mission New Journey Community Outreach YMCA of Reading-Berks County United Way of Berks County Reading Hospital Foundation
	Provide remote access to Street Medicine health professionals via Telemedicine Kiosk	X	X	X	480 telemedicine kiosk virtual visits per year	
	Expand Telemedicine Kiosk program to a second location		X		Launch second telemedicine kiosk location	
	Develop and implement plans for Street Medicine Specialty Clinic	X	X	X	Launch Street Medicine Specialty Clinic	
Mobile Mammography Coach	Operationalize Mobile Mammography program	X			Mobile coach construction completed PA Department of Health inspection passed	Community-Based Organizations Reading Hospital Foundation
	Coordinate community-based screening events	X	X	X	200 screening events per year 3,000 community members screened per year	
Pathways Programs	Increase enrollment in High School Internship Program through expansion efforts	X	X	X	Minimum of 10 high schools represented 30 high school interns per year 10 college interns per year	Berks County School Districts Local Colleges
	Explore opportunities to attain post-secondary academic credits for students participating in High School Internship Program	X	X		Exploratory meetings held with local institutions Receive approvals from schools	Alvernia University Albright College Penn State Berks Reading Area Community College

GOAL:

Increase access to equitable care by community members, particularly those considered disparate and vulnerable populations.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Remote Patient Monitoring	Increase heart failure RPM Program enrollment	X	X	X	100% of enrollment capacity Decrease 30-day all cause heart failure readmissions	
	Develop and pilot RPM Program for diabetes patients		X	X	Diabetes patient pilot launched 100% of enrollment capacity	
	Develop and pilot RPM Program for COPD patients		X	X	COPD pilot launched 100% of enrollment capacity	
Community Paramedicine Program	Provide support to Remote Patient Monitoring heart failure program by offering in-home assessment and education	X	X	X	100% of RPM heart failure patients receive in-home assessment and education	
Hospital at Home Program	Develop and implement Hospital and Home Program	X	X		Hospital at Home Program launched	
	Provide acute care to eligible patients via virtual technology		X	X	100% of eligible patients receive care	
Ride Health	Utilize Ride Health platform to coordinate free transportation to and from appointments for eligible patients	X	X	X	2,600 Rides provided Decrease no show rate in participating sites	Ride Health
	Conduct internal education campaign to increase awareness and utilization	X	X	X	Increase utilization by 5% each year	

GOAL:

Increase access to equitable care by community members, particularly those considered disparate and vulnerable populations.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Community Connection Program	Conduct SDOH Screenings	X	X	X	10,000 patient screenings per year	WellSky® Community-Based Organizations Community Connection Program Consortium
	Offer Community Health Worker (CHW) services and community resources to patients with positive SDOH screenings	X	X	X	75% of patients assigned a CHW 100% of patients with positive screenings receive community resources	
	Utilize clinical-community linkages to create closed-loop referrals to community-based organizations	X	X	X	50% of CHW outreach attempts successful 1,200 referrals generated 60% referral completion rate	
	Apply CCP as an intervention for addressing health disparities in high-risk, vulnerable patient populations	X	X	X	4 health disparities addressed	
	Provide and maintain CHW certification through training and continuing education	X	X	X	100% CHW certification rate 100% CHW re-certification rate	
Access Center/ MyTowerHealth	Continue efforts to migrate decentralized practices to centralized scheduling model	X	X	X	5% increase in practices under centralized scheduling model each year	
	Deploy schedulers in Emergency Department to facilitate follow-up appointment scheduling prior to discharge	X	X	X	50% scheduling success rate	
	Implement Proactive Scheduling Initiative for patients with active orders and no future dated appointment	X	X	X	50% scheduling success rate	
	Promote MyTowerHealth portal to encourage patients to manage individual health	X	X	X	Increase enrollment and engagement in MyTowerHealth platform	


Breast Cancer
Screening
3D Mammography
he Kindness Coalition • Dan and Kath

B) BEHAVIORAL HEALTH

Populations often struggle with overlapping physical and behavioral health issues that stem from psychosocial determinants of health including housing instability or homelessness, unemployment or underemployment, "food desert" neighborhoods and food insecurity, language barriers and health literacy, as well as substance misuse and pollution. These factors can be barriers to how residents can access behavioral health services and impact behavioral health outcomes.

The COVID-19 pandemic has intensified mental health issues. Addressing issues related to care post-COVID is challenging; however, it is important that health care institutions develop or support policies that identify loneliness as the issue is a public health concern that impacts people of all ages. Loneliness, according to the American Medical Association, is a significant cause of premature death resulting from impaired sleep, symptoms of depression, and poor general health. Policies must include structures that combat loneliness.[5]

More than 60% of community survey respondents noted behavioral health as having the greatest impact on overall community health. The COVID-19 pandemic, social distancing policies, mandatory lockdowns, isolation, and the fear of getting sick made the need and ability to access to behavioral health services even more challenging.

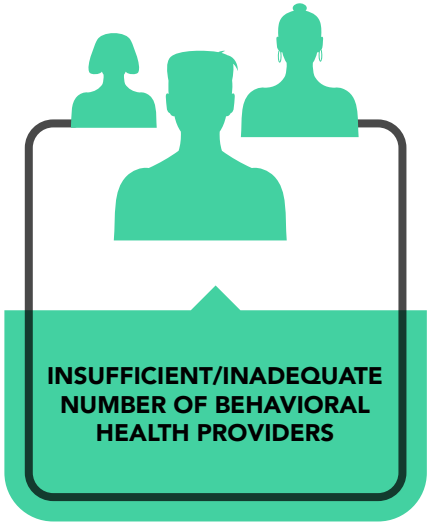
The 2022 CHNA IS embraces addressing the needs of these high-risk populations and provides behavioral health services, support systems, human services and housing support. Successful behavioral health outcomes require data sharing among clinicians and collaborative case management.

[5] American Medical Association, 2022 AMA Annual Meeting, Public Health. June 2022

COMMENTS FROM PRIMARY DATA COLLECTION:

LACK OF BEHAVIORAL HEALTH AND MENTAL HEALTH SERVICES

MANY ARE UNAWARE OF BEHAVIORAL HEALTH AND MENTAL HEALTH SERVICES AVAILABLE



INSUFFICIENT/INADEQUATE NUMBER OF BEHAVIORAL HEALTH PROVIDERS

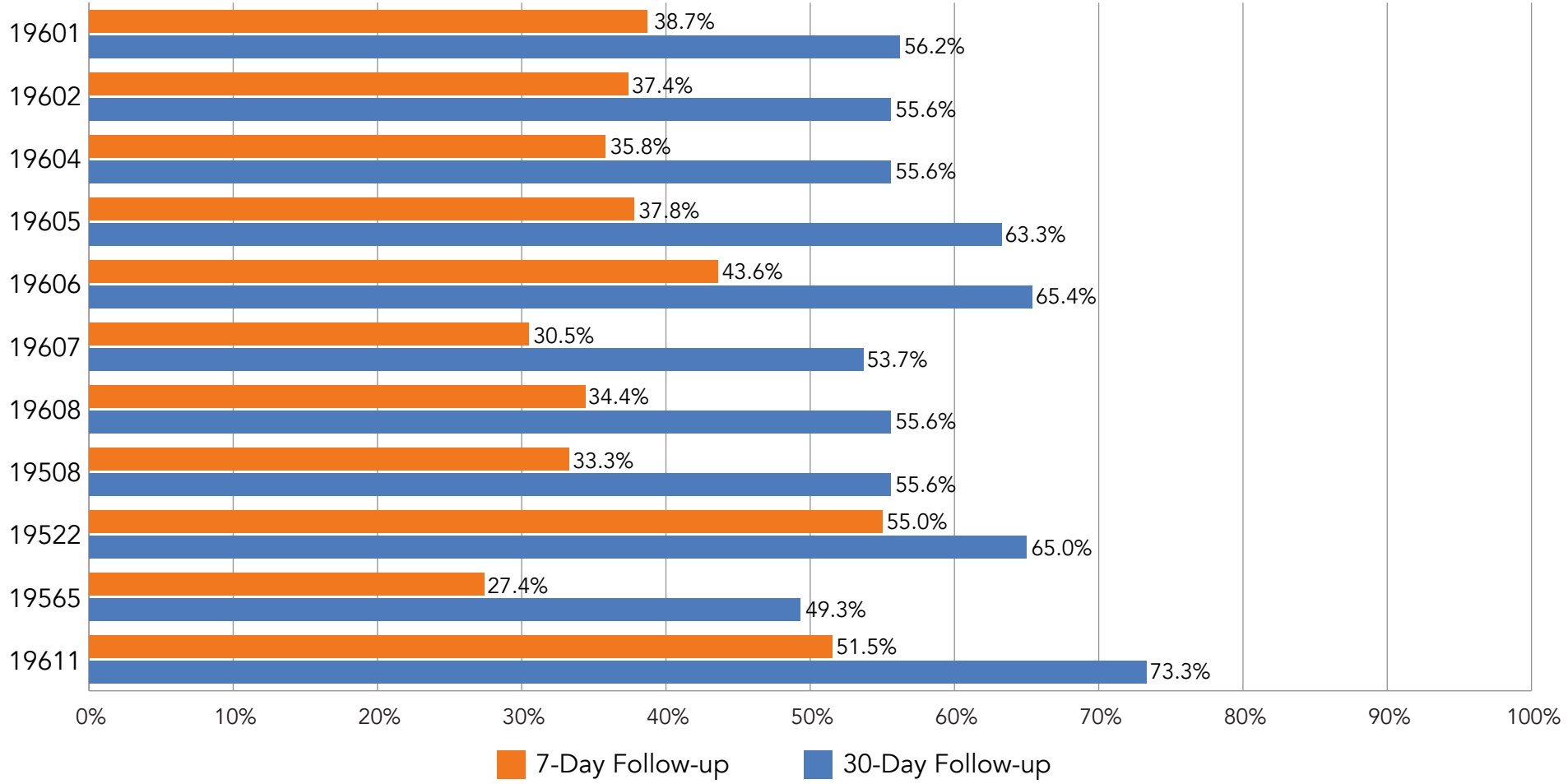
LACK OF BEHAVIORAL HEALTH SUPPORT SERVICES

HIGH DRUG AND ALCOHOL USAGE

BETTER COORDINATION AND INTEGRATION OF SERVICES NEEDED

Figure 6 illustrates percentages of adults by ZIP codes of mental health admissions with either a seven-day or 30-day follow-up. Follow-up care after hospitalization for mental illness or intentional self-harm helps improve health outcomes and prevent readmissions. Recommended post-discharge treatment includes a visit with a mental health provider within 30 days after discharge. Ideally, patients should see a mental health provider within seven days after discharge.[6]

Figure 6: Percent of Readmissions by ZIP code



Data was unavailable for ZIP codes 19508, 19510, 19522, 19523, 19536, 19540, 19560, 19565, 19611, 19612, and 19542.

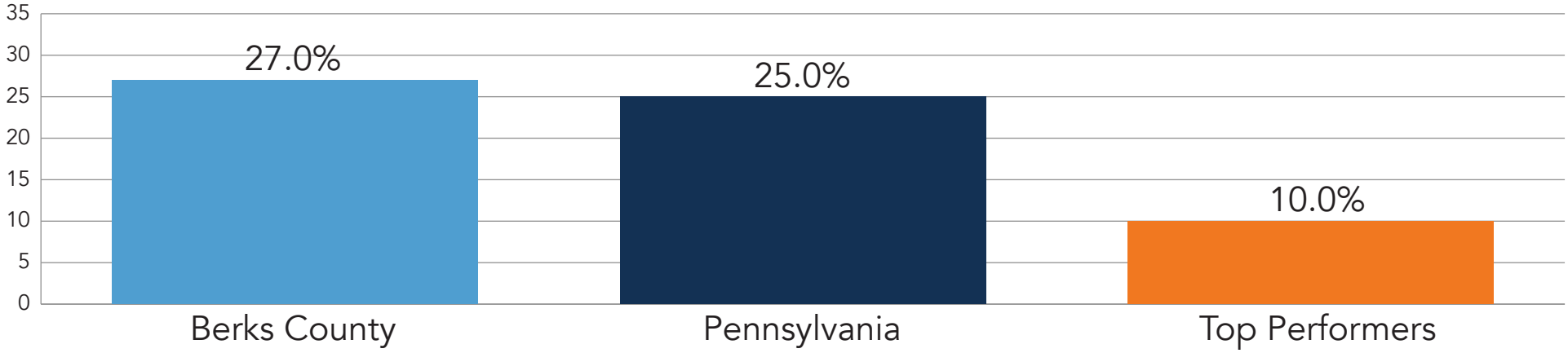
Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[6] Medicaid.gov.

Alcohol and tobacco use are root causes of and can further exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk. When analyzing driving deaths involving alcohol impairment, rates in Berks County are worse when compared to the state. Comparing a county's value to top U.S. performers (10% of the nation's counties are doing better than this value for this measure) can provide information about how well the county is doing in a national context.

Figure 7 illustrates the percentage of driving deaths involving alcohol impairment for Berks County, the state, and top performers.

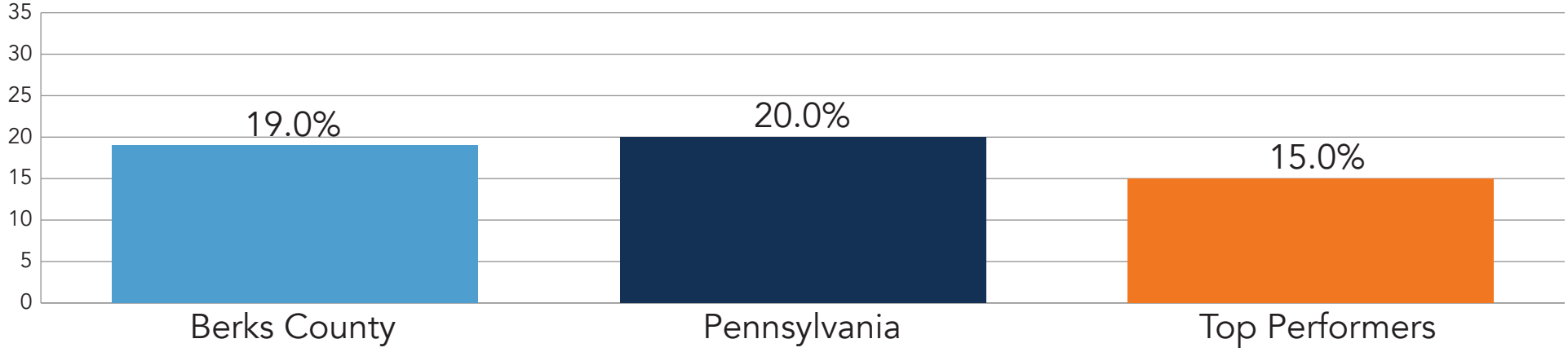
Figure 7: Driving Deaths Involving Alcohol Impairment



Source: County Health Rankings & Roadmaps 2016-2020

Figure 8 illustrates the percentage of adults in the past 30 days who reported binge drinking or heavy drinking in Berks County, the state, and top performers.

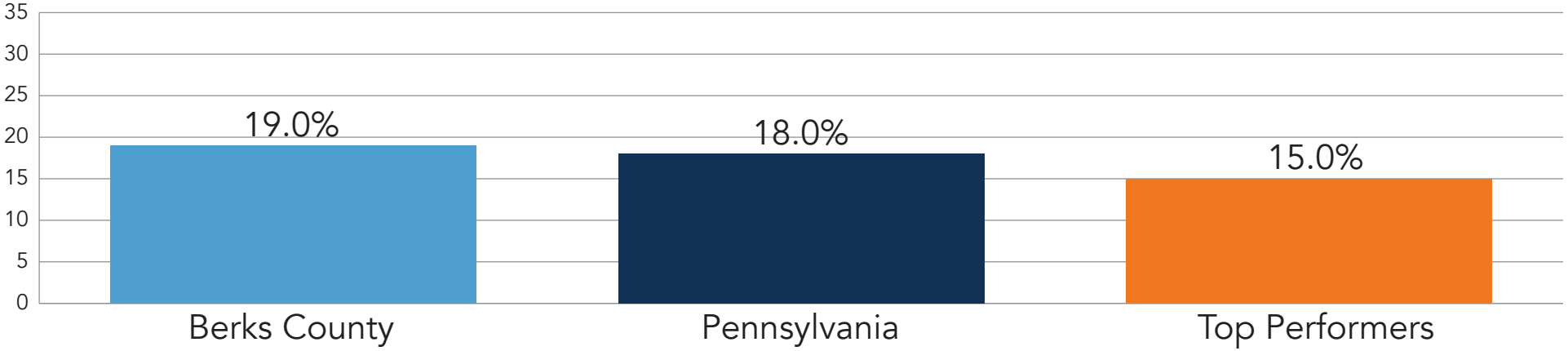
Figure 8: Adult Excessive Drinking[7]



Source: County Health Rankings & Roadmaps 2019

Figure 9 shows adults 18 and older who smoke in Berks County and the state. Adult smoking is the percentage of the adult population in a county who both report that they smoke every day or some days and have smoked at least 100 cigarettes in their lifetime. The prevalence of tobacco can alert communities to the adverse health outcomes and can be valuable for implementing needed cessation programs or evaluating the effectiveness of existing tobacco control programs.

Figure 9: Adult Smoking — Current Smokers



Source: County Health Rankings & Roadmaps 2019

[7] 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. 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.


8
7
15
22
21
quit today

GOAL:

Improve access to support for behavioral health services.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Opioid Use Disorder Center of Excellence	Screen patients for Opioid Use Disorder (OUD) and appropriate level of care via the ASAM placement model	X	X	X	400 patient encounters per year 50% referred to follow-up care via ASAM LOC	Berks County Children & Youth Berks County Probation Office Berks Community Health Center Recovery Coaching Services Adult and Teen Challenge Pyramid
Soft Landing Program	Screen patients for substance use disorder (SUD) and appropriate level of care via the ASAM placement model	X	X	X	97% of all patients complete ASAM and GPRAs (intake, follow up, and discharge)	
	Complete the GPRA on all program participants	X	X	X		
Mental Health First Aid (MHFA) Training	Identify and train 2 Reading Hospital staff to conduct MHFA Trainings	X			2 Reading Hospital staff receive MHFA Trainer certification Trained staff conduct 6 MHFA Trainings per year	National Council for Mental Wellbeing
	Conduct MHFA trainings at Reading Hospital and in community		X	X	Host two Reading Hospital employee MHFA trainings per year Train 60 hospital employees per year Support community based MHFA trainings per year	Berks Counseling Center
	Provide financial assistance to eligible CBOs with limited resources to increase access to trainings	X	X	X	Financial assistance provided to eligible organizations	

GOAL:

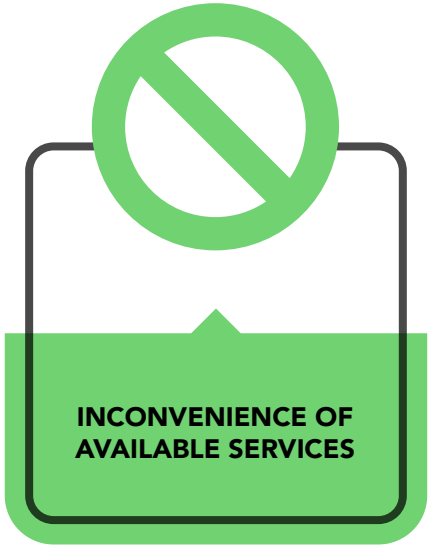
Improve access to support for behavioral health services.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Tower Employee Wellness Initiatives	Conduct Schwartz Rounds, multidisciplinary forum for employees to discuss social and emotional issues that arise in caring for patients	X	X	X	Host 9 Schwartz Rounds per year	The Schwartz Center for Compassionate Healthcare
	Promote RethinkCare app to support employees' personal, professional, and parental needs	X	X	X	15% of staff actively using app	
	Implement Marvin Telemedicine Program to provide digital behavioral health services for hospital staff	X	X	X	95% use of service satisfaction rate reported	
	Launch Well-Being Index to assess provider burnout and develop resources to mitigate stressors	X	X	X	100% participation by residents and fellows 40% participation by physicians	Mayo Clinic

C) HEALTH EDUCATION AND PREVENTION

Health education and health literacy play a vital role in accessing care as knowledge and understanding empowers individuals to make informed health decisions and helps them effectively navigate today's complex health care delivery system. Providing health education to increase understanding of health issues enables patients and families to successfully implement treatment plans and is essential to managing chronic conditions and preventing complications or frequent hospitalizations. By improving health literacy and education on how to address and prevent chronic diseases and illness to the broader community, the health organization's paradigm shifts from treating disease to a focus on wellness, healthy behaviors, and positive health outcomes.

COMMENTS FROM PRIMARY DATA COLLECTION:



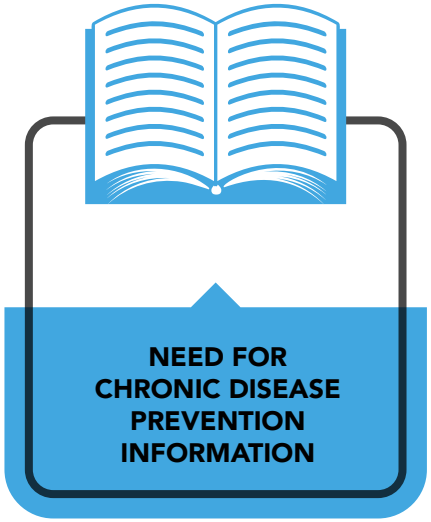


Figure 10 from the community survey shows health behaviors for which people in the community need more information.

Figure 10: Top Health Behaviors for Which People Need More Information

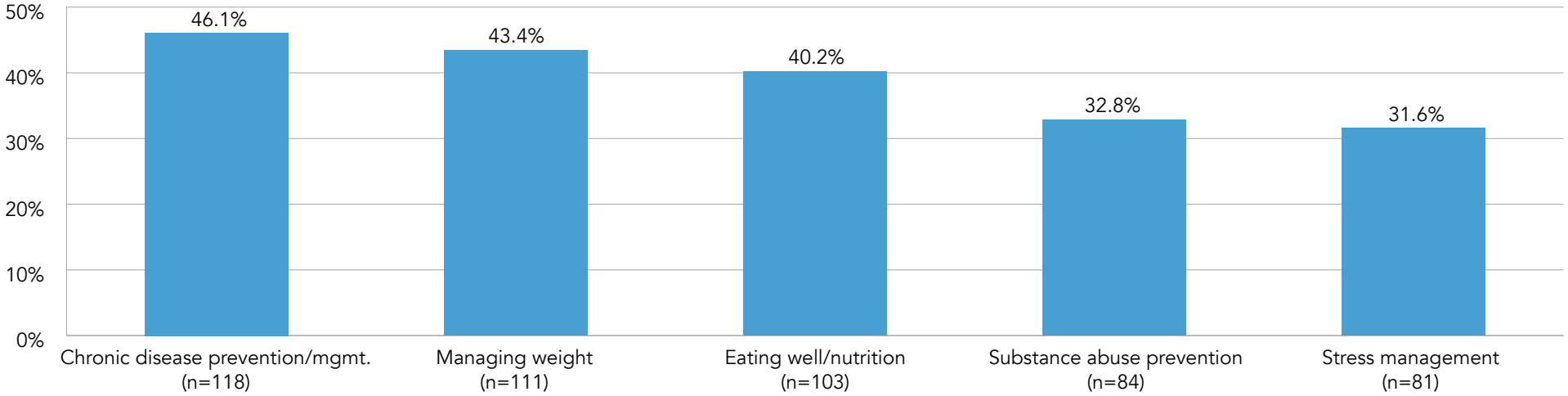


Figure 11 from the community survey reports how the community wants to receive health information.

Figure 11: Top Ways Community Wants to Receive Information

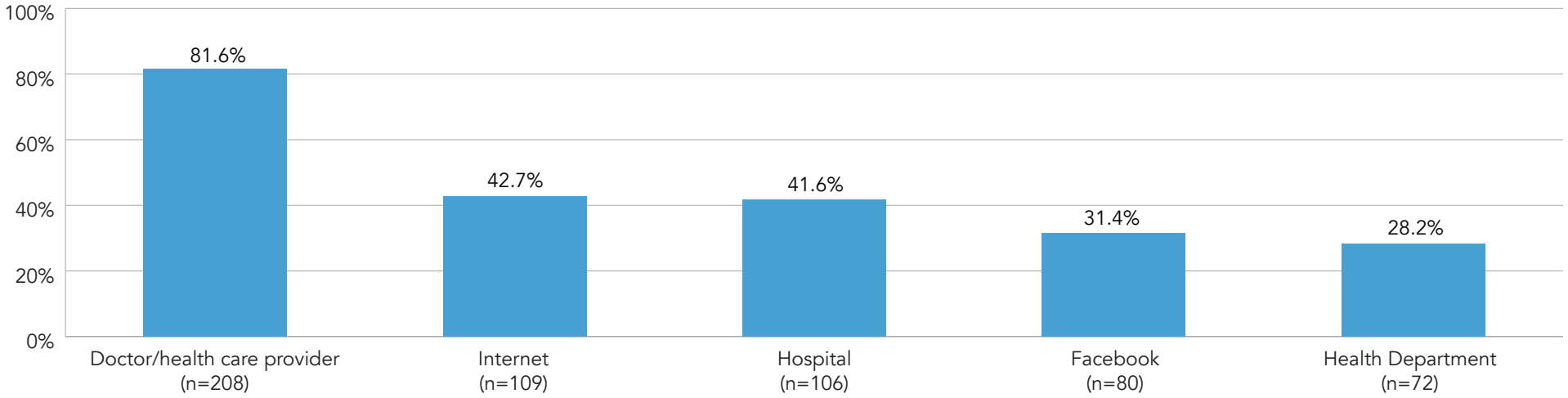
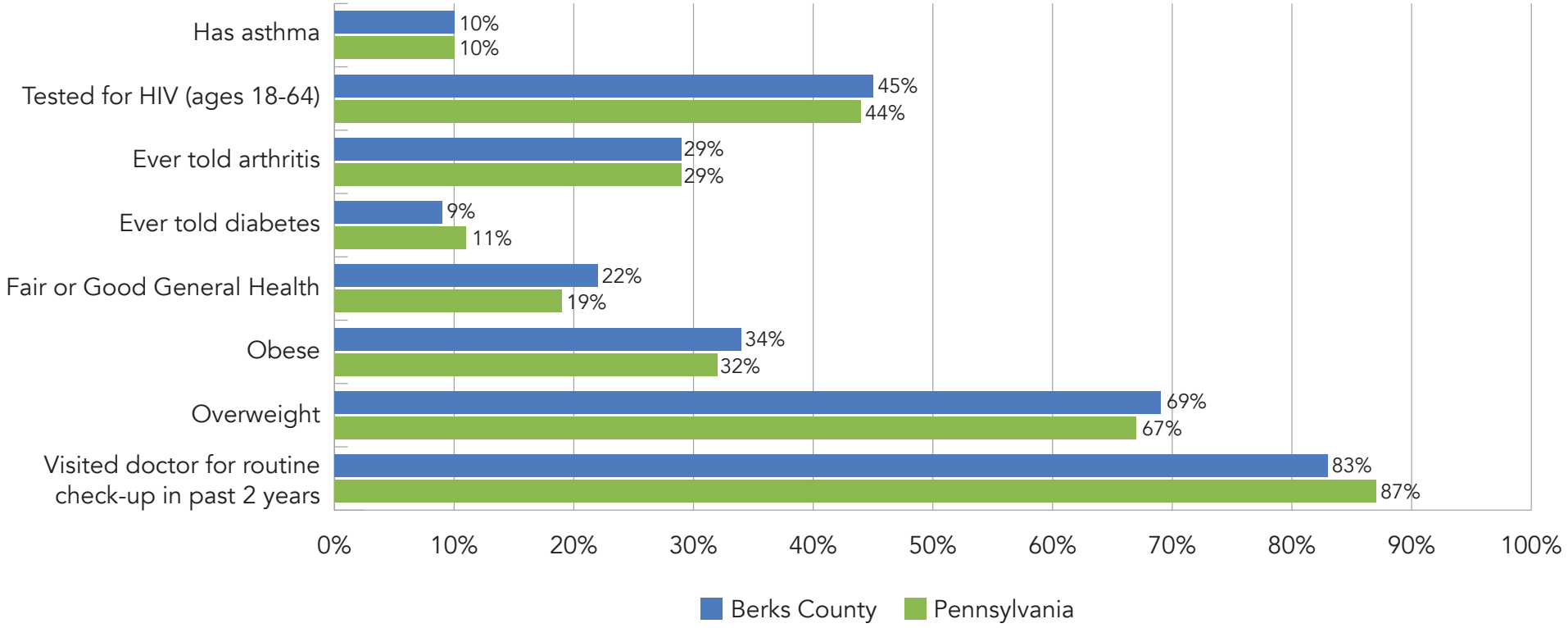


Figure 12 shows adult health risk behaviors, health outcomes, and general health in Berks County and Pennsylvania. Specifically, the graph depicts a higher rate of Berks County adults at risk of being obese/overweight compared to the state rate and a lower rate of Berks County adults having completed a routine checkup in the past two years.

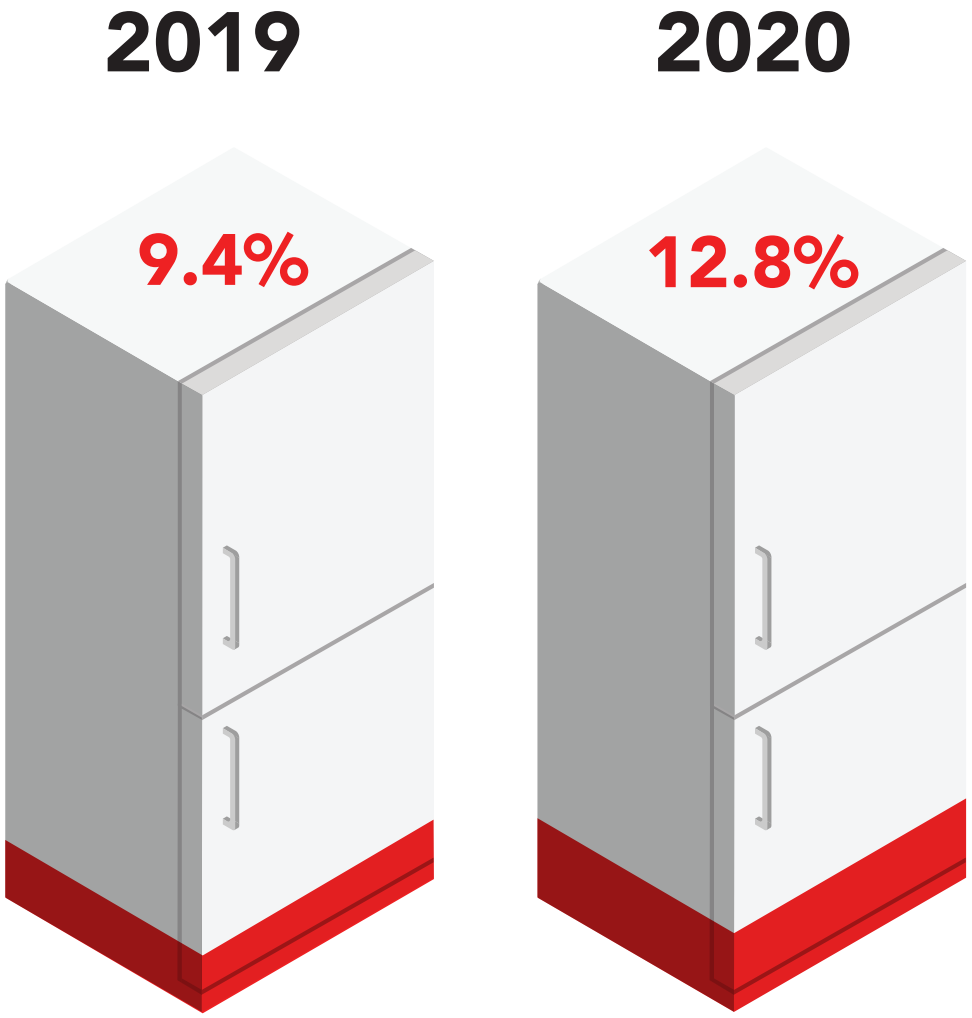
Figure 12: Overall Adult Health Risks



Source: Pennsylvania Department of Health 2017-2019

The continued effects of the COVID-19 pandemic have negatively impacted access to food for millions of people, many of whom are experiencing food insecurity for the first time along with those who faced food insecurity before the crisis began. Improving food security impacts health outcomes particularly as it relates to chronic diseases such as diabetes, heart disease, and certain forms of cancer. Providing health education and promoting prevention enables patients and families to better manage and avoid chronic diseases.

Figure 13: Food Insecurity in Berks County



Source: Feeding America 2019

"

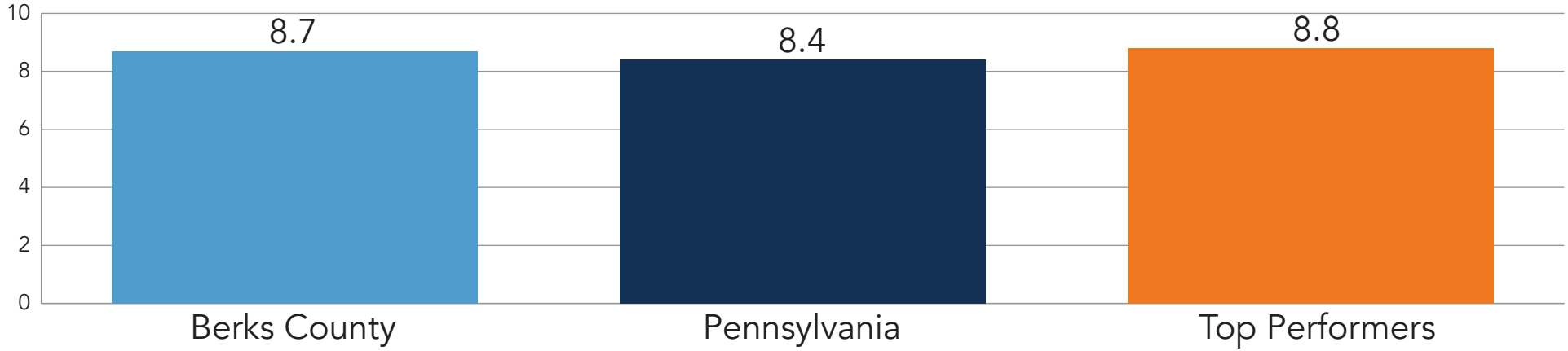
"Helping Harvest Fresh Food Bank distributed **5.4 million pounds** of food valued at **$7.2 million** in Berks County in 2019. In 2020, those numbers rose dramatically to **9.1 million pounds** valued at **$12 million**."

Jay Worrall

President
Helping Harvest

The County Health Rankings measure of the food environment accounts for both proximities to healthy foods and income. This measure includes access to healthy foods by considering the distance an individual lives from a grocery store or supermarket, locations for health food purchases in most communities, and the inability to access healthy food because of cost barriers. Figure 14 reveals that Berks County has a higher index when compared to the state. The index ranges from 0 (worst) to 10 (best). Low-income populations face multiple barriers to leading a healthy lifestyle. The lack of healthy foods is related to negative health outcomes and increased health care costs.

Figure 14: Food environment index



Source: County Health Rankings

GOAL:

Provide disease education and prevention opportunities in the community, specifically targeting disparate and vulnerable populations.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Berks Trail Challenge	Plan and execute annual Berks Trail Challenge encouraging exploration of local parks and trails through a free, mindful leisure activity	X	X	X	350 participants per year	Berks County Parks and Recreation Department Blue Mountain Eagle Climbing Club
Green Commute Initiatives	Relaunch Bike Share Program		X	X	50 new users per year 200 rides taken	Movatic
	Coordinate annual Bike to Work Week Ride		X	X	40 participants per year	Commuter Services of Pennsylvania
	Promote green commuting as a healthy, environmentally friendly option		X	X	4 events promoting bike safety and/or green commuting per year	
Disease and Preventive Screenings	Conduct blood pressure screenings	X	X	X	15 blood pressure screening events per year	Community-Based Organizations
	Conduct breast and cervical cancer screening events	X	X	X	12 screening events per year 100 community members screened per year	
	Conduct prostate cancer screening events	X	X	X	2 screening events per year 30 community members screened per year	
Fresh Food Pharmacy	Develop plans and launch a Fresh Food Pharmacy targeting vulnerable patient population(s)	X	X	X	Fresh Food Pharmacy launched 20 participants per year	Alvernia University Project 6 Helping Harvest
Tower Employee Wellness Initiatives	Conduct Know Your Numbers Campaign (BMI, BP, lipids, A1C) through Virgin Health app		X	X	30% of staff participating in campaign	
	Engage employees with PCP		X	X	65% of staff attest to establishing care with PCP	
	Encourage engagement with Virgin Health platform for wellness-based education and activities	X	X	X	50% of staff enrolled in platform by 2024	

GOAL:

Provide disease education and prevention opportunities in the community, specifically targeting disparate and vulnerable populations.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Community OutReach & Engagement (CORE) Programs	Develop community calendar to increase awareness and participation in Community OutReach & Engagement (CORE) Programs	X	X		Community calendar created	Community-Based Organizations
	Provide health and wellness education in community	X	X	X	50 events per year	
	Conduct chronic disease education and prevention campaigns	X	X	X	1 campaign per year	
	Relaunch Employee Volunteering Program in community		X	X	15 events per year 250 staff participants per year	
	Provide sponsorship dollars to eligible community-based organizations with similar community benefit objectives	X	X	X	Funding distributed to eligible organizations	
Violence Prevention Initiatives	Conduct Stop the Bleed Trainings	X	X	X	125 community members trained	
	Develop and implement a Hospital-Based Violence Intervention Program (HVIP)		X	X	HVIP program created Baseline metrics established	
	Establish violence screening and referral processes and pilot in clinical sites		X	X	Processes developed Pilot program in Peds and OB/GYN (2023) and primary care practices (2024)	
	Establish annual employee violence education addressing patients, patient care, and the workplace		X	X	100% of staff complete annual education	
	Utililize BulletPoints evidence-based curriculum to educate providers about firearm injury prevention		X	X	100% of physicians in screening and referral pilots complete curriculum	The BulletPoints Project
	Create a Workplace Violence Policy	X			Workplace Violence Policy created	
	Establish team to analyze workplace violence incidents	X	X	X	Review team established	

D) HEALTH EQUITY

Across the nation, gaps in health are large, persistent, and increasing — many of them are caused by barriers set up at all levels of our society. After all, it is hard to be healthy without access to good jobs, quality schools, and safe, affordable homes. Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, or how much money we make (Robert Woods Johnson Foundation).

The 2022 CHNA IS places a strong focus on health equity as essential to improving health status. Health providers must be equipped with the consciousness, tools, and resources to confront embedded health inequities and to advance equity within and across all aspects of the health care system. Because many health inequities are rooted in historical and contemporary injustices and discrimination, achieving health equity is difficult and daunting work that must be strengthened, amplified, and sustained.

Just as the health care sector has expanded its focus beyond illness treatment alone to addressing social determinants of health, we also recognize that there are complex forces and systems that shape the conditions of our daily lives and impact health outcomes. These forces are described as inequities, social injustice, structural racism, and discrimination. Likewise, we must expand our perspectives and heighten our understanding to address health inequities.

According to the Centers for Diseases Control and Prevention (CDC), health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

Understanding and addressing the needs of diverse and disparate populations is a significant challenge for health care organizations. As a critical aspect of creating health equity, efforts to provide culturally competent and linguistically appropriate care to very diverse racial and ethnic communities with various cultural beliefs, perceptions, and health practices must be continuous. Achieving health equity requires us to systemically define, measure, and improve the community infrastructure and enhance health system leadership perspectives, operations, and practices. The following goal to achieve health equity is designed to eliminate health inequities, close disparity gaps, and improve health outcomes.

COMMENTS FROM PRIMARY DATA COLLECTION:

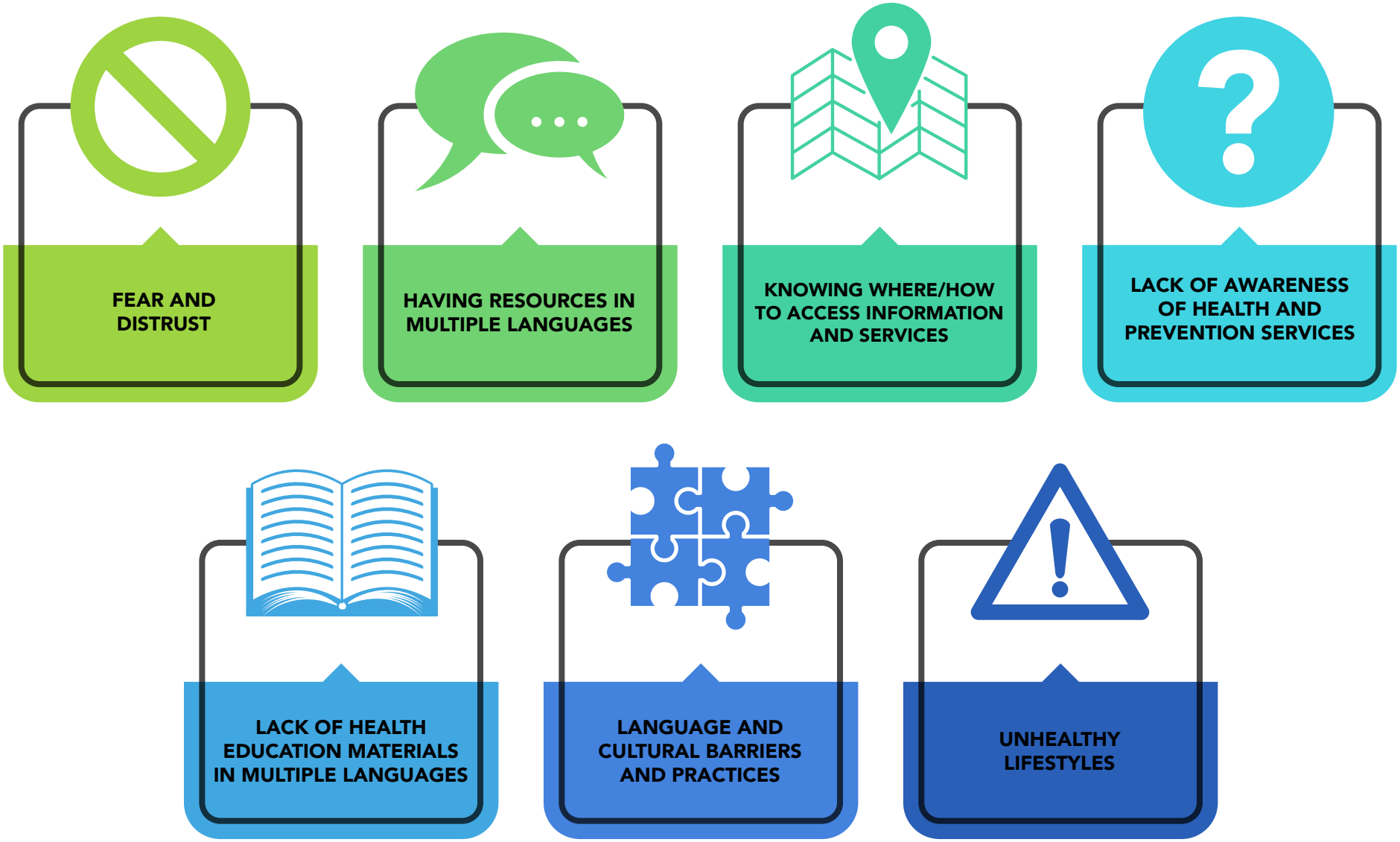
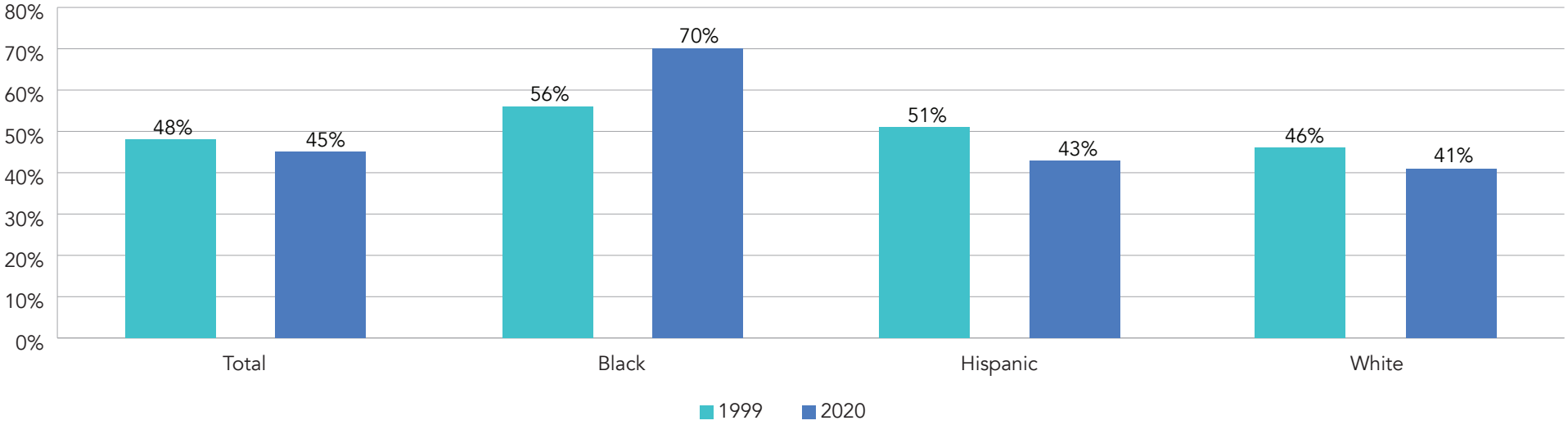


Figure 15 reveals the rates at which people perceive that healthcare systems mistreat people based on race and ethnicity in the years 1999 and 2020. This data highlights disparities in demographics that should be considered when providing healthcare services.

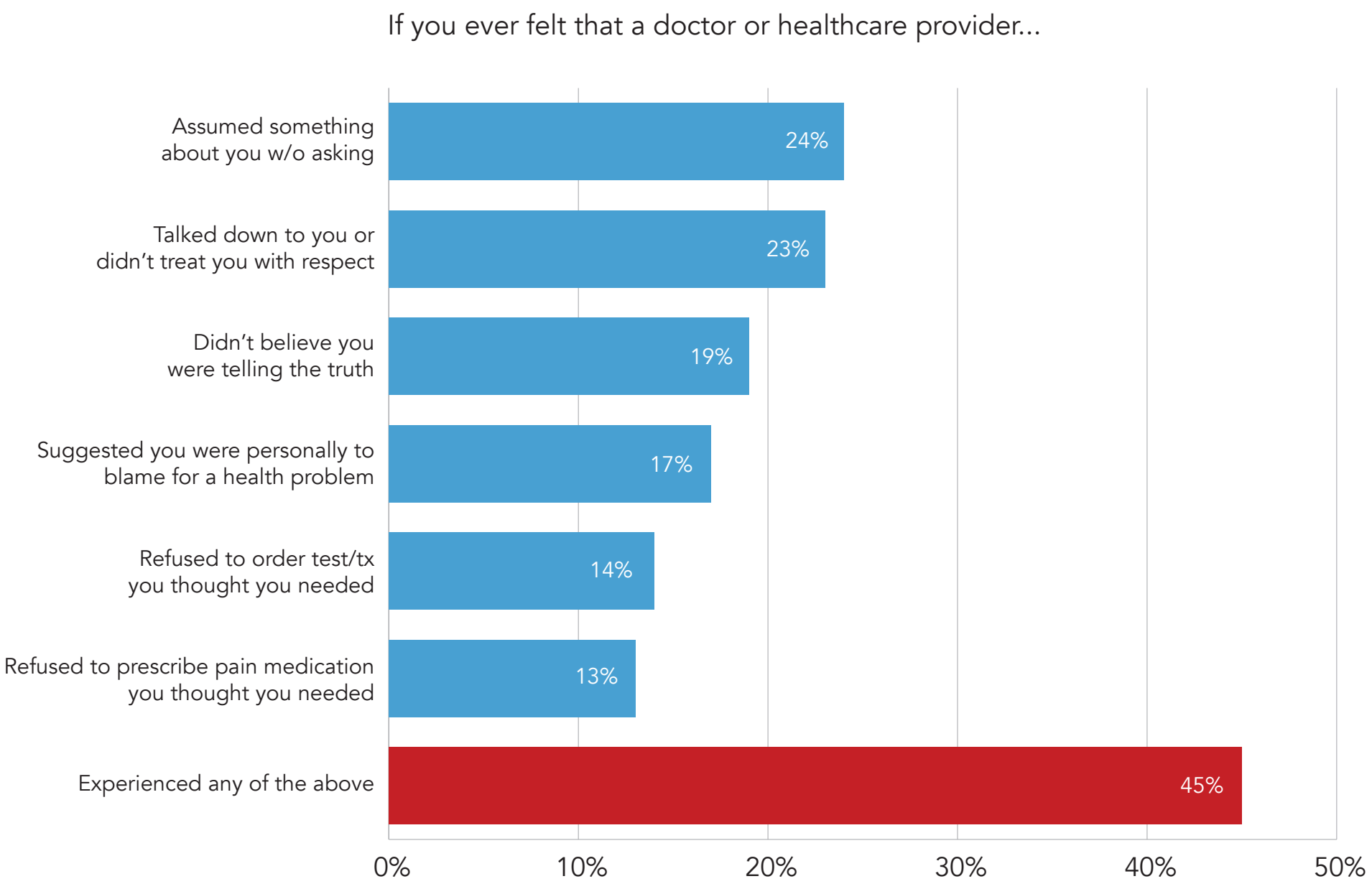
Figure 15: Percentage That Thinks the Healthcare System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often



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

Figure 16 reports that nearly half of adults reported one of six negative experiences with healthcare providers in the last three years.

Figure 16: Percentage Reporting Yes to Negative Experiences with a Doctor or Healthcare Provider

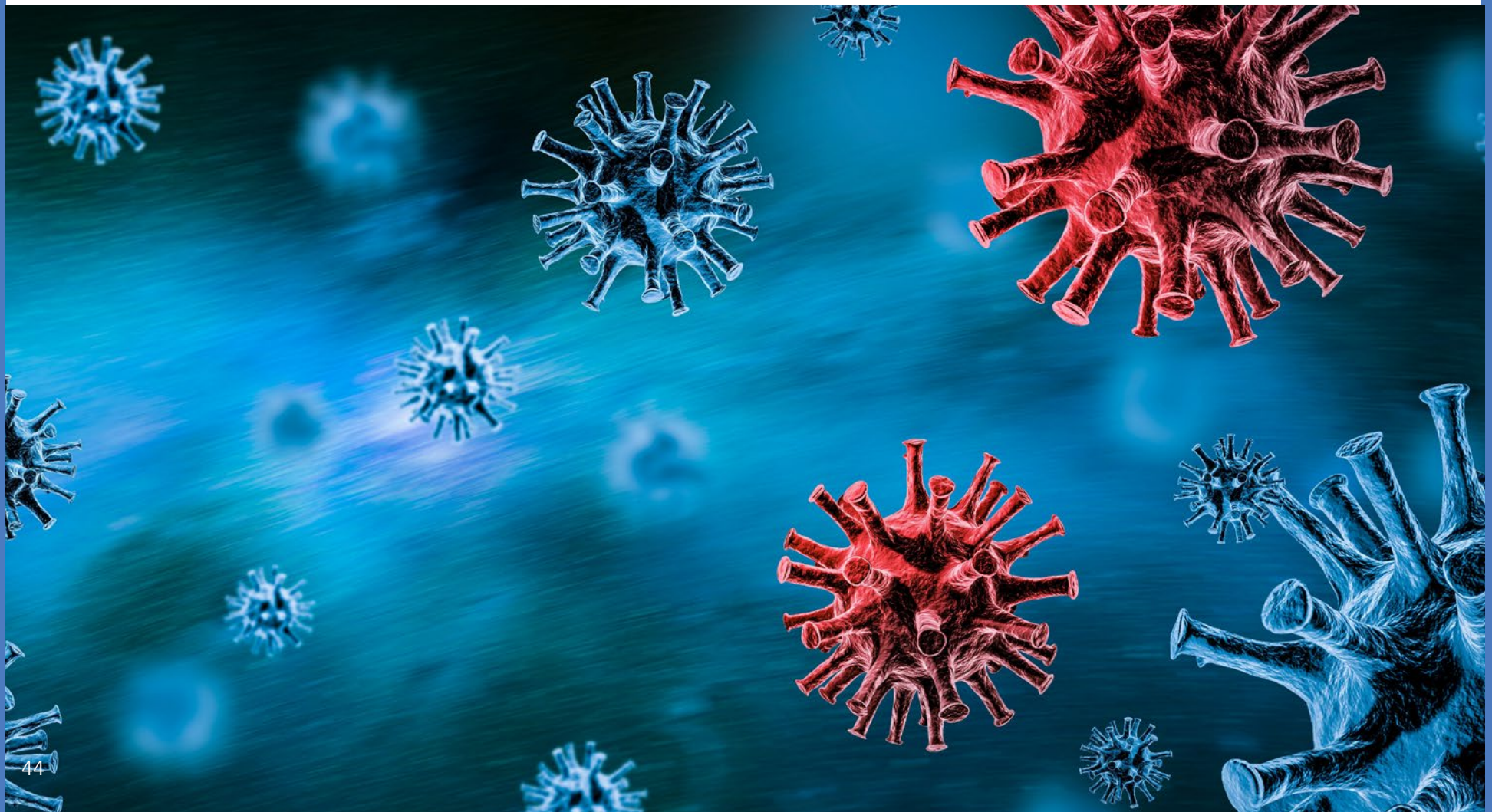


Source: KFF/The Undefeated Survey on Race and Health 2020

COVID-19 AND HEALTH EQUITY

The response to COVID-19 highlighted issues of health inequity and revealed that those hardest hit by the virus faced economic and housing challenges, lacked health insurance coverage, and had severe food insecurity issues. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC). 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. The CDC reported that essential employees (those in health care, food services, and transportation) were much more likely to die than other workers.

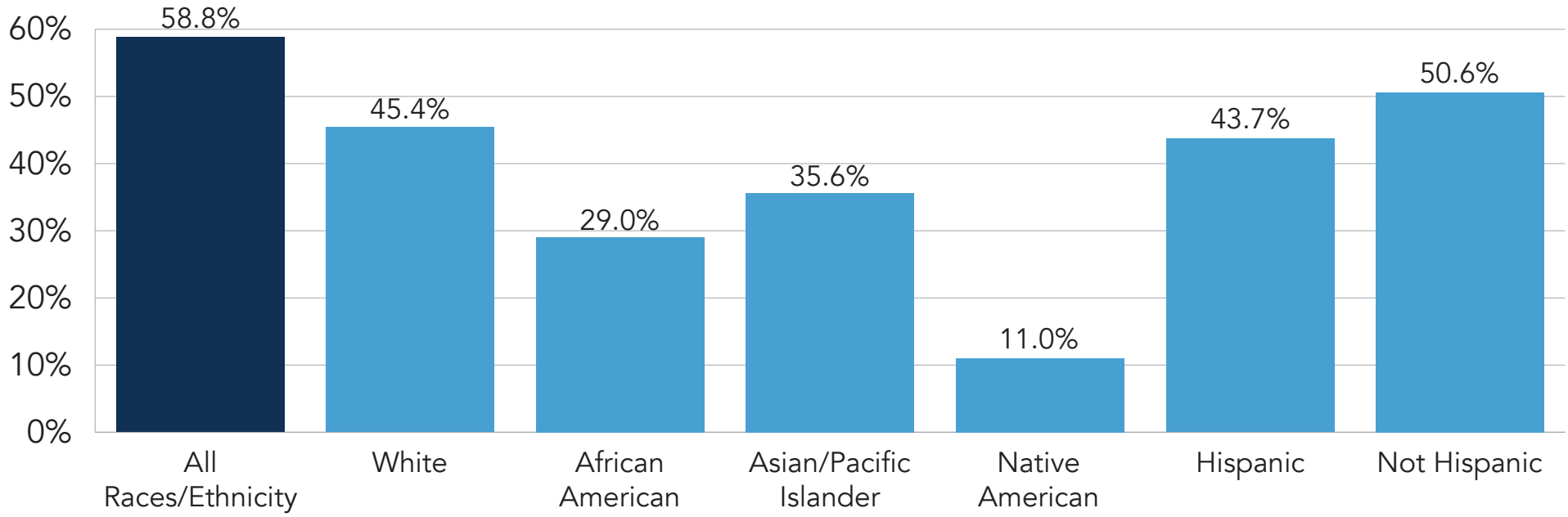


COVID-19 has further exacerbated existing inequalities, with many people suffering from chronic illnesses and other conditions that increase their risk of severe illness. Underserved communities continue to feel the brunt, and the lack of investment in addressing barriers to healthy and productive lives 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.

More collaboration and community support are necessary to combat issues of health equity. Improvements in health services and patient care experience in rural communities will address existing inadequacies, unique cultural needs, and pitfalls experienced and highlighted through the COVID-19 pandemic.[8] Encouragement and the use of telehealth services provided within service areas should continue to familiarize health care providers and the community on how effective these platforms can fuse the gap between patients and providers.[9]

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 17: Full Vaccination Coverage for Race/Ethnicity in Berks County



Source: The PA Department of Health

GOAL:

Integrate Health Equity into care delivery, strategy, and operations at Reading Hospital.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Health Equity Council	Establish and convene council	X	X	X	Council convened	
	Complete Health Equity Assessment and review Transformation Action Plan	X			Assessment completed TAP Reviewed	
	Create Health Equity Action Plan and Evaluation Plan to identify and address disparities through actionable strategies		X		Health Equity Action Plan adopted Evaluation Plan created Baseline data report compiled 4 priority strategies identified	
	Create Health Equity Dashboard report to communicate plan and progress		X	X	Progress shared annually	
REaL Data Program	Conduct education campaign on the importance of collecting REL data for staff and patients		X	X	Decrease rate of unknown, refused, and blank REaL data fields in patient records 100% training completion rate for Patient Registration staff	
Patient Family Advisory Council	Develop a Patient Family Advisory Council		X		Advisory Council created	
Expand Language Access	Expand use of language and interpretation services offered through virtual visits	X	X	X	Increase use of virtual visits for non-English speaking patients	
	Train current bilingual staff to become Certified Medical Interpreters		X	X	30 staff trained annually	
	Enhance Advance Access Center phone prompts to include Spanish options	X	X	X	Phone prompts updated	
Broadband Access Initiatives	Participate in county-wide broadband access coalition and assist with development and implementation of group activities	X	X	X	Attendance at recurring meetings Support provided to initiatives identified by group	

EQUALITY

EQUITY

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Reading Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.