CHNA 2019

APPENDIX
ACUTE CARE HOSPITALS

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Appendix B. Methodology and data sources: Full text

This CHNA was developed using a data and partnership driven approach, multiple data sources, and engagement from a variety of community constituents. As part of this process, MLH contracted with Public Health Management Corporation's (PHMC) Research & Evaluation Group (R&E Group), to collect and analyze data, as well as engage the Greater Delaware Valley community residents and key stakeholders serving the community to comprehensively characterize the populations and inform understanding of community health needs. Data sources included:

- **The 2018 Southeastern Pennsylvania Household Health Survey (SEPA HHS)**, R&E Group developed and has fielded the SEPA HHS for the past 35 years. The 2018 SEPA HHS was administered to 7,501 households, using a random-digit dial phone survey method, across Montgomery, Chester, Delaware, Philadelphia, and Bucks Counties. The SEPA HHS provides the most unique and comprehensive source of health-related data, solely focused on the SEPA region. Additionally, the SEPA HHS offers unique insights into the local health and social services issues, and includes questions unavailable from other sources. It is the principal data source for this CHNA report. In-depth survey methodology and accompanying documentation can be found at www.chdbdata.org

- **2018 United States Census** data estimates provided by Claritas Pop-Facts® Premier provided a picture of the socioeconomic and demographic characteristics of MLH's service area. Census-based demographic data are derived from 2018 Claritas Pop-Facts® Premier and processed by PHMC. Claritas Pop-Facts® Premier is a proprietary database comprised of demographic data adapted from the U.S. Census, American Community Survey (ACS) and other known and highly utilized data sources, such as residential data from the U.S. Postal Service, utility companies and marketing firms.

- **Vital Statistics** data from the Pennsylvania Department of Health details trends in births, birth outcomes, prenatal care, leading causes of death, and cancer incidence for the communities served by MLH.[1]

- **Key Informant Interviews and Focus Group** data from community members and service area constituents was also collected by speaking with patients, business and government stakeholders, faith-based stakeholders, and social services organizations. MLH and PHMC co-developed all relevant guides and survey questions to elicit information and perspective across multiple stakeholders about community health needs. Thematic and descriptive analysis of data elucidate additional, unique health-related barriers, needs, resources, and strengths of prominent population subgroups for example, otherwise limited in scope or unable to be captured by broadband, quantitative means. MLH staff identified potential participants based on recommendations received from other MLH administrators and knowledge with the community. Fifteen out of 37 invited individuals participated in key informant interviews, and fourteen of approximately 90 invited individuals participated in focus groups. Patient focus groups were open to patients and their families.

  Representatives from the following organizations participated in focus groups or key informant interviews: Radnor Police Department, Merrill Lynch, Montgomery County Children

[1]These data were provided by the Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

and Youth, Regional EMS Delaware County, Montgomery County Office of Aging and Older Adult Services, Chester County Health Department, EarthSmart Consulting Rails to Trails program, PALM Senior Center of Ardmore, The Foundation for Delaware County, West Philadelphia Library Cluster, Montgomery County Health & Human Services, Delaware and Chester Counties Medical Society, Bryn Mawr Presbyterian Church, Surrey Services for Seniors, Alzheimer's Association Greater PA Chapter, representatives from Chester County District Attorney's Office, Drexel University College of Health Professions, Philadelphia Corporation for Aging, The Food Trust.

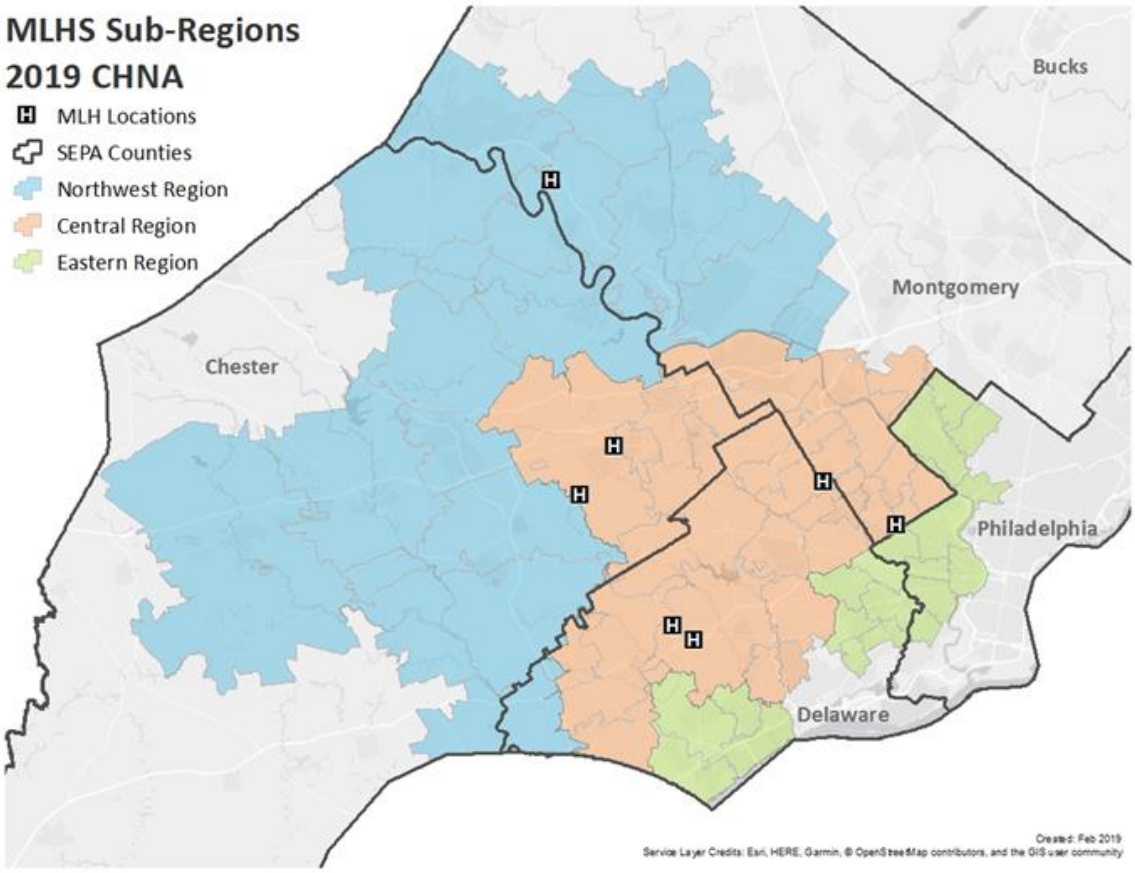
MLH representatives from the following facilities also participated in key informant interviews: Bryn Mawr Rehabilitation Hospital, Lankenau Medical Center, Paoli Hospital, Main Line Health Centers, Riddle Hospital, Bryn Mawr Hospital.

- **Community Leader and Member Survey** data on a convenience sample of community partners and residents was collected to understand perceptions of global community health, health equity, local resources and utilization of health care services. A select number of questions were also included for comparative analyses with SEPA HHS. MLH and PHMC co-developed survey questions. The convenience sample of community members was identified from a MLH e-newsletter mailing list containing current and prior patients, as well as other individuals connected to MLH. The sample of community leaders was from a list of individuals nominated by various MLH staff members.

The CHNA additionally incorporates broad measures related to health and well-being, including Healthy People 2020 goals, as a comparator for findings from our secondary data analyses, and to assist with prioritization of health needs in our hospital communities.

Service area zip codes included for this CHNA report included:

Central: 19355, 19008, 19060, 19073, 19373, 19087, 19010, 19083, 19301, 19312, 19064, 19063,19003, 19342, 19333, 19041, 19081, 19406, 19096, 19004, 19072, 19085, 19066, 19035,19428,19319, 19444
Eastern: 19014, 19061, 19015, 19026, 19036, 19018, 19013, 19082, 19050, 19151, 19127, 19131, 19128, 19023, 19118, 19139, 19104, 19129, 19143, 19119, 19142
Northwest: 19453, 19341, 19335, 19380, 19382, 19425, 19460, 19372, 19317, 19320, 19405, 19426, 19475, 19468, 19403, 19465, 19401, 19464, 19383, 19473



Health needs were identified and prioritized by chi-square tests of significance comparing the health status, access to care, health behaviors, and utilization of services for residents to results for SEPA from the 2018 SEPA HHS. Where possible mortality, birth outcomes, and indicators from the HHS were compared to state and national benchmarks, such as Healthy People 2020 goals. Direct comparisons to data from the 2015 CHNA were not made in this report due to differences in service area ZIP codes. Input from community stakeholders was used to fill information gaps and to further identify and prioritize unmet needs, particularly for populations of interest. Additional data sources were also incorporated, such as the online surveys, and contributed to the evidence base behind identified needs.

Appendix C. PHMC qualifications

Public Health Management Corporation (PHMC) is a 501(c)(3) non-profit corporation founded in 1972. PHMC serves as a facilitator, developer, intermediary, manager, advocate, innovator, and researcher in the field of public health.

The Research & Evaluation Group (R&E Group) at PHMC has extensive experience working in applied research and evaluation of health services, public health, social services, and education systems in the Southeastern Pennsylvania region. With more than 50 successfully completed Community Health Needs Assessments (CHNA) since 2013—including Main Line Health's CHNA reports in 2013 and 2016 —R&E Group brings a wealth of expertise and content knowledge to the CHNA process.

R&E Group develops CHNAs in partnership with our clients, using a number of data-oriented approaches, to best integrate secondary and primary data in order to describe the most pressing health-related needs of hospitals' service populations. We leverage data to produce actionable CHNAs that detail the health-related characteristics, real world implications, and community health needs of hospitals' communities. For more information about R&E Group, please visit us at www.phmcresearch.org

Core CHNA Team

Diana Harris, MBe, PhD, CHNA Director – gave oversight to the CHNA process, including, budget management, as well leading the data collection and analytic processes, and guiding the overarching architecture and design of all MLH CHNA report writing from pre-to post-production. Dr. Harris is a Research Scientist with 15+ years of combined professional work experience in nationally ranked academic medical settings, as well as public and private industry sectors. She is a health disparities researcher with excellent qualitative data and research design skills; an ability to conceptualize, initiate, and foster R&E collaborations with multiple stakeholders and constituents; as well as disseminate data orally and through peer reviewed publications to wide-ranging audiences. Dr. Harris has a PhD in Public Health from Temple University and a Masters in Bioethics from University of Pennsylvania.

Gary Klein, Senior Data Analyst, PhD – responsible for creating all data files and performing all statistical analyses of the quantitative data. Dr. Klein has over 25 years of experience working on diverse research and evaluation projects, including the Southeastern Pennsylvania Household Health Survey and supportive demographic-based files. He specializes in programming tasks to clean, merge, aggregate and analyze data as well as weighting survey data. Dr. Klein has a PhD in Sociology from Temple University.

Sarah String, M.P.H., Project Manager- earned her M.P.H. from Arcadia University in 2016; she also has a B.S. in Biology with a minor in Chemistry from Houghton College. Sarah has worked on the Community Health Database team since 2015, processing data and working with members to conduct meaningful program evaluations using the Southeastern Pennsylvania Household Health Survey data and supportive demographic files.

Mattie Bodden, Research Coordinator, B.S. - assisted with scheduling focus groups, development of qualitative instruments, facilitation of focus groups and interviews, extracting themes, and report writing. Ms. Bodden has also developed data visualization for the CHNAs, coordinated tasks around building reports, and assisted with technical logistics of CHNA implementation. Ms. Bodden has five years of experience in implementing research and program evaluation including qualitative and quantitative data coding, analysis and interpretation skills; visualization of both qualitative and quantitative data findings; ability to disseminate data orally and in writing; as well as ability to

communicate and collaborate with stakeholders broadly. Ms. Bodden has a Bachelor of Science in Public Health from Rutgers University- New Brunswick.

Darion Porter, Research Assistant, B.A. – assisted with the logistics of CHNA implementation, including developing flyers and recruitment materials, screening and tracking participants, and scheduling focus groups. He also assisted with focus group and interview development, facilitation, analysis, and report writing. Mr. Porter assisted Dr. Klein in secondary data file preparation and analysis and will prepare maps that describe geovisualization of data findings. Mr. Porter also has experience in qualitative research including developing interview guides; conducting interviews, focus groups, and observations; and coding and analyzing data. Mr. Porter has a BA in Environmental Studies from Temple University.

Acknowledgements:

Shyanne Ruiz, Operations Assistant (formatting and visualization)

Emma Pitcher, B.S. Candidate 2019, Project Assistant (data and review)

Andrew Jones, M.P.A. Candidate 2019, Intern (data and review)

Venise Salcedo, M.P.H. Candidate 2020, Intern (data and review)

Justine Wilson, B.S. Candidate 2019, Intern (data and review)

Appendix D. Focus group interview guide

Hello! My name is (facilitator name) and I will be facilitating today's discussion [introduce additional staff as appropriate]. We work for the Public Health Management Corporation (PHMC), as part of the Research & Evaluation Group. We are a private nonprofit public health institute and PHMC's R&E Group tagline, *Where Numbers Count and Communities Matter,* reflects our commitment to engaging a diverse set of external stakeholders and constituents and making meaning of that data accordingly. We are partnering with Main Line Health to develop its 2018 Community Health Needs Assessment report.

You were all invited to participate in this group and SPEAK UP FOR HEALTH because of the work you do in your business organizations and government agencies, and services you provide to Main Line communities. This discussion will take about an hour and a half. As you know, there are no right or wrong answers, we want to hear your gut reactions and perspectives. We will be recording what you say and taking notes. We are not taking down who said what, and everything you say here is confidential. Your name will never be used in connection with anything you say in either our report, to any agency, or to any foundation staff. The information from the focus groups and other sources will be used to help the Main Line CHNA team to consider what types of health programs are needed for residents, how to prioritize, etc. While a final CHNA report will be made publicly available on our website in 2019, the real work rests with all of us, as we continue to strive to improve the quality of life and health of all of fellow Main Line Health community members – which is why we have asked you to, together, engage in this dialogue today!

Before we start, I'll share some housekeeping info and basic ground rules. Please feel free to use the rest room at any point during the discussion. We have refreshments for you, take freely. We have quite a few questions to cover, so I may need to cut short the discussion of a question or move on, a bit more abruptly than I would like. Also, because we want to get as many viewpoints as possible, let's please be mindful when a fellow participant is speaking. Any questions before we get started?

Ice breaker (if group of <10) otherwise start w/ Q1 below.
Please, 1) share your name, 2) a little bit about the community(ies) you see yourself as a part of, 3) where you work and the role you play in the communities you serve day-to-day 3) and 4) TOP 3 most pressing unmet health (or other) related needs you believe the communities you serve are experiencing

1. For starters, we are interested in hearing about how you think about "the community," since we want to make sure that everyone knows how everyone else in our group understands or defines community. So, let's begin with a brief conversation …When we say 'the community' what do you think about? How do you define community*? (This should be a brief conversation—intended to gain focus, get everyone thinking about community in the same way…).*

Everyone defines community in different ways, as we have just heard. For the remainder of the discussion, when we say community, we would like for you to think about and reflect on the communities that you work with, that surrounding area, and that your organization serves.

2. When we say 'your community' within this "revised" scope, what do you think about? (Brief)

3. Sometimes in communities, there are groups of people who cluster together. Who are the 'groups' within your community?

   (Probe: For example, is there an immigrant population in your community? Who are they? Elderly? A particular ethnic or racial group?)

4. We are interested in first identifying the communities that your organization serves, and we will follow with a discussion about needs.

5. Along these lines, who, if anyone would be considered a part of a vulnerable population in your community?

6. Based on your experiences, what makes the community you serve a healthy place to live?
   (Probe – health care services, health clinic, hospital, walking paths, access to nature, access to healthy foods)

7. What are some strengths of the existing resources, including health care resources in the area?
   (Probes – as needed)
   i. Place to go for help with heating or cooling a home
   ii. Place to go with a sick elderly friend
   iii. Place to go for health care when someone has no health insurance
   iv. Place to go for help with getting food
   v. Place to go for help with getting a mammogram? Diabetes treatment?
   vi. Place to go to learn about health and wellness?

8. In general, what types of problems, if any, do you see or hear about among the communities you serve?

9. What are the health and wellness, social and basic needs that are currently unmet in the communities you serve?

10. What are some other important health and wellness needs of your community?

11. What is the TOP health care issue in this community that you think people are the most concerned about? Why?

12. What do you think keeps people in the communities you serve from achieving “exceptional” health and wellness?

This last set of questions will focus on how Main Line Health partners with you.

13. In what ways, if any, does MLH work with you?

14. Does MLH have a responsibility to work with you and others in the community? Why or why not? *Should also inquire about community-based hospital systems broadly.

15. Where are the opportunities for future partnership with MLH to meet community needs?

16. What else can you tell us about community needs, how MLH is doing in the community, or other community concerns related to health and quality of life that we have not addressed?

Appendix E. Key informant interview guide

Introduction
Hello. May I speak with [INSERT INTERVIEWEE NAME]? This is _____ from the Public Health Management Corporation (PHMC), is now a good time? Thank you for your time and agreeing to participate in this key informant interview.

As you are aware, Main Line Health is conducting this Community Health Needs Assessment (CHNA) to inform population health and social services planning for the Delaware Valley region. The purpose of the CHNA is to identify and prioritize community health needs so that Main Line Health can develop strategies and implementation plans that benefit the public as well as satisfy the requirements of the Affordable Care Act (ACA).

We at the Public Health Management Corporation (PHMC), a non-profit public health institute, are partnering closely with Main Line Health, and, as part of this robust process, we are engaging the community at large area service providers, community leaders, professionals, and community residents], through surveys, focus groups, and 1:1 conversations such as this one. You were invited to participate in this interview because of your knowledge and experience with the community.

The interview will last about 30-45 minutes. There are no right or wrong answers, you do not have to respond to any questions that you do not wish to, and we can stop the interview at any time. Findings from this interview will be reported in aggregate only (such that your name will not be used in connection to anything said during the interview); combined with findings from the other key informant interviews we are conducting, and summarized in a report that will available in the public domain (Main Line Health's website) summer 2019. We will be recording what you say and taking notes (with your permission), although as I mentioned, we will not be taking down who said what, and your name will not be used in connection with the CHNA report, or any agency. Your contribution is very important!!

Ice Breaker
First, please share, a bit about where you work and the role you play in the organization, the populations that your organization/agency/church serves and in 1-3 words, a pressing unmet health (or other) related needs you believe the communities you serve are experiencing. –

Next, we are interested in hearing about how you think about "the community, so, let's begin with a brief conversation …When we say 'the community' what do you think about? How do you define community*?*

Everyone defines community in different ways. For the remainder of the discussion, when we say community, we would like for you to think about and reflect on the communities that you work with, that surrounding area, and that your organization serves.

COMMUNITY HEALTH/HEALTH DISPARITIES

Our next questions are about community health. What would you say are surrounding service areas that you/r organization serves?

1. What makes the communities you serve a healthy place to live?
   (Probe – health care services, health clinic, hospital, walking paths, access to nature, access to healthy food, community spirit, social supports)

    a. What are some strengths of the existing health care resources in the … area?

2. In general, what types of health concerns do you see among the communities you serve (and/or residents of surrounding area)?

    a. What factors contribute to health concerns/problems among residents in this area?
        i. Why do you think their health/quality of life is not as good as others?
3. What type of problems, if any, do residents of … have getting health care services?
    a. Are there people in … area who have more difficulty than others in getting health care services?
        i. Who are these people/groups?
        ii. Why do you think they have more trouble getting health care services than others?

4. What barriers, if any, exist to improving health and quality of life in … community?

5. From your perspective, what are the most pressing health care issues in this community (that you would like to elaborate on)?
    a. What can be done to address these health care issues?

COMMUNITY HEALTH/HEALTH EQUITY

Now I would like to ask about ways to improve community health.

6. What are some of your ideas to help the … area community get or stay healthy or otherwise improve their quality of life?
    a. Where are the opportunities for future partnership with MLH to meet community needs?
    b. Specific programming that they are aware of in the community...

FINAL QUESTION

We have discussed all the questions that I planned to go through. Is there anything else that I have not asked you that is important to know about the health in the … area? What else can you tell us about how MLH is doing in the community, or other community concerns related to health and quality of life that we have not addressed?

Close:

Thanks so much for sharing your thoughts about health and quality of life for Main Line area residents. The information you have provided will contribute to a better understanding about factors impacting health and quality of life in this community. Should you have any additional comments or questions about Main Line Health's community health needs assessment, please feel free to reach out.

Appendix F. Community leader online survey

Speak up for health!
2018-19 Community health needs assessment survey

Please take five minutes to complete this survey. At the end of the survey, you may enter into a raffle for a chance to win 1 of five $30 gift cards.

Thank you for your time and consideration!

Everyone defines community in different ways. When we say community, we would like for you to think about and reflect on the communities that you work with, that surrounding area, and that your organization serves.

1. **What do you think are the three most important factors for a "Healthy Community"? Select up to <u>THREE</u> choices.**
   - Low crime/safe neighborhoods
   - Good jobs and healthy economy
   - Good schools
   - Good place to raise children
   - Affordable housing
   - Access to health care
   - Clean environment
   - Presence of religious or spiritual facilities
   - Parks and recreation
   - Race/ethnic diversity
   - Arts and cultural events
   - Other (fill in)

2. **What do you think are the three most pressing health conditions in the communities you serve? Select up to <u>THREE</u> choices.**
   - Mental health problems
   - Cancer
   - Aging problems (e.g. arthritis, health/vision loss, etc)
   - Heart disease and stroke
   - High blood pressure
   - Alcohol use disorder
   - HIV/AIDS
   - Diabetes
   - Respiratory/lung disease
   - Infectious Diseases (e.g. hepatitis, TB, etc)
   - Dental problems
   - Sexually transmitted infections
   - Infant death
   - Opioid use disorder (Fentanyl, oxycodone, Vicodin, etc)
   - Other Illicit substance use disorder (marijuana, Cocaine, Methamphetamine, etc)
   - Other (fill in)

3. **What do you think are the three most pressing social issues related to health in the communities you serve? Select up to THREE choices.**
   - Access to affordable and safe housing

- Access to healthy food
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Domestic violence
- Education
- Jobs
- Literacy
- English as second language
- Violence against children
- Teenage pregnancy
- Transportation options
- Suicide
- Motor vehicle crash injuries
- Homicide
- Public Safety
- Rape/sexual assault
- Residential segregation
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Social Support and contact (isolation)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Firearm related injuries
- Other (fill in)

4. Below were the top health needs identified for Main Line Health's 2016 hospital CHNAs. What, if any, improvements have you seen in the communities you serve for the following health needs over the last 3 years?

Health Needs	**No improvement**	**Some improvement**	**Significant improvement**	**I don't know**
Weight management				
Diabetes				
Metabolic Syndrome				
Cardiovascular Health/ Stroke				
Smoking and tobacco use				
Cancer				
Lung disease				
Transportation				
Senior Health				
Behavioral (or Mental) Health				

Injury Prevention

Substance use disorder
(substance abuse/mis(use))

Pre-natal care

Low birth weight infants

Disparity of Care

---

5. **Where do you usually go when you are sick or want advice about health? (Select one)**
   ___Private doctor's office
   ___Community health center/Public health clinic ___Hospital emergency department
   ___Hospital outpatient clinic ___Other (Please specify):_____

6. **Would you say in general that your health is… (Select one)**
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

7. **Please select your current employer (or agency) type:**
   - Business
   - Government
   - Faith-based
   - Hospital/ Clinic
   - Rehabilitation Hospital
   - Social Services/Schools
   - Other (fill in)

8. **What do you think are the three most important factors that make it difficult to get healthcare in the communities you serve?**
   - Cost of insurance
   - Cost of healthcare
   - Cost of medications
   - Lack of child care
   - Lack of doctors
   - Lack of information about available services
   - Healthcare community not welcoming
   - Lack of non-emergency services
   - Lack of transportation to services
   - Language barriers
   - Long wait times
   - No healthcare services available on nights/weekends
   - No pharmacy close by
   - Other (fill in)

9. **Please select your age category**
   - 18 to 34

- 35 to 49
- 50 to 64
- 65+

10. What is your gender? (fill in)

11. Which one of these groups would you say best represents your race?
- White
- Black or African American
- Asian or Pacific Islander
- American Indian or Alaska Native
- Biracial/Multiracial
- Other

12. Are you of Hispanic or Latino origin or descent?
- Yes
- No

13. Within the past 12 months, when receiving health care, do you feel your experiences were worse than, the same as, or better than for people of other races?
- Worse than other races
- The same as other races
- Better than other races
- Worse than some races, better than others
- Only encountered people of the same race
- No healthcare in past 12 months
- Don't know/not sure

14. Do you provide rehabilitation treatment or services to the communities you serve?
- Yes (skip logic pattern, move to rehab questions below)
- No

15. Please share any additional comments:

Appendix G. Community member online survey

Speak up for health!
2018-2019 Community health needs assessment survey

Greetings! Please take about 5 minutes of your time to complete this brief survey and speak up for the health of the communities you live. At the end of the survey, you may enter into a raffle for a chance to win a $30 gift card. Ten winners will be selected.

Thank you for your time and consideration!

15. What do you think are the three most important factors for a "Healthy Community"? Select up to <u>THREE</u> choices.

- Low crime/safe neighborhoods
- Good jobs and healthy economy
- Good schools
- Good place to raise children
- Affordable housing
- Access to health care
- Clean environment
- Presence of religious or spiritual facilities
- Parks and recreation
- Race/ethnic diversity
- Arts and cultural events
- Other (fill in)

16. **What do you think are the three most pressing health conditions in your community? Select up to <u>THREE</u> choices.**

- Mental health problems
- Cancer
- Aging problems (e.g. arthritis, health/vision loss, etc)
- Heart disease and stroke
- Alcohol use disorder
- High blood pressure
- HIV/AIDS
- Diabetes
- Opioid use disorder (Fentanyl, oxycodone, Vicodin, etc)
- Respiratory/lung disease
- Infectious Diseases (e.g. hepatitis, TB, etc)
- Dental problems
- Sexually transmitted infections
- Infant death
- Other illicit substance use disorder (marijuana, Cocaine, Methamphetamine, etc)
- Other (fill in)

17. What do you think are the three most pressing social issues related to health in the communities you serve? Select up to THREE choices.

- Access to affordable and safe housing
- Access to healthy food
- Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- Domestic violence
- Education

- Jobs
- Literacy
- English as second language
- Violence against children
- Teenage pregnancy
- Transportation options
- Suicide
- Motor vehicle crash injuries
- Homicide
- Public Safety
- Rape/sexual assault
- Residential segregation
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- Social Support and contact (isolation)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Firearm related injuries
- Other (fill in)

18. **How would you rate the overall health of your community?**
- Very healthy
- Healthy
- Unhealthy
- Very unhealthy

19. Where do you usually go when you are sick or want advice about health? (Select one)

___Private doctor's office

___Community health center/public health clinic ___Hospital emergency department

___Hospital outpatient clinic ___Other (Please specify):_____

20. **Would you say in general that your health is… (Select one)**
- Excellent
- Very good
- Good
- Fair
- Poor

21. What do you think are the three most important factors that make it difficult to get healthcare in your community?
- Cost of insurance
- Cost of healthcare
- Cost of medications
- Lack of child care
- Lack of doctors
- Lack of information about available services
- Healthcare community not welcoming
- Lack of non-emergency services
- Lack of transportation to services
- Language barriers
- Long wait times
- No healthcare services available on nights/weekends
- No pharmacy close by
- Other (fill in)

22. Please select your age category

- 18 to 34
- 35 to 49
- 50 to 64
- 65+

23. What is your gender? (fill in)

24. What was the last grade of school that you completed?

- Less than high school (0-11 years)
- High school graduate (grade 12 or GED certificate)
- Some college (includes Associates degree, technical, trade or vocational school AFTER high school)
- College graduate (B.S., B.A. or other four –year degree)
- Post-graduate (M.S, MD, JD, PhD, etc.)

25. Which one of these groups would you say best represents your race?

- White
- Black or African American
- Asian or Pacific Islander
- American Indian or Alaska Native
- Biracial/Multiracial
- Other

26. Are you of Hispanic or Latino origin or descent?

- Yes
- No

27. Which of the following best describes your current employment status?

- Full time (30 or more hours per week)
- Part-time
- Retired
- Unemployed
- Other (fill in)

28. How do you pay for your health care? (Check all that apply)

- Pay cash (no insurance)
- Health insurance (eg, private insurance, Blue Shield, HMO)
- Medicaid
- Medicare
- Other (fill in)

29. Which of the following income categories best describes your total 2017 family income?

1=$0-10,000
2=$10,001-$20,000
3=$20,001-$40,000
4=$40,001-$60,000
5=$60,001-80,000
6=$80,001+
99=I do not want to answer this question

30. Within the past 12 months, when receiving health care, do you feel your experiences were worse than, the same as, or better than for people of other races?

- Worse than other races
- The same as other races
- Better than other races
- Worse than some races, better than others
- Only encountered people of the same race
- No healthcare in past 12 months
- Don't know/not sure

31. What zip code do you live in? (fill in)

32. If you receive primary care or other patient related services at Main Line Health, please check which hospital(s) you currently go to.

- Lankenau
- Paoli
- Riddle
- Bryn Mawr
- Bryn Mawr Rehab
- Not applicable

33. Have you or a family member ever received rehabilitation services?

- Yes (skip logic pattern, move to rehab questions below)
- No (if no, survey end – takes you to raffle page)

34. Please share any additional comments:

Appendix H. Chi-square tests of significance data table

Acute care service area & remainder of southeastern Pennsylvania (SEPA) comparison

Key: **ns** = not significant, **.05** = statistically significant,
.01 = very statistically significant, **.001** = very highly statistically significant
Green = Region is statistically significantly better than the other
Red = Region is statistically significantly worse than the other

Health Measure	Acute Care Service Area	Remainder of SEPA	P Value
ADULT (18 – 64)	**N=2,964**	**N=4,466**	
	%	**%**	
In fair or poor health	**17.2**	**20.6**	**.001**
Has ever been told by a health professional they have or had high blood pressure	**30.9**	**32.0**	**ns**
Has ever been told by a health professional they have or had Diabetes	**11.7**	**12.9**	**ns**
Has ever been told by a health professional they have or had Asthma	**18.4**	**18.0**	**ns**
Currently overweight or obese (BMI 25+) compared to neither (BMI < 25)	**63.6**	**64.4**	**ns**
Currently obese (BMI 30+) compared to not obese (BMI < 30)	**30.8**	**29.6**	**ns**
Ever been diagnosed with a mental health condition	**22.8**	**22.0**	**ns**
Is NOT currently receiving treatment for said mental health condition	**40.4**	**45.0**	**ns (p=.06)**
Did NOT seek health care due to the cost during a time they were sick or injured in the past year	**9.5**	**10.9**	**ns (p=.06)**
Did NOT fill a prescription due to the cost in the past year	**12.4**	**13.8**	**ns (p=.09)**
Currently uninsured	**9.5**	**11.7**	**.01**
Does not have a USUAL person or place of care to go when they are sick or need health advice	**13.2**	**13.7**	**ns**
Has NOT visited a healthcare provider in the past year	**11.5**	**13.6**	**ns (p=.06)**
Has NOT seen a dentist in the past year	**27.9**	**31.1**	**.01**

Has visited the emergency room in the past year	**26.8**	**27.4**	**ns**
Has NOT had a blood pressure reading in the past year	**6.1**	**8.1**	**.01**
Adult 50 years or older that has not had a sigmoid/colonoscopy in the past 10 years	**23.6**	**28.6**	**.001**
Women 18 to 64 years old that have not had a pap test in the past 3 years	**13.5**	**21.2**	**.001**
Women ages 50 to 74 that have not had a mammogram in the past 2 years	**16.8**	**21.7**	**.01**
Men over the age of 45 that have not had a prostate exam in the past year	**46.1**	**50.4**	**ns (p=.06)**
Usually has LESS than 4 servings of fruits or vegetables a day	**74.0**	**79.3**	**.001**
Usually exercises for 30+ minutes LESS than 3 days a week	**40.1**	**43.8**	**.01**
Currently smokes cigarettes	**11.7**	**17.7**	**.001**
Smokes and has NOT tried to quit in the past year	**51.3**	**48.6**	**ns**
Smokes and has used an e-cigarette in the past month	**7.8**	**8.1**	**ns**
Rated as having low social capital	**26.6**	**31.6**	**.01**
Has drank soda, a fruit drink, or bottled tea once or more a day in the past month	**24.8**	**27.8**	**.05**
OLDER ADULTS (65+)	**N=1,197**	**N=1,890**	
In fair or poor health	**22.2**	**22.8**	**ns**
Has an ADL limitation	**16.0**	**14.3**	**ns**
Has an IADL limitation	**33.3**	**29.3**	**ns (p=09)**
Has signs of major depression	**10.3**	**12.6**	**ns (p=.08)**
Talks with friends or relatives less than once a week	**7.4**	**4.9**	**.05**
CHILDREN (0-17)	**N=528**	**N=708**	
In fair or poor health	**4.4**	**3.1**	**ns**
Participates in physical activity less than 3 times per week (Ages 3+)	**11.6**	**13.2**	**ns**

Currently obese (BMI 95-100 percentile) (Ages 6+)	**29.1**	**23.2**	**ns**
Currently overweight (BMI 85-94 percentile) (Ages 6+)	**24.9**	**27.1**	**ns**
Has NOT seen a dentist in the past year	**20.3**	**25.9**	**.05**

Eastern service area & remainder of southeastern Pennsylvania (SEPA) comparison

Key: **ns** = not significant, **.05** = statistically significant,
.01 = very statistically significant, **.001** = very highly statistically significant
Green = Region is statistically significantly better than the other
Red = Region is statistically significantly worse than the other

Health Measure	Eastern Service Area	Remainder of SEPA	P Value
ADULT (18 – 64)	**N=1,202**	**N=6,228**	
	%	**%**	
In fair or poor health	**23.8**	**18.4**	**.001**
Has ever been told by a health professional they have or had high blood pressure	**36.8**	**30.6**	**.001**
Has ever been told by a health professional they have or had Diabetes	**14.2**	**12.1**	**.05**
Has ever been told by a health professional they have or had Asthma	**21.0**	**17.6**	**.01**
Currently overweight or obese (BMI 25+) compared to neither (BMI < 25)	**67.1**	**63.5**	**.05**
Currently obese (BMI 30+) compared to not obese (BMI < 30)	**37.6**	**28.7**	**.001**
Ever been diagnosed with a mental health condition	**22.7**	**22.2**	**ns**
Is NOT currently receiving treatment for said mental health condition	**37.4**	**44.2**	**.05**
Did NOT seek health care due to the cost during a time they were sick or injured in the past year	**11.3**	**10.2**	**ns**
Did NOT fill a prescription due to the cost in the past year	**13.0**	**13.3**	**ns**
Currently uninsured	**13.2**	**10.4**	**.01**
Does NOT have a USUAL person or place of care to go when they are sick or need health advice	**14.4**	**13.3**	**ns**
Has NOT visited a healthcare provider in the past year	**10.7**	**12.7**	**ns (p=.06)**
Has NOT seen a dentist in the past year	**36.5**	**28.6**	**.001**
Has visited the emergency room in the past year	**34.8**	**25.7**	**.001**

Has NOT had a blood pressure reading in the past year	**4.5**	**7.9**	**.001**
Adult 50 years or older that has NOT had a sigmoid/colonoscopy in the past 10 years	**22.4**	**27.4**	**.01**
Women 18 to 64 years old that have NOT had a pap test in the past 3 years	**15.7**	**18.6**	**ns**
Women ages 50 to 74 that have NOT had a mammogram in the past 2 years	**13.8**	**20.8**	**.01**
Men over the age of 45 that have NOT had a prostate exam in the past year	**50.2**	**48.5**	**ns**
Usually has LESS than 4 servings of fruits or vegetables a day	**78.9**	**76.9**	**ns**
Usually exercises for 30+ minutes LESS than 3 days a week	**42.7**	**42.3**	**ns**
Currently smokes cigarettes	**14.2**	**15.5**	**ns**
Smokes and has NOT tried to quit in the past year	**51.5**	**49.1**	**ns**
Smokes and has used an e-cigarette in the past month	**7.9**	**8.0**	**ns**
Rated as having low social capital	**35.4**	**28.6**	**.01**
Has drank soda, a fruit drink, or bottled tea once or more a day in the past month	**30.6**	**25.8**	**.01**
OLDER ADULTS (65+)	**N=497**	**N=2,590**	
In fair or poor health	**30.4**	**21.3**	**.001**
Has an ADL limitation	**21.3**	**13.8**	**.01**
Has an IADL limitation	**43.6**	**28.5**	**.001**
Has signs of major depression	**13.2**	**11.4**	**ns**
Talks with friends or relatives LESS than once a week	**7.5**	**5.1**	**ns**
CHILDREN (0-17)	**N=189**	**N=1,047**	
In fair or poor health	**6.0**	**3.2**	**.05**
Participates in physical activity LESS than 3 times per week (Ages 3+)	**15.2**	**12.0**	**NS**
Currently obese (BMI 95-100 percentile) (Ages 6+)	**44.8**	**21.6**	**.001**

Currently overweight (BMI 85-94 percentile) (Ages 6+)	**27.3**	**26.1**	**ns**
Has NOT seen a dentist in the past year	**20.2**	**24.3**	**ns**

Northwest service area & remainder of southeastern Pennsylvania (SEPA) comparison

Key: **ns** = not significant, **.05** = statistically significant,
.01 = very statistically significant, **.001** = very highly statistically significant
Green = Region is statistically significantly better than the other
Red = Region is statistically significantly worse than the other

Health Measure	Northwest Service Area	Remainder of SEPA	P Value
ADULT (18 – 64)	**N=857**	**N=6,573**	
	%	**%**	
In fair or poor health	**13.9**	**20.0**	**.001**
Has ever been told by a health professional they have or had high blood pressure	**26.0**	**32.4**	**.001**
Has ever been told by a health professional they have or had Diabetes	**10.6**	**12.7**	**ns (p=.08)**
Has ever been told by a health professional they have or had Asthma	**19.2**	**18.0**	**ns**
Currently overweight or obese (BMI 25+) compared to neither (BMI < 25)	**65.7**	**63.9**	**ns**
Currently obese (BMI 30+) compared to not obese (BMI < 30)	**29.1**	**30.2**	**ns**
Ever been diagnosed with a mental health condition	**22.8**	**22.3**	**ns**
Is NOT currently receiving treatment for said mental health condition	**45.6**	**42.8**	**ns**
Did NOT seek health care due to the cost during a time they were sick or injured in the past year	**10.1**	**10.4**	**ns**
Did NOT fill a prescription due to the cost in the past year	**13.1**	**13.3**	**ns**
Currently uninsured	**9.2**	**11.1**	**ns**
Does NOT have a USUAL person or place of care to go when they are sick or need health advice	**10.6**	**13.9**	**.01**
Has NOT visited a healthcare provider in the past year	**12.9**	**12.4**	**ns**
Has NOT seen a dentist in the past year	**26.5**	**30.3**	**.05**
Has visited the emergency room in the past year	**21.3**	**28.0**	**.001**

Has NOT had a blood pressure reading in the past year	**7.9**	**7.3**	**ns**
Adult 50 years or older that has NOT had a sigmoid/colonoscopy in the past 10 years	**25.1**	**26.9**	**ns**
Women 18 to 64 years old that have NOT had a pap test in the past 3 years	**15.3**	**18.5**	**ns**
Women ages 50 to 74 that have NOT had a mammogram in the past 2 years	**16.9**	**20.3**	**ns**
Men over the age of 45 that have NOT had a prostate exam in the past year	**49.3**	**48.7**	**ns**
Usually has LESS than 4 servings of fruits or vegetables a day	**72.6**	**77.9**	**.001**
Usually exercises for 30+ minutes LESS than 3 days a week	**40.9**	**42.5**	**ns**
Currently smokes cigarettes	**13.3**	**15.6**	**ns (p=.07)**
Smokes and has NOT tried to quit in the past year	**58.5**	**48.3**	**.05**
Smokes and has used an e-cigarette in the past month	**10.0**	**7.7**	**.05**
Rated as having low social capital	**26.8**	**30.0**	**ns**
Has drank soda, a fruit drink, or bottled tea once or more a day in the past month	**20.9**	**27.3**	**.01**
OLDER ADULTS (65+)	**N=313**	**N=2,774**	
In fair or poor health	**19.4**	**23.0**	**ns**
Has an ADL limitation	**12.9**	**14.8**	**ns**
Has an IADL limitation	**25.8**	**30.5**	**ns**
Has signs of major depression	**8.4**	**12.1**	**ns (p=.06)**
Talks with friends or relatives less than once a week	**7.3**	**5.3**	**ns**
CHILDREN (0-17)	**N=172**	**N=1,064**	
In fair or poor health	**4.1**	**3.6**	**ns**
Participates in physical activity less than 3 times per week (Ages 3+)	**11.3**	**12.8**	**ns**
Currently obese (BMI 95-100 percentile) (Ages 6+)	**16.7**	**27.2**	**ns (p=.07)**

Currently overweight (BMI 85-94 percentile) (Ages 6+)	**25.7**	**26.1**	**ns**
Has NOT seen a dentist in the past year	**24.1**	**23.6**	**ns**

Central service area & remainder of southeastern Pennsylvania (SEPA) comparison

KEY: **ns** = not significant, **.05** = statistically significant,
.01 = very statistically significant, **.001** = very highly statistically significant
Green = Region is statistically significantly better than the other
Red = Region is statistically significantly worse than the other

Health Measure	Central Service Area	Remainder of SEPA	P Value
ADULT (18 – 64)	**N=905**	**N=6,525**	
	%	**%**	
In fair or poor health	**11.5**	**20.2**	**.001**
Has ever been told by a health professional they have or had high blood pressure	**27.8**	**32.1**	**.05**
Has ever been told by a health professional they have or had Diabetes	**9.3**	**12.8**	**.01**
Has ever been told by a health professional they have or had Asthma	**13.6**	**18.7**	**.001**
Currently overweight or obese (BMI 25+) compared to neither (BMI < 25)	**56.3**	**65.1**	**.001**
Currently obese (BMI 30+) compared to not obese (BMI < 30)	**23.0**	**31.0**	**.001**
Ever been diagnosed with a mental health condition	**22.7**	**22.3**	**ns**
Is NOT currently receiving treatment for said mental health condition	**38.7**	**43.7**	**ns**
Did not seek health care due to the cost during a time they were sick or injured in the past year	**6.5**	**10.9**	**.001**
Did not fill a prescription due to the cost in the past year	**10.9**	**13.6**	**.05**
Currently uninsured	**4.1**	**11.6**	**.001**
Does NOT have a USUAL person or place of care to go when they are sick or need health advice	**14.1**	**13.4**	**ns**
Has NOT visited a healthcare provider in the past year	**11.1**	**12.6**	**ns**
Has NOT seen a dentist in the past year	**17.6**	**31.4**	**.001**
Has visited the emergency room in the past year	**21.6**	**27.9**	**.001**

Has NOT had a blood pressure reading in the past year	**6.7**	**7.4**	**ns**
Adult 50 years or older that has NOT had a sigmoid/colonoscopy in the past 10 years	**23.9**	**27.1**	**ns**
Women 18 to 64 years old that have NOT had a pap test in the past 3 years	**8.0**	**19.4**	**.001**
Women ages 50 to 74 that have NOT had a mammogram in the past 2 years	**20.0**	**19.8**	**ns**
Men over the age of 45 that have NOT had a prostate exam in the past year	**37.9**	**50.2**	**.001**
Usually has LESS than 4 servings of fruits or vegetables a day	**68.7**	**78.3**	**.001**
Usually exercises for 30+ minutes LESS than 3 days a week	**35.4**	**43.2**	**.001**
Currently smokes cigarettes	**6.3**	**16.4**	**.001**
Smokes and has NOT tried to quit in the past year	**35.3**	**50.1**	**.05**
Smokes and has used an e-cigarette in the past month	**5.2**	**8.3**	**.01**
Rated as having low social capital	**14.1**	**31.5**	**.001**
Has drank soda, a fruit drink, or bottled tea once or more a day in the past month	**15.8**	**27.7**	**.001**
OLDER ADULTS (65+)	**N=387**	**N=2,700**	
In fair or poor health	**15.6**	**23.6**	**.001**
Has an ADL limitation	**7.5**	**15.1**	**.05**
Has an IADL limitation	**18.7**	**30.9**	**.01**
Has signs of major depression	**8.7**	**12.1**	**ns (p=.07)**
Talks with friends or relatives LESS than once a week	**7.5**	**5.3**	**ns**
CHILDREN (0-17)	**N=167**	**N=1,069**	
In fair or poor health	**2.4**	**3.8**	**ns**
Participates in physical activity LESS than 3 times per week (Ages 3+)	**6.9**	**13.3**	**ns (p=.07)**
Currently obese (BMI 95-100 percentile) (Ages 6+)	**20.0**	**26.6**	**ns**

Currently overweight (BMI 85-94 percentile) (Ages 6+)	**21.3**	**27.0**	**ns**
Has NOT seen a dentist in the past year	**16.2**	**24.5**	**.05**

Appendix I. Additional data tables: Demographic characteristics, birth outcomes, and mortality

Table 1. 2018 U.S. Census Socio-Demographic Indicators: Main Line Health Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Population N(%)	420,728	608,432	561,070	1,590,230	4,111,194
Age					
0-17	83,968 (20.0)	136,425 (22.4)	126,676 (22.6)	347,069 (21.8)	897,970 (21.8)
18-34	92,248 (21.9)	170,222 (28.0)	118,819 (21.2)	381,289 (24.0)	968,461 (23.6)
35-64	161,595 (38.4)	219,677 (36.1)	230,047 (41.0)	611,319 (38.4)	1,592,845 (38.7)
65+	82,917 (19.7)	82,108 (13.5)	85,528 (15.2)	250,553 (15.8)	651,918 (15.9)
Gender					
Male	201,949 (48.0)	285,354 (46.9)	278,290 (49.6)	764,900 (48.1)	1,981,595 (48.2)
Female	218,778 (52.0)	323,077 (53.1)	282,779 (50.4)	825,329 (51.9)	2,129,598 (51.8)
Race/Ethnicity*					
White	355,094 (84.4)	227,553 (37.4)	441,001 (78.6)	1,024,108 (64.4)	2,622,941 (63.8)
Black	19,774 (4.7)	314,559 (51.7)	55,545 (9.9)	389,606 (24.5)	916,796 (22.3)
Asian	34,078 (8.1)	35,289 (5.8)	33,103 (5.9)	101,774 (6.4)	279,561 (6.8)
Other	11,359 (2.7)	31,030 (5.1)	31,419 (5.6)	74,740 (4.7)	287,783 (7.0)
Latino	13,042 (3.1)	28,596 (4.7)	39,835 (7.1)	81,101 (5.1)	374,118 (9.1)

Note : *Race is defined as a person's self identified social group. Ethnicity determines whether a person is of Hispanic or Latino descent. Source: 2018 Claritas Pop-Facts Data Base. Calculations prepared by PHMC.

Table 2. Older adults (age 60+) population by race: Main Line Health Acute Care Service Areas

N (%)

Race	Central	Eastern	Northwest	All MLH Acute Care
White	104,935 (93.8)	50,912 (44.1)	103,792 (85.2)	25,4517 (72.2)
Black	965 (.9)	44,263 (38.8)	10,456 (8.6)	59,193 (17.0)
Asian	1,710 (1.5)	1,165 (1.0)	1,737 (1.4)	4,561 (1.3)
Other	4,249 (3.8)	19,096 (16.5)	5,893 (4.8)	30,728 (8.8)

Note: White, Black, Asian, and Other races include Latino/as. Source: PHMC's 2018 Southeastern Pennsylvania Household Health Survey. Calculations prepared by PHMC.

Table 3. 2018 U.S. Census Socio-Economic Indicators: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Population	420,728	608,432	561,070	1,590,230	4,111,194
Income					
Median Household Income	$114,506	$49,839	$91,044	$81,073	$70,807

Source: 2018 Claritas Pop-Facts Data Base. Calculations prepared by PHMC.

Table 3.1 2018 U.S. Census Socio-Economic Indicators: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Population 25+ N(%)	290,629	401,342	382,379	1,074,350	2,824,892
Education					
Less than HS	11,043 (3.8)	49,365 (12.3)	26,001 (6.8)	87,022 (8.1)	302,263 (10.7)
HS Graduate	105,788 (36.4)	23,9601 (59.7)	181,630 (47.5)	527,505 (49.1)	1,474,593 (52.2)
College or More	173,796 (59.8)	111,974 (27.9)	174,747 (45.7)	459,821 (42.8)	1,048,034 (37.1)

Note: Educational attainment refers to the highest level of education completed in terms of the highest degree or the highest level of schooling completed, and is asked of all civilians 25 years old and over.

Source: Claritas 2018 Pop-Facts Data Base. Calculations prepared by PHMC.

Table 3.2 2018 U.S. Census Socio-Economic Indicators: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Population 16+ N(%)	347,832	486,928	449,316	1,284,076	3,317,575
Employment					
Employed	332,180 (95.5)	438,235 (90.0)	424,604 (94.5)	1,196,758 (93.2)	3,062,122 (92.3)
Unemployed	15,652 (4.5)	48,693 (10.0)	24,317 (5.5)	87,317 (6.8)	255,453 (7.7)

Note: Employment is calculated as all civilians 16 years old and over who were either (1) "at work" or (2) "with a job but not at work". Source: Claritas 2018 Pop-Facts Data Base. Calculations prepared by PHMC.

Table 3.3 2018 U.S. Census Socio-Economic Indicators: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Families with children N(%)	48,265	69,494	68,071	185,830	478,192
Poverty Status					
Families living in poverty WITH children	1,925 (4.0)	17,698 (25.5)	5,261 (7.7)	24,884 (13.4)	77,947 (16.3)

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Families without children N(%)	59,597	59,597	73,774	192,968	535,454
Poverty Status					
Families living in poverty WITHOUT children	1,208 (2.0)	5,797 (9.7)	1,769 (2.4)	8,774 (4.5)	26,855 (5.0)

Source: Claritas 2018 Pop-Facts Data Base. Calculations prepared by PHMC.

Table 3.4 2018 U.S. Census Socio-Economic Indicators: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Households N(%)	161,141	239,030	208,451	608,622	1,582,081
Household Type*					
Renter-occupied	38,029 (23.6)	108,281 (45.3)	56,282 (27.0)	202,671 (33.3)	537,681 (34.0)
Owner-occupied	123,112 (76.4)	130,794 (54.7)	152,169 (73.0)	405,951 (66.7)	1,044,400 (66.0)

Note: Household type is calculated from all occupied housing units.
Source: Claritas 2018 Pop-Facts Data Base. Calculations prepared by PHMC.

Table 4. 2018 U.S. Census Language Spoken at Home: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Total Population N(%)	399,452	568,645	528,234	1,496,331	3,864,457
Language Spoken at Home					
English	351,118 (87.9)	498,701 (87.7)	469,071 (88.8)	1,318,891 (88.1)	3,249,121 (79.0)
Spanish	8,388 (2.1)	17,059 (3.0)	22,714 (4.3)	48,161 (3.2)	231,712 (5.6)
Asian Language	16,776 (4.2)	19,333 (3.4)	14,262 (2.7)	50,373 (3.4)	154,549 (3.8)
Indo-European Language	20,372 (5.1)	23,314 (4.1)	19,016 (3.6)	62,702 (4.2)	193,466 (4.7)
Other Language	2,396 (0.6)	10,235 (1.8)	2,641 (0.5)	15,273 (1.0)	35,609 (0.9)

Note: Language spoken at home is calculated for all citizens 5 years and over. Source: Claritas 2018 Pop-Facts Data Base. Calculations prepared by PHMC.

Table 5. 2012 - 2016 Fertility Rates for Women 15-44 Years by Race and Ethnicity: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Avg Births per Year (rate per 1,000)	3,924 (51.6)	8,227 (57.9)	6,164 (59.4)	18,315 (56.9)	47,453 (58.9)
Race/Ethnicity*					
White	3,169 (51.0)	2,359 (43.7)	4,351 (53.3)	9,878 (49.9)	24,426 (48.2)
Black	142 (40.2)	4,786 (66.1)	738 (69.2)	5,666 (65.4)	13,289 (64.7)
Asian	470 (59.6)	448 (45.0)	453 (66.3)	1,371 (55.6)	3,526 (55.1)
Other	91 (37.5)	379 (66.2)	483 (103.7)	953 (74.4)	4,582 (19.6)
Latina	139 (51.4)	422 (65.7)	696 (99.5)	1,257 (78.0)	6,060 (75.9)

Note : The fertility rate is live births calculated per 1,000 women 15-44 years of age. White, Black, Asian and Other races include Latinas. *Unknown race and ethnicity appear only for the total. Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research. Calculations prepared by PHMC.

Table 6. 2012 - 2016 Fertility Rates for Women 15-19 Years by Race and Ethnicity: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
Avg Births per Year (rate per 1,000)	28 (1.8)	588 (26.0)	203 (11.5)	819 (14.7)	2,592 (19.3)
Race/Ethnicity*					
White	16 (1.3)	54 (6.6)	74 (5.5)	145 (4.3)	541 (6.6)
Black	7 (7.1)	482 (40.6)	77 (34.5)	566 (37.5)	1,377 (40.4)
Asian	.	6 (3.7)	.	8 (2.3)	43 (5.1)
Other	.	28 (24.9)	37 (30.3)	68 (21.5)	495 (11.1)
Latina	.	40 (34.0)	62 (49.2)	107 (34.8)	686 (50.5)

Note : The fertility rate is calculated per 1,000 women 15-19 years of age. White, Black, Asian and Other races include Latinas. . =Not Displayed. Rates are not calculated when there are less than 25 occurrences (5 per year) of the event over the course of 2012-2016. *Unknown race and ethnicity appear only for the total. Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research. Calculations prepared by PHMC.

Table 7. 2012-2016 Percentage of Women Receiving Late or No Pre-natal Care by Race and Ethnicity: Main Line Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
All Live Births N(%)	933 (24.2)	3,598 (47.5)	1,646 (27.9)	6,176 (35.7)	16,946 (37.6)
Race/Ethnicity*					
White	687 (22.0)	790 (34.5)	905 (21.4)	2,382 (24.7)	6,430 (27.0)
Black	61 (44.9)	2,280 (53.2)	330 (49.2)	2,671 (52.5)	6,302 (52.0)
Asian	134 (29.1)	200 (47.2)	108 (24.7)	441 (33.4)	1,244 (36.9)
Other	33 (38.4)	191 (54.5)	245 (57.6)	469 (54.4)	2,213 (51.5)
Latina	44 (33.2)	210 (53.4)	335 (53.6)	589 (51.2)	2,851 (50.0)

Note : White, Black, Asian, and Other races include Latina/os.The percentage of women receiving late or no pre-natal care is calculated as the percentage of all live births that have birth certificate data on receipt of prenatal care. Late prenatal care is defined as not having started prental care visit in the 1st or 2nd trimesters, or none at all. *Unknown race and ethnicity only appear for the total. Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research. Calculations prepared by PHMC.

Table 8. 2012-2016 Low Birth Weight Births by Race and Ethnicity: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
All Live Births (Rate per 1,000)	277 (70.2)	920 (111.4)	451 (72.8)	1,648 (89.6)	4,329 (90.9)
Race/Ethnicity*					
White	213 (66.8)	173 (73.0)	263 (60.2)	649 (65.4)	1,686 (68.7)
Black	18 (126.1)	639 (133.0)	100 (135.0)	758 (133.1)	1,779 (133.3)
Asian	35 (74.3)	36 (79.1)	39 (85.8)	110 (79.7)	282 (79.7)
Other	7 (80.8)	37 (96.4)	36 (74.7)	80 (83.9)	406 (88.3)
Latino/a	11 (77.6)	36 (85.0)	52 (74.1)	99 (78.2)	527 (86.7)

Note : White, Black, Asian and Other races include Latino/as. Low birth weight is defined as an infant weighing less than 2500 grams (5.5 lbs.) at birth. The low birth weight rate is calculated per 1,000 live births. *Unknown race and ethnicity appear only for the total. Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research. Calculations prepared by PHMC.

Table 9. 2012-2016 Percentage of Infants Born Prematurely by Race and Ethnicity: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
All Live Births N(%)	319 (8.1)	914 (11.1)	541 (8.8)	1,774 (9.7)	4,622 (9.7)
Race/Ethnicity*					
White	263 (8.3)	208 (8.8)	350 (8.0)	821 (8.3)	2,041 (8.4)
Black	15 (10.9)	604 (12.6)	96 (13.0)	715 (12.6)	1,703 (12.8)
Asian	30 (6.5)	33 (7.4)	34 (7.5)	98 (7.1)	256 (7.3)
Other	6 (6.8)	35 (9.2)	48 (10.0)	89 (9.4)	434 (9.5)
Latino/a	13 (9.1)	39 (9.2)	67 (9.7)	118 (9.5)	576 (9.5)

Note : Prematurity is defined as the birth of an infant before 37 weeks gestation. The percentage of infants born prematurely is calculated as a percentage of all live births that have birth certificate data on gestational age. White, Black, Asian and Other races include Latino/as.*Unknown race and ethnicity appear only for the total. Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research. Calculations prepared by PHMC.

Table 10. 2012-2016 Infant Mortality Rate by Race and Ethnicity: Main Line Health Acute Care Service Areas

	Central	Eastern	Northwest	All MLH Acute Care	SEPA
All Live Births (Rate per 1,000)	15 (3.7)	83 (10.0)	27 (4.4)	125 (6.8)	315 (6.6)
Race/Ethnicity*					
White	11 (3.4)	13 (5.5)	14 (3.2)	38 (3.8)	92 (3.8)
Black	1 (9.8)	55 (11.5)	8 (10.8)	65 (11.4)	148 (11.1)
Asian	2 (3.4)	2 (4.0)	2 (4.0)	5 (3.8)	11 (3.0)
Other	1 (6.6)	3 (7.9)	3 (5.4)	6 (6.5)	28 (6.0)
Latino/a	1 (4.3)	2 (5.2)	4 (5.4)	7 (5.2)	35 (5.7)

Note : Infant mortality is defined as the death of an infant within the first year of birth and is calculated per 1,000 live infant births. White, Black, Asian and Other races include Latino/as. *Unknown race and ethnicity is included only in the total. Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research. Calculations prepared by PHMC.

Table 11. 2012-2016 Age-Adjusted Annualized Mortality Rates for Selected Causes of Death: Main Line Acute Care Service Areas

	Healthy People 2020 Goal	Central	Eastern	Northwest	All MLH Acute Care	SEPA
All Causes of Death (Rate per 100,000)		566.8	840.8	640.4	690.0	732.4
All Cancers	161.4	137.3	191.3	151.0	160.9	168.4
Female Breast Cancer	20.7	18.7	26.6	20.9	22.3	22.9
Lung Cancer	45.5	31.6	51.9	36.3	40.2	43.2
Colorectal Cancer	14.5	11.7	19.0	13.7	14.9	15.2
Prostate Cancer	21.8	15.0	31.3	16.4	20.4	21.6
Cervical Cancer	2.2	.	2.6	.	1.8	2.2
Heart Disease	.	130.5	201.9	154.8	163.8	167.8
Stroke	34.8	34.5	45.9	39.1	40.0	39.2
Diabetes	.	10.5	22.7	14.2	16.0	17.9
Kidney Disease	.	10.0	20.0	12.0	14.1	15.5
Liver Disease	.	5.7	8.8	6.3	7.0	7.1
Chronic Lower Respiratory Disease	.	27.2	37.3	32.0	32.4	34.1
Influenza and Pneumonia	.	11.7	16.4	12.4	13.6	13.7
Septicemia	.	7.3	16.6	11.2	11.8	14.3
HIV/AIDS	3.3	.	4.8	1.1	2.3	2.6
Alzheimer's Disease	.	13.4	13.1	13.8	13.4	14.1
Homicide	5.5	.	16.4	2.1	7.9	8.7
Homicide by firearm	.	.	13.6	1.4	6.4	7.0
Firearm Deaths	9.3	3.7	17.4	5.9	10.3	11.4
Suicide	10.2	9.5	9.8	10.3	9.9	10.6
Suicide by Firearm	.	3.1	3.4	4.4	3.7	4.0
Fatal Injuries	53.7	42.5	75.4	50.3	58.1	65.7
Drug Overdose (all substances)	.	15.5	29.4	19.5	21.8	26.0
Drug -Induced Causes	11.3	15.6	30.0	20.0	22.2	26.8
All Accidents (Unintentional injuries)	36.4	30.0	46.5	37.1	38.6	44.9
Motor Vehicle Accidents	.	3.2	5.7	5.6	5.0	5.9

Note: *Diabetes-related mortality data are derived from the multiple-cause-of-death files. Data include all mentions of diabetes on the death certificate, whether as an underlying cause or a multiple cause of death. Diabetes is approximately three times as likely to be listed as multiple cause of death than as underlying cause. Mortality rates are calculated per 100,000 population. Denominators to calculate age-adjusted rates to the Standard 2000 population derive from 2010 Census Zip Code Tabulation Area data broken down into 11 age groups. .=Not displayed.
Source: Pennsylvania Department of Health, Bureau of Health Statistics and Research. Calculations prepared by PHMC.

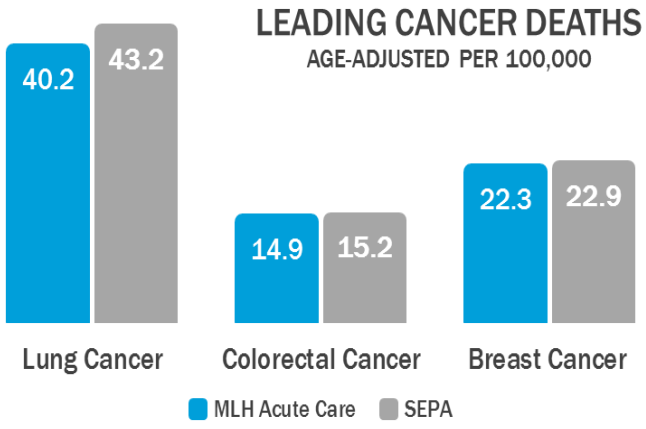
Appendix J. Leading causes of death: Rationale and data table

Causes of death in this report are ranked by following procedures consistent with CDC National Vital Statistics Reports and are defined by their international classification of diseases, tenth edition (i.e. ICD-10) codes. Causes of disease which had overlapping ICD-10 codes were not included in the ranking of the top ten causes of death for the ACH service area. For example, lung cancer accounted for an average annual number of 755 deaths in the area, which would have made it the fourth leading cause of death, but it was omitted due to its inclusion under malignant neoplasms (i.e. cancer). Colorectal cancer accounted for 278 average annual deaths, which would have ranked it as the eighth leading cause of death. The table below presents the leading causes of death in the MLH community with their ICD-10 definition, number of deaths, and mortality rate.[2]

Cause of death (based on ICD-10)		Rank	Average annual number of deaths	Age-Adjusted Annualized Mortality Rates	Percent of total deaths
All causes			13,115	690.0	100.0
Diseases of the heart	I00–I09,I11,I13,I20–I51	1	3,209	163.8	24.5
Malignant neoplasms (cancer)	C00-C97	2	3,021	160.9	23.0
Cerebrovascular disease (stroke)	*U0[illegible]X84,Y87.0	3	788	40.0	6.0
Accidents (unintentional injuries)	V01–X59,Y85–Y86	4	659	38.6	5.0
Chronic lower respiratory diseases	J40-J47	5	615	32.4	4.7
Drug Overdose	X40-44,X60-64, X85, Y10-Y14	6	347	21.8	2.6
Diabetes mellitus	E10-E14	7	300	16.0	2.3
Alzheimer's Disease	G30	8	273	13.4	2.1
Nephritis, Nephrotic Syndrome, and Nephrosis (kidney disease)	N00–N07,N17–N19,N25–N27	9	271	14.1	2.1
Influenza and Pneumonia	J09-J18	10	268	13.6	2.0

When using age-adjusted mortality rates to compare the MLH acute care service area to SEPA, the areas had comparable rates of cancer mortality.

"Fatal injuries" was not included in the top ten leading causes of death due to its close definition to accidents (i.e. unintentional injuries). Fatal injuries include all unintentional injuries, as well as injuries for which the cause was deemed intentional (i.e. homicide, suicide, undetermined, or other).



[2] Pennsylvania Department of Health, Bureau of Health Statistics and Registries. (2018). 2012-2016 Mortality [Data file]. Calculations by PHMC.; Heron, M. (2018). Deaths: Leading causes for 2016. National Vital Statistics Reports; vol 67 no 6. Hyattsville, MD: National Center for Health Statistics. 2018.

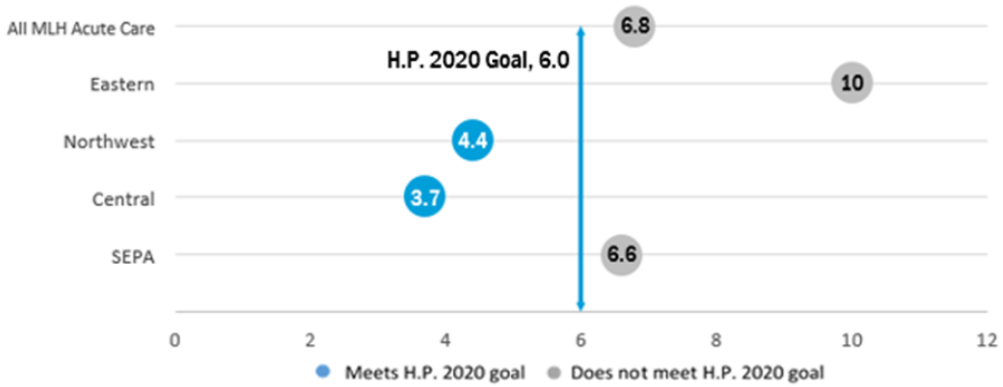
Fatal injuries accounted for 973 average annual deaths, which would have made it the third leading cause of death in the area.

Drug overdose includes deaths where a drug or multiple drugs were the underlying causes, whether it is of unintentional, suicidal, homicidal, undetermined, or other intent. Given the overlap with accidents, suicide, and undetermined manner, the National Vital Statistics Reports produced by the U.S. Department of Health and Human Services does not include drug overdose deaths as a leading cause of death.[3] Given that drug overdose deaths are a public health crisis nationally, statewide and locally PHMC decided that it was important to include drug overdose deaths when analyzing leading causes of death.

Drug-induced deaths were not included in the leading cause of death table because drug-induced cause is a broader category which also encompasses deaths due to medical conditions resulting from chronic drug use. Drug-induced cause of death had an average of eight more annual deaths than drug overdoses alone (i.e., 355 deaths compared to 347).

Infant Mortality

In the MLH Acute care service area, there were 6.8 infant deaths per 1,000 live births, which does not meet the HP 2020 goal for infant deaths (6.0 infant deaths per 1,000 live births). Alarmingly, black infants are experiencing disproportionately high mortality rates (11.4 deaths per 1,000 live births) than other races and ethnicities in the MLH Acute care area.



[3] Heron M. Deaths: Leading causes for 2016. National Vital Statistics Reports; vol 67 no 6. Hyattsville, MD: National Center for Health Statistics, 2018.

Appendix K. Community resource index

In order to identify the existing community resources throughout the MLH community, organizations were identified using PA 2-1-1, an online database of health, social services, and other providers. The following is a list of the community resources with the highest total referrals in their respective zip codes, along with a list of services they offer taken directly from the PA 2-1-1 database. This list is not exhaustive, but rather a snapshot of other organizations meeting community needs. A complete listing and further information is available online at http://211sepa.org/

1. **19004 – Jewish Relief Agency (10 total referrals)**
   200 Monument Road, Bala Cynwyd
   - Food pantry; hunger/food issues
   - Kosher food
2. **19008 – Community Interactions, Main Line Health – Behavioral Health (1 referral each)**
   a. **Community Interactions**
      388 Reed Road, Broomall
      - Disabilities and health conditions
      - Supported employment

   b. **Main Line Health – Behavioral Health**
      600 Abbott Drive, Broomall
      - General counseling services
      - Mental health counselors
3. **19010 – ElderNet of Lower Merion and Narberth (44 total referrals)**
   9 South Bryn Mawr Avenue, Bryn Mawr
   - Escorted rides
   - Emergency assistance
   - Emergency housing assistance
   - Community resource center and food pantry
4. **19013 – CityTeam Ministries (108 total referrals)**
   634 Sproul Street, Chester
   - Second chance program
   - Family services ministry
   - Mother and baby care program
   - Homeless shelter
   - Food services
5. **19014 – St. Matthew's CME Church (20 total referrals)**
   2349 Thomas Ave, Upper Chichester
   - Food pantry
6. **19023 – Blessed Virgin Mary Church and Parish (139 total referrals)**
   1101 Main Street, Darby
   - Food pantry
7. **19061 – Community Action Agency of Delaware County, Inc. (CAADC) (1,216 total referrals)**
   1414 Meetinghouse Road, Boothwyn
   - Transportation assistance
   - Pharmacy technician training program
   - CAADC water conservation measures
   - Welfare to work programs
   - Food assistance
   - Rental assistance

- Building trades training program
- Fuel assistance
- Transitional housing and rapid re-housing
- Rental housing
- Supportive Services for Veteran Families (SSVF)
- Temporary shelter program
- Case management
- CAADC homeowners assistance – renovations and energy efficiency
- CAADC utility assistance
- Emergency shelter

8. **19063 – Pennsylvania Department of Military and Veteran Affairs (36 total referrals)**
   201 W. Front Street, Media
   - Active military
   - Burial benefits
   - Families of military personnel/veterans
   - Government information lines
   - Memorials/monuments
   - Military reserves
   - Military transition assistance programs
   - Property tax exemption information
9. **19064 – Crozer Keystone Community Foundation, Divine Providence Village (1 referral each)**
   a. **Crozer Keystone Community Foundation**
      1260 Woodland Ave, Suite 211, Springfield
      - Pregnant women

   b. **Divine Providence Village**
      686 Old Marple Road, Springfield
      - Supported living for adults with disabilities
10. **19072 – Lower Merion – Narberth Community Coalition (1 referral)**
    P. O. Box 23, Narberth
    - Summer program
11. **19073 – Pennsylvania Agency of Nurses (PAN) (1 referral)**
    15 Saint Albans Circle, Newtown Square
    - In-home special needs and disability care
12. **19081 – Horizon House (6 total referrals)**
    1601 Parklane Road, Swarthmore
    - Mental retardation services
    - Homeless services
13. **19082 – Community Action Agency of Delaware County, Inc. (CAADC) (55 total referrals)**
    6310 Market Street, Upper Darby
    - Case management
    - Daily feeding program
    - Homeless shelter
    - Emergency shelter
14. **19083 – Child Guidance Resource Centers, Sunny Days Early Childhood Developmental Service, Surrey Services for Seniors (1 referral each)**
    a. **Child Guidance Resource Centers**
       2000 Old West Chester Pike, Havertown
       - Community behavioral health

    b. **Sunny Days Early Childhood Developmental Service**

1 North Belfield Avenue, Havertown
- Child care providers
- Early intervention for children with disabilities
- Occupational therapy
- Physical therapy
- Speech therapy

c. **Surrey Services for Seniors**
1105 Earlington Road, Havertown
- Escort programs
- Non-emergency medical transportation
- Older adults
- Ride sharing programs
- Transportation issues

15. **19085 – Devereux Pennsylvania (1 total referral)**
444 Devereux Drive, P. O. Box 638, Villanova
- Special needs care for children and adults

16. **19087 – Wayne Senior Center (3 total referrals)**
108 Station Road, Wayne
- Healthy living, living well, and enrichment programs

17. **19096 – Alex's Lemonade Stand Foundation, Center for Advancement in Cancer Education, Council for Relationships (1 referral each)**

a. **Alex's Lemonade Stand Foundation**
333 East Lancaster Ave. #414, Wynnewood
- Cancer
- Funding
- Travel issues

b. **Center for Advancement in Cancer Education**
300 E. Lancaster Avenue, Suite 100, Wynnewood
- Alternative medicine
- Cancer clinics

c. **Council for Relationships**
300 Lancaster Avenue, Suite 211, Wynnewood
- Couples
- Existential therapy
- Families
- Family/individual counseling

18. **19104 – Intercultural Family Services (73 total referrals)**
4225 Chestnut St, Philadelphia
- Housing counseling program

19. **19118 – Chestnut Hill Health System (2 total referrals)**
8835 Germantown Avenue, Philadelphia
- Freedom from smoking
- CPR Heartsaver with AED

20. **19119 – Germantown SDA Church (19 referrals)**
200 East Cliveden Street, Philadelphia
- Emergency food cupboard

21. **19127 – North Light Community Center (5 total referrals)**
175 Green Lane, Philadelphia
- Summer day camp
- FISH community food cupboard

22. **19128 – Fairmount Behavioral Health System (38 total referrals)**
561 Fairthorne Avenue, Philadelphia

- Inpatient adult psychiatric services
- Acute partial program
- Chemical dependency treatment
- 224 hour assessment center

23. **19129 – Visiting Nurse Association (VNA) of Greater Philadelphia (6 total referrals)**
    3300 Henry Avenue, Suite 500, Philadelphia
    - House calls
    - Hospice of Philadelphia
    - Home care for chronically ill patients
    - Home health care
24. **19131 – Belmont Behavioral Health for Comprehensive Treatment (43 total referrals)**
    4200 Monument Road, Philadelphia
    - General psychiatric help
    - Outpatient program
    - Substance abuse treatment
25. **19139 – Pennsylvania Department of Human Services (191 total referrals)**
    5740 Market Street, Philadelphia
    - Early learning resource center
    - Telephone assistance programs
    - Burial and cremation services payment
    - Emergency shelter allowance
    - LIHEAP (energy assistance, utility help)
    - Food stamps/SNAP – Delancey District
26. **19142 – Southwest Community Development Corporation (301 total referrals)**
    6328 Paschall Avenue, Philadelphia
    - Resource center
    - Housing retention program (HRP)
    - Strengthening multi-ethnic families and communities
    - REACH homeless prevention
    - Housing counseling
    - Utility service payment assistance
27. **19143 – Catholic Social Services – Southeast Pennsylvania (100 total referrals)**
    6214 Grays Avenue, Philadelphia
    - Kids Stop summer camp
    - Emergency food cupboard
28. **19151 – Good Samaritan Baptist Church (22 total referrals)**
    6148 Lansdowne Avenue, Philadelphia
    - Emergency food cupboard
29. **19301 – Paoli Presbyterian Church (8 total referrals)**
    225 South Valley Road, Paoli
    - Food closet
    - Furniture donations/ministry
30. **19312 – Daemion Counseling Center (6 total referrals)**
    95 Howelville Road, Berwyn
    - Counseling
31. **19320 – Connect Points (164 total referrals)**
    1003 East Lincoln Highway, Coatesville
    - Homelessness services
32. **19333 – Main Line Meals on Wheels (2 total referrals)**
    235 Lancaster Avenue, Devon
    - Convalescents

- Disabilities and health conditions
- Homebound
- Home-delivered meals

33. **19335 – Salvation Army, Philadelphia (23 total referrals)**
    (No Address), Downington
    - Emergency utility/rental assistance
34. **19341 – Home of the Sparrow (46 total referrals)**
    969 East Swedesford Road, Exton
    - Housing search assistance
    - Counseling
    - Personal financing counseling
35. **19342 – Aardvark Child Care and Learning Program (1 total referral)**
    335 Cheyney Road, Glen Mills
    - Summer camp
36. **19355 – Malvern Institute (7 total referrals)**
    940 King Road, Malvern
    - Outpatient/inpatient substance abuse treatment
    - Outpatient services
    - Detoxification
37. **19372 – Pennsylvania Department of Human Services (54 total referrals)**
    100 James Buchanan Drive, Thorndale
    - LIHEAP (energy assistance, utility help)
    - Emergency shelter allowance (ESA)
    - Medical assistance/Medicaid
    - Food stamps/SNAP
38. **19380 – Safe Harbor of Chester County (28 total referrals)**
    20 North Matlack Street, West Chester
    - Overnight shelter
    - Emergency homeless shelter
39. **19382 – Act In Faith of Greater West Chester (117 total referrals)**
    212 S. High Street, West Chester
    - Transportation
    - Medical care expense assistance
    - Rent payment assistance
    - Rental deposit assistance
    - Food pantry
    - Utility service payment assistance
40. **19401 – Montgomery County Community Action Development Commission (CADCOM) (624 total referrals)**
    113 East Main Street, Norristown
    - Emergency food program
    - Emergency utility assistance
    - Budget and credit counseling
    - Weatherization programs
    - Food stamps
    - Fatherhood initiative program
    - Self-sufficiency/case management programs
    - Family savings account
41. **19403 – Adventist Community Service Center (103 total referrals)**
    3253 West Germantown Pike, Norristown
    - Clothing

- CPR instruction
- Disease/disability specific screening
- Food pantries
- Furniture
- Neighborhood multipurpose centers
- Nutrition education

42. 19406 – Pennsylvania Assistive Technology Foundation (8 total referrals)
1004 West 9th Avenue, King of Prussia
- Financing for assistive technology services and equipment

43. 19426 – Tri-State Advocacy Project (1 referral)
345 Beverly Drive, Collegeville
- Advocacy

44. 19428 – Cradles to Crayons (46 total referrals)
30 Clipper Road, PO Box 799, West Conshohocken
- Clothing donations for babies and children
- School supplies
- Children's need collection drive
- Diapers

45. 19444 – Action Alliance for Parents of the Deaf, Hearing Loss Association of America – Pennsylvania State Office (1 referral each)

a. Action Alliance for Parents of the Deaf
3033 Mathers Mill Road, Lafayette Hill
- Support group

b. Hearing Loss Association of America – Pennsylvania State Office
4051 Joshua Road, William Jeanes Library, Lafayette Hill
- Advocacy
- Audiology
- Deafness
- Hearing loss
- Speech and hearing volunteer opportunities
- Speech and language pathology

46. 19460 – Phoenixville Area Community Services (57 total referrals)
257 Church Street, Phoenixville
- Food pantry
- Basic needs assistance – food, rent payment, clothing, diapers, utility service payment assistance, advocacy, mortgage payment assistance, heating fuel payment assistance
- Interpretation/translation
- Emergency services

47. 19464 – Pennsylvania Department of Human Services (109 total referrals)
24 Robinson Street, Pottstown
- Temporary Assistance for Needy Families (TANF) cash assistance
- Food stamps/SNAP – Pottstown
- Burial and cremation services payment – Pottstown
- Medical assistance/Medicaid – Pottstown
- LIHEAP (energy assistance, utility help) – Pottstown
- Emergency shelter allowance (ESA) - Pottstown

48. 19465 – North Coventry Food Pantry (4 total referrals)
845 South Hanover Street, Pottstown
- Food pantry

49. 19468 – Spring-Ford Project Outreach (49 total referrals)

410 Washington Street, Royersford

- Rent payment assistance
- Heating oil assistance program

50. 19473 – New Life Youth and Family Services (2 total referrals)

585 Freeman School Road, Schwenksville

- Residential programs
- Independent living program

51. 19475 – Open Hearth (9 total referrals)

101 North Main Street, Suite A-1, Spring City

- Emergency housing
- Financial Insight and resource Management (FIRM)
- Family savings partner program
- Rental deposit assistance