2025

REGIONAL

Community Health Needs Assessment

FOR SOUTHEASTERN PENNSYLVANIA

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Executive Summary

Identifying and addressing the unmet health needs of local communities is a fundamental responsibility of hospitals and health systems across the United States. The Affordable Care Act (ACA) formalized this role by requiring tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and implement strategies to address the most pressing priorities identified. This assessment serves as a cornerstone of community benefits planning and social accountability for not-for-profit hospitals and health systems. By gaining deeper insights into service needs and gaps, organizations can develop ACA-mandated implementation plans that respond effectively to high-priority concerns.

Recognizing that many hospitals and health systems serve overlapping communities, a group of local hospitals and health systems has again collaborated on a Southeastern Pennsylvania (SEPA) Regional CHNA (rCHNA), covering Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This ongoing collaboration ensures a consistent, data-driven approach while offering opportunities to refine and enhance the assessment process. By working together, participating organizations aim to strengthen the impact of the CHNA, fostering multi-sector partnerships and community-driven solutions that drive meaningful and sustainable change. Additionally, this collaborative model reduces the burden on community members while leveraging shared knowledge and resources.

The 2025 rCHNA is specifically designed to advance health equity and foster authentic community engagement. Beyond guiding hospital and health system strategies, the rCHNA plays a vital role in amplifying the voices of community members and providing localized health indicators that are essential for nonprofits and community-serving organizations. These data and insights support grant writing, program development, and evaluation efforts, ensuring that organizations working to improve community health have the evidence they need to advocate for funding and implement impactful initiatives.

PARTNERING HEALTH SYSTEMS AND HOSPITALS

- **Children's Hospital of Philadelphia**
  - Children's Hospital of Philadelphia
  - Middleman Family Pavilion at CHOP, King of Prussia
- **ChristianaCare – West Grove**
- **Doylestown Health**
- **Grand View Health: Grand View Hospital**
- **Jefferson Health**
  - Jefferson Einstein Montgomery Hospital
  - Jefferson Einstein Philadelphia Hospital
  - Jefferson Abington Hospital
  - Jefferson Bucks Hospital
  - Jefferson Frankford Hospital
  - Jefferson Hospital for Neuroscience
  - Jefferson Lansdale Hospital
  - Jefferson Methodist Hospital
  - Jefferson Torresdale Hospital
  - Jefferson Moss Magee Rehabilitation Center City (Magee Rehabilitation)
  - Jefferson Moss Magee Rehabilitation – Elkins Park (Moss Rehab)
  - Rothman Orthopedic Specialty Hospital
  - Thomas Jefferson University Hospital
- **Main Line Health**
  - Bryn Mawr Hospital
  - Bryn Mawr Rehabilitation Hospital
  - Lankenau Medical Center
  - Paoli Hospital
  - Riddle Hospital
- **Penn Medicine**
  - Chester County Hospital
  - Hospital of the University of Pennsylvania
  - Hospital of the University of Pennsylvania – Cedar Avenue
  - Penn Presbyterian Medical Center
  - Pennsylvania Hospital
- **St. Christopher's Hospital for Children**
- **Temple University Health System**
  - Fox Chase Cancer Center
  - Temple University Hospital
  - Temple University Hospital – Episcopal Campus
  - Temple University Hospital – Jeanes Campus
  - Temple University Hospital – Northeastern Campus
- **Trinity Health Mid-Atlantic**
  - Mercy Catholic Medical Center, Mercy Fitzgerald Hospital Campus
  - Nazareth Hospital
  - St. Mary Medical Center and St. Mary Rehabilitation Hospital
- **Wills Eye Hospital**

OUR COLLABORATIVE APPROACH

In collaboration with the Steering Committee—comprising representatives from partnering hospitals and health systems—the project team, consisting of staff from the Health Care Improvement Foundation (HCIF) and the Philadelphia Association of Community Development Corporations (PACDC), developed a collaborative, community-engaged approach. This methodology involved collecting and analyzing both quantitative and qualitative data while incorporating secondary data sources to comprehensively assess the region's health status.

The HCIF team and quantitative consultant compiled, analyzed, and aggregated over 70 health indicators encompassing: access to care, community demographic characteristics, chronic disease and health behaviors, disabilities, injuries, maternal, infant and child health, mental and behavioral health, and social and economic conditions. Additionally, HCIF, in collaboration with hospitals, health systems, and community-based organizations (CBOs), conducted a general population survey with six core questions and demographic queries to better understand community health experiences across all counties. The survey was offered in English and seven additional languages and analyzed at county and sub-geography levels to reflect diverse community perspectives.

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

- **General Population Focus Groups:**
  30 community conversations engaging residents from geographic communities across five counties.
- **Diverse Language Focus Groups:**
  Two sessions facilitated in partnership with SEAMAAC to engage Latine and Asian populations.
- **Youth Engagement:**
  15 focus groups capturing insights from youth across all counties.
- **Spotlight Topic Discussions:**
  10 discussions with community organizations and government agencies on key topics, such as health and social services integration, aging, primary care access, maternal health, caring for uninsured and undocumented populations, culturally appropriate mental health care, and housing.
- **Targeted Focus Groups:**
  10 discussions on specific health concerns, including cancer care, vision care, disabilities, and maternal health.
- **Key Informant Interviews:**
  15 interviews with subject matter experts from health systems, local government, and CBOs to explore spotlight topics in-depth.

A qualitative data expert facilitated adult discussions, analyzed findings, and synthesized key themes. Additionally, a trained youth facilitator led youth conversations to ensure meaningful engagement of young voices in the assessment process.

The project team also conducted or supported targeted primary data collection to address specific community needs, focusing on:

- Cancer
- Disability/Rehabilitation
- Maternal Health
- Older Adults
- Vision
- Youth Voice

Reports and summaries from other community engagement efforts were integrated into the assessment. For example, findings from a local PCORI grant initiative (PC3) informed the cancer focus area section.

HCIF staff aggregated top priorities from general community conversations, youth engagement, and survey data. These findings were presented to the Steering Committee, which conducted a grouping exercise to categorize concerns into 12 general population priorities and 8 youth-focused priorities.

Using the Hanlon ranking method, each participating hospital and health system rated the identified needs. Average ratings were calculated, and community health priorities were organized based on:

- Magnitude of the health issue based on population impact
- Severity of the issue within hospital and health system catchment areas
- Effectiveness of potential interventions
- Feasibility of implementing solutions

Potential solutions for each of the community health priorities, based on findings from the qualitative data collection, were also included. Using this updated information, the Steering Committee and project team developed a collaborative, community-engaged approach that involved collecting and analyzing quantitative and qualitative data and aggregating data from a variety of secondary sources to comprehensively assess the health status of the region.

The assessment resulted in a list of priority health needs that will be used by participating hospitals and health systems to develop implementation plans outlining how they will address these needs individually and in collaboration with other partners. In the below summary, participant solutions are provided for insight on community driven ways to address the priorities.

COMMUNITY HEALTH PRIORITIES:
General Population

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
1. **Trust and Communication**	• National surveys (from ABIM, AcademyHealth, and IHI) indicate declining patient trust in healthcare institutions, often due to provider burnout, high turnover, disparities in treatment, and financial barriers, which disproportionately affect uninsured and minoritized communities. Community conversations reinforced this issue in the region. • Patients feel rushed during short appointments and unheard by providers, leading to concerns about potential medical errors, particularly with conflicting prescriptions. • ER staff have the most pronounced communication issues, which are closely linked to long wait times and patient frustration. • Poor front-desk interactions, including last-minute appointment cancellations and unprofessional behavior, contribute to negative patient experiences and decreased trust.	• Desire for more empathetic, respectful, and culturally responsive care and support staff. • Suggestions included more social workers in hospitals and improved communication about healthcare changes. • Ensure benefit notices and appointment information are received on time, not after due dates, and provide regular updates on healthcare changes and medication protocols. • Adjust mechanisms for healthcare and social service staff to provide consequences when institutions or workers drop the ball on paperwork or communication. • A dream solution expressed by multiple participants was a system where everyone receives the same quality of care, regardless of insurance status.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
2. **Racism and Discrimination in Health Care**	• People of color, immigrants, people with disabilities, people with mental illness, people with substance addiction, LGBTQ+ individuals, and other minority groups continue to **experience discrimination and institutional barriers to health care**. • **Insufficient health care staff from diverse and representative backgrounds** play a major role in this issue – people do not see themselves reflected in the healthcare workforce; can lead to not "feeling seen." • **Intersecting identities** lead to exponential impacts on discrimination and racism, and subsequent trauma. • The **political climate** in the United States contributes to feelings of vulnerability within marginalized communities.	• Participants called for healthcare professionals to update their knowledge and attitudes beyond outdated textbooks. • Strong calls for in-person translation services and recruitment of bilingual providers. Languages mentioned: Spanish, Arabic, French, several African languages. • Participants suggested that providers should reflect the communities they serve — racially, culturally, and linguistically. • Address the way patients with substance use or mental health needs are often denied full treatment, especially pain management. • Recognize and address structural racism — such as how funding, communication, and service offerings exclude or deprioritize certain communities.
3. **Chronic Disease Prevention and Management**	• **Community gyms and recreation spaces that are well maintained and free/affordable**, were recognized as desirable neighborhood resources, along with safe neighborhoods, and support disease prevention & management. • **Limited access to healthy food options and limited food education** were noted as some of the greatest barriers to maintaining health and preventing or improving health conditions. • Some participants shared knowledge of and experiences with **Long COVID**, while a significant number were unfamiliar with the condition. Millions of adults in the U.S. have been affected by Long COVID. Participants are still generally concerned about acute COVID-19 infection. • **People with disabilities, who are not all older adults, face barriers to disease prevention and management** due to accessibility issues and require greater advocacy.	• Increase access to local fitness centers and programs that accept health insurance. • Promote community gardens and green spaces for physical activity and healthy eating. • Provide consistent access to nutritional education for both children and adults. • Offer more accessible chronic disease screenings and follow-up care, especially for older adults. • Ensure health centers and providers are open during evenings/weekends to improve access.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
4. **Access to Care (Primary and Specialty)**	• **Prevailing barriers** in accessing care include: **inadequate health insurance coverage** (insurance not accepted, high out-of-pocket costs, no dental coverage), **limited transportation/accessibility of offices/hospitals** (primarily an issue in non-urban settings and amongst older adults), **extended wait times for appointments** (prompting use of ER and urgent care more often), **closures of local hospitals**, and **specialists not covered by insurance or not available for appointments/too far**. • In addition to hospital closures, **pharmacy closures** present challenges related to obtaining prescriptions, resulting in increased utilization of prescription deliveries. • Some pandemic-era changes to access have persisted, including more pervasive **telehealth services**, **increased interaction with health portals**, and **virtual health-related programming**.	• Extend clinic hours to evenings and weekends. • Reduce wait times for appointments, especially for urgent needs. • Simplify the referral and authorization process, which often delays care. • Provide local urgent care and dental options, especially in rural or underserved areas. • Address insurance instability (frequent changes to accepted plans or providers).
5. **Healthcare and Health Resources Navigation**	• Community members' lack of awareness of resources is reflective of both **community needs and a lack of knowledge.** • The perception of a lack of resources where some might exist is **indicative of a need to improve information dissemination and methods of accessing that information**. Participants frequently felt compelled to share resources and experiences with one another, when needs and complaints arose about health services among the focus group members. • **Navigating insurance policies, coverages, web platforms, related resources and healthcare costs prove challenging** – especially for older adults who feel less confident with technology use and the transition to Medicare. • **Mentorship for medical decision-making**, particularly for older adults who live alone, can promote social support, advocacy, and safety.	• Expand non-emergency medical transportation options, particularly for older adults and rural residents. • Provide help navigating insurance plans, applications, and renewals (e.g., in-person or phone-based support). • Create centralized, updated lists of services and locations (e.g., food vouchers, clinics). • Provide tech support or training for those who struggle with using healthcare portals or telehealth.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
6. Mental Health Access	• Community members shared the **quantity and availability of mental health providers are insufficient** to meet ever increasing needs (particularly post-pandemic). • Additionally, health **insurance coverage for mental health services and providers is inadequate**. • **Stigma** around this topic was cited as a barrier – especially in ethnic minority communities. • The **intersection of mental illness, substance use, and/or homelessness** was recurring concern. • The general population expressed **significant concerns related to youth mental health** – which is reflected in the youth prioritization. • Mental health **needs for older adults** focus on grief support and opportunities for community-based social engagement.	• Increase the number of behavioral health providers, especially in rural areas. • Reduce wait times and eliminate long delays between referrals and services. • Normalize seeking help by reducing cultural stigma around mental health through community education. • Offer telehealth mental health options for those without transportation. • Provide trauma-informed mental health support tailored to children, youth, and families.
7. Substance Use and Related Disorders	• Community members shared concerns about **substance use in their communities, co-occurring mental illness**, the potential **implications on youth**, and the association with **poor neighborhood safety**. • Drug overdose rates continue to be high due to **opioid epidemic**. • **Community-based services** to treat substance use are perceived as **insufficient** in number by some, and/or are not well-known by others. • **Prevention and education measures** can serve **as protective factors** against misuse and abuse; questions arose regarding the usefulness and impact of policing related to substance use.	• Expand community-based rehabilitation programs as alternatives to incarceration. • Provide trauma-informed care and education during health visits, especially for youth. • Increase provider training to eliminate bias toward individuals with histories of substance use. • Offer drug education at the provider level (not just in schools) with resources for both youth and families. • Reduce stigma through culturally competent and empathetic behavioral health care.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
8. Healthy Aging	• Community members raised concerns about **older adult isolation**, impacting **mental health**, food access, and healthcare interactions. Senior centers and community services were frequently mentioned. • **Transportation barriers** contribute to **food insecurity** and **limited community engagement**. Free ride programs often involve long waits, indirect routes, and lengthy travel. • **Limited digital literacy** and unfamiliarity with technology restrict older adults' access to healthcare and social services. • **Medicare transitions** are often confusing, causing **missed benefits**.	• Improve transportation services for older adults to attend appointments, social events, and access groceries. • Provide free or subsidized exercise classes (e.g., Tai Chi) to support mobility and wellness. • Increase availability of nutritious foods by offering more options and ability to share restrictions in senior food distribution programs. • Establish or re-open senior centers and day programs for social engagement and resource access. • Offer help with documentation and paperwork (e.g., birth certificates, benefits forms). • Create anonymous and accessible reporting systems for elder abuse or neglect.
9. Culturally and Linguistically Appropriate Services	• **Language barriers are the greatest contributing factor to healthcare access** issues for immigrants and ASL speakers. Language issues lead to misunderstandings between patients and healthcare providers or can dissuade patients from attending appointments altogether. • Provision of **high-quality language services (oral interpretation and written translation) is critical** for providing equitable care to these communities; inquiring of patients at the time of appointment-setting about interpreter needs is ideal. • Beyond language access, **cultural and religious norms influence individual beliefs about health**; stigma can create barriers to seeking help, particularly mental health services. • Undocumented individuals may be discouraged from seeking medical help due to **fear or lack of health insurance**.	• Hire bilingual/multilingual providers and translators (languages mentioned: Spanish, Arabic, French, African dialects). • Provide in-person interpreters, especially during complex or urgent health interactions. • Ensure all signage, forms, and digital tools are translated into key community languages. • Train providers in culturally responsive care that respects beliefs and traditions of immigrant communities.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
10. Food Access	• Maintaining diets consisting of fresh produce and healthy foods is **consistently difficult and cost prohibitive**. Cheaper fast food and corner store options are also more convenient, readily accessible, and more prevalent – particularly in urban neighborhoods. Likewise, large grocery stores may require transportation to access them. • A **lack of food literacy and longevity of poor dietary habits** over time also contribute to food choices. • Local food banks/pantries serve as an **indispensable community resource**. When available, community gardens offer neighborhoods opportunities to grow their own food in the company of neighbors. • Older adults have enjoyed **meal delivery services**, as a part of their benefits. • Immigrants and ethnic minorities face challenges with finding **foods that are culturally relevant to them**.	• Maintain and expand community gardens, fresh food access, and local markets. • Offer nutritional education for both children and parents. • Increase oversight of food stamp benefit security (e.g., prevent theft and fraud). • Improve quality of food provided at pantries or senior meal programs – not just quantity.
11. Housing	• The overall health of homeless individuals was also of concern to community members, feeling as though **resources were not readily available** and that homeless individuals contributed to sentiments around neighborhoods being unsafe. • A growing **lack of affordable housing** has led to a year's long waiting list for subsidized housing, as well as evictions, and individuals sleeping in places not meant for human dwelling (e.g., cars, outdoors). This phenomenon is **pervasive across counties**, but particularly in Philadelphia. • Housing for certain sub-groups, such as **older adults and veterans**, was also noted as priorities.	• Invest in affordable housing and shelters, especially for people experiencing homelessness or with substance use challenges. • Improve transitional housing and reentry programs to prevent homelessness post-incarceration. • Ensure stable housing for vulnerable groups to support health management (e.g., medication, food access).

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
12. **Neighborhood Conditions (e.g., blight, green space, air/water quality, etc.)**	• Availability of green spaces, dog parks, libraries, and health centers (with parks, walking trails, gyms, pools) contribute significantly to positive perceptions about neighborhood conditions; named as **desired neighborhood features.** • Lack of overall neighborhood safety, caused by criminal activity, community violence, or road conditions, are risk factors for **poor mental health and limited physical activity outside.** • Uncollected trash build-up and littered streets negatively impact neighborhood morale and contribute to air pollution that can preclude some from opening their windows • Community events were praised as **opportunities to foster neighborly connections** and cohesion. • Local pride from residents who have lived in the area for several decades, particularly in Philadelphia, contribute to **vested interests in improvement**, and informed perspectives on neighborhood history and nature of changes.	• Increase investment in neighborhood clean-up efforts (e.g., trash removal, illegal dumping). • Expand tree canopy and green spaces to reduce heat and support walkability. • Maintain and rebuild parks and rec centers to offer both safety and engagement for youth. • Improve sidewalks and streets for better mobility and pedestrian safety. • Recognize the mental health impacts of environmental stressors like blight and noise.

COMMUNITY HEALTH PRIORITIES:
Youth

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
1. **Youth Mental Health**	• Youth community members and partners recognize **mental health as the primary health concern** in the region. • Youth mental health was prioritized at **12 of 15 youth meetings**. • The top issues raised in youth voice meetings included: access to **mental health services**, needing more support and resources related to **coping skills**, the negative impacts of **social media**, and overall feelings of **loneliness**. • The age-adjusted suicide rate for the region is 11%, with 1**8% of youth across the five counties seriously considering suicide**.	• **Peer-led support spaces** in schools like "Relationships First" circles where trained student leaders facilitate discussions. • **Early emotional support**: Incorporating social-emotional learning (SEL) from a younger age, not just in high school. • **Accessible mental health resources in schools** beyond overwhelmed counselors. • **Parent/community education** on youth mental health, potentially offered at school events like back-to-school nights. • **Mandated parenting education/training** to better equip caregivers. • **Reducing stigma** through community awareness and generational conversations.
2. **Lack of Resources/ Knowledge of Resources**	• Youth **prioritized help with health resources at 30% of youth meetings**. • Youth community members and partners expressed that **navigating healthcare services and accessing health resources, such as mental health programs and reporting outlets, is a significant challenge**. This difficulty arises from a general lack of awareness, fragmented systems, and resource constraints. • Youth shared feelings of **not having anyone to talk to**, or report "bad things" to. • Effective navigation involves not only providing information but also addressing transportation needs. **Many individuals, especially youth, encounter substantial obstacles in finding a trusted adult and obtaining transportation to healthcare services.**	• **Community events** (e.g., Healthy Kids Day) that attract families with incentives (bounce houses, food) while sharing resources. • **More community-based outreach** instead of only web-based referrals. • **Increased transportation access** or bringing services closer to communities (e.g., having more rec centers or clinics locally). • **Youth-friendly formats** like social media campaigns to spread resource awareness. • **Cultural and language access**: Hiring bilingual staff and making materials culturally relevant.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
3. **Substance Use and Related Disorders**	• Youth community members and partners identified **substance use as a health priority at 9 of the 15 youth community conversations**. • **Substance use disorders frequently co-occur with mental health conditions, posing significant challenges** for individuals and communities. These conditions are often linked to issues such as community violence and homelessness. • Key issues raised include the **prevalence of binge drinking, along with increasing use of cigarettes, marijuana, and vaping** among young people. • Youth noted **increased exposure to, and trauma, due to drugs**. • Discussions highlighted **the need for better support in navigating drug and behavioral issues, accessing treatment, and addressing exposure to trauma** related to substance use.	• **Youth-focused recovery spaces:** Suggestion of AA-style meetings for adolescents. • **Safe reporting systems** where youth can help others (e.g., calling for overdose support) without fear of punishment. • **Integrated recovery and workforce development programs:** Pairing mental health support with skill-building and community service. • **CIT (Counselor-in-Training) programs** and volunteer work for youth as alternatives to substance use and ways to build confidence and responsibility.
4. **Bullying**	• Youth community members and partners identified **bullying as a prevalent issue**. Bullying adversely impacts mental health and negatively affects youth's academic performance and social well-being. • Social media has a significant impact on youth, contributing to issues like **cyberbullying** and **unrealistic comparisons**. • Instances of racial profiling, discrimination, sexual harassment, and inappropriate behavior were mentioned highlighting the need for more **inclusive and respectful youth interactions**.	• **Social media etiquette education** starting at young ages to combat online bullying. • **Safe spaces in schools** to talk about feelings, led by peers or trained youth facilitators. • **Early interventions** to prevent verbal and cyberbullying from escalating. • **Support for immigrant and bilingual children** facing bullying due to language barriers.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
5. **Gun Violence**	• Youth community members and partners recognize **gun violence as a significant concern** in the region – with young people having easy access to guns and engaging in violent activities. • Violence driven by community disadvantage **disproportionately impacts** various communities in Philadelphia. Poverty, lack of resources, and inadequate support systems are compounding threats to youth's overall wellbeing and safety. • Trauma associated with exposure to gun violence is widely felt among youth. Challenges in **accessing the necessary mental health supports** to address those negative impacts were also reported. • Youth from immigrant communities, and LGBTQ+ communities are at **higher risk** of interpersonal violence, including intimate partner violence (IPV), sexual assault, and sex trafficking.	• **Reallocation of funding:** Instead of heavy spending in one area, directing more toward youth mental health and education. • **Safe community spaces** where youth can express fears and ideas (e.g., community art like the "community plate" activity). • **Community involvement and cleanup events** to reclaim and uplift neighborhoods. • **Critical feedback on ineffective policing** and calls for greater investment in actual youth-centered prevention and safety measures.
6. **Access to Physical Activity**	• Youth community members and partners widely associate the word "health" with **exercise** and **physical activity**. • 6 out of 15 youth meetings prioritized **physical activity and places** to engage in physical activity. • Access to outdoor **green spaces** and recreation areas like parks and trails are lower in some neighborhoods. The negative impact of such lack of spaces on mental and physical health was shared by youth community members. • 13% of of general population community survey respondents reported that places to be active such as **parks are rarely or never available**.	• **Community gardens and step challenges** tied to school programs. • **Block parties and community clean-ups** that include physical activity components. • **Rec centers and gym access** where youth feel welcome and included. • **Peer involvement at gyms** and modeling healthy physical routines in neighborhood spaces.
7. **Activities for Youth**	• Youth community members and partners emphasized the **importance of extracurricular activities**, which were a priority in 11 out of 15 meetings. • About 92% of youth in the region participate in activities outside of class, but they expressed a need for **more accessible programs**, especially in underserved areas. • Opportunities like summer camps, leadership programs, libraries and STEM clubs were **highly desired** across the five counties.	• **Volunteering and leadership opportunities** like CIT programs, community cleanups, or school clubs. • **Skills-based training with incentives** (e.g., small stipends or "training pay") even before official working age. • **Reviving youth programs** (e.g., Girl Scouts, Boy Scouts) and emphasizing mentorship. • **Creative expression projects** like community plates or mural work to connect youth to their environment and voice.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
8. **Access to Good Schools**	• Access to quality schools was discussed widely among youth. While some counties have ample funding, others have **limited resources**, affecting clubs, programs, and mental health support. • Youth generally appreciate opportunities provided by their schools but highlight significant gaps in **mental health resources**, relevant education, teaching methods, and overall student well-being. Key attributes of **good schools** discussed include: – Quality of Education – Mental Health & Support Systems – Qualified Educators – Supportive Environment & Policies – Resources and Facilities – Diversity, Equity, and Inclusion	• **Support for bilingual learners** and anti-bullying efforts to ensure comfort in school environments. • **Creating welcoming and identity-affirming clubs** for students of all backgrounds. • **Better sexual health and emotional learning programs** that students feel engaged in. • **Training for teachers and school staff** to be culturally competent and approachable.

Introduction

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

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

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

At the request of local non-profit hospitals and health systems, the Health Care Improvement Foundation (HCIF) continued its effort to collaboratively develop a regional Community Health Needs Assessment (rCHNA) for the Southeastern Pennsylvania (SEPA) region in 2025. Building on the success of previous assessments in 2019 and 2022, the 2025 rCHNA maintains the regional collaborative model while integrating new partners and expanding its data collection approach to enhance community representation.

The 2025 rCHNA includes all five counties of the SEPA region—Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. Notably, this year's assessment includes the participation of ChristianaCare - West Grove, St. Christopher's Hospital for Children, and Wills Eye Hospital, further strengthening the breadth and depth of regional collaboration. As in prior years, participants recognize the CHNA as a key tool for health systems, multi-sector partners, and communities to work together toward meaningful and positive community change.

Several enhancements distinguish the 2025 rCHNA from previous iterations:

- **Community-Based Survey Expansion:** A community-based survey was conducted in eight languages to improve accessibility and inclusivity, ensuring a broader representation of community voices in the assessment process.
- **Piloting of Diverse Language Sessions:** In response to the diverse linguistic needs of SEPA communities, the 2025 rCHNA piloted facilitated discussions in multiple languages, increasing engagement and cultural responsiveness.
- **Youth-Focused Priorities:** Recognizing the unique challenges faced by young people, the 2025 rCHNA includes a dedicated youth-focused priority list, incorporating input from youth-serving organizations, schools, and young residents.
- **Expansion of Spotlights:** The assessment features an expanded set of Spotlights, providing in-depth analyses of specific health topics, populations, or geographic areas. These Spotlights highlight key trends, disparities, and innovative community initiatives addressing pressing health concerns.

While the basic structure and format of the report remain consistent with prior assessments, the 2025 rCHNA reflects an evolving and deepening commitment to health equity, community engagement, and data-driven decision-making. The continued collaborative approach allows for shared learning, increased efficiencies, and a reduced burden on communities participating in multiple assessments.
As the SEPA region continues to navigate ongoing public health challenges and disparities, the 2025 rCHNA serves as a vital resource for guiding collective efforts toward improved health outcomes and a stronger, more equitable healthcare system for all.

Children's Hospital of Philadelphia

Children's Hospital of Philadelphia

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
600+	1,200+	34,000+	1.6M+	125,000+

MISSION:

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

VISION:

We relentlessly pursue answers to the most complex problems to give every child hope for a healthy future. We translate our research into life-changing solutions and advocate for and deliver the best care for children in our backyard and around the world.

VALUES:

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

Children's Hospital of Philadelphia (CHOP) is the nation's first hospital devoted exclusively to the care of children. Since 1855, CHOP has been the birthplace for countless breakthroughs and dramatic firsts in pediatric medicine. CHOP's footprint across Pennsylvania and New Jersey has grown to include:

- 2 hospital locations (with 600+ beds) in Philadelphia and King of Prussia;
- 10 hospital affiliations, across 20+ community locations;
- 50+ care network sites: 16 specialty care centers, 3 ambulatory surgery centers, 30+ primary care practices, and 4 urgent care centers;
- 576,000 sq. ft. of dedicated research space;
- A new Behavioral Health & Crisis Center with 46 inpatient psychiatric beds and 24/7 Crisis Response Center in West Philadelphia;
- The Center for Advanced Behavioral Healthcare, an outpatient facility in West Philadelphia.

Core Services

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

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

At CHOP, we know that a healthier future means addressing the environmental and social factors that contribute to children's health. To foster healing and prosperity in our communities, we apply our expertise beyond the walls of our hospital to collaboratively tackle the most significant challenges impacting children across our region. In 2013, CHOP began the CHOP Cares Community Grant Program, in which a Community Advisory Board comprised of CHOP employees and civic leaders advise on a competitive grant process. The program awards small grants to CHOP employees to support work in their own communities that address needs identified in the CHNA. In its 10 years, the CHOP Cares Program has supported 200 employee-led initiatives investing over $1 million in Southeastern PA.

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

- **Center for Health Equity (CHE)** - The CHE seeks to discover, implement, and disseminate evidence-based practices and policies so that every child in Philadelphia has equitable care and achieves their best health. The CHE brings together experts whose initiatives align with our four core work streams: Community Translation, Clinical Quality and Safety, Advocacy and Justice, and Research and Education.
- **Center for Violence Prevention (CVP)** - The CVP model works to reduce the incidence and impact of violence and aggression on children and families in the community. CVP includes efforts to reduce: 1) bullying in schools; 2) domestic violence in the home; and 3) violent assault in the community.
- **Healthier Together (HT)** - HT tackles the social drivers of health to improve the health and well-being of children in West and Southwest Philadelphia, in response to the most pressing needs identified in the 2019 RCHNA: housing, hunger, trauma and poverty.
- **Homeless Health Initiative (HHI)** – The HHI provides health outreach services through a coordinated, multidisciplinary approach that aims to reduce health disparities and improve healthcare access and health outcomes for children residing in homeless shelters. Services provided in family shelters include CHOP Night medical and dental exams and Operation CHOICES, an obesity prevention program, and art therapy for mothers and children.
- **Karabots Community Garden (Garden)** – The Garden, which opened in 2016, donates produce to the West Philadelphia community and hosts cooking demonstrations and educational events throughout the year. The Garden harvests and distributes 2,400 pounds of organic produce annually to patients and families.
- **Safe Place: The Center for the Child Protection and Health** – Provides services to children and their families for whom a concern for child abuse or neglect has been identified, including: the Children's Collaborative Clinic for evaluation of suspected child sexual abuse co-located and in partnership with the City of Philadelphia; Safe Place Treatment and Support Program, a comprehensive medical program, called Fostering Health Program; and PriCARE, a parent training program to facilitate positive parenting behaviors.

Accolades Received

Every year since 2007, when U.S. News and World Report published the first ranking of U.S. children's hospitals, CHOP has been among the top-ranked institutions in the country. We are proud to once again be on the prestigious Best Children's Hospitals Honor Roll in the 2024–25 U.S. News and World Report rankings, a recognition awarded to only 10 pediatric hospitals across the nation. CHOP also excelled in U.S. News' evaluation of specialty areas. Eight of our specialties are ranked in the top five for 2024–2025, led by the No. 1 ranked Orthopedic Center and the Division of Endocrinology and Diabetes. U.S. News also ranked Children's Hospital No. 1 in the Mid-Atlantic Region, and No. 1 in Pennsylvania.

In recognition as an outstanding employer, CHOP was ranked No. 1 on Forbes' 2022 list of America's Best Large Employers and has been included on Forbes' list of Best Employers for Diversity. CHOP has also been named one of the Disability Equality Index's Best Places to Work for Disability Inclusion for six years in a row.*

For its impact in the community, CHOP has been named an honoree of The Civic 50 Greater Philadelphia by Philadelphia Foundation as one of the most community-minded organizations in the region since 2021.

* Ranking reflects a tie with another regional institution

Partnerships and Affiliations

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

CHOP has 10 hospital affiliations across 20+ community hospital locations that collaborate to provide high quality, efficient pediatric care at the host hospitals. CHOP provides the hospital with newborn and pediatric services including physician staffing, clinical program management, as well as education for the host hospital staff and patients. CHOP views these arrangements as an important part of its mission of improving access to and improving the quality of newborn and pediatric care in the communities it serves.

Impact of Prior Community Health Needs Assessment and Implementation

The 12 priority needs identified in the 2022 RCHNA serve as the focus of CHOP's implementation plan. Due to CHOP's long history of working with the community, many of the health needs uncovered by the RCHNA were not unexpected and are actively being addressed by CHOP's existing programs. In response to the 2022 RCHNA, CHOP has worked on cross-collaborative partnerships, continued investing in strategies from previous implementation plans, and led new initiatives to respond to the needs identified.

In CHOP's service area, young and adult members and community partners continue to prioritize mental health as their top health need. In response, CHOP opened new facilities to increase access to behavioral healthcare. New/expanded facilities include:

- Center for Advanced Behavioral Healthcare
- Middleman Family Pavillion on CHOP's King of Prussia Campus expansion to include an adolescent malnutrition unit
- Behavioral Health & Crisis Center at the PHMC Health Center on Cedar Avenue in West Philadelphia

Since CHOP launched the Healthier Together Initiative in 2019, a $25 million initiative to tackle social drivers of health as a path to improving the health of children, the initiative has reached more than 15,000 individuals. This initiative partners with government agencies, nonprofits and community groups to develop programs that focus on housing, hunger, trauma and poverty. Within each of the four areas, key impacts include:

- **Creating Healthier Homes:** Via the Community Asthma Prevention Program-Plus, 200 homes have been renovated through repairs that reduce asthma triggers in the homes of children with severe asthma.
- **Accessing Healthy Foods:** Distributed the equivalent of 145,056 meals, installed 243 home and community gardens, and supported early childhood centers with serving 4,470 healthy meals weekly.
- **Achieving Financial Stability & Prosperity:** Through tax preparation services, over $1.4 million in returns to community members served by the Medical Financial Partnership program.
- **Overcoming Trauma & Growing Resilience:** Trauma services provided to 1,348 children, caregivers, and educators.

Other notable program impacts include:

- CHOP Youth Heart Watch (YHW) program conducted community heart health screenings with 206 children and adolescents across three events to identify whether participants have potential heart conditions that put them at risk for a sudden cardiac arrest. Health information is distributed at the events to help keep families healthy and safe beyond the heart screening they receive that day. YHW also worked with over 101 schools and organizations to provide education on sudden cardiac arrest and death prevention through site visits, presentations, and CPR/AED trainings, reaching 2,500 community members.
- To ensure children have access to meals during summer months, CHOP partners with Pennsylvania Department of Education, United States Department of Agriculture, and Nutritional Development Services to operate a summer food service program in the clinical setting, called Complete Eats. In its eighth year of operation, the program has served over 150,000 meals.
- To address the gun violence crisis in our region, CHOP's Gun Safety Program has created a model for safe storage education and gun lock distribution that is standardized and rooted in best practices, yet flexible enough for integration into a wide range of clinical and non-clinical settings. Since July 2022, the program has distributed over 5,700 gun locks, trained over 600 healthcare providers from 13 professional backgrounds, and has served as outside consultants for 7 healthcare institutions around implementation of gun safety programming.
- CHOP's Family Planning and Health Resource Center Programs provide confidential and barrier-free sexual and reproductive healthcare and counseling, including contraception methods, STI testing and treatment, and HIV counseling and testing to adolescents. Since July 2022, the Family Planning program has provided 8,200 clinical services within Primary Care appointments. Via the Health Resource Center in select Philadelphia high schools, services have been provided to 1,700 youth, with almost 1,000 mental health screenings and appropriate follow-up referrals.

A full report of CHOP's progress toward addressing needs in our community can be found at community.chop.edu.

Children's Hospital of Philadelphia

Service Area Demographics

ESTIMATED POPULATION

4,203,459

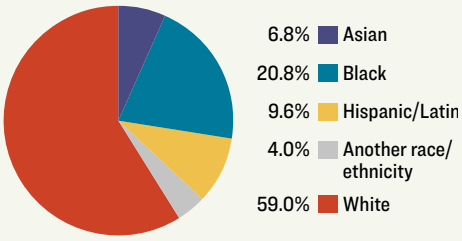
MEDIAN HOUSEHOLD INCOME

$91,123

NOT FLUENT IN ENGLISH

2.5%

RACIAL COMPOSITION



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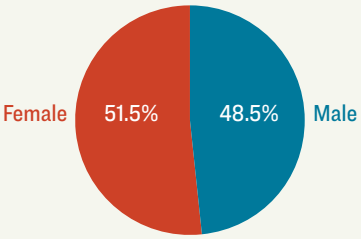
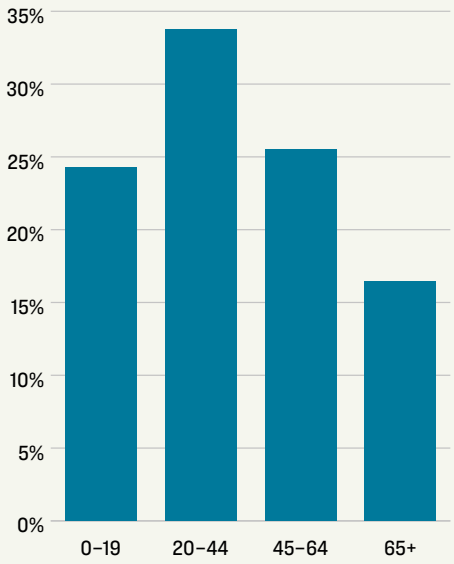
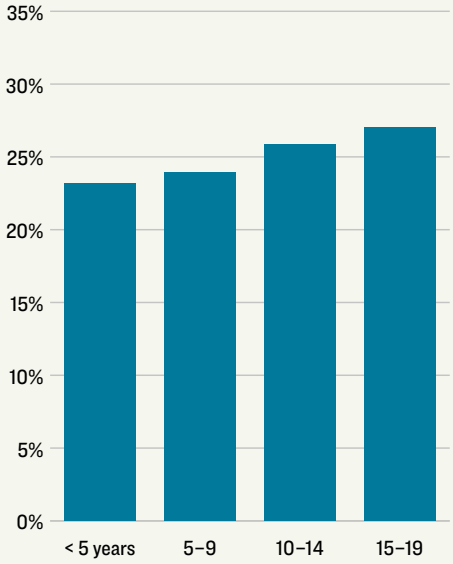






TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ChristianaCare West Grove Campus

ChristianaCare

BEDS:	EMPLOYEES:	PHYSICIANS	INPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
10	41	12	1,424*	46,036*

*Anticipated by year 5

MISSION:

ChristianaCare's mission, the ChristianaCare Way, is to serve our neighbors as expert, caring partners in their health. We do this by creating innovative, effective, affordable, and equitable systems of care that our neighbors value.

VISION:

Creating health together so every person can flourish.

VALUES:

We serve together guided by our values of love and excellence.

For more than 130 years, ChristianaCare has served the health needs of its communities. Today, that reach extends through Delaware, Maryland, Pennsylvania, and New Jersey.

Headquartered in Wilmington, Delaware, ChristianaCare is one of the country's most dynamic health care organizations, centered on improving health outcomes, making high-quality care more accessible and lowering health care costs. ChristianaCare is also one of the largest community-based teaching hospitals conducting research in the United States. Robust partnerships in clinical, translational and outcomes research boost ChristianaCare's national reputation and speed new ideas, technologies and treatments to communities challenged by today's most pressing health concerns.

As a nonprofit health system, our mission is one of service. We believe that the key to providing truly great health care is to partner with our patients and their families, building a system of care that is effective, affordable and valuable to everyone who is touched by it.

ChristianaCare expects to open its West Grove Campus Hospital in the summer of 2025 to bring new and needed health and wellness services to the West Grove, Pennsylvania community. ChristianaCare's West Grove Campus will house a micro hospital also known as a neighborhood hospital. Neighborhood hospitals provide a new model of care that will help us deliver the right care at the right place and in the right time. Neighborhood hospitals are acute care hospitals that offer emergency services and maintain facilities for at least ten inpatient beds with a narrow scope of inpatient acute care services.

Our new 22,000-square-foot neighborhood hospital facility will be open 24 hours a day, 7 days a week. In addition to the 10-bed emergency department, we will have a 10-bed inpatient unit and provide diagnostic radiological/imaging services such as x-ray, CT scan, and ultrasound as well as lab services and a pharmacy.

Adjacent to the neighborhood hospital, the West Grove Campus can also host a new medical office building. The medical office building is not yet open and will develop as we learn more about our neighbors' needs. We expect to offer primary care, women's health, outpatient diagnostics, and cardiology among other services.

Since 2020, ChristianaCare has been serving southern Pennsylvania residents through three Chester County primary care practices in Jennersville, Kennett Square, and West Grove and in Delaware County in our Concord Health Center multispeciality site.

Accolades received

ChristianaCare is rated by Healthgrades as one of America's 50 Best Hospitals and continually ranked among the nation's best by U.S. News & World Report, Newsweek and other national quality ratings. ChristianaCare is also nationally recognized as a great place to work, rated by Forbes as the 2nd best health system for diversity and inclusion, and the 29th best health system to work for in the United States, and by IDG Computerworld as one of the nation's Best Places to Work in IT.

Partnerships and affiliations

Patients at the West Grove Campus will benefit from ChristianaCare's extensive network of primary care and outpatient services, home health care, urgent care centers, three hospitals (1,336 beds), a freestanding emergency department, a Level I trauma center and a Level III neonatal intensive care unit, a comprehensive stroke center and regional centers of excellence in heart and vascular care, cancer care and women's health. Further, we are partnering with Ermerus Holdings Inc, the nation's leading developer of neighborhood hospitals, to build and operate our West Grove neighborhood hospital.

ChristianaCare

Service Area Demographics

ESTIMATED POPULATION

100,041

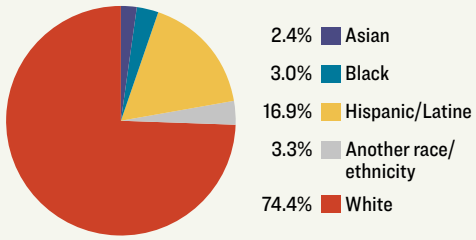
MEDIAN HOUSEHOLD INCOME

$121,760

NOT FLUENT IN ENGLISH

5.88%

RACIAL COMPOSITION



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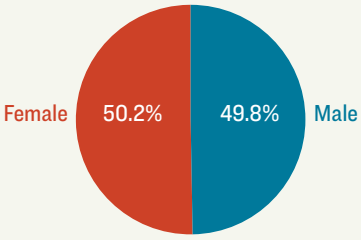

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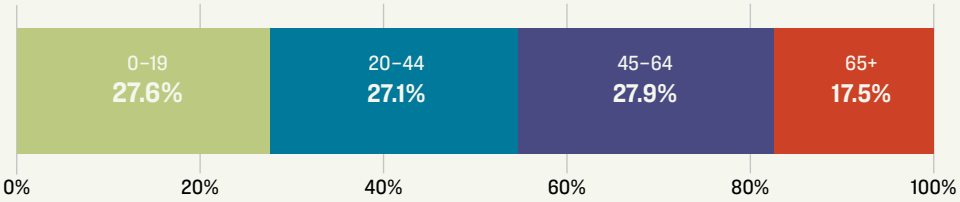


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

The targeted service area of the West Grove Campus is southern Chester County. Once our neighborhood hospital begins operations, we will gain more insight into our neighbors and service area.

Zip codes in our service area are:

19311 - Avondale; 19330 - Cochranville; 19350 - Landenburg; 19347 - Kemblesville; 19351 - Lewisville; 19352 - Lincoln University; 19360 - New London; 19362 - Nottingham; 19363 - Oxford; 19318 - Chatham; 19346 - Kelton; 19348 - Kennett Square; 19357 - Mendenhall; 19375 - Unionville; 19374 - Toughkenamon; 19390 - West Grove

Doylestown Health

Doylestown Health

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
247	435+	15,299	537,936	53,294

MISSION:

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

VISION:

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

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

SERVICE VALUES:

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

Doylestown Health

HISTORY

The Village Improvement Association was the guiding force behind the founding of Doylestown Hospital in 1923, and still governs the operation of the hospital today. Founded in 1895 by a small but inspired group of women from Doylestown, the VIA is nationally recognized as the only Women's Club to own and operate a community hospital. The first meeting was held April 26, 1895 with 14 women present. Since that time the VIA has grown in size and scope to its present membership of over 300 members.

Throughout its history, the VIA has continued to be a progressive organization, while maintaining their original goals to promote "every proper means of improving and beautifying Bucks County," and "improving the health and welfare of the residents." Each year members rededicate themselves to these commitments made in 1895.

Even then, the VIA recognized the need for public health initiatives and community healthcare services close to home, where people would have access to family and familiarity, beginning with the employment of a Visiting Nurse in 1916. The arrival of the 1918 Spanish Influenza epidemic galvanized the need for formalized community-based health care. The VIA, together with local medical professionals and the Doylestown community, opened the Doylestown Emergency Hospital, an eight-bed facility, at Pine and Oakland streets in 1923.

In 1939, as demand for care increased, Doylestown Emergency Hospital moved to a new location at Belmont and Spruce streets in Doylestown. Originally a 21-bed facility, this hospital expanded to accommodate 54 beds in 1951. As the community grew, a larger facility was needed. Doylestown Hospital was dedicated in 1975 as a 165-bed facility on West State Street in Doylestown. In 2001 the Village Improvement Association added the Health and Wellness Center in Warrington to its family. In 2015 the VIA Health System changed its name to Doylestown Health to represent a connected system of outpatient, inpatient, and community services.

In 2022, Doylestown Health launched its first-ever residency program, proudly educating and training the next generation of family medicine physicians. Doylestown Hospital celebrated 100 years of service in 2023, with 247 beds and a medical staff of more than 435 physicians in over 50 specialties. Despite this growth, the culture of personalized care that was inspired by our Founder's desire to help their beloved community remains present in the high-tech high-touch care that patients have come to expect from Doylestown Health.

This patient-first philosophy and team approach is proof of our commitment to meet the healthcare needs of patients in our community and region, now and for generations to come. Here at Doylestown Health, where grace meets humanity, our focus is YOU.

Doylestown Health

The Doylestown Health System includes:

- Doylestown Hospital
- Doylestown Hospital Outpatient Testing
- Doylestown Health Home Care
- Doylestown Health Hospice
- Doylestown Health Physicians
- Doylestown Health Urgent Care
- Children's Village - Early Childhood Education

From the beginning, Doylestown Hospital was an emergency and maternity hospital and has continued that emphasis with an expanded emergency department and state-of-the-art VIA Maternity Center where more than 1,200 babies are born each year.

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

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

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

A Nationally Accredited Community Cancer Center by the American College of Surgeons (ACoS) Commission on Cancer, Doylestown Health's Cancer Institute offers patients, families and caregivers access to specialists and advanced screening, diagnostic, treatment and supportive services – including a cancer rehabilitation program that is designated among the Physiological Oncology Rehabilitation Institute's Centers of Excellence.

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

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

Doylestown Health's offsite Urgent Care Association accredited Urgent Care accepts unscheduled, walk-in patients in need of X-rays, sutures, and minor prescriptions, procedures, and other urgent care, 365 days per year.

Doylestown Health

ACCOLADES

- **September 2024:** The American College of Cardiology recognized Doylestown Health for its demonstrated expertise and commitment in treating patients who come to an electrophysiology (EP) lab for care. Doylestown Hospital earned renewed Electrophysiology Accreditation based on rigorous onsite evaluation of the staff's ability to evaluate, diagnose and treat patients who come to the EP lab.
- **September 2024:** Doylestown Hospital's Cancer Rehabilitation Program is named among the inaugural recipients of the Physiological Oncology Rehabilitation Institute's Centers of Excellence.
- **August 2024:** The Hospital and Healthsystem Association of Pennsylvania honors Doylestown Hospital with "platinum" award status in recognition of awareness efforts to champion organ, eye, and tissue donation within the hospital and community during National Donate Life Month.
- **August 2024:** The American Heart Association presents Doylestown Hospital with five Get With The Guidelines® achievement awards for demonstrating commitment to following up-to-date, research-based guidelines for the treatment of heart disease and stroke, ultimately leading to more lives saved, shorter recovery times and fewer readmissions to the hospital. Recognition includes: Get With The Guidelines® Stroke Gold Plus Award with Target: Stroke Elite Honor Roll and Target: Type 2 Diabetes Honor Roll, Get With The Guidelines® Heart Failure Gold Plus Award with Target: Heart Failure Honor Roll and Target: Type 2 Diabetes Honor Roll, Get With The Guidelines® Resuscitation Gold Award (Adult) for treating in-hospital cardiac arrest, Get With The Guidelines® Coronary Artery Disease NSTEMI Gold with Target: Type 2 Diabetes, and Get With The Guidelines® Coronary Artery Disease STEMI Receiving Gold with Target: Type 2 Diabetes.
- **July 2024:** The VIA Maternity Center receives a Pennsylvania Perinatal Quality Collaborative awards in recognition of efforts to establish multidisciplinary teams who demonstrated improvements in maternal and newborn care with an emphasis on Immediate Postpartum Long-Acting Reversible Contraception (IPLARC), substance use disorders (SUD), and substance exposed newborn (SEN).
- **July 2024:** Doylestown Health Urgent Care receives the Urgent Care Association (UCA) Accreditation designation, the highest level of distinction for an urgent care center. UCA Accreditation illustrates an organization's overriding commitment to safety, quality and scope of services.
- **May 2024:** Doylestown Health Earns its 16th consecutive "A" safety grade from the Leapfrog group. In earning this distinction, Doylestown Health is among just 29% of hospitals nationwide (70 in total) and the only hospital in Pennsylvania to have done so. A national nonprofit watchdog, Leapfrog assigns an "A," "B," "C," "D" or "F" grade to general hospitals across the country based on over 30 measures of errors, accidents, injuries and infections as well as the systems hospitals have in place to prevent them.
- **April 2024:** Selected among the best in the region by their peers, 77 members of Doylestown Health's Medical Staff were named to Philadelphia Magazine's list of Top Doctors 2024, reflecting the health system's nationally recognized quality of care.
- **March 2024:** One of only 26 hospitals in Pennsylvania to be recognized, Doylestown Hospital is ranked first among Bucks County hospitals, 8th in Pennsylvania, and 126th in the United States in Newsweek's 2024 World's Best Hospitals annual listing, and received the extra distinction for being a leader in both infection prevention and patient experience.

AFFILIATIONS

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

Doylestown Health

Impact of Prior Community Health Needs Assessment and Implementation

Based on Doylestown Health's strengths and the outcomes of the 2022 needs assessment, we prioritized the five following areas: Mental Health/Substance Abuse, Access to Care, Chronic Disease, Healthcare and Health Resource Navigation and Racism and Discrimination in Healthcare. A description of activities and implementation strategies are below.

1. MENTAL HEALTH CONDITIONS/SUBSTANCE USE AND RELATED DISORDERS

a. Educated and trained staff to present education and collaborate with community groups and school districts on child sex abuse prevention. Collaborated with local school district before/after care programs to create structured activities for kids to stay away from drug and alcohol use.

b. Expanded the knowledge of the medication assisted treatment (MAT) program and use of certified recovery specialists at Doylestown Health by hosting educational programs, including fentanyl education with the Bucks County Drug and Alcohol Commission (BCDAC) detailing what Doylestown Health does in the community to prevent drug abuse and overdoses. Doylestown Emergency Department (ED) obtained a grant to train physicians on the use of micro-doses to reduce patient withdrawal. Lastly, there were increased efforts to educate the community on the BCARES Warm Handoff program through the ED.

c. Doylestown Health teams co-hosted education and awareness programs during Mental Health Month, including resource tables and information displays throughout the hospital campus.

d. Increased awareness of Narcan by distributing information at community events, and during an onsite drug take-back day, organized with the BCDAC.

e. Spread awareness on pediatric mental health through educating the community.

f. Trained staff in mental health first aid in order to deliver education within the wider community, and continued work with Bucks Co Department of Behavioral Health to deliver annual QPR trainings. Doylestown Health broke ground on the first stand-alone crisis center in PA with Lenape Valley Foundation.

2. ACCESS TO CARE (PRIMARY AND SPECIALTY)

a. Offered events with the Ann Silverman Clinic and Family Residency Practice to increase awareness of services for the underinsured or uninsured population, including free breast and colon cancer screenings. Family residency clinicians provided education to community groups to increase knowledge of services.

b. Focused on increasing knowledge of free programs by partnering with FindHelp.org to build out referral network for community resources. In addition, through interactive webinars, increased access to information for free resources and screening materials.

c. Held reduced and no cost biometric and blood pressure screenings at community partners including senior centers, the local YMCA, and libraries. Doylestown worked closely with BCHIP to promote homebound program in Bucks County for COVID and flu vaccines.

d. To increase access to services, primary care practices are now scheduling mammograms.

Doylestown Health

3. CHRONIC DISEASE PREVENTION AND MANAGEMENT

a. Screening efforts to increase awareness of lipid metrics and waist circumference were advanced through partnership with senior centers, libraries and places of worship.

b. Outreach, Cancer, Cardiac and Dietetics team offered in-person and virtual educational events, averaging three per month. Doylestown Health's registered dieticians provided food education and recipes to low-income families through a partnership with the BCOC. The Outreach team initiated partnerships with senior centers and the YMCA to provide monthly blood pressure screenings. In addition, in partnership with Doylestown Borough, Doylestown Health hosted a TV show distributing free healthcare education to those with access to the station.

c. Increased access to resources to advance physical activity by growing partnerships with organizations that focus on physical activity through community outreach and associates' wellness programming.

d. Worked with community partners to create larger engagement for screenings and education, including new senior centers, the townships, and the YMCA.

4. HEALTHCARE AND HEALTH RESOURCES NAVIGATION

a. To increase public awareness of community resources, Doylestown Health utilizes two resource navigation tools by partnering with United Way's 211 system and FindHelp.org. For pediatric resources, hosted a health and wellness pediatric fair featuring mental health and wellness resources in bucks county.

b. DoylestownHealth.org was expanded for easier patient navigation including a Patient Advocacy and Navigating the Hospital Stay Page, which feature educational information to help patients and families understand hospital stays and their care team, and advocate for loved ones. In addition, a Patient's Guide to Being a Good Patient Advocate and Patient Brochure became available.

c. External resource navigation included teaching teens on patient advocacy and understanding healthcare, doing advanced care planning onsite and in our primary care settings, and hosting table events at multiple cancer awareness day events. Doylestown Health provided supermarket tours for cancer survivors, and initiated a "memory café" to provide support for caregivers and relay local resources.

5. RACISM AND DISCRIMINATION IN HEALTH CARE

a. Staff members were trained on trauma-informed care, mental health and de-escalation tips. Equity and Inclusion committee met monthly and hosted first "OUCH" program, including conversations about understanding poverty and its impact on access and use of healthcare.

b. To reduce discrimination in patient care, racial bias was removed in kidney and pulmonary calculations. Voluntary questions on sexual orientation and gender identification have been introduced to the registration process.

c. Doylestown Health participates in the Hospital and Health System Association of Pennsylvania with a focus on reducing racial disparities in healthcare.

Doylestown Health

Service Area Demographics

ESTIMATED POPULATION

829,776

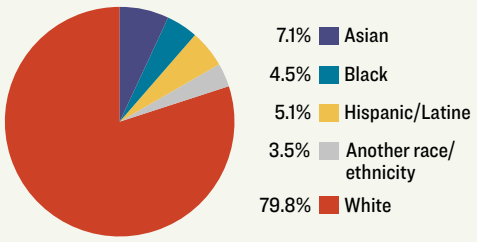
MEDIAN HOUSEHOLD INCOME

$114,215

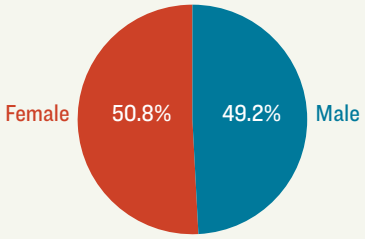
NOT FLUENT IN ENGLISH

1.07%

RACIAL COMPOSITION



SEX



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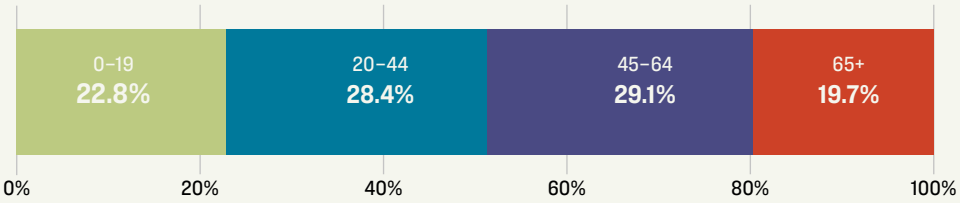


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 18914, 18902, 18938, 18947, 18925, 18942, 18972, 18923, 18912, 18920, 18913, 18980, 18976, 18929, 18077, 18949, 19053, 19047, 19020, 19067, 18940, 18974, 18954, 18966, 18977, 19006, 18915, 19446, 19454, 18932, 19440, 18936, 19438, 18950, 18963, 18933, 18916, 18931, 18953, 18928, 18921, 18926, 18946, 18943, 18956, 18922, 18927, 18911, 18910, 18917, 18960, 18944, 18962, 18951, 18964, 18969, 19044, 19002, 18901, 19090, 19038, 18934, 18054, 19001

Grand View Health

GVH GRAND VIEW HEALTH

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
207	452	10,774	167,257	29,554

True to its mission of leading the community to a healthier future, Grand View Health provides exceptional care to residents of Bucks and Montgomery Counties. Headquartered in Sellersville, PA., Grand View offers a wide array of inpatient and outpatient services with specialized expertise in cancer care, cardiology, obstetrics and gynecology, neurosurgery, orthopedic surgery, trauma, women's and children's health, physical therapy and post-acute care. The hospital achieved a 5-star rating for quality in 2024 by the Centers for Medicare and Medicaid, one of only 21 hospitals in Pennsylvania to achieve 5-star status and has received national recognition by Leapfrog with an "A" rating for safety.

The Pavilion at Grand View Health, opened in Spring 2023, added services to meet the growing demands of the community and accommodate new healthcare technologies. The 190,000-square-foot expansion of Grand View Hospital includes 52 state-of-the-art patient rooms, a new Emergency Department with 30 treatment rooms and two trauma bays.

The Pavilion is equipped with a rooftop helipad enabling rapid transport for inbound and outbound patients and features 10 new operating rooms including two hybrid ORs, two daVinci Xi robotic surgery suites, and the latest diagnostic imaging technology. The emergency department is also equipped with a special unit for patients at risk.

In July 2024, Grand View Health's Level II Adult Trauma Center received a three-year re-accreditation from the Pennsylvania Trauma Systems Foundation. The trauma center, opened in 2021, has made it possible to deliver critical care to the community within the so-called "magic hour" of a traumatic incident, improving the chances of survival in cases of a life-threatening injury.

Grand View Health operates five outpatient locations in Bucks and Montgomery Counties, and offers early morning, evening and weekend hours for added convenience and accessibility. In the past five years, as part of the health system's strategic plan to enhance the experience for patients and provide even greater access, newly constructed outpatient centers were opened in Dublin borough and Pennsburg.

In 2020, Grand View opened the Center for Orthopedics and Neurosurgery in Colmar. The state-of-the-art center offers patients an extensive array of services including sports medicine, neurosurgery consults, and orthopedics expertise as well as physiatry, athletic training and physical therapy, all in one convenient location.

The hospital's cardiology program received the American/Heart/American Stroke Association's Get with the Guidelines® Heart Failure Gold Plus Quality Achievement Awards in 2024, while the stroke program, designated a Primary Stroke Center by the American Heart Association and Joint Commission achieved American Heart/American Stroke Association's Get with the Guidelines® Gold Plus recognition also in 2024. Grand View's PCI program lab received reaccreditation by Corazon in November 2023.

A Childrens' Hospital of Philadelphia (CHOP) pediatrician is always available on site at Grand View Hospital, allowing access to high-quality pediatric and neonatal care. In partnership with CHOP, Grand View operates a Level 2 NICU.

Grand View Health signed a Definitive Agreement to join St. Luke's University Health Network (SLUHN) December 31, 2024. The two organizations look forward to continued growth for Grand View and increased access to subspecialty care for the community. Pending regulatory approval, Grand View anticipates it will become part of SLUHN in July 2025.

Grand View Health is committed to educating the community and providing resources to manage or improve health and well-being. In-person classes and seminars resumed in the fall of 2023. Outreach includes annual health fairs, attendance at community health expos, participation in DEA drug takeback events and physician-led classes to manage and treat common health challenges. Grand View partners with local organizations for blood drives, smoking cessation classes and instruction for the management of psycho-social challenges facing families and teens.

Impact of Prior Community Health Needs Assessment and Implementation

Grand View Health's 2022 Community Health Needs Assessment identified the following health issues in the community:

1. Mental Health Conditions
2. Access to Care
3. Chronic Disease Prevention and Management

1. MENTAL HEALTH CONDITIONS

Suicide risk assessments and depression screening are completed in the ED, inpatient acute care, and maternal/child health and home care with referrals to appropriate agencies. Primary care practices screen for depression with referrals to nurses, social workers, mobile crisis, and the ED. Grand View Health's objectives in meeting this need included increasing access to behavioral health services through continued development and growth of community partnerships across the healthcare continuum.

One of the unique features of the new hospital Pavilion is a specially designated unit for patients-at-risk and when necessary, space to accommodate security staff or patient companions. The unit, equipped with specialized furnishings, includes four behavioral health beds, delayed egress and alarmed doors, camera visualization and ligature resistant bathrooms. Our patient companions have training in de-escalation and behavioral needs to provide a supportive and safe environment for our at-risk patients.

The Grand View Crisis Team is in the Pavilion just outside of the Patient at Risk Area and is nearing 24/7 operations. Our team of skilled mental health professionals provide the full spectrum of crisis services for patients in the ED and inpatient areas including but not limited to psychoeducation and support for patients and their loved ones, suicide risk and level of care assessments, and placement and referrals to community-based mental health services. Additionally, an onsite inpatient psychiatrist and psychologist are part of the clinical staff supporting the care of behavioral health patients in inpatient areas. As part of our commitment to the behavioral needs of our community, Crisis Prevention Institute's (CPI) Non-Violent Crisis Prevention and Intervention training is a requirement for our clinical staff.

To address family and youth issues impacting mental health and well-being, Grand View joined the Pennridge Partnership. Programming of events, presented by experts and primarily targeted to parents of teens within the Pennridge school system, covers a range of topics including suicide awareness, vaping, internet safety and anxiety and stress management.

2. ACCESS TO CARE

As part of its strategic plan, Grand View both identified the need for greater access to care and completed the construction of new facilities throughout its service area to meet the geographical and technological needs of caring for the community.

The opening of the hospital Pavilion increased bed capacity and patient throughput for emergency services. Additional surgical suites, robotic technology and upgraded telemetry and ICU capacity has enabled Grand View to increase access to a wider array of services enabling the system to treat higher acuity patients without the need to travel to Philadelphia.

Interventional cardiology services are now offered by Grand View Health employed cardiologists through two practices at seven-office locations throughout the primary and secondary service area, improving access for patients to routine, emergent and post-acute care.

Within the past year, Grand View reopened a new primary care location in Hatfield to better meet the demands of this growing and ethnically diverse community.

3. CHRONIC DISEASE PREVENTION AND MANAGEMENT

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

Overall, the health needs identified by the CHNA and prioritized by Grand View Health and community stakeholders are being addressed and will continue to be enhanced through the addition of resources, outreach and education as well as all the existing services.

GVH GRAND VIEW HEALTH

Service Area Demographics

ESTIMATED POPULATION

391,805

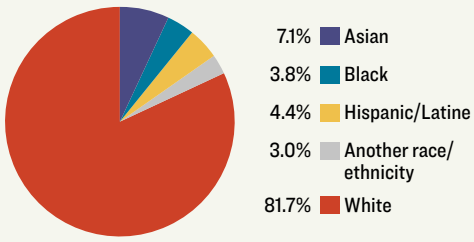
MEDIAN HOUSEHOLD INCOME

$114,434

NOT FLUENT IN ENGLISH

0.9%

RACIAL COMPOSITION



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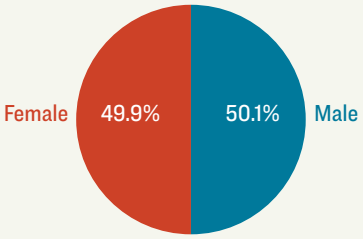

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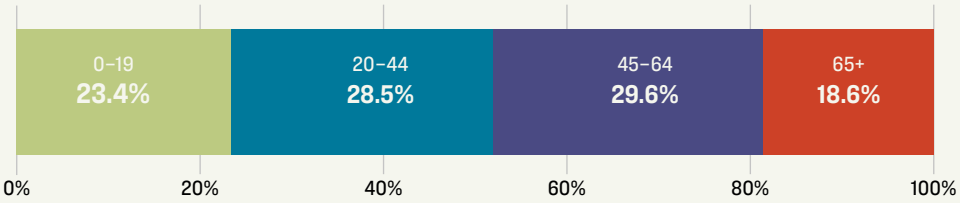


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 18054, 18917, 18930, 18932, 18944, 18951, 18955, 18960, 18070, 18074, 18901, 18902, 18923, 18942, 18041, 18073, 18076, 18964, 18969, 19438, 19440, 19446, 19426, 19454, 19473

Jefferson Health

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

MISSION

We Improve Lives.

VISION

Reimagining health, education and discovery to create unparalleled value.

VALUES

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

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

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

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

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

Jefferson Health, which merged with Lehigh Valley Health Network in August 2024, now includes 32 hospitals with 5,500 licensed beds throughout eastern Pennsylvania and southern New Jersey. They are: Jefferson Abington Hospital, Jefferson Bucks Hospital, Jefferson Cherry Hill Hospital, Jefferson Einstein Philadelphia Hospital, Jefferson Einstein Montgomery Hospital, Jefferson Frankford Hospital, Jefferson Hospital for Neuroscience, Jefferson Lansdale Hospital, Jefferson Methodist Hospital, Jefferson Moss-Magee Rehabilitation – Center City, Jefferson Moss-Magee Rehabilitation – Elkins Park, Jefferson Stratford Hospital, Jefferson Torresdale Hospital, Jefferson Washington Township Hospital, Lehigh Valley Hospital - Carbon, Lehigh Valley Hospital - Cedar Crest, Lehigh Valley Hospital - 1503 N. Cedar Crest, Lehigh Valley Hospital - Dickson City, Lehigh Valley Hospital - Gilbertsville, Lehigh Valley Hospital - Hazleton, Lehigh Valley Hospital - Hecktown Oaks, Lehigh Valley Hospital - Highland Avenue, Lehigh Valley Hospital - Macungie, Lehigh Valley Hospital - Muhlenberg, Lehigh Valley Hospital - Pocono, Lehigh Valley Hospital - Schuylkill E. Norwegian St., Lehigh Valley Hospital - Schuylkill S. Jackson St. , Lehigh Valley Hospital - 17th Street, Lehigh Valley Hospital – Tilghman, Physicians Care Surgical Hospital, Rothman Orthopaedic Specialty Hospital, and Thomas Jefferson University Hospital.

Jefferson Health also includes Jefferson Health Plans, a nonprofit health insurance organization that provides CHIP, Medicare Advantage and Dual Eligible Special Needs plans, and a nationally recognized Medicaid plan throughout Pennsylvania and New Jersey.

Jefferson Health

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Combined, Jefferson Health, Jefferson Health Plans and Thomas Jefferson University have more than 65,000 employees, which includes more than 10,200 physicians and advanced practice professionals, 13,700 nurses, and more than 1,800 faculty. Jefferson is the second largest employer in Philadelphia and the largest health system in Philadelphia based on total licensed beds. Jefferson Health now includes over 700 outpatient and urgent care locations throughout eastern Pennsylvania and southern New Jersey; 4 Magnet®-designated locations; an NCI-designated comprehensive cancer center - Sidney Kimmel Comprehensive Cancer Center; and one of the largest faculty-based telehealth networks in the country that began more than 10 years ago.

In 2024, more than 650 Jefferson physicians were named among the region's best by Castle Connolly in Philadelphia magazine's 2024 Top Docs™ issue. Also, this same year, we were nationally ranked by U.S. News & World Report in: Ear, Nose & Throat; Gastroenterology and GI Surgery; Neurology & Neurosurgery; Ophthalmology; Orthopedics; Pulmonology and Lung Surgery; Rehabilitation; and Urology.

IN THE COMMUNITY

In FY23 Jefferson Health contributed more than $813 million in charitable care and community benefits. Service to the community and helping the underserved have been a part of Jefferson's rich legacy for over 200 years. This year, Jefferson celebrates its bicentennial, and to mark this momentous occasion employees have committed to donating 200,000 hours of volunteer service to make a positive impact in communities throughout southeastern Pennsylvania and southern New Jersey.

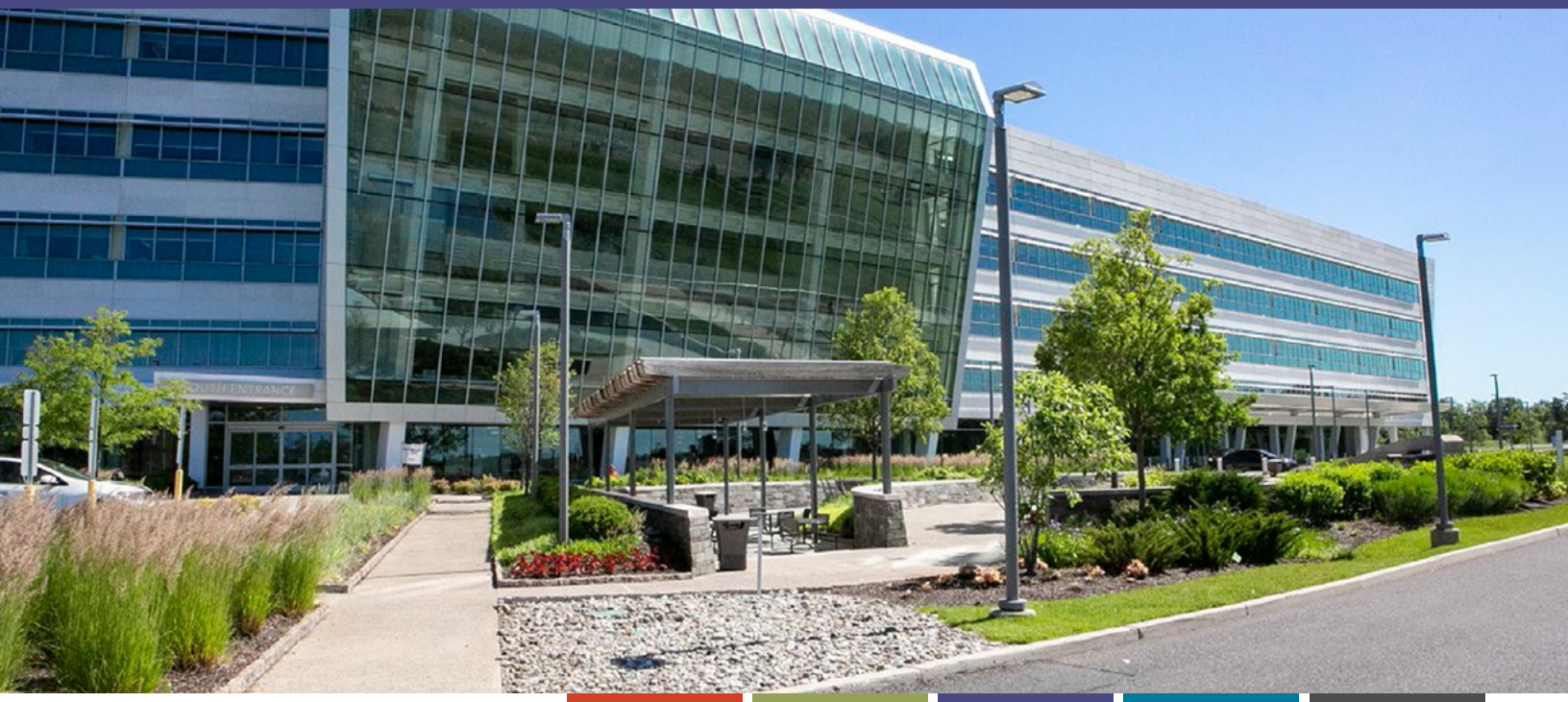
This past year, thanks to Lindy Family Catalyst Grant program, the Jefferson Collaborative for Health Equity, Office of Community Impact and Belonging awarded $540K in grants to four community-based organizations: Corporate Alliance for Drug Education (CADEKids), Philly Truce, The Reawakening Agency, and Timoteo Philadelphia, Inc. They were selected for their focus on addressing the social determinants of health and other vital conditions that shape the community's relationship with violence. The Collaborative addresses the complex issues related to health inequities facing our communities by aligning resources, building trust and sustainable partnerships.

In 2024, the Human Rights Campaign Foundation's Healthcare Equality Index awarded Jefferson the LGBTQ+ Healthcare Equality High Performer designation to recognize its Pride Care practices. Notably, our Pride Care at Jefferson Center for Healthy Aging is the first program of its kind in the nation, offering affirming, safe and competent clinical services for LGBTQIA+ older adults ages 55+.

Understanding the significant human toll caused by the opioid crisis, Jefferson established the Stephen and Sandra Sheller Consult and Bridge Program this past year. This program is an ecosystem of coordinated, high-quality care for people with severe substance use disorders and serves as a vital safe harbor for patients in the earliest stages of medical and substance use recovery. A single interdisciplinary care team provides comprehensive services for Bridge Program patients across community, hospital, emergency department, and psychiatric settings. In addition, staff assists patients with social needs such as housing, legal assistance and food insecurity.

Significant work is also being done through Jefferson's Community Health Worker Academy - an enhanced community health training and employment pathway that offers an accessible on-ramp for new health care workers to develop their careers while helping to reduce health disparities in Philadelphia's most underserved neighborhoods and beyond. Community health workers help bridge the gap between health/social services and the community, improving cultural competency — or how we communicate and explain important services, instructions and aspects of health care to people who are socially, culturally, and economically diverse.

Jefferson Einstein Montgomery Hospital



Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
195	254	10,572	8,180	31,195

Jefferson Einstein Montgomery Hospital offers the outstanding care Jefferson is known for in a technologically advanced hospital located in central Montgomery County. Patients have access to a full-service hospital with a wide range of medical care and surgical interventions delivered by highly skilled providers. In 2023, the hospital added a helipad on campus for patients in need of immediate transfers.

The hospital's Leonard and Madlyn Abramson Family Emergency Department is staffed 24/7 by board-certified emergency medicine physicians.

Primary and specialty care medical practices and outpatient centers are located in communities surrounding the hospital giving patients easy access to a variety of ambulatory services close to home.

Jefferson Einstein Montgomery Hospital operates one of the most experienced labor and delivery programs in the region. The hospital employs a unique model of midwives working in close collaboration with the physicians, maintains low Cesarean section rates, and hosts the Level III Arthur and Lea Powell Neonatal Intensive Care Unit (NICU) staff by neonatologists from Children's Hospital of Philadelphia. In recognition of the hospital's commitment to supporting mothers who choose to breast feed, the Pennsylvania Department of Health awarded Jefferson Einstein Montgomery Hospital with their Keystone 10 designation.

Jefferson Einstein Montgomery Hospital

The hospital's Women's Resource Center provides a wide range of classes and services making care accessible and flexible. Services include lactation consultation and wellness programs along with prenatal/postpartum group support.

The Sidney Kimmel Comprehensive Cancer Center at Jefferson Einstein Montgomery Hospital is part of Jefferson's National Cancer Institute (NCI)-designated Comprehensive Cancer Center offering medical, surgical, and radiation oncology services, an infusion center, on-site medical imaging, and supportive care. A wide breadth of clinical trials are available.

The hospital's breast health program is accredited by the National Accreditation Program for Breast Centers, a program of the American College of Surgeons. It is also an accredited Breast Imaging Center of Excellence by the American College of Radiology.

As part of the Vickie and Jack Farber Institute for Neuroscience – Jefferson Health, the hospital offers advanced diagnostics and treatment in neurology and neurosurgery, including stroke, headaches, movement disorders, spinal disorders, tumors of the brain and spine, and other neurological conditions.

Cardiac care at the Bruce and Robbi Toll Heart and Vascular Institute includes open heart surgery, cardiac catheterization and electrophysiology intervention.

The hospital's educational commitment includes providing health education to the community, and training and educating medical school students, graduate and practicing physicians, and other healthcare professionals.

Jefferson Einstein Montgomery Hospital offers residency programs in diagnostic radiology, internal medicine, emergency medicine, transitional year, family medicine, and vascular surgery, and a fellowship program in hospice and palliative care.

The hospital also supports clinical research for the purpose of enhancing the quality of patient care and advancing the science of medicine.

ACCOLADES

Jefferson Einstein Montgomery Hospital has been the recipient of many awards and accolades. The hospital is accredited for Heart Failure by the American College of Cardiology and as a Chest Pain Center from the American College of Cardiology for Percutaneous Coronary Intervention. Additionally, the cardiac surgery team earned the highest rating of three stars in Mitral Valve Repair/Replacement by the Society of Thoracic Surgeons.

Jefferson Einstein Montgomery is also an Advanced Thrombectomy Capable Stroke Center as designated by The Joint Commission and has received the American Heart Association/American Stroke Association's Get With the Guidelines® -Stroke Gold Plus With Honor Role Elite Award.

The Joint Commission also awarded their Gold Seal of Approval to Jefferson Einstein Montgomery's Hip and Knee Joint Replacement Program.

Other accolades include an I Am Patient Safety 2023 award from the Pennsylvania Patient Safety Authority for our high compliance with treatment of Sepsis. And the Drs. David and Es Nash Safety Award for establishing a Medication History Pharmacy Technician program to improve accuracy of patient's home medication list documentation and medication reconciliation in our computer system.

Impact of Prior Community Health Needs Assessment and Implementation

Jefferson Einstein Montgomery Hospital continues to address the unmet needs of central Montgomery County by increasing access to care and expanding its reach in the community. The 2022 implementation plan focused on meeting the needs of the community where they work and live, making access to preventive health services and healthcare more convenient and easier to navigate.

We strategically focused the priority health needs across three domains:

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

HEALTH ISSUES:

At Jefferson Einstein Montgomery Hospital, our commitment to community health is reflected in our patient-centered approach, which emphasizes preventive care and education. Through comprehensive health screenings and risk assessments, we address critical health issues such as cardiovascular disease, diabetes, and cancer.

Our efforts extend beyond individual care; we actively engage with the community to promote healthy lifestyles and provide resources that empower residents to make informed health choices. By fostering partnerships and offering educational initiatives, we strive to enhance the overall well-being of our community and reduce the incidence of chronic conditions.

ACCESS AND QUALITY:

We are committed to enhancing the health and well-being of our community by providing patient navigation and case management for chronic conditions and high-burden diseases. Our dedicated Patient Advocates guide individuals through the complexities of healthcare access, financial challenges, and patient rights, ensuring that every patient receives the support they need. By addressing physical, psychosocial, and economic issues related to care, we strive to empower patients and their families. Our Financial Counselors assist those in need, ensuring equitable access to medical services for all, regardless of their financial situation.

We hold the HealthyWoman designation by the Pennsylvania Department of Health which funds free breast and cervical cancer screenings as well as free diagnostic follow up care for uninsured or under insured patients. To make healthcare services more accessible, we have implemented many of the proposed solutions from the CHNA and continue to collaborate internally to improve quality care. Tactics include centralized and online appointment scheduling, extended evening/weekend appointment hours, and telehealth care coordination.

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Einstein Montgomery Hospital

COMMUNITY FACTORS:

True population health improvement extends beyond clinical care to encompass our patients' social related health needs. Through targeted point-of-care screenings and the development of community resources, we actively address critical issues such as food access, housing insecurity, and transportation barriers. Our dedicated care managers collaborate with local agencies to connect individuals with essential services, fostering resilience and well-being. Additionally, our workforce development initiatives empower the community by way of career exploration and job readiness programs. Our partnership with Norristown Area School District's GEAR UP program, funded by the U.S. Department of Education, provides an introduction to a healthcare career and onsite experiences for high school students enrolled in the program.

Einstein is dedicated to improving health outcomes of our vulnerable populations by implementing evidence-based programs. Our grant-funded initiatives focus on critical areas such as maternal and child health, youth obesity prevention, and preventive health screenings for uninsured/underinsured populations. By prioritizing these vital health challenges, we aim to create a healthier future for our community, ensuring that all individuals have access to the resources and support they need to thrive.

The Nurse-Family Partnership is a community-based program serving low income, first time pregnant women. Patients are partnered with a highly trained nurse who provides home visiting and one-to-one guidance during pregnancy and through the child's second birthday. With over forty years of evidence, this program follows model elements that support improved birth outcomes, early childhood development and economic self-sufficiency. Our nursing team serves 140 patients annually. This program is funded by the Pennsylvania Office of Child Development and Early Learning and the Montgomery County Office of Children and Youth.

In Norristown, the Nicholas and Athena Karabots Medical Building, houses a produce garden that yields over 500 lbs. of fresh produce annually. Garden beds are maintained by staff and the produce is distributed in the patient waiting rooms. Through a grant from the Pennsylvania Academy of Family Physicians Foundation, our family medicine residents run a monthly prevention program for their patients. Children and their families participate in hands-on activities at the onsite garden, receive nutrition education through cooking demonstrations and an introduction to various physical activities. This program has reached approximately 100 participants and is conducted in partnership with Greener Partners, a local nonprofit organization that aims to improve community health through food, education and farms.

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Einstein Montgomery Hospital

Recognizing that individuals with unstable housing experience worse health outcomes and higher health costs, Jefferson Einstein Montgomery Hospital works collaboratively with the Norristown Hospitality Center to explore strategies that promote access to healthcare in times of need. Our internal medicine residency program implemented a monthly wellness screening administered by internal medicine residents and volunteer hospital staff. The program was initially funded by an Einstein Society grant and continues with volunteer support and donated resources.

Strengthening relationships with community leaders representing culturally diverse populations enables us to bridge gaps in care related to health literacy, cultural sensitivity, and alternative service access. Program highlights include:

- Free Smoking Cessation Classes held quarterly; Approximately 50 participants annually
- Monthly education programs conducted in Spanish at ACLAMO, Norristown; provided by our family medicine program; Over 150 participants annually
- Mobile Health Screening Van pilot program in partnership with Jefferson Health Plans and the Latino Connection; Over 150 participants were screened in 10 locations
- Pediatric Heart Screenings in partnership with JEMH, Simons Heart, and Norristown Area School District; 150 screened; 300 attendees
- Education and screening programs at Bharatiya Temple and Norristown Ministerium; Over 200 attendees annually
- Monthly blood pressure screenings and education at East Norriton Parks and Recreation events; Over 300 attendees annually
- Community Resource Fair after-hours at Elmwood Park Zoo; 400 attendees annually

We continue to support local efforts for screening, education and awareness by providing routine blood pressure checks, health education and sponsorship of many community events. Totaling over $50,000 in sponsorships and volunteer time, we participate in 75 community events reaching over 10,000 people annually. By fostering a network of support, we not only promote healthier lifestyles but also build a resilient community dedicated to wellness and prevention. Through these collective efforts, we strive to create a healthier future for all residents.

Service Area Demographics

ESTIMATED POPULATION

413,028

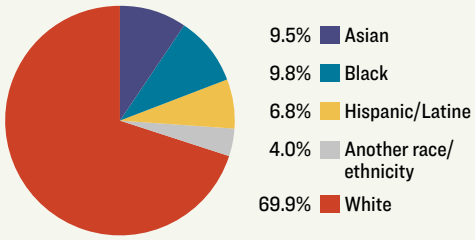
MEDIAN HOUSEHOLD INCOME

$107,764

NOT FLUENT IN ENGLISH

1.7%

RACIAL COMPOSITION



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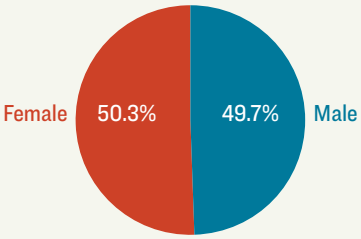

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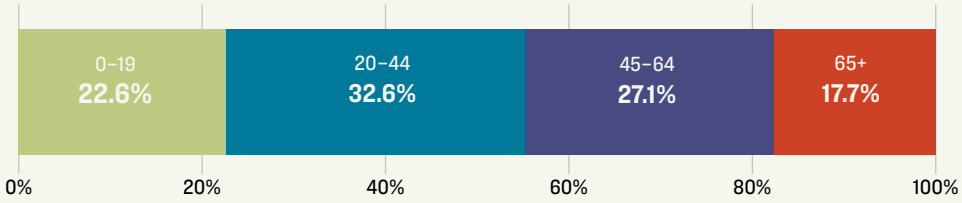


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 19002, 19401, 19403, 19405, 19406, 19422, 19426, 19428, 19438, 19446, 19454, 19462, 19464

Jefferson Einstein Philadelphia Hospital

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
485	730	17,724	8,170	77,227

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

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

Jefferson Einstein Philadelphia Hospital

Jefferson Einstein Philadelphia Hospital (JEPH), formerly Einstein Medical Center Philadelphia, is a community-based academic medical center situated in North Philadelphia, serving a diverse and disadvantaged population. It also includes Jefferson Moss-Magee Rehabilitation – Elkins Park.

Jefferson Einstein Philadelphia Hospital, is Magnet designated for nursing excellence; less than 7% of hospitals nationwide are Magnet designated. Additionally, JEPH received an "A" Hospital Safety Grade from The Leapfrog Group. JEPH is considered a private healthcare safety-net hospital, bearing a large share of responsibility for caring for the poor as measured by services to Medicaid, Medicare SSI, and uninsured patients.

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

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

Robotic surgery for urologic and gynecologic procedures and minimally invasive spine and joint replacement surgery. Services include radiology, cardiology, neurology, ophthalmology, neuro-ophthalmology, and more.

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

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

Jefferson Einstein Philadelphia Hospital

The Center for Organ Disease and Transplantation is an established leader in kidney, liver and pancreatic transplantation in the Philadelphia region. Einstein has the best kidney patient one-year survival rates in the area and is the only 5 tier program in the area for 1-year patient survival. Einstein is the second highest performing liver transplant program in the area. Einstein transplant continues to outperform others and maintains a solid and successful transplant rate, performs highly with strong survival while on the waitlist and has consistently solid one year patient survival outcomes. The center is staffed by physicians and surgeons specializing in nephrology, hepatology and organ transplantation. These team members work closely with patients, families and referring physicians to best manage a patient's individual treatment. JEPH also offers the latest technology, medications and interventions for kidney, liver and pancreatic disease.

JEPH is also the home to the Minerva and Fred Braemer Heart Center. With expertise in medication management, cardiovascular surgery, cardiac catheterization, electrophysiology and circulatory support devices, you'll receive exactly the care you need, right in your neighborhood. Our renowned experts are trained in a range of cardiovascular specialties designed with you in mind. Beyond medications and lifestyle changes, our team has helped pioneer non-invasive and minimally invasive procedures, which mean a faster recovery for you. Jefferson Einstein Philadelphia is recognized as a Blue Distinction Center+ for Cardiac Care by Independence Blue Cross. Additionally, JEPH is recognized as high performing in Heart Failure by U.S. News & World Report.

As part of Jefferson's Sidney Kimmel Comprehensive Cancer Center, patients have access to a wide breadth of research and advanced cancer care. From navigators who help patients through the process and coordinate their care, to pain management, support groups, rehabilitation, counseling and more.

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

The program also offers rehabilitation robotics, helping patients to rehabilitate and transition through inpatient and outpatient care. The Jefferson Moss-Magee Rehabilitation network includes multiple inpatient and outpatient locations in Philadelphia, Montgomery and lower Bucks counties, as well as in New Jersey.

Additionally, the Jefferson Moss Rehabilitation Research Institute aims to develop groundbreaking research with rapid translation to clinical application.

MossRehab recently received Innovation Center designation by CMS, one of 16 facilities in the country. MossRehab has been designated by the federal government as a Traumatic Brain Injury Model System (TBIMS) since 1997.

The Moss TBIMS provides state-of-the-art, research and potentially lifelong treatments for persons with traumatic brain injury (TBI) and their families in the Philadelphia region and southern New Jersey.

Innovative treatments are provided in comprehensive inpatient and transitional outpatient rehabilitation and community re-entry programs, including a full complement of vocational services, a brain injury clubhouse, a concussion center, and a neuro-mental health clinic specialized for the needs of people with TBI and other neurologic disorders.

The TBIMS program exemplifies a culture of clinical research integration in which patients across the continuum of care are provided an opportunity to participate in cutting-edge studies to help advance scientific and clinical knowledge.

Jefferson Einstein Philadelphia Hospital

ACCOLADES

JEPH's cancer program is accredited by the Commission on Cancer, has received the American Cancer Society's Cancer Control Award, and the American Society of Clinical Oncology has recognized JEPH's cancer program for improving care through high-quality clinical trials. Along with top doctors and a full range of support services for patients and their families. Using state-of-the-art diagnostic tools and treatments, cancer specialists develop highly personalized treatment plans to arm patients with the most advanced therapeutic tools.

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

JEPH also earned the American Stroke Association's Stroke Gold Plus and Honor Roll Elite and Target: Type 2 Diabetes Honor Roll, an Advanced Therapy Quality Achievement Award for adherence to standards of care for stroke patients which speeds recovery and saves lives. JEPH is the first hospital in PA and one of only a few in the country to earn The Joint Commission's advanced certification as a Thrombectomy-Capable Stroke Center in collaboration with the American Heart Association/American Stroke Association.

The certification signifies that the hospital meets rigorous standards for performing mechanical endovascular thrombectomy, a surgical procedure used to remove a blood clot from the brain during an ischemic stroke.

Our cardiology program has received multiple accolades including

- Healthgrades has consistently rated the program as one of the best in the nation. We have been recognized as one of the Top 100 hospitals for cardiac care in the US from 2022-2024. Healthgrades has also given JEPH the Cardiac Surgery Excellence Award for superior outcomes in heart bypass and heart valve surgery.
- JEPH is the only hospital in Philadelphia awarded the Heart Care Center National Distinction of Excellence by the American College of Cardiology (2020-2024)
- JEPH is the only hospital in Philadelphia with an Electrophysiology Program accredited by the American College of Cardiology (2020-2024).

Impact of Prior Community Health Needs Assessment and Implementation

Community Health Needs Assessments (CHNA) have been performed every three years since 2015 to determine the health status and healthcare needs of residents in the Jefferson Einstein Philadelphia Hospital and Jefferson Moss-Magee Rehabilitation – Elkins Park service areas. The following strategies were adopted to address Health Issues, Access and Quality of Healthcare and Health Resources, and Community Factors identified by the CHNA:

- Early prenatal care to reduce infant mortality through implementation of CenteringPregnancy©, CenteringParenting©, and Baby Friendly Designation.
- Implemented a Doula Support Program for Laboring Women, which focuses on improving birth outcomes, decreasing cesarean births, shortening length of labor and decreasing use of pain medication and obstetric interventions in labor.
- Primary care for low-income adults through multiple outpatient care centers, and dozens of physician practices throughout Philadelphia.
- More than 50 Jefferson Einstein providers received MAT (Medication Assistance Treatment) training and provide medication to support the treatment of substance use disorders. For those with an opioid use disorder, medication addresses the physical difficulties that one experiences when they stop taking opioids.
- In partnership with Philabundance, Fresh for All provides 150-200 families/week with fresh produce. In partnership with The Food Trust, 40% of Philly Food Bucks prescriptions redeemed for fresh produce at local markets.
- The Community Practice Center (CPC) at JEPH provides health and wellness education, screening for asthma, hypertension, and diabetes.
- Established a DEI Committee, which aligns with Jefferson Health's DEI program.
- Implemented Einstein PRIDE Educational Institute - online interactive training curriculum for employees and organizations throughout the service area.
- Screening inpatients for housing security and provided referrals to our community partner, Face-to-Face for assistance with rent, utilities, placement and/or repairs. Face-to-Face participants are primarily JEPH patients, with 87% of participants reporting being JEPH patients, 9% other, and 4% reporting no primary care.
- Provided opportunities to local middle/high school students through leadership lectures, mentorship/work-ready programs, Career Days, and Sim Center tours. Students from Imhotep Charter, Building 21, Philadelphia High School for Girls and Wissahickon Charter-Awbury Campus participated.
- Expanded screening services for IPV (Intimate Partner Violence) to inpatient areas at JEPH. Through our partnership with Lutheran Settlement House, patients received counseling services and resources.
- The Trauma Intervention Program (TIP) provides an integrated care model of trauma focused healing services to victims of violent injury (stabbings, shootings) as well as bystanders to such violent episodes who may display acute symptoms of trauma.
- The Gun Violence Taskforce was established in 2021. The goal of the Taskforce is to identify initiatives in which JEPH can independently or in partnership work to reduce gun violence in our community and or help mitigate the impact. The Taskforce has partnered in community events, roundtable discussions with community leaders, created a PSA with an Emergency Medicine physician on gun safety and raised funds to distribute more than 1,500 gun locks throughout the community. In 2024, patients treated at JEPH for gun violence decreased by 40%.
- Einstein staff partnered with legislative offices, the city and community organizations to clean, repair and beautify public spaces that had been neglected or misused in the community.

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

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

Service Area Demographics

ESTIMATED POPULATION

1,044,917

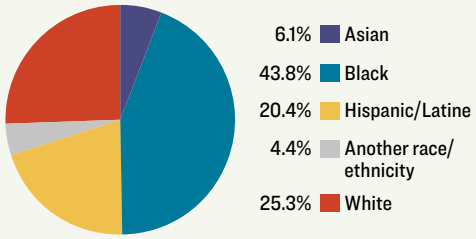
MEDIAN HOUSEHOLD INCOME

$51,640

NOT FLUENT IN ENGLISH

6.2%

RACIAL COMPOSITION



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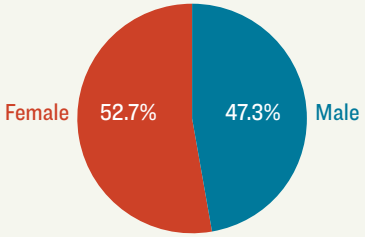

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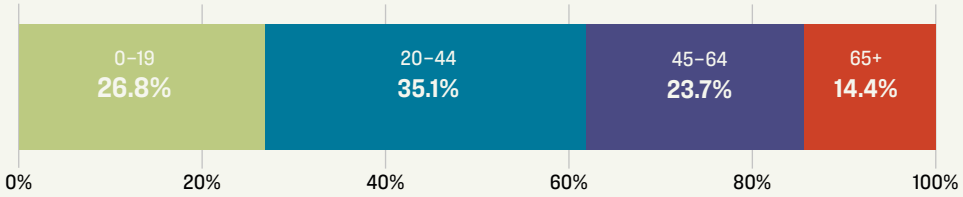


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 19027, 19111, 19114, 19115, 19119, 19120, 19121, 19124, 19126, 19128, 19131, 19132, 19133, 19134, 19135, 19136, 19138, 19140, 19141, 19143, 19144, 19149, 19150, 19152, 19401

Jefferson Abington Hospital

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
667	1,104	32,298	6,886	82,552

Jefferson Abington Hospital is a regional referral center and teaching hospital located in Abington, Montgomery County, and has served the residents of Bucks and Montgomery counties since 1914. Jefferson Abington Hospital offers comprehensive healthcare services at a level not often found in a community hospital, including a Level II trauma center, six critical care units, advanced robotic and minimally invasive surgical techniques, neurovascular care, a Level III neonatal intensive care unit and more.

Additional services and specialties include: primary care, obstetrics and gynecology, cardiovascular, orthopedic and spine, neuroscience, metabolic and bariatric surgery, senior health and more.

Jefferson Abington Hospital, part of Jefferson Health, is committed to improving lives and providing high quality, compassionate care that is easily accessible to the community.

Jefferson Abington Hospital

An important complement to the hospital's Emergency Trauma Center is The Safe Center which opened in January 2023. Patients seeking care after experiencing abuse now have a dedicated space staffed by forensic nurses. The Safe Center provides support for victims of sexual assault, child abuse, elder abuse, cognitive delay abuse, human trafficking and domestic violence.

In October 2021, Jefferson Abington Hospital launched a program that offers extracorporeal membrane oxygenation (ECMO) as part of its Critical Care Services. ECMO can be an option for those who need more critical care support than ventilation and medications.

In 2023, the hospital acquired a portable MRI system with an ultra-low field magnet that gives clinicians access to brain imaging at the bedside. It's being used in the Critical Care setting to evaluate conditions such as stroke, hemorrhage, hydrocephalus or change in mental status without having to move seriously ill patients.

Jefferson Abington Hospital maintains associations with Philadelphia College of Osteopathic Medicine and Sidney Kimmel Medical College at Thomas Jefferson University.

ACCOLADES

In FY23 and FY24, Jefferson Abington Hospital received numerous awards and accolades for high quality patient care, excellence and safety.

In the area of maternity care, Jefferson Abington Hospital earned Baby-Friendly Redesignation in 2023, as well as Safe Sleep Certification and Birthing Friendly Hospital designation in the same year. In 2024, U.S. News & World Report named Jefferson Abington Hospital a Best Hospital for Maternity Care.

In 2024, Jefferson Abington Hospital earned the Coronary Artery DiseaseSTEMI Receiving Center – Gold Plus with Target: Type 2 Diabetes for 2024 and Get with the Guidelines – Heart Failure from the American Heart Association for applying the most up-to-date evidence-based treatment guidelines to improve patient care and outcomes in the community. The Hospital was also granted the American Heart Association/American Stroke Association's Get with the Guidelines Stroke Gold Plus with Target: Stroke Elite Plus and Target: Type 2 Diabetes Honor Roll designations.

Jefferson Abington Hospital was ranked seventh in the Philadelphia region and thirteenth in the state in U.S. News & World Report's annual "Best Hospitals" ranking in 2024. The Hospital scored high-performing in the following 11 categories: Congestive Heart Failure, Hip Replacement, Knee Replacement, Colon Cancer Surgery, Lung Cancer Surgery, Leukemia, Lymphoma & Myeloma, Chronic Obstructive Pulmonary Disease, Pneumonia, Stroke, Diabetes, and Kidney Failure.

In 2024, Jefferson Abington Hospital was honored with the Platinum Award by the Gift of Life Donor Program and the Hospital and Health System Association of Pennsylvania (HAP).

Impact of Prior Community Health Needs Assessment and Implementation

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

In fiscal year 2023, Jefferson Abington Hospital provided over $106.7 million dollars to individuals in our communities seeking resources for care and education, in alignment with our Community Health Implementation Plan developed in response to our 2022 Community Health Needs Assessment:

- Over $78.5 million dollars in financial assistance and subsidized health services was provided to the members of the community. Jefferson Abington Hospital provides access to affordable primary/preventative/ specialty care through the following programs:
  - Abington Family Medicine
  - Abington Dental Clinic
  - Corinne Santerian Newborn Center
  - Hartnett Health Services, which recently expanded space to provide better services
  - OB/GYN Clinic
- Jefferson Abington Hospital provides many free or low- cost programs throughout the year designed to educate the community regarding health risk factors, chronic disease prevention or to support early detection through health screenings. In addition to cardiovascular-related health screenings, a free Cancer Screening Day is held twice a year. Jefferson Abington Hospital collaborates with many community organizations to support community health improvement initiatives.
- Jefferson Abington Hospital also provides programs and services designed to support seniors with activities, information and care close to home. A low-cost “Memory Fitness” program offers physical and social activities on an outpatient basis to sharpen the memory skills of older adults who are experiencing early memory loss.
- JAH Safe Center
- JAH warm hand off program for Mental Health
- 988 Campaign (National Suicide Hotline Awareness)
- Integrated Social Worker/ Care Coordinator for mental health services into Jefferson owned primary care physician offices
- Provided MHFA (Mental Health First Aid Education) for community (partnered with MCOPH)
- Partnering with the Montgomery County Public Safety and the Abington Health Foundation Women’s Board, Narcan® kits were made available to patients in Jefferson Abington Hospital’s Emergency Trauma Center.
- Throughout fiscal year 2023, Jefferson Abington Hospital provided more than $2.5 million dollars in free health education, screenings, in-kind donations and other community support.
- As a teaching hospital, Jefferson Abington Hospital educates many physicians, nurses and allied healthcare professionals. The Hospital maintains residency programs in family medicine, internal medicine, OB/GYN, general surgery and dentistry. In fiscal year 2023 Jefferson Abington Hospital provided over $25.6 million dollars in medical education programs.

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

Service Area Demographics

ESTIMATED POPULATION

1,083,706

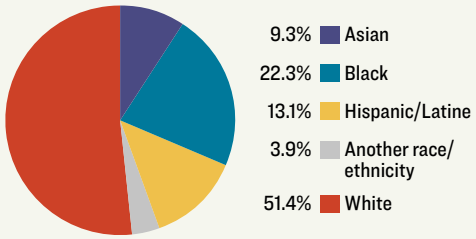
MEDIAN HOUSEHOLD INCOME

$80,566

NOT FLUENT IN ENGLISH

3.5%

RACIAL COMPOSITION



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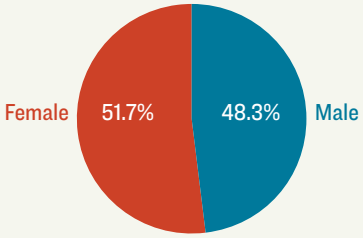

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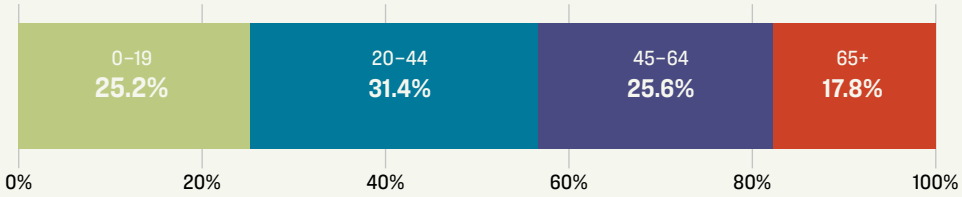


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 18974, 19038, 19002, 19040, 19090, 19001, 19046, 19111, 19149, 19027, 19446, 19044, 19006, 18966, 19454, 19138, 19150, 19120, 19152, 19095, 18976, 19115, 19136, 19020, 19154, 19116, 19025, 19422, 19075, 19124, 19126, 19114, 19141, 19034

Thomas Jefferson University Hospitals

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
884	1,618	35,667	18,765	121,222

This data is combined for Thomas Jefferson University Hospital (+Methodist and Jefferson Health Neurology)

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

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

As an academic medical center, Thomas Jefferson University Hospitals stands out among the nation's best hospitals as ranked by U.S. News & World Report. In 2024-25 , the hospital ranked nationally in seven specialties: Gastroenterology and GI Surgery; Ophthalmology; Orthopedics; Urology; Ear, Nose & Throat; Neurology & Neurosurgery; and Pulmonology & Lung Surgery. Thomas Jefferson University Hospital also continues to rank highly in the list of top hospitals in Pennsylvania (2nd) and the Philadelphia metro area (2nd). Jefferson Health – Center City hospitals are Magnet®— designated for nursing excellence; less than 7% of hospitals nationwide are Magnet® designated. Additionally, Thomas Jefferson University Hospital has received a 4/5 star rating from Medicare, based on how the hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care.

Several clinical programs have also been recognized for outstanding performance and outcomes. The Sidney Kimmel Comprehensive Cancer Center, is one of only 57 designated National Cancer Institute (NCI) Comprehensive Cancer Centers, and one of only eight NCI-designated Prostate Centers of Excellence in the country. The Center has also received accreditation from the American College of Surgeons National Accreditation Program for Breast Centers (NAPBC) and has top outcomes in bone marrow and stem cell transplantation.

The kidney and pancreas transplant programs received a 4/5 rating — also placing them among the top-rated programs in the region for transplant outcomes.

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

Orthopedic services at Jefferson Health includes Rothman Orthopedics, and Philadelphia Hand to Shoulder Center at Jefferson. Jefferson's Orthopedic program located at TJUH is currently ranked #20 by U.S. News & World Report. Jefferson's orthopedic program was also the first to earn the advanced Joint Commission certification for Total Hip & Total Knee Replacement.

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

The Institute is also home to the first and only center in Philadelphia dedicated solely to ALS research — the Frances & Joseph Weinberg Research Unit within the Jefferson Weinberg ALS Center. Jefferson is an ALS Association Certified Treatment Center of Excellence.

The Institute also includes a comprehensive Parkinson's Disease & Movement Disorder Center — also recognized as a Center of Excellence by the Parkinson's Foundation.

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

Impact of Prior Community Health Needs Assessment and Implementation

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

From the 2022 regional Community Health Needs Assessment, Jefferson identified the following priority areas in the three-year implementation plan:

- Mental Health Conditions
- Access To Care (Primary and Specialty)
- Chronic Disease Prevention and Management
- Substance Use and Related Disorders
- Healthcare and Health Resources Navigation
- Racism and Discrimination in Health Care
- Food Access
- Culturally and Linguistically Appropriate Services
- Community Violence
- Housing
- Socioeconomic Disadvantage
- Neighborhood Conditions

Highlights of the implementation plan include:

Jefferson Opiate Task Force

Jefferson Opiate Task Force focuses on reducing access to opiate pain killers and raising public awareness about addiction enterprise- wide. The Task Force successfully implemented electronic methods to dramatically impact prescribing behavior and provide real-time feedback on guideline adherence. A multi-disciplinary care program with staff, pharmacists and a behavioral health team was implemented. One hundred percent of primary care clinicians were certified on medication-assisted treatment. Patient education materials have been developed and delivered for patients and families regarding pain medication and other methods of pain management. Jefferson's onsite pharmacy continued to provide a drug take back program that is open to all community members. Additionally, the Stephen and Sandra Sheller Consult and Bridge Program opened in February 2024, providing post-acute care coordination, MOUD, Full spectrum primary care, SDOH support, and continued recovery support services.

Community Health Education

In partnership with community organizations, Jefferson brings healthcare services such as blood pressure screenings, health information and resources, flu vaccinations, and other services to community sites. The COVID-19 pandemic prompted Jefferson to increase its online educational workshops and address technology barriers for patients and community members. Many of the educational workshops have returned to in person activities, while others continued online to increase flexible offerings to community members. To review the list of programs and classes, please visit JeffersonHealth.org/Events

Diabetes Prevention and Management

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

Housing Support

Jefferson's Better Together at Home program is a pilot project of the Jefferson Collaborative for Health Equity, focusing on housing repairs. By addressing housing repairs, the program seeks to improve food access and alleviate barriers to care that prevent individuals from focusing on their physical health and well-being. The innovative upstream program is done in partnership with MANNA and Habitat for Humanity, and has successfully rehabilitated 23 homes, fostering an environment where program participants can safely store and prepare food within their residences. Currently progressing towards the rehabilitation of the 24th home by Spring 2025.

Cancer Screening and Support

Through the HealthyWomen grant, free mammograms are offered to uninsured and underinsured women. Our Cancer Welcome Center serves patients, families and community members. Comprehensive services including support groups, educational workshops, fitness and wellness sessions, transportation, legal assistance and more are offered without charge. The Dietz & Watson and Sidney Kimmel Comprehensive Cancer Center's mobile screening van provides preventive services and education at community events and other local venues, meeting community members where they are to provide critical services.

Serving people who experience homelessness

The JeffHOPE (Health Opportunities, Prevention & Education) program supports four homeless shelters and one needle exchange harm reduction program in Philadelphia every week. The team provides acute and basic medical care and helps individuals and families experiencing homelessness access other health and social resources and healthcare providers who are better equipped to care for them long-term. Jefferson also donated lab and pharmaceutical services to this program. The JeffHOPE clinics are responsible for over 5,000 patient visits per year.

Workforce Development and Health

Jefferson's Community Health Worker (CHW) Academy led by the Jefferson Collaborative for Health Equity, Office of Community Impact and Belonging, aims to transform the way community members engage with healthcare providers and the way healthcare providers engage with the community. Jefferson-trained CHWs meet the unique medical and social needs of the patients and the communities they serve. CHWs are in the Jefferson Emergency Department to provide social determinants of health screenings and connect patients with needed resources, while helping them navigate health care and social service systems. Since the program's kick off in 2023, 10 HWs have been trained, certified, and 8 have found clinical placements throughout the health system. A second cohort of 15 new community members were recruited and onboarded in May 2024.

Community Building

Jefferson has also engaged in a variety of community building activities to improve the community's health and safety by addressing poverty, food insecurity, homelessness, workforce development, built environment and substance abuse. Community building activities are also focused on providing opportunities for youth to explore careers in health care through health awareness education, mentoring and internships. The JeffCARES Mobile Van is designed to support community engagement and community outreach operations. It comprises of a van and a repurposed airstream trailer, used to promote health, provide community education and awareness, and enhance Jefferson's community presence through various activities, including: health screenings and educational programs, participation in community health fairs and events, conducting community health needs assessments, hosting community conversations and information sessions, organizing pop-up events, creating exhibits, engaging with community members, and addressing other Jefferson Healthy Communities priorities.

Jefferson Connected Care Services opened its first community-facing space in Fall 2024. This location, which was formerly the Jefferson Cancer Welcome Center, functions as a social needs support center for patients and community members. The center is staffed by the Jefferson Center for Connected Care staff and Jefferson Collaborative for Health Equity CHWs. It is intended to be a place where individuals can be referred to by healthcare providers or just walk into off the street and get help with social needs, including screening and assistance with community resource navigation, healthcare navigation including appointment scheduling, and other referrals as appropriate. In the future it will also provide a space to login to and or receive assistance for MyChart and other digital literacy support. Informational resources such as brochures for upcoming health education and screening events, are kept on site.

Service Area Demographics

ESTIMATED POPULATION

2,978,674

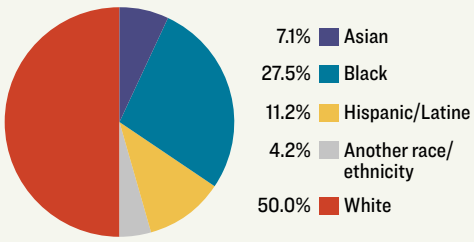
MEDIAN HOUSEHOLD INCOME

$77,503

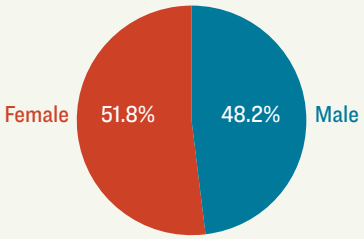
NOT FLUENT IN ENGLISH

8.5%

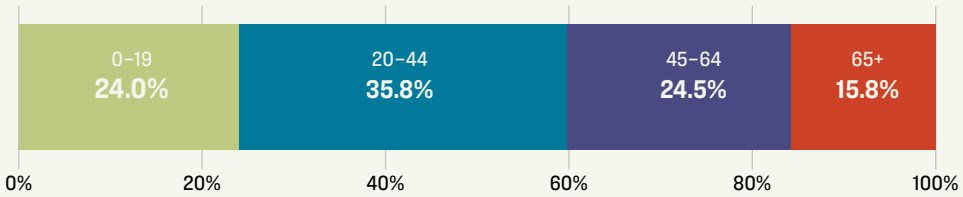
RACIAL COMPOSITION



SEX



AGE DISTRIBUTION



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 18901, 18940, 18966, 18974, 19002, 19006, 19007, 19013, 19018, 19020, 19023, 19026, 19027, 19030, 19032, 19036, 19038, 19040, 19046, 19047, 19050, 19053, 19054, 19055, 19056, 19057, 19061, 19063, 19064, 19067, 19078, 19079, 19082, 19083, 19096, 19102, 19103, 19104, 19106, 19107, 19111, 19114, 19115, 19116, 19119, 19120, 19121, 19122, 19123, 19124, 19125, 19126, 19128, 19129, 19130, 19131, 19132, 19133, 19134, 19135, 19136, 19137, 19138, 19139, 19140, 19141, 19142, 19143, 19144, 19145, 19146, 19147, 19148, 19149, 19150, 19151, 19152, 19153, 19154, 19320, 19382, 19401, 19403, 19406, 19426, 19428, 19446, 19454, 19460, 19462, 19464

Jefferson Health- Northeast

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

BEDS:	PHYSICIANS:	INPATIENT DISCHARGES:	OUTPATIENT PROCEDURES:	EMERGENCY DEPT. VISITS:
464	1,037	23,301	8,552	104,437

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

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

- The Sidney Kimmel Comprehensive Cancer Center at Jefferson Torresdale Hospital celebrated the opening of the translational research lab, allowing the team to offer advanced clinical research protocols to patients right in their community.
- In 2023, The Sidney Kimmel Comprehensive Cancer Center at Jefferson Torresdale Hospital began offering patients the latest CyberKnife, a robotic, non-invasive radiation therapy device designed to treat cancerous and non-cancerous tumors.
- Clinicians at Jefferson Torresdale Hospital introduced microwave ablation for treatment of recurrent lung cancer.
- Robotic Bronchoscopy launched at Jefferson Torresdale Hospital. This advanced technology allows access to smaller pulmonary nodules that are suspicious for cancer and diagnose lung cancer earlier, ultimately increasing the ability to save more lives.
- Jefferson Torresdale Hospital formally marked the opening of the Jefferson Moss-Magee Rehabilitation Outpatient Center in 2023 to offer physical, occupational and speech therapies and private treatment rooms to help patients achieve their therapy goals while staying close to home.

Jefferson Health – Northeast

Jefferson Bucks Hospital continues to offer the Bucks County community world-class, orthopedic care delivered by 3B Orthopedics. In partnership with the Vickie & Jack Farber Institute for Neuroscience, Jefferson Bucks also offers neurosurgery and neuro-spine services. Since its inception, it has offered the latest surgical techniques to provide exceptional care, outstanding outcomes, and a better quality of life for our patients. Jefferson Bucks Hospital earned the Pathways to Excellence designation from the American Nurses Credentialing Center and the Lantern Award in Nursing.

The Pet Therapy Program at Jefferson's Bucks, Frankford, and Torresdale hospitals expanded, supporting the nursing team's well-being with the help of Angels on a Leash, an organization of human volunteers and their certified Pet Therapy dogs, who round weekly. Staff members often report having more energy and a better outlook on the day following a Pet Therapy visit.

Jefferson Frankford Hospital opened a new nursing-centered Respite Room, developed with direct feedback from nursing staff. The room features equipment that promotes rest and rejuvenation.

Jefferson Frankford Hospital harvested vegetables in the community garden outside of the hospital in the fall months. The hospital provided large amounts of vegetables to our community members who have limited access to healthy food choices.

ACCOLADES

The Patient Safety Authority's "I am Patient Safety Award" was earned by an ED physician, residents and electronic health records experts at Jefferson Torresdale Hospital for their extensive review and updating of existing tools that aid in decision-making, including clinical scores and assessments. The updates are more user-friendly and help clinicians create patient care plans more efficiently across 11 Jefferson Emergency Departments.

Jefferson Bucks, Frankford, and Torresdale Hospitals rank high performing in four procedures and conditions, including Congestive Heart Failure, Knee Replacement, Chronic Obstructive Pulmonary Disease, Pneumonia, according to U.S. News & World Report in 2024.

In addition, the Stroke Program at Jefferson Health – Northeast was recognized with the 2024 Get With The Guidelines® - Stroke GOLD PLUS Award as well as Get With the Guidelines - Coronary Artery Disease, STEMI GOLD PLUS with Target: Type 2 Diabetes Honor Roll and Target: Stroke Honor Roll.

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

Impact of Prior Community Health Needs Assessment and Implementation

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

Jefferson Health- Northeast completed and published its fourth community health needs assessment and three-year implementation plan in 2022, which addressed some of the following priority health needs for the populations of Jefferson community benefits area:

- Mental Health Conditions
- Access to care
- Chronic Disease Prevention and Management
- Substance Use Disorder
- Healthcare and Health Resources Navigation
- Racism and Discrimination in Healthcare
- Food Access
- Language Services
- Community Violence
- Housing
- Socioeconomic Disadvantage
- Neighborhood Conditions

Cancer Prevention and Spreading Awareness

Sidney Kimmel Comprehensive Cancer Center is dedicated to spreading awareness about cancer prevention and providing the community the most advanced and cutting-edge cancer treatments and therapies available. While we are a located in the local community, Sidney Kimmel Comprehensive Cancer Center brings clinical research, Phase 1 trials, supportive oncology, and precision medicine to our neighbors right where they live. Additionally, supportive programs outside of the medical treatment are available, such as cancer survivor celebrations and living beyond survivorship for younger women.

SKCCC host bi-annual Community Cancer Screening & Education Days at Jefferson Torresdale Hospital which are free to the community and allow participants to get up to 8 different types of screenings in 1 visit. This outreach program will be provided to the Bucks & Frankford campuses soon.

There are dedicated Oncology Community Outreach & Education Coordinator who focuses on informing the patient populations we care for, about the importance of preventative cancer screening, and our commitment to our community. We are expanding the SKCCC footprint to include a second infusion center and Medical Oncology practice at Jefferson Bucks Hospital in 2025.

Partnership with Lutheran Settlement House

Jefferson Health Northeast collaborates with Lutheran Settlement House (LSH), which was founded in 1902, and is a non-profit, community-based organization committed to serving children, adults, and families living in Philadelphia. Over the past century, the programs and services offered by LSH have changed in response to the evolving needs of the community. The mission stays the same: to empower individuals, families, and communities to achieve and maintain self-sufficiency through an integrated program of social, educational, and advocacy services.

Jefferson Health Northeast has developed a true relationship to the mission of this organization over the last 10 years. Four times a year, our nursing outreach committee provides resources of women toiletries, back to school items, food drives around Thanksgiving, and adoption of families for gifts to bring joy and humanity to these families in the community. The smiles and feeling of making impact to those in need has been inspiring and continued motivation to continue this partnership.

In alignment with Jefferson Health's mission of improving lives, Lutheran Settlement provides a domestic violence liaison to our Northeast hospitals to consult if a patient arrives to our hospital with a domestic violence situation. This ensures not only caring for the physical safety, but also the emotional, mental and psychological safety.

Chronic Disease Prevention and Management

The growing elderly population presents significant challenges, particularly concerning health and safety. Falls are a leading cause of injury among older adults, making education on fall prevention crucial. Common orthopedic conditions, such as arthritis, can play a part in this as well as unhealthy eating habits. Importance of education on falls and fall prevention is supported by the following:

1. **Awareness of Risks:** Many older adults may not recognize their risk factors, such as medications, vision changes, or balance issues.
2. **Preventive Measures:** Teaching about home modifications (like removing tripping hazards and improving lighting), using assistive devices, and engaging in strength and balance exercises can significantly reduce fall risks.
3. **Emergency Preparedness:** Educating seniors about what to do in case of a fall, including how to call for help and the importance of wearing medical alert devices, can enhance their safety.
4. **Community Resources:** Providing information about local resources, such as fall prevention programs or health screenings, empowers seniors to take proactive steps.

By raising awareness and providing practical solutions, we can help seniors maintain their independence and reduce the incidence of falls, ultimately enhancing their quality of life. We have provided community education sessions at local community groups from our outstanding rehabilitation aides, physical therapists, and speech pathologists. The insights and feedback about sessions are powerful and motivates Jefferson Health Northeast to continue this work.

Jefferson Frankford Hospital Garden of Giving Food Access

Jefferson Frankford Hospital in Northeast Philadelphia is transforming how it supports patients and the community through its “Garden of Giving” program. This initiative, maintained entirely by hospital staff who volunteer their time, produces around 100 pounds of fresh vegetables each week, including tomatoes, cucumbers, peppers, and leafy greens. The garden not only promotes healthy eating by providing nutritious, locally grown produce but also fosters a sense of teamwork and community engagement.

The fresh vegetables are distributed to patients in bags with a loaf of bread upon discharge and delivered to the Frankford Veterans Administration Center to assist veterans in need.

Hospital staff, whether experienced or new to gardening, volunteer to maintain the garden, handling everything from planting and weeding to harvesting and delivering the produce. This project has become a rewarding opportunity for employees to de-stress, bond with colleagues, and contribute to the community in a meaningful way. The garden also supplies a farmer’s market for patients, visitors, and the surrounding neighborhood, further extending its impact.

Jefferson Frankford’s commitment to the garden reflects a broader mission of nurturing health and community, and is a place where hope, health, and teamwork come together.

Discharge with Dignity

Jefferson Health Northeast Hospitals has been providing articles of clothing, such as pants, or shirts for hospital discharged patients over the last 15 years. Recently, there has been focused attention on the needs for additional items for patients in need. As of the latest data, and Philadelphia having one of the highest poverty rates among major US cities, there has been an increased need to expand this offering.

Jefferson Health Northeast Community Outreach committee has conducted fundraising efforts to enhance our clothing closet, Discharge with Dignity. The supply in this closet is now filled with undergarments, shoes, toiletries, activities, books, games and other personal hygiene items. We want to ensure all our patients, who live in the community, feel that their local hospital cares about them both inside and outside of organization. Recently, a food pantry has been added to the Discharge with Dignity program to support those patients who are identified with food insecurities. On discharge, patients are sent with a supply of non-perishable food. Plans for grants and more fundraising is underway.

Service Area Demographics

ESTIMATED POPULATION

781,639

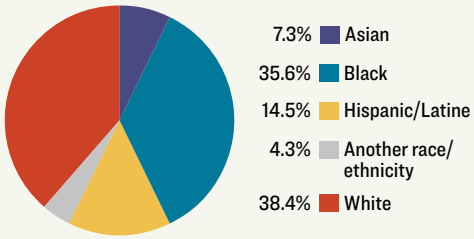
MEDIAN HOUSEHOLD INCOME

$69,094

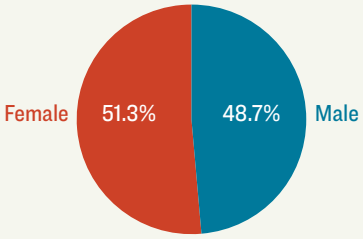
NOT FLUENT IN ENGLISH

5.3%

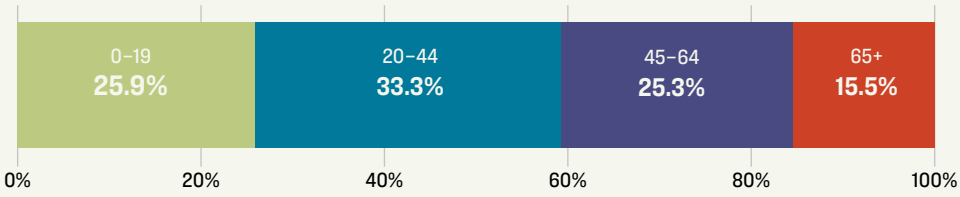
RACIAL COMPOSITION



SEX



AGE DISTRIBUTION



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 19124, 19114, 19136, 19116, 19067, 19115, 19152, 19149, 19054, 19135, 19030, 19055, 19047, 19020, 19134, 19057, 19131, 19056, 19111, 19053, 19007

Jefferson Lansdale Hospital

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
140	750	5,535	3,235	26,836

Located in Lansdale, Montgomery County, Jefferson Lansdale Hospital provides primary, emergency and specialty care to patients and families in the North Penn community. Specialty care includes an 18-bed Orthopedic and Spine Institute, interventional radiology, gynecology, endocrinology, urology, pulmonology, cardiology, general surgery, oral surgery, pain services, opthamology, podiatry and more.

Jefferson Lansdale Hospital, part of Jefferson Health, is dedicated to improving lives and caring for the community.

Jefferson Lansdale Hospital is a 140-bed, acute care general hospital providing a comprehensive range of inpatient and outpatient healthcare services. Its employees and physicians are proud to know that the hospital has been recognized by the Institute for Healthcare Improvement as a leader in the Age Friendly Care movement which is designed to improve the health of the senior population by addressing the physical, mental and emotional aspects of care. The hospital's Emergency Department is accredited by the American College of Emergency Physicians as a Level 3 Geriatric Emergency Department.

Jefferson Lansdale Hospital is also home to Community Health programs for dental care and elder care. These programs provide easily accessible care to local underinsured or uninsured patients of all age groups:

- The Dental Care Access Program is designed to provide a full range of dental care services to children and young adults under 21 years of age to those who cannot afford dental care. In 2024, the Dental Care Access Program celebrated 10 years of providing dental care to the community providing more than $1M in dental services and serving nearly 1,000 community members since its inception.
- The Adult Day Services Program provides an economic and family-friendly alternative for seniors in need of in-home care, care in a nursing home or an assisted living facility, such as those who are unable to be left at home during the workday due to behavioral health needs, chronic illness or disability.

In FY23 and FY24, Jefferson Lansdale Hospital received numerous awards and accolades for high quality patient care, excellence and safety. In 2023, Jefferson Lansdale Hospital earned Pathway to Excellence Redesignation by the American Nurse Credentialing Center for the fourth time.

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Jefferson Lansdale Hospital

US News & World Report designated Jefferson Lansdale Hospital as high performing in Hip and Knee Replacements.

Additionally, the Gift of Life donor program and Hospital and Health System Association of Pennsylvania (HAP) honored Jefferson Lansdale Hospital with their Platinum Award in 2024.

Jefferson Lansdale Hospital maintains academic associations with Thomas Jefferson University School of Nursing, Gwynedd Mercy University, Bucks County Community College and Montgomery County Community College for nursing and allied health professions.

Impact of Prior Community Health Needs Assessment and Implementation

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

In fiscal year 2023, Jefferson Lansdale Hospital provided over $8.3 million dollars to individuals in our communities seeking resources for care and education, in alignment with our Community Health Implementation Plan developed in response to our 2022 Community Health Needs Assessment:

- More than $7.2 million dollars were provided to the community in uninsured and underinsured health services, including Jefferson Lansdale Hospital's Children's Clinic, Adult Day Services Program, and Dental Care Access Program. In addition, the Children's Clinic screens all families for food insecurity and provides opportunities for these families to access fresh fruits and vegetables through a partnership program with Montgomery County Office of Public Health.
- Jefferson Lansdale Hospital provides many free or low- cost programs throughout the year designed to educate the community regarding health risk factors, chronic disease prevention or to support early detection through health screenings. In addition to cardiovascular-related health screenings, a free Cancer Screening Day is held twice a year.
- Jefferson Lansdale Hospital collaborates with many community organizations to support community health improvement initiatives.
- JAH Safe Center
- JLH Age-Friendly Care Award / Distinction
- JLH Warm handoff program for Mental Health
- 988 Campaign (National Suicide Hotline Awareness)
- Integrated Social Worker/ Care Coordinator for mental health services into Jefferson owned primary care physician offices
- Provided MHFA (Mental Health First Aid Education) for community (partnered with MCOPH)
- Telehealth option to increase access to care
- Primary Stroke Center designation by the Joint Commission
- Acute Heart Attack Ready designation by the Joint Commission
- Women's Center of Montgomery County on site with medical advocate and virtual Sexual Assault Nurse Examiner (SANE)
- Jaisohn Center on site providing medical and health care, senior employment training, and social services along with educational and cultural programs to our Asian American community.
- Implemented screening and referral for food insecurity (Epic and BP screenings)
- Partnering with the Montgomery County Public Safety and the Abington Health Foundation Women's Board, Narcan® kits were made available to patients in Jefferson Lansdale Hospital's Emergency Department.
- Throughout fiscal year 2023, Jefferson Lansdale Hospital provided over $737,000 in free health education, screenings, in- kind donations and other community support.
- Jefferson Lansdale Hospital provided over $333,000 in medical education programs in fiscal year 2023, ensuring that students in medical professions have opportunities for internships and clinical rotations.

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

Service Area Demographics

ESTIMATED POPULATION

199,341

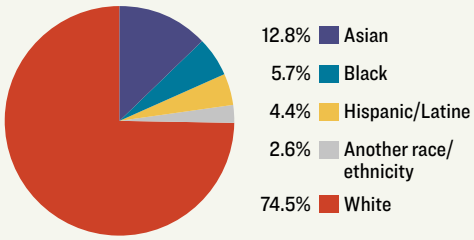
MEDIAN HOUSEHOLD INCOME

$116,053

NOT FLUENT IN ENGLISH

0.9%

RACIAL COMPOSITION



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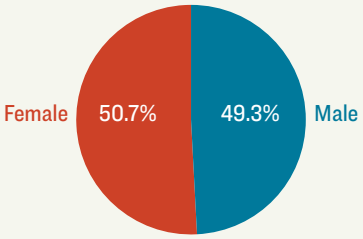
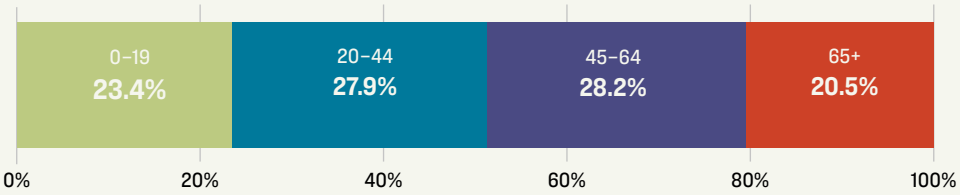


AGE DISTRIBUTION



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 19446, 19454, 19440, 19438, 19002, 19422, 18964

Jefferson Moss-Magee Rehabilitation- Center City

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

BEDS:	PHYSICIANS:	INPATIENT DISCHARGES:
270	113	4,129

Jefferson Moss- Magee Rehabilitation—Center City is the Philadelphia region's first rehabilitation hospital, opening its doors in 1958.

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

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

Jefferson Moss-Magee Rehabilitation – Center City is home to the nation's first brain injury rehabilitation program to be accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Magee has been accredited by CARF for its rehab programs in:

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

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

Jefferson Moss-Magee Rehabilitation- Center City

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

Inpatient services are delivered at the main facility located at 1513 Race Street, in Center City Philadelphia.

Outpatient programs are provided in a variety of community settings including the Riverfront outpatient center at 1500 South Columbus Boulevard, and Oxford Valley, which is located at 400 North Buckstown Road in Langhorne.

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

Impact of Prior Community Health Needs Assessment and Implementation

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

Magee Rehabilitation Hospital completed and published its Community Health Needs Assessment and three-year Implementation Plan in 2022, which addresses the following priority health needs for the population of the Hospital's Community Benefit area:

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

Jefferson Moss-Magee Rehabilitation- Center City

Service Area Demographics

ESTIMATED POPULATION

2,978,674

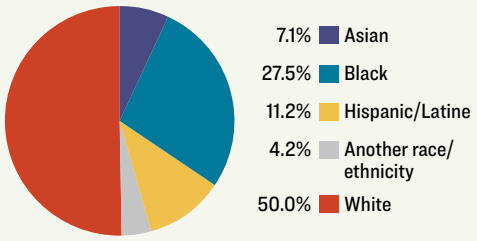
MEDIAN HOUSEHOLD INCOME

$77,503

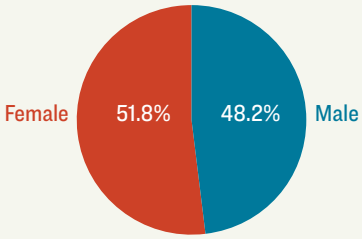
NOT FLUENT IN ENGLISH

3.1%

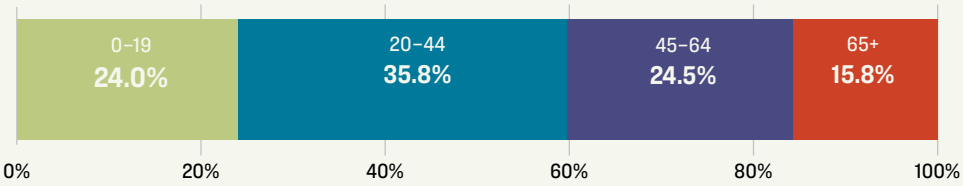
RACIAL COMPOSITION



SEX



AGE DISTRIBUTION



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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Main Line Health

Main Line Health®

BEDS:	MEDICAL STAFF:	TOTAL DISCHARGES:	OUTPATIENT PROCEDURES:	EMERGENCY DEPT. VISITS:
1,383	2,100+*	66,287	1,402,408	204,018

* system-wide total

Founded in 1985, Main Line Health® is a not-for-profit health system serving the Philadelphia region and beyond. Main Line Health consists of five hospitals, six health centers and 150+ medical practice locations. The system has more than 13,000 employees and over 2,100 employed and independent physicians and advanced practice providers. At its core are four of the region's most respected acute care hospitals — Lankenau Medical Center, Bryn Mawr Hospital, Paoli Hospital and Riddle Hospital — as well as one of the nation's premier facilities for rehabilitative medicine, Bryn Mawr Rehab Hospital. Main Line Health also includes Mirmont Treatment Center for drug and alcohol recovery; Main Line Health HomeCare & Hospice, providing skilled home healthcare, hospice and home infusion services; Main Line Health Centers, primary and specialty care, lab and radiology and other outpatient services located in Broomall, Collegeville, Concordville, Exton, King of Prussia and Newtown Square; and Lankenau Institute for Medical Research, a biomedical research organization.

Main Line Health's medical staff benefits from a collaborative relationship including independent physicians, community healthcare professionals and hospital-based experts from Main Line HealthCare, the employed multi-specialty physician network of Main Line Health.

Main Line Health collaborates with top experts to deliver exceptional specialty care. Through our affiliation with the Children's Hospital of Philadelphia, doctors and advanced practice providers care for pediatric patients at select Main Line Health locations, including the neonatal intensive care units at Main Line Health's four acute care hospitals, as well as Bryn Mawr Hospital's Inpatient Pediatric Unit and Emergency Department. Jefferson Health neurosurgeons and neurointerventionalists provide 24/7 specialized care, including neurointervention and lifesaving stroke care, and trauma surgeons provide critical care to our patients.

Main Line Health®

Main Line Acute Hospitals

Through our affiliation with Sheppard Pratt — a nonprofit provider of mental health services, substance use, developmental disability and other comprehensive behavioral health support — patients receive compassionate care in a welcoming environment.

Main Line Health also launched its inaugural Community Health Impact Report in 2025. The Community Health Impact Report is a publication that highlights the important work being done by Main Line Health's Community Health and Outreach programs, focused on improving community health through educational outreach events, screenings and innovative programs. The report covers work across the System from 2020-2024.

MISSION

To meet the health care needs of the communities we serve and to improve the quality of life for all people, by providing a comprehensive range of safe, equitable and high-quality health services, complemented by interdisciplinary education and research programs.

VISION

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

VALUES

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

SYSTEMWIDE AWARDS, HONORS AND RECOGNITION

- Physicians continuously ranked as Top Doctors by Philadelphia Magazine and Main Line Today.
- System NICHE designed (Nurses Improving Care for HealthSystem Elders).
- CertifiedTM by Great Place To Work® for three years in a row.
- Forbes also selected the system as a 2024 Best Employer by State for Pennsylvania.
- American Hospital Association's 2023 Quest for Quality Award
- American Hospital Association's 2024 Carolyn Boone Lewis Equity of Care Award, Transforming Winner
- American Hospital Association's 2023 Quest for Quality Award
- American Hospital Association's 2024 Carolyn Boone Lewis Equity of Care Award, Transforming Winner

Impact of Prior Community Health Needs Assessment and Implementation

The information provided by community members and leaders informed the 2022 Community Health Needs Assessment for the Main Line Health Acute Care Hospitals to develop 19 system initiatives across 7 overall community health need priorities to focus on over the three-year cycle. The community health needs that were addressed included: Access to Care, Mental Health and Substance Use and Related Disorders, Chronic Disease Prevention and Management, Racism and Discrimination in Healthcare settings, Social and Economic Conditions, and additionally pursued initiatives to address Maternal Health and Senior Care. Highlighted are the Main Line Health initiatives to address needs identified through our 2022 Regional Community Health Needs Assessment:

Access to Care

To improve access to primary and specialty care, Main Line Health pursued exploration of a collaborative site in the West Philadelphia region, engaging key health system partners. T4WP is a coalition of healthcare institutions and community-based organizations which was incubated through Main Line Health and established as a 501c3 in 2018 to promote collaboration among the healthcare organizations of West Philadelphia. The core of T4WP is a network of "Trusted Venues," faith-based organizations and community schools, which represent an estimated 20,000 members of the West Philadelphia community.

In partnership with IBX-AHE and with funding raised from partner organizations, the T4WP Health Access Coalition, launched in February 2025, will work to enhance health access for community members in need. Ambassadors from the Trusted Venues will refer patients to a Program Manager who will then direct them to Community Health Workers at Lankenau Medical Center, Penn Medicine or Spectrum Health based on their geography, needs and preference. The T4WP HAC hopes to help community members solve problems such as finding PCPs, insurance coverage, and specialty care as well as shortening wait-times to appointments for problems of acuity and being sure that patients are connected to resources for their social needs.

Additionally, Main Line Health's Community Health Worker (CHW) program serves as an access point for patients and community members who need to connect with and navigate complex systems. CHWs conduct Social Determinants of Health (SDoH) screenings and provide resource navigation and case management, particularly for food, transportation, utility payment assistance, health insurance, housing, and primary and specialty care physician appointments. CHWs are of the key staff for the West Philadelphia Health Access Coalition, a new partnership between T4WP and AHE that works together to improve access and alleviate barriers to health care.

Other ongoing system strategies to improve ease of access include:

- Improving new primary care patient access
- Enhancing virtual care strategies for outpatient visits, including triaging patients to the appropriate level of care and offering virtual on-demand appointments with nurse practitioners in primary care
- Adding self-scheduling capabilities for primary, specialty and urgent care, and imaging and lab services, offering rescheduling through text messages, automating timelier appointment offers via the patient portal, and transitioning more services to a centralized scheduling to make it easier for patients
- Assessment of patient demographics and contributing factors of high utilizers in our emergency departments and targeting interventions on how to reduce the proportion of patients with four or more visits
- Continuing to increase our access to primary care for our LGBTQ inclusive care services

Mental Health and Substance use and Related Disorders

Mental health access for outpatient behavioral health care was pursued through continued integration of behavioral health in primary care and specialty care (initiating in OBGYN and Pain Management services). Consolidation of our system's centralized call center, improved ease of access to behavioral health appointment scheduling. The addition of dedicated behavioral health services for outpatient therapy and integrating behavioral health across primary care, contributes to increasing visit volume and future opportunities for growth continue to be assessed.

Chronic Disease Prevention and Management

A number of system initiatives focus on identifying and addressing chronic conditions in our community including:

- Improving women's heart health by conducting risk assessment screenings and cardiac educational opportunities in the community and for patients to increase women who have engaged with Main Line Health providers post-assessment
- Continued efforts to increase patients meeting the diabetes control target of HbA1c of less than 8
- Cancer screenings for our Main Line Health patients for breast, colorectal and lung cancers. Increasing access to colorectal screenings, in particular, has a key focus on our Medicaid population, by providing these patients with FIT kits and efforts to partner with community-based GI providers who accept Medicaid for colonoscopies
- Working towards reducing readmissions, specifically 30-day readmissions for medical MSDRG Medicare patients across our acute care settings

Racism and Discrimination in Healthcare

Several system-wide efforts have been deployed to impact the communities we serve, including initiatives to reduce disparities as it relates to addressing patient care gaps across different demographics, for congestive heart failure, palliative care consults, stroke treatment, etc. For our employees, we continue to foster a culture of belonging with system employee-led groups who focus on increasing employee engagement, impacting patient and family experience and collaborating with community-based organizations to educate on health-related topics.

Social and Economic Conditions

To address social needs that impact care of our Main Line Health patient population, SDOH screening has been deployed across our inpatient acute care settings. We continue to optimize ways and develop a workflow to connect patients to resources (e.g. through our FindHelp platform) who screen positive, with a focus on Food Insecurity, Transportation, Utilities and Housing resources, and track utilization of those resources. Additionally, we have rolled out SDOH screening across our primary care settings and look to expand in specialty care, such as OBGYN.

Maternal Health

An example of one of our maternal health initiatives is increasing screening compliance for substance use and opioid use disorders for patients who are pregnant or postpartum in our acute care settings. Another key maternal health-focused initiative is to decrease primary cesarean section (c-section) rates, while also tracking these rates by race/ethnicity.

Senior Care

One of our ongoing system-wide initiatives for older adult patients, is to reduce the number of falls in our acute care settings. A system interdisciplinary falls committee continues to track and monitor trends in root causes, for when these falls occur during a patient's stay (e.g. walking to the bathroom), and ways in which to continue to educate both patients and community members on fall prevention.

Service Area Demographics

ESTIMATED POPULATION

1,743,957

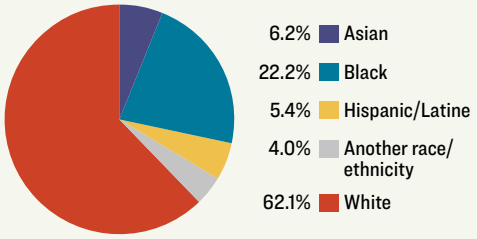
MEDIAN HOUSEHOLD INCOME

$98,311

NOT FLUENT IN ENGLISH

1.1%

RACIAL COMPOSITION



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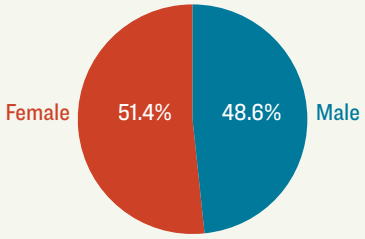

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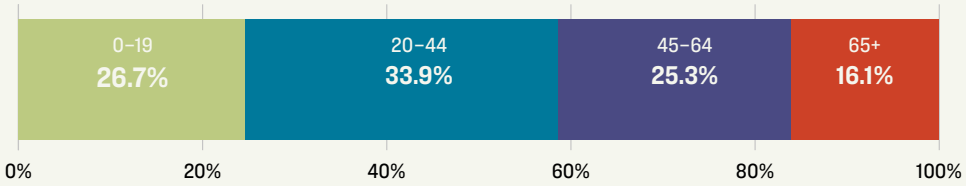


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Main Line Health defines its service area for acute hospitals as 75 percent of each hospitals' inpatient and outpatient market area, Main Line Health acute hospitals include the combined Primary Service Area (PSA) ZIP codes for respective acute facilities, accouting for approximately 79 percent of total Main Line Health acute encournters.

ZIP codes: 19003, 19004, 19008, 19010, 19013, 19014, 19015, 19018, 19022, 19023, 19026, 19033, 19035, 19036, 19041, 19043, 19050, 19060, 19061, 19063, 19064, 19066, 19070, 19072, 19073, 19074, 19076, 19078, 19081, 19082, 19083, 19085, 19086, 19087, 19094, 19096, 19104, 19118, 19127, 19128, 19131, 19139, 19143, 19144, 19151, 19301, 19312, 19317, 19319, 19320, 19333, 19335, 19341, 19342, 19343, 19344, 19348, 19355, 19372, 19373, 19380, 19382, 19383, 19390, 19401, 19403, 19405, 19406, 19425, 19426, 19428, 19453, 19460, 19462, 19464, 19465, 19468, 19473, 19475, 19525

Bryn Mawr Hospital

Main Line Health®

BEDS:	MEDICAL STAFF:	TOTAL ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
284	2,100+*	15,881	234,444	52,030

* system-wide total

ABOUT

Founded in 1893, Bryn Mawr Hospital is a top-rated institution in the Philadelphia metro area, recognized for its exceptional patient care. The hospital and its outpatient offices offer a wide range of services, including cancer care, orthopaedics, cardiovascular, maternity, bariatric surgery, and plastic and reconstructive surgery. Clinicians from Children's Hospital of Philadelphia provide care for pediatric patients at Bryn Mawr Hospital, including 24/7 coverage of the pediatric emergency department, pediatric inpatient unit and level III NICU. Main Line Health's affiliation with Jefferson Health enables a neurointervention center for advanced stroke care at Bryn Mawr Hospital. Behavioral Health services are provided in collaboration with Sheppard Pratt, leaders in mental health and substance use services.

Our commitment to innovation is seen through advanced technologies for minimally invasive procedures and expert surgical care. Additionally, Bryn Mawr Hospital is dedicated to developing the next generation of healthcare professionals, training medical students, residents and fellows in numerous specialties.

AWARDS, HONORS AND RECOGNITION

- Ranked among the top hospitals in the Philadelphia region by U.S. News & World Report's Best Hospitals for 2024-2025.
- Nationally recognized by the American Heart Association for heart and stroke care, receiving Mission: Lifeline and Get With The Guidelines® awards.
- "A" grades from The Leapfrog Group, America's voice for patient safety, quality, and transparency.

Lankenau Medical Center

Main Line Health®

BEDS:	MEDICAL STAFF:	TOTAL ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
370	2,100+*	20,281	327,813	62,257

* system-wide total

ABOUT

Founded in 1860, Lankenau Medical Center is recognized among the top hospitals in the Philadelphia region for exceptional patient care. We offer a comprehensive range of primary care, disease prevention, and specialized medical and surgical services, including advanced treatments in cardiovascular, cancer care, maternity, orthopaedics and a Level II trauma center. Neonatologists from Children's Hospital of Philadelphia provide specialized newborn and neonatal intensive care in our Level III NICU. A leader in medical education, Lankenau Medical Center trains a diverse group of residents and fellows participating in various programs across multiple specialties. The hospital is also home to the Lankenau Institute for Medical Research, where groundbreaking research advances the detection, diagnosis and treatment of diseases and offers access to clinical trials. Lankenau Medical Center combines compassionate care with cutting-edge technology in a patient-centered environment.

AWARDS, HONORS AND RECOGNITION

- Ranked among the top hospitals in the Philadelphia region by U.S. News & World Report's Best Hospitals for 2024-2025.
- Nationally recognized by the American Heart Association for heart and stroke care, receiving Mission: Lifeline and Get With The Guidelines® awards.
- "A" grades from The Leapfrog Group, America's voice for patient safety, quality, and transparency.

Paoli Hospital

Main Line Health®

BEDS:	MEDICAL STAFF:	TOTAL ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
261	2,100+*	15,944	254,269	50,573

* system-wide total

ABOUT

Founded in 1913, Paoli Hospital is recognized for its exceptional medical and surgical services, advanced technology and personalized approach to care. We offer a wide range of services, including orthopaedics, maternity care, cardiovascular, cancer care and a Level II trauma center. Neonatologists from Children's Hospital of Philadelphia provide specialized newborn and neonatal intensive care in our Level II NICU. Main Line Health's affiliation with Jefferson Health enables a neurointervention center for advanced stroke care at Paoli Hospital. The hospital features an award-winning Patient Care Pavilion, designed to enhance clinical outcomes, patient safety and the overall experience with private rooms and family accommodations. Consistently recognized for excellence, Paoli Hospital remains a leader in patient-centered care in the region.

AWARDS, HONORS AND RECOGNITION

- Ranked among the top hospitals in the Philadelphia region by U.S. News & World Report's Best Hospitals for 2024-2025.
- Nationally recognized by the American Heart Association for heart and stroke care, receiving Mission: Lifeline and Get With The Guidelines® awards.
- "A" grades from The Leapfrog Group, America's voice for patient safety, quality, and transparency.

Riddle Hospital

Main Line Health®

BEDS:	MEDICAL STAFF:	TOTAL ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
230	2,100+*	10,939	208,883	40,087

* system-wide total

ABOUT

Founded in 1963, Riddle Hospital provides comprehensive services, including orthopaedic, maternity, cardiovascular, cancer and stroke care, as well as emergency medicine and outpatient services such as imaging, audiology and sleep studies. Riddle Hospital is known for providing advanced treatment options and innovative approaches, including cutting-edge technology for cardiac and cancer care. Neonatologists from Children's Hospital of Philadelphia provide specialized newborn and neonatal intensive care in our Level II NICU. Consistently recognized for excellence in patient care, Riddle Hospital is a trusted healthcare provider in the region, known for its high-quality services and patient-centered approach. The hospital recently completed a modernization and expansion project — the Riddle Hospital new patient pavilion. The new five-story, 230,000 square foot patient pavilion is the cornerstone of an overall campus revitalization and modernization project.

AWARDS, HONORS AND RECOGNITION

- Ranked among the top hospitals in the Philadelphia region by U.S. News & World Report's Best Hospitals for 2024-2025.
- Nationally recognized by the American Heart Association for heart and stroke care, receiving Mission: Lifeline and Get With The Guidelines® awards.
- "A" grades from The Leapfrog Group, America's voice for patient safety, quality, and transparency.

Bryn Mawr Rehab Hospital

Main Line Health®

BEDS:	MEDICAL STAFF:	TOTAL ADMISSIONS:	OUTPATIENT VISITS:
148	2,100+*	2,203	109,578

* system-wide total

ABOUT

Bryn Mawr Rehab Hospital is a leader in the field of physical medicine and rehabilitation, offering advanced inpatient and outpatient rehabilitation services. As one of the most comprehensive rehabilitation systems in the region, Bryn Mawr Rehab Hospital offers services at eight convenient locations. With more than 50 years of clinical excellence, Bryn Mawr Rehab provides outstanding inpatient therapy and medical care for conditions as diverse as spinal cord injury, traumatic brain injury, stroke and orthopaedic injuries. Bryn Mawr Rehab offers a full range of outpatient services, including cancer rehab, post-COVID recovery, comprehensive concussion rehabilitation, driver rehabilitation, assistive technology and vestibular (balance) rehabilitation.

AWARDS, HONORS AND RECOGNITION

- Donate Life Pennsylvania Hospital Challenge: Gold recognition
- Newsweek Best Rehab Hospital recognition
- Commission on Accreditation for Rehabilitation Facilities (CARF):
  - Inpatient comprehensive integrated inpatient rehabilitation program (adults)
  - Inpatient amputation specialty program (adults)
  - Inpatient brain injury specialty program (adults and adolescents)
  - Inpatient cancer rehabilitation program (adults)
  - Inpatient spinal cord system of care (adults)
  - Inpatient stroke specialty program (adults)
  - Interdisciplinary outpatient brain injury specialty program (adults, children, adolescents)
  - Interdisciplinary outpatient spinal cord system of care (adults)
- Awarded Joint Commission Gold Seal of Approval

Service Area Demographics

ESTIMATED POPULATION

1,470,729

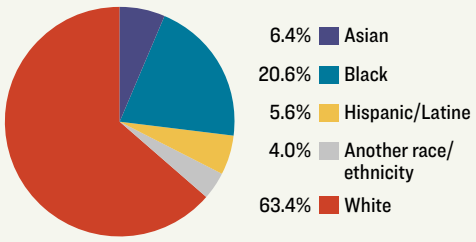
MEDIAN HOUSEHOLD INCOME

$103,311

NOT FLUENT IN ENGLISH

1.2%

RACIAL COMPOSITION



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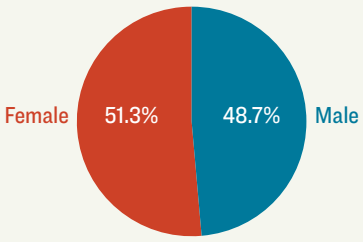

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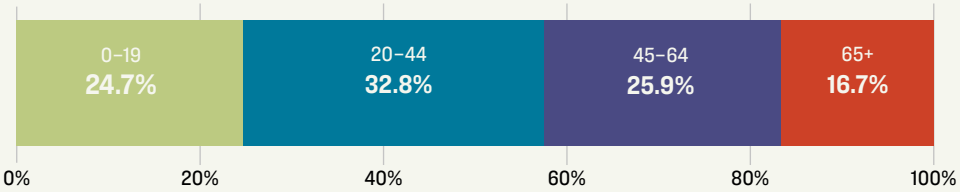


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 19003, 19004, 19008, 19010, 19013, 19014, 19015, 19018, 19026, 19041, 19050, 19060, 19061, 19063, 19064, 19066, 19072, 19073, 19082, 19083, 19085, 19086, 19087, 19096, 19131, 19139, 19143, 19151, 19301, 19312, 19317, 19319, 19320, 19333, 19335, 19341, 19342, 19343, 19344, 19348, 19355, 19372, 19373, 19380, 19382, 19383, 19390, 19401, 19403, 19405, 19406, 19425, 19426, 19428, 19453, 19460, 19462, 19464, 19465, 19468, 19475, 19525

Penn Medicine Philadelphia

Hospital of the University of Pennsylvania

Penn Medicine

BEDS:	FACULTY, RESIDENTS & FELLOWS:	ADULT ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
1,991	5,236	75,917	7,636,854	203,166

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

Penn Medicine consists of the Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania, founded in 1765 as the nation's first medical school, and the University of Pennsylvania Health System (UPHS), which together form a $11.9 billion enterprise.

The Perelman School of Medicine and UPHS are committed to improving lives and health through clinical care, research, medical education, and community service. In the 2023 fiscal year, Penn Medicine provided more than $737.3 million in benefit to the community. The School conducts more than $969 million in annual sponsored research and is consistently among the nation's top recipients of funding from the National Institutes of Health, with $580 million awarded in the 2023 fiscal year.

The School of Medicine has 791 M.D. students, 1,947 residents and fellows, and 3,289 full-time faculty members as of FY23. In the City of Philadelphia, UPHS' patient care facilities include: The Hospital of the University of Pennsylvania, Hospital of the University of Pennsylvania – Cedar Avenue, Penn Presbyterian Medical Center, and Pennsylvania Hospital. At the end of fiscal year 2023, UPHS had 1,991 licensed beds in Philadelphia; it is a valued health care resource in the community.

The Hospital of the University of Pennsylvania (HUP) was established in 1874 as a teaching hospital to complement the medical education received by students at the Perelman School of Medicine. Today, it has 20 clinical departments and provides training in more than 40 clinical specialties. Major areas of clinical focus across HUP include cardiac care, oncology, neurosciences, and women's health.

HUP is one of the only hospitals in this region that performs transplants of all major organs. HUP's campus is a hub for innovative medical care, and home to the Pavilion—the largest capital project in the University of Pennsylvania's history—which opened in October 2021. The Pavilion is one of the largest hospital projects in the U.S.—and the largest in the Philadelphia region. The building rises 17 stories on Penn Medicine's West Philadelphia campus as a place where Penn's world-renowned researchers, clinicians, and faculty will continue to pioneer advanced patient care. The $1.6 billion facility houses 504 private patient rooms and 47 operating rooms.

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

Pennsylvania Hospital

Penn Presbyterian Medical Center

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

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

Within our Philadelphia facilities, in keeping with our charitable purpose, UPHS accepts patients in serious need of medical care regardless of their financial status. UPHS also provides care to patients who do not have health insurance or meet the criteria to qualify for its charity care policy. In fiscal year 2023, Penn Medicine, as an institution, provided $421.9 million in charity and underfunded care for patients in need.

Impact of Prior Community Health Needs Assessment and Implementation

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

Mental and Behavioral Health and Substance Use

The Hospital of the University of Pennsylvania–Cedar Avenue (HUP Cedar) Crisis Response Center (CRC) was established in 2023 to make critical psychiatric and substance use care easily accessible for West and Southwest Philadelphia residents. In addition to moving inpatient and drug and alcohol detoxification units from Penn Presbyterian Medical Center to HUP Cedar, the newly established CRC provided care for more than 4,500 patient visits in its first year. Together, Pennsylvania Hospital and the HUP Cedar have a total of 73 licensed inpatient psychiatric beds and 16 beds for substance use treatment.

In 2023, there were more than 107,000 drug overdose deaths in the United States, and in Philadelphia, death rates continue to rise. Penn Medicine's **Center for Opioid Recovery and Engagement** (CORE) provides free peer support for individuals struggling with opioid use and their loved ones. The program provides multiple pathways to recovery by removing barriers and facilitating access to recovery resources. CORE offers hands-on medical and behavioral help to ensure individuals receive continued treatment and are supported within their communities. CORE's opioid use disorder (OUD) care team is made up of Certified Recovery Specialists who use their personal OUD experiences to provide participants with long-term guidance for recovery. CORE also offers enhanced case management services, providing assistance with obtaining housing, education, social service needs, support groups and access to treatment.

Chronic Disease Prevention and Management

Stroke Community Education Program: In recognition that stroke is the number-one preventable cause of disability, Penn Medicine offers community-based, stroke-related educational programming at every hospital in the system. Risk factors are identified through a community health needs assessment, with program staff striving to help residents combat any risk factors that emerge, while working to increase awareness of stroke and its symptoms.

National Diabetes Prevention Program (NDPP): This year-long, research-based program uses curriculum published by the Centers for Disease Control and Prevention to promote healthy eating and physical activity in individuals at risk for developing type 2 diabetes. Provided at most Penn Medicine Diabetes Education Centers, the NDPP encourages healthy lifestyle changes to delay or prevent a diagnosis of type 2 diabetes.

Diabetes Self-Management Education and Support programs (DSMES): Diabetes is a complex condition that involves many daily self-management habits. DSMES programs provide individuals living with diabetes with the tools and support needed to address the behavioral, educational, medical, and mental aspects of diabetes management. These skills can help people with diabetes enhance their daily self-care, decrease complications of diabetes, and improve overall health outcomes. In the past fiscal year, over 500 individuals have attended diabetes self-management education and support sessions offered at the accredited Penn Medicine Diabetes Education Centers, including Pennsylvania Hospital.

Primary and Preventive Care Navigation and Access

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

The United Community Clinic (UCC), housed in the New River Church, has been a cornerstone of preventative care in West Philadelphia for nearly 25 years. Led by medical students and faculty from the Perelman School of Medicine, the UCC has consistently evolved to meet the needs of its community. In the last two years, Penn Medicine and UCC have expanded their services to Southwest Philadelphia, another medically underserved community. UCC clinicians address a wide range of health needs from routine check-ups and diabetes management to treating common illness and providing X-rays for injuries. Over the past year, UCC has treated 158 patients across two community clinic locations. The clinic also assists patients in finding insurance to ensure they have continued access to necessary medical services in the future.

Philadelphia Department of Public Health Partnership: The Division of General Internal Medicine faculty and residents provide primary care at two of the city's ambulatory health centers in West Philadelphia. This unique partnership increases the pool of primary care providers who are able to serve Philadelphia residents, regardless of insurance status or their ability to pay.

Federally Qualified Health Center (FQHC) Prenatal Care Partnership: The Department of Family Medicine and Community Health faculty and residents provide prenatal care at four local West Philly FQHCs and these patients deliver on the Family Medicine service at our university hospital. This innovative model of care expands access to high quality primary care, ensures continuity of care, and improves health outcomes.

Perelman School of Medicine Community Clinics: Penn Medicine physicians and staff provide primary and specialty care access in a network of community-based, student-led clinics in medically underserved communities throughout Philadelphia. These clinics provide support to communities that face significant access barriers to care.

Specialty Care Navigation and Access

The Penn Center for Surgical Health (CSH) aims to create sustainable infrastructure for access to high-quality, cost-conscious surgical care before it becomes an emergency. CSH pairs patients with a Personal Patient Navigator (PPN)—typically a medical student who has undergone CHS's PPN Training Program—to help patients through obtaining insurance or other funding and understanding and navigating from preoperative through to postoperative care. Since its inception in Fall 2021, the CSH has provided more than 1,000 patient referrals, facilitated transportation to surgeries for 333 patients, and helped 180 patients get access to care that would otherwise be out of reach.

Penn Medicine is actively working to **decentralize cancer screenings and bring cancer care to communities** by enabling access to preventative care outside of hospitals in the communities that need them most. Inequities in access to cancer screenings for early detection, cutting-edge treatments, and participation in breakthrough clinical trials contribute to persistent inequities in outcomes for underserved and minority patients. Black patients are 20 percent more likely to get colorectal cancer and 40 percent more likely to die of the disease, and underinsured women are 60 percent more likely to die from breast cancer due to barriers to early detection. Through collaborative efforts, like the partnership between Enon Tabernacle Baptist Church and the Abramson Cancer Center, Penn Medicine has provided at-home colorectal cancer screening kits at community events and drive-throughs, coupled with navigation support for follow-up care. These efforts, which also include mailed screening kits with research-backed text reminders, have significantly improved cancer screening rates for Black patients, particularly during the pandemic.

Similarly, the **Penn Medicine Breast Health Initiative** has delivered free breast cancer screenings and breast health education, among other support services that have reached more than 3,000 uninsured and underinsured women in the region since 2014. Abramson has also engaged in numerous community outreach efforts to boost enrollment of Black patients in research, resulting in nearly doubling of participation rates in the five years. By focusing on community-based outreach and patient navigation, Penn Medicine is closing gaps in care for underserved populations, boosting participation in screenings and clinical trials, and improving outcomes across racial, socioeconomic, and geographic lines.

Violence Prevention and Intervention

Deeply Rooted was launched in 2022 by the Penn Urban Health Lab as a community-academic collaborative that promotes health equity and justice in neighborhoods in West and Southwest Philadelphia. With a $6 million investment from Penn Medicine and Children's Hospital of Philadelphia (CHOP), the collaborative has cleaned and greened more than 700 vacant lots, planted more than 820 trees, and built miniparks designed by the community. The program has also awarded multiple micro-grants for resident-led projects that support vacant lot cleanups, community space programming, job training, education, and more. These efforts are backed by Penn Medicine research that shows greening vacant spaces reduces violent crime, improves mental health and has various other positive impacts on health outcomes.

The Penn Trauma Violence Recovery Program is a Hospital-Based Violence Intervention Program (HVIP) that provides survivors of violent injuries with psychosocial support and wraparound services to promote their holistic healing. The program is made up of Penn Presbyterian Medical Center (PPMC) employees who work alongside Penn Medicine trauma teams to improve care and outcomes for injured patients. To date, the program has enrolled 80 patients, provided 363 patients with bedside counseling, and made 143 referrals to community services and resources. Penn Trauma Violence Recovery Program leaders have also established a fund to meet program participant's basic needs, from transportation costs to food and other necessities.

Advancing Maternal Health

New and expectant mothers in the United States are more likely to die than those in any other developed country in the world. More than 80 percent of these deaths are preventable. Black mothers are disproportionately impacted; their risk of death is four times that of their white counterparts in Philadelphia. To ensure comprehensive care for every mother, Penn Medicine has developed a unified system-wide effort to reduce maternal health disparities through faculty research, community engagement, and a broad array of quality improvements and innovations in patient care. One such innovation, the Heart Safe Motherhood remote blood pressure monitoring program, was implemented to help postpartum mothers manage high blood pressure from home via text messages, reducing the need for in-office visits. In the 2023 fiscal year, Heart Safe Motherhood received more than 250,000 patient-reported blood pressure readings, resulting in a 50 percent reduction in 6-month readmissions for mothers with blood pressure-related conditions. Heart Safe Motherhood is not only standard of care for at-risk patients in all Penn Medicine birthing hospitals, but has expanded to several other Philadelphia hospitals outside of Penn.

Penn Medicine's approach to maternal health involves interventions at every stage in the continuum of maternal care, from pregnancy and delivery, through the first few weeks postpartum, as well as after and in between pregnancies. This comprehensive approach resulted in a 30 percent reduction in maternal morbidity—health problems resulting from pregnancy and childbirth—in the first year alone.

Food Security

The Food Access Support Technology (FAST) program addresses the needs of food-insecure residents in Philadelphia whose lack of access to nutritious food exacerbates chronic health conditions with a digital platform that enables health systems, community-based organizations, and small businesses to improve food delivery to underserved populations in the region. The program has successfully provided thousands of meals to families in need since the app launched in 2021.

The HUP Harvest food pantry began in May 2020, shortly after the onset of the COVID-19 pandemic. Created and led by HUP nursing staff, and with guidance from hospital nutrition professionals, pantry volunteers assemble bags of food to feed a family of four for a day. Bags are distributed every Wednesday. Many recipients are Penn Medicine employees, who may receive one bag of food with no questions asked. HUP Food Pantry partners with Philabundance to receive a minimum of 500 pounds of food each week. In October 2020, the pantry cemented relationships with the Penn Food and Wellness Collaborative and started receiving produce from Penn Farm. The program again expanded in December 2021, offering bags of food to food-insecure, diabetic prenatal and postpartum patients at Penn's Helen O. Dickens Center for Women's Health. In this past year, Penn Medicine expanded the HUP Pantry program to Hospital of the University of Pennsylvania - Cedar Avenue, which serves West and Southwest Philadelphia. To date, 14,160 clients have been served with 163,210 pounds of food and the help of 762 volunteer hours.

Addressing a Wide Array of Social Determinants of Health

The Social Needs Response Team (SNRT) addresses the socioeconomic challenges of underserved patient populations. By conducting surveys that identify issues like food and housing insecurity, SNRT connects patients with community resources both during their treatment and after discharge from care at Penn Medicine. Since it began, SNRT has received over 1000 referrals, with food assistance, housing, and employment among the community's primary needs.

The **Penn Medicine CAREs Grant** program was created to provide institutional support for initiatives that address community health needs while recognizing the volunteer efforts of employees and medical students. Since its inception in 2012, the program has funded 1,200 service projects across the Penn Medicine service area. These initiatives have included programs at community centers, farmers' markets, and places of worship, benefiting communities from Philadelphia, Lancaster, and Chester counties to New Jersey's suburbs and shore areas. To date, nearly $1.25 million has been awarded to support volunteerism and projects that aim to improve health, wellness, and reduce health disparities in underserved communities. In October 2024, Penn Medicine announced an increase in annual funding for the CAREs program, further expanding its potential for future impact.

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

Service Area Demographics

ESTIMATED POPULATION

566,988

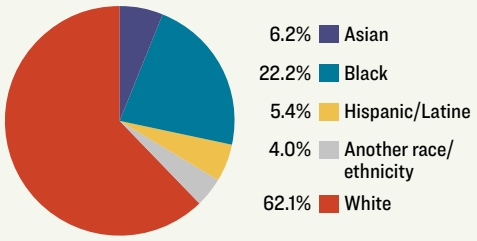
MEDIAN HOUSEHOLD INCOME

$65,201

NOT FLUENT IN ENGLISH

1.5%

RACIAL COMPOSITION



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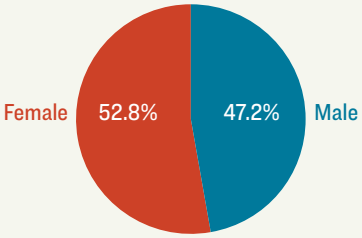

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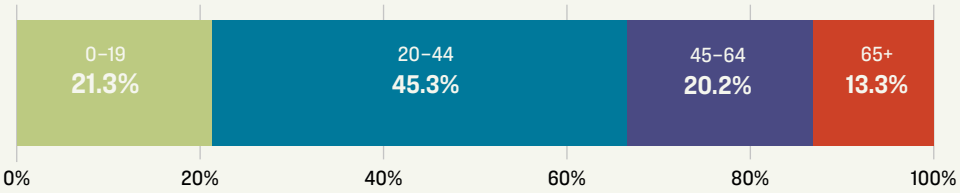


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 19102, 19103, 19104, 19106, 19107, 19123, 19130, 19131, 19139, 19142, 19143, 19145, 19146, 19147, 19148, 19151, 19153

Chester County Hospital

Penn Medicine

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT TESTS & PROCEDURES	EMERGENCY DEPT. VISITS:
329	833	18,063	718,480	64,182

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

Chester County Hospital is a 329-bed inpatient facility in West Chester. Its outpatient services extend to satellite locations in Exton, West Goshen, New Garden, Jennersville, and Kennett Square. Chartered in 1892 as a 10-bed dispensary, the hospital has served Chester County and its surrounding communities for over 130 years. Chester County Hospital joined the University of Pennsylvania Health System in 2013 as part of its ongoing effort to provide the most progressive services available. In 2020, the hospital completed the most significant expansion in its history. The project welcomed a state-of-the-art procedural platform with 15 operating room suites, a 99-bed patient tower, a new main entrance, and an expanded and renovated Emergency Department.

VISION STATEMENT

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

OUR VALUES

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

Innovation, Collaboration, Accountability, Respect, and Excellence. These are known internally by their acronym, ICARE.

ACCOLADES RECEIVED

Centers for Medicare and Medicaid Services

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

Cancer Commendation

In 2023, the Abramson Cancer Center at Chester County Hospital's cancer program was reviewed and reaccredited with commendation by the Commission on Cancer (CoC) of the American College of Surgeons. The National Accreditation Program for Breast Cancers also reaccredited the Breast Health Program.

Magnet Team: Reaccreditation

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

Chester County Hospital Baby-Friendly

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

Diabetes Education Program: Reaccreditation

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

National Diabetes Prevention Program (NDPP)

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

Chester County Hospital Recognized for Excellence in Emergency Nursing

Chester County Hospital's emergency department has been selected as a recipient of the Emergency Nurses Association's 2024 Lantern Award for demonstrating excellence in leadership, practice, education, advocacy, and research performance. Only 94 emergency departments across the U.S. were recognized in 2024.

Primary Stroke Center

Chester County Hospital is recognized for its commitment to providing high-quality stroke care. The Joint Commission certified Chester County Hospital as a Primary Stroke Center. The American Heart Association presented Get with The Guidelines® —Stroke GoldPlus award for its proven dedication to ensuring that all stroke patients have access to best practices and life-saving care.

U.S. News & World Report: 2024/2025

Chester County Hospital is ranked #13 in Pennsylvania and #7 in the Philadelphia Metro Area. The hospital is recognized as High-Performing in gastroenterology (GI) and GI surgery, neurology and neurosurgery, pulmonology and lung surgery, heart failure, heart attack, stroke, back surgery, hip replacement, chronic obstructive pulmonary disease (COPD), and pneumonia.

Chester County Hospital Named One of America's 50 Best Hospitals by Healthgrades

Healthgrades recently recognized Chester County Hospital as one of America's 50 Best Hospitals for 2023. This acknowledgment places Chester County Hospital in the top 1% of hospitals nationwide for consistently providing overall clinical excellence across a broad spectrum of conditions and procedures.

Penn Medicine Hospitals Awarded Spring 2024 "A" Hospital Safety Grade

Chester County Hospital was one of six Penn Medicine health system hospitals to receive an "A" grade for Spring 2024. The Leapfrog Hospital Safety Grade is the only hospital ratings program based exclusively on hospital prevention of medical errors and patient harm.

50 Top Cardiovascular Hospitals 2024

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

2024 AHA-GWTG Atrial Fibrillation Gold Quality Achievement Award
This award recognizes the hospital's consistency in quality and the provision of the latest evidence-based treatments for AFIB patients.

Accredited in 2023 as a Chest Pain Center with Primary Percutaneous Coronary Intervention
This distinction is awarded to heart and vascular teams focused on the efficient and effective care of acute coronary syndrome (ACS) patients.

The American College of Cardiology NCDR Chest Pain: MI Registry Gold Performance Achievement Award
This award recognizes Chester County Hospital's commitment and success in implementing a higher standard of care for heart attack patients. It signifies that Chester County Hospital has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology/American Heart Association clinical guidelines and recommendations.

CCH Receives National Recognition for its Commitment to Providing High-Quality Heart Failure Care
This award recognizes CCH's commitment to improving outcomes for patients with heart failure, meaning reduced readmissions and more healthy days at home.

The International Board of Lactation Consultant Examiners® (IBLCE®)
The IBCLC Care Award recognizes hospitals and community-based facilities that demonstrate their commitment to promoting, protecting, and supporting breastfeeding and the lactation consultant profession.

Vizient 2023, Bernard A. Birnbaum Quality Leadership Award, Complex Care Medical Centers - Top Performer
The Bernard A. Birnbaum, MD, Quality Leadership Award recognizes participating healthcare organizations in four cohorts through the Vizient Quality and Accountability Study, which measures performance on the quality of patient care in six domains: safety, mortality, effectiveness, efficiency, patient-centeredness, and equity. The study factors in measures from the Vizient Clinical Data Base and includes performance data from the HCAHPS survey and the CDC's National Healthcare Safety Network.

Press Ganey Human Experience Pinnacle of Excellent Award 2024
This award recognizes clients who have maintained consistently high levels of excellence over three years in patient experience, employee engagement, physician engagement, or clinical quality performance.

Impact of Prior Community Health Needs Assessment and Implementation

The 2022 CHNA and resulting three-year implementation plan identified multiple priorities and actions to address our community's health needs. Highlights of the impact of this plan over the past two years include the following:

Access to Primary and Specialty Care

- Provided care for 13,604 uninsured and underinsured patients in the Chester County Hospital OB/Gyn Clinic.
- Identified 2,974 patients eligible for primary and specialty care in-home visits in collaboration with Penn Medicine at Home providers.
- Provided free screenings, labs, and diagnostic radiology services for underserved populations referred by community partner agencies.

Chronic Disease Prevention and Management

- Facilitated 1,422 chronic disease prevention and management wellness and health education programs for 35,084 participants.
- Hosted 336 chronic disease management support group meetings for 2,170 participants.
- Provided 88 blood pressure and cardiovascular risk screenings for 1,390 participants.

Culturally and Linguistically Appropriate Care

- Provided 14,232 hours of clinical and non-clinical interpretation for a broad range of languages.
- Provided gestational diabetes counseling to 108 Spanish-speaking patients using a bilingual diabetes educator.
- Provided 1,000 Spanish-speaking expectant parents with culturally appropriate printed materials.

Food Access

- Collaborated with the Chester County Food Bank to create an on-site food pantry which provided food for the households of 1,170 OB/Gyn Clinic patients with food insecurity.
- Provided resources and community education programs on food insecurity in collaboration with the Chester County Food Bank.

Healthcare and Health Resources Navigation

- Provided free transportation to 3,364 cancer treatment patients.
- Aided 3,610 patients with transitions in care through Penn Partners in Care nurse care managers in each Penn primary care practice.
- Followed up with 72,640 discharged patients via the Penn Medicine Connects program.

Mental Health Conditions

- Created the Behavioral Health service line to streamline and enhance processes to meet the needs of patients with mental health concerns.
- Provided free suicide prevention training (Mental Health First Aid, Youth Mental Health First Aid, and QPR– Question, Persuade, Refer) for community members and hospital staff.
- Collaborated with community and faith-based organizations (CFBOs) to identify community mental health needs, and provided programs to meet those needs.

Racism and Discrimination in Healthcare

- Promoted staff educational forums aligned with diversity recognition awareness months (e.g., Black History, AAPI, Pride, and Hispanic Heritage).
- Reported on stratified health outcomes metrics (e.g., length of stay, mortality, readmission rates) using Race, Ethnicity, Ancestry, and Language (REAL) data. Reported outcomes to the CCH management team and Community Advisory Board meetings.
- Provided multiple staff training modules on racism, discrimination, diversity, equity, and inclusion.

Substance Use and Related Disorders

- Provided support to 672 patients seen by a Certified Recovery Specialist (CRS) through the Community Outreach & Prevention Education (COPE) program.
- Provided eight community education programs on substance use disorder.
- Provided naloxone nasal spray (Narcan®) upon discharge to patients at risk for an opioid emergency or overdose (1,004 outpatient prescriptions written, 341 prescriptions dispensed by hospital pharmacy).

Service Area Demographics

ESTIMATED POPULATION

439,614

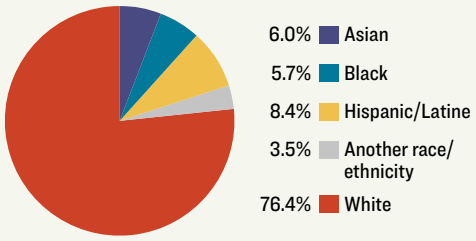
MEDIAN HOUSEHOLD INCOME

$123,608

NOT FLUENT IN ENGLISH

2.1%

RACIAL COMPOSITION



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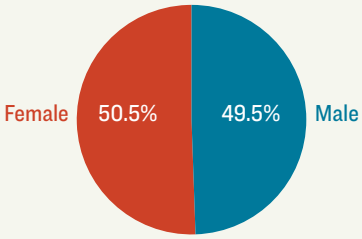

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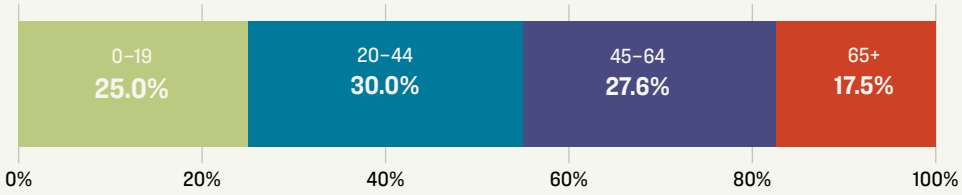


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Chester County Hospital defines its service area as the ZIP codes that attract the highest market share, as well as those that contribute greater than 4 percent of inpatient volumes or are contiguous to ZIP codes that meet that criteria.

ZIP codes: 19311, 19316, 19317, 19319, 19320, 19330, 19335, 19341, 19342, 19343, 19344, 19348, 19350, 19352, 19355, 19358, 19362, 19363, 19365, 19367, 19372, 19374, 19375, 19380, 19382, 19390, 19425

St. Christopher's Hospital for Children

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
188*	299	5,040	345,000	60,000

* Includes Neonatal Intensive Care 38-bed Unit (one of four NICUs in the state designated Level IV—the highest level of distinction)

MISSION

Provide a full range of high-quality healthcare services to all children and youth up to age 21 who seek our care or who are referred to us.

VISION

Our long-term vision is to be the best children's medical center by attaining excellence in patient care, education, and research. We are committed to providing high-quality, family-centered care in a collaborative, nurturing manner and in an environment that reflects the communities we serve and culturally diverse environment. We will continue to value, attract, and retain the best people while satisfying our mission through the use of state-of-the-art technological advances in research and constant innovation.

VALUES

Everything we do — every conversation, recommendation, and decision — is grounded in our values:

- Reverence for life, health, and independence
- Integrity, sensitivity, fairness, and justice
- Respect for all and inclusion as a source of strength
- Collegiality and compassion
- Accessibility to health care with dignity for all, especially for those who are unable to pay
- Pursuit of excellence and continuous improvement

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

St. Christopher's Hospital for Children

HISTORY

St. Christopher's was founded in 1875 as a charitable ambulatory clinic for a working-class neighborhood at a time of acute infectious disease and no public assistance. Social service and community outreach were an important part of St. Christopher's mission from day one, when volunteers visited families in their homes to offer support for nutrition, hygiene, and more.

St. Christopher's offers nationally recognized programs and more than 220 pediatric specialists who provide exceptional care to children throughout the Greater Philadelphia region and beyond. St. Christopher's provides primary pediatric care and a wide range of pediatric specialties and sub-specialties at its main campus and seven satellite locations. St. Christopher's is home to many programs and centers, including our:

- Pediatric Emergency Services including a Level I Pediatric Trauma Center
- Level IIIC Neonatal Intensive Care Unit
- Pediatric Intensive Care Unit
- Pediatric Burn Center
- Pediatric Dialysis Center and Kidney Transplant Program
- Oncology/Infusion Center and Bone Marrow Transplant Unit
- Center for the Urban Child
- Adolescent Medicine and Family Planning Center
- Center for Children and Youth Special Health Needs

St. Christopher's serves those in need, turning no one away. An essential focus of St. Christopher's is to provide the highest level of pediatric healthcare while connecting families to other essential services, especially valuable for those in the nearby economically challenged neighborhoods. St. Christopher's offers an array of resources—behavioral health, legal support, nutritional and parenting guidance, lactation consultation, and much more. Additionally, the hospital distributes a host of essentials, such as Thanksgiving turkeys, diapers, baby formula, clothing, and fresh food and other staples from our community refrigerator and pantry.

ACCOLADES RECEIVED

St. Christopher's has received numerous awards and recognition. The hospital is now a three-time recipient of the Leapfrog Top Hospital award, widely acknowledged as one of the most competitive honors American hospitals can receive. Plus, the hospital is a four-time recipient of the Magnet recognition from the American Nurses Credentialing Center, pointing to nursing excellence and quality patient outcomes. Approximately 9% of hospitals have this designation, and fewer have earned it multiple times. Other recognitions include:

- America's Best Children's Hospitals for Orthopedic Care by Newsweek Magazine (2024)
- America's Best Children's Hospital for Emergency Care by the Women's Choice Award® (2019)
- Best Children's Hospital by the Women's Choice Award® (2019)
- Pennsylvania Pediatricians of the Year, Norrell Atkinson Pediatrician, MD (2024) and Renee M. Turchi, MD, MPH, FAAP (2017), by the Pennsylvania Chapter of American Pediatrics.

In the 2024 Philadelphia Magazine list, 29 of St. Christopher's doctors were named "Top Doctors."

PARTNERSHIPS AND AFFILIATIONS

St. Christopher's is a partnership of Tower Health and Drexel University and maintains affiliations with Temple University School of Medicine and Albert Einstein Medical Center. These relationships strengthen our mission as a teaching hospital, helping to train the next generation of leaders in pediatric medicine.

We train undergraduate and graduate nursing students from several colleges and universities, including Drexel University, Villanova University, Thomas Jefferson University, Holy Family University, and LaSalle University.

Impact of Prior Community Health Needs Assessment and Implementation

St. Christopher's Hospital for Children's 2022 CHNA identified the following key health issues:

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

St. Christopher's serves some of the most economically under-resourced neighborhoods in the country, and we are committed to meeting their needs by combatting food insecurity, supporting those affected by gun violence, connecting families to legal support, mitigating stress, and more. Building on the vital work that has been long underway, St. Christopher's Hospital for Children places an unrelenting focus on actions to continually improve health and quality of life for its community residents.

Access to Equitable Care

St. Christopher's Hospital for Children works to better understand the contributing factors that impede access to equitable care and to address identified barriers and gaps in the provision of health care and services. Over 85% of the patients served at St. Christopher's are covered by Medicaid. More than 8,000 patients are screened annually through **Social Determinants of Health (SDOH) screeners** to help us to better understand individual family needs. In response, St. Christopher's has deployed **Community Health Workers** to provide navigation services and serve as a health and social services liaison for eligible patients and their families in clinics, inpatient and outpatient care. The **Ronald McDonald House Charities Dental Van** serves as a full service dental home for 2,300 children annually and makes care accessible at schools and recreation centers. Each year 90 School District of Philadelphia high school students participate in the **Health Tech School-to-Career Program** and the **Shadowing Health Tech Program** that increases access to and awareness of healthcare careers. Annually for the last 14 years, St. Christopher's hosts an **Annual Carnival** with food, fun, community resources and school supplies and backpacks for 4,000 members of the North Philadelphia Community. St Christopher's coordinated and provided free transportation for over 2,000 eligible families to and from appointments through the RideHealth platform.

Behavioral Health

Access to behavioral health services for children is in a state of crisis nationwide. St. Christopher's is building a more effective, accessible, and inclusive care model in which behavioral health is central, by integrating the screening, assessment, and treatment of behavioral health disorders within all aspects of physical health care. Access to behavioral health staff within this integrated model leads to a seamless and supportive transition from physician to behavioral health provider, limiting redundancy and challenges with follow-through when referrals are made to off-site behavioral health providers.

The roots of many mental health, substance use, and behavioral problems that contribute to morbidity and premature death develop during early childhood and adolescent years. A focus has been placed on providing **Integrated Behavioral Health in Specialty Care and Primary Care (InCK)**. Integrated Care for Kids is a Centers for Medicare and Medicaid model designed to improve child health and reduce avoidable inpatient hospitalizations and out-of-home placements.

The InCK program is staffed by an interdisciplinary care team that works in partnership with the primary care teams in the Center for the Urban Children, and the Center for Children and Youth with Special Healthcare Needs and is expanding into the Adolescent Medicine Practice. This team includes Community Behavioral Health Clinical Care Managers, who work onsite with St. Christopher's Behavioral Health Care Navigators and clinical psychologists, to screen for social determinants of health, child behavioral health or developmental concerns, and unmet parental behavioral health needs. Families are provided onsite resources to address SDOH as well as onsite behavioral health services to engage children and adults with unmet behavioral health needs. The program also engages community partners, including a medical legal partnership and parent advocacy groups, to assist with educational supports. Since its inception, the InCK program has received over 4,000 referrals.

St. Christopher's Hospital for Children

Over 1,000 patients are receiving behavioral health services through pediatric gastroenterology, endocrinology, child protection, and nephrology. A new **Sensory Adapted Dental Program** was created to enhance oral care for children with autism spectrum disorders. The Center for the Urban Child offers **Parent-Child Interaction Therapy (PCIT)** to support children with behavioral health needs. St. Christopher's has partnered with Elwyn and Easter Seals to provide **Early Intervention for children ages 3-5, and autism evaluations** to limit gaps in care and ensure continuity of intervention services. **Patient- Family Support Groups** are hosted by the Burn Center, NICU and Oncology Departments.

St. Christopher's also has recruited its second cohort of psychology residents which fosters access and education. In addition, St. Christopher's provides inpatient and outpatient psychiatry services which will continue to expand to support the Tower Health child adolescent psychiatry fellowship program.

The hospital increased the number of **Schwartz Rounds**, a multidisciplinary forum for caregivers to discuss social and emotional issues that arise in caring for patients. The hospital's deep commitment to improving access to behavioral health services resulted in an **Integrated Primary Care (IPC) Rotation** and a **Neurodevelopmental Assessment Rotations** for interns and externs.

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.

The **Reach Out and Read Program** which is integrated throughout the inpatient and outpatient practice distributes thousands of books each year to the patients in the community.

Having access to health education programs which help people better understand how to manage an existing health condition and prevent further illness is paramount to good health. St. Christopher's has created and supported Gun Violence Prevention Programs, including **distributing gun locks** at the Center for the Urban Child, conducting **Stop the Bleed Trainings**, and hosting a **Gun Violence Prevention Forum**. More than 100 young people participated in **HIV and STI screenings** at community events. The Adolescent Medicine Department offers free sexual and reproductive health services to more than 2,000 patients a year.

St. Christopher's is active in community outreach and education, including **Period of Purple Crying Program**, an evidence-based education program to prevent shaken baby syndrome/abusive head trauma. The hospital attended health fairs during **Black Breastfeeding Week** to promote benefits of breastfeeding. Two lactation consultants provide on-site services to over 400 families each year to support breastfeeding services. More than 300 families per year attend **Car Seat and Crib Safety Training**.

St. Christoper's also recognizes that access to nutritious foods is a daily challenge for many patients. The hospital provides **food pantry** services to hematology and oncology patients and families. The hospital is a **summer meals site** and distributes 8,000 meals annually. The **Mama-Tee's Community Fridge** is new project that gets fresh healthy food to children and families in need. The **onsite WIC office** provides and supports services for the community and supports the food, formula and needs of families on campus and in the North Philadelphia Community.

Health Equity

Just as the health care sector has expanded its focus beyond illness treatment alone to addressing social determinants of health, the hospital also recognizes that there are complex forces and systems that shape the conditions of our daily lives and impact health outcomes. Likewise, we must expand our perspectives and heighten our understanding to address health inequities. In response, we collectively established and convened a **Health Equity Council** that has created a **Health Equity Assessment, Transformation Action Plan and Health Equity Dashboard**. The dashboard was developed as a tool for transparent accountability in health equity. **Parent Advisory Councils** convene for hospital inpatient families, those served by the Center for Children and Youth with Special Healthcare Needs and the Hematology Clinic. St. Christopher's has focused on **expanding language access** through in-person and virtual language interpretation services.

In order to continue the high quality patient care and communication we offer to families, bilingual staff have the opportunity to be certified as proficient in another language via **ALTA Language Services**. Forty five providers have been certified in the first two years. Almost 70% of certifications were completed for Spanish, one of the nine languages that were represented with the certifications.

St. Christopher's Hospital for Children

Service Area Demographics

ESTIMATED POPULATION

476,621

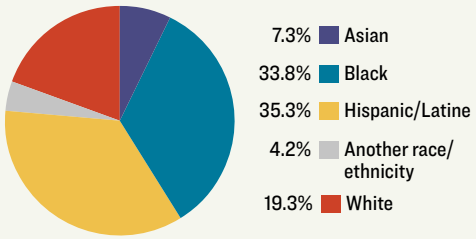
MEDIAN HOUSEHOLD INCOME

$44,214

NOT FLUENT IN ENGLISH

19.5%

RACIAL COMPOSITION



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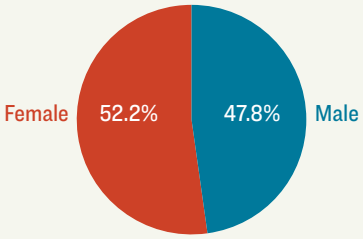

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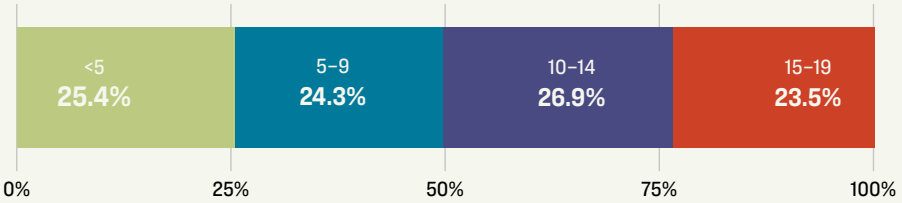


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

St. Christopher's Hospital for Children defines its targeted service area for community benefit as the 9 ZIP codes representing where approximately 40% of ambulatory patients reside. The North Philadelphia region is St. Christopher's primary service area. SCHC provides services in Montgomery County, Bucks County, Berks County, throughout Philadelphia and in Southern New Jersey.

ZIP codes: 19111, 19120, 19124, 19132, 19133, 19134, 19135, 19140, 19149.

Chestnut Hill Hospital

Temple Health

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
148	350	8,058	89,852	45,353

Temple Health—Chestnut Hill Hospital (CHH) is a 148-bed freestanding, licensed acute care community hospital under a not-for-profit company owned and controlled, since January 2023, by an alliance comprising Temple Health (which has 60 percent ownership of CHH), and Redeemer Health and Philadelphia College of Osteopathic Medicine—each with 20 percent ownership. This cooperative relationship strengthens the community hospital while bringing additional expertise, networks and academic support to its employees, physicians and patients.

Serving its community for more than 100 years, CHH has more than 350 board-certified physicians offering inpatient and outpatient services including emergency care, minimally invasive laparoscopic and robotic-assisted surgery, cardiology, gynecology, oncology, pulmonology, orthopedics, primary care practices, two Women's Centers, and an off-site physical therapy center.

Temple Health continues to add new academic-level specialty services to CHH, strengthening access to the world-class care of a university health system in a community setting close to home.

Temple Health

Chestnut Hill Hospital

Advanced cancer care is now available at CHH by Fox Chase Cancer Center specialists focusing on breast cancer, plastic surgery, urology, and access to innovative clinical trials. Specialists from the Fox Chase—Temple Urologic Institute offer comprehensive care for oncologic and non-oncologic conditions including subspecialties like urogynecology and prostate care. CHH is one of the few regional locations offering Aquablation, a minimally invasive treatment for enlarged prostate with fewer side effects. Fox Chase infusion services are also now available at CHH.

Temple Lung Center at CHH offers specialized care to patients with complex conditions such as COPD and Interstitial Lung Disease (ILD) and offers access to cutting-edge clinical trials. The Center's Thoracic Surgery team provides state-of-the-art treatments for common and rare conditions such as lung cancer, and thoracic outlet syndrome. Renowned for treating high-risk and complex cases, the team collaborates closely with Temple's Digestive Disease Center and Fox Chase Cancer Center to offer advanced, personalized cancer treatments.

Temple's Vascular & Endovascular Surgery Program offers advanced, minimally invasive treatments at CHH for vascular disease and specializes in open, hybrid, and endovascular techniques to repair arteries and veins, restoring circulation.

The Temple Neurology Program at CHH provides advanced, personalized care for complex brain, spinal cord, and nervous system disorders. The program is also a Certified Comprehensive Stroke Center, recognized for providing top-tier care from diagnosis to rehabilitation.

Temple's experienced gynecologists at CHH provide comprehensive care to support women's health at every stage of life including well-woman exams, family planning, menopause management, and cancer screenings. The team is skilled in treating various conditions including abnormal pap smears, endometriosis, menstrual disorders, and urinary issues. When surgery is needed, they utilize the latest minimally invasive and robotic techniques for procedures like hysterectomies and fibroid removals.

Temple Ophthalmology at CHH focuses on early diagnosis and treatment and offers services including cataract surgery, glaucoma treatment, and retinal procedures.

Premier Orthopaedics at CHH offers comprehensive care for bone, muscle, and joint conditions. The board-certified specialists treat various issues, including arthritis, extremity injuries, sports medicine, spine disorders, fractures, and ligament or tendon damage.

CHH's Senior Behavioral Health Unit is a 20-bed inpatient facility led by experienced psychiatrists and psychiatric nurse practitioners, and dedicated to older adults requiring short-term care for conditions including depression, psychosis, bipolar disorder, and anxiety.

Impact of Prior Community Health Needs Assessment and Implementation

In CHH's 2022 CHNA, four areas of focus were prioritized based our community's greatest needs:

1. Access to Equitable Care
2. Behavioral Healthcare Access
3. Health Education and Prevention

CHH's Implementation Strategy includes goals and strategies on how to address and solve these key findings from the CHNA. See the complete strategy here: https://www.templehealth.org/locations/chestnut-hill-hospital/about/community-health

Below is a summary of the steps taken since the 2022 CHNA to meet community health needs:

- **Actions to Increase access to equitable care:**
  - We provided patients with free transportation to and from the hospital via UberHealth.
- **Actions to increase behavioral healthcare access:**
  - We developed and filled new position of Nurse Practitioner for our behavioral health team.
  - We trained staff in crisis management.
- **Actions to strengthen health education and prevention:**
  - Outside the hospital walls, we facilitated support groups focused on healthy living.
  - We partnered with local schools to provide health education to students and their caregivers.
  - We strengthened our community outreach efforts through health education and screenings at events in our neighborhoods.
  - We partnered with local nonprofits that address social determinants of health in our community such as Mt. Airy Community Development Corporation, Fact to Face and Meals on Wheels.

Service Area Demographics

ESTIMATED POPULATION

280,048

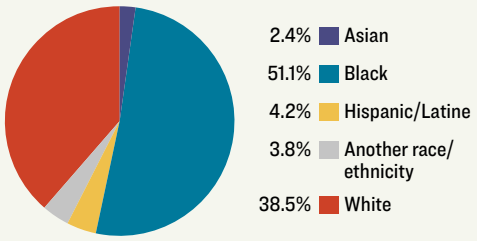
MEDIAN HOUSEHOLD INCOME

$74,876

NOT FLUENT IN ENGLISH

0.7%

RACIAL COMPOSITION



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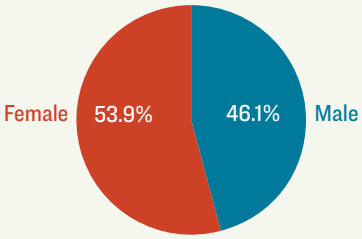

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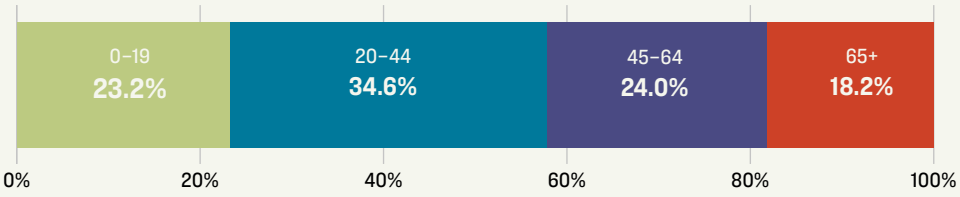


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Temple University Hospital's primary service area is comprised of 11 zip codes: 19031, 19038, 19118, 19119, 19128, 19138, 19141, 19144, 19150, 19444 and 19462. These are the zip codes from which about 70% of our patients seen on an inpatient and observation basis reside.

Fox Chase Cancer Center

Temple Health

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
100	141	3,554	125,461	5,122

MISSION:

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

Fox Chase Cancer Center is committed to excellent clinical outcomes, foundational research expertise, and community outreach and engagement. The center was one of the first to receive comprehensive designation from the National Cancer Institute in 1974 as a combination of the American Oncologic Hospital (1904) and the Institute for Cancer Research (1927). Fox Chase joined Temple University Health System in 2012, which further expanded its research and treatment expertise and accomplishments.

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

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

Temple Health

Fox Chase Cancer Center

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

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

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

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

Fox Chase's *Marvin & Concetta Greenberg Pancreatic Cancer Institute* is another asset of a center committed to achieving breakthroughs in early detection and treatment. The Pancreatic Cancer Institute features collaboration between Fox Chase scientists, researchers, and physicians. The institute's vision includes finding new ways to detect cancer earlier, extend the lives of pancreatic cancer patients, and to eventually find a cure. Fox Chase has also been designated a National Pancreas Foundation Center by the National Pancreas Foundation, a nonprofit organization that provides support for patients with pancreatic cancer and other pancreas-related diseases. Fox Chase is the only institution in the Philadelphia region to earn this designation.

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

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

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

Fox Chase recognizes that the beginning of its compassionate culture begins with cultivating interest among young adults in STEM programs. Under the Immersion Science Program, Fox Chase established classroom laboratories in 11 Philadelphia schools with support from the Howard Hughes Medical Institute. The program enhances the science and math foundation of participants, thus building confidence and preparing students for rigorous science, technology, engineering, and math majors. Of the 1,000 students who benefit from the program annually, 80% are from the School District of Philadelphia; 75% receive paid positions in research labs as undergraduates and 22% become published authors prior to college graduation.

NOTABLE RECOGNITIONS

The special brand of care offered at Fox Chase has earned it widespread recognition. Fox Chase doctors are consistently ranked among the best in their specialties in Philadelphia Magazine's Top Doctors list, and the center's nursing teams have received the Magnet designation for excellence in nursing services by the American Nurses Credentialing Center's Magnet Recognition Program. Fox Chase is the first in Pennsylvania and first acute specialty hospital in the United States to receive Magnet status. Fox Chase programs are frequently recognized for excellence among their peers. For two years in a row, the Fox Chase Bone Marrow Transplant Program's performance for one-year survival has been above the expected survival rate when compared to similar programs in the United States. It is the only center with this distinction in the tristate area of Pennsylvania, New Jersey, and Delaware.

Impact of Prior Community Health Needs Assessment and Implementation

As a result of Fox Chase's 2022 Community Health Needs Assessment, the center strategically focused on the following three (3) priority areas:

1. Enhance Cancer Care Access:

Community members identified healthcare access as a major health need in the 2022 Community Health Needs Assessment. Barriers to specialty and primary care and cancer screening include lack of neighborhood providers, medical insurance, transportation, and health education and information; affordability, language/cultural barriers, misinformation, and fear of cancer diagnosis and treatment. In response, Fox Chase is increasing the availability of community cancer screening services to underserved communities. The center's Community Screening Program provides community-based breast cancer and other types of screening through the Mobile Screening Unit (MSU). The MSU helps ensure access to care among the medically underserved populations that may have many barriers to obtaining proper health care, including a lack of health insurance. Patients screened on the MSU also receive healthcare navigation services for follow-up services if needed or if they have financial, language, transportation, or other barriers. Lastly, Fox Chase is working to increase access to research/clinical trials opportunities, especially among high-risk, understudied populations.

2. Lower Burden of Chronic Disease:

Fox Chase delivers evidence-based cancer education and resources to address the regional cancer burden. Fox Chase has also developed bilingual cancer education materials to strengthen outreach to the many communities we serve. Additionally, Fox Chase has enhanced their evidence-based smoking cessation services to reduce community's tobacco use. One example of this is the Community Tobacco Treatment Program. This four-week smoking cessation program is delivered by a health educator with a national certificate in tobacco treatment practice and a certified nurse practitioner. This program was brought into community partner sites in underserved areas where smoking rates are high to help address barriers to seeking cessation counseling.

3. Increase Behavioral Health Support:

Fox Chase addresses mental health concerns among patients and caregivers through support groups and a telephone-based network. The Patient-to-Patient/Caregiver Network is a telephone-based support program that connects trained survivors/caregivers to new patients/caregivers. In addition, Fox Chase provides evidence-based mental health services for patients with anxiety, depression, fear of recurrence, insomnia, chronic pain and end of life distress. Fox Chase is also working to increase the community's awareness of behavioral health services and resources available at Fox Chase and in the community.

Service Area Demographics

ESTIMATED POPULATION

2,320,434

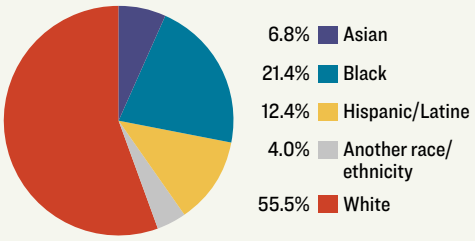
MEDIAN HOUSEHOLD INCOME

$85,006

NOT FLUENT IN ENGLISH

3.4%

RACIAL COMPOSITION



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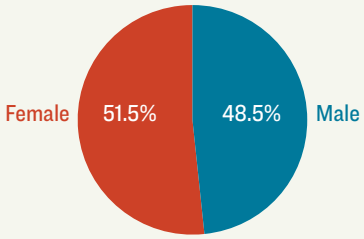

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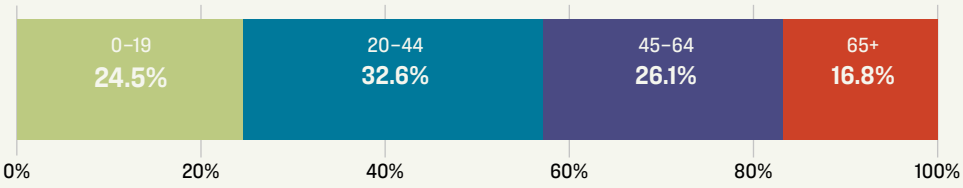


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Fox Chase Cancer Center's primary service area is comprised of the following zip codes: 18901, 19111, 19115, 19116, 19120, 19152, 19149, 18966, 18974, 19114, 19046, 19136, 19020, 19124, 19006, 19138, 19150, 19154, 19053, 19027, 19038, 19135, 19047, 19446, 19002, 19067, 19140, 19141, 19040, 19128, 18940, 18976, 19134, 19144, 19454, 19403, 19090, 19126, 19119, 19044, 19422, 19401, 18914, 19132, 19007, 19001, 19054, 19426, 19012, 18938, 19056, 18954, 19464, 19438, 18944, 19444, 19057, 19021, 19075, 19131, 19025, 18902, 19125, 18951, 19462, 19118, 19121, 19473, 19031, 19137, 19095, 19030, 18964, 19440, 19133, 18929, 19034, 19055, 19009, 19129, 19428, 19406, 19004

Temple University Hospital

Temple Health

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
890	840	34,048	600,000+	159,866

MISSION:

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

ABOUT TEMPLE UNIVERSITY HOSPITAL

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

Temple University Hospital's commitment to healthcare excellence for all is at the core of everything we do. From expanding access points and preventive health programs to addressing social determinants of health and workforce development focused on socioeconomic, educational, and geographic disparities, our efforts are driving quality outcomes for the communities we serve.

Temple Health

Temple University Hospital

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

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

As our chief clinical teaching site, Temple University Hospital has 48 accredited medical specialty residency programs training over 765 medical residents and fellows each year. Our medical residency programs focus on the "human side" of medicine, teaching residents to treat the whole patient by considering the cultural experiences and communities of those served. Residents enhance their clinical education by engaging in service projects benefiting our communities, preparing them to care for a wide range of populations and health conditions.

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

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

Temple Health

Temple University Hospital

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

Temple Heart & Vascular Institute

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

Temple Lung Center

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

Transplant Program

Temple University Hospital has a 40-year history of excellence in organ transplantation, having performed Philadelphia's first heart transplant in 1984. Today, we have transplant programs for lungs, livers, kidneys, and pancreases, and bone marrow with excellent results. Our transplant teams have pioneered methods to improve organ donor health and avoid post-transplant complications.

Digestive Disease Center

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

Neurosciences Center

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

Orthopaedics & Sports Medicine

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

Temple Health

Temple University Hospital

NOTABLE AWARDS & DISTINCTIONS

Our commitment to improving lives through healthcare access and clinical excellence drives our organization forward. It's one of the reasons TUH was named one of the most socially responsible hospitals in the nation by the Lown Institute, ranking in the top 2%, and earning 'A' grades for community benefit, inclusivity, clinical outcomes, patient safety, avoiding overuse, and cost efficiency.

Temple University Hospital recently earned its 7th Safety Grade 'A' from Leapfrog, a national quality award for Stroke Care from the American Heart Association, and recognition by Healthgrades with the 2024 Patient Safety Excellence Award, putting TUH in the top 10% of hospitals nationwide for patient safety.

Impact of Prior Community Health Needs Assessment and Implementation

In TUH's 2022 CHNA, six areas of focus were prioritized based our community's greatest needs:

1. Behavioral Health Conditions
2. Substance Use and Related Disorders
3. Chronic Disease Prevention, Management and Access to Care
4. Address Healthcare Disparities
5. Social Determinants of Health
6. Community Violence

Through a collaborative process with community stakeholders, TUH developed an implementation plan with strategies, goals and programs to address community needs including those described in our Community Benefit Report. See: https://www.templehealth.org/locations/temple-university-hospital/about/community-health. Additional programs developed since the 2022 CHNA include the following innovative programs to improve outcomes and advance health equity:

Women & Families Campus Opening: This new campus is the Philadelphia region's only hospital dedicated to women and family health. Our physician practices include obstetrics, gynecology and pediatrics. We also offer outpatient diagnostic imaging. Inpatient services are beginning in 2025.

Emergency Department Expansion: We expanded the Emergency Departments of our Episcopal and Jeanes Campuses to significantly enhance access to Temple's high-quality care.

Outpatient Substance Use Disorder Clinic: Our comprehensive licensed outpatient Substance Use Disorder Clinic treats patients with both addiction and behavioral health diagnoses. This clinic offers coordinated Certified Recovery Specialist support and flexible walk-in appointments for seamless warm handoffs.

Crisis Response Center Expansion: To meet our community's growing need for behavioral health care, we tripled the size of the Crisis Response Center located at our Episcopal Campus.

Hospital to Housing: Temple Health has been a key partner in the Estadt-Lubert Collaborative with Project Home which emphasizes the transition from hospital to housing for people who are experiencing homelessness and opioid use disorder.

Healthy Together Hub: Through our mobile outreach program, we address undiagnosed chronic conditions such as diabetes and hypertension. In collaboration with Temple University's schools of medicine, pharmacy, and public health, we offer a wide range of services for our community. We address social drivers of health by connecting community members with transportation, food, housing and more.

Community Advisory Council: Representing the neighborhoods we serve, community leaders offer unique perspectives to hospital leadership with the goal of reducing health disparities and increasing access to care.

Multi-Visit Patient Clinic: Provides a full continuum of care for patients with high emergency department use and frequent inpatient admissions. Community Health Workers link patients with follow-up healthcare, meals, transportation, and other social supports. The clinic offers expedited diagnostic workups for potential cancer findings, with a navigator assigned for care coordination and support during the diagnostic journey.

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

Service Area Demographics

ESTIMATED POPULATION

620,684

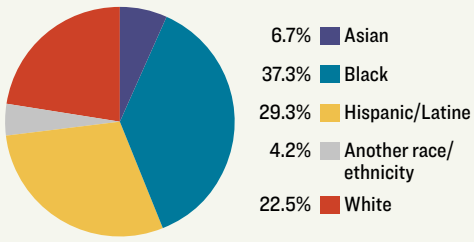
MEDIAN HOUSEHOLD INCOME

$46,728

NOT FLUENT IN ENGLISH

9.3%

RACIAL COMPOSITION



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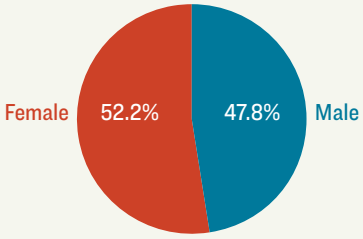

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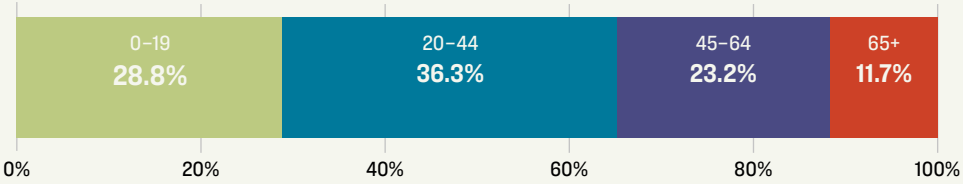


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Temple University Hospital's primary service area is comprised of 14 zip codes: 19111; 19120; 19121; 19122; 19124; 19125; 19129; 19132; 19133; 19134; 19135; 19140; 19144 and 19149. These are the zip codes from which about 68% of our patients seen on an inpatient and observation basis reside.

Trinity Health Mid-Atlantic

Trinity Health Mid-Atlantic

Trinity Health Mid-Atlantic includes Mercy Fitzgerald Hospital, Nazareth Hospital, St. Mary Medical Center & St. Mary Rehabilitation Hospital

PROMISE

Trinity Health Mid-Atlantic is a Catholic, mission-driven organization focused on the health and well-being of our local communities. Convenience and access will be a differentiator and make THMA an indispensable partner for primary and secondary care. We will serve as the first step in the community care experience and use navigation resources and partnerships to further enhance convenience for our patients while creating linkages to other providers that enable access to a comprehensive care platform.

MISSION

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

WHO WE ARE Community hospitals imbedded in your neighborhood. We provide emergency services and specialty care, and are always there for you and your family for all your health care needs.

WHO WE HELP From emergency to specialty care to routine checkups, we are here for you.

WHY WE HELP We want to provide the best health care to you and your family. We are committed to care of the whole person, for all our patients.

Impact of Prior Community Health Needs Assessment and Implementation

Trinity Health Mid-Atlantic (THMA) Pennsylvania hospitals completed a comprehensive regional Community Health Needs Assessment (rCHNA) which was adopted by the Trinity Health Mid-Atlantic Board on May 26, 2022.

Trinity Health Mid-Atlantic's approach to addressing the needs of the community is through collaboration with community partners, community members, patients, internal and external stakeholders in which an investment of finances, staffing and in-kind support has given rise to transformational outcomes in mental health, food access & access to care and their root causes.

THMA has taken a regional collective impact approach to addressing the community needs of each hospital with local individual partners and strategies. The impact of this collaborative approach will advance the health equity outcomes of each community while promoting sustainability by utilizing best practices from each hospital. THMA has extended the reach of those initiatives throughout the Mid-Atlantic region to identify the root causes of social & health needs identified in the regional community health needs assessment. Trinity Mid-Atlantic will continue to evaluate these measures and outcomes to develop additional strategies to ensure a policy, system and environmental change addressing the needs.

The prior CHNA and Implementation Strategy were made available for public review electronically at:

https://www.trinityhealthma.org/assets/documents/community-benefit/chna-sfhc-implementation-

Printed copies were also available at St. Mary Medical Center, 1201 Langhornne-Newtown Rd, Langhorne, PA 19047.

The links on the website also include the federal IRS Form 990 tax return and an overview of Community Benefit. No written comments on the last CHNA and Implementation Strategy have been received.

Trinity Health Mid-Atlantic

Trinity Health Mid- Atlantic has reached target strategies for Mental Health Conditions, Food Access, and Access to Care across the region. Please find the outcomes below.

Mental Health Conditions:

1. Increase the percentage of BIPOC & LTGBQ+ youth diagnosed with a mental health condition receiving treatment once identified in school or in safety net clinics a rise in mental health referrals has brought the percentage well over 2% with a 10% rise in referral with treatment.
2. Increase the number of school & primary care facilities integrating mental health services with co-location especially within BIPOC and LGBTQ+ communities has been challenging with staffing constraints but co location continued with THMA having 8 sites with and potential to collocate in 4 additional.
3. Reduce the proportion of students in crisis through school-based mental health counseling and community initiatives with a community partner- 333 counseling sessions were conducted over the 2023 & 2024 school year in a Bucks County school.
4. Increase the number of referrals to the community medication assisted treatment program received 46 referrals.
5. Increase the number community-based organizations, ambulatory and clinical staff serving BIPOC & LGBTQ+ community members participated in simulation of poverty &/or Trauma informed care to 301 participants.
6. Increase awareness of 988 behavioral health resources and services in 100 community organizations was exceeded through coalition and community sharing of materials, strategies, and education to over 218 partners.

Food Access:

1. Decrease the number of food insecure community members in the black & brown neighborhoods with limited or no access to healthy food. Though the access to healthy foods seems to have improved with over 44,487 food encounters, the food security rate has gone unchanged.
2. Participate with collaborating health systems and community-based partners in shared learning around implementation strategies through the COACH Food Security workgroup to increase cross-sector organizational partners have successful created over 25 partners in the food access space.
3. Increase number of trusted food network partners within the community resource directory accepting food resource referrals has fluctuated over last several years most do not accept online referrals but require phone or in person application totaling 34 partners across the region.

Access to Care:

1. Increase the number of uninsured and underinsured persons receiving mobile health & social care through community initiatives 1967 encounters for FY23 & FY24 combined.
2. Increase community health worker integration into ambulatory and community settings with high volume of uninsured or underinsured from 1 to 8 currently across THMA region.
3. Increase number of Lyft rides to healthcare services & appointments for patients identified by THMA Care Coordination team by 2% annually. The total Lyft ride usage was over 2,100 for the PA hospitals in THMA.
4. Increase the number of translation and interpreter services used in ambulatory and community settings with high concentration of immigrant and refugee populations with a transition to new vendor interpretive services increased by over 40% across the region.

Service Area Demographics

ESTIMATED POPULATION

1,084,779

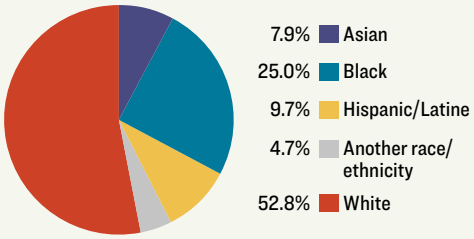
MEDIAN HOUSEHOLD INCOME

$75,943

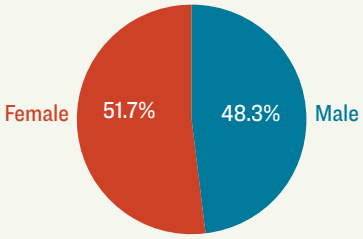
NOT FLUENT IN ENGLISH

2.4%

RACIAL COMPOSITION



SEX



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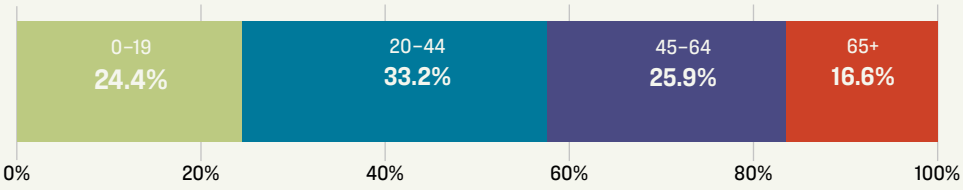


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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

ZIP codes: 18940, 18954, 18966, 18974, 18976, 18977, 19007, 19018, 19020, 19021, 19023, 19026, 19030, 19036, 19047, 19050, 19053, 19054, 19055, 19056, 19057, 19067, 19079, 19082, 19111, 19114, 19115, 19116, 19135, 19136, 19139, 19142, 19143, 19149, 19152, 19153

Nazareth Hospital

Trinity Health Mid-Atlantic | Nazareth Hospital

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
189	450	6,667	75,813	43,578

Since 1940, Nazareth Hospital has provided compassionate, high-quality care to residents of Northeast Philadelphia. Nazareth Hospital offers a variety of services to the community, including emergency care, cardiology, oncology, specialized geriatric care, orthopedics and wound care, among others.

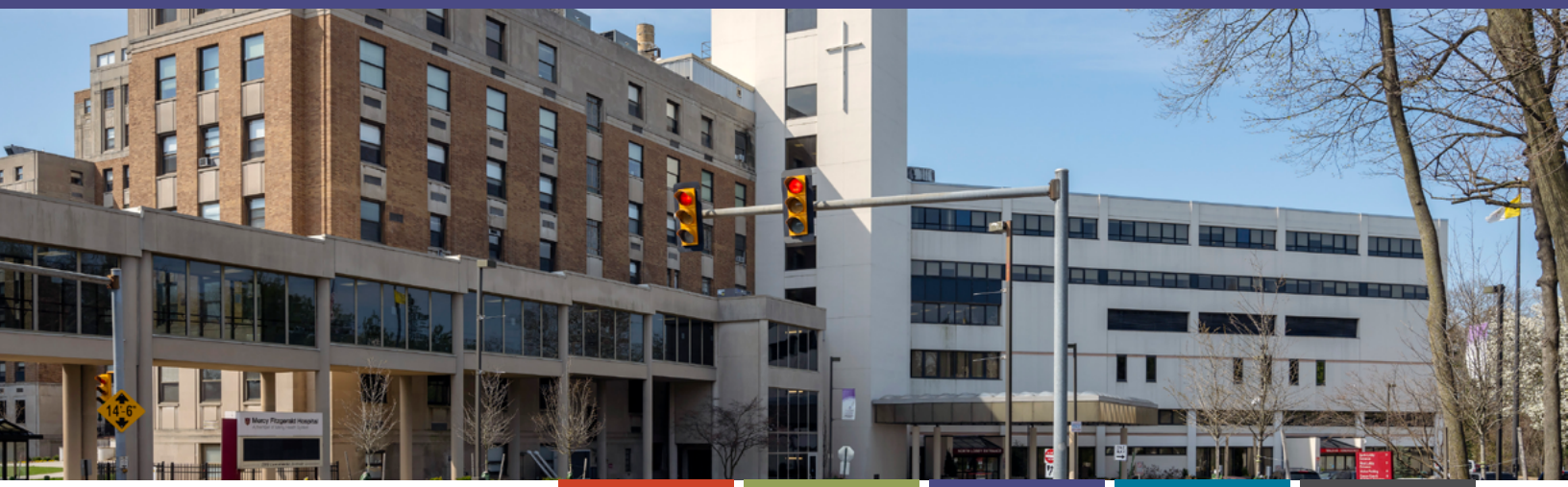
Founded by the Sisters of the Holy Family of Nazareth, the hospital's mission is to serve anyone who requires medical care regardless of religion, race, color, creed or economic status. Nazareth Hospital is consistently recognized by leading health care accreditors and insurers for the quality of care provided to patients.

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

AWARDS AND ACCREDITATIONS

- TJC Hospital Accreditation
- TJC Transitional Care Unit Accreditation
- TJC Disease Specific Heart Failure Certification
- TJC Disease Specific Primary Stroke Certification
- Intersocietal Accreditation Commission (IAC) Echocardiography Accreditation
- Corazon Service Line of Excellence designation for CathPCI, Chest Pain Center, and Electrophysiology programs.
- ACR Accreditation MRI (Head, Spine, Body, MSK, MRA) except breast
- ACR Accreditation CT (Head/Neck, Chest, Abdomen) including Cardiac
- ACR Designated Lung Cancer Screening Center
- ACR Accreditation Nuclear Medicine (Planar, Spect, Nuclear Cardiology)
- ACR Accreditation Ultrasound Obstetrical (1st and 2nd Trimester only), Gynecological, General, Vascular
- Mammography: ACR and MQSA (Mammography Quality Standard Acts, FDA certified)
- College of American Pathologist for Lab Services
- AHA -Get With the Guidelines for Stroke Gold Plus Elite – Target Diabetes Type 2 Honor Roll Award 2
- Hospital Association of Pennsylvania Achievement Award for Safety 2024

Mercy Fitzgerald Hospital



Trinity Health Mid-Atlantic | Mercy Fitzgerald Hospital

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
183	319	7,230	106,126	38,350

Located in Darby, Pa., Mercy Fitzgerald Hospital is an acute care community teaching hospital that has been serving a large number of economically fragile neighborhoods in Delaware County and Southwest Philadelphia since 1933. Since its founding, Mercy Fitzgerald's mission has been to help and heal patients through accessible, compassionate health care that is tailored to their needs.

Mercy Fitzgerald is home to cardiology services, comprehensive cancer care, bariatrics and ambulatory services, advanced diagnostic and interventional radiology, gastroenterology services including a heartburn clinic, an endoscopy center, wound care, acute inpatient rehabilitation, and physical and occupational therapy.

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

Mercy Fitzgerald Hospital is consistently recognized by leading health care accreditors and insurers for the quality of care provided to patients.

AWARDS AND ACCREDITATIONS

- The Joint Commission Accredited
- Leapfrog Spring 2024 C
- Primary Stroke Center Certification by the Joint Commission
- Three-year accreditation from the National Accreditation Program for Breast Centers (NAPBC)
- AHA Get With The Guidelines Gold Plus Quality •Achievement Award for Stroke since 2012
- AHA Get With The Guidelines Gold Plus Quality Achievement Award for Heart
- Environmental Protection Agency (EPA) Energy Star facility
- Wound Center of Excellence Certification
- Accredited Chest Pain Center with PCI by the Society of Cardiovascular Patient Care
- Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program by the American College of Surgeons (ACS) and American Society for Metabolic and Bariatric Surgery (ASMBS)
- Mercy Cancer Care accredited by The American College of Surgeons Commission on Cancer (CoC)
- Cardiac Rehabilitation Certification from the American Association of Cardiovascular and Pulmonary Rehabilitation
- American College of Radiology Accreditations for CT, MRI, Nuclear Medicine, Ultrasound, Breast Ultrasound, Mammography, Stereotactic Breast Biopsy and Breast MRI.
- Breast Imaging Center of Excellence and a Designated Lung Cancer Screening Center

St. Mary Medical Center

Trinity Health Mid-Atlantic | St. Mary Medical Center

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
373	746	16,023	205,125	50,109

Since 1973, St. Mary Medical Center has provided transformative, high-quality care to generations of families in Bucks County and nearby communities. St. Mary Medical Center offers a variety of services, including adult and pediatric emergency care, cardiology, oncology as an affiliate of Penn Medicine, orthopedics, maternity care, a full-spectrum of surgical services, and advanced non-invasive treatments, among others.

Founded by the Sisters of St. Francis, who opened the original, Philadelphia-based St. Mary Hospital in 1860, the Hospital relocated in 1973, answering the call to address a regional need for health services in Bucks County's most underserved area. St. Mary's mission is to serve the needs of the whole person physically, emotionally, and spiritually, with special commitment to those experiencing poverty. St. Mary Medical Center is consistently recognized by leading health care accreditors and insurers for the quality of care provided to patients.

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

AWARDS AND ACCREDITATIONS

- TJC Hospital Accreditation
- TJC Disease Specific Primary Stroke Certification
- TJC Disease Specific Hip & Knee Certification
- Intersocietal Accreditation Commission Echocardiography (IAC) Accreditation
- 2024 Gold Plus: Stroke Honor Roll Elite& Diabetes Type 2 Honor Roll from AHA/GWTG
- 2024 Gold Heart Failure AHA/GWTG
- Cancer Center accredited by ACOS (American College of Surgeons)
- NAPBC: National Accreditation Program for Breast Centers
- ACR (American College of Radiology) accredited in: Ultrasound, Nuclear Medicine, CT Scan, MRI
- Mammography: ACR and MQSA (Mammography Quality Standard Acts, FDA certified)
- Trauma Center accredited by the Pennsylvania Trauma Systems Foundation
- College of American Pathologist for Lab Services
- Association for the Advancement of Blood and Biotherapies
- Bariatric Center of Excellence accredited by MBSAQIP/ACS

Wills Eye Hospital

WillsEye Hospital

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
4	68	144	140,896	15,739

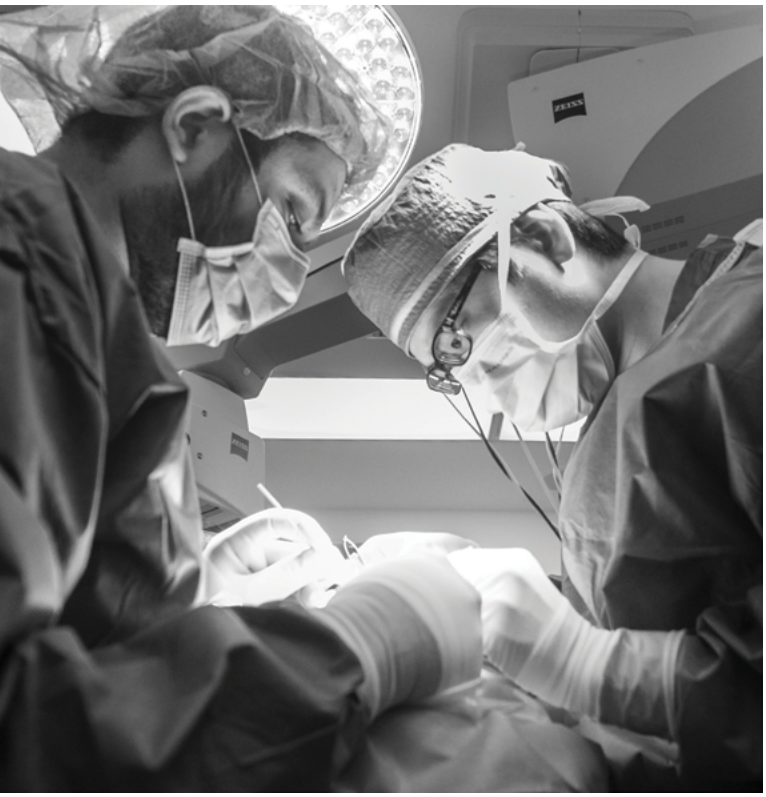
MISSION:

"Skill with Compassion", Wills Eye Hospital's long-standing motto, encapsulates the hospital's driving principle: to cure eye disease through state-of-the-art treatments and advancements in scientific knowledge while embracing empathy not only for each individual patient, but for entire communities in need.

HISTORY AND OVERALL PURPOSE

In 1832, Wills Eye Hospital was founded with the bequest of James Wills, Jr., a Quaker merchant, who left $116,000 in trust to the City of Philadelphia to establish a hospital or asylum for indigent blind and lame. In 1834, the first eye hospital in the world, Wills Eye Hospital, opened its doors. The establishment of Wills Eye Hospital played a vital role in instituting ophthalmology as a distinct branch of medicine in the United States and pioneering advances in the prevention and treatment of eye diseases.

The governing body of Wills Eye Hospital is the Board of Directors of City Trusts, which was established in 1869 by Pennsylvania legislature to administer all funds left in trust to the City of Philadelphia, including the bequest from James Wills, Jr. The Wills Eye Committee of the Board of Directors of City Trusts is responsible for overseeing all matters relating to Wills Eye Hospital and works closely with the Chief Executive Officer and Ophthalmologist-in-Chief on all policy, organizational changes, and major operational matters.



WILLS EYE FACILITIES AND CORE SERVICES

Today, Wills Eye Hospital's dedication to improving the vision health of all residents in Philadelphia and around the world is faithful to its founder's vision. Wills Eye Hospital is composed of 140,000 square foot facility that houses four inpatient beds, operating rooms, examination rooms, state of the art diagnostic testing facilities, an ophthalmic library, teaching facilities including a surgical training lab, research spaces and the Vickie and Jack Farber Vision Research Center.

Wills Eye Hospital provides primary and subspecialty eye care including clinical expertise in cataracts, cornea, glaucoma, retinal disease, neuro-ophthalmology, oculoplastic surgery, ocular oncology, pediatric ophthalmology, and ocular pathology. The breadth of clinical expertise and surgical capabilities makes Wills Eye Hospital a worldwide referral center.

- The **Cataract and Primary Eye Care Service** is the hub of Wills Eye. Approximately 22,000 patients are seen each year. Wills physicians perform routine eye exams and refer any serious complications to the hospital's subspecialty services. Each year thousands of patients also undergo cataract surgery at Wills Eye, benefiting from the experience of world-class surgeons consistently rated as America's best.
- The **Cornea Service** is a leading center for corneal transplants and the treatment of corneal diseases and conditions. More than 400 corneal transplants are performed at Wills Eye each year. In addition to corneal transplants, physicians in the Cornea Service diagnose and treat corneal dystrophies, abrasions, scars, congenital corneal problems and complex cataract surgery.
- The **Glaucoma Service** is the country's largest, and treats patients with the newest laser and surgical techniques, as well as drug therapies available. The Glaucoma Service Diagnostic Laboratory provides advanced computerized techniques to uncover the earliest signs of glaucoma in suspected patients. It also charts the progression of the condition, including the slightest change in the optic nerve, in patients who have already been diagnosed.

- The physicians on the **Neuro-Ophthalmology Service** have a long history of investigating and treating optic neuritis, thyroid-related eye disease, ischemic optic neuropathy, blepharospasm, and hemifacial spasm.
- The **Oculoplastics & Orbital Surgery Service** is one of the largest of its kind in the country. Oculoplastic surgery is a subspecialty of ophthalmology that focuses on problems surrounding the eyeball (the lids, the orbit and the lacrimal system). The service also includes a cosmetic surgery unit.
- The **Ocular Oncology Service**, one of the largest in the world, serves a large national and international patient population. The physicians are leaders in the diagnosis and treatment of ocular oncology, particularly melanoma and retinoblastoma, and have developed new techniques to save eyes that, in the past, would have been removed.
- The **Ocular Pathology Department** is the backbone of teaching at Wills Eye. It conducts ongoing research into the broad spectrum of ocular diseases. It features state-of-the-art technology, and is a center of activity for Wills Eye residents and fellows, as well as for Thomas Jefferson University medical students.
- The **Pediatric Ophthalmology Service** treats the unique ocular problems of children. This includes strabismus (crossed eyes) and amblyopia (lazy eye). Physicians also perform cataract surgery on infants as early as a few weeks old. The pediatric contact lens service at Wills Eye fits and stocks lenses exclusively for children.
- The **Retina Service** was the first subspecialty service at Wills Eye. Today, the Retina Service is one of the largest in the United States and an average of 15,000 patients are diagnosed and treated each year. All vitreoretinal diseases are treated at Wills Eye, including macular degeneration, diabetic retinopathy, uveitis, and retinitis pigmentosa.
- In partnership with Thomas Jefferson University Hospital, Wills Eye also operates one of the few 24/7 dedicated **Eye Emergency Departments**, treating almost 16,000 cases each year.
- Wills Eye's **Ophthalmology Training Programs** are recognized worldwide for setting the highest standard in the field. Our residency program consistently ranks as the best in the nation, with 24 residents (8 per year / 3 years) and 32 advanced clinical and research fellows. Wills Eye alumni hold key leadership positions in prestigious medical centers both in the U.S. and globally, reflecting the program's influence and reach. Additionally, Wills Eye's Online Knowledge Portal provides Continuing Medical Education credits to over 8,000 users across 141 countries, further expanding its impact on global ophthalmic education.

ACCOLADES RECEIVED

- **Top-Ranked Eye Care:** Wills Eye Hospital has been consistently ranked among the Top 2 Eye Hospitals by *U.S. News & World Report*.
- **Nation's Leading Experts:** Wills Eye is a frequent standout on Castle Connolly Medical Ltd.'s Annual Top Doctors list, boasting the highest number of "Top Docs" in Ophthalmology of any hospital nationwide.
- **Premier Residency Program:** Wills Eye's residency program, in partnership with the Sidney Kimmel Medical College at Thomas Jefferson University, is consistently recognized as the best in the nation, setting the standard in ophthalmic training.
- **Global Influencers in Ophthalmology:** Wills Eye physicians regularly earn spots on the "Power 100: World's Most Influential Ophthalmologists," underscoring their leadership and impact in the field.

PARTNERSHIPS AND AFFILIATIONS

Even though Wills Eye Hospital and Jefferson Health System are separate corporate entities and share no ownership or governance, they have had a strong partnership since 1972. Wills Eye Hospital is the Department of Ophthalmology for Sidney Kimmel Medical School at Jefferson University and is the home of the nationally top ranked residency program in Ophthalmology. Many of the Wills Eye physicians have duel medical staff appointments at Wills Eye Hospital and Jefferson Health and academic faculty appointments at Sidney Kimmel Medical School at Jefferson University, making it one of the largest and most productive academic departments of ophthalmology in the country.

Wills Eye also has many global partnerships through the Wills Eye Center for Academic Global Ophthalmology (CAGO). CAGO is dedicated to leadership in ophthalmology by bridging the gaps in education, research, and clinical care that exist across the globe in an effort to prevent blindness worldwide. The most effective strategy to transform eye care around the world is to support and strengthen local partners who are committed to the long and arduous task of building up eye care delivery systems for their own country.

Wills Eye is extremely fortunate to have identified dedicated international ophthalmologists and organizations who are up to this challenge:

- Haitian University Eye Hospital, Port au Prince, Haiti
- Himalayan Cataract Project
- Kabgayi Eye Hospital, Rwanda
- Kibuye Hope Hospital, Burundi
- LV Prasad Eye Institute, India
- Project Orbis
- Rwanda International Institute of Ophthalmology (RIIO)
- Global Eye Project, Fonds-des-Blancs, Haiti
- Southern Eye Clinic, Serabu, Sierra LeoneSurgical Eye Expedition (SEE) International Tenwek Hospital, Kenya
- Vision Plus Clinique, Cap-Haitien, Haiti

Impact of Prior Community Health Needs Assessment and Implementation

The following vision health needs of children and adults in underserved areas of Philadelphia were identified based on the results of the 2022 CHNA in order of priority:

1. Low awareness of vision threatening conditions and associated risk factors and the importance of routine eye exams
2. Creating a sustainable model for vision screenings and adherence to follow-up care in community centers in underserved areas
3. Routine pediatric vision screenings in children under 17 and low adherence to obtain glasses or follow-up care with a pediatric ophthalmologist
4. Lack of city-specific data on eye and vision health for residents of Philadelphia

Many of these needs were not unexpected and are being addressed by some of our existing programs.

- The **Wills Eye Vision Screening Program for Children** is a crucial initiative that provides vision screenings to K-5 students in urban Philadelphia schools, assessing visual acuity and color vision to enhance student vision through eyeglass prescriptions and referrals to pediatric ophthalmology at Wills Eye Hospital. Early detection of vision problems is vital for academic success, making this program essential for students in need.
- Wills Eye is dedicated to raising awareness and improving healthcare access for marginalized communities through initiatives like the annual "**Give Kids Sight Day**," which offers free eye screenings to up to 1,000 children each year. Supported by over 500 volunteers, this event has provided free eye care to more than 12,000 children since 2009.

Additionally, several new initiatives were started to raise awareness of vision threatening diseases such as diabetic eye disease by screening high risk patients, educating patients on preventive care and risk factors and connecting patients with appropriate follow up care.

- Established "**Wills Eye on Diabetes Day**", a one-day, annual event for diabetics in the community to be screened for diabetic eye disease at no cost. This day will also be used to educate diabetics on healthy living, provide resources for insurance, and preventive care. Free follow up care will be offered to patients who don't have insurance and test positive for eye disease. In 2024, our program was shared with Scheie Eye Institute at the University of Pennsylvania Health System and Temple University Hospital and they held their own events simultaneously, and increased the access to care by offering other locations and more physicians. In 2025, we hope to expand to additional hospitals and centers to help more patients receive the care they need.
- Educate the next generation about the importance of the field of ophthalmology and eye and vision care by working with adolescent mentoring programs or job fairs and exposing adolescents to the colligate and non-colligate career opportunities in ophthalmology.
- A recently established medical clinic named the Hansjörg Wyss Wellness Center in South Philadelphia provides clinical and educational outreach to the surrounding immigrant population. Its goal is to create a full-spectrum primary care clinic with social services, wellness activities, and other community-focused programming. In late May 2021, Wills Eye formed a community clinic to provide specialized and sustainable ophthalmic services to the population served by the Wyss Wellness Center primarily composed of immigrants from SE Asia, Central and South America, West Africa, and Eastern Europe. To date, the clinic has been very successful in provisioning needed ophthalmic care to a multitude of underserved immigrant families (primarily those from South America and Southeast Asia).

Service Area Demographics

ESTIMATED POPULATION

4,203,459

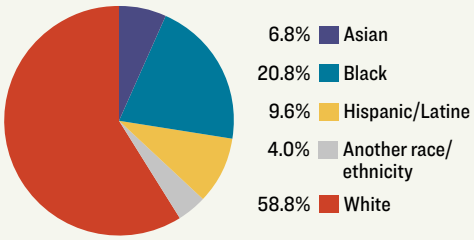
MEDIAN HOUSEHOLD INCOME

$91,123

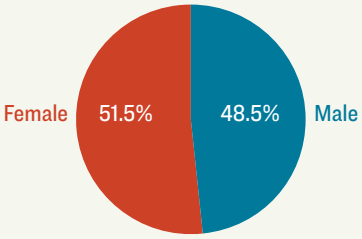
NOT FLUENT IN ENGLISH

2.5%

RACIAL COMPOSITION



SEX



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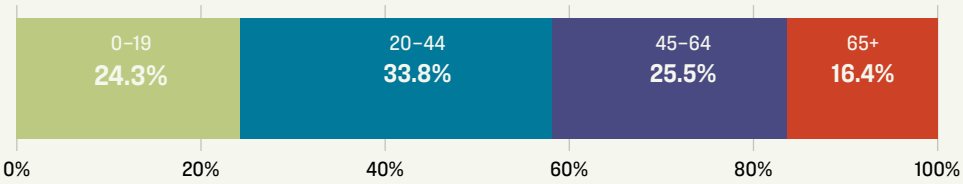


TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Wills Eye defines our targeted service area as all the ZIP codes in the Greater Philadelphia region. Wills Eye sees patients from all 50 states and throughout the world. They also have physician offices in Paoli, PA, King of Prussia, PA, Plymouth Meeting, PA, and Rittenhouse area of Philadelphia in addition to the hospital/clinic location in Center City Philadelphia.

Partner Organizations

In addition to the participating hospitals and health systems, the organizations below provided support to the rCHNA process in significant ways – through the provision of data, offering county and community specific insight, informing plans for community engagement, hosting community conversations, community survey translation, outreach, and dissemination.

Local Health Departments

- Chester County Health Department
- Delaware County Health Department
- Montgomery County Office of Public Health
- Philadelphia Department of Public Health

Community Hubs

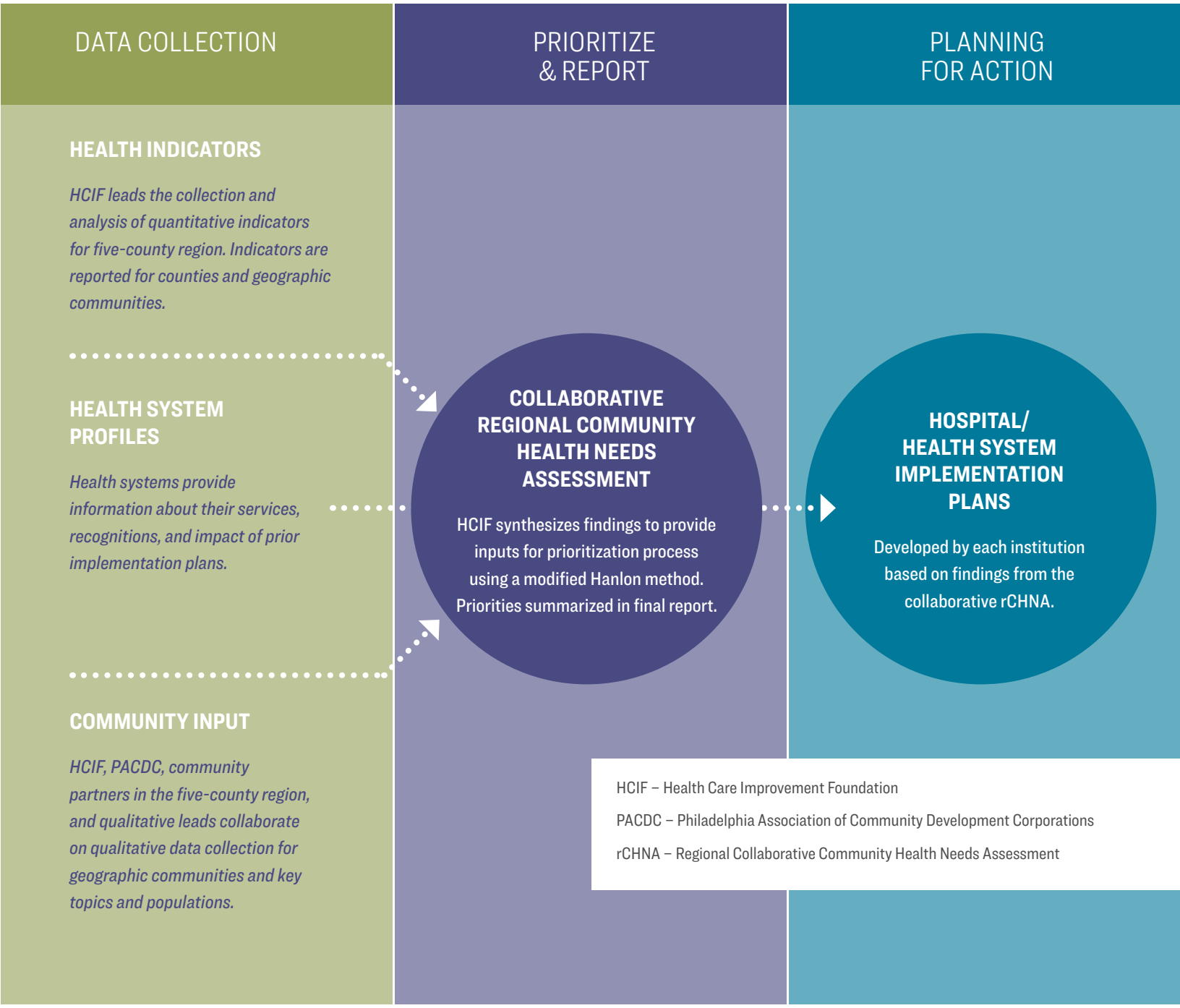
- Bucks County Health Improvement Partnership (BCHIP)
- HealthSpark Foundation
- Philadelphia Association of Community Development Corporations (PACDC)
- SEAMAAC
- The Foundation for Delaware County

Community Conversation Host Sites

- Bucks
  - Bucks County Opportunity Council
  - Family Service Association of Bucks County
  - Immigrant Rights Action
  - United Way of Bucks County
  - YWCA Bucks County
- Chester
  - Brandywine Valley Active Aging
  - Charles A. Melton Center
  - Honey Brook Food Pantry
  - The Garage Community and Youth Center
  - United Way of Southern Chester County
- Delaware
  - ChesPenn Health Services
  - Middletown Free Library
  - Multicultural Community Family Services
  - The Helen Kate Furness Free Library
  - Wayne Senior Center
- Montgomery
  - Abington Township Public Library
  - Bethel Deliverance International Church
  - George Washington Carver Community Center
  - Lansdale Area Family YMCA
- Philadelphia
  - ACHIEVEability
  - Awbury Arboretum
  - Congregation Temple Beth 'El
  - Esperanza College of Eastern University
  - Friends Center
  - Greener Partners
  - Netter Center for Community Partnerships
  - New Kensington Community Development Corporation
  - Northeast Family YMCA
  - Paseo Verde South
  - Philadelphia Association of Community Development Corporations
  - Philadelphia Chinatown Development Corporation
  - Southwest Community Development Corporation
  - Tacony Mayfair Sons of Italy

Our Collaborative Approach

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



HCIF – Health Care Improvement Foundation

PACDC – Philadelphia Association of Community Development Corporations

rCHNA – Regional Collaborative Community Health Needs Assessment

GOVERNANCE

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

Steering Committee Representatives

Name	Title	Institution
Jeanne Franklin, MPH, PMP	Public Health Director	Chester County Health Department
Falguni Patel, MPH	Director, Community Impact	Children's Hospital of Philadelphia
Kathleen Lane, MPH	Associate Director, Government Affairs	Children's Hospital of Philadelphia
Sarah Ingerman, MSW	Policy Manager	Children's Hospital of Philadelphia
Katie W. Coombes	Community Benefit Program Manager	ChristianaCare
Erin Booker	Chief Biopsychosocial Officer	ChristianaCare
Jacqueline Ortiz, M.Phil.	VP Health Equity and Cultural Competence	ChristianaCare
Pauline M. Corso	Regional Executive Director SEPA	ChristianaCare
Rosemarie Halt, MPH	President	Delaware County Board of Health
Monica Taylor, PhD, MS	Vice Chair	Delaware County Council
Kellye Remshifski, MS, CHES, NBH-HWC	Director of Community Health & Wellness	Doylestown Health
Laura Steigerwalt	Senior Director of Human Resources	Doylestown Health
Millie Johnson, CHES*	Education Outreach Liaison	Doylestown Health
Joanne Craig	Chief Impact Officer	Foundation for Delaware County
Jill Laudenslager	Vice President and Chief Nursing Officer (CNO)	Grand View Health
Wendy Kaiser	Director of Marketing and Communications	Grand View Health
Cassidy Tarullo Burrell, MPP	Project Manager	Health Care Improvement Foundation
Kelly Rand, MA CPH	Senior Director, Community Health and Impact	Health Care Improvement Foundation
Lauren Eckel, MPH, CHES	Project Manager	Health Care Improvement Foundation
Meghan Smith, MPH	Senior Project Manager	Health Care Improvement Foundation
Sehrish Rashid, MPH, MA	Senior Project Manager	Health Care Improvement Foundation
Abigail O. Akande, PhD, CRC	Qualitative Consultant	Health Care Improvement Foundation
David Martin, PhD	Quantitative Consultant	Health Care Improvement Foundation
Dani Perra, MPH	Program Manager, Community Health Benefits & Engagement, Jefferson Collaborative for Health Equity	Jefferson Health
U. Tara Hayden, MHSA	Vice President, Community Health Equity, Jefferson Collaborative for Health Equity	Jefferson Health
Katie Farrell	Chief Administrative Officer	Jefferson Health (Abington – Lansdale)
Sue Smith Lamar, M Ed., RN	Ambulatory Nurse Manager, Community Health	Jefferson Health (Abington – Lansdale)
Brandi Chawaga, M.Ed.	Director, Community Wellness	Jefferson Health (Einstein Montgomery)
Joan Boyce	Senior Director, Government Relations & Public Affairs	Jefferson Health (Einstein Philadelphia)

Name	Title	Institution
Tricia Nichols MSN, RN, NEA-BC, CPXP	Patient Experience Director	Jefferson Health (North)
Debbie Mantegna, MSN, RN	System Director, Community Health & Outreach	Main Line Health
Debbie McKetta, MS, CLSSGB	System Director, Diversity, Respect & Inclusion (DRI)	Main Line Health
K.C. Maskell	Director, Strategy & Business Development	Main Line Health
Rosangely Cruz-Rojas, DrPH	VP and Chief Diversity & Equity Officer	Main Line Health
Feba Cheriyan, MPH	Epidemiology Research Associate	Montgomery County Office of Public Health
Ruth Cole, RN, MPH	Director, Division of Clinical Services	Montgomery County Office of Public Health
Ajeenah Amir	Director of Civic Engagement and Community Partnerships	Penn Medicine
Courtney Summers, MSW	Administrator, Division of Community Health	Penn Medicine
Heather Klusaritz, PhD, MSW	Chief, Division of Community Health Department of Family Medicine and Community Health	Penn Medicine
Kristen Molloy	Corporate Director, Government and Community Relations	Penn Medicine
Laura Kim	Associate Director, Community Relations	Penn Medicine
Rose Thomas, MPH, CHES	Director of Operations, Center for Health Equity Advancement and Program for LGBTQ+ Health	Penn Medicine
Chad Thomas, MPH, PMP	Community Health Education Coordinator	Penn Medicine (Chester County Hospital)
Michele Francis, MS, RD, CDCES, LDN	Director, Community Health & Wellness Services	Penn Medicine (Chester County Hospital)
Garrett O'Dwyer, MPH	Associate Policy Director	Philadelphia Association of Community Development Corporations
Frank Franklin, PhD, JD, MPH	Deputy Health Commissioner	Philadelphia Department of Public Health
Megan Todd, PhD	Chief Epidemiologist	Philadelphia Department of Public Health
Claire Alminde, MSN, RN, CPN, NEA-BC	Chief Nursing Officer	St. Christopher's Hospital for Children
Ed Bleacher II, MBA, CHFP, CRCR, FHFMA	Chief Financial Officer	St. Christopher's Hospital for Children
Joanne Ferroni	Assistant Vice Provost for Anchor Partnerships, , Office of University and Community Partnerships of Drexel University	St. Christopher's Hospital for Children
Maura Heidig	Director of Population Health	St. Christopher's Hospital for Children
Renee Turchi, MD, MPH	Pediatrician-in-Chief	St. Christopher's Hospital for Children
Lakisha Sturgis, RN, BSN, MPH, CPHQ	Director, Community Care Management, Temple Center for Population Health	Temple Health
Marybeth Taylor, MPH	Community Benefit & Special Projects Manager	Temple Health
Allison Zambon, MHS, MCHES	Program Manager, Office of Community Outreach and Engagement	Temple Health (Fox Chase Cancer Center)
Joann Dorr, RN, BSN	Regional Director, Community Health and Well-Being	Trinity Health Mid-Atlantic
Stacy Ferguson, MHSc	Regional Senior Community Benefit Director, CHWB Director South, Project Manager, The Healthy Village at Saint Francis	Trinity Health Mid-Atlantic

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

METHODS: DATA COLLECTION AND ANALYSIS

Health Indicators

HCIF and the Steering Committee reviewed and finalized the list of quantitative health indicators. The list of indicators from the 2022 report provided a starting point, and indicators were removed and added based on the following considerations:

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

Data were gathered, cleaned, organized and analyzed primarily by quantitative data consultant, David Martin, PhD; University of Virginia, with support from the Pennsylvania Department of Health, Philadelphia Department of Public Health and HealthShare Exchange.

Data Collection & Analysis

Data collection began with the use of the United States Census Bureau's American Community Survey (ACS) data. This dataset provided essential demographic and population information, enabling the calculation of rates and proportions for various indicators. ACS data was particularly useful for deriving rates requiring total population values (e.g., total population, population by age group, population by race/ethnicity, etc.). Where available, estimates were collected in both absolute numbers and percentages/rates, along with accompanying measures of error, such as margins of error (MOE) and confidence intervals (CI), ensuring robust statistical backing for any subsequent analysis. Data sources were accessed between June 2024 through April 2025.

Data was gathered and analyzed at both the Zip Code Tabulation Area (ZCTA) and county levels to allow for comparisons and aggregation to the hospital service area (HSA) and geographic community area (GCA) levels. The most recent 5-year estimates were utilized (2018–2022 and 2019–2023).

Following the compilation of census data, additional indicators were sourced from the Behavioral Risk Factor Surveillance System (BRFSS), CDC/ATSDR Social Vulnerability Index, Pennsylvania Department of Health, County Health Rankings, and others. If data was missing for either the estimates or measures of variation, estimates were calculated using available data from the source and census data.

When aggregating data to HSA or GCA, indicator values were calculated with weights based on the size of the affected population in each ZIP Code (e.g., age groups such as 65+, 18-64, or total population).

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

- County level – For all five counties
- Geographic community level – These represent clusters of ZIP codes grouped into 46 distinct geographic communities, based on guidance from Steering Committee members. Geographic communities were developed for the 2022 assessment, with no changes made to the groupings in 2025.

Community Survey Analysis

Community survey results were analyzed to ensure all respondents were eligible due to age and provided ZIP codes included in the rCHNA service area. Survey responses were assessed for quality and completeness. One survey option was removed from reported results due to unreliable response counts: Question - "Thinking about the community where you live, how available are the following resources?", Response: Public Transportation.

For the GCA profiles, responses were aggregated into the corresponding geography based on respondents ZIP code. GCAs with fewer than 35 responses were combined with adjacent GCAs, prioritizing those with similar demographics. Combined responses are noted within the respective profile. Lastly, each survey question was examined by calculating the percentage of respondents selecting each response, ranking the top three most selected responses by percentage, and reporting those values.

Software

Data was either manually transposed in Microsoft Excel, downloaded directly from data sources websites, or gathered from the tidycensus (1.6.7) package (a product which uses the Census Bureau Data API) in R (4.4.1) and RStudio (2024.09.0). All Excel files were then merged and appended in RStudio using the tidyverse package (Version 1.3.0).

Health Indicators

This assessment features over 70 health indicators from varied data sources, aggregated at various levels. The table below presents information about the included indicators.

Indicator	Details	Year(s)	Source
ABOUT THE COMMUNITY			
Population	Total population size	2023	American Community Survey, Census Bureau (5-yr)
Age distribution by sex		2022	American Community Survey, Census Bureau (5-yr)
Race/ethnicity		2022	American Community Survey, Census Bureau (5-yr)
Educational attainment	High school as highest education level (26+ years)	2022	American Community Survey, Census Bureau (5-yr)
Income	Median household income	2022	American Community Survey, Census Bureau (5-yr)
Social Vulnerability Index	Percentile ranking of 4 socioeconomic indicators	2022	CDC/ATSDR Social Vulnerability Index
Foreign-born status	Born outside of United States	2022	American Community Survey, Census Bureau (5-yr)
Ability to speak English	Speak English less than "very well" (5+ years)	2022	American Community Survey, Census Bureau (5-yr)
Disability status	With a disability	2022	American Community Survey, Census Bureau (5-yr)
Leading causes of death	Top 5 causes	2023	Vital Statistics, PA Department of Health, County Health Rankings **
GENERAL			
All-cause mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Life expectancy by sex	Years	2022	Vital Statistics, PA Department of Health **
Years of potential life lost before 75	Years	2022	Vital Statistics, PA Department of Health **

Indicator	Details	Year(s)	Source
CHRONIC DISEASE & HEALTH BEHAVIORS			
Adult obesity prevalence	Body mass index 30-99.8 among adults 18+ years	2021	Behavioral Risk Factor Surveillance System
Diabetes prevalence	Told by a doctor that they have diabetes	2021	Behavioral Risk Factor Surveillance System
Diabetes-related hospitalization	Rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Chlamydia	Rate per 100,000	2020-2022	Pennsylvania Department of Health, Bureau of Communicable Diseases
Flu vaccinations	Adults	2021	County Health Rankings, Mapping Medicare Disparities Tool
Hypertension prevalence	Told by a doctor that they have high blood pressure	2021	Behavioral Risk Factor Surveillance System
Hypertension-related hospitalization	Rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Potentially preventable hospitalization	Rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Premature cardiovascular disease mortality	Death before 65 years, rate per 100,000	2022	Vital Statistics, PA Department of Health **
Major cancer incidence	Prostate, breast, lung, colorectal cancers; rate per 100,000	2022	Vital Statistics, PA Department of Health **
Major cancer mortality	Prostate, breast, lung, colorectal cancers; rate per 100,000	2022	Vital Statistics, PA Department of Health **
Mammography screening	Mammogram in the past 2 years among women 50-74 years	2022	Behavioral Risk Factor Surveillance System
Colorectal cancer screening	Fecal occult blood test, sigmoidoscopy, or colonoscopy among adults 50-75 years	2022	Behavioral Risk Factor Surveillance System
DISABILITIES			
Disability status	With a disability	2022	American Community Survey, Census Bureau (5-yr)
Hearing difficulty	Deaf or having serious difficulty hearing	2022	American Community Survey, Census Bureau (5-yr)
Vision difficulty	Blind or having serious difficulty seeing, even when wearing glasses	2022	American Community Survey, Census Bureau (5-yr)
Cognitive difficulty	Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions	2022	American Community Survey, Census Bureau (5-yr)
Ambulatory difficulty	Having serious difficulty walking or climbing stairs	2022	American Community Survey, Census Bureau (5-yr)
Self-care difficulty	Having difficulty bathing or dressing	2022	American Community Survey, Census Bureau (5-yr)
Independent living difficulty	Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping	2022	American Community Survey, Census Bureau (5-yr)
Poverty status	Poverty status of those with a disability in the past 12 months	2022	American Community Survey, Census Bureau (5-yr)

Indicator	Details	Year(s)	Source
INFANT & CHILD HEALTH			
Asthma hospitalization	Children <18 years, rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council * +
Infant mortality	Deaths before age 1 per 1,000 live births	2022	Vital Statistics, PA Department of Health **
Lead levels in children	>=5 µg/dL	2021	CDC
Low birthweight births	Percent low birthweight (<2,500 grams) births out of live births	2022	Vital Statistics, PA Department of Health **
Pre-term births	Percent preterm (before 37 weeks gestation) births out of live births	2022	Vital Statistics, PA Department of Health **
Child Opportunity Index	Composite score, measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development.	2021	Institute for Equity in Child Opportunity & Healthy Development at Boston University School of Social Work; diversitydatakids.org
BEHAVIORAL HEALTH			
Adult binge drinking	5+ (men) or 4+ (women) alcoholic drinks on one occasion in past 30 days	2021	Behavioral Risk Factor Surveillance System
Adult smoking	Current smoker status	2021	Behavioral Risk Factor Surveillance System
Drug overdose mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Opioid-related hospitalization	Rate per 100,000	2023	Pennsylvania Health Care Cost Containment Council *
Substance-related hospitalization	Rate per 100,000	2023	Pennsylvania Health Care Cost Containment Council *
Poor mental health (adults)	Poor mental health for 14+ days in past 30 days (adults)	2021	Behavioral Risk Factor Surveillance System
Suicide mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Youth binge drinking	5+ alcoholic drinks in a row on ≥1 days in past 30 days among teens	2023	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey
Youth ever attempted suicide	Suicide attempt ever among teens	2023	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey
Youth mental health	Depressed/sad most days or sad/hopeless almost every day 2+ weeks in past 12 months among teens	2023	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey
Youth smoking	Smoked cigarettes in past 30 days among teens	2023	Youth Risk Behavior Surveillance System
Youth vaping	Used electronic vapor products in past 30 days among teens	2023	Youth Risk Behavior Surveillance System
INJURIES			
Fall-related hospitalization	Ages <64; rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Gun-related emergency department utilization	Rate per 100,000	2023	HealthShare Exchange
Homicide mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Mortality due to gun violence	Rate per 100,000	2021	Vital Statistics, PA Department of Health **

Indicator	Details	Year(s)	Source
ACCESS TO CARE			
Health insurance (public) status - Adults	Adults 19-64 years with Medicaid	2022	American Community Survey, Census Bureau (5-yr)
Health insurance (public) status - Children	Children <19 years with public insurance	2022	American Community Survey, Census Bureau (5-yr)
Health insurance status - Population	Population without insurance	2022	American Community Survey, Census Bureau (5-yr)
Health insurance status - Children	Children <19 years without insurance	2022	American Community Survey, Census Bureau (5-yr)
High emergency department utilization	5+ visits in 12 months, rate per 100,000	2023	HealthShare Exchange
SOCIAL & ECONOMIC CONDITIONS			
Poverty status - Population	Population in poverty	2022	American Community Survey, Census Bureau (5-yr)
Poverty status - Children	Children <18 years in poverty	2022	American Community Survey, Census Bureau (5-yr)
Commute	Commute greater than 60 minutes	2022	American Community Survey, Census Bureau (5-yr)
Employment status	Adults 19-64 years unemployed (not in labor force)	2022	American Community Survey, Census Bureau (5-yr)
Food insecurity	Population experiencing food insecurity, county-level only	2022	Feeding America
Homeownership	Proportion of households that are owner-occupied	2022	American Community Survey, Census Bureau (5-yr)
Household type – older adults	Householders living alone who are 65+ years	2022	American Community Survey, Census Bureau (5-yr)
Household type – same sex couples	Same sex couple households; rate per 1,000	2022	American Community Survey, Census Bureau (5-yr)
Household type – single parent	Single parent households	2022	American Community Survey, Census Bureau (5-yr)
Households receiving food assistance	Households receiving Supplement Nutrition Assistance Program (SNAP) benefits	2022	American Community Survey, Census Bureau (5-yr)
Housing cost burden - severe	Households who spend >50% of income on housing	2022	American Community Survey, Census Bureau (5-yr)
Housing occupancy status	Vacant housing units	2022	American Community Survey, Census Bureau (5-yr)
Income Inequality	Assesses income or wealth distribution within a population	2022	American Community Survey, Census Bureau (5-yr)
Violent crime rate	Rate per 100,000	2022	PA Uniform Crime Reporting System

* Data analysis conducted by the Philadelphia Department of Public Health.

** These data were supplied by the Bureau of Health Statistics & Registries, Pennsylvania Department of Health, Harrisburg, Pennsylvania.

+ Data only available for geographic communities in Philadelphia County.

COMMUNITY INPUT

Overview

A critical complement to the quantitative data represented by the health indicators is qualitative data that capture the perspectives, priorities, and ideas of those who live, learn, work, and play in local communities. Building on the qualitative data collection approach developed for the 2019 and 2022 rCHNA, the Steering Committee and project team sought to expand, enhance, and refine strategies to thoughtfully gather and incorporate community input into the 2025 rCHNA. A subset of the Steering Committee, as well as several additional representatives from participating health systems, formed a Qualitative Team to guide the planning process. HCIF also engaged an expert in qualitative data collection and analysis as a consultant to serve as Qualitative Lead, Abigail Akande, PhD; Penn State - Abington College, as well as a trained youth facilitator, Briana Bronstein, PhD; Widener University.

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

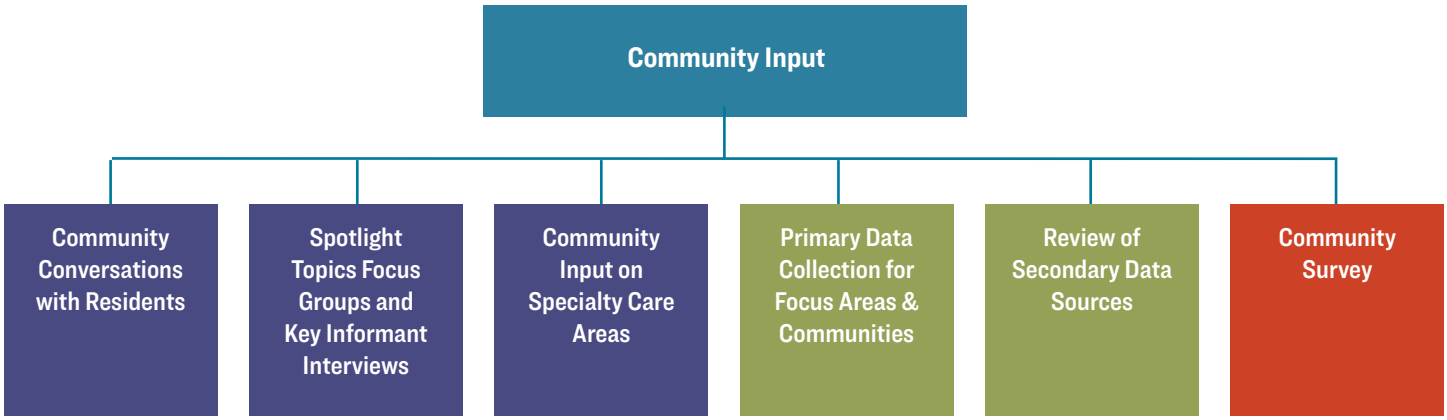
- Primary data collection was undertaken by the project team June 2024 – April 2025. To offer the greatest level of accessibility, both in person and virtual sessions were held in each county.
- Focus group-style, 90-minute "community conversations" were held to gather input from residents of the region. Building on the trust built through prior rCHNAs, the team used a "trusted messenger" approach. The Steering Committee guided the selection of community-based organizations reaching important populations within the region. The identified organizations were then compensated with a small stipend for their help with the recruitment of eight to ten individuals. The organizations were also provided with organizationally specific write ups of qualitative data and geographic information from the community survey for use in evaluation and grant efforts. The number of conversations increased to 30: Bucks (5), Chester (4), Delaware (5), Montgomery (4), and Philadelphia (12). This method also increased engagement and diversity of participants.
- To capture the insights of those who provide important health, human, and social services in each of the counties, 60-minute group discussions centered on "spotlight" topics were conducted with organization and local government agency representatives. A list of topics was generated by the Steering Committee based on priorities from past CHNAs. Spotlights were divided into two categories – Care and Community. Two meetings were held in each county concurrently except for Montgomery County where only one meeting was held. An additional 15 key informant interviews were held with community-based organization leaders and subject matter experts. Additional questions were asked to each group on community-based organizations capacity to handle the increase in social needs screening occurring due to new federal requirements. A special session with new mothers and expecting mothers was held to better understand the community perspective on maternal health.

SPOTLIGHT TOPICS

Care	Community Issues
Maternal Health	Housing
Older Adults and Aging in Place	Better Integration of Health and Social Services in the Community
Caring for Uninsured and Undocumented Individuals	Increase Community Member Capacity to Serve as Care Navigators
Culturally Appropriate Mental Health	Involve Community in Solutions and Implementation
Primary Care Access	Preventative Care and Education in the Community

- The project team either undertook directly or supported partners with targeted primary data collection to better understand the needs of particular communities or populations. These focus areas and communities were specific to different types of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) and other areas identified by the steering committee:
  - **Cancer:** In addition to cancer-related information gathered from community conversation and spotlight discussions described above, partner cancer center board members they conducted.
  - **Disability:** HCIF worked with a subcommittee of rehabilitation facilities to develop and administer an online survey of people with disabilities and held three focus groups with individuals living with disabilities.
  - **Older Adults:** New to the rCHNA in 2025, HCIF thematically analyzed the community conversations held in senior centers and communities as well as the community conversations. Responses from adults over 65 were extracted from a larger dataset of the general population to better identify their specific needs and were compared with broader community trends.
  - **Vision:** New to the rCHNA in 2025, HCIF staff held three community conversations with people specifically focused on vision care. Support for the qualitative guide came from the Wills Eye hospital.
  - **Youth Voice:** In the 2025 round, HCIF staff again used the trusted partner approach and provided a small stipend to youth serving organizations to help with recruitment. Additionally, a trained youth facilitator led each of the 15 conversations.
- Secondary data in the form of reports and summaries from other community engagement efforts were important inputs for this report. A full list of sources incorporated is included in the "Resources" section.
- Community Survey: As part of this assessment, an additional quantitative component was incorporated to complement community input, providing a more comprehensive picture of local health needs and priorities. HCIF, in collaboration with hospital systems and community-based organizations (CBOs), conducted a general population survey consisting of six core questions along with demographic information to ensure broad representation across all counties. To enhance accessibility and inclusivity, the survey was administered in English and seven additional languages. The data collected was then analyzed at both the county and sub-geographic levels, allowing for a deeper understanding of the diverse experiences and needs of different communities.

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



QUALITATIVE DATA COLLECTION AND ANALYSIS

The Qualitative Team guided the development of discussion guides (see online Appendix) for both the community conversations and the spotlight discussions. These were adapted from those used for the 2022 rCHNA and included questions addressing community assets; community health challenges and barriers (including those related to social determinants of health, access to care, COVID-19); specific needs of older adults, children and youth, and additional underrepresented groups; and potential solutions for particular needs.

Values guiding participant engagement included respecting community members' time and expertise (one expression of this was providing community members with $25 Visa gift cards for their participation) and ensuring that voices of minoritized communities were well-represented in the discussions. With these values in mind, Steering Committee members contributed suggestions of partner organizations for outreach (to participate in meetings themselves or assist with community member engagement), which were organized into a centralized partner database. HCIF conducted outreach based on this database, researched additional organizations, and employed a snowball technique to elicit other potential partners for Town Hall meetings, which were larger gatherings held for the entire county and in some Philadelphia meetings. However, for most Philadelphia-based meetings, a trusted messenger approach was prioritized. This approach involved partnering with embedded community organizations to engage participants who might not typically attend such meetings.

When meetings were held in person, they took place in trusted community venues, ensuring accessibility and cultural relevance. Culturally appropriate food was provided, and incentives were offered not only to individual participants but also to the hosting venues. This strategy enabled engagement in settings such as YMCAs, food pantries, homeless shelters, and other spaces serving minoritized populations, fostering a more inclusive and participatory process.

To promote these discussions, Steering Committee members, PACDC, partner organizations, and HCIF utilized varied outreach methods, including phone and email outreach, social media posts, intranet outreach, listserv posts, and community flyer distribution. The Qualitative Lead facilitated all community conversations and the Maternal Health conversation, with technical support provided by the HCIF team. These discussions were recorded and transcribed for later analysis, with access to the recordings and transcripts limited to the project team and the Qualitative Lead. Transcripts were imported as Word documents into NVivo software to manage, code, and interpret qualitative data.

The Qualitative Lead consultant identified recurrent themes from these transcripts, created a set of codes, coded for these themes, and generated summaries featuring themes and accompanying quotes. To ensure confidentiality, participants were assigned numbers in the transcripts to replace names, and care was taken to avoid disclosing any individual's identity in the summaries. Participant quotes are presented verbatim to preserve authenticity and reflect the diverse ways participants express their experiences and perspectives. While Philadelphia's individual meetings are represented in the full report, Bucks, Chester, Delaware, and Montgomery's discussions were analyzed at a county level. Individual write ups of the conversations held in those counties can be found in the appendix.

For Spotlight and Focus Area discussions, transcripts were also coded using deductive coding based on the qualitative guides. Coding teams, made up of HCIF masters or doctorly prepared staff, met regularly to ensure agreement on codes, and summaries were generated featuring key themes and illustrative quotes.

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

- **Geographic Communities** – County-level summaries for Bucks, Chester, Delaware, and Montgomery Counties, as well as five summaries for distinct geographic sections of Philadelphia County (individual summaries for each of the 26 Community Conversations are available in the online Appendix).
- **Spotlight Topics** – Aggregated topic summaries across counties.

Summaries are organized around key sections of the discussion guide. Within each section, themes are generally presented in order of greatest frequency of mention. However, in some cases, related topics are grouped together for clarity and coherence. The themes are accompanied by illustrative quotes to capture participants' voices as authentically as possible.

DETERMINING AND PRIORITIZING COMMUNITY HEALTH NEEDS

Top priorities gathered in the general community conversations, youth conversations and extrapolated from the general population survey were aggregated by HCIF staff and presented to the Steering Committee for voting on how best to group concerns. This grouping exercise led to 12 general population priorities and 8 youth focused priorities, representing three categories: health issues, access and quality of healthcare and health resources, and community factors.

Once the grouping process was completed, the Steering Committee used the Hanlon Method to prioritize the categories. The Hanlon Method is a structured and systematic approach widely used in public health to prioritize community health needs based on severity, impact, feasibility, and resource availability. Below is a detailed account of the process used to implement the Hanlon Method for prioritization in this assessment.

The first step involved identifying and listing key community health priorities. These priorities were determined through extensive engagement with community members via live meetings and a community needs survey. The resulting priority list was recorded in Column A of the assessment spreadsheet.

To understand the extent of each health issue, we assessed the proportion of the population affected by each identified priority. A quantitative consultant provided statistical data, which was used to populate Column B. The detailed data sources and calculations were available to health systems for reference. This step involved evaluating how serious each identified issue is for the population served by the health system. The assessment was conducted on a 0 to 10 scale, where 0 represents a minimally serious issue, 5 represents moderate seriousness, and 10 represents the most serious health concerns. The ratings were entered in Column C of the assessment tool. This rating process helped determine the urgency and potential health impact of each problem.

Priorities Identified by the Community	**Magnitude or extent of the problem for the population** *Magnitude of health priority based on size of population(s) impacted - from 0 - 5 based on % of population affected by the problem*	**Seriousness** *Is the problem considered serious? 0-10*	**Effectiveness** *Can the problem be easily solved?*	**Pertinence** *Is it relevant to intervene in the problem; is the intervention approprate*	**Economic Feasibility** *Is there economic feasibilty for the intervention?*	**Acceptibility** *Does the community accept/ want an intervention in the problem?*	**Resources** *Are there resources available for the intervention?*	**Legality** *Does the law allow the intervention?*
	5 – Greater than 40%	0 – Not at all serious	0.5 – Problem is very difficult to solve	0 – It is **NOT** relevant to intervene	0 – There are **NO** resources or resources can **NOT** be found to address the issue	0 – The community **does not** want hospitals and health systems to take action on this issue	0 – There are **NO** resources to address this issue	0 – The intervention is **NOT** legal
	4 – 30-39.9%	5 – Moderately serious	1 – Problem needs moderate effort to solve	1 – It is relevant to intervene	1 – There are resources or resources can be found to address the issue	0 – The community wants hospitals and health systems to take action on this issue	1 – There are available resources to address this issue	1 – The intervention is legal
	3 – 20-39.9%	10– Most serious	1.5 – Problem has an easy solution					
	2 – 10-19.9%							
	1 – 1-9.9%							
	0 – <1%							
ADULT								
Access to Primary and Specialty Care	**3**							
Mental Heath Access	**3**							
Trust and Communication	**5**							
Healthcare Resources Navigation	**4**							
Food Access	**1**							
Neighborhood Conditions	**1**							
Healthy Aging	**2**							
Housing	**2**							
Chronic Disease Prevention & Management	**4**							
Culturally & Linguistically Appropriate Services	**1**							
Substance Use and Related Disorders	**2**							
Racisim and Discrimination in Healthcare	**5**							
YOUTH								
Youth Mental Health	**4**							
Activities for Youth	**1**							
Substance Use and Related Disorders	**1**							
Access to Good Schools	**2**							
Lack of Resources/ Knowledge of Resources	**2**							
Gun Violence	**1**							
Access to Physical Activity	**1**							
Bullying	**2**							

An essential component of the Hanlon Method is assessing the feasibility of addressing each issue. In this step, we evaluated the level of difficulty in implementing solutions for each problem. Using a predetermined scale:

- 0.5 was assigned if the problem is very difficult to solve.
- 1 was assigned if the problem requires moderate effort to solve.
- 1.5 was assigned if the problem has an easy solution.

These ratings were recorded in Column D to reflect the complexity of addressing each issue.

To further refine our prioritization, we performed a PEARL assessment, which considers the following feasibility factors:

Propriety: Is intervention appropriate and relevant?

Economics: Is there economic feasibility or financial support?

Acceptability: Will the community accept and engage with the intervention?

Resources: Are sufficient resources (funding, staffing, infrastructure) available?

Legality: Can the intervention be legally implemented?

Each factor was rated as 0 (No) or 1 (Yes) and documented in Columns E through I to determine the feasibility of each intervention. This assessment ensured that selected priorities were not only urgent but also actionable.

With all relevant data entered, the final score for each health priority was calculated using an embedded formula. This final step provided a ranked list of community health needs based on magnitude, severity, feasibility, and potential for intervention. The scoring process ensured that decision-makers had a clear, evidence-based understanding of the most pressing and actionable health issues in the community. Those scores were then aggregated and shared back with the Steering Committee with their ranking and standard deviation.

The Hanlon Method provided a transparent and data-driven approach to prioritizing community health needs in the 2025 rCHNA. By integrating quantitative data, expert assessments, and community perspectives, this approach facilitated an equitable and strategic prioritization process. The final prioritized list will guide the allocation of resources, program development, and policy initiatives to address the most significant health challenges in the region.

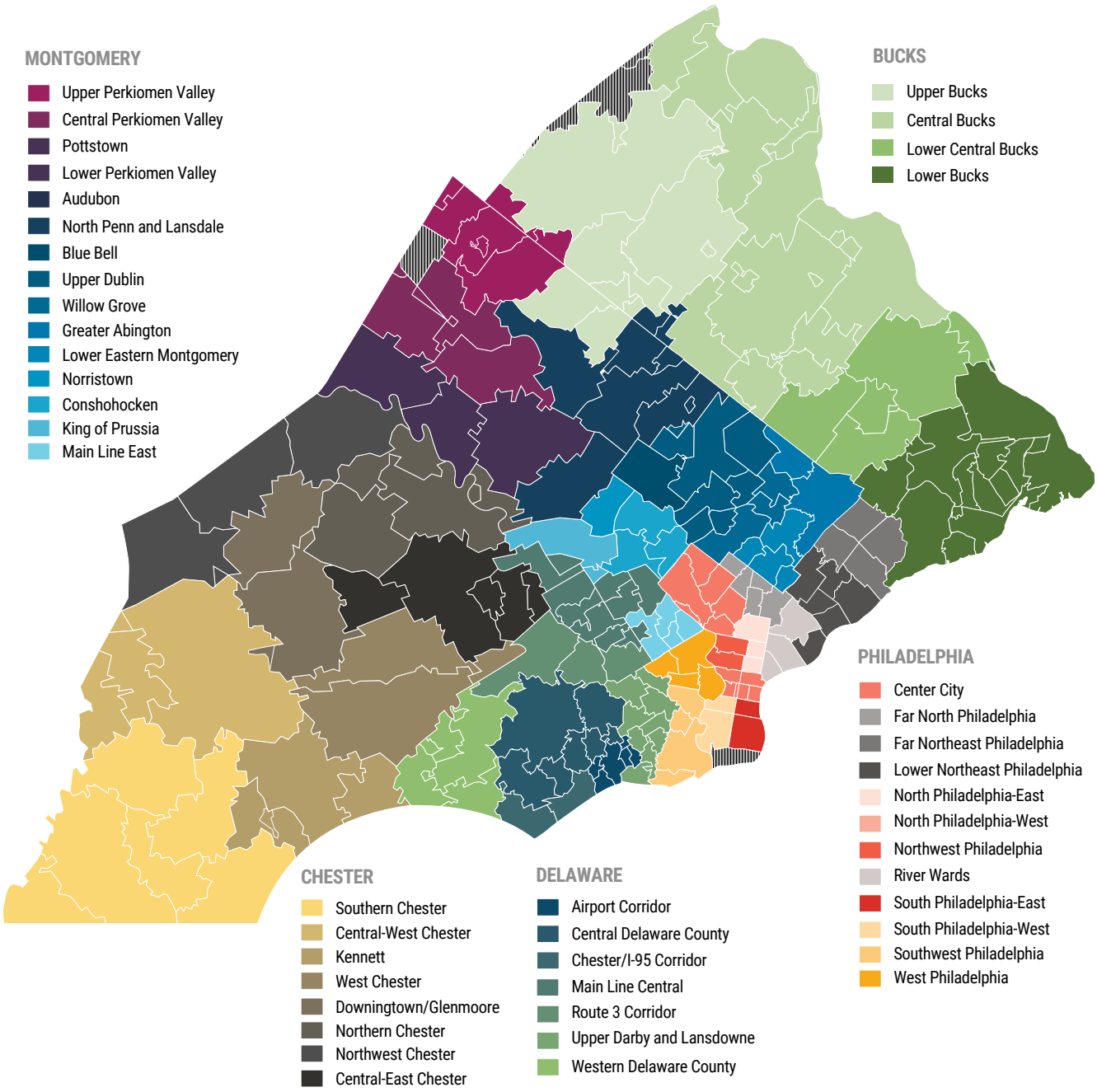
This structured prioritization process ensures that health interventions are both impactful and feasible, ultimately improving health outcomes for the communities served by the regional health system.

FINAL REPORT

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

About the Service Area

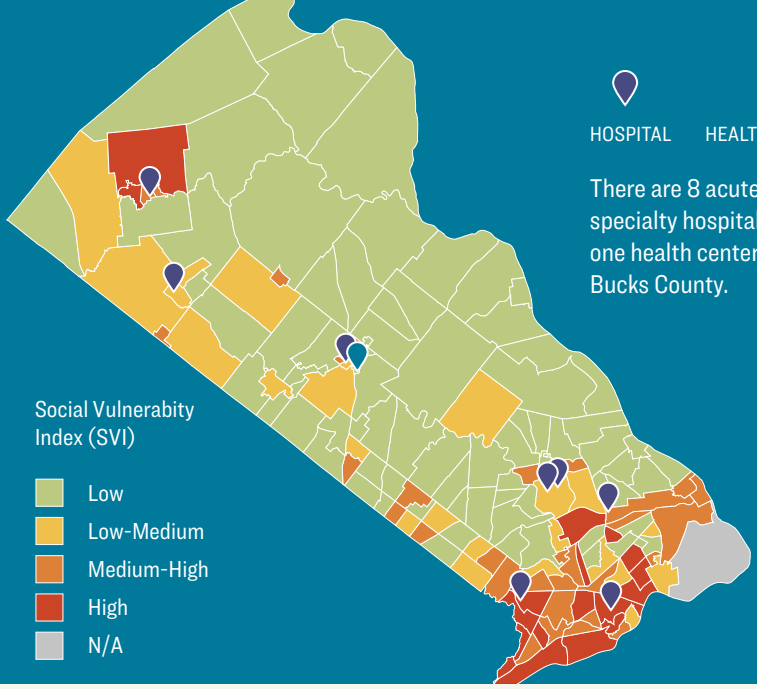
The overall service area includes Bucks, Chester, Delaware, Montgomery, and Philadelphia and represents a diverse population of 4,206,741. All ZIP codes in the five counties were grouped into 46 distinct geographic communities, as shown below. In the next section, each quantitative county profile is followed by relevant summaries of qualitative data collected through geographic community conversations in that county, as well as quantitative profiles of the geographic communities within each county.



Bucks County

SOCIAL VULNERABILITY INDEX (SVI)*

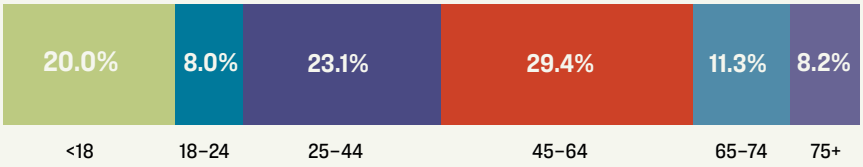
*SVI is a measure developed by the CDC to identify communities that may need support before, during, or after disasters. This measure is made up of a combination of 16 different U.S. Census variables, which are grouped into four themes (socioeconomic status, household charateristics, racial & ethnic minority status, and housing type & transportation), and cover major areas of social vulnerability.



Demographics

AGE DISTRIBUTION

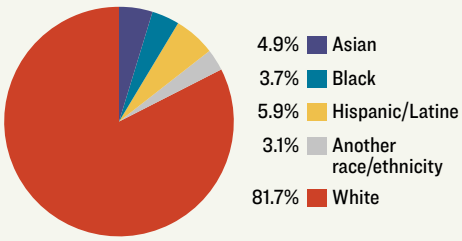
Bucks County has an estimated population of 645,993 with the largest proportion of residents between the ages of 45 - 64.



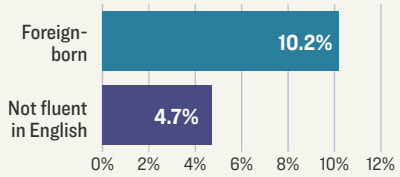
SEX

RACE/ETHNICITY/LANGUAGE

82% of residents are non-Hispanic White. Hispanic/Latine residents make the next largest population, comprising nearly 5.9% of the county's residents.



Approximately 10% of residents are foreign-born and about 5% speak English less than "very well."



HOUSEHOLDS

Median Household Income
$118,574

Homeownership
75%

Severe Housing Cost Burden
% spending >50% of household income
12%

High School as Highest Education
27.8%

Household Food Insecurity
8.8%

Single Parent Households
18.2%

Same Sex Couples
per 1,000 households
3.4

Commute Greater than 60 minutes
12.4%

Bucks County

Health

LEADING CAUSES OF DEATH - All Ages

1. Cancer
2. Heart Disease
3. COVID-19
4. Cerebrovascular Diseases
5. Chronic Lower Respiratory Diseases

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

4.7%

Depressed/Sad Most Days in the Past 12 Months

25.9%

Binge Drinking

6.8%

Cigarette Smoking

2.3%

Vaping

11.0%

Exposure

Lead Levels in Children (<16 years old)

1.5%

PEOPLE WITH DISABILITIES

Percent of Population

10.6%

Poverty Status in the Past 12 Months

17.6%

Percent who have difficulty with:

Hearing	2.9%
Vision	1.4%
Cognition	4.1%
Ambulatory	5.3%
Self-care	2.0%
Independent Living	4.1%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

N/A*

Violent Crime Rate per 100,000

85.9

Gun-related ED utilization per 100,000

1.5

*Too small to report

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

374.5

This measure reflects limited access to primary care as individuals may rely on emergency departments non-emergency health needs due to barriers like insurance, trust, clinician shortages, etc.

Flu Vaccinations (Adult)

60.0%

This measure is a strong indicator of overall community vaccination levels because they reflect access to healthcare, public trust in vaccines, and the effectiveness of outreach efforts in promoting immunization.

Chlamydia per 100,000

201.9

This measure is a good marker for STIs in a community because it is the most commonly reported bacterial infection, often asymptomatic, and indicates the overall level of STI transmission, screening, and prevention efforts in a population.

Income Inequality

0.45

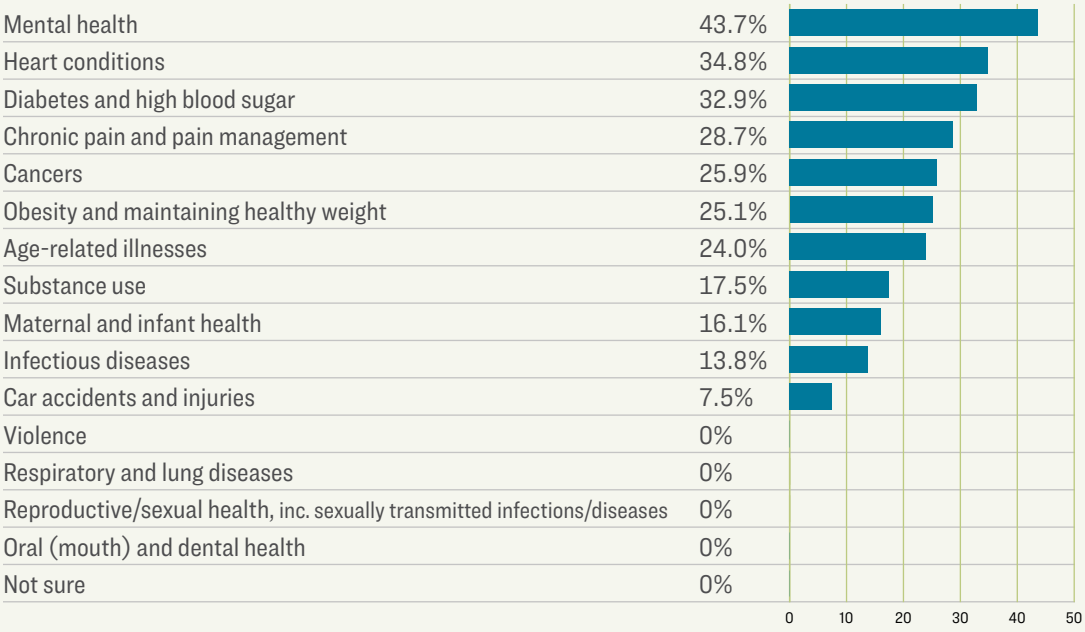
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Bucks County

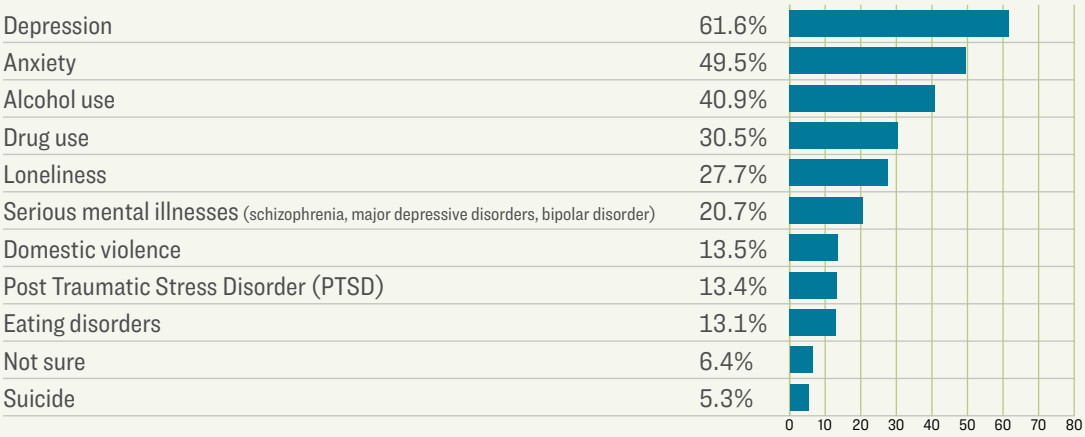
County Survey Results

Number of Respondents: 762

Thinking about yourself or other ADULTS in the community where you live, what are the top 3 HEALTH problems?



Thinking about yourself or other ADULTS in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

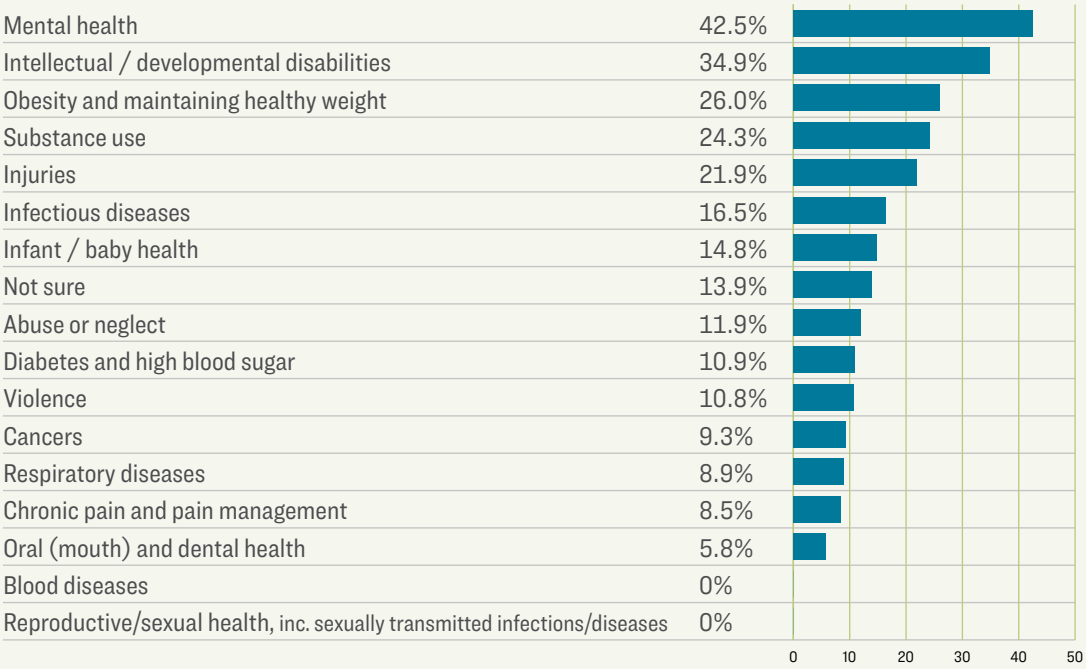


Bucks County

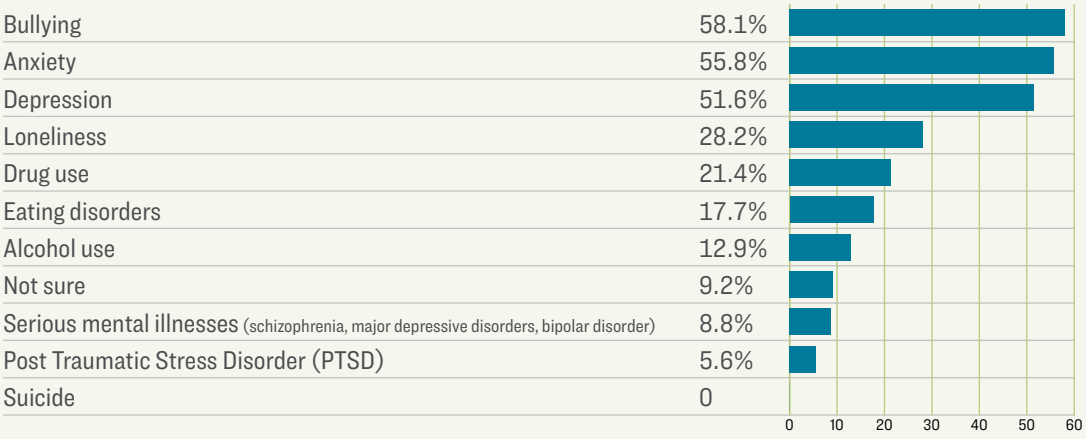
County Survey Results

Number of Respondents: 762

Thinking about your or other CHILDREN in the community where you live, what are the top 3 HEALTH problems?



Thinking about your or other CHILDREN in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

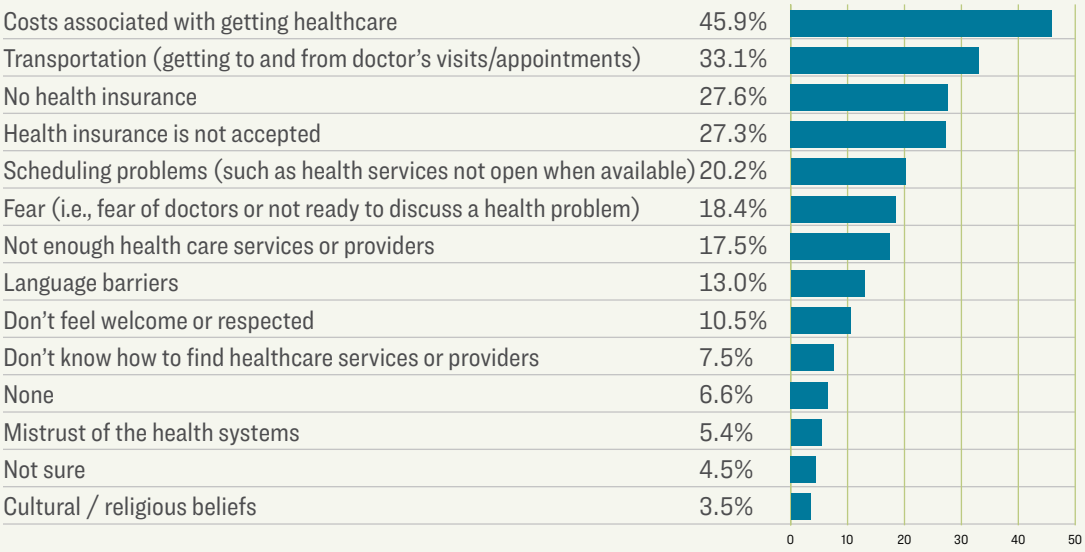


Bucks County

County Survey Results

Number of Respondents: 762

Thinking about the community where you live, which barriers prevent access to health care? (Select all that apply)



Thinking about the community where you live, how available are the following resources?

	Never Available	Rarely	Sometimes	Often	Always Available	Not Sure
Affordable healthy foods	14.3%	15.8%	24.45%	13.0%	8.1%	4.6%
Clean outdoor environment	11.9%	4.1%	17.3%	30.8%	34.7%	1.2%
Good paying jobs	13.4%	13.3%	32.7%	27.7%	9.1%	3.9%
Good schools	12.5%	5.8%	14.3%	26.0%	39.4%	2.1%
Health care services	11.4%	4.6%	17.1%	27.2%	38.7%	1.1%
Mental health services	13.8%	18.4%	31.1%	14.8%	13.4%	8.5%
Places to be active such as parks	12.5%	4.6%	13.0%	25.7%	43.0%	1.2%
Safe neighborhood	14.7%	20.2%	24.5%	20.0%	15.8%	4.9%
Services that support people as they age	11.6%	8.7%	23.4%	25.5%	20.5%	10.5%
Substance use services	12.9%	14.2%	25.6%	16.8%	11.7%	18.9%

Bucks County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

Walkability, access to parks, recreational programming, and gyms encouraged physical activity. Fresh air and trees were recognized as positive neighborhood features. Gym memberships for older adults were easier to find than for other age groups.

COMMUNITY RESOURCES

For the most part, community members felt safe and described neighborhoods as friendly. Some residents spoke of feeling welcomed at various churches and denominations, despite differences in culture and ethnicity. Community organizations have assisted with emergencies, utility payments, organizing food drives, an economic self-sufficiency program, and assistance with taxes. "If you have anything you need, you can give them a call."

There was a slow increase in the number of restaurants that served healthier foods. There were also more crosswalks, and "police setting up cameras on the corners," contributing to a sense of safety.

ON GREEN SPACE & RECREATION

"I think the fact that there are a lot of trees in the community helps us to breathe fresh air. So that's something positive in our community."

"In the Warminster community, they sometimes do yoga free classes or any kind of events, like workout exercise"

"There's like soccer field and basketball courts where you can go and play. A lot of people get together at a team and go play in there. So, I think it's good to stay healthy."

"I feel that Bensalem is a walkable community. They are putting sidewalks in where areas there wasn't sidewalks. It gives you an opportunity to walk to the supermarket, to walk to Wawa and places like that."

"...the Y.M.C.A. I love the classes. I'm an active member, the beautiful parks, a lot of tracks. People enjoy walking..."

ON COMMUNITY RESOURCES

"I'd say security... Well, policing. I feel very secure..."

"I left my keys on the lock and my neighbor like, hi neighbor, I saw that, so I just took it out, put it in and closed the door."

"So it's a walkable community and your neighbors are close enough to get out to meet your neighbors and things like that. So it adds to your mental well being."

"There's some good churches."

"The Levittown area has brought some new healthy restaurants... They opened up 2 or 3 different smoothie places."

COMMUNITY ASSETS

HEALTH SERVICES

Availability and convenience of holistic health services were mentioned by residents. It was noted that ambulatory services had quick response times. Mental health services were accessible and advertised.

ON HEALTH SERVICES

"I feel like there are a lot of doctors here. So that's make it more comfortable for the community. I think we have centers here, emergency centers and all that and hospitals too. So it's very convenient to go to any hospital around here."

"...resources for mental health and hospitals and dentists."

"When I had my daughter they had advertised a lot of like mental health providers that was nearby that accepted the policy."

COMMUNITY CHALLENGES

COUNSELING NEEDS

Residents have noticed substance use treatment needs in some areas. More pervasive counseling services for family members and family issues, that are covered by insurance, were needed. Mental health services were described as inadequate and not designed to get to the root of the problem.

ON COUNSELING NEEDS

"The drug problem in Sellersville has gotten bad."

"My wife and I have had issues because of everything that's been going on to see about doing couples counseling and our insurance does not cover marriage counseling."

"Terrible mental health coverage in the area, terrible mental health availability. It's so hard especially for people like us. We don't all have cars; we don't all have ways to get there, it's really difficult. The other thing is I came in on domestic violence and there is terrible domestic violence support in this area. I was told 15 places were full and I ended up here and nobody is trained in domestic violence. So, it has been a really, really rough road from there and then my health insurance, nobody takes it..."

"I spent an extensive amount of time in mental health facilities in different places. And I will honestly say that there is no real health treatment in facilities in mental health hospitals and behavioral facilities. There's a minimum of group therapy and far too much unstructured time and very little if none, one-on-one when you go. They're like, 'Ok, so are you taking meds, are they taking meds? Okay, we'll put you back on meds.' Or it's very rapid-fire sort of like they'll bandage you up and get you out..."

LIMITED HEALTHCARE ACCESS

Barriers related to low socioeconomic status, undocumented status, expensive insurance, high co-pays, and insufficient insurance coverage were mentioned. Community members avoided seeing a doctor for years because of a lack of affordability. Differences in language proficiency and culture also limited the frequency of visits and confidence in healthcare providers. Language barriers didn't only limit verbal communications but also written and health education opportunities that supported preventative health. There were also communication issues and perceived negligence, that resulted in patients not having complete information about their own health conditions. There were concerns about doctors being systematically replaced by nurse practitioners and physician assistants.

There was limited access to dentists, especially those who were multilingual and affordable.

Available resources for a variety of services needed to be publicized in more accessible ways for community members. And some health insurance plans covered gym memberships that were not geographically accessible.

ON LIMITED HEALTHCARE ACCESS

"If you don't have an employment because you don't have papers, it's just so hard to get health insurance coverage."

"I have a small business and small business owners have to pay their own insurance, and it's too expensive to pay a health insurance."

"Yeah, even though if you have health insurance, like in my case I pay around $600 a month and every time that I go to see a doctor, it's $75 for a regular doctor copay. And then if I have to go to a specialist, I have to pay $120."

"If there is a language barrier, people just don't want to go there. Because one, they don't understand what they are saying. Two, they don't know that they have the right to request an interpreter and interpreter should be provided to these people. And third, because of our cultural beliefs, we are not completely understood when we talk about our bodies and the things that we do to take care of ourselves."

"I feel like in the Latino community, there's a big percentage of people who doesn't know how to read or write, don't have an education. So it's very hard to be aware of what being healthy means."

"...a lot of the young kids have the teeth rotten because their parents cannot afford taking them to the dentist. And also they come from small villages in our countries and they don't know the right way to take care of the teeth of the kids."

"almost every medical insurance now come with free gym membership but a lot of people don't know that. I mean, I use the Y but it's free, it's through my insurance. So it's not just having the physical gym, it's getting the information out there."

"I can say the communication between medical provider and the patient. For example, I just delivered a baby and after I deliver it, I didn't know that I'm anemic... nobody told me... I was focusing everything for the baby. So, I did not check my own reports.... So there is lack of communication between medical professional and patient."

"I think some doctors like if you go in and complain about pain, I think they look at you and say, oh well, maybe because of the way you look, I'm not going to believe that you're really in pain. Maybe you're just here trying to get some drugs. So I do think racism plays a part sometimes."

HEALTHY FOOD ACCESS ISSUES

Attempts to eat healthier were thwarted by the higher costs of these foods and the proliferation of unhealthy, fast-food restaurants that were more affordable. There was also a need for community-based programs that supported healthy eating and weight loss for residents. There was also a lack of trust in the quality of produce, the origins of seedless varieties, and the use of chemicals in production. "There's not been enough education for people to really realize like how bad it is."

ON HEALTHY FOOD ACCESS ISSUES

"...the point is the healthy food is very important for us because we eat a lot of things it's not healthy."

"Yeah, money, if you want to try to buy organic or do something like that, it can also be a lot more expensive. I'm just buying the cheapest option available. But you never know what they put in the food."

"Everybody eats fast food. Some of them forget or they're not aware of the effects of that."

"It's not a lot of farmers markets in Bucks County."

TRANSPORTATION NEEDS

Not having a vehicle was limiting when trying to meet daily life needs. For some, it was dangerous when walking because of traffic. Reliable public transportation options were needed, particularly ones that were affordable and met the needs of older adults. Some used cab services which could become too expensive.

ON TRANSPORTATION NEEDS

"I don't feel this is a very walkable neighborhood."

"If you don't have a car, you can't go anywhere."

"I have to be checking if a car is not gonna run over me, because it's just not a place to walk."

"So the place where I go for treatment right now, the buses aren't running."

COMMUNITY DISSENSION

Some residents have experienced conflict with neighbors, due to religious and political differences, as well as homophobia in their neighborhoods. Discrimination has been experienced in hospital settings as well.

ON COMMUNITY DISSENSION

"It seems like it's a tale of two cities, right? It's so people are either, like, super friendly, super nice, you know, lean that way you, you know, accepting you get along with them, great. Or they're just absolute complete haters. And it's like, there's no way. There's not really in between. In fact, when I talk to people who are from this area, and I tell them that and they're like, yeah, that's."

"They have followed us in vehicles. Right now, there's a sign across the street that has our number on it and two pictures of dogs. And it says P period O period S period."

"Being a Black single mom and, you know, delivering a child at this particular hospital, I would never deliver another baby there again."

LACK OF AFFORDABLE HOUSING

Housing costs and high taxes were prohibitive to home ownership and healthy eating. According to residents, Bucks County did not provide housing assistance like other counties did, and did not have a year-round homeless shelter.

ON LACK OF AFFORDABLE HOUSING

"I hear people saying that the rental costs are going up again and people can't find any affordable housing whatsoever..."

"...the housing market has gone insane. Yes, race plays a part in housing I feel, or even your background."

"...there's less time spent in the home due to the high cost of living. Everyone must work full time, therefore less time to be able to prepare healthy meals."

SPECIAL POPULATIONS

OLDER ADULTS

Immigrant residents expressed their surprise about seeing adults in their 70s and 80s still working and shared that more resources should be available to support them. Not having adequate funds for retirement was a concern. This was especially true for immigrants who send significant amounts of money back to their countries of origin, and did not have adequate savings in their retirement years. Undocumented older adults "don't have family, don't have health insurance, don't receive social security and they're almost unemployable because they're too old." Residents shared that undocumented immigrants may also carry trauma and untreated mental illness related to their migrations, that remain unresolved in their old age. Multiple groups expressed the language barriers experienced by older adults in Bucks County.

Free and discounted public transportation services for older adults were helpful. Some Bucks County residents have stated some older adults still face transportation problems. There were also recreational centers for adults that included transportation as an aspect of their services. Overall awareness about resources for older adults seemed limited because of minimized technology use.

ON OLDER ADULTS

"I see these old people working here. I never saw that in Argentina. What's happening? He was like, where are their sons? Where are their daughters? Where are they? What happened? So there's that cultural thing..."

"It takes a village to take care of the older people... Here it's very individualistic."

"Most of our undocumented do the hard work, the hard labor. When you hit 60-65 you can't be out there working construction or landscaping or doing things like that."

"There is an epidemic of loneliness."

CHILDREN AND YOUTH

The Central Bucks School District was praised for their support of struggling students. But school meals could be improved, as well as the overall standards for youth diets in their communities. Summer school programs and other education-oriented activities were desired among residents. Concerns were raised about how limited public transportation made it difficult for youth to engage in community recreational activities. A resident in Bensalem brought up the prevalence of playgrounds and parks, although there was insufficient public transportation to get to them. Overall, these resources were greatly beneficial for young children and their parents who brought them.

Young people were also experiencing increased mental health issues, due in part to being more isolated and an increased use of electronics. They were moving into a "virtual world." Social media in particular facilitated unrealistic social and beauty standards that could be harmful to adolescent minds.

In addition, cultural stigmas regarding mental illness impeded the seeking out of services. It was perceived that in some ways, "... kids are growing up way too fast... it's accelerating their aging." Yet they were also immature compared to prior generations at their developmental stage (e.g. life skills, socialization skills, independence). It was also suggested that parents needed a "toolbox" to address the various needs of their children, especially when therapy was not accessible.

Immigrant youth needed financial education, to adjust to financial systems in the U.S., understand education and health expenses (e.g., credit, debt, collections), and the implications of debt on mental health.

ON CHILDREN AND YOUTH

"When your kids are below basic read level, they read on grade level now, so I'm really happy for that."

"I think they have a cross section of playgrounds and little league activities for the young children in our community so that helps with parents and children keeping them off the streets and things that can engage in healthy activities."

"Yeah, their breakfast is a pop tart or something like that."

"They just wanna be at home, they just wanna be on the screens, on the phone or a TV, PlayStation, and then you don't stimulate your body, you don't stimulate your emotions, you don't have that many friends. Everything is virtual, everything is imaginary, because you don't see it, you don't feel it, and that's now affecting the mental health at the end."

"Thing with social media and especially young people, before, you were only comparing yourself to your neighbor and that's it. Now you are comparing yourself to 100,000, gazillion, billion dollar 20-year-old guy in the middle on the other part of the world that's saying that if you don't have what he has at his age, you're a bad person or whatever. It sets very unhealthy expectations for what someone in a specific age group should be because again, they are not localizing their group anymore. It's... all expanded."

"...therapy is like you're crazy."

"Yeah, we have a kid, an 18-year-old from Guatemala with papers. He bought a car, $42,000 along with 16% of interest rate and a credit card for $5000. And he is like, how are we gonna pay for all this?"

ADDITIONAL POPULATIONS

There was a perception that veterans have been disregarded, and that veterans were not inclined to seek help when they needed it.

Residents have taken note of several free resources and community centers for the LGBTQ+ population.

Concerns were raised about the needs of people with disabilities (PWDs) who were young, in school, and who had invisible disabilities. There was a lack of empathy when disabilities couldn't be seen, and a desire for more resources that encouraged privacy, dignity, and autonomy with service providers. For older people with disabilities, home health aide services didn't last long enough, especially for those who lived alone.

Immigrants didn't have access to interpreters to speak the variety of their languages, such as those from Uzbekistan, Algeria, and Afghanistan. Immigrants experienced difficulties with job placement.

Financial hardships related to single parenthood involved housing, health insurance, and healthy food.

Rural communities were also named as a unique group with "limited access to health services and healthy food options."

Residents discussed inadequacies with services for homeless individuals, such as the need for mixed-gender shelters and the expectation for homeless individuals to have identification cards.

"

VETERANS

"I feel like the system was like, okay, you serve and then bye, thank you. Then it's so hard for them to get help. A lot of them have health, mental issues and PTSD... And especially for someone with military training, it's hard to acknowledge, it's hard to admit that you have mental issues. You're trained... to just suck it up."

PWDS

"...my brother he cannot talk or walk and when we go to the playground, there's less stuff that he can play with and he just see the little kids play."

"I was a teacher for children with autism. There is not enough support or training there."

IMMIGRANTS

"Also need like some places to take all of them together. And then maybe you can get some information with the old immigrants, with new immigrants... not all of them have families..."

HOMELESSNESS

"Sometimes it's hard for them to get help, because they're not aware, because they don't have phones."

"

ACCESS TO CARE

Perceptions of a complicated healthcare system served as a barrier to information and services. There were complaints of delayed appointment dates, long emergency room waits, with health professionals passing by patients who were violently ill. Virtual appointments have helped to ease some of these problems. Emergency room co-pays, upwards of $500, and bills were not affordable. Geographical distance served as a barrier to care.

Community members spoke of poor experiences with health professionals that made it difficult for them to return, such as stereotyping, and prejudiced diagnosing and treatment. Having less access to providers of color and dentists was noted as problematic.

For the most part, long waiting lists have limited access to substance use treatment and mental health treatment. Participants who worked in the mental health field spoke of community members who were hesitant to use mental health hotlines, perceived as impersonal. Some individuals have heard of social services being made available at churches.

ON ACCESS TO CARE

"...some people just don't know how the system works so they don't know what to do."

"They just let you wait. They'll wait until you drop on the floor and then they'll probably take you in if you passed out from the pain. But I had to wait 45 minutes too, and it was the worst 45 minutes of my life..."

"...they checked me in and I was there for three hours. I left and I still didn't know what I had. But I got a $10,000 bill and I still didn't know what I had. They couldn't tell me what was going on with me, what was the reason I was feeling like that... Some people rather just stay home."

"I listen to some people that say like, hey, I went to this doctor and I felt like they were racist to me and I don't wanna go again."

"...there's way too much demand for substance abuse and mental health. We have one center... it's the one that treats fentanyl or heroin."

"...it took me a number of years to assemble a good mental healthcare team, which I have now, and I couldn't be any happier with the whole lot of them."

TRUSTWORTHINESS

Residents have had mixed experiences regarding trust in their healthcare providers. Undiagnosed health conditions and medication-focused treatment interventions were cited as reasons why. One community member spoke about the poor communication and insufficient support when his partner was in hospice.

ON TRUSTWORTHINESS

"I can say no that way because, I'll just give my example, my mother-in-law, she suffered from brain cancer, GBM glioblastoma. She's been seeing doctor like she was like filling out her all appointments and the doctor did not notice until the last moment she diagnosed with GBM at the stage four and that is too late for her. She couldn't make it."

"I've had to follow my doctor because she's leaving, going to another practice and I'm going to run right behind her because I truly trust this doctor. I think trust has a lot to do with communication. You want a doctor that's going to listen to you and not just tell you."

"I think it feels to me hit or miss...it depends on what you're working with. Like the hospice organizations are notoriously terrible... for most people I've spoken to about it, maybe not as bad as what we went through, but more bad than good."

"Trust them, 100% with my health? No, I would say no. But the dignity and respect is definitely there. It's just that I feel there are different ways they can go about things instead of always suggesting a medication."

COVID-19 PANDEMIC

Respondents had mixed opinions about the use of technology post-COVID, dependent upon symptomology, comfort with technology, convenience, and trust. Some felt that telehealth appointments allowed for more and undivided attention from health providers. Ready access to medical records was appreciated.

There were mixed responses as to whether respondents were still concerned about COVID-19. "I agree with [name] that it's a concern, but it's a greatly reduced concern." There were greater concerns among people with pre-existing health conditions. Some community members were aware of Long COVID.

ON COVID-19 PANDEMIC

"...they have mental health awareness and health over technology, which I think is very beneficial because there's still a little bit of taboo to like go into therapy or something like that. So having it virtual just works the best for everyone."

"...when you fill out your information, I noticed then... I'm getting spam calls up a lot."

"So my understanding is that if you had COVID, Long COVID is the symptoms that are still prevalent in your system after you've supposedly have been cured from COVID?"

"My husband... His sense of smell he lost it."

"So I don't worry about getting it anymore. I actually had it twice."

"I have COVID long-haul syndrome, it affected my brain and it damaged my pancreas... my pancreas doesn't produce the enzymes to breakdown fats so I have to take pills all the time..."

SUGGESTED ACTIONS

Bucks County

What is already working well to improve health in your community?

The benefits of telehealth services are generally recognized.

"But I also think telehealth is a great communication access because you need your doctor's notes to match what you're saying inside of your doctor's office when regarding communication and trust within the facility... we can email our doctors and say, hey, per our conversation, this is what happened, and this is what I need. And you can put your chief complaint in writing. So then when your doctor is not giving you that respect you can always bring it back."

What are the most important issues to address to improve health in your community?

Community members are not well-oriented to their benefits and community resources.

"I think getting information out to the community. These insurance companies could have just like we're meeting here, they could host an informational exchange with their base, their groups of people who are insured with them. So they could explain what their benefits are. No one wants to read through books of information. So it would be easy if they could make that information available at a sit down group meeting or group forum or something of that manner."

There is a need for affordable childcare.

"Childcare is another mortgage. More than a mortgage. It's crazy."

Transparency and choice are needed to help manage medical expenses and encourage autonomy in healthcare.

"...sometimes when you get a bill from the doctor, there are a lot of charges that are just [a scam]. It's like they charge you for the ambulance ride... for a bed. I don't even know what they're charging me for but it's $45 for this one... for things that probably you don't need."

Language barriers limit healthcare access in disproportionate ways among non-native English speakers.

"Translators. I don't know if it exists, but it is something like a hotline you can call and you would be able to have access for free to any translator."

Community needs for people with low incomes are varied.

"Support for people with a low income, such as free events with free food, free clothing, home items. I have seen some chat comments about pantries, but like clothing closet, it sounds like it would be a good idea also."

Healthcare should be treated as a basic human need.

"Universal healthcare... from what I understand it can [have] its own challenges because there's like long, long waits, still -- it doesn't solve all their problems. But I'm like, yeah, but still it's universal. It's horrible that we don't have, like, how do you treat your citizen? How do you not provide basic needs? Healthcare is a basic need."

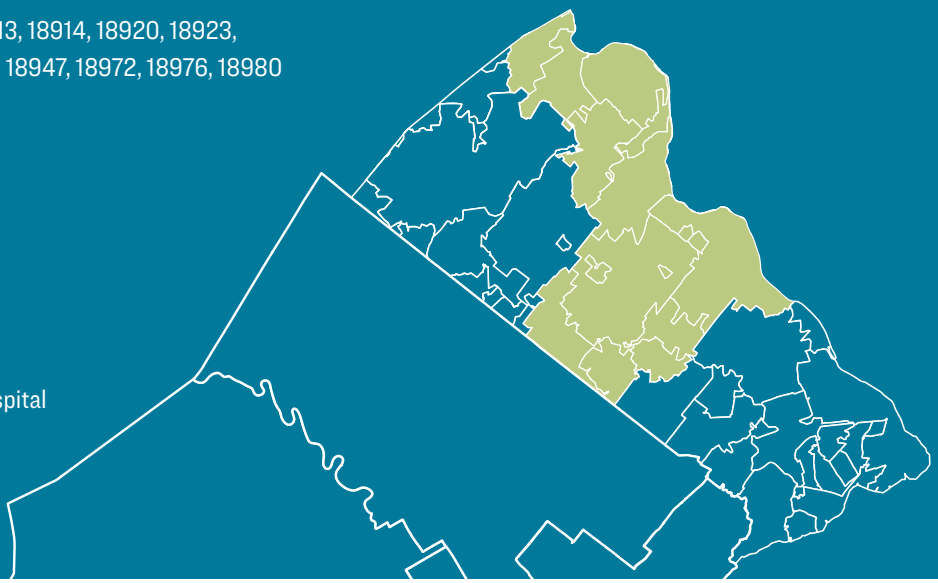
Central Bucks

ZIP Codes: 18077, 18901, 18902, 18912, 18913, 18914, 18920, 18923, 18925, 18929, 18930, 18938, 18942, 18946, 18947, 18972, 18976, 18980

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Landsdale Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)



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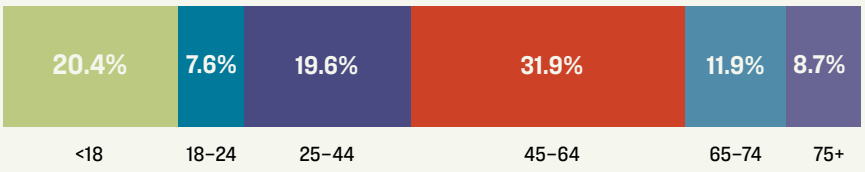
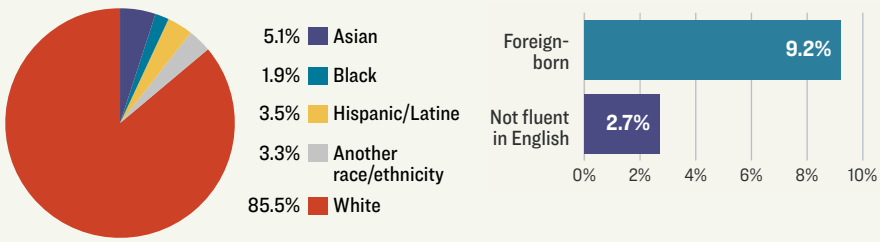


SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

142,976

MEDIAN HOUSEHOLD INCOME

$140,297

EDUCATIONAL ATTAINMENT

18.8% High school as highest education level

PEOPLE WITH DISABILITIES

9.8%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Central Bucks	Bucks County
GENERAL	All-cause mortality rate (per 100,000)	934.0	1,057.9
	Life expectancy: Female (in years)	82.3	80.4
	Life expectancy: Male (in years)	78.9	76.8
	Years of potential life lost before 75	5,811	38,150
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	28.6%	29.7%
	Diabetes prevalence	10.3%	10.5%
	Diabetes-related hospitalization rate (per 100,000)	116.0	134.0
	Hypertension prevalence	31.5%	31.4%
	Hypertension-related preventable hospitalization rate (per 100,000)	24.0	34.0
	Potentially preventable hospitalization rate (per 100,000)	700.0	692.0
	Premature cardiovascular disease mortality rate (per 100,000)	21.7	33.3
	Major cancer incidence rate (per 100,000)*	325.3	323.0
	Major cancer mortality rate (per 100,000)*	74.9	82.0
	Colorectal cancer screening (adults age 45-75)	72.5%	71.2%
	Mammography screening (women age 50-74)	79.2%	78.4%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	1.0	3.8
	Percent low birthweight births out of live births	6.1%	7.0%
	Percent preterm births out of live births	7.4%	8.8%
	Child Opportunity Index**	86.2	47.0
BEHAVIORAL HEALTH	Adult binge drinking	17.9%	18.0%
	Adult smoking	11.8%	13.5%
	Drug overdose mortality rate (per 100,000)	15.4	28.1
	Opioid-related hospitalization rate (per 100,000)	270.8	257.4
	Substance-related hospitalization rate (per 100,000)	309.2	346.3
	Poor mental health for 14+ days in past 30 days	13.4%	14.6%
	Suicide mortality rate (per 100,000)	10.5	12.6
INJURIES	Fall-related hospitalization rate >64 years (per 100,000 >64 years)	2,295.0	2,299.0
	Homicide mortality rate (per 100,000)	0.7	1.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	6.2%	9.6%
	Children <19 years with public insurance	14.8%	24.8%
	Population without insurance	2.3%	4.0%
	Children <19 years without insurance	1.4%	2.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	3.2%	5.6%
	Children <18 years in poverty	2.4%	6.0%
	Adults 19-64 years unemployed	3.5%	4.2%
	Householders living alone who are 65+ years	22.5%	23.5%
	Households receiving SNAP benefits	4.0%	7.5%
	Households that are housing cost-burdened (% spending >50% of household income)	10.7%	11.8%
	Vacant housing units	3.8%	3.4%
	Single parent households	15.7%	18.2%
	Commute greater than 60 minutes	14.2%	12.4%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 233

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Heart conditions

Mental health

Cancer

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Substance use

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Safe neighborhoods

Affordable healthy food

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Scheduling problems (such as health services not open when available)

Health insurance is not accepted

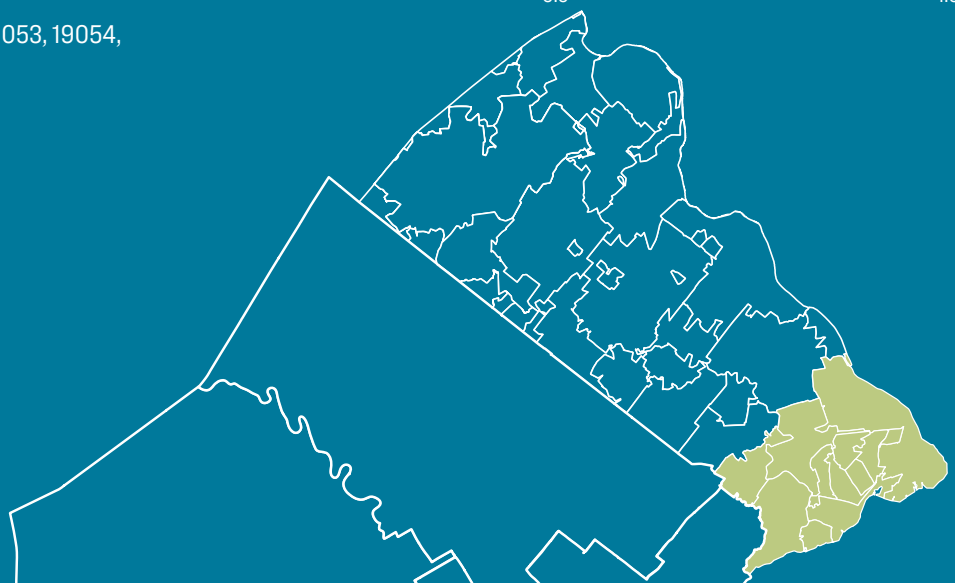
Lower Bucks

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

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)



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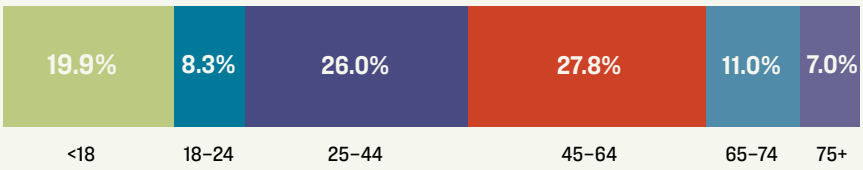
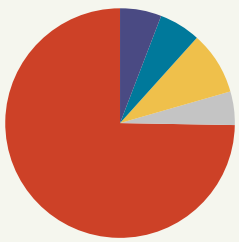
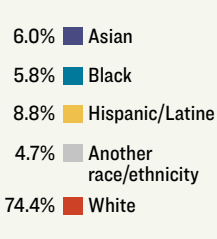
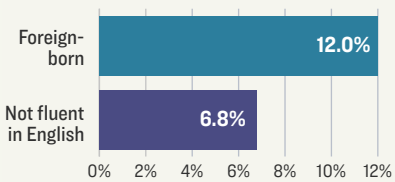


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

282,354

MEDIAN HOUSEHOLD INCOME

$98,393

EDUCATIONAL ATTAINMENT

32.2% High school as highest education level

PEOPLE WITH DISABILITIES

15.0%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Lower Bucks	Bucks County
GENERAL	All-cause mortality rate (per 100,000)	1,009.7	1,057.9
	Life expectancy: Female (in years)	79.0	80.4
	Life expectancy: Male (in years)	75.0	76.8
	Years of potential life lost before 75	20,166	38,150
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	31.7%	29.7%
	Diabetes prevalence	11.2%	10.5%
	Diabetes-related hospitalization rate (per 100,000)	250.0	134.0
	Hypertension prevalence	31.5%	31.4%
	Hypertension-related preventable hospitalization rate (per 100,000)	62.0	34.0
	Potentially preventable hospitalization rate (per 100,000)	1,136.0	692.0
	Premature cardiovascular disease mortality rate (per 100,000)	39.4	33.3
	Major cancer incidence rate (per 100,000)*	300.6	323.0
	Major cancer mortality rate (per 100,000)*	77.6	82.0
	Colorectal cancer screening (adults age 45-75)	68.7%	71.2%
	Mammography screening (women age 50-74)	76.6%	78.4%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	4.8	3.8
	Percent low birthweight births out of live births	8.0%	7.0%
	Percent preterm births out of live births	9.3%	8.8%
	Child Opportunity Index**	47.0	47.0
BEHAVIORAL HEALTH	Adult binge drinking	18.0%	18.0%
	Adult smoking	16.2%	13.5%
	Drug overdose mortality rate (per 100,000)	40.1	28.1
	Opioid-related hospitalization rate (per 100,000)	274.0	257.4
	Substance-related hospitalization rate (per 100,000)	413.7	346.3
	Poor mental health for 14+ days in past 30 days	16.4%	14.6%
	Suicide mortality rate (per 100,000)	14.9	12.6
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,381.0	2,299.0
	Homicide mortality rate (per 100,000)	1.4	1.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	14.0%	9.6%
	Children <19 years with public insurance	33.9%	24.8%
	Population without insurance	5.2%	4.0%
	Children <19 years without insurance	1.7%	2.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	8.3%	5.6%
	Children <18 years in poverty	11.6%	6.0%
	Adults 19-64 years unemployed	4.9%	4.2%
	Householders living alone who are 65+ years	23.1%	23.5%
	Households receiving SNAP benefits	12.4%	7.5%
	Households that are housing cost-burdened (% spending >50% of household income)	13.6%	11.8%
	Vacant housing units	3.1%	3.4%
	Single parent households	30.3%	18.2%
	Commute greater than 60 minutes	11.2%	12.4%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 288

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Diabetes and high blood sugar

Chronic pain and pain management

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Loneliness

Anxiety

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Intellectual / developmental disabilities

Infant / baby health

Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Bullying

Loneliness

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Mental health services

Affordable healthy food

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

No health insurance

Transportation (getting to and from doctor's visits and appointments)

Costs associated with getting healthcare

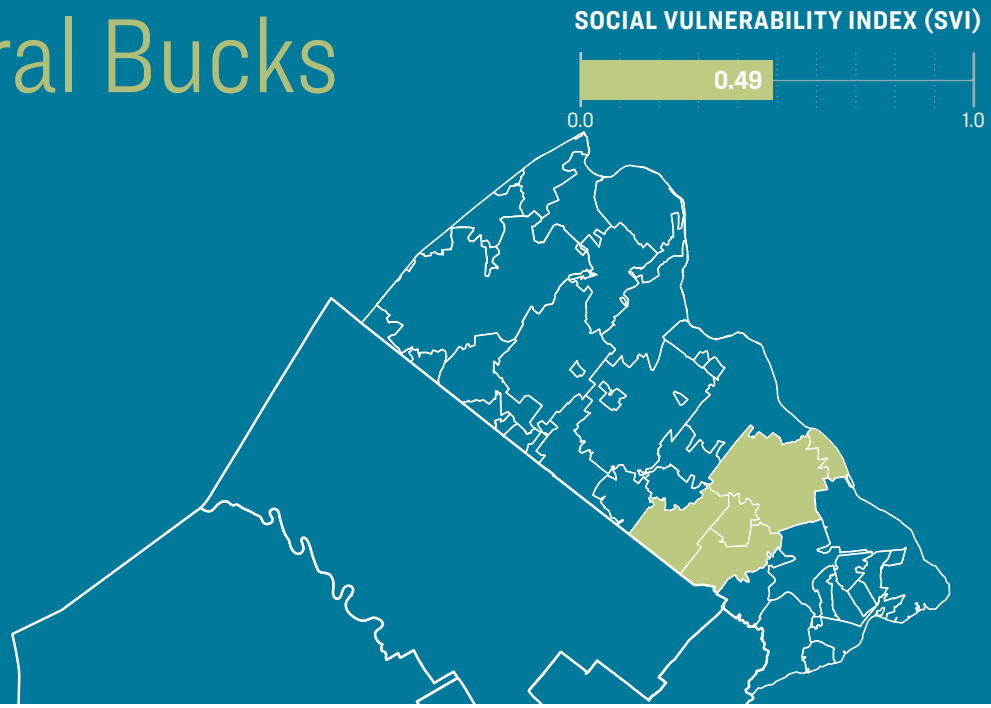
Lower Central Bucks

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

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Methodist Hospital
- Magee Rehab
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)



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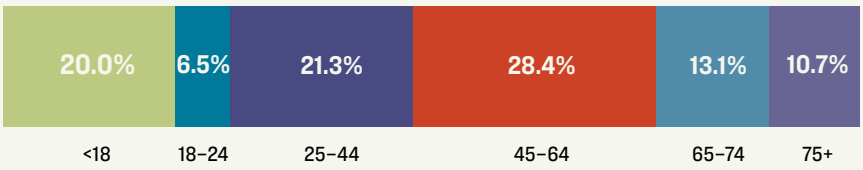
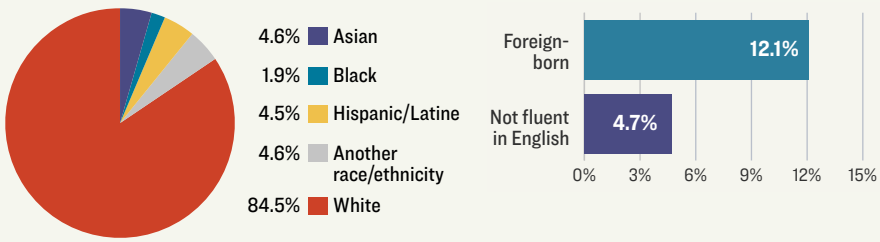


SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

124,017

MEDIAN HOUSEHOLD INCOME

$127,786

EDUCATIONAL ATTAINMENT

23.3% High school as highest education level

PEOPLE WITH DISABILITIES

11.4%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Lower Central Bucks	Bucks County
GENERAL	All-cause mortality rate (per 100,000)	1,197.5	1,057.9
	Life expectancy: Female (in years)	81.5	80.4
	Life expectancy: Male (in years)	78.2	76.8
	Years of potential life lost before 75	5,795	38,150
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.4%	29.7%
	Diabetes prevalence	10.2%	10.5%
	Diabetes-related hospitalization rate (per 100,000)	152.0	134.0
	Hypertension prevalence	31.5%	31.4%
	Hypertension-related preventable hospitalization rate (per 100,000)	43.0	34.0
	Potentially preventable hospitalization rate (per 100,000)	832.0	692.0
	Premature cardiovascular disease mortality rate (per 100,000)	20.2	33.3
	Major cancer incidence rate (per 100,000)*	322.5	323.0
	Major cancer mortality rate (per 100,000)*	87.1	82.0
	Colorectal cancer screening (adults age 45-75)	73.8%	71.2%
	Mammography screening (women age 50-74)	79.8%	78.4%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.5	3.8
	Percent low birthweight births out of live births	7.3%	7.0%
	Percent preterm births out of live births	10.1%	8.8%
	Child Opportunity Index**	80.0	47.0
BEHAVIORAL HEALTH	Adult binge drinking	17.4%	18.0%
	Adult smoking	10.4%	13.5%
	Drug overdose mortality rate (per 100,000)	20.2	28.1
	Opioid-related hospitalization rate (per 100,000)	200.8	257.4
	Substance-related hospitalization rate (per 100,000)	240.3	346.3
	Poor mental health for 14+ days in past 30 days	12.8%	14.6%
	Suicide mortality rate (per 100,000)	11.3	12.6
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,289.0	2,299.0
	Homicide mortality rate (per 100,000)	4.8	1.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	6.9%	9.6%
	Children <19 years with public insurance	18.7%	24.8%
	Population without insurance	2.7%	4.0%
	Children <19 years without insurance	3.3%	2.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.2%	5.6%
	Children <18 years in poverty	5.7%	6.0%
	Adults 19-64 years unemployed	3.9%	4.2%
	Householders living alone who are 65+ years	24.3%	23.5%
	Households receiving SNAP benefits	4.9%	7.5%
	Households that are housing cost-burdened (% spending >50% of household income)	10.8%	11.8%
	Vacant housing units	2.9%	3.4%
	Single parent households	15.2%	18.2%
	Commute greater than 60 minutes	12.2%	12.4%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 158

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Heart conditions
- Obesity and maintaining healthy weight

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Intellectual / developmental disabilities
- Mental health
- Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Safe neighborhoods
- Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Transportation (getting to and from doctor's visits and appointments)
- Health insurance is not accepted

Upper Bucks

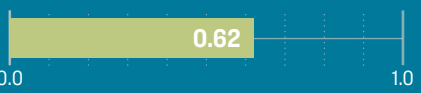
ZIP Codes: 18917, 18935, 18944, 18951, 18955, 18960, 18962, 18964, 18969, 18970

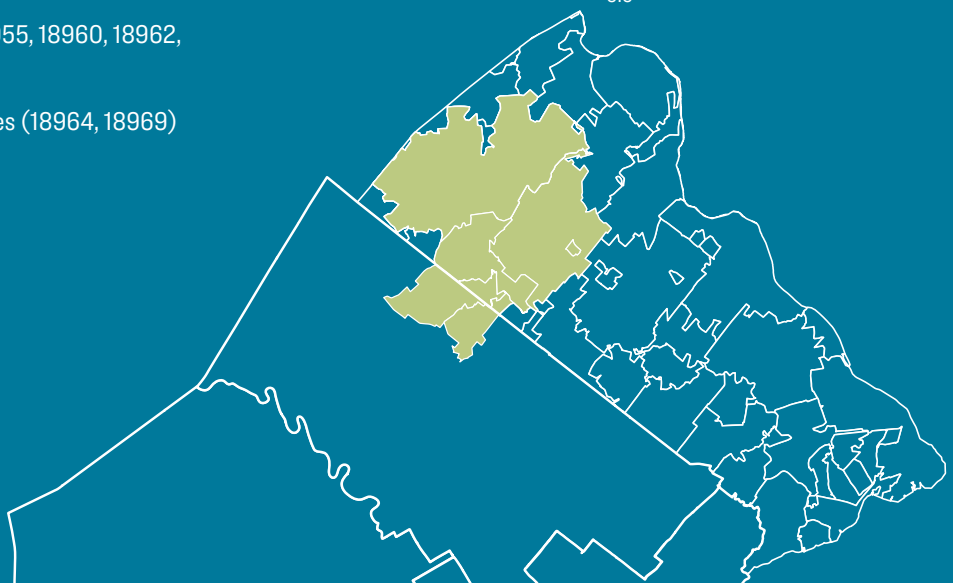
Note: This community includes two ZIP codes (18964, 18969) which cross into Montgomery County.

This community is served by:

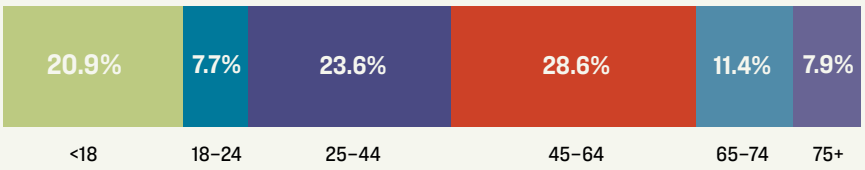
- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Lansdale Hospital
- Jefferson Methodist Hospital
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)



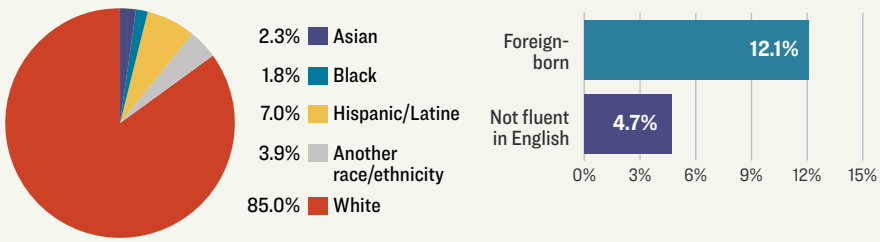


AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

111,035

MEDIAN HOUSEHOLD INCOME

$105,057

EDUCATIONAL ATTAINMENT

32.8% High school as highest education level

PEOPLE WITH DISABILITIES

12.3%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Upper Bucks	Bucks County
GENERAL	All-cause mortality rate (per 100,000)	1,039.8	1,057.9
	Life expectancy: Female (in years)	79.6	80.4
	Life expectancy: Male (in years)	76.9	76.8
	Years of potential life lost before 75	6,378	38,150
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	30.5%	29.7%
	Diabetes prevalence	10.2%	10.5%
	Diabetes-related hospitalization rate (per 100,000)	172.0	134.0
	Hypertension prevalence	31.3%	31.4%
	Hypertension-related preventable hospitalization rate (per 100,000)*	43.0	34.0
	Potentially preventable hospitalization rate (per 100,000)*	875.0	692.0
	Premature cardiovascular disease mortality rate (per 100,000)	43.1	33.3
	Major cancer incidence rate (per 100,000)*	333.4	323.0
	Major cancer mortality rate (per 100,000)*	85.4	82.0
	Colorectal cancer screening (adults age 45-75)	70.6%	71.2%
	Mammography screening (women age 50-74)	78.5%	78.4%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	5.4	3.8
	Percent low birthweight births out of live births	6.0%	7.0%
	Percent preterm births out of live births	8.1%	8.8%
	Child Opportunity Index**	67.9	47.0
BEHAVIORAL HEALTH	Adult binge drinking	18.6%	18.0%
	Adult smoking	14.6%	13.5%
	Drug overdose mortality rate (per 100,000)	18.9	28.1
	Opioid-related hospitalization rate (per 100,000)	238.1	257.4
	Substance-related hospitalization rate (per 100,000)	325.3	346.3
	Poor mental health for 14+ days in past 30 days	15.2%	14.6%
	Suicide mortality rate (per 100,000)	9.0	12.6
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,941.0	2,299.0
	Homicide mortality rate (per 100,000)	0.9	1.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	9.1%	9.6%
	Children <19 years with public insurance	26.4%	24.8%
	Population without insurance	4.4%	4.0%
	Children <19 years without insurance	2.7%	2.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.3%	5.6%
	Children <18 years in poverty	6.1%	6.0%
	Adults 19-64 years unemployed	3.8%	4.2%
	Householders living alone who are 65+ years	24.3%	23.5%
	Households receiving SNAP benefits	7.2%	7.5%
	Households that are housing cost-burdened (% spending >50% of household income)	9.8%	11.8%
	Vacant housing units	4.6%	3.4%
	Single parent households	23.1%	18.2%
	Commute greater than 60 minutes	11.0%	12.4%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 87

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Heart conditions

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Affordable healthy food

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

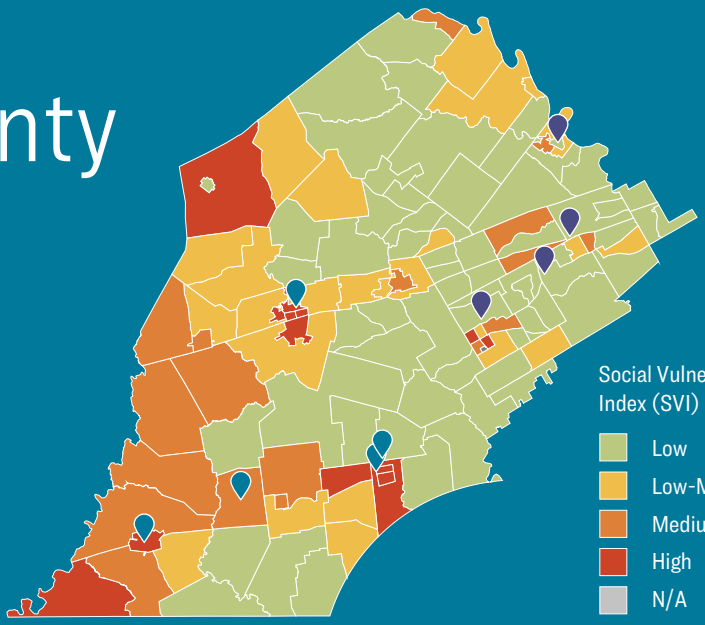
Transportation (getting to and from doctor's visits and appointments)

Health insurance is not accepted

Chester County

SOCIAL VULNERABILITY INDEX (SVI)*

*SVI is a measure developed by the CDC to identify communities that may need support before, during, or after disasters. This measure is made up of a combination of 16 different U.S. Census variables, which are grouped into four themes (socioeconomic status, household charateristics, racial & ethnic minority status, and housing type & transportation), and cover major areas of social vulnerability.



HOSPITAL HEALTH CENTER

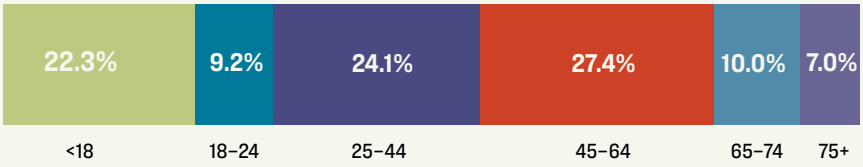
There are 5 hospitals and 4 health centers in Chester County.*

*ChristianaCare - West Grove anticipated opening Summer 2025

Demographics

AGE DISTRIBUTION

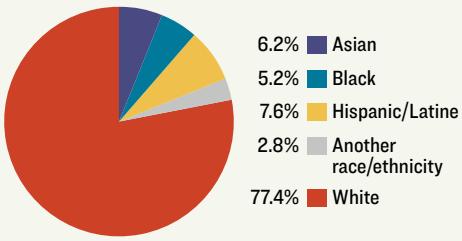
Chester County has an estimated population of 540,896 with the largest proportion of residents between the ages of 45 - 64.



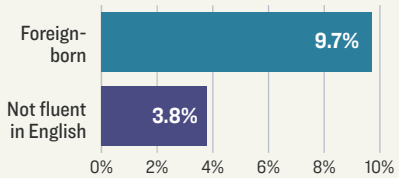
SEX

RACE/ETHNICITY/LANGUAGE

77% of residents are non-Hispanic White. Hispanic/Latine residents make the next largest population, comprising about 7.6% of the county's residents.



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



HOUSEHOLDS

Median Household Income
$107,826

Homeownership
75%

Severe Housing Cost Burden
% spending >50% of household income
11%

High School as Highest Education
19.3%

Household Food Insecurity
8.1%

Single Parent Households
18.2%

Same Sex Couples
per 1,000 households
2.8

Commute Greater than 60 minutes
9.2%

Chester County

Health

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases
4. COVID-19
5. Chronic Lower Respiratory Diseases

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

4.0%

Depressed/Sad Most Days in the Past 12 Months

23.6%

Binge Drinking

8.8%

Cigarette Smoking

2.7%

Vaping

9.2%

Exposure

Lead Levels in Children (<16 years old)

2.3%

PEOPLE WITH DISABILITIES

Percent of Population

9.1%

Poverty Status in the Past 12 Months

16.7%

Percent who have difficulty with:

Hearing	2.6%
Vision	1.3%
Cognition	3.8%
Ambulatory	3.7%
Self-care	1.5%
Independent Living	3.1%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

1.9

Violent Crime Rate per 100,000

115.2

Gun-related ED Utilization per 100,000

3.1

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

377.7

This measure reflects limited access to primary care as individuals may rely on emergency departments non-emergency health needs due to barriers like insurance, trust, clinician shortages, etc.

Flu Vaccinations (Adult)

60.0%

This measure is a strong indicator of overall community vaccination levels because they reflect access to healthcare, public trust in vaccines, and the effectiveness of outreach efforts in promoting immunization.

Chlamydia per 100,000

212.3

This measure is a good marker for STIs in a community because it is the most commonly reported bacterial infection, often asymptomatic, and indicates the overall level of STI transmission, screening, and prevention efforts in a population.

Income Inequality

0.45

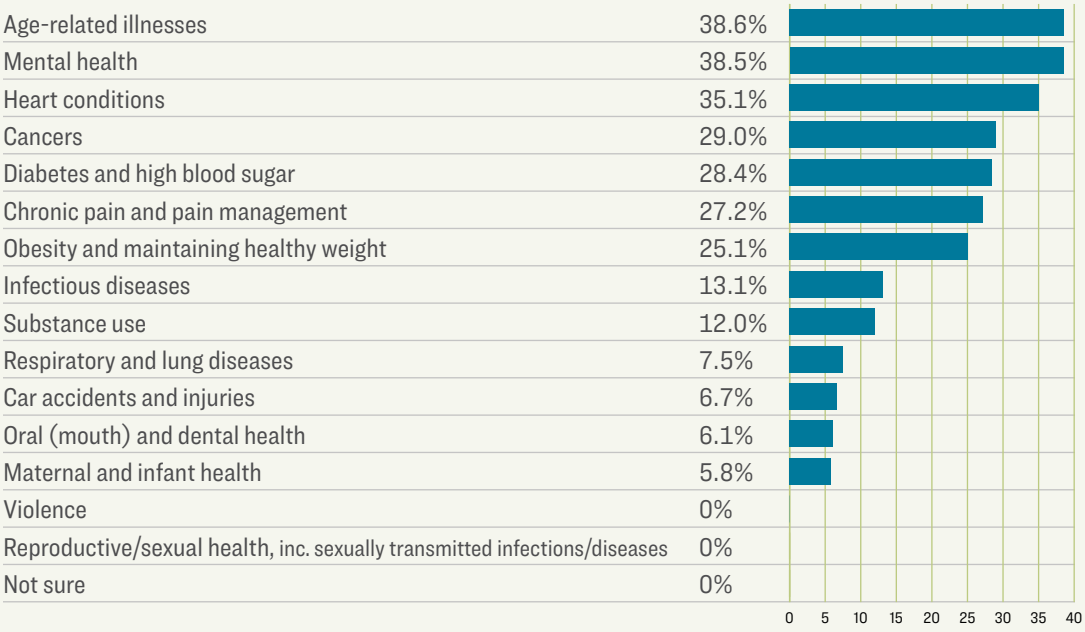
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Chester County

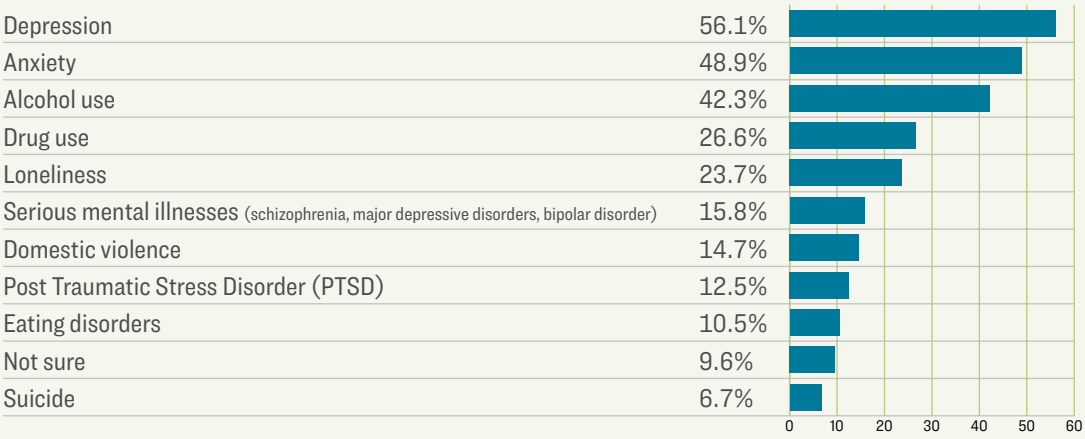
County Survey Results

Number of Respondents: 658

Thinking about yourself or other ADULTS in the community where you live, what are the top 3 HEALTH problems?



Thinking about yourself or other ADULTS in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?



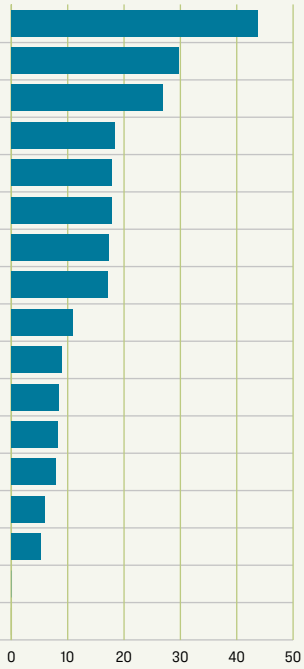
Chester County

County Survey Results

Number of Respondents: 658

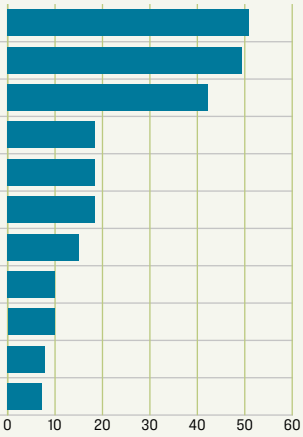
Thinking about your or other CHILDREN in the community where you live, what are the top 3 HEALTH problems?

Mental health	43.8%
Intellectual / developmental disabilities	29.8%
Obesity and maintaining healthy weight	26.9%
Not sure	18.4%
Substance use	17.9%
Injuries	17.9%
Infectious diseases	17.3%
Abuse or neglect	17.2%
Respiratory diseases	10.9%
Violence	9.0%
Chronic pain and pain management	8.5%
Oral (mouth) and dental health	8.2%
Diabetes and high blood sugar	7.9%
Infant / baby health	5.9%
Blood diseases	5.2%
Cancers	0.0%
Reproductive/sexual health, inc. sexually transmitted infections/diseases	0%



Thinking about your or other CHILDREN in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying	50.9%
Anxiety	49.4%
Depression	42.3%
Loneliness	18.5%
Drug use	18.4%
Not sure	18.4%
Eating disorders	15.1%
Alcohol use	10.0%
Suicide	9.9%
Serious mental illnesses (schizophrenia, major depressive disorders, bipolar disorder)	7.9%
Post Traumatic Stress Disorder (PTSD)	7.3%

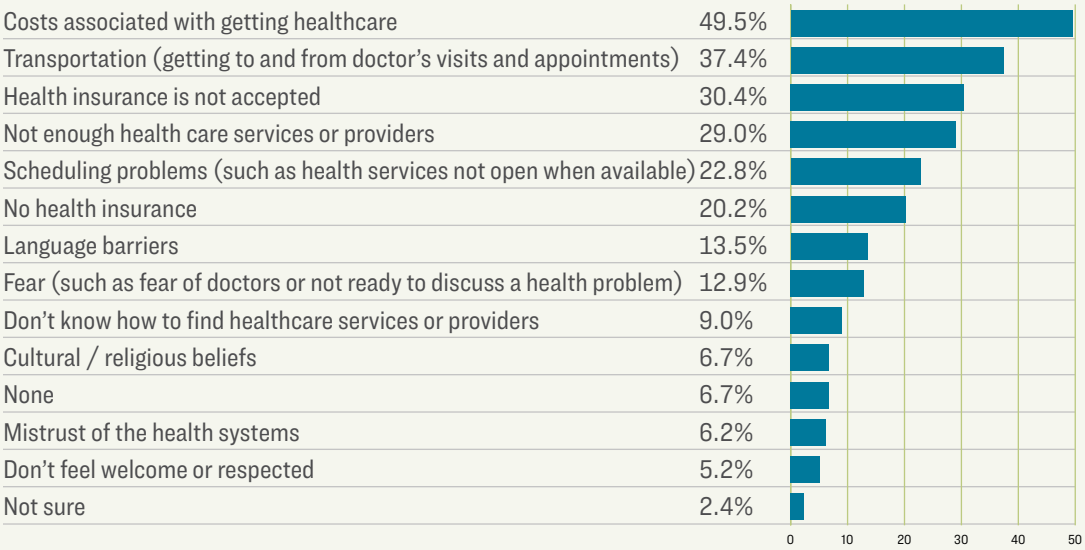


Chester County

County Survey Results

Number of Respondents: 658

Thinking about the community where you live, which barriers prevent access to health care? (Select all that apply)



Thinking about the community where you live, how available are the following resources?

	Never Available	Rarely	Sometimes	Often	Always Available	Not Sure
Affordable healthy foods	3.7%	12.9%	33.6%	29.6%	17.0%	3.2%
Affordable housing	10.3%	32.7%	26.9%	15.1%	5.5%	9.6%
Clean outdoor environment	2.1%	4.1%	19.2%	31.3%	40.1%	3.2%
Good paying jobs	2.3%	13.7%	30.1%	30.1%	14.1%	9.7%
Good schools	1.2%	5.6%	14.1%	27.1%	45.0%	7.0%
Health care services	1.8%	6.1%	20.1%	33.4%	36.2%	2.4%
Mental health services	4.6%	16.6%	23.9%	21.9%	12.6%	20.5%
Places to be active such as parks	2.0%	3.7%	15.8%	25.7%	50.2%	2.7%
Safe neighborhood	9.0%	21.4%	25.2%	19.6%	14.6%	10.2%
Services that support people as they age	1.5%	9.9%	26.9%	29.2%	17.2%	15.4%
Substance use services	4.3%	10.6%	22.0%	18.4%	13.5%	31.2%

Chester County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

Some residents shared that they appreciated having access to parks and walking paths. Opportunities for physical activity contributed to overall positive health experiences.

ON GREEN SPACE & RECREATION

"...there's a lot of group walking and people doing things. It's not just individuals from the house, it's people who together to do some form of activity."

"I'll say the area that I live in which is Kennett Square, Southern Chester County, there are a number of health and fitness facilities and some of them are very affordable and you can take advantage of a number of different health facilities from swimming, physical activity, Pilates, pickleball, everything like that. So it's a good way to maintain a level of health."

"And we have a great department of parks and recs. The borough does music in the park to bring the community together, the township does sporting activities and things."

HEALTHY FOOD RESOURCES

Community members have recognized social and health benefits related to the availability of fresh, local produce. Food banks also provided a variety of options to residents.

ON HEALTHY FOOD RESOURCES

"I live in Chadds Ford for which is close to Kennett Square in Southern Chester County, and we have a lot of local farmers and local produce and there's been some nice sharing of that, especially in the summertime with raised beds and that sort of thing. We're starting a co-op in Kennett Square because we want to be able to have local food all year round and local products. But I feel like there's a commitment to having space for agriculture, which is the food we need."

"The food pantry, serves hundreds of people a distribution and they do that twice a month, once in the daytime, once in the evening..."

COMMUNITY ASSETS

A SENSE OF COMMUNITY

Community members valued relationships with neighbors and the support that they provided for one another.

ON A SENSE OF COMMUNITY

"I live in... a retired community, and walking, conversations and talking about how your day is going and we form bonds and then... when we see somebody that is needy in terms of physically, mentally or anything like that, we rise to the occasion and do what it is we need to do and it's reciprocal. So it's a good feeling and that is good for your spirit, your mind, your health."

"I know every community has some problems, but for the most part, I always feel safe walking."

"I think I can speak, for, like the Hispanic community, I feel like Southern Chester County is really inclusive..."

ENVIRONMENTAL QUALITY

Air and noise pollution improvements were referenced by community members as playing active roles in an enhanced quality of life.

ON ENVIRONMENTAL QUALITY

"I think one thing that may have helped the community health wise is the local steel company... for many years they've had a new system they use it with the electric furnace and they don't produce the pollution."

"We have not had the smell from the treatment plant which is in South Coatesville. And it seemed like every Wednesday you have to feel, it was bad. But it has gotten better because I haven't noticed it in maybe a couple of years now."

"The quiet rural atmosphere, it is calming."

HEALTH RESOURCES

Respondents noted the importance of local health education opportunities, and access to medical specialists.

ON HEALTH RESOURCES

"I think the local hospital community department provides a lot of education around different topics that are great into the community that we tend to spread to the community that there's access in education as well."

"I think we have many high-quality healthcare providers in Chester County. I know we have the cancer center, we have all these specialties that I feel like a lot of communities do not have. I'm grateful for that in the specialist that you can take referrals to, and that we partner with Philadelphia and their resources. So there's that kind of partnership too."

"I was really happy to find how easy it was to find a dentist, a foot doctor, a chiropractor. In this small community, there are many ways to take care of yourself, that are easily accessible."

COMMUNITY CHALLENGES

HEALTHCARE ACCESS

Hospitals were not readily accessible to all residents, which could prove harmful in emergency situations. There were further implications related to where ambulances were allowed to transport patients. There were also no urgent care centers that were close enough. There were concerns about dental neglect, for residents of all ages, and a lack of oral health literacy.

A respondent, and nurse, spoke to the need for patients to be assisted in the navigation of health services, needs, and options. Language barriers could limit access, particularly Portuguese and Eastern European languages.

Lastly, certain hospitals and mental health providers didn't accept Medicaid and it was believed that "they're just trying to find a way to cut those who are most expensive off their list."

ON HEALTHCARE ACCESS

"...we are far from a local hospital, pretty much have to decide. Where I work, we had to call for ambulances and you don't know where to tell people to take them..."

"I mean you look at someone and they have rampant decay and they go to the dentist... some of them have the fear, lack of transportation, lack of funds, if they do have insurance, they really don't have money for the copay."

"It's very hard to find the Medicaid dentist – anywhere. Other than the FQHCs, there's one in Coatesville, one in Pottstown."

"You're talking about technology but not everybody has access to the technology or the knowledge of how to use it."

"I also feel that we really don't have health navigators that help people through the system, and I think hospitals could do so much better with that in helping people see what are the steps they go through... I don't feel like we're navigating through those steps that you have to take to get the treatment and to finish and mental health, all the things that you need when you've been diagnosed with something."

"I drive my son to Philly for his doctor, for someone who knows how to work with people with disabilities, but you know not everybody can do that..."

TRANSPORTATION

Insufficient public transportation made access to health services, grocery stores, and recreation activities difficult for people who didn't live near them. Many areas did not have sidewalks, or the sidewalks were in disrepair.

ON TRANSPORTATION

"So transportation can become a huge issue if you have like an elderly person that needs the power of attorney or needs support, those resources are not available without going out of town."

"So they either live adjacent to them or they've got to drive because public transportation in Chester County is not good."

BEHAVIORAL HEALTH ISSUES

Residents found it difficult to find mental health services. When they did, there tended to be long waits for appointments. There seemed to be a lack of access to information or efficient dissemination of information about local services.

The mental health of residents of all ages was a concern, particularly that of parents who should be emotionally well-equipped in their roles.

ON BEHAVIORAL HEALTH ISSUES

"...we have groups that meet here that finding psychiatric or emotional support is a desert around here."

"...to go back to what she was saying, I think it is also a lack of education, for the fact that people here probably could video chat with a therapist or a psychiatrist or emotional support like that, they just don't know that that's like an option. So I think that's probably something that's worth talking about."

"From reading historically, in the 70s, we opened up psychiatric facilities, said nobody should be in here, they should be out and amongst people and, but we didn't build resources, not like we have resources for other parts, good resources for here down in healthcare."

"We have a shortage of counselors and we have a shortage of psychiatrists. We really do, and then Spanish-speaking or other language ones, we are really short."

"I see that in my work as a police chaplain, you know, I get called out on emergencies and stuff, and there's just no place to put anybody. We just are so short of beds."

HOUSING

High housing costs, and long waiting lists for affordable housing exacerbated the problems of "the poorest of the poor."

ON HOUSING

"...the rents and the lot rents all that's going up, they can't afford it, they can't meet, they get evicted, they're living in their cars. It's a cycle of poverty."

"And especially if they're in the trailer parks, they think their costs aren't going to change, but the trailers need new roofs or the plumbing goes or something catastrophic. I know many of them with space heaters because their regular heating is not working."

"There's even people and I don't know if you've ever heard, but like in my community when I first moved there, with the homelessness and that. There's people living in the tree line of the forest back there, there's tents in the woods."

SPECIAL POPULATIONS

CHILDREN AND YOUTH

Participants were complimentary of the schools in their communities. But "right now, there's disparity. Those that can afford pre-K go, those that can't, don't go."

Concerns raised by community members revolved around parents needing support with childrearing, navigating services for children with disabilities, the mental health of youth, and hungry children. Also, for those "living in poverty, with parents in jail or gone, or raised by grandparents," support was needed.

Different activities and resources, such as youth centers, vacation bible school, and swim lessons were appreciated.

ON CHILDREN AND YOUTH

"I think we have a great public school system. We have locally, we have Honey Brook Elementary Center, multiple preschool options here that serves an underserved area of the community. So we have after school programs, there's people to people that does a youth center right here in the borough."

"Also you have a lot of one household. So these kids are basically raising themselves. So they're not eating healthy and that's a problem and they're the ones that you might find out on the street late at night because nobody's looking after our babies."

"I lived in a area where we had three suicides at the high school level and my grandson went to that school. I saw firsthand what he went through, so I think that that needs to be addressed at a high level because there are so many things and peer pressure is going on with the students, with the kids, the Internet and those types of things and how can they be that be serviced for their needs?"

"...children that have been identified to be at risk for not eating properly over the weekend will get a backpack every Friday when they go home from school. With food that they can prepare themselves..."

OLDER ADULTS

Senior residential communities provided a myriad of resources and activities, that also helped to foster connectedness. Those living alone (mostly women), lacking transportation, and located far from resources were more vulnerable. Limited technology use with this population not only served as a barrier to health services, but also for taking advantage of grocery delivery services through apps. Residents have sought help from the Department of Aging, but responses were delayed.

ON OLDER ADULTS

"[Name] and I live in a 55 community here... where they let us know of all the activities and events that are going on. We have access to the pool, with the membership and a fitness room. So it is nice that there are things to do for the seniors as well."

"I think there's a concern too for support as aging residents of the community get older, because a lot of support services are either in larger cities or they're around hospital settings, neither of which is Honey Brook."

"We don't have a senior center. We used to have Honey Brook Senior Club and everybody just faded away. But we don't have a senior center like Coatesville, and Downingtown and places like that."

"We fund Meals on Wheels, and we are seeing that the number of people that are accessing those services is growing."

"I think it's very lonely for some seniors who are not part of a community..."

ADDITIONAL POPULATIONS

Families with low-income faced issues with childcare, health insurance coverage and other benefits, and maintaining full-time employment.

Members of the Amish community faced unique barriers to health care related to being disengaged with modern technologies, such as motor vehicles and phones. The nature of their work also put them at greater risk for injuries.

Immigrants required culturally and linguistically appropriate services.

Veterans needed assistance with housing, health, and dental services. Residents noted that the VA hospital offered some assistance, but they "fix them up and send them back on the street, on Lincoln Highway." Greater awareness of services was needed.

"

LOW INCOME

"...she has to go do Instacart with a baby with her, in order to make enough to try to pay a rent."

"And they're like, 'Well, you should just get a full time job and you have benefits.' And I'm like, 'I would rather not have the benefits and be able to pay rent and everything else compared to getting health insurance.'"

"I think there's no daycare options for families in need either. We have daycare in the area but it's expensive."

"...what do you do when your kid's sick and daycare sends them home? It says, would it have to be fever-free for 24 hours before they come back?"

AMISH COMMUNITY

"Amish customers have a lot of accidents. I was at a home yesterday and I tried not to cry but their nephew is two and he's in a body brace... They're not going to have a car to put them in there and take them anywhere. They have to walk to find a phone to call for help, somebody has to come and take them to the hospital. Now, the kid's in a hospital, miles and miles away from home, you can't even get there by horse and carriage."

IMMIGRANTS

"There's a huge Spanish-speaking population..."

"A number of years ago for Thanksgiving, people would distribute turkeys. At least in this particular situation, Latinos and turkeys didn't mix. What they wanted was chicken. So now we get chicken, the food banks distributing chicken. So it's kind of understanding the cultural differences and whether you're talking about eating better or whether you're talking about certain diseases, which might be unique to a certain culture..."

VETERANS

"My husband is a veteran and you have to know the inroads. He gets everything he needs. But if you don't know about the program and you don't go to find out, then you suffer. But my husband, he gets what he needs."

"

ACCESS TO CARE

Geographic residence near county borders is sometimes complicated where community members could and could not receive health coverage, inconveniently increasing travel time and prolonging 911 responses. Residents didn't understand why some hospitals remained "decaying" and abandoned when they were needed. Some relied on urgent care centers, which health insurance may not have covered in full.

Waiting for appointments with specialists took months. Respondents expressed the desire for more transparency with health costs and billing. Neighborhood pharmacies were closing. Lastly, people with disabilities who relied on medical transportation services had long wait times for pick up and drop off. Transit services through Medicaid were further complicated when patients needed to travel to different counties.

ON ACCESS TO CARE

"A lot of facilities are like 45 minutes away. I have County insurance and I can't go anywhere in here."

"And there's even been fire trucks that ran medical... ran as an ambulance. There's not enough to go around."

"But I know people who tried to get an appointment with someone in mental health services. It's a long time."

"My son needed physical therapy. So we went and I said, is there cost? No, no, don't worry about it. Health insurance will cover it. Eight appointments later -- You get the bill. We have a $3,500 deductible. We wouldn't have made eight appointments in a row if we knew that."

"I will tell you that the folks in the disability community what they call para transit, they call it Para-stranded."

"We lost a large community pharmacy. They delivered to the elderly."

"I think they could have appointments on the portal... they're trying to get all their clients trained on the portal. And then you can go in for an appointment. Wouldn't it be wonderful just to set up your appointment on the portal..."

TRUSTWORTHINESS

Longevity was a common factor in the patient/provider relationships where trust was present. One respondent explained that trust could be difficult to foster when there were language barriers.

ON TRUSTWORTHINESS

"The only one that I have is my gynecologist and she will go back to talking to me about my grandmother who raised me. And my mother and I's relationship, like she generally takes time and that's the only person that takes time with me."

"Well, yes, again, because I have the same doctors and so forth that I've had for years and years and years and I trust them."

COVID-19 PANDEMIC

For most, post-COVID technology use in healthcare presents convenience and accessibility. There were older individuals who preferred in-person and telephone access. There was a sense that the pandemic's residual impact was a provider shortage.

Persistent concerns about COVID-19 were mixed, as was knowledge of Long COVID. There was a greater concern for older adults and people with disabilities. There were concerns about symptoms and contagion and how they continued to negatively interfere with work and childcare.

ON COVID-19 PANDEMIC

"It makes it more accessible. I don't have to leave work for hours, just 15 minutes."

"They don't know how to do it and they're afraid because they've heard of all the scams and everything. They're afraid to put any personal information online if they did not grow up that way and that's very difficult for the older population."

"People are scared to say that they have it, because of that. Like to not be able to go to work... or working in the daycare."

"I just didn't know what it was called. So my sister-in-law has [Long COVID]. But she has it into where it's like anxiety and stuff."

"...we're in a crisis. We're so far behind, the system is overwhelmed and the only way to get under it is to spend more resources with preventative care."

SUGGESTED ACTIONS

Chester County

What is already working well to improve health in your community?

Telehealth is convenient and facilitates treatment planning.

"...I have access to a portal that I can go into, it's very convenient for me and the portal works so well because all my data is in there and looking at my data, I can make decisions and I can go to my doctors and they can make decisions, we can make decisions together. I can easily access them through that portal, and I just find it amazing because I can do this all from sitting at home and it really works well, especially after you are 65 years old and you're retired..."

What are the most important issues to address to improve health in your community?

More can be done to make telehealth services more accessible.

"There's a lot of health care services where someone does not have to be in person or they might not want to be in person, especially if you're talking about mental health or behavioral health issues, they might be much more comfortable doing that in their home. So what is Chester County's digital health component of its health strategy and how is it going to execute that so that the people who really need those services can get those services? There's many, many people in Chester County who have excellent Internet, can afford subscription costs, have devices."

Artificial intelligence can be explored to help remediate language barriers.

"I'm taking an AI course right now just to understand more about AI and there are the same things. People are saying it's dangerous, but there is so many advantages to it too. One of the advantages, by the way, is it can interpret languages so perfectly. I work with the Guatemalans and we could not find an interpreter to speak the languages of the Guatemalans and for healthcare. You can get AI to get the perfect accent and the perfect script that they will totally understand what you're saying and you don't have to hire an interpreter. You've got this wonderful voice coming through that sounds like them."

Long-term support and resources for parents/families is needed.

"So what kind of services are we giving to those parents? How are we finding them? How do we keep track of them after they have babies? Ten years [later], are we checking in on them? Are we giving them resources? Are we empowering to connect with other people in the community to help support them? So many people feel like they just have to do it on their own and they don't, we weren't raised to raise a village. We were raised to be in a village where we were."

Community and faith leaders can be leveraged to meet community health needs across cultures.

"I was going to say there's one positive thing that happens here and it's Pastor [omitted], once a month, they have a meal here. And it's just by their age and there's so many older people that come out and they sit around these tables and they talk. And if more churches could do that, and we have a Baptist church in town. We have a Baptist church and if we can get together with some of those ministers and talk to them, then maybe, they can do a service, a meal..."

Community health navigators and advocates can support patients with accessibility issues, such as older adults living alone, non-English speakers, and people with disabilities.

"In our area, I'd like to see the availability of advocates for all these people that don't know where to go, what to do. And even if we have them, the people have to be aware that we have them, and know how to get the help. So I'd really like to see advocates of filling out forms, just all those things that we take for granted too."

Central-East Chester

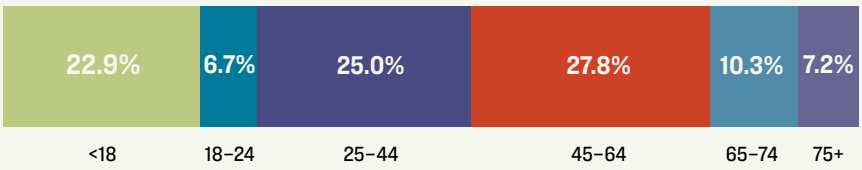
ZIP Codes: 19301, 19312, 19333, 19341, 19345, 19355

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health
- Wills Eye Hospital

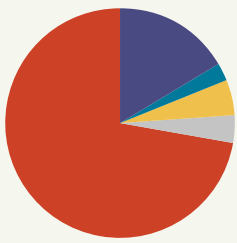
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

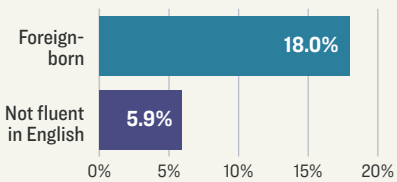


SEX

RACE/ETHNICITY/LANGUAGE



16.6% Asian
2.4% Black
5.1% Hispanic/Latine
3.7% Another race/ethnicity
72.1% White



POPULATION

77,897

MEDIAN HOUSEHOLD INCOME

$155,513

EDUCATIONAL ATTAINMENT

10.3% High school as highest education level

PEOPLE WITH DISABILITIES

8.4%

LEADING CAUSES OF DEATH – All Ages

1 Cancer
2 Heart Disease
3 Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Central-East Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	746.4	763.5
	Life expectancy: Female (in years)	82.7	81.7
	Life expectancy: Male (in years)	79.1	78.5
	Years of potential life lost before 75	2,982	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	26.2%	31.1%
	Diabetes prevalence	8.6%	9.7
	Diabetes-related hospitalization rate (per 100,000)	92.0	112.0
	Hypertension prevalence	27.7%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	36.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	626.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	20.7	23.5
	Major cancer incidence rate (per 100,000)*	279.4	260.2%
	Major cancer mortality rate (per 100,000)*	44.0	60.8
	Colorectal cancer screening (adults age 45-75)	74.1%	70.3%
	Mammography screening (women age 50-74)	81.8%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.6	3.3
	Percent low birthweight births out of live births	7.0%	6.7%
	Percent preterm births out of live births	8.0%	8.3%
	Child Opportunity Index**	92.7	74.1
BEHAVIORAL HEALTH	Adult binge drinking	17.6%	18.6%
	Adult smoking	8.0%	12.6%
	Drug overdose mortality rate (per 100,000)	11.6	20.9
	Opioid-related hospitalization rate (per 100,000)	69.2	111.1
	Substance-related hospitalization rate (per 100,000)	113.6	167.8
	Poor mental health for 14+ days in past 30 days	12.6%	15.1%
	Suicide mortality rate (per 100,000)	11.6	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,868	2,094.0
	Homicide mortality rate (per 100,000)	2.6	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	4.6%	7.6%
	Children <19 years with public insurance	14.9%	20.4%
	Population without insurance	2.9%	4.7%
	Children <19 years without insurance	2.8%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.3%	5.8%
	Children <18 years in poverty	3.5%	6.5%
	Adults 19-64 years unemployed	4.4%	3.7%
	Householders living alone who are 65+ years	22.3%	24.0%
	Households receiving SNAP benefits	3.1%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.4%	10.8%
	Vacant housing units	4.0%	3.9%
	Single parent households	15.2%	14.0%
	Commute greater than 60 minutes	10.8%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 58

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Age-related illnesses

Mental health

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Substance use

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Mental health services

Safe neighborhoods

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Health insurance is not accepted

Scheduling problems (such as health services not open when available)

Central-West Chester

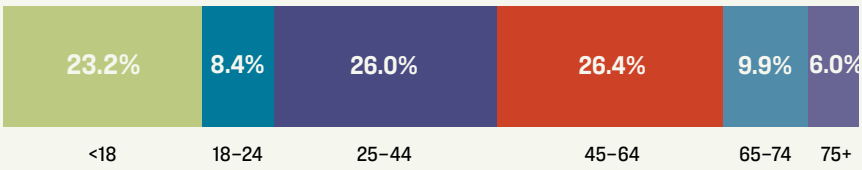
ZIP Codes: 19310, 19320, 19358, 19365, 19367, 19372

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

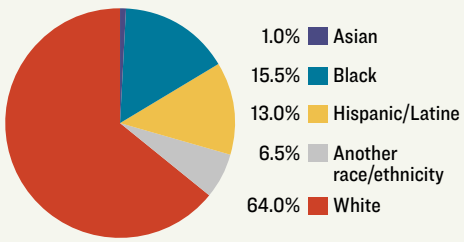
SOCIAL VULNERABILITY INDEX (SVI)

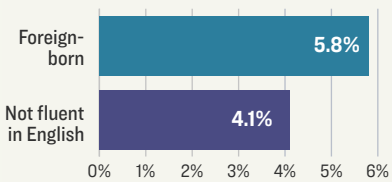
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

68,829

MEDIAN HOUSEHOLD INCOME

$90,115

EDUCATIONAL ATTAINMENT

34.3% High school as highest education level

PEOPLE WITH DISABILITIES

16.6%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Accidents

SUMMARY HEALTH MEASURES

Category	Measure	Central-West Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	969.5	763.5
	Life expectancy: Female (in years)	78.5	81.7
	Life expectancy: Male (in years)	73.9	78.5
	Years of potential life lost before 75	5,009	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	35.0%	31.1%
	Diabetes prevalence	11.1%	9.7
	Diabetes-related hospitalization rate (per 100,000)	327.0	112.0
	Hypertension prevalence	31.7%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	66.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	1,428.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	42.5	23.5
	Major cancer incidence rate (per 100,000)*	310.5	260.2
	Major cancer mortality rate (per 100,000)*	83.5	60.8
	Colorectal cancer screening (adults age 45-75)	68.0%	70.3%
	Mammography screening (women age 50-74)	78.0%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.6	3.3
	Percent low birthweight births out of live births	7.4%	6.7%
	Percent preterm births out of live births	10.3%	8.3%
	Child Opportunity Index**	50.2	74.1
BEHAVIORAL HEALTH	Adult binge drinking	18.5%	18.6%
	Adult smoking	16.3%	12.6%
	Drug overdose mortality rate (per 100,000)	57.1	20.9
	Opioid-related hospitalization rate (per 100,000)	212.4	111.1
	Substance-related hospitalization rate (per 100,000)	339.8	167.8
	Poor mental health for 14+ days in past 30 days	16.5%	15.1%
	Suicide mortality rate (per 100,000)	11.7	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,305	2,094.0
	Homicide mortality rate (per 100,000)	4.40	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	15.9%	7.6%
	Children <19 years with public insurance	38.3%	20.4%
	Population without insurance	6.7%	4.7%
	Children <19 years without insurance	6.4%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	10.6%	5.8%
	Children <18 years in poverty	18.6%	6.5%
	Adults 19-64 years unemployed	4.4%	3.7%
	Householders living alone who are 65+ years	22.1%	24.0%
	Households receiving SNAP benefits	13.6%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	11.5%	10.8%
	Vacant housing units	5.2%	3.9%
	Single parent households	28.4%	14.0%
	Commute greater than 60 minutes	11.0%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 98

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Heart conditions

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Alcohol use

Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

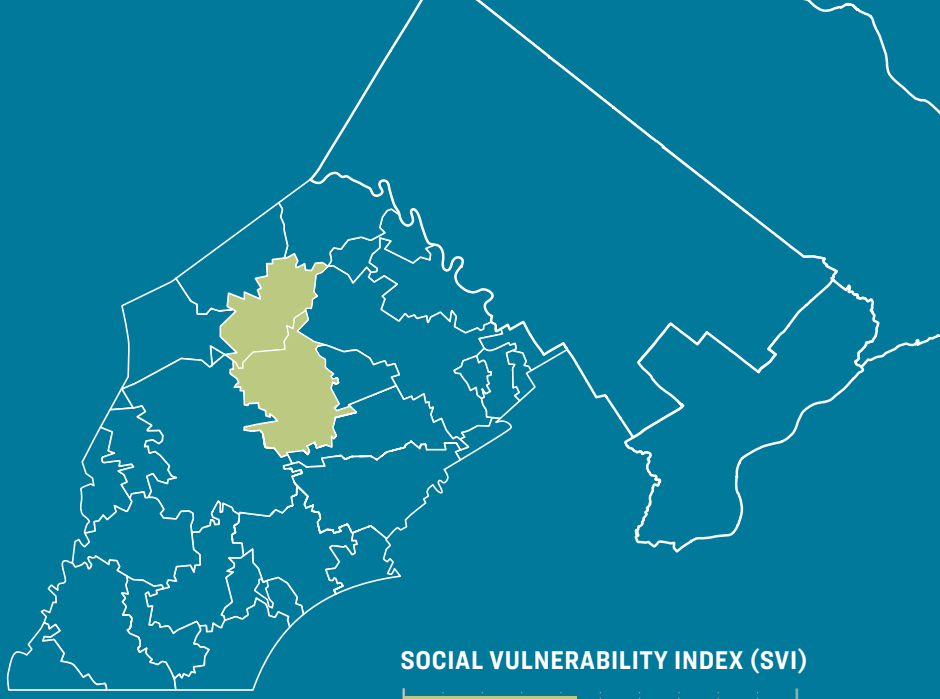
Not enough health care services or providers

Downingtown/ Glenmoore

ZIP Codes: 19335, 19343

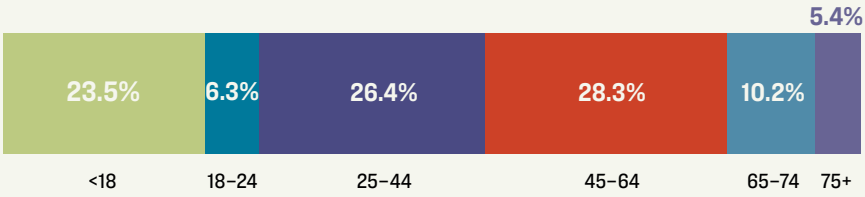
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health
- Wills Eye Hospital



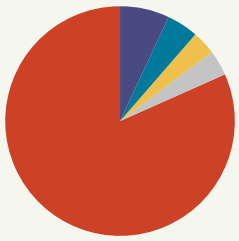
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

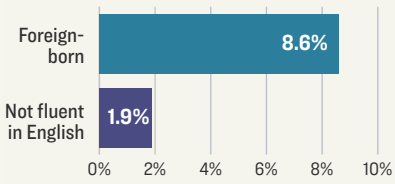


SEX

RACE/ETHNICITY/LANGUAGE



7.1% Asian
4.4% Black
3.4% Hispanic/Latine
3.6% Another race/ethnicity
81.5% White



POPULATION

61,119

MEDIAN HOUSEHOLD INCOME

$140,197

EDUCATIONAL ATTAINMENT

16.9% High school as highest education level

PEOPLE WITH DISABILITIES

8.2%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Downingtown/Glenmoore	Chester County
GENERAL	All-cause mortality rate (per 100,000)	561.9	763.5
	Life expectancy: Female (in years)	83.3	81.7
	Life expectancy: Male (in years)	80.9	78.5
	Years of potential life lost before 75	1,649	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.8%	31.1%
	Diabetes prevalence	8.9%	9.7
	Diabetes-related hospitalization rate (per 100,000)	136.0	112.0
	Hypertension prevalence	27.9%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	43.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	760.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	16.8	23.5
	Major cancer incidence rate (per 100,000)*	375.9	260.2
	Major cancer mortality rate (per 100,000)*	32.0	60.8
	Colorectal cancer screening (adults age 45-75)	72.3%	70.3%
	Mammography screening (women age 50-74)	81.3%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	3.3
	Percent low birthweight births out of live births	6.9%	6.7%
	Percent preterm births out of live births	9.3%	8.3%
	Child Opportunity Index**	73.6	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.7%	18.6%
	Adult smoking	10.4%	12.6%
	Drug overdose mortality rate (per 100,000)	10.1	20.9
	Opioid-related hospitalization rate (per 100,000)	119.4	111.1
	Substance-related hospitalization rate (per 100,000)	161.5	167.8
	Poor mental health for 14+ days in past 30 days	13.1%	15.1%
	Suicide mortality rate (per 100,000)	15.1	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,232	2,094.0
	Homicide mortality rate (per 100,000)	1.70	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.8%	7.6%
	Children <19 years with public insurance	16.5%	20.4%
	Population without insurance	2.3%	4.7%
	Children <19 years without insurance	1.8%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	2.9%	5.8%
	Children <18 years in poverty	2.1%	6.5%
	Adults 19-64 years unemployed	3.6%	3.7%
	Householders living alone who are 65+ years	24.5%	24.0%
	Households receiving SNAP benefits	3.7%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.1%	10.8%
	Vacant housing units	2.3%	3.9%
	Single parent households	13.9%	14.0%
	Commute greater than 60 minutes	8.3%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 72

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Age-related illnesses

Obesity and maintaining healthy weight

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Mental health services

Safe neighborhoods

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Health insurance is not accepted

Transportation (getting to and from doctor's visits and appointments)

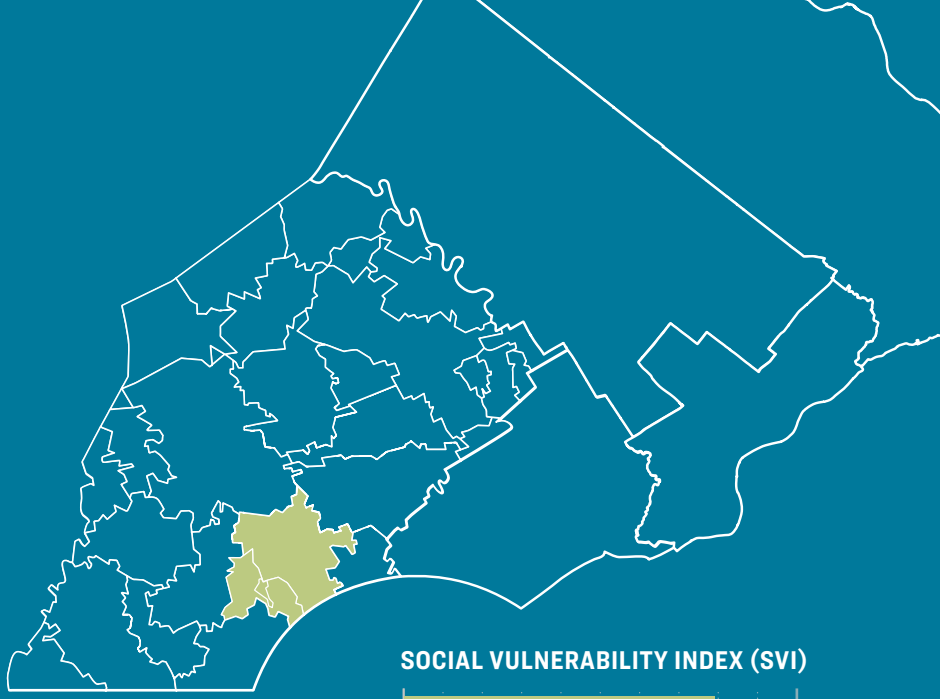
Kennett

ZIP Codes: 19311, 19348, 19374, 19375

This community is served by:

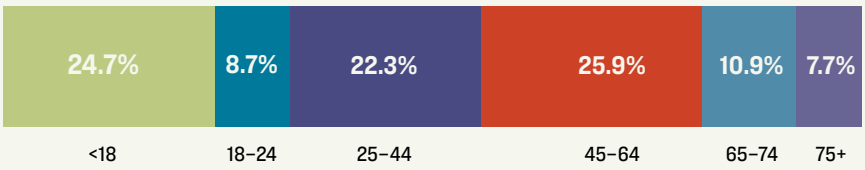
- Bryn Mawr Rehab Hospital
- Chester County Hospital*
- Children's Hospital of Philadelphia
- ChristianaCare - West Grove*
- Main Line Health
- Wills Eye Hospital

* ChristianaCare - West Grove Campus anticipated opening Summer 2025



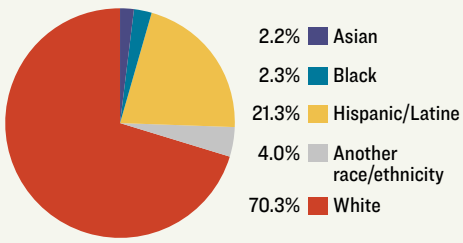
SOCIAL VULNERABILITY INDEX (SVI)

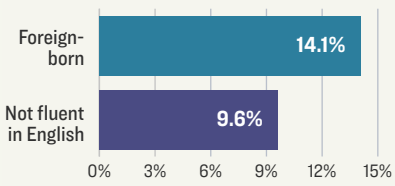
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

36,429

MEDIAN HOUSEHOLD INCOME

$124,622

EDUCATIONAL ATTAINMENT

17.5% High school as highest education level

PEOPLE WITH DISABILITIES

10.7%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Kennett	Chester County
GENERAL	All-cause mortality rate (per 100,000)	702.7	763.5
	Life expectancy: Female (in years)	83.2	81.7
	Life expectancy: Male (in years)	81.7	78.5
	Years of potential life lost before 75	1,258	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.2%	31.1%
	Diabetes prevalence	10.0%	9.7
	Diabetes-related hospitalization rate (per 100,000)	96.0	112.0
	Hypertension prevalence	27.4%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	30.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	590.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	22.3	23.5
	Major cancer incidence rate (per 100,000)*	220.3	260.2
	Major cancer mortality rate (per 100,000)*	47.4	60.8
	Colorectal cancer screening (adults age 45-75)	67.1%	70.3%
	Mammography screening (women age 50-74)	79.5%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	3.3
	Percent low birthweight births out of live births	7.5%	6.7%
	Percent preterm births out of live births	8.5%	8.3%
	Child Opportunity Index**	70.9	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.6%	18.6%
	Adult smoking	12.0%	12.6%
	Drug overdose mortality rate (per 100,000)	8.4	20.9
	Opioid-related hospitalization rate (per 100,000)	36.2	111.1
	Substance-related hospitalization rate (per 100,000)	53.0	167.8
	Poor mental health for 14+ days in past 30 days	13.9%	15.1%
	Suicide mortality rate (per 100,000)	13.9	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,506	2,094.0
	Homicide mortality rate (per 100,000)	8.40	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.2%	7.6%
	Children <19 years with public insurance	23.6%	20.4%
	Population without insurance	7.7%	4.7%
	Children <19 years without insurance	6.0%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.1%	5.8%
	Children <18 years in poverty	6.9%	6.5%
	Adults 19-64 years unemployed	3.2%	3.7%
	Householders living alone who are 65+ years	24.7%	24.0%
	Households receiving SNAP benefits	4.5%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	8.2%	10.8%
	Vacant housing units	3.9%	3.9%
	Single parent households	22.2%	14.0%
	Commute greater than 60 minutes	8.2%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 45

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Age-related illnesses

Mental health

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Affordable healthy foods

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Transportation (getting to and from doctor's visits and appointments)

Costs associated with getting healthcare

Not enough health care services or providers

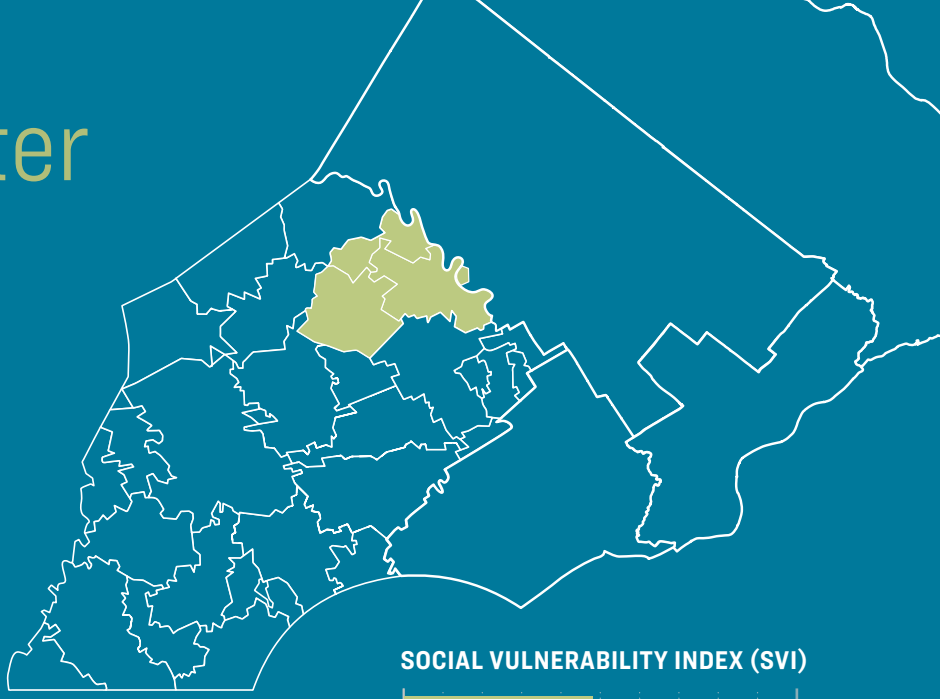
Northern Chester

ZIP Codes: 19425, 19453, 19460, 19475

Note: This community includes one ZIP code (19453) which crosses into Montgomery County.

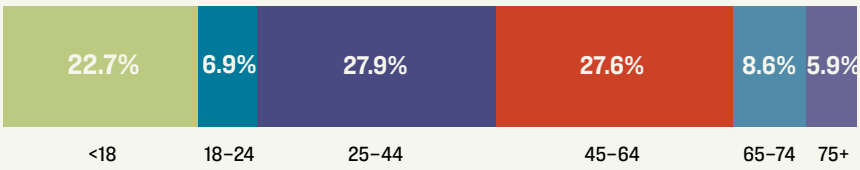
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



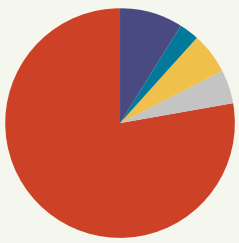
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

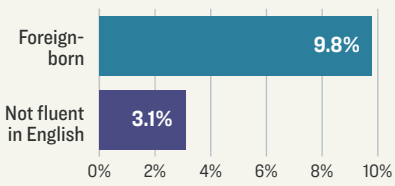


SEX

RACE/ETHNICITY/LANGUAGE



9.0% Asian
2.9% Black
5.7% Hispanic/Latine
4.7% Another race/ethnicity
77.6% White



POPULATION

74,801

MEDIAN HOUSEHOLD INCOME

$131,569

EDUCATIONAL ATTAINMENT

17.1% High school as highest education level

PEOPLE WITH DISABILITIES

10.3%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Northern Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	785.0	763.5
	Life expectancy: Female (in years)	79.4	81.7
	Life expectancy: Male (in years)	78.0	78.5
	Years of potential life lost before 75	4,024	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.9%	31.1%
	Diabetes prevalence	9.3%	9.7
	Diabetes-related hospitalization rate (per 100,000)	169.0	112.0
	Hypertension prevalence	28.4%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	33.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	943.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	24.3	23.5
	Major cancer incidence rate (per 100,000)*	264.8	260.2%
	Major cancer mortality rate (per 100,000)*	73.0	60.8
	Colorectal cancer screening (adults age 45-75)	72.2%	70.3%
	Mammography screening (women age 50-74)	81.3%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	6.4	3.3
	Percent low birthweight births out of live births	6.5%	6.7%
	Percent preterm births out of live births	7.5%	8.3%
	Child Opportunity Index**	81.7	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.2%	18.6%
	Adult smoking	11.5%	12.6%
	Drug overdose mortality rate (per 100,000)	24.3	20.9
	Opioid-related hospitalization rate (per 100,000)	129.7	111.1
	Substance-related hospitalization rate (per 100,000)	198.6	167.8
	Poor mental health for 14+ days in past 30 days	13.5%	15.1%
	Suicide mortality rate (per 100,000)	10.8	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,628	2,094.0
	Homicide mortality rate (per 100,000)	1.4	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.0%	7.6%
	Children <19 years with public insurance	18.5%	20.4%
	Population without insurance	3.6%	4.7%
	Children <19 years without insurance	2.7%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.3%	5.8%
	Children <18 years in poverty	7.9%	6.5%
	Adults 19-64 years unemployed	2.9%	3.7%
	Householders living alone who are 65+ years	26.8%	24.0%
	Households receiving SNAP benefits	7.0%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	8.3%	10.8%
	Vacant housing units	4.1%	3.9%
	Single parent households	21.7%	14.0%
	Commute greater than 60 minutes	8.4%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 37

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Heart conditions

Obesity and maintaining healthy weight

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Public transportation

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Scheduling problems (such as health services not open when available)

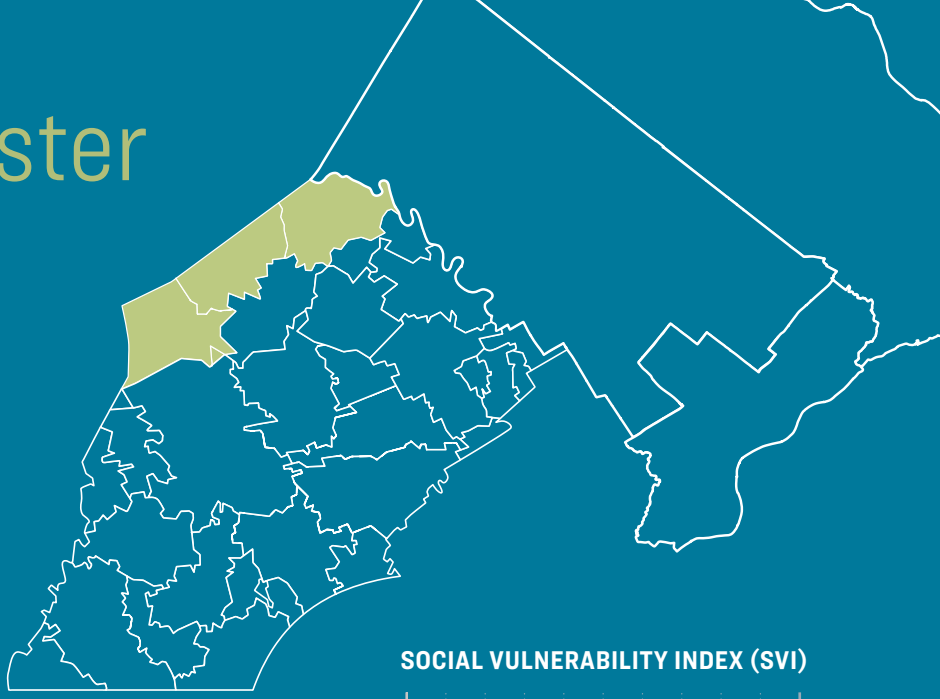
Health insurance is not accepted

Northwest Chester

ZIP Codes: 19316, 19344, 19465, 19520

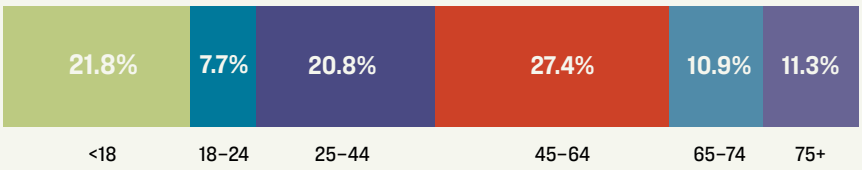
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health
- Wills Eye Hospital



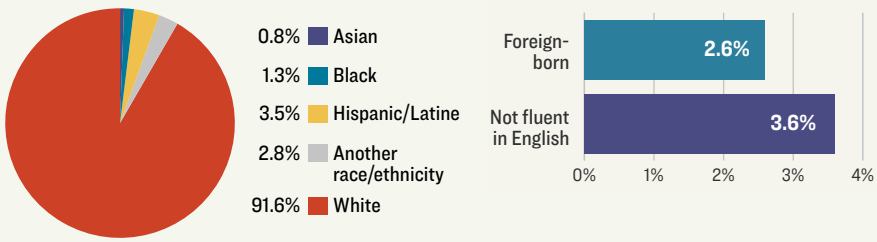
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

37,543

MEDIAN HOUSEHOLD INCOME

$97,751

EDUCATIONAL ATTAINMENT

32.2% High school as highest education level

PEOPLE WITH DISABILITIES

15.7%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Northwest Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	1,141.6	763.5
	Life expectancy: Female (in years)	79.9	81.7
	Life expectancy: Male (in years)	74.2	78.5
	Years of potential life lost before 75	2,605	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.0%	31.1%
	Diabetes prevalence	11.0%	9.7
	Diabetes-related hospitalization rate (per 100,000)	192.0	112.0
	Hypertension prevalence	31.7%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	42.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	867.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	34.4	23.5
	Major cancer incidence rate (per 100,000)*	251.6	260.2%
	Major cancer mortality rate (per 100,000)*	98.0	60.8
	Colorectal cancer screening (adults age 45-75)	71.1%	70.3%
	Mammography screening (women age 50-74)	79.6%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	7.6	3.3
	Percent low birthweight births out of live births	5.3%	6.7%
	Percent preterm births out of live births	9.1%	8.3%
	Child Opportunity Index**	64.1	74.1
BEHAVIORAL HEALTH	Adult binge drinking	18.0%	18.6%
	Adult smoking	14.8%	12.6%
	Drug overdose mortality rate (per 100,000)	26.5	20.9
	Opioid-related hospitalization rate (per 100,000)	145.7	111.1
	Substance-related hospitalization rate (per 100,000)	196.0	167.8
	Poor mental health for 14+ days in past 30 days	15.0%	15.1%
	Suicide mortality rate (per 100,000)	34.4	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,868	2,094.0
	Homicide mortality rate (per 100,000)	7.90	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	9.8%	7.6%
	Children <19 years with public insurance	22.4%	20.4%
	Population without insurance	9.8%	4.7%
	Children <19 years without insurance	15.3%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.8%	5.8%
	Children <18 years in poverty	10.0%	6.5%
	Adults 19-64 years unemployed	3.8%	3.7%
	Householders living alone who are 65+ years	23.4%	24.0%
	Households receiving SNAP benefits	7.7%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	11.8%	10.8%
	Vacant housing units	2.8%	3.9%
	Single parent households	18.7%	14.0%
	Commute greater than 60 minutes	10.8%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 50

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Diabetes and high blood sugar

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obesity and maintaining healthy weight

Substance use

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Substance use services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

Health insurance is not accepted

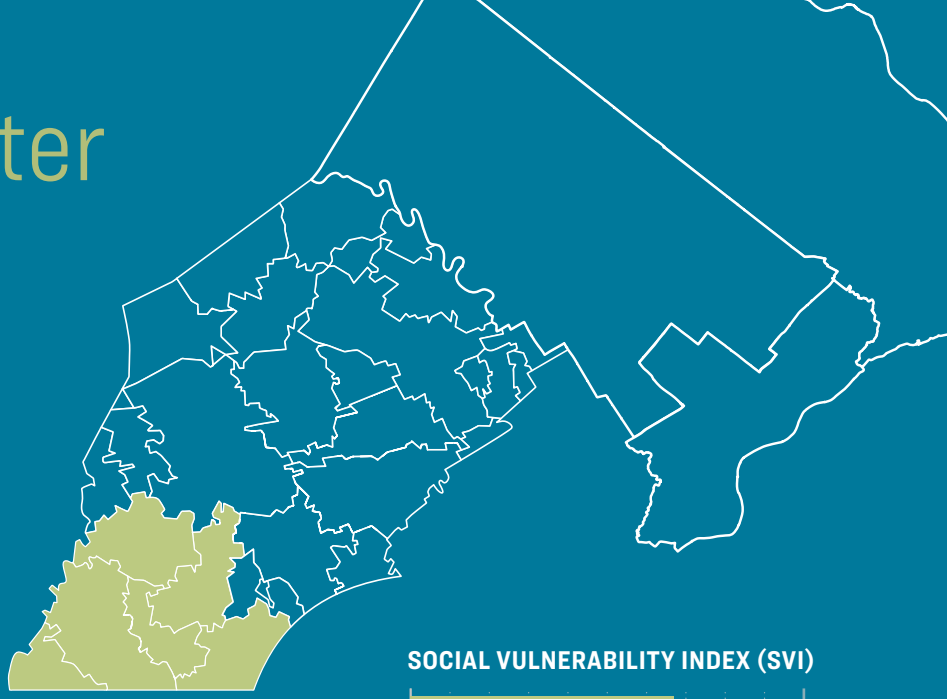
Southern Chester

ZIP Codes: 19330, 19350, 19352, 19362, 19363, 19390

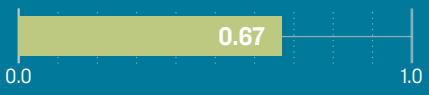
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- ChristianaCare – West Grove*
- Main Line Health
- Wills Eye Hospital

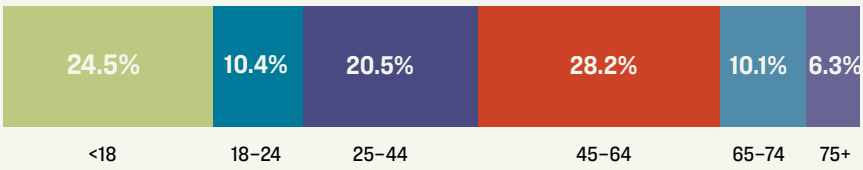
* ChristianaCare - West Grove Campus anticipated opening Summer 2025



SOCIAL VULNERABILITY INDEX (SVI)

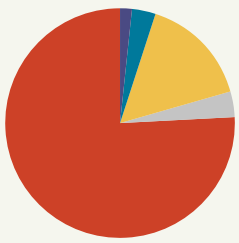


AGE DISTRIBUTION

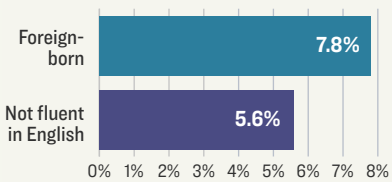


SEX

RACE/ETHNICITY/LANGUAGE



1.8% Asian
3.4% Black
15.4% Hispanic/Latine
3.8% Another race/ethnicity
75.6% White



POPULATION

63,927

MEDIAN HOUSEHOLD INCOME

$123,681

EDUCATIONAL ATTAINMENT

25.7% High school as highest education level

PEOPLE WITH DISABILITIES

11.5%

LEADING CAUSES OF DEATH – All Ages

1 Heart Disease
2 Cancer
3 Accidents

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Southern Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	645.3	763.5
	Life expectancy: Female (in years)	82.4	81.7
	Life expectancy: Male (in years)	79.3	78.5
	Years of potential life lost before 75	2,423	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.8%	31.1%
	Diabetes prevalence	10.5%	9.7
	Diabetes-related hospitalization rate (per 100,000)	94.0	112.0
	Hypertension prevalence	30.3%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	22.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	623.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	23.4	23.5
	Major cancer incidence rate (per 100,000)*	215.6	260.2%
	Major cancer mortality rate (per 100,000)*	48.4	60.8
	Colorectal cancer screening (adults age 45-75)	69.6%	70.3%
	Mammography screening (women age 50-74)	78.4%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.7	3.3
	Percent low birthweight births out of live births	5.9%	6.7%
	Percent preterm births out of live births	7.2%	8.3%
	Child Opportunity Index**	58.0	74.1
BEHAVIORAL HEALTH	Adult binge drinking	18.7%	18.6%
	Adult smoking	14.6%	12.6%
	Drug overdose mortality rate (per 100,000)	23.4	20.9
	Opioid-related hospitalization rate (per 100,000)	85.9	111.1
	Substance-related hospitalization rate (per 100,000)	70.3	167.8
	Poor mental health for 14+ days in past 30 days	15.8%	15.1%
	Suicide mortality rate (per 100,000)	14.1	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,336	2,094.0
	Homicide mortality rate (per 100,000)	--	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.8%	7.6%
	Children <19 years with public insurance	22.7%	20.4%
	Population without insurance	7.7%	4.7%
	Children <19 years without insurance	7.7%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.6%	5.8%
	Children <18 years in poverty	9.1%	6.5%
	Adults 19-64 years unemployed	3.0%	3.7%
	Householders living alone who are 65+ years	24.0%	24.0%
	Households receiving SNAP benefits	5.2%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	9.3%	10.8%
	Vacant housing units	4.8%	3.9%
	Single parent households	22.6%	14.0%
	Commute greater than 60 minutes	12.7%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 54

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Age-related illnesses

Heart conditions

Chronic pain and pain management

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Loneliness

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Not enough health care services or providers

Transportation (getting to and from doctor's visits and appointments)

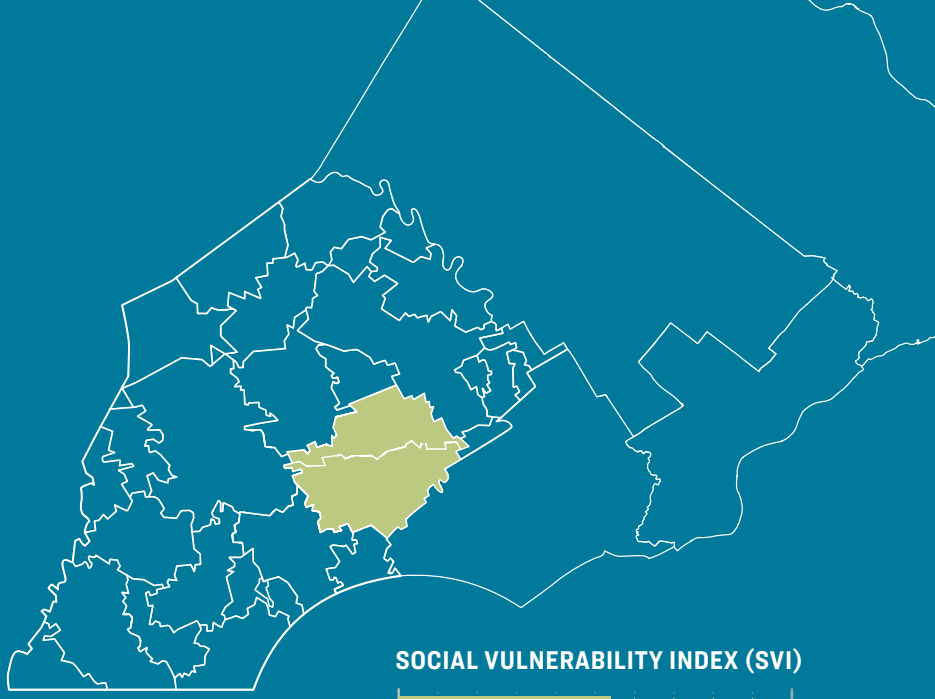
Costs associated with getting healthcare

West Chester

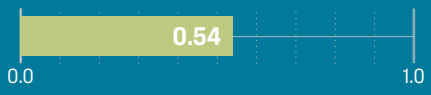
ZIP Codes: 19380, 19382, 19383

This community is served by:

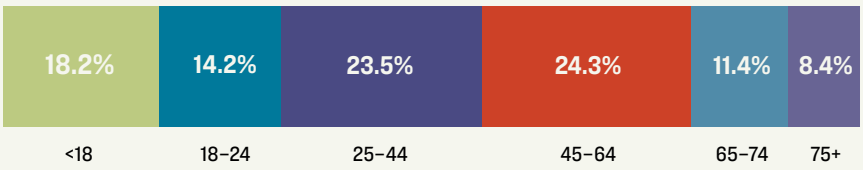
- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



SOCIAL VULNERABILITY INDEX (SVI)

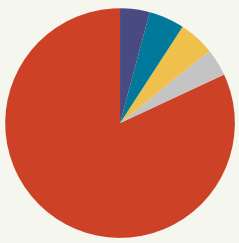


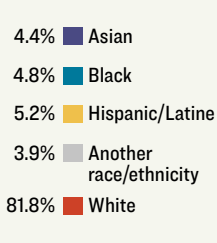
AGE DISTRIBUTION

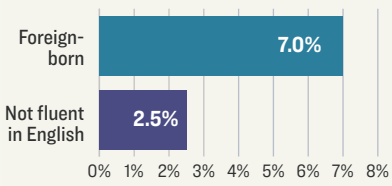


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

109,020

MEDIAN HOUSEHOLD INCOME

$124,126

EDUCATIONAL ATTAINMENT

15.1% High school as highest education level

PEOPLE WITH DISABILITIES

9.9%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	West Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	777.0	763.5
	Life expectancy: Female (in years)	82.9	81.7
	Life expectancy: Male (in years)	79.7	78.5
	Years of potential life lost before 75	3,571	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	30.0%	31.1%
	Diabetes prevalence	6.8%	9.7
	Diabetes-related hospitalization rate (per 100,000)	129.0	112.0
	Hypertension prevalence	21.8%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	34.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	753.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	15.6	23.5
	Major cancer incidence rate (per 100,000)*	271.9	260.2%
	Major cancer mortality rate (per 100,000)*	70.7	60.8
	Colorectal cancer screening (adults age 45-75)	66.7%	70.3%
	Mammography screening (women age 50-74)	77.9%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.1	3.3
	Percent low birthweight births out of live births	6.3%	6.7%
	Percent preterm births out of live births	7.2%	8.3%
	Child Opportunity Index**	82.9	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.1%	18.6%
	Adult smoking	11.9%	12.6%
	Drug overdose mortality rate (per 100,000)	11.0	20.9
	Opioid-related hospitalization rate (per 100,000)	98.3	111.1
	Substance-related hospitalization rate (per 100,000)	156.1	167.8
	Poor mental health for 14+ days in past 30 days	20.5%	15.1%
	Suicide mortality rate (per 100,000)	3.7	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,064	2,094.0
	Homicide mortality rate (per 100,000)	*	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.7%	7.6%
	Children <19 years with public insurance	14.0%	20.4%
	Population without insurance	2.6%	4.7%
	Children <19 years without insurance	1.6%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.1%	5.8%
	Children <18 years in poverty	4.7%	6.5%
	Adults 19-64 years unemployed	3.8%	3.7%
	Householders living alone who are 65+ years	24.3%	24.0%
	Households receiving SNAP benefits	4.0%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	13.6%	10.8%
	Vacant housing units	3.4%	3.9%
	Single parent households	17.1%	14.0%
	Commute greater than 60 minutes	5.7%	9.2%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 133

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Cancer

Diabetes and high blood sugar

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Alcohol use

Anxiety

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obesity and maintaining healthy weight

Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Safe neighborhoods

Affordable healthy foods

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

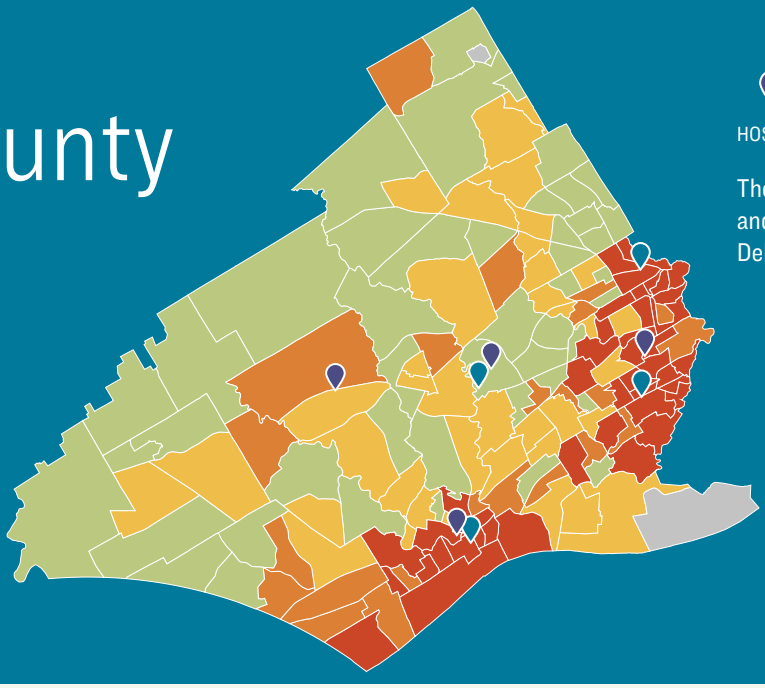
Health insurance is not accepted

Transportation (getting to and from doctor's visits and appointments)

Delaware County

SOCIAL VULNERABILITY INDEX (SVI)*

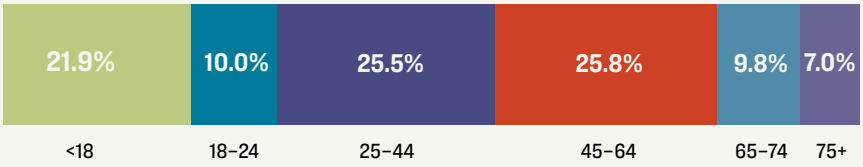
*SVI is a measure developed by the CDC to identify communities that may need support before, during, or after disasters. This measure is made up of a combination of 16 different U.S. Census variables, which are grouped into four themes (socioeconomic status, household charateristics, racial & ethnic minority status, and housing type & transportation), and cover major areas of social vulnerability.



Demographics

AGE DISTRIBUTION

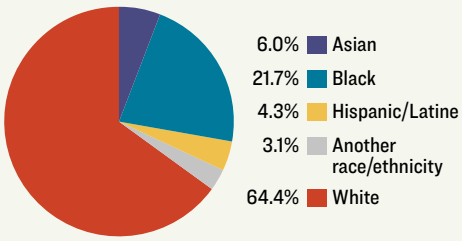
Delaware County has an estimated population of 576,195 with the largest proportion of residents between the ages of 45 - 64.



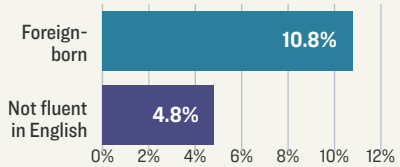
SEX

RACE/ETHNICITY/LANGUAGE

64% of residents are non-Hispanic White. Black residents make the next largest population, comprising 21.7% of the county's residents.



Nearly 11% of residents are foreign-born and about 5% speak English less than "very well."



HOUSEHOLDS

Median Household Income
$86,390

Homeownership
69%

Severe Housing Cost Burden
% spending >50% of household income
15%

High School as Highest Education
27.6%

Household Food Insecurity
9.7%

Single Parent Households
27.1%

Same Sex Couples
per 1,000 households
4.4

Commute Greater than 60 minutes
8.8%

Delaware County

Health

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases
4. COVID-19
5. Chronic Lower Respiratory Diseases

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

6.7%

Depressed/Sad Most Days in the Past 12 Months

27.7%

Binge Drinking

8.0%

Cigarette Smoking

2.5%

Vaping

10.8%

Exposure

Lead Levels in Children (<16 years old)

2.8%

PEOPLE WITH DISABILITIES

Percent of Population

11.6%

Poverty Status in the Past 12 Months

22.7%

Percent who have difficulty with:

Hearing	2.9%
Vision	2.3%
Cognition	4.9%
Ambulatory	5.7%
Self-care	2.3%
Independent Living	4.3%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

7.5

Violent Crime Rate per 100,000

257.8

Gun-related ED Utilization per 100,000

8.5

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

822.1

This measure reflects limited access to primary care as individuals may rely on emergency departments non-emergency health needs due to barriers like insurance, trust, clinician shortages, etc.

Flu Vaccinations (Adult)

57.0%

This measure is a strong indicator of overall community vaccination levels because they reflect access to healthcare, public trust in vaccines, and the effectiveness of outreach efforts in promoting immunization.

Chlamydia per 100,000

490.9

This measure is a good marker for STIs in a community because it is the most commonly reported bacterial infection, often asymptomatic, and indicates the overall level of STI transmission, screening, and prevention efforts in a population.

Income Inequality

0.48

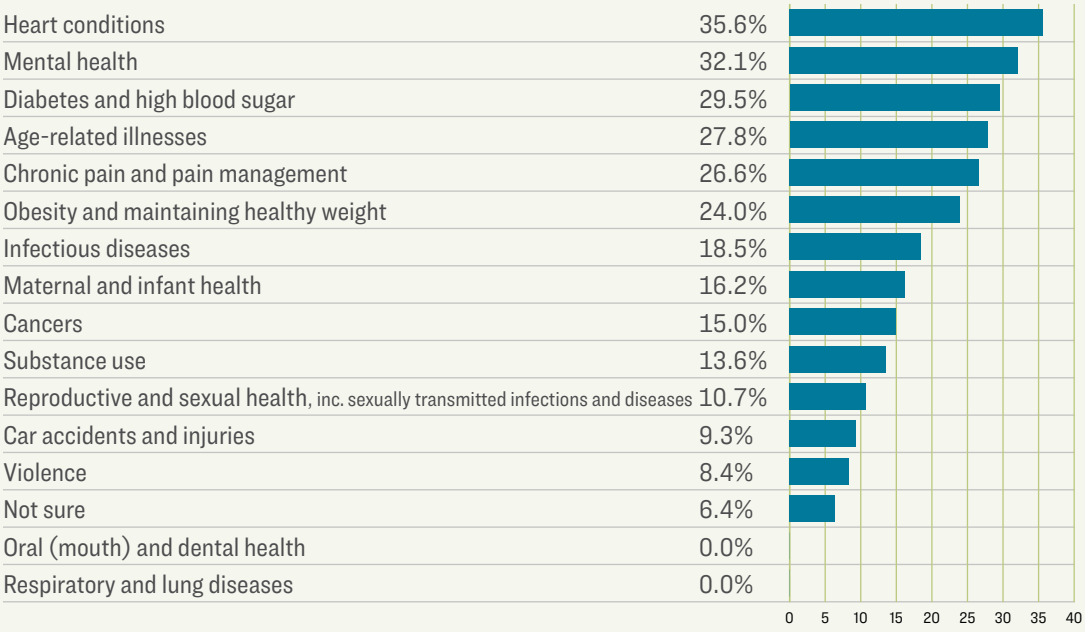
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Delaware County

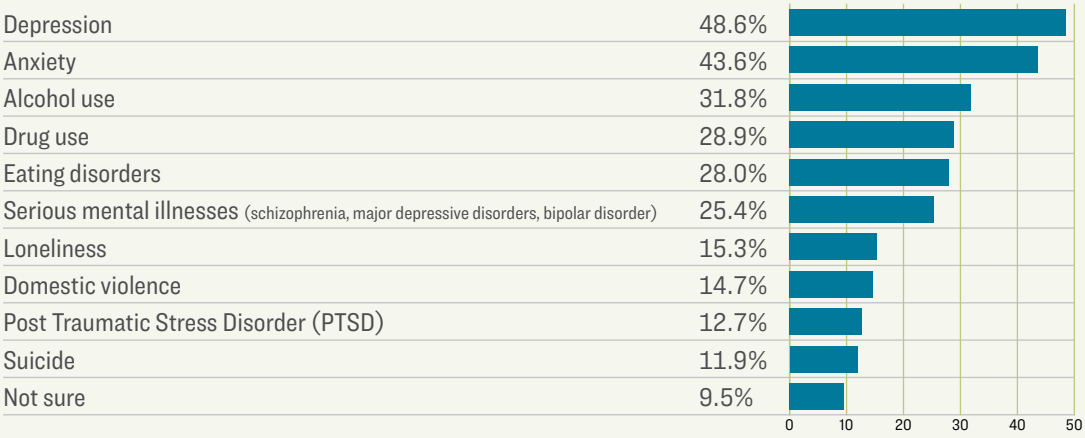
County Survey Results

Number of Respondents: 346

Thinking about yourself or other ADULTS in the community where you live, what are the top 3 HEALTH problems?



Thinking about yourself or other ADULTS in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

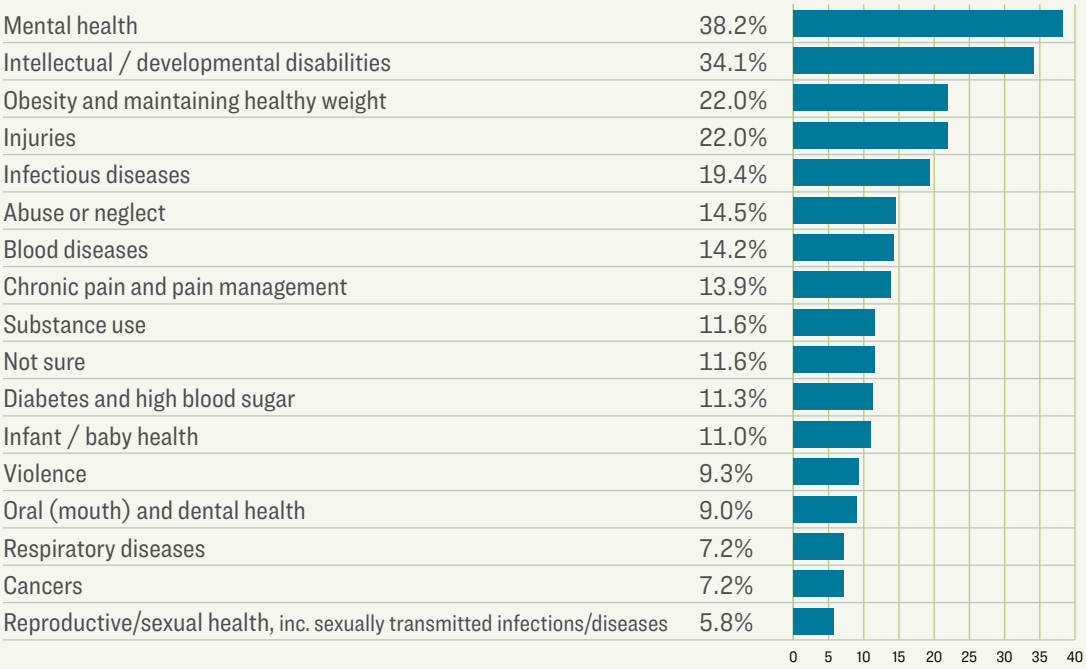


Delaware County

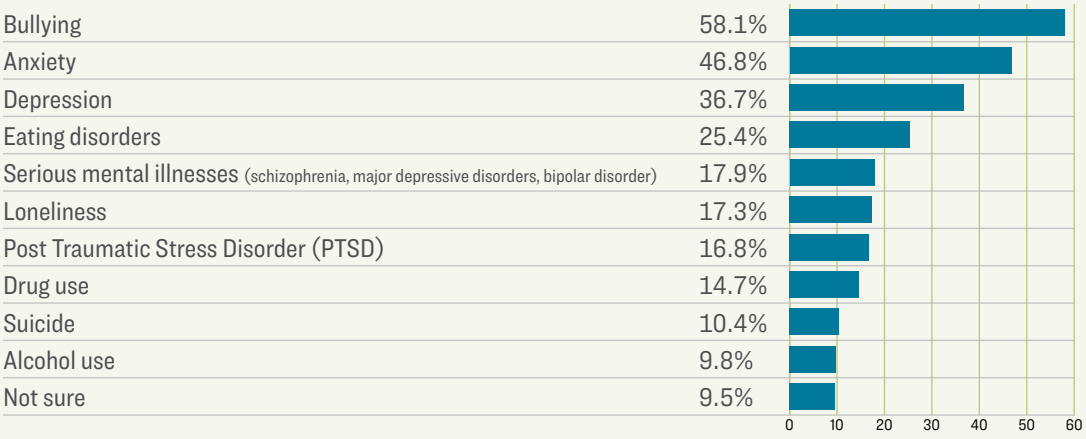
County Survey Results

Number of Respondents: 346

Thinking about your or other CHILDREN in the community where you live, what are the top 3 HEALTH problems?



Thinking about your or other CHILDREN in the community where you live, what are the top 3 MENTAL HEALTH and substance use problems?

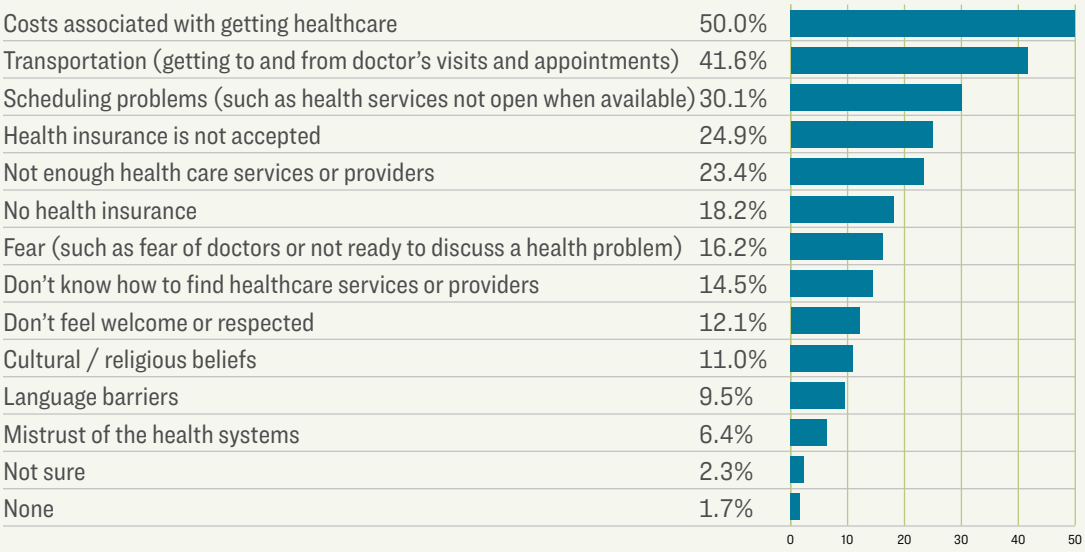


Delaware County

County Survey Results

Number of Respondents: 346

Thinking about the community where you live, which barriers prevent access to health care? (Select all that apply)



Thinking about the community where you live, how available are the following resources?

	Never Available	Rarely	Sometimes	Often	Always Available	Not Sure
Affordable healthy foods	3.8%	23.7%	27.5%	26.3%	17.3%	1.5%
Affordable housing	9.0%	26.0%	31.5%	18.8%	9.5%	5.2%
Clean outdoor environment	2.0%	14.7%	22.5%	31.8%	26.6%	2.3%
Good paying jobs	8.4%	11.6%	36.4%	25.4%	13.3%	4.9%
Good schools	2.0%	19.4%%	21.1%	21.7%	32.7%	3.2%
Health care services	0.9%	3.5%	35.3%	31.5%	26.6%	2.3%
Mental health services	11.6%	16.2%	30.1%	22.0%	11.3%	9.0%
Places to be active such as parks	1.2%	16.8%	22.0%	24.0%	35.3%	0.9%
Safe neighborhood	2.9%	14.2%	27.2%	28.6%	25.7%	1.5%
Services that support people as they age	3.5%	24.9%	21.1%	24.3%	16.2%	10.1%
Substance use services	3.2%	20.8%	30.6%	16.2%	11.9%	17.3%

Delaware County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION AREAS

Some residents shared that they appreciated having access to parks and walking paths. Opportunities for physical activity contributed to overall positive health experiences.

ON GREEN SPACE AND RECREATION AREAS

"...a lot of centers within the surrounding communities that you're able to participate.

"Activities that they offer like paint and sips and these things are free...center which offers sewing. Just the senior center within itself is something that can alleviate stress and anxiety. I love it."

"My community, I've got a community center where they offer Zumba and yoga."

"We're lucky to have quite a few parks in this area and they're well-spaced out."

"I would also add on to the green spaces, especially the Chester Creek Trail is something that has been a really nice add to our community over the last few years. I would love to see more of that. But those are really positive."

HEALTHY FOOD RESOURCES

With the acknowledgement that this was not true everywhere, some residents of Delaware County had ready access to markets with high quality, healthy food.

ON HEALTHY FOOD RESOURCES

"So, in my community, there's plenty of access to fresh fruits and vegetables and healthy food choices because there are some communities where it's food desert and there's corner grocers with probably not very fresh fruits and vegetables."

"Grocery stores and particularly the people that-- if you're really sticklers about whole foods and places where you can get. Also, farmers markets provide a lot of fresh produce."

COMMUNITY CHALLENGES

HEALTHCARE ACCESS

Most residents were able to identify areas for improvement here, and issues when accessing quality primary healthcare. Many who relied on medical transportation faced the inconvenience of long wait times, before and after their appointments. Navigating health systems could be challenging, sometimes the insured were not aware of how to inquire about their health needs or the availability of local resources. And there were language barriers and limited options for undocumented individuals. Medical appointments were harder to make, and women's health needs were of particular concern. Residents were aware of local hospital closures and the subsequent limitations to emergency room access. There were also issues with certain providers not accepting certain types of health insurance.

ON HEALTHCARE ACCESS

"And I've heard about the medical transportation, they give you these wide windows and you pretty much have to block out your whole day."

"I don't know if any place people can call and ask, just ask questions like, what are the different transportation things? I run out of money and prescriptions. What do I do?"

"...we didn't have a health department in Delaware County. Now we have one. But now like, where is it? How do I utilize it? What's the phone number? What do you offer for seniors or disabled people?"

"...resources for groups, for women going through menopause... We can't sleep at night. There's no gynecologist available anywhere, you know, leaving or retiring and there's no one taking their place to get it and they're so busy..."

"I heard today of the closure of the surgical center at [Name] Hospital... And then there's hospitals in certain regions of this county that are closing or... people can't access. And so, there's larger swaths of this community that... don't have a hospital emergency room that's close to them."

"I think health departments can do a lot more educating and outreach to all the different parts of our community and make sure a lot more information gets out there."

"Like people come in the country for a better life. But some people come, you don't have the papers... where you will get insurance and stuff like that? It's hard."

"Some of the costs of the medications are skyrocketing."

BEHAVIORAL HEALTH ISSUES

There were mental health support needs, but a lack of knowledge about the availability of resources and how to access them.

ON BEHAVIORAL HEALTH ISSUES

"I was just going to add importance of exercise or some sort of community events where people can just be together that help them with their mental health. And to be able to socialize with people..."

"And also, mental health support groups. I'm wondering about what the networks of that are and I don't perceive that there are a lot of those."

"...it took me forever to find a mental health specialist, a therapist. Almost two years to find someone to be a therapist for me..."

COMMUNITY CHALLENGES

ENVIRONMENTAL HAZARDS

Some neighborhoods required upkeep and better lighting to allow for safer navigating, especially for people with disabilities. Sidewalks and crosswalks should have been more accessible. Trash and litter build up presented hygienic concerns. Residents explained that there were not enough "sidewalks or available walking routes."

ON ENVIRONMENTAL HAZARDS

"And the other thing is better lighting at night because I'm visually impaired due to glaucoma."

"...when you're walking, and the cars are not necessarily following along with speed limits or the traffic signals for a person who doesn't have a mobility issue that can be hazardous. So, I can only imagine what it would be for someone who does."

"I don't know if all of Radnor Township is ADA, Americans with Disabilities Act compliant. But at every sidewalk nearing a street crossing, there should be an open curve so that people who are using walkers or wheelchairs have access to be able to cross over."

"I think trash that's not emptied is hazardous... it looks bad too but it's unhealthy. Garbage smells, things like that. I don't know why they're not emptied more frequently... People just throw everything all over the place."

SPECIAL POPULATIONS

CHILDREN AND YOUTH

There was concern for when youth were not provided with productive ways to spend their time and engaged in harmful behaviors.

Residents desired more extracurricular activities and opportunities for youth to learn life skills. Interventions were needed to meet the mental health, nutritional, and academic needs of youth. Caregivers were having trouble finding affordable childcare.

ON CHILDREN AND YOUTH

"And like I said, it takes a village to raise. And I used to teach in Upper Darby school district. I'm retired, of course, now. Special needs children, autistic children. And again, that's an uptick too because when I was growing we never heard it was a different name, starting with the aura with special classes. Now, there's a whole uptick in that. And I'm like, where is this coming from? Why is it like this? Why are our kids on medication? Why is there so many mental health issues?"

"I would say access to affordable childcare, especially for the under school age and preschool age that is there are pockets of that in places but it's not affordable for some... And then I would also say access to more community kind of after school programs."

"I think nutrition is a big thing. I think the school lunch program has to be upgraded to maybe a breakfast and lunch program and they have to think about getting all that food to kids during the summertime. I think that's a huge problem in the summer when the school lunch program isn't there."

"I went to school in 90s and 80s or whatever, the things that we learned, basically, our children isn't even learning the same thing. So how are we supposed to help them with their homework and things of that nature? We have our children looking at us like we're stupid at this point."

"They're engaging in risky activities, dangerous activity."

SPECIAL POPULATIONS

OLDER ADULTS

"Having some of the elderly population get to a doctor's appointment" was difficult because of limited transportation options. At home support with activities of daily living could have been helpful for some older adults living alone. Residents believed that training older adults in the use of technology would be helpful also.

ON OLDER ADULTS

"Access to healthier foods. But that correlates to the transportation. My mother was at Ridley Park. She didn't drive because of her diabetes. She lost her license and my father died. So, taking her up to Sharon Hill where Philabundance was distributing [food]. Well, she couldn't carry all that because she was 85 years old."

"I've heard of resources offering box fans for the elderly and disabled. But it's a measure of getting to them, carrying them and I wish they would offer air conditioners if you don't have it and have somebody come and help you install it. Not just like, here you go, good luck."

"...nobody had seen her, and I left food at her door and the next day it was still there and I thought strange. She had to get her mail and stuff, and she goes out for the paper every day. I don't know what you do with people like that. And she has a rotary phone. She won't change. And she just had her 90th birthday so whatever she does, it's working."

"It should be a pharmacy for easily, for them to get to, or some type of delivery service to give them their medicine."

"I think something that might help speaking as a senior citizen is help with computer stuff and e-mail stuff and technical stuff. Those of us who might not have a local grandchild that will come in and teach us all this stuff."

ADDITIONAL POPULATIONS

Housing costs and the low minimum wage in Pennsylvania contributed to the homelessness problem. Residents believed that unused buildings could be repurposed for affordable housing units.

It was not uncommon for residents to provide support for older family members or neighbors. They sought resources to support themselves and those they were caring for. Likewise, grandparents raising grandchildren required legal and other types of support.

Adjustment services for people with newly acquired disabilities, such as vision loss, were needed. Also, education and awareness about the benefits and options related to medical marijuana might have helped to minimize the implications of some chronic health conditions.

HOMELESS

"...as far as the public housing situation, the waiting lists are like forever. You have buildings just sitting and thinking that there's nothing being done..."

CAREGIVERS

"I go to one in person caretaker group... they have a nurse coach that you talk to every so many weeks so...I do [the] caretaking group online."

"...I did go to a meeting they had several years back, and it was all caregivers and they presented us with a list of things to be aware of for your own health and then some organizations that would help you as well. And the interesting thing for me was that this meeting was actually sponsored by a church group that I was not familiar with. And even if you didn't belong to this particular church they were saying, please feel free to contact us and we will help you."

"So there's a whole bunch but there's no legal bearing on grandparents. In other words, no matter what that parent can all of a sudden, [say] I want my child back... You haven't had them for 15 years."

PEOPLE WITH DISABILITIES

"And also with my visual impairment, I'm having trouble finding [help] even though there's blind associations, Library of Blind. I want somebody to teach me braille while I can, yeah. And I can't seem to find that help anywhere..."

ACCESS TO CARE

Some participants spoke of generally positive experiences with accessing and the quality of primary healthcare services. Yet a lack of reliable transportation served as a barrier for older adults, individuals with smaller social networks, and those with low incomes. Social stigmas related to mental illness acted as a deterrent to seeking assistance.

ON ACCESS TO CARE

"Well, one thing that I discovered when I came here, it has a very good health care. But I had no way to get there, and I am not good with computers at all."

"It's a huge issue for people whose friends either no longer drive or have moved away because if you want to go for a colonoscopy, you have to have someone take you there because they're gonna put you under with Propofol and they want someone there to take you back. And it's almost impossible for some people."

"There's a bigger issue here and that is that there is inadequate education as people are nearing the age of 65 to learn from an unbiased source about all options necessary that the government requires for when you sign up for Medicare. What level of care? What kind of prescription drug plan, PDP, is going to-- How do you even analyze any of this? Someone who is nearing the age of 65 needs to know how far in advance to start doing research. If they are unable to do that themselves, then who else is available? There are some community volunteers, and I don't remember the acronym name for the group, but there are too few involved."

"...think that there's still such a stigma that comes with many mental health issues, even though we've made great strides in trying to accept that overall. But I still think that a lot of people are embarrassed or ashamed to come forward and admit to people that they have these issues."

ACCESS TO CARE

TRUSTWORTHINESS

Responses were varied, with some trusting their providers, others skeptical, and others lacking trust. Reasons for not fully trusting medical professionals were related to experiences with incompetence, high turnover, poor communication, and malpractice.

ON TRUSTWORTHINESS

"I haven't had any bad experiences."

"My son was in the trauma unit... we specified he has celiac, gluten-free and... he's really hungry. And so, they contacted the dietary and they sent up a chicken sandwich and I said, well... he can't have bread. And I said, I'm sorry, you can't just take off the bun and give him the chicken. It's not going to work. So, I had to go, I went home. I had to bring him food because I couldn't trust that they were going to give him the right food. And that's pretty basic."

"I think they're trying... After COVID everybody just up and left. So, you have a lot of, I don't want to say inexperienced but people that are learning as they go along."

"I take a lot of notes now, like before I go to the doctor. So, I know [what] to ask because sometimes... you go and they don't tell you things."

"I can only speak of a recent situation with a friend of mine who became ill several years back, something was detected but not acted upon and as a result now it's become extremely serious. And I just can't even imagine how she feels about this because she certainly realizes that this one particular physician really didn't have her best interest at heart. And now, she might just have months left."

COVID-19 PANDEMIC

Post-COVID, most respondents remained concerned about the implications of COVID-19 – especially older adults and those with preexisting conditions. There was a heightened awareness about one's health and longer waits for appointments. Many people were aware of Long COVID and some residents had personal or family experiences with Long COVID symptoms.

ON COVID-19 PANDEMIC

"Since COVID, you'll go into different clinics regardless again, of whatever health system, some of the employees are wearing masks and some of them are not. So for those of us who are older or people who are immunocompromised, who need to come into a place where there are all kinds of people congregating from different neighborhoods, each has his or her own health issues, there needs to be some consistency across the board what type of mask at least that health institution wants their employees to wear…"

"I lost a asthma doctor, gynecologist, my husband's urologist and two of the primaries, they all stopped after the pandemic. They were so burned out."

"I don't know if it's still a concern."

"I feel like it is in a sense because it's still out here so it can still be caught and things of that nature. And if either of us was to catch it, it would throw us completely off with working and things of that nature."

"…ever since I had COVID, my taste never went back 100%."

"I think I'm more willing to go to the doctor than I was before. I would put it off before."

SUGGESTED ACTIONS

Delaware County

What is already working well to improve health in your community?

Delaware County's green and recreational spaces are enjoyable and continue to improve.

"Green spaces supporting the little borough that I live in. They do a good job of making sure the parks are cut. They're working on and waiting for funding to install playgrounds, additional playgrounds for younger families..."

During the pandemic, a local senior center was equipped to mitigate a crisis and support older adults.

"...when the pandemic hit and everybody was locked down, a lot of people turned to the senior center to provide meals. And they were, I think, at the forefront doing that. And if you couldn't come and get them, they actually had a team of volunteers that delivered them. They also set up this iPad program they have to keep people connected. They absolutely started that in this area."

Health Navigators have provided needed support.

"I think the availability of social workers to help people navigate the system and know what's covered and where to go. I mean, they're invaluable, you have to know to ask for them and then they have to be available."

What are the most important issues to address to improve health in your community?

Better dissemination of information about health services is needed.

"So, there are areas that still need help and a lot of people don't know that the help exists so they need to be educated as to what's out there and what's available to them."

Local dog parks could support the well-being of whole families and neighborhoods.

"We need a dog park... Yeah, I mean animals for people is help, is therapy. So, if we have a place that we can go and feel comfortable with our dogs and things of that nature, that would be pretty cool. A lot of that is not feeling comfortable around other people or other dogs and things of that nature because we don't know the next person and how they're training their dogs..."

The minimum wage in Pennsylvania is not a livable wage.

"And then the price of everything is going up, the price of food, everything. But they will not raise minimum wage. Minimum wage is crazy at $7.25 still. And if you have a job where you're making tips, they can pay you at $2.37... how can you even live off of that?"

People who are homeless need greater access to resources, seven days a week.

"...the homeless community is completely forgot about on the weekends when we really need it. So, yeah, even if it was just the truck that comes out on Saturdays and Sundays, that would be pretty cool because they give out waters and clean underwear and things of that nature."

There is a perceived lack of empathy in medical care.

"They need to put a human face to it... it's business still but put your loved one in that position. How would you feel? What would you do with the cost and not getting what they need if your loved one was going through this and that you couldn't afford it?"

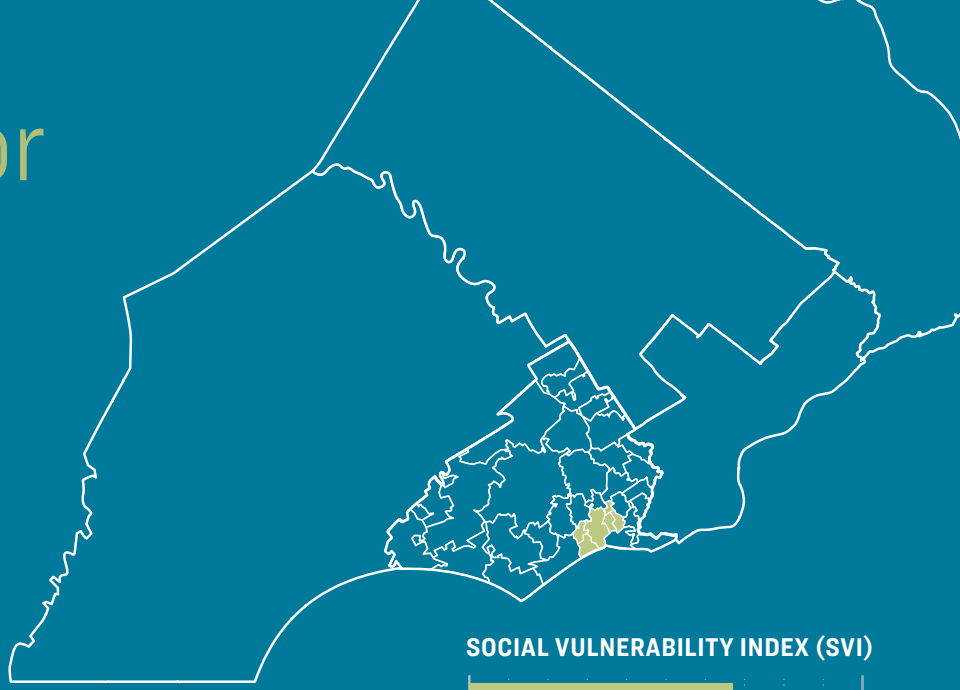
Airport Corridor

ZIP Codes:

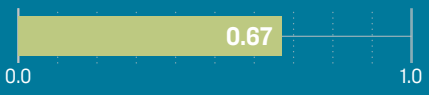
19022, 19033, 19043, 19074, 19076, 19078

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



SOCIAL VULNERABILITY INDEX (SVI)



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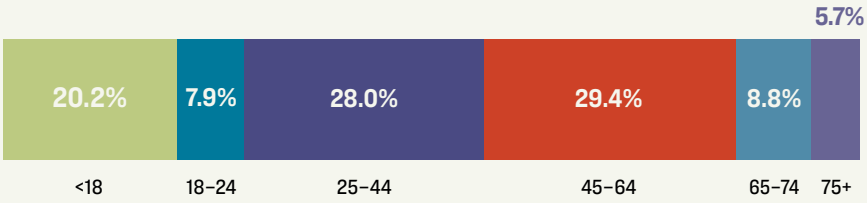
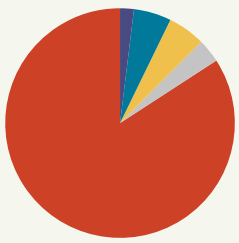
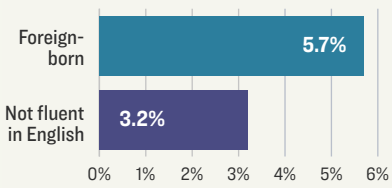


SEX

RACE/ETHNICITY/LANGUAGE



2.2% Asian
5.4% Black
5.4% Hispanic/Latine
3.3% Another race/ethnicity
85.5% White



POPULATION

39,114

MEDIAN HOUSEHOLD INCOME

$86,367

EDUCATIONAL ATTAINMENT

38.3% High school as highest education level

PEOPLE WITH DISABILITIES

15.8%

LEADING CAUSES OF DEATH – All Ages

1 Cancer
2 Heart Disease
3 Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Airport Corridor	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	959.2	1,020.3
	Life expectancy: Female (in years)	79.5	79.9
	Life expectancy: Male (in years)	73.5	76.0
	Years of potential life lost before 75	2,710	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.4%	31%
	Diabetes prevalence	10.7%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	218.0	170.0
	Hypertension prevalence	32.7%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	44.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	1,116.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	46.7	49.2
	Major cancer incidence rate (per 100,000)*	277.4	263.3%
	Major cancer mortality rate (per 100,000)*	93.3	80.3
	Colorectal cancer screening (adults age 45-75)	66.7%	68.6%
	Mammography screening (women age 50-74)	76.2%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.3	5.9
	Percent low birthweight births out of live births	8.8%	9.0%
	Percent preterm births out of live births	9.9%	9.5%
	Child Opportunity Index**	47.9	59.0
BEHAVIORAL HEALTH	Adult binge drinking	19.9%	18.8%
	Adult smoking	16.8%	13.9%
	Drug overdose mortality rate (per 100,000)	18.1	28.0
	Opioid-related hospitalization rate (per 100,000)	363.0	220.6
	Substance-related hospitalization rate (per 100,000)	565.2	366.0
	Poor mental health for 14+ days in past 30 days	17.3%	15.8%
	Suicide mortality rate (per 100,000)	25.9	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,806.0	2,661.0
	Homicide mortality rate (per 100,000)	7.8	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	15.7%	15.1%
	Children <19 years with public insurance	33.7%	34.2%
	Population without insurance	5.1%	5.0%
	Children <19 years without insurance	3.0%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	9.1%	9.3%
	Children <18 years in poverty	11.7%	11.5%
	Adults 19-64 years unemployed	5.5%	6.2%
	Householders living alone who are 65+ years	33.6%	29.7%
	Households receiving SNAP benefits	14.4%	13.8%
	Households that are housing cost-burdened (% spending >50% of household income)	13.1%	14.3%
	Vacant housing units	5.6%	5.8%
	Single parent households	37.2%	27.1%
	Commute greater than 60 minutes	4.9%	8.8%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from residents of the Airport Corridor and Chester/I-95 Corridor communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 120

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Chronic pain and pain management
- Age-related illnesses
- Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Alcohol use
- Drug use
- Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Abuse or neglect
- Injuries
- Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Mental health services
- Affordable housing
- Affordable healthy foods

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Transportation (getting to and from doctor's visits and appointments)
- Costs associated with getting healthcare
- No health insurance

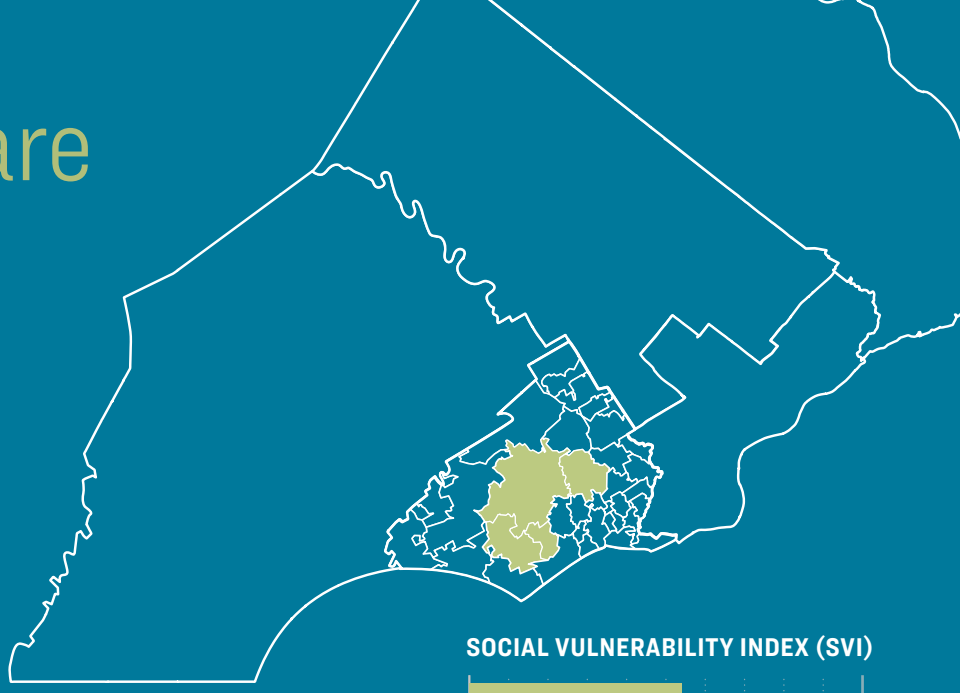
Central Delaware County

ZIP Codes:

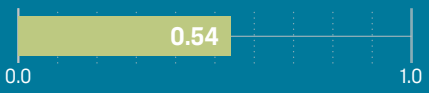
19014, 19015, 19017, 19052, 19063, 19064, 19070, 19081, 19086

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



SOCIAL VULNERABILITY INDEX (SVI)



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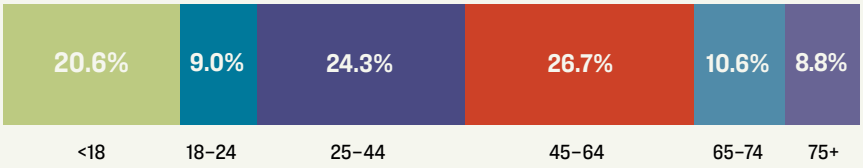
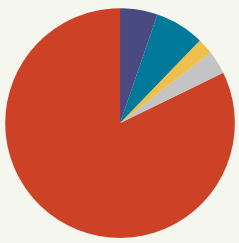
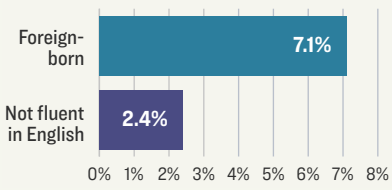


SEX

RACE/ETHNICITY/LANGUAGE



5.3% Asian
7.0% Black
2.2% Hispanic/Latine
3.5% Another race/ethnicity
81.8% White



POPULATION

131,047

MEDIAN HOUSEHOLD INCOME

$114,917

EDUCATIONAL ATTAINMENT

23.6% High school as highest education level

PEOPLE WITH DISABILITIES

11.9%

LEADING CAUSES OF DEATH – All Ages

1 Heart Disease
2 Cancer
3 Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Central Delaware County	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	1025.2	1,020.3
	Life expectancy: Female (in years)	80.6	79.9
	Life expectancy: Male (in years)	77.7	76.0
	Years of potential life lost before 75	6,767	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.1%	31%
	Diabetes prevalence	10.2%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	141.0	170.0
	Hypertension prevalence	31.8%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	29.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	782.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	40.6	49.2
	Major cancer incidence rate (per 100,000)*	272.6	263.3%
	Major cancer mortality rate (per 100,000)*	81.9	80.3
	Colorectal cancer screening (adults age 45-75)	70.1%	68.6%
	Mammography screening (women age 50-74)	80.4%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.8	5.9
	Percent low birthweight births out of live births	7.1%	9.0%
	Percent preterm births out of live births	7.8%	9.5%
	Child Opportunity Index**	70.1	59.0
BEHAVIORAL HEALTH	Adult binge drinking	19.3%	18.8%
	Adult smoking	12.7%	13.9%
	Drug overdose mortality rate (per 100,000)	16.1	28.0
	Opioid-related hospitalization rate (per 100,000)	139.4	220.6
	Substance-related hospitalization rate (per 100,000)	224.3	366.0
	Poor mental health for 14+ days in past 30 days	14.9%	15.8%
	Suicide mortality rate (per 100,000)	8.4	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,298.0	2,661.0
	Homicide mortality rate (per 100,000)	3.1	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	8.0%	15.1%
	Children <19 years with public insurance	21.0%	34.2%
	Population without insurance	2.3%	5.0%
	Children <19 years without insurance	1.3%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.8%	9.3%
	Children <18 years in poverty	5.7%	11.5%
	Adults 19-64 years unemployed	4.7%	6.2%
	Householders living alone who are 65+ years	27.8%	29.7%
	Households receiving SNAP benefits	6.7%	13.8%
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	Vacant housing units	4.4%	5.8%
	Single parent households	23.1%	27.1%
	Commute greater than 60 minutes	7.6%	8.8%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from residents of the Central and Western Delaware County communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 121

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Age-related illnesses
- Heart conditions
- Mental health

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Loneliness

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Intellectual / developmental disabilities
- Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Mental health services
- Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Transportation (getting to and from doctor's visits and appointments)
- Health insurance is not accepted

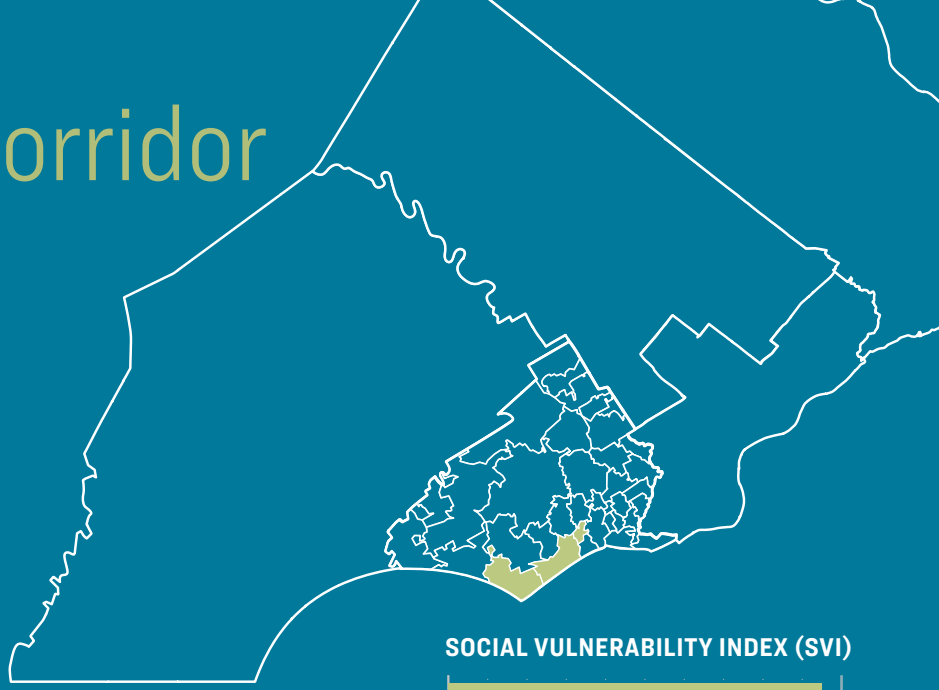
Chester/I-95 Corridor

ZIP Codes:

19013, 19061, 19094

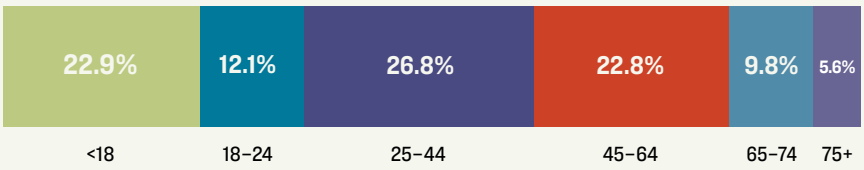
This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



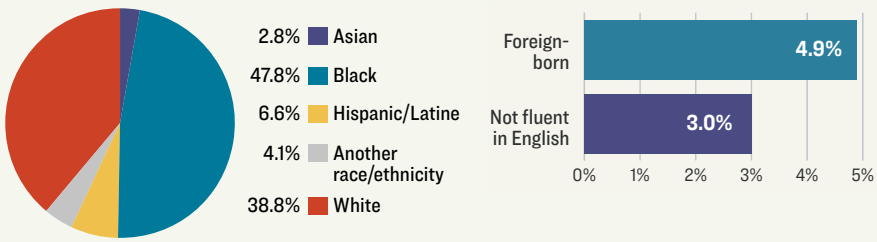
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

59,349

MEDIAN HOUSEHOLD INCOME

$54,570

EDUCATIONAL ATTAINMENT

44.5% High school as highest education level

PEOPLE WITH DISABILITIES

17.0%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Chester/ I-95 Corridor	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	1158.0	1,020.3
	Life expectancy: Female (in years)	74.4	79.9
	Life expectancy: Male (in years)	69.2	76.0
	Years of potential life lost before 75	6,876	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	36.8%	31%
	Diabetes prevalence	13.8%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	498.0	170.0
	Hypertension prevalence	37.7%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	124.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	1,939.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	84.3	49.2
	Major cancer incidence rate (per 100,000)*	225.9	263.3%
	Major cancer mortality rate (per 100,000)*	89.3	80.3
	Colorectal cancer screening (adults age 45-75)	64.8%	68.6%
	Mammography screening (women age 50-74)	77.7%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	12.1	5.9
	Percent low birthweight births out of live births	12.8%	9.0%
	Percent preterm births out of live births	12.9%	9.5%
	Child Opportunity Index**	27.2	59.0
BEHAVIORAL HEALTH	Adult binge drinking	17.2%	18.8%
	Adult smoking	19.3%	13.9%
	Drug overdose mortality rate (per 100,000)	59.0	28.0
	Opioid-related hospitalization rate (per 100,000)	492.2	220.6
	Substance-related hospitalization rate (per 100,000)	886.6	366.0
	Poor mental health for 14+ days in past 30 days	18.7%	15.8%
	Suicide mortality rate (per 100,000)	6.7	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,961.0	2,661.0
	Homicide mortality rate (per 100,000)	28.7	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	26.9%	15.1%
	Children <19 years with public insurance	59.5%	34.2%
	Population without insurance	6.4%	5.0%
	Children <19 years without insurance	3.7%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	18.8%	9.3%
	Children <18 years in poverty	29.6%	11.5%
	Adults 19-64 years unemployed	11.2%	6.2%
	Householders living alone who are 65+ years	40.3%	29.7%
	Households receiving SNAP benefits	32.3%	13.8%
	Households that are housing cost-burdened (% spending >50% of household income)	17.7%	14.3%
	Housing with potential lead risk		5.8%
	Single parent households	65.3%	27.1%
	Commute greater than 60 minutes	5.7%	8.8%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from residents of the Airport Corridor and Chester/I-95 Corridor communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 120

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Chronic pain and pain management
- Age-related illnesses
- Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Alcohol use
- Drug use
- Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Abuse or neglect
- Injuries
- Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Mental health services
- Affordable housing
- Affordable healthy foods

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Transportation (getting to and from doctor's visits and appointments)
- Costs associated with getting healthcare
- No health insurance

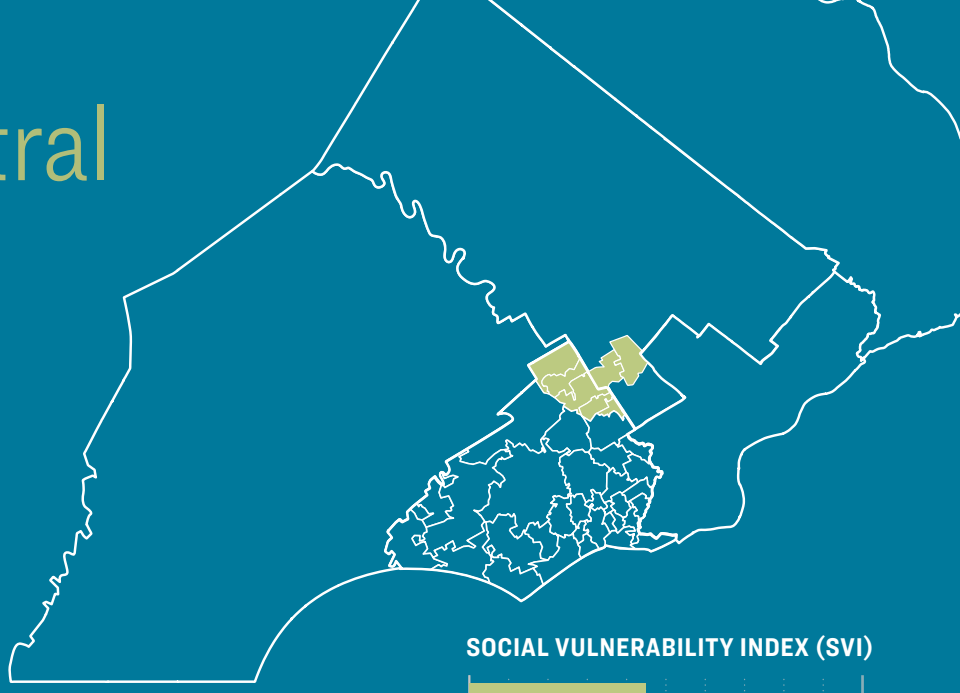
Main Line Central

ZIP Codes: 19003, 19010, 19035, 19041, 19085, 19087

Note: This community includes three ZIP codes (19003, 19035, 19041) which cross into Montgomery County.

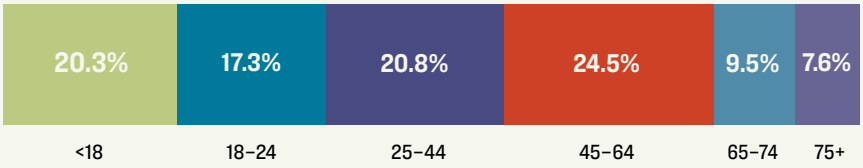
This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Main Line Health
- Wills Eye Hospital



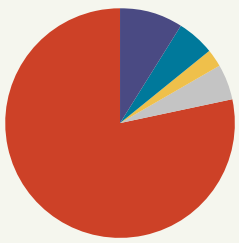
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

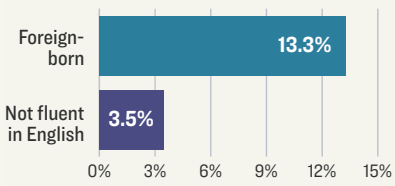


SEX

RACE/ETHNICITY/LANGUAGE



8.9% Asian
4.9% Black
2.5% Hispanic/Latine
4.8% Another race/ethnicity
76.0% White



POPULATION

90,731

MEDIAN HOUSEHOLD INCOME

$157,335

EDUCATIONAL ATTAINMENT

8.8% High school as highest education level

PEOPLE WITH DISABILITIES

9.1%

LEADING CAUSES OF DEATH – All Ages

1 Heart Disease
2 Cancer
3 Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Main Line Central	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	754.6	1,020.3
	Life expectancy: Female (in years)	83.1	79.9
	Life expectancy: Male (in years)	81.5	76.0
	Years of potential life lost before 75	2,188	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	25.5%	31%
	Diabetes prevalence	8.1%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	80.0	170.0
	Hypertension prevalence	27.5%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	30.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	597.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	17.7	49.2
	Major cancer incidence rate (per 100,000)*	215.8	263.3%
	Major cancer mortality rate (per 100,000)*	48.7	80.3
	Colorectal cancer screening (adults age 45-75)	72.4%	68.6%
	Mammography screening (women age 50-74)	81.7%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	1.5	5.9
	Percent low birthweight births out of live births	6.5%	9.0%
	Percent preterm births out of live births	7.8%	9.5%
	Child Opportunity Index**	92.3	59.0
BEHAVIORAL HEALTH	Adult binge drinking	19.7%	18.8%
	Adult smoking	7.7%	13.9%
	Drug overdose mortality rate (per 100,000)	10.0	28.0
	Opioid-related hospitalization rate (per 100,000)	42.0	220.6
	Substance-related hospitalization rate (per 100,000)	87.4	366.0
	Poor mental health for 14+ days in past 30 days	13.5%	15.8%
	Suicide mortality rate (per 100,000)	13.3	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,961.0	2,661.0
	Homicide mortality rate (per 100,000)	2.2	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.4%	15.1%
	Children <19 years with public insurance	8.9%	34.2%
	Population without insurance	2.5%	5.0%
	Children <19 years without insurance	2.1%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	3.7%	9.3%
	Children <18 years in poverty	2.0%	11.5%
	Adults 19-64 years unemployed	4.1%	6.2%
	Householders living alone who are 65+ years	27.2%	29.7%
	Households receiving SNAP benefits	3.1%	13.8%
	Households that are housing cost-burdened (% spending >50% of household income)	13.2%	14.3%
	Vacant housing units	5.6%	5.8%
	Single parent households	13.1%	27.1%
	Commute greater than 60 minutes	6.3%	8.8%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from residents of the Main Line Central and Route 3 Corridor communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 73

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Heart conditions
- Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Intellectual / developmental disabilities
- Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Anxiety
- Bullying
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Good paying jobs
- Affordable housing
- Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Scheduling problems (such as health services not open when available)
- Health insurance is not accepted

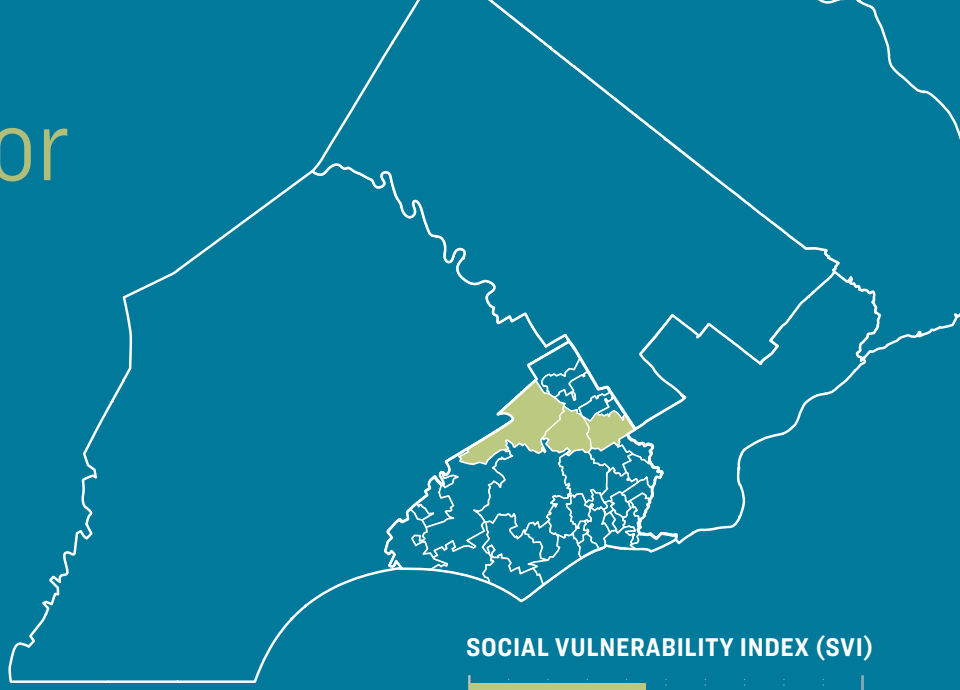
Route 3 Corridor

ZIP Codes:

19008, 19073, 19083

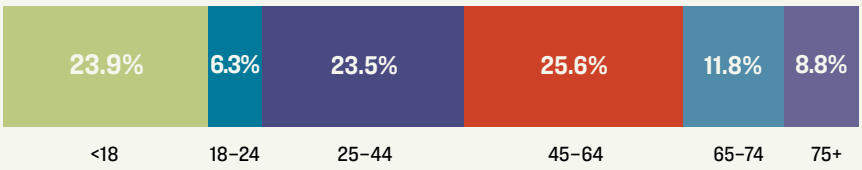
This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



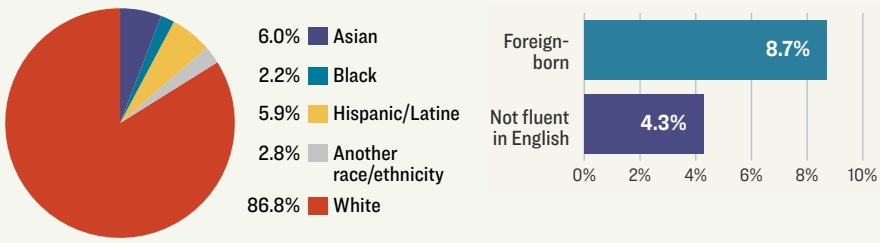
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

79,000

MEDIAN HOUSEHOLD INCOME

$125,168

EDUCATIONAL ATTAINMENT

19.4% High school as highest education level

PEOPLE WITH DISABILITIES

10.8%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Route 3 Corridor	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	957.8	1,020.3
	Life expectancy: Female (in years)	82.7	79.9
	Life expectancy: Male (in years)	78.9	76.0
	Years of potential life lost before 75	2,763	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.2%	31%
	Diabetes prevalence	10.0%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	119.0	170.0
	Hypertension prevalence	32.0%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	26.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	706.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	19.0	49.2
	Major cancer incidence rate (per 100,000)*	263.5	263.3%
	Major cancer mortality rate (per 100,000)*	69.7	80.3
	Colorectal cancer screening (adults age 45-75)	72.1%	68.6%
	Mammography screening (women age 50-74)	80.7%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	1.1	5.9
	Percent low birthweight births out of live births	5.6%	9.0%
	Percent preterm births out of live births	6.7%	9.5%
	Child Opportunity Index**	82.0	59.0
BEHAVIORAL HEALTH	Adult binge drinking	18.6%	18.8%
	Adult smoking	10.7%	13.9%
	Drug overdose mortality rate (per 100,000)	16.5	28.0
	Opioid-related hospitalization rate (per 100,000)	72.2	220.6
	Substance-related hospitalization rate (per 100,000)	107.7	366.0
	Poor mental health for 14+ days in past 30 days	13.0%	15.8%
	Suicide mortality rate (per 100,000)	12.7	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,539.0	2,661.0
	Homicide mortality rate (per 100,000)	2.5	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.6%	15.1%
	Children <19 years with public insurance	14.9%	34.2%
	Population without insurance	2.4%	5.0%
	Children <19 years without insurance	1.2%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	3.2%	9.3%
	Children <18 years in poverty	2.6%	11.5%
	Adults 19-64 years unemployed	3.2%	6.2%
	Householders living alone who are 65+ years	24.7%	29.7%
	Households receiving SNAP benefits	5.2%	13.8%
	Households that are housing cost-burdened (% spending >50% of household income)	10.2%	14.3%
	Vacant housing units	2.8%	5.8%
	Single parent households	11.0%	27.1%
	Commute greater than 60 minutes	7.1%	8.8%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

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COMMUNITY SURVEY

These results reflect responses from residents of the Main Line Central and Route 3 Corridor communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 73

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Heart conditions
- Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Intellectual / developmental disabilities
- Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Anxiety
- Bullying
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Good paying jobs
- Affordable housing
- Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Scheduling problems (such as health services not open when available)
- Health insurance is not accepted

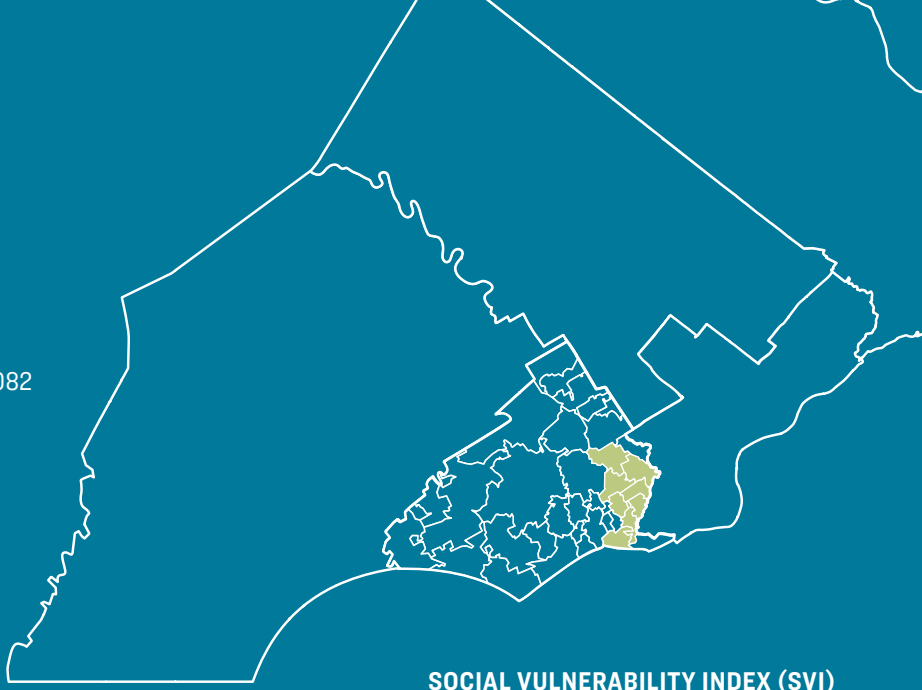
Upper Darby and Lansdowne

ZIP Codes:

19018, 19023, 19026, 19029, 19032, 19036, 19050, 19079, 19082

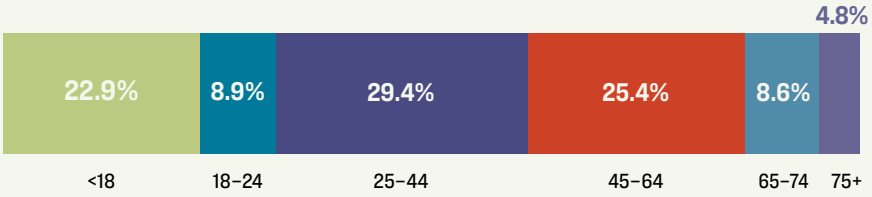
This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital



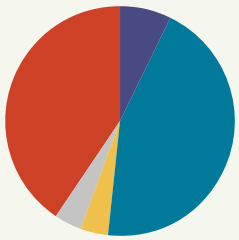
SOCIAL VULNERABILITY INDEX (SVI)

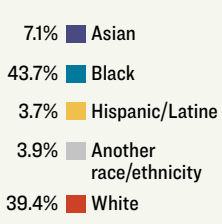
AGE DISTRIBUTION

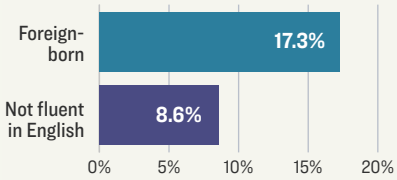


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

182,310

MEDIAN HOUSEHOLD INCOME

$65,946

EDUCATIONAL ATTAINMENT

32.2% High school as highest education level

PEOPLE WITH DISABILITIES

17.2%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Upper Darby and Lansdowne	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	851.7	1,020.3
	Life expectancy: Female (in years)	78.0	79.9
	Life expectancy: Male (in years)	72.9	76.0
	Years of potential life lost before 75	15,342	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	37.0%	31%
	Diabetes prevalence	13.7%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	329.0	170.0
	Hypertension prevalence	37.3%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	91.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	1,413.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	65.2	49.2
	Major cancer incidence rate (per 100,000)*	193.9	263.3%
	Major cancer mortality rate (per 100,000)*	75.0	80.3
	Colorectal cancer screening (adults age 45-75)	64.4%	68.6%
	Mammography screening (women age 50-74)	77.9%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	9.7	5.9
	Percent low birthweight births out of live births	11.6%	9.0%
	Percent preterm births out of live births	11.2%	9.5%
	Child Opportunity Index**	30.0	59.0
BEHAVIORAL HEALTH	Adult binge drinking	16.6%	18.8%
	Adult smoking	18.8%	13.9%
	Drug overdose mortality rate (per 100,000)	37.8	28.0
	Opioid-related hospitalization rate (per 100,000)	310.0	220.6
	Substance-related hospitalization rate (per 100,000)	516.0	366.0
	Poor mental health for 14+ days in past 30 days	18.3%	15.8%
	Suicide mortality rate (per 100,000)	8.8	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,096.0	2,661.0
	Homicide mortality rate (per 100,000)	15.3	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	23.1%	15.1%
	Children <19 years with public insurance	54.2%	34.2%
	Population without insurance	8.3%	5.0%
	Children <19 years without insurance	3.9%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	15.1%	9.3%
	Children <18 years in poverty	22.4%	11.5%
	Adults 19-64 years unemployed	8.4%	6.2%
	Householders living alone who are 65+ years	31.3%	29.7%
	Households receiving SNAP benefits	20.3%	13.8%
	Households that are housing cost-burdened (% spending >50% of household income)	17.9%	14.3%
	Vacant housing units	6.5%	5.8%
	Single parent households	50.6%	27.1%
	Commute greater than 60 minutes	12.7%	8.8%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 116

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Heart conditions

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Drug use

Anxiety

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Depression

Anxiety

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Mental health services

Good paying jobs

Affordable housing

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

Not enough health care services or providers

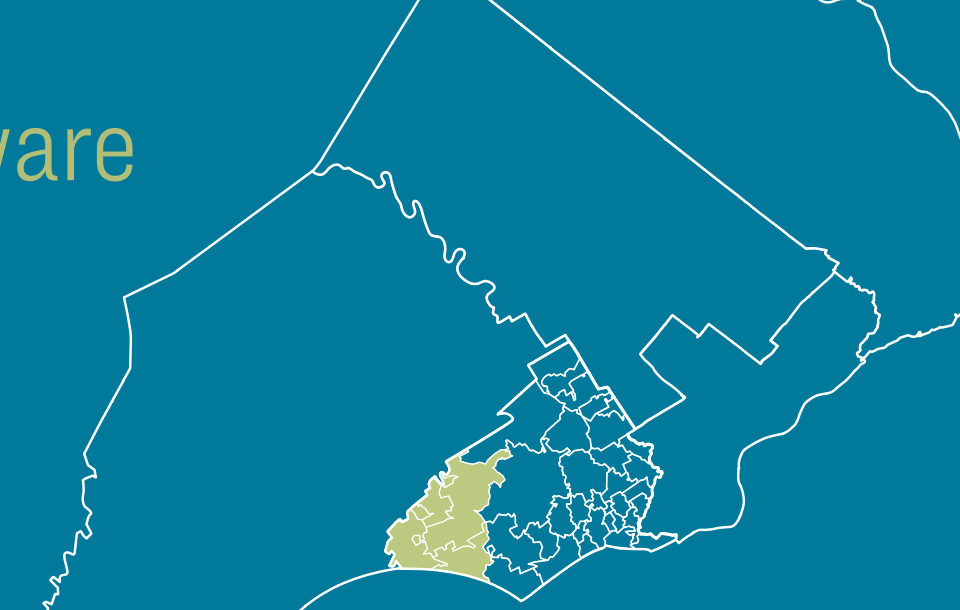
Western Delaware County

ZIP Codes: 19060, 19317, 19319, 19342, 19373

This community is served by:

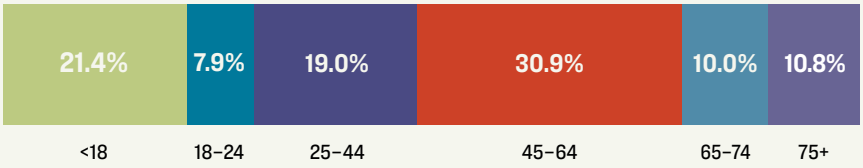
- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- ChristianaCare – West Grove*
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

* ChristianaCare - West Grove Campus anticipated opening Summer 2025



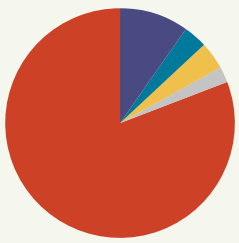
SOCIAL VULNERABILITY INDEX (SVI)

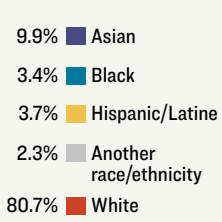
AGE DISTRIBUTION

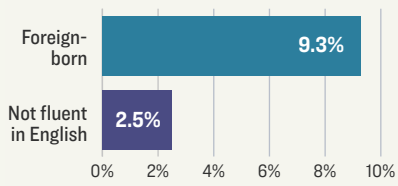


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

45,975

MEDIAN HOUSEHOLD INCOME

$151,623

EDUCATIONAL ATTAINMENT

18.8% High school as highest education level

PEOPLE WITH DISABILITIES

11.3%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Western Delaware County	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	1058.7	1,020.3
	Life expectancy: Female (in years)	82.3	79.9
	Life expectancy: Male (in years)	78.8	76.0
	Years of potential life lost before 75	1,658	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	25.6%	31%
	Diabetes prevalence	8.6%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	99.0	170.0
	Hypertension prevalence	28.5%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	33.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	649.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	26.4	49.2
	Major cancer incidence rate (per 100,000)*	354.4	263.3
	Major cancer mortality rate (per 100,000)*	66.0	80.3
	Colorectal cancer screening (adults age 45-75)	71.4%	68.6%
	Mammography screening (women age 50-74)	80.7%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	5.9
	Percent low birthweight births out of live births	4.7%	9.0%
	Percent preterm births out of live births	5.8%	9.5%
	Child Opportunity Index**	89.3	59.0
BEHAVIORAL HEALTH	Adult binge drinking	20.5%	18.8%
	Adult smoking	9.3%	13.9%
	Drug overdose mortality rate (per 100,000)	15.4	28.0
	Opioid-related hospitalization rate (per 100,000)	158.5	220.6
	Substance-related hospitalization rate (per 100,000)	213.5	366.0
	Poor mental health for 14+ days in past 30 days	13.3%	15.8%
	Suicide mortality rate (per 100,000)	15.4	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,077.0	2,661.0
	Homicide mortality rate (per 100,000)	2.2	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	3.9%	15.1%
	Children <19 years with public insurance	11.0%	34.2%
	Population without insurance	3.7%	5.0%
	Children <19 years without insurance	5.7%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	1.5%	9.3%
	Children <18 years in poverty	0.3%	11.5%
	Adults 19-64 years unemployed	3.9%	6.2%
	Householders living alone who are 65+ years	26.8%	29.7%
	Households receiving SNAP benefits	3.2%	13.8%
	Households that are housing cost-burdened (% spending >50% of household income)	15.2%	14.3%
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"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from residents of the Central and Western Delaware County communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 121

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Age-related illnesses
- Heart conditions
- Mental health

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Loneliness

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Intellectual / developmental disabilities
- Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

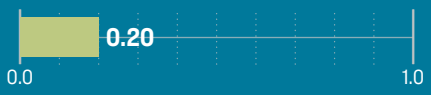
- Affordable housing
- Mental health services
- Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

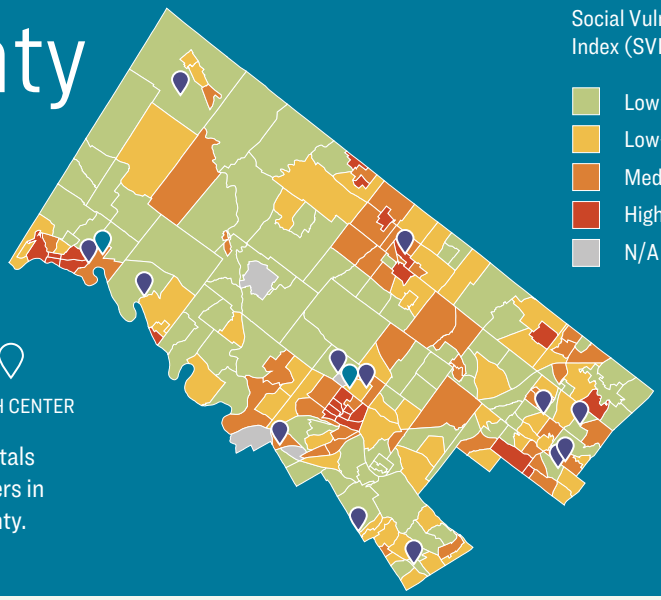
- Costs associated with getting healthcare
- Transportation (getting to and from doctor's visits and appointments)
- Health insurance is not accepted

Montgomery County

SOCIAL VULNERABILITY INDEX (SVI)*



*SVI is a measure developed by the CDC to identify communities that may need support before, during, or after disasters. This measure is made up of a combination of 16 different U.S. Census variables, which are grouped into four themes (socioeconomic status, household charateristics, racial & ethnic minority status, and housing type & transportation), and cover major areas of social vulnerability.



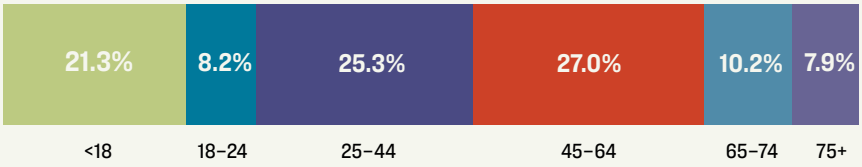
HOSPITAL HEALTH CENTER

There are 13 hospitals and 2 health centers in Montgomery County.

Demographics

AGE DISTRIBUTION

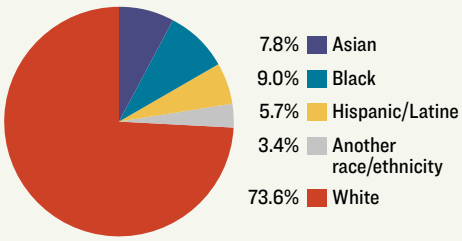
Montgomery County has an estimated population of 861,225 with the largest proportion of residents between the ages of 45 - 64.



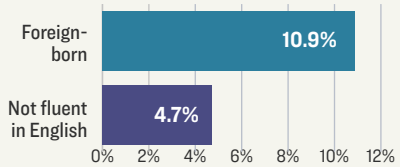
SEX

RACE/ETHNICITY/LANGUAGE

74% of residents are non-Hispanic White. Black residents make the next largest population, comprising 9% of the county's residents.



Nearly 11% of residents are foreign-born and about 5% speak English less than "very well."



HOUSEHOLDS

Median Household Income
$107,441

Homeownership
72%

Severe Housing Cost Burden
% spending >50% of household income
12%

High School as Highest Education
22.6%

Household Food Insecurity
8.6%

Single Parent Households
17.1%

Same Sex Couples
per 1,000 households
3.9

Commute Greater than 60 minutes
9.0%

Montgomery County

Health

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases
4. COVID-19
5. Accidents

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

4.6%

Depressed/Sad Most Days in the Past 12 Months

26.4%

Binge Drinking

6.5%

Cigarette Smoking

1.9%

Vaping

9.5%

Exposure

Lead Levels in Children (<16 years old)

2.8%

PEOPLE WITH DISABILITIES

Percent of Population

10.6%

Poverty Status in the Past 12 Months

17.6%

Percent who have difficulty with:

Hearing	2.9%
Vision	1.4%
Cognition	4.1%
Ambulatory	5.3%
Self-care	2.0%
Independent Living	4.1%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

2.2

Violent Crime Rate per 100,000

125.3

Gun-related ED Utilization per 100,000

2.7

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

472.4

This measure reflects limited access to primary care as individuals may rely on emergency departments non-emergency health needs due to barriers like insurance, trust, clinician shortages, etc.

Flu Vaccinations (Adult)

62.0%

This measure is a strong indicator of overall community vaccination levels because they reflect access to healthcare, public trust in vaccines, and the effectiveness of outreach efforts in promoting immunization.

Chlamydia per 100,000

233.4

This measure is a good marker for STIs in a community because it is the most commonly reported bacterial infection, often asymptomatic, and indicates the overall level of STI transmission, screening, and prevention efforts in a population.

Income Inequality

0.47

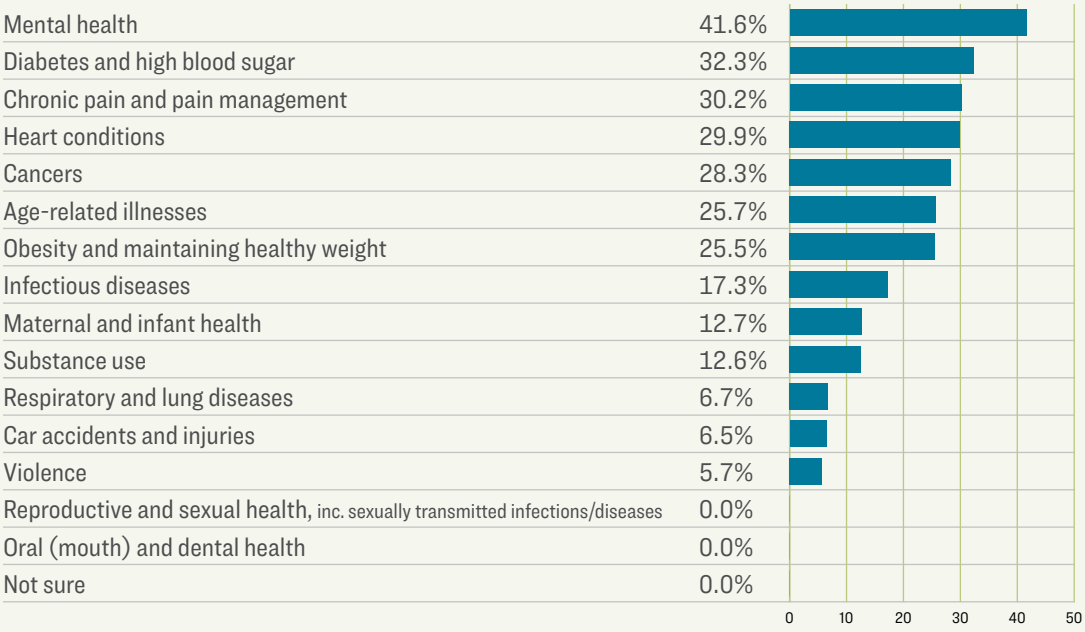
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Montgomery County

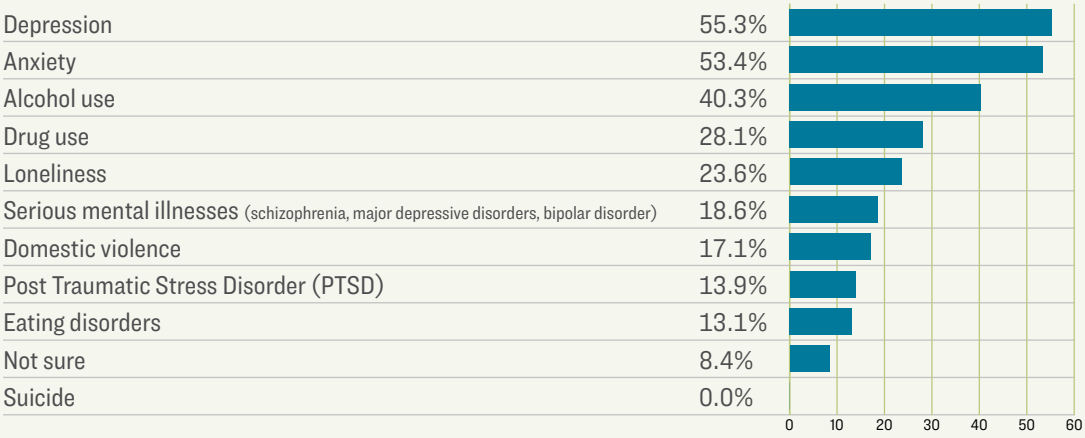
County Survey Results

Number of Respondents: 526

Thinking about yourself or other ADULTS in the community where you live, what are the top 3 HEALTH problems?



Thinking about yourself or other ADULTS in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

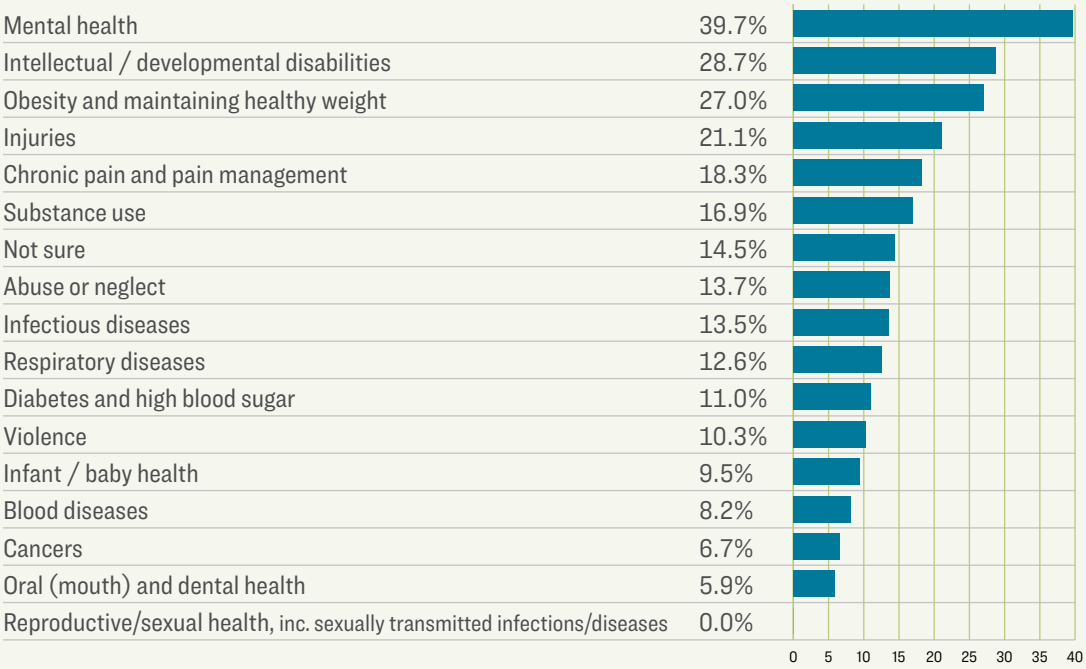


Montgomery County

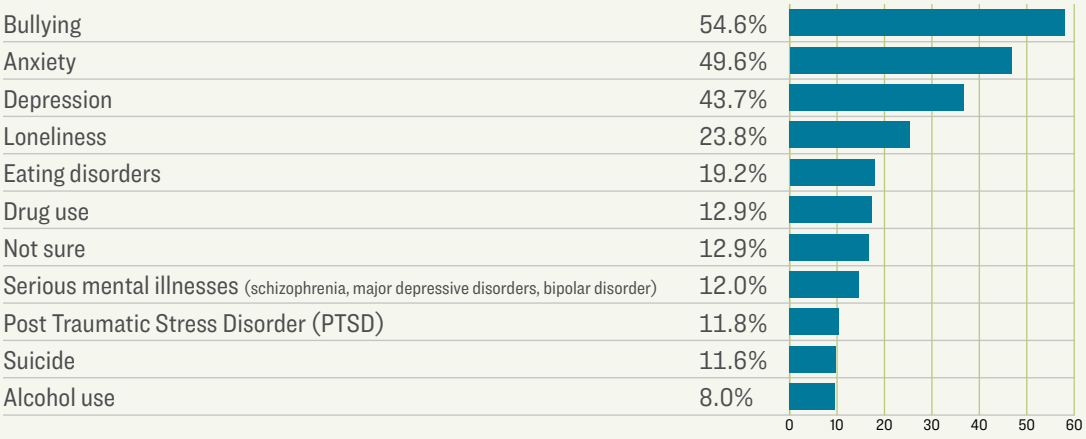
County Survey Results

Number of Respondents: 526

Thinking about your or other CHILDREN in the community where you live, what are the top 3 HEALTH problems?



Thinking about your or other CHILDREN in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

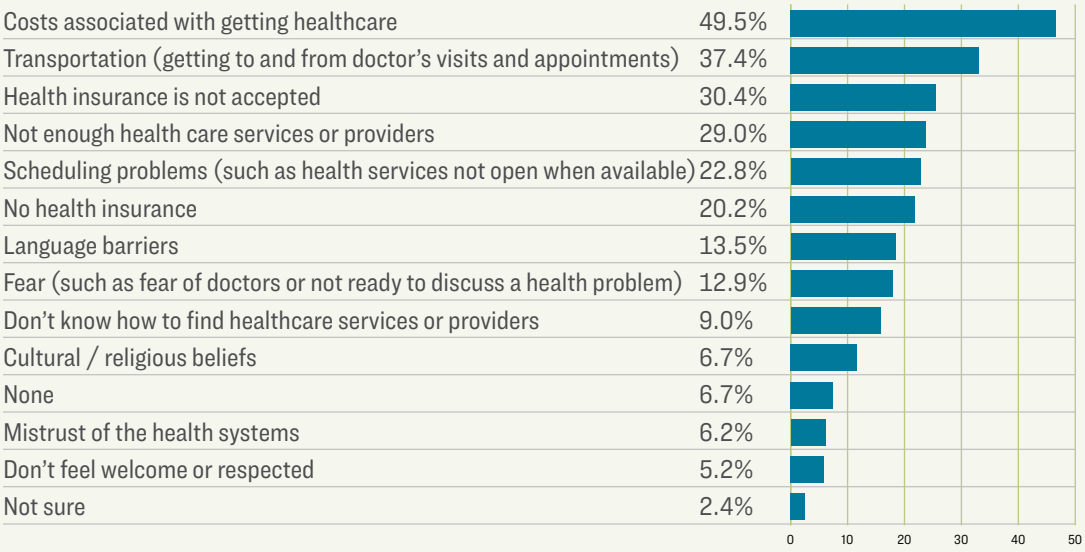


Montgomery County

County Survey Results

Number of Respondents: 526

Thinking about the community where you live, which barriers prevent access to health care? (Select all that apply)



Thinking about the community where you live, how available are the following resources?

	Never Available	Rarely	Sometimes	Often	Always Available	Not Sure
Affordable healthy foods	4.9%	14.1%	31.6%	26.65	20.05	2.95
Affordable housing	7.8%	24.9%	30.4%	17.3%	14.8%	4.8%
Clean outdoor environment	3.0%	6.3%	17.9%	34.8%	35.2%	2.9%
Good paying jobs	6.5%	12.7%	29.9%	30.4%	14.8%	5.7%
Good schools	2.7%	7.8%	17.1%	31.8%	36.3%	4.4%
Health care services	3.4%	7.2%	18.4%	31.8%	37.3%	1.9%
Mental health services	5.5%	14.6%	28.9%	21.5%	15.6%	13.9%
Places to be active such as parks	2.7%	5.3%	12.4%	28.9%	47.7%	3.0%
Safe neighborhood	5.1%	7.6%	28.0%	29.5%	23.8%	6.1%
Services that support people as they age	3.8%	9.3%	24.3%	26.6%	22.2%	13.7%
Substance use services	4.8%	14.3%	23.0%	20.7%	12.4%	24.9%

Montgomery County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

Montgomery County residents appreciated their access to parks and recreational activities, used by residents of all ages.

ON GREEN SPACE AND RECREATION

"...it's just really nice to have a neighborhood where you can just go outside and feel comfortable to just take a breath or go somewhere if you just need a break."

"And then there's parks and stuff where some of my little cousins can go. And then my family loves to do walks in the evening."

"...the senior center that we have, we don't even call it a senior center, but that's what it would be publicly, they have a lot of programming."

"There are walking places. So there are tracks... lots of tracks, even the junior high and high school tracks are being used as well. And I believe there are at least I want to say an upwards to about 6 to 8 pools in the summer, like outdoor pools being utilized."

PUBLIC TRANSPORTATION

Some residents admired the relative accessibility of community resources, based on numerous public transportation options.

ON PUBLIC TRANSPORTATION

"...you got Bucks Smart, you got Transnet, you got SEPTA, and you have your friends and family to get you where you need to go. But nobody has to go a far distance to assist you. That's critical. It's five minutes."

"...transportation. You have free passes for senior citizens for whether it's train or a bus, then they have a very good type of token system for students connecting to school. So, I would say those are definitely advantages."

COMMUNITY ASSETS

SOCIAL ENVIRONMENT

People of multiple faith backgrounds were represented in the community. Residents had opportunities to socialize with one another and took pride in their supportive relationships.

ON SOCIAL ENVIRONMENT

"...and I think that we are also extremely diverse in our community. So, whatever your religion it's here. It doesn't make any difference what it is. And I don't think that every community can offer that. And I think that this is a pocket where you could consider it a treasure because not every community can offer you all those things at the same time: safety, convenience, and all the possibilities of whatever your religion may be."

"...through the years have been able to enjoy socializing here at the library. I don't know that anyone has used that term, but I've been here for many receptions, for book signings, for fundraising activities, for things for children, for older people, middle-aged people."

"Norristown is a very tight knit community. So, like, if something happens, if somebody passes, or if something's going on, we do tend to come together..."

COMMUNITY CHALLENGES

HEALTHCARE ACCESS

Technology integration by healthcare systems served as a barrier for older adults who were not comfortable using it. It could also be a barrier for patients desiring a human experience. Patients faced many barriers and discrimination due to minoritized identities.

"It takes too long to get a doctor's appointment. That is the worst..." Subsequently, emergency room waits lasted up to 24 hours. Poor customer service experiences and a perceived lack of professionalism also served as barriers. High healthcare costs made people "afraid to go into the emergency room. You have to mortgage your house to pay the bill." Delayed service provision then led to advanced health conditions – a greater concern among African Americans. Anxiety about health conditions was also a deterrent for seeking care.

ON HEALTHCARE ACCESS

"...and a common thing, especially, not exclusively, but especially with older people is the digital divide when it comes to the patient portal."

"And I must say this because I'm discriminated against three times. I'm African American, I'm a woman, and I'm a mental patient. Just try to navigate your whole life that way. And what I'm saying, all that discrimination that I had to face all the time, there should be no reason for that."

"I'm saying the hospitals don't do the things that I think are common sensible, not necessarily costly, only because they're so caught up in AI that that's their favorite toy. Oh, we got AI. It does everything. What do we need an 800 number for? I think that's what we're facing."

"...I'm in this dilemma right now [of] finding a good doctor because I'm seeing turnovers in doctors and I had two of my specialists just leave and yeah, just go."

"It's like the attitudes of the people in the different [medical] facilities they act like, I mean, you go in, their attitudes are just so nasty."

"...we experience here working with children, parents who aren't open to having their kids tested for autism and different things like that, because of the challenges [they're] gonna face and them not knowing how to navigate a new life that they weren't expecting."

COMMUNITY CHALLENGES

BEHAVIORAL HEALTH ISSUES

Accessing mental health services presented challenges for respondents and their family members.

ON BEHAVIORAL HEALTH ISSUES

"I was trying to find a therapist. And I ended up finding one through the Jenkintown community page. And I couldn't find anything online and I was desperate. And it was just such a struggle."

"...the resources are not there or they may be there but you don't know how to get to them and that's critical."

"We had a daughter who had mental, drug and alcohol and mental issues and it was very difficult to figure out where in God's name do you go?"

FOOD ACCESS

Residents in Wyncote shared concerns about unhealthy food options within their community, particularly regarding older adults and youth – citing "it's predominantly in certain ethnic areas, lower income areas." Food needs and habits were rooted in culture, and the lack of diverse food options complicated attempts at healthy eating.

ON FOOD ACCESS

"...the 30s to 50s that are always on the run and always eating this ultra processed food. And it is becoming a serious health problem for them. But I don't know how much is going on as an alternative. So, I would just hope that we include that whole issue because following up on what Number One said, from what I gather, doctors are not taught anything about nutrition. And so, it's very hard to have a conversation with your doctor about your eating habits and all that. That's for the nutritionist."

"And someone brought to my attention one day when we go back to the fast food, children can go to a particular well-known store and they can get espressos and cappuccinos and I'm like, are you kidding me? If they're not allowed to get cigarettes and beer, why would you give them this?"

"What I like to see is a good ethnic food supply to the people to stay healthy. What happens especially in the Indian community, their food making is so specific and the expectation of the family is to fulfill those needs. It put strains on a lot of senior citizens because they cannot get a support from the community. And then their food habits are so rigid all their life."

SPECIAL POPULATIONS

CHILDREN AND YOUTH

Social pressures and recent historical events impacting youth were of great concern, particularly since schools appeared to be under-resourced. Youth in some communities did not have direct access to support or sufficient health education. "The information has to be right out in your face." Finding culturally sensitive ways to engage parents was important. There was an expressed need to support young and single parents, to help end cycles of detrimental behaviors.

ON CHILDREN AND YOUTH

"...suicide is very high among the young children. All of a sudden... And the teachers, they have special counselors, extra counselors come in and help them. But in order for a child to open up, you have to really be there every day, not twice a week or once a week or something like that."

"And I understand why it's difficult because parents are working so the hours may not be convenient for them to come in. So, we need to think about, okay, if they can't be here by 5 o'clock and they can then have it after five. Provide some transportation. Provide some food."

"...as a young 20 something, I don't necessarily any solution but I just feel like one thing that's really big for my generation is just burn out and things that have just happened to back to back to back."

"The word of God says my people perish because of lack of knowledge and if they don't know, then people can't get involved. Inner city kids, they need a direct line, they need a resource."

"And also education about their medications because the issues that I have in the school is, a lot of kids are overdosing on medications because their parents are just buying them. They just say they have allergies, they're buying them over the counter antihistamine and if they're not getting no relief, they do not understand that it's every 12 hours or some of it is once a day..."

"So mothers that... lack education or did not know they were pregnant, they continue their... lifestyle. So the chemical imbalances in a lot of our children's brains, that's the issue. So that's why you have depression... because drugs and alcohol affects your brain quickly. That's why when they tell you the very first three months is so precious."

OLDER ADULTS

Recreational activities and meal delivery services for older adults were helpful. "... system is doing a good job with the elderly." Yet there were concerns about this population's isolation, which led to a lack of advocacy, overmedicating, and under-medicating.

ON OLDER ADULTS

"And we have we have programs for people who are relatively healthy, who can line dance and can do various other kinds of exercise programs. They serve lunch at least two days a week. And so, there are a lot of benefits if you can get connected to a senior center..."

"I've seen... the little senior truck that comes in and they'll delivers the dinners in the neighborhood to the seniors."

"What I would like to see when it comes to seniors, a lot of seniors don't have children to look after them to check on them..."

ADDITIONAL POPULATIONS

Concern for veterans was expressed by residents, with their high rates of homelessness, mental illness, and lack of benefits. Their caregivers needed support as well.

Language barriers experienced by immigrants limited their access to care.

People with disabilities face accessibility issues.

The role of religion and faith communities in promoting health was represented significantly among respondents in Montgomery County.

VETERANS

"I have a problem with the veterans thing. What I don't understand why don't the government take care of those people. We pay taxes, those guys go to serve at the time in the service and they come out with different disabilities..."

"So if they are dishonorably discharged, they do not get any benefits. So that's why you see that they are homeless and they have no resources and a lot of them need psychiatric help."

"So we have caretakers taking care of vets with PTSD which need a whole lot of support to them. So it's a horrendous task, it really, really is."

"My son-in-law who's working, he's a Vietnam vet. He did three tours and he's had more people commit suicide than he lost in combat."

PEOPLE WITH DISABILITIES

"So when I think about handicaps, I think about accessibility and I haven't seen a community yet, not one place that really makes accessibility easy."

FAITH AND RELIGION

"...And then the other thing in terms of an asset and I'll just put a shameless [plug], our church, we have a ESL program. It's free. English as a second language. So every Tuesday there, oh, about 100 people from a bunch of different languages that come in and to learn English. So it's free English classes..."

"As a pastor, I really value the work that the chaplains do and the communication that can exist between when patients are there and connecting with their place of worship and so we know who's where and who's in and who's out and have the opportunity to serve them and pray with them. That is invaluable."

"The other thing I found as a doctor, hospitals must be sensitive to-- For example, let's say there's a Islamic patient, they must be respectful of all the different religions. It's no longer just a Christian country. There are Islamic people, the Hindus, the Jewish people. So hospitals must address when they give their menu, for example. They must be respectful of all people."

"I would add health initiatives sponsored by churches in the community like... my church, we are currently holding a diabetes reversal program right now... It's free to the community."

ACCESS TO CARE

Urgent care centers were being used more, as patients had a harder time getting appointments for primary care. Uninsured residents relied on them as well. One respondent noted the barriers presented by pharmacists that were not multilingual. Overall, there was a call for more culturally inclusive health services. Another individual admitted that their own personal lack of motivation limited the positive trajectory of their health. Lastly, the Affordable Care Act improved coverage for residents with pre-existing conditions.

ON ACCESS TO CARE

"The fact that there is urgent care, which there wasn't 20 or 30 years ago is good."

"Well, I actually had to use urgent care because I couldn't get a doctor, right? I went to the hospital, they had me sit there for 12 hours, right? And still didn't do any service..."

"...the need for bilingual and other languages with pharmacies..."

"For example, one of my good friends in Lansdale told me America was created by whites for whites. They do not understand the needs of others. For example, if you get admitted in a big hospital, it's quite intimidating to get into a hospital with all kinds of machines all over you. So hospitals must have in addition to what [respondent] said about chaplains, you must have other staff who are culturally sensitive so that they can communicate."

"Determination, like most people are not motivated enough to keep good health... That's kind of my problem right there."

TRUSTWORTHINESS

One patient shared about reluctantly having an invasive procedure that was not fully successful. A former nurse would periodically advocate for patients – "then when I address the issue, I'm causing a problem. So this happens a lot. I don't trust them." Trust issues developed when residents experienced high turnover with providers, prescriptions that didn't agree with them, a lack of cultural awareness, or being left "in the hands of the interns" after procedures.

ON TRUSTWORTHINESS

"And after he had surgery I would go see him a couple of weeks and after I see him the third time, you know what he said to me? He said to me, I think we're going to need a second surgery. And I said to him, you didn't get it right the first time, you won't do it again, believe it or not. I still have a little problem but it's not near as bad but I'm just telling, I don't have a lot of confidence in doctors. Let me get to it like that. Not at all. I really don't."

"And I said that to the doctor, if you know that this causes a coughing problem which later causes other medical problems in African Americans, why would you prescribe it to me? I'm not taking it."

COVID-19 PANDEMIC

Post-COVID, residents had generally good experiences with the integration of healthcare and technology, including access to health records. Some lamented the requirement of having to see a doctor in-person first, before being eligible for telehealth. Older adults needed technological support.

Most residents still had heightened concerns about COVID-19, while some did not. One respondent was skeptical about the U.S. response to the pandemic, compared to other countries that didn't seem to be affected as gravely. "We have our Western philosophy but there's opportunity perhaps to have more integrated medicine where we can think of some of the Eastern concepts as well." Some unhygienic conditions within health settings were believed to exacerbate contagion. Respondents shared experiences with and knowledge of Long COVID.

ON COVID-19 PANDEMIC

"...I know there are doctors now like you can do virtual visits but the insurance they are scaling back..."

"...it's something that exists because it's like any other thing that's out there. I just don't like [it] to become a factor. You do what you need to do... clean your hands. It's just normal taking care of yourself to me."

"And for me, my long thing with COVID is that I have balance issues and then short-term memories. A lot of times when I'm trying to articulate and say stuff it's just gone."

"I serve 100 patients in one location, so the cost goes down. It's not a healthy situation for all, especially for infectious patients because then you spread and you have infectious community per se which doesn't solve the problem..."

"It's a major concern with myself and my family because in 1993, I was diagnosed with systemic lupus... I have a very, very low immune system."

SUGGESTED ACTIONS

Montgomery County

What is already working well to improve health in your community?

There are Montgomery County neighborhoods with efficient transportation and walkability.	"...what I find about our community is first, there's just endless convenience, okay? That's critical for you no matter what stage of life you're at, whether you're a mother, a grandmother or older, senior citizen so that transportation is available for you..."
Religious institutions provide a variety of services and resources that are open to the community.	"I'm fortunate that -- and I'll say it this way, our church, the senior center that we have, we don't even call it a senior center, but that's what it would be publicly, they have a lot of programming. They also have a social worker that you can talk to and get the resource information. So that's one thing. For those of you who are in that age bracket, our senior center is open to the community. It's not just for our church people. It's for anybody in the community."
The availability of childcare is vital for busy parents.	"One, I'm grateful as someone who is a working parent that there are aftercare pre-care options because school day is not a workday. And then if you add transportation or your commute, it is quite challenging."
Insurance companies with outreach initiatives make a positive impression on residents.	"I see a lot of insurances, health insurance initiatives popping up in communities and hosting health forums and information. So that has become huge in the last several years between emergent cares and your insurances per se setting up things in the community as an outreach of wanting to connect."
The Affordable Care Act has improved healthcare access for Montgomery County residents.	"...that's one thing I would say to Obama that he extended the insurance, health insurance to our kids to the age of [26]."

What are the most important issues to address to improve health in your community?

Medical centers can strengthen and diversify the health workforce by incentivizing training for health careers.

"It is very hard to get an appointment. It's a huge barrier. So things like incentivizing people to go into those fields would help because they're not paid well and people don't want to do that for a living when they can do something else. So, when we talk about forgiving student loans or offering scholarships, you have to look at where the areas of need are. And everyone agrees whether you're looking at whatever issue in the world, that mental health is a component. So, I think if the hospitals who have lobbying power could help push incentives for folks to go into that and make a good living or not have to pay for it or some sort of incentive. And then, at the risk of talking too much, I would say we can notice that there's not any men here. And the needs of men and boys fall through the cracks. And I'm not sure what the solution for that is."

Local hospitals can play an active role in gun violence prevention, as a public health issue.

"Let's just talk about gun violence for a second. We haven't really touched on it. And I think that the hospital systems that are in and out of the city and surrounding the city, there is perhaps more they could do from an advocacy. I know it gets tricky because they don't wanna alienate donors and they don't wanna be political. But there's like a stay in your lane, I think. And then there's the doctors that say this is our lane, trauma, pediatricians, ER doctors. They are firsthand seeing these things. It's devastating our communities."

Culturally appropriate treatment interventions should be informed by research with diverse participants.

"I think that is becoming an urgent matter now because as the country diversifies more, then the health care system has to catch up. And that's one of the ways they can catch up is by having diversified clinical trials."

Community liaisons, or community leaders, can serve as brokers of trust between health providers and communities.

"...you can even start out with the block captains in some communities because they're pretty active. Everyone knows the block captain. So if they can penetrate the communities that way, I feel like they would be successful."

Audubon

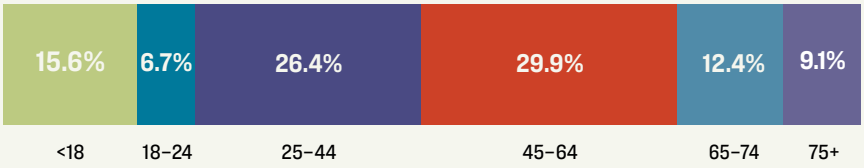
ZIP Codes: 19403

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Montgomery Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

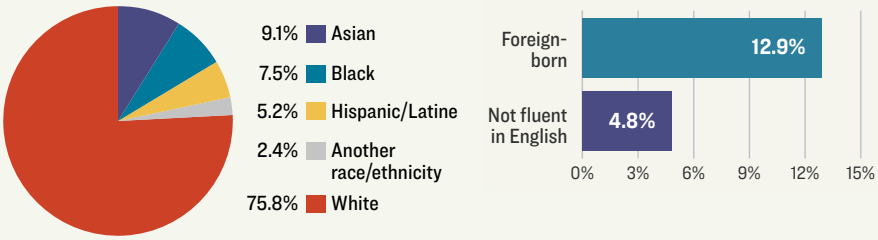
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

43,967

MEDIAN HOUSEHOLD INCOME

$101,996

EDUCATIONAL ATTAINMENT

26.9% High school as highest education level

PEOPLE WITH DISABILITIES

14.3%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Audubon	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	1,183.4	883.5
	Life expectancy: Female (in years)	79.8	80.5
	Life expectancy: Male (in years)	77.2	77.4
	Years of potential life lost before 75	2,519	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	30.6%	30.2%
	Diabetes prevalence	10.1%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	230.0	152.0
	Hypertension prevalence	32.7%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	45.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	1,026.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	34.0	32.7
	Major cancer incidence rate (per 100,000)*	331.0	258.4
	Major cancer mortality rate (per 100,000)*	124.7	67.6
	Colorectal cancer screening (adults age 45-75)	70.1%	70.4%
	Mammography screening (women age 50-74)	79.1%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.6	4.2
	Percent low birthweight births out of live births	7.5%	8.3%
	Percent preterm births out of live births	8.3%	9.0%
	Child Opportunity Index**	65.2	67.4
BEHAVIORAL HEALTH	Adult binge drinking	18.5%	19.0%
	Adult smoking	13.0%	11%
	Drug overdose mortality rate (per 100,000)	36.3	21.1
	Opioid-related hospitalization rate (per 100,000)	249.4	180.5
	Substance-related hospitalization rate (per 100,000)	378.6	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	15.9	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,583.0	2,354.0
	Homicide mortality rate (per 100,000)	4.5	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	8.2%	8.4%
	Children <19 years with public insurance	18.8%	22.2%
	Population without insurance	4.1%	3.8%
	Children <19 years without insurance	4.6%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.7%	6.1%
	Children <18 years in poverty	10.2%	6.5%
	Adults 19-64 years unemployed	5.5%	4.2%
	Householders living alone who are 65+ years	31.8%	27.7%
	Households receiving SNAP benefits	5.2%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.6%	11.4%
	Vacant housing units	4.1%	4.9%
	Single parent households	18.7%	17.1%
	Commute greater than 60 minutes	9.4%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from residents of the Aubodon and Blue Bell communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 53

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Heart conditions
- Diabetes and high blood sugar
- Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Post traumatic stress disorder
- Depression
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)
- Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Good paying jobs
- Affordable housing
- Services that support people as they age

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

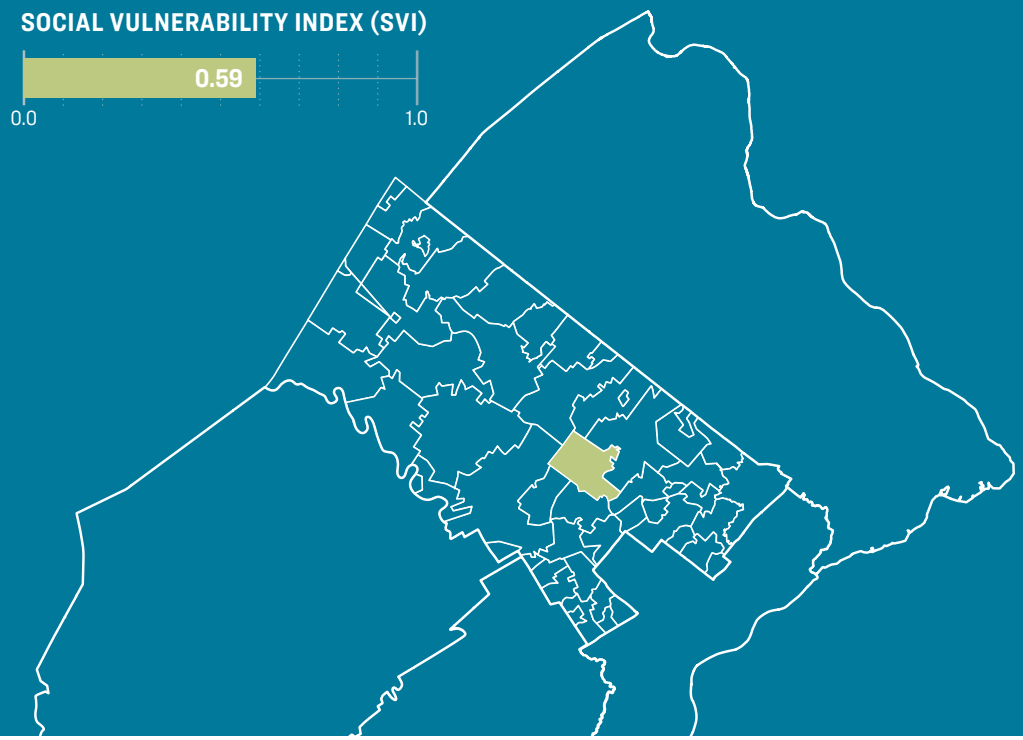
- Costs associated with getting healthcare
- Transportation (getting to and from doctor's visits and appointments)
- Fear (such as fear of doctors or not ready to discuss a health problem)

Blue Bell

ZIP Codes: 19422

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Montgomery Hospital
- Jefferson Lansdale Hospital
- Wills Eye Hospital



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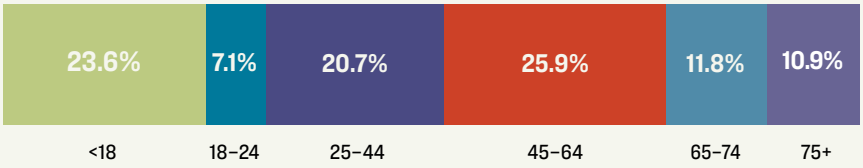
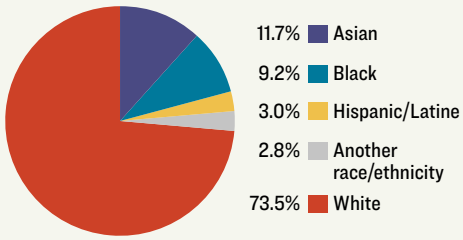
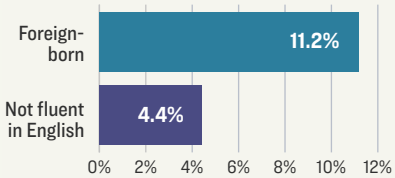


SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

20,068

MEDIAN HOUSEHOLD INCOME

$153,344

EDUCATIONAL ATTAINMENT

12.5% High school as highest education level

PEOPLE WITH DISABILITIES

10.9%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Blue Bell	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	897.8	883.5
	Life expectancy: Female (in years)	81.3	80.5
	Life expectancy: Male (in years)	80.0	77.4
	Years of potential life lost before 75	837	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.4%	30.2%
	Diabetes prevalence	9.6%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	95.0	152.0
	Hypertension prevalence	31.9%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	37.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	624.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	29.9	32.7
	Major cancer incidence rate (per 100,000)*	354.1	258.4
	Major cancer mortality rate (per 100,000)*	84.8	67.6
	Colorectal cancer screening (adults age 45-75)	72.6%	70.4%
	Mammography screening (women age 50-74)	81.4%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	6.1	4.2
	Percent low birthweight births out of live births	11.0%	8.3%
	Percent preterm births out of live births	12.2%	9.0%
	Child Opportunity Index**	88.6	67.4
BEHAVIORAL HEALTH	Adult binge drinking	17.9%	19.0%
	Adult smoking	8.3%	11%
	Drug overdose mortality rate (per 100,000)	15.0	21.1
	Opioid-related hospitalization rate (per 100,000)	64.8	180.5
	Substance-related hospitalization rate (per 100,000)	99.8	278.5
	Poor mental health for 14+ days in past 30 days	12%	13.9%
	Suicide mortality rate (per 100,000)	5.0	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,764.0	2,354.0
	Homicide mortality rate (per 100,000)	--	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	3.0%	8.4%
	Children <19 years with public insurance	10.2%	22.2%
	Population without insurance	2.3%	3.8%
	Children <19 years without insurance	2.0%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	3.4%	6.1%
	Children <18 years in poverty	4.3%	6.5%
	Adults 19-64 years unemployed	5.4%	4.2%
	Householders living alone who are 65+ years	26.5%	27.7%
	Households receiving SNAP benefits	3.3%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	11.4%	11.4%
	Vacant housing units	4.1%	4.9%
	Single parent households	16.8%	17.1%
	Commute greater than 60 minutes	11.2%	9.0%

COMMUNITY SURVEY

These results reflect responses from residents of the Aubodon and Blue Bell communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 53

ADULTS

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- Diabetes and high blood sugar
- Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Post traumatic stress disorder
- Depression
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)
- Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Good paying jobs
- Affordable housing
- Services that support people as they age

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

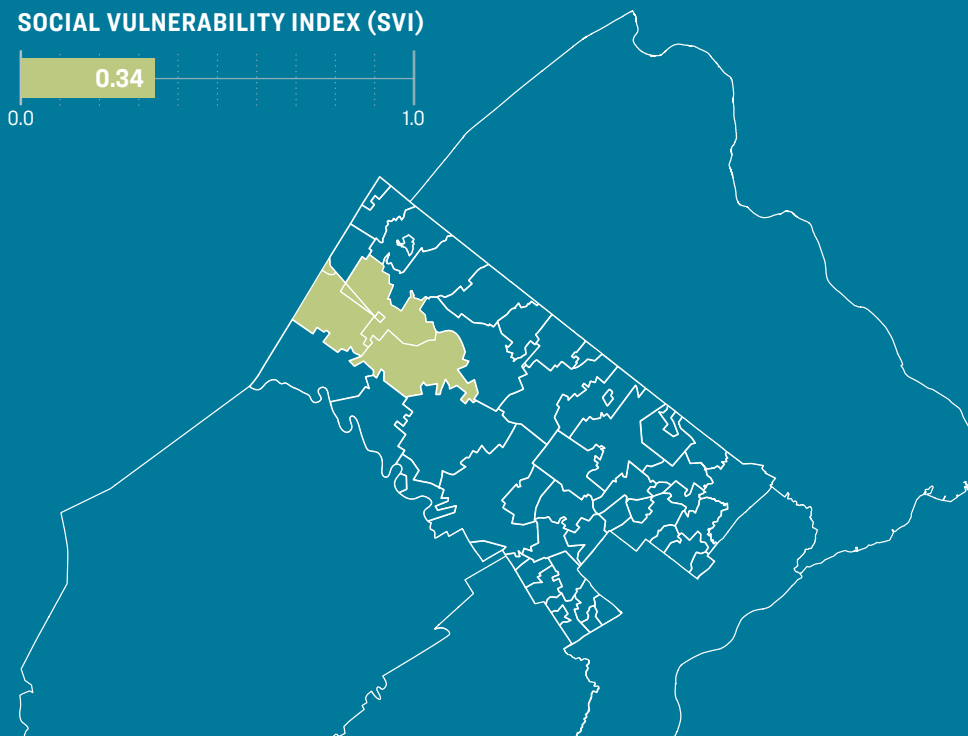
- Costs associated with getting healthcare
- Transportation (getting to and from doctor's visits and appointments)
- Fear (such as fear of doctors or not ready to discuss a health problem)

Central Perkiomen Valley

ZIP Codes: 18074, 19435, 19472, 19473, 19492, 19525

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Einstein Montgomery Hospital
- Main Line Health
- Wills Eye Hospital



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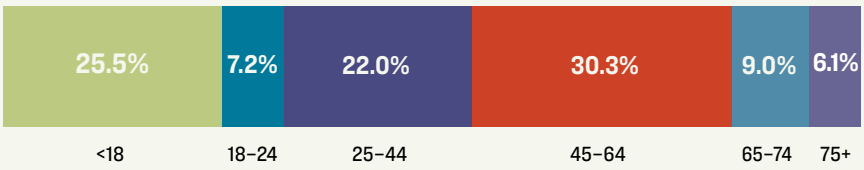
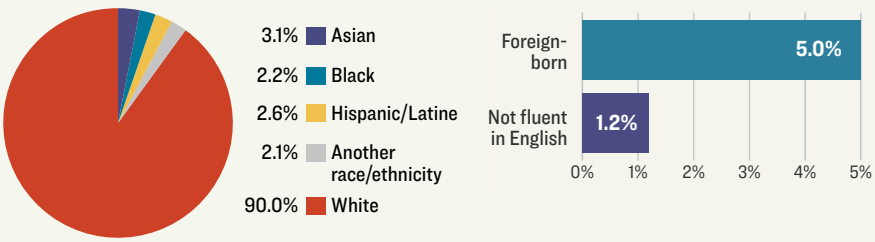


SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

41,750

MEDIAN HOUSEHOLD INCOME

$135,333

EDUCATIONAL ATTAINMENT

24.5% High school as highest education level

PEOPLE WITH DISABILITIES

11.6%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Central Perkiomen Valley	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	724.7	883.5
	Life expectancy: Female (in years)	81.8	80.5
	Life expectancy: Male (in years)	79.4	77.4
	Years of potential life lost before 75	1,644	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	30.8%	30.2%
	Diabetes prevalence	10.6%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	184.0	152.0
	Hypertension prevalence	35.0%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	32.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	761.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	17.2	32.7
	Major cancer incidence rate (per 100,000)*	272.7	258.4
	Major cancer mortality rate (per 100,000)*	63.9	67.6
	Colorectal cancer screening (adults age 45-75)	69.6%	70.4%
	Mammography screening (women age 50-74)	78.2%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	4.2
	Percent low birthweight births out of live births	8.2%	8.3%
	Percent preterm births out of live births	6.8%	9.0%
	Child Opportunity Index**	75.4	67.4
BEHAVIORAL HEALTH	Adult binge drinking	18.2%	19.0%
	Adult smoking	12.2%	11%
	Drug overdose mortality rate (per 100,000)	12.3	21.1
	Opioid-related hospitalization rate (per 100,000)	135.1	180.5
	Substance-related hospitalization rate (per 100,000)	167.0	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	19.7	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,565.0	2,354.0
	Homicide mortality rate (per 100,000)	--	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	6.8%	8.4%
	Children <19 years with public insurance	16.7%	22.2%
	Population without insurance	2.5%	3.8%
	Children <19 years without insurance	2.3%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.1%	6.1%
	Children <18 years in poverty	8.6%	6.5%
	Adults 19-64 years unemployed	3.0%	4.2%
	Householders living alone who are 65+ years	23.0%	27.7%
	Households receiving SNAP benefits	4.4%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	8.6%	11.4%
	Vacant housing units	3.1%	4.9%
	Single parent households	17.9%	17.1%
	Commute greater than 60 minutes	11.0%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Central, Lower, and Upper Perkiomen Valley, and Pottstown communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 45

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obseity and maintaining healthy weight

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Substance use

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

No health insurance

Conshohocken

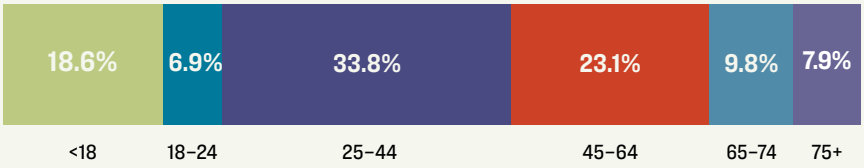
ZIP Codes: 19428, 19444, 19462

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Grand View Health
- Main Line Health
- Temple Health - Chestnut Hill Hospital
- Wills Eye Hospital

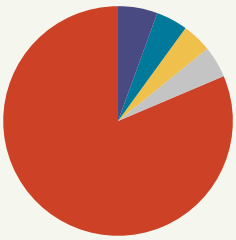
SOCIAL VULNERABILITY INDEX (SVI)

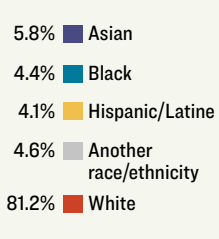
AGE DISTRIBUTION

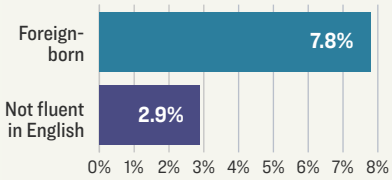


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

47,510

MEDIAN HOUSEHOLD INCOME

$130,282

EDUCATIONAL ATTAINMENT

19.2% High school as highest education level

PEOPLE WITH DISABILITIES

9.9%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Conshohocken	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	981.4	883.5
	Life expectancy: Female (in years)	80.2	80.5
	Life expectancy: Male (in years)	77.0	77.4
	Years of potential life lost before 75	2,434	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.5%	30.2%
	Diabetes prevalence	8.3%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	150.0	152.0
	Hypertension prevalence	28.8%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	46.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	920.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	25.3	32.7
	Major cancer incidence rate (per 100,000)*	225.8	258.4
	Major cancer mortality rate (per 100,000)*	92.9	67.6
	Colorectal cancer screening (adults age 45-75)	71.4%	70.4%
	Mammography screening (women age 50-74)	79.4%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.6	4.2
	Percent low birthweight births out of live births	5.8%	8.3%
	Percent preterm births out of live births	6.2%	9.0%
	Child Opportunity Index**	77.9	67.4
BEHAVIORAL HEALTH	Adult binge drinking	21.1%	19.0%
	Adult smoking	10.5%	11%
	Drug overdose mortality rate (per 100,000)	21.1	21.1
	Opioid-related hospitalization rate (per 100,000)	92.9	180.5
	Substance-related hospitalization rate (per 100,000)	179.4	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	8.4	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,366.0	2,354.0
	Homicide mortality rate (per 100,000)	2.1	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.6%	8.4%
	Children <19 years with public insurance	14.0%	22.2%
	Population without insurance	3.0%	3.8%
	Children <19 years without insurance	3.9%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.0%	6.1%
	Children <18 years in poverty	3.9%	6.5%
	Adults 19-64 years unemployed	4.2%	4.2%
	Householders living alone who are 65+ years	28.0%	27.7%
	Households receiving SNAP benefits	3.9%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.6%	11.4%
	Vacant housing units	4.9%	4.9%
	Single parent households	21.2%	17.1%
	Commute greater than 60 minutes	6.0%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Conshohocken, King of Prussia, and Main Line East communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 35

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Cancer

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Good paying jobs

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Not enough health care services or providers

Scheduling problems (such as health services not open when available)

Greater Abington

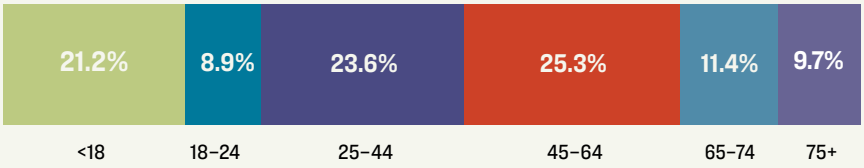
ZIP Codes: 19006, 19009, 19040

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

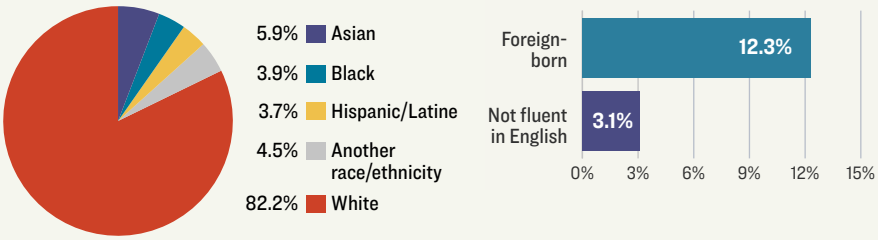
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

46,230

MEDIAN HOUSEHOLD INCOME

$117,535

EDUCATIONAL ATTAINMENT

25.9% High school as highest education level

PEOPLE WITH DISABILITIES

11.9%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Greater Abington	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	996.3	883.5
	Life expectancy: Female (in years)	82.8	80.5
	Life expectancy: Male (in years)	78.0	77.4
	Years of potential life lost before 75	1,901	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.6%	30.2%
	Diabetes prevalence	9.7%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	154.0	152.0
	Hypertension prevalence	31.5%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	41.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	821.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	32.3	32.7
	Major cancer incidence rate (per 100,000)*	266.8	258.4
	Major cancer mortality rate (per 100,000)*	92.5	67.6
	Colorectal cancer screening (adults age 45-75)	72.1%	70.4%
	Mammography screening (women age 50-74)	78.8%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.6	4.2
	Percent low birthweight births out of live births	6.4%	8.3%
	Percent preterm births out of live births	7.4%	9.0%
	Child Opportunity Index**	68.9	67.4
BEHAVIORAL HEALTH	Adult binge drinking	19.5%	19.0%
	Adult smoking	11.7%	11%
	Drug overdose mortality rate (per 100,000)	10.8	21.1
	Opioid-related hospitalization rate (per 100,000)	161.4	180.5
	Substance-related hospitalization rate (per 100,000)	232.4	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	4.3	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,879.0	2,354.0
	Homicide mortality rate (per 100,000)	--	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	6.8%	8.4%
	Children <19 years with public insurance	20.0%	22.2%
	Population without insurance	4.4%	3.8%
	Children <19 years without insurance	4.4%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.2%	6.1%
	Children <18 years in poverty	5.8%	6.5%
	Adults 19-64 years unemployed	5.4%	4.2%
	Householders living alone who are 65+ years	29.6%	27.7%
	Households receiving SNAP benefits	6.6%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	13.4%	11.4%
	Vacant housing units	4.2%	4.9%
	Single parent households	18.4%	17.1%
	Commute greater than 60 minutes	10.7%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Greater Abington and Lower Eastern Montgomery communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 58

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Age-related illnesses
- Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Intellectual / developmental disabilities
- Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Anxiety
- Bullying
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Affordable healthy foods
- Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Health insurance is not accepted
- Scheduling problems (such as health services not open when available)

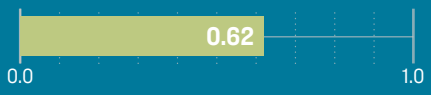
King of Prussia

ZIP Codes: 19405, 19406

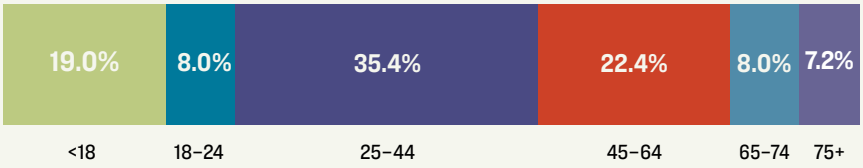
This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Einstein Montgomery Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)

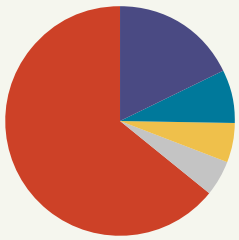


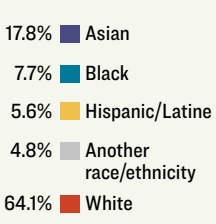
AGE DISTRIBUTION

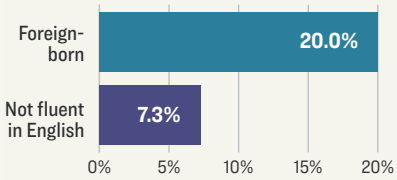


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

34,555

MEDIAN HOUSEHOLD INCOME

$105,738

EDUCATIONAL ATTAINMENT

17.6% High school as highest education level

PEOPLE WITH DISABILITIES

10.8%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	King of Prussia	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	810.3	883.5
	Life expectancy: Female (in years)	79.5	80.5
	Life expectancy: Male (in years)	77.8	77.4
	Years of potential life lost before 75	1,701	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	30.4%	30.2%
	Diabetes prevalence	8.3%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	176.0	152.0
	Hypertension prevalence	27.9%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	24.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	812.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	26.5	32.7
	Major cancer incidence rate (per 100,000)*	224.0	258.4
	Major cancer mortality rate (per 100,000)*	44.2	67.6
	Colorectal cancer screening (adults age 45-75)	68.9%	70.4%
	Mammography screening (women age 50-74)	79.1%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	4.2
	Percent low birthweight births out of live births	9.6%	8.3%
	Percent preterm births out of live births	8.9%	9.0%
	Child Opportunity Index**	56.7	67.4
BEHAVIORAL HEALTH	Adult binge drinking	20.9%	19.0%
	Adult smoking	11.0%	11%
	Drug overdose mortality rate (per 100,000)	17.7	21.1
	Opioid-related hospitalization rate (per 100,000)	132.6	180.5
	Substance-related hospitalization rate (per 100,000)	191.5	278.5
	Poor mental health for 14+ days in past 30 days	15%	13.9%
	Suicide mortality rate (per 100,000)	23.6	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,446.0	2,354.0
	Homicide mortality rate (per 100,000)	2.9	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.2%	8.4%
	Children <19 years with public insurance	22.5%	22.2%
	Population without insurance	3.4%	3.8%
	Children <19 years without insurance	2.9%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.0%	6.1%
	Children <18 years in poverty	9.0%	6.5%
	Adults 19-64 years unemployed	6.0%	4.2%
	Householders living alone who are 65+ years	29.7%	27.7%
	Households receiving SNAP benefits	4.4%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	11.0%	11.4%
	Vacant housing units	8.1%	4.9%
	Single parent households	21.7%	17.1%
	Commute greater than 60 minutes	5.6%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Conshohocken, King of Prussia, and Main Line East communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 35

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Cancer

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Good paying jobs

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Not enough health care services or providers

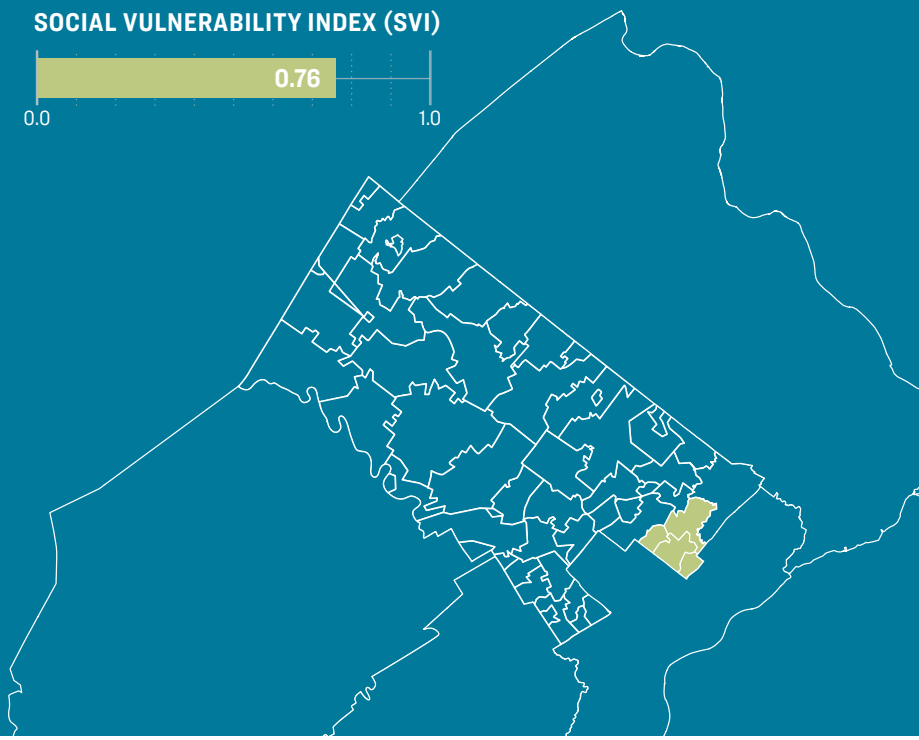
Scheduling problems (such as health services not open when available)

Lower Eastern Montgomery

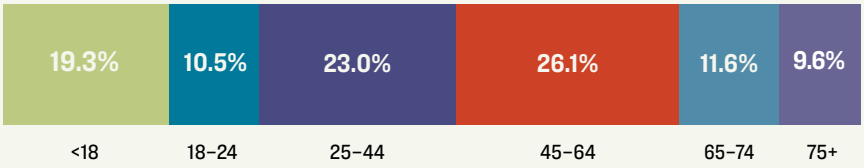
ZIP Codes: 19012, 19027, 19046, 19095

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

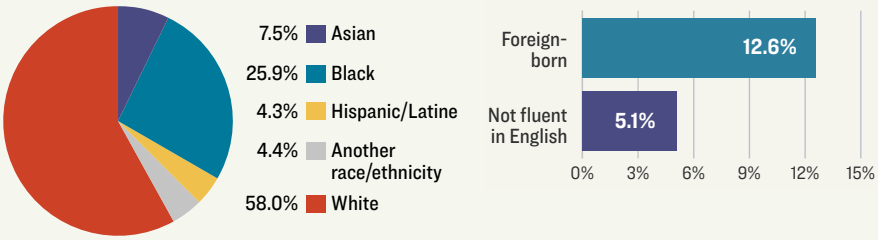


AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

54,101

MEDIAN HOUSEHOLD INCOME

$109,686

EDUCATIONAL ATTAINMENT

18.8% High school as highest education level

PEOPLE WITH DISABILITIES

13.2%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Lower Eastern Montgomery	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	1,172.6	883.5
	Life expectancy: Female (in years)	78.1	80.5
	Life expectancy: Male (in years)	77.6	77.4
	Years of potential life lost before 75	3,192	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.8%	30.2%
	Diabetes prevalence	11.2%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	247.0	152.0
	Hypertension prevalence	34.3%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	62.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	1,003.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	41.5	32.7
	Major cancer incidence rate (per 100,000)*	287.0	258.4
	Major cancer mortality rate (per 100,000)*	71.8	67.6
	Colorectal cancer screening (adults age 45-75)	70.9%	70.4%
	Mammography screening (women age 50-74)	80.7%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	4.5	4.2
	Percent low birthweight births out of live births	11.7%	8.3%
	Percent preterm births out of live births	12.4%	9.0%
	Child Opportunity Index**	36.0	67.4
BEHAVIORAL HEALTH	Adult binge drinking	17.3%	19.0%
	Adult smoking	11.4%	11%
	Drug overdose mortality rate (per 100,000)	20.8	21.1
	Opioid-related hospitalization rate (per 100,000)	151.1	180.5
	Substance-related hospitalization rate (per 100,000)	205.8	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	9.4	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,928.0	2,354.0
	Homicide mortality rate (per 100,000)	5.7	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	9.7%	8.4%
	Children <19 years with public insurance	21.0%	22.2%
	Population without insurance	3.8%	3.8%
	Children <19 years without insurance	2.3%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	8.7%	6.1%
	Children <18 years in poverty	5.4%	6.5%
	Adults 19-64 years unemployed	4.7%	4.2%
	Householders living alone who are 65+ years	27.9%	27.7%
	Households receiving SNAP benefits	7.6%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	16.8%	11.4%
	Vacant housing units	7.5%	4.9%
	Single parent households	23.6%	17.1%
	Commute greater than 60 minutes	11.1%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Greater Abington and Lower Eastern Montgomery communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 58

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Age-related illnesses

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Health insurance is not accepted

Scheduling problems (such as health services not open when available)

Lower Perkiomen Valley

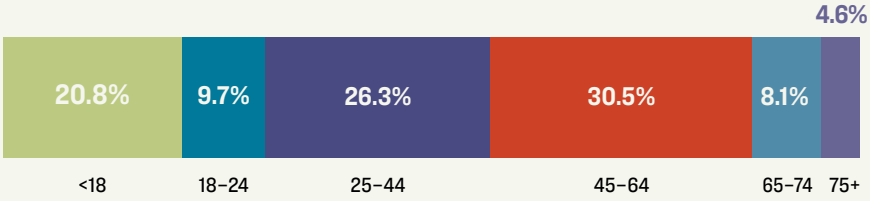
ZIP Codes: 19426, 19468, 19474

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Einstein Montgomery Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

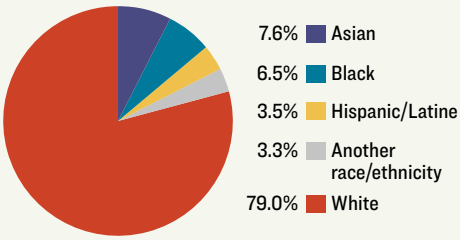
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

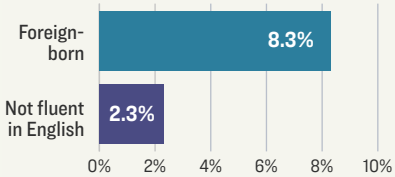


SEX

RACE/ETHNICITY/LANGUAGE



7.6% Asian
6.5% Black
3.5% Hispanic/Latine
3.3% Another race/ethnicity
79.0% White



POPULATION

71,620

MEDIAN HOUSEHOLD INCOME

$130,270

EDUCATIONAL ATTAINMENT

24.7% High school as highest education level

PEOPLE WITH DISABILITIES

10.7%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Lower Perkiomen Valley	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	760.6	883.5
	Life expectancy: Female (in years)	79.5	80.5
	Life expectancy: Male (in years)	77.5	77.4
	Years of potential life lost before 75	3,164	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	30.6%	30.2%
	Diabetes prevalence	8.7%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	166.0	152.0
	Hypertension prevalence	29.6%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	43.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	942.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	30.9	32.7
	Major cancer incidence rate (per 100,000)*	234.8	258.4
	Major cancer mortality rate (per 100,000)*	61.9	67.6
	Colorectal cancer screening (adults age 45-75)	67.6%	70.4%
	Mammography screening (women age 50-74)	78.4%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	8.3	4.2
	Percent low birthweight births out of live births	7.3%	8.3%
	Percent preterm births out of live births	8.7%	9.0%
	Child Opportunity Index**	82.0	67.4
BEHAVIORAL HEALTH	Adult binge drinking	20.9%	19.0%
	Adult smoking	11.2%	11%
	Drug overdose mortality rate (per 100,000)	11.2	21.1
	Opioid-related hospitalization rate (per 100,000)	171.5	180.5
	Substance-related hospitalization rate (per 100,000)	236.2	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	8.4	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,603.0	2,354.0
	Homicide mortality rate (per 100,000)	2.8	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.2%	8.4%
	Children <19 years with public insurance	15.9%	22.2%
	Population without insurance	1.9%	3.8%
	Children <19 years without insurance	1.0%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	3.8%	6.1%
	Children <18 years in poverty	4.8%	6.5%
	Adults 19-64 years unemployed	3.1%	4.2%
	Householders living alone who are 65+ years	27.6%	27.7%
	Households receiving SNAP benefits	4.7%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	8.9%	11.4%
	Vacant housing units	3.9%	4.9%
	Single parent households	17.8%	17.1%
	Commute greater than 60 minutes	8.9%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Central, Lower, and Upper Perkiomen Valley, and Pottstown communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 45

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obseity and maintaining healthy weight

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Substance use

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

No health insurance

Main Line East

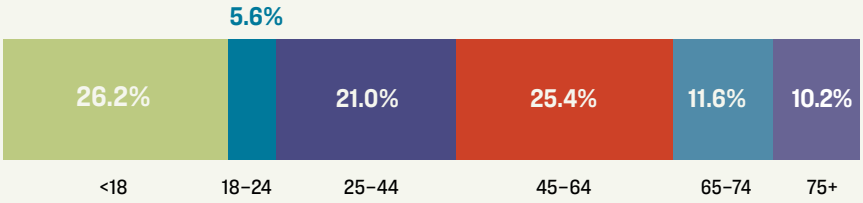
ZIP Codes: 19004, 19066, 19072, 19096

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

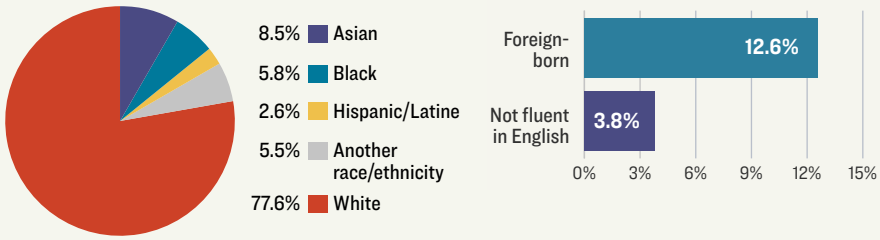
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

41,820

MEDIAN HOUSEHOLD INCOME

$178,887

EDUCATIONAL ATTAINMENT

9.1% High school as highest education level

PEOPLE WITH DISABILITIES

9.5%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Main Line East	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	816.7	883.5
	Life expectancy: Female (in years)	83.5	80.5
	Life expectancy: Male (in years)	80.7	77.4
	Years of potential life lost before 75	1,358	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.7%	30.2%
	Diabetes prevalence	8.8%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	78.0	152.0
	Hypertension prevalence	30.1%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	33.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	477.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	19.3	32.7
	Major cancer incidence rate (per 100,000)*	240.9	258.4
	Major cancer mortality rate (per 100,000)*	50.6	67.6
	Colorectal cancer screening (adults age 45-75)	71.8%	70.4%
	Mammography screening (women age 50-74)	81.3%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	4.2
	Percent low birthweight births out of live births	9.0%	8.3%
	Percent preterm births out of live births	11.0%	9.0%
	Child Opportunity Index**	85.4	67.4
BEHAVIORAL HEALTH	Adult binge drinking	18.9%	19.0%
	Adult smoking	8.1%	11%
	Drug overdose mortality rate (per 100,000)	14.5	21.1
	Opioid-related hospitalization rate (per 100,000)	55.4	180.5
	Substance-related hospitalization rate (per 100,000)	110.8	278.5
	Poor mental health for 14+ days in past 30 days	12%	13.9%
	Suicide mortality rate (per 100,000)	14.5	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,134.0	2,354.0
	Homicide mortality rate (per 100,000)	--	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.8%	8.4%
	Children <19 years with public insurance	12.1%	22.2%
	Population without insurance	1.4%	3.8%
	Children <19 years without insurance	1.2%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.4%	6.1%
	Children <18 years in poverty	6.9%	6.5%
	Adults 19-64 years unemployed	3.9%	4.2%
	Householders living alone who are 65+ years	30.7%	27.7%
	Households receiving SNAP benefits	3.2%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	11.7%	11.4%
	Vacant housing units	3.5%	4.9%
	Single parent households	15.6%	17.1%
	Commute greater than 60 minutes	6.6%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Conshohocken, King of Prussia, and Main Line East communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 35

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Cancer

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Good paying jobs

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Not enough health care services or providers

Scheduling problems (such as health services not open when available)

Norristown

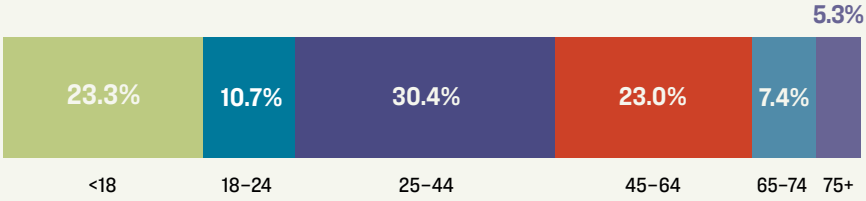
ZIP Codes: 19401

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Montgomery Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

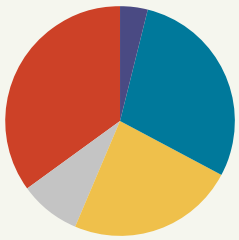
SOCIAL VULNERABILITY INDEX (SVI)

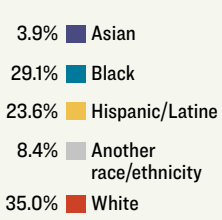
AGE DISTRIBUTION

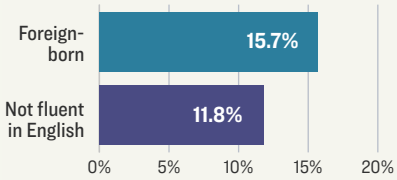


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

43,099

MEDIAN HOUSEHOLD INCOME

$68,646

EDUCATIONAL ATTAINMENT

33.8% High school as highest education level

PEOPLE WITH DISABILITIES

15.4%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Accidents

SUMMARY HEALTH MEASURES

Category	Measure	Norristown	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	1,060.4	883.5
	Life expectancy: Female (in years)	76.6	80.5
	Life expectancy: Male (in years)	71.1	77.4
	Years of potential life lost before 75	3,911	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	38.8%	30.2%
	Diabetes prevalence	12.4%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	407.0	152.0
	Hypertension prevalence	34.0%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	135.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	1,848.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	88.6	32.7
	Major cancer incidence rate (per 100,000)*	230.7	258.4
	Major cancer mortality rate (per 100,000)*	76.9	67.6
	Colorectal cancer screening (adults age 45-75)	62.9%	70.4%
	Mammography screening (women age 50-74)	76.5%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.2	4.2
	Percent low birthweight births out of live births	11.2%	8.3%
	Percent preterm births out of live births	11.8%	9.0%
	Child Opportunity Index**	31.9	67.4
BEHAVIORAL HEALTH	Adult binge drinking	18.0%	19.0%
	Adult smoking	17.5%	11%
	Drug overdose mortality rate (per 100,000)	51.1	21.1
	Opioid-related hospitalization rate (per 100,000)	293.7	180.5
	Substance-related hospitalization rate (per 100,000)	678.2	278.5
	Poor mental health for 14+ days in past 30 days	18%	13.9%
	Suicide mortality rate (per 100,000)	7.0	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,523.0	2,354.0
	Homicide mortality rate (per 100,000)	16.3	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	21.2%	8.4%
	Children <19 years with public insurance	58.5%	22.2%
	Population without insurance	11.0%	3.8%
	Children <19 years without insurance	7.1%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	16.5%	6.1%
	Children <18 years in poverty	22.2%	6.5%
	Adults 19-64 years unemployed	5.8%	4.2%
	Householders living alone who are 65+ years	42.8%	27.7%
	Households receiving SNAP benefits	22.7%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	18.9%	11.4%
	Vacant housing units	9.3%	4.9%
	Single parent households	43.3%	17.1%
	Commute greater than 60 minutes	7.4%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 65

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Chronic pain and pain management

Diabetes and high blood sugar

Cancer

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Substance use

Obesity and maintaining healthy weight

Violence

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Mental health services

Affordable healthy foods

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Language barriers

No health insurance

Fear (such as fear of doctors or not ready to discuss a health problem)

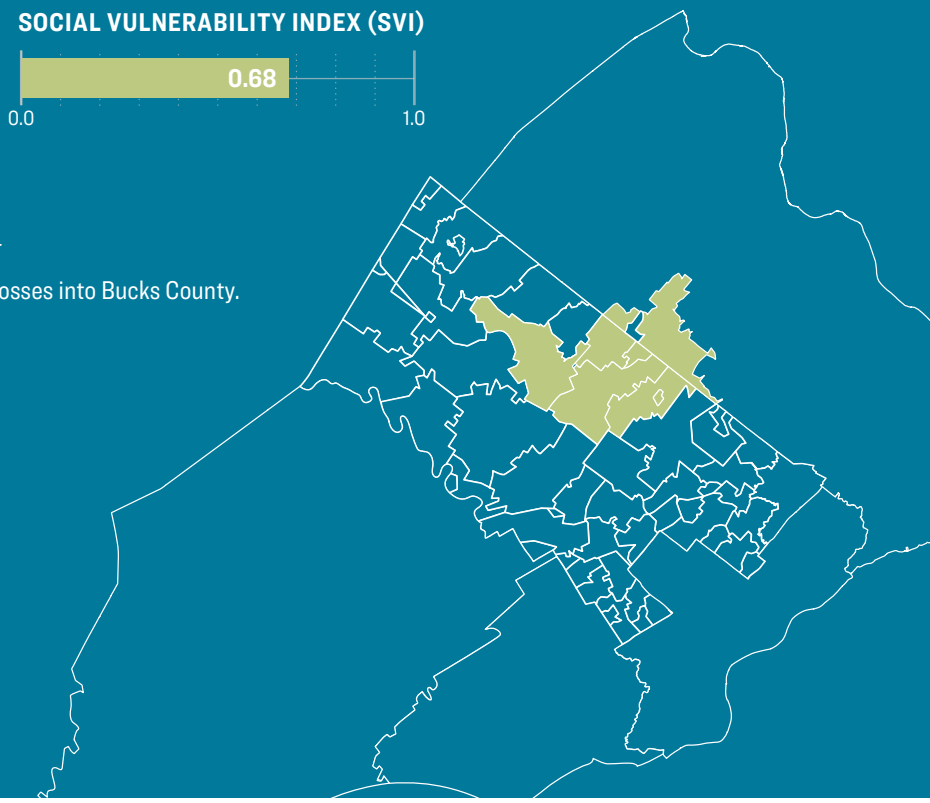
North Penn and Lansdale

ZIP Codes: 18915, 18932, 18936, 19438, 19440, 19446, 19454

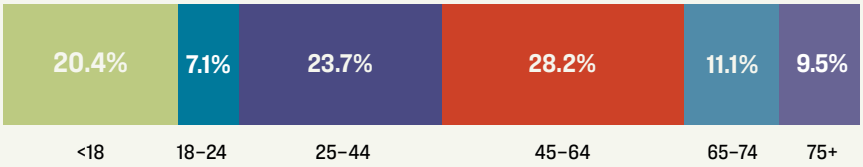
Note: This community includes one ZIP code (18932) which crosses into Bucks County.

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Einstein Montgomery Hospital
- Jefferson Lansdale Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

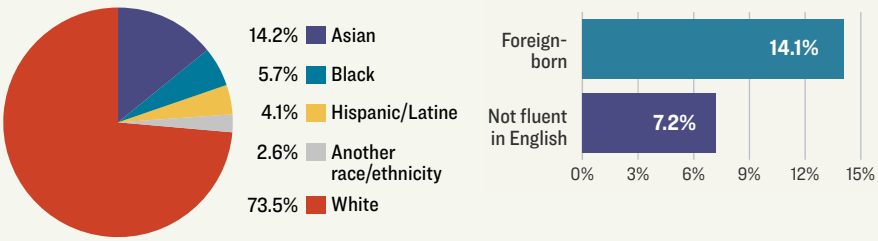


AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

163,958

MEDIAN HOUSEHOLD INCOME

$112,422

EDUCATIONAL ATTAINMENT

22.0% High school as highest education level

PEOPLE WITH DISABILITIES

12.5%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	North Penn and Lansdale	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	953.3	883.5
	Life expectancy: Female (in years)	81.1	80.5
	Life expectancy: Male (in years)	79.1	77.4
	Years of potential life lost before 75	6,422	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	28.8%	30.2%
	Diabetes prevalence	9.8%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	199.0	152.0
	Hypertension prevalence	30.6%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	36.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	916.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	30.3	32.7
	Major cancer incidence rate (per 100,000)*	285.2	258.4
	Major cancer mortality rate (per 100,000)*	59.9	67.6
	Colorectal cancer screening (adults age 45-75)	69.5%	70.4%
	Mammography screening (women age 50-74)	79.9%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	5.5	4.2
	Percent low birthweight births out of live births	7.3%	8.3%
	Percent preterm births out of live births	8.2%	9.0%
	Child Opportunity Index**	76.8	67.4
BEHAVIORAL HEALTH	Adult binge drinking	18.5%	19.0%
	Adult smoking	11.7%	11%
	Drug overdose mortality rate (per 100,000)	12.6	21.1
	Opioid-related hospitalization rate (per 100,000)	147.1	180.5
	Substance-related hospitalization rate (per 100,000)	202.5	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	12.6	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,845.0	2,354.0
	Homicide mortality rate (per 100,000)	2.2	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.4%	8.4%
	Children <19 years with public insurance	23.3%	22.2%
	Population without insurance	3.3%	3.8%
	Children <19 years without insurance	2.0%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.6%	6.1%
	Children <18 years in poverty	5.4%	6.5%
	Adults 19-64 years unemployed	3.1%	4.2%
	Householders living alone who are 65+ years	24.9%	27.7%
	Households receiving SNAP benefits	5.6%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	9.5%	11.4%
	Vacant housing units	2.8%	4.9%
	Single parent households	19.4%	17.1%
	Commute greater than 60 minutes	9.7%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 66

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obesity and maintaining healthy weight

Cancer

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obesity and maintaining healthy weight

Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Substance use services

Affordable housing

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Health insurance is not accepted

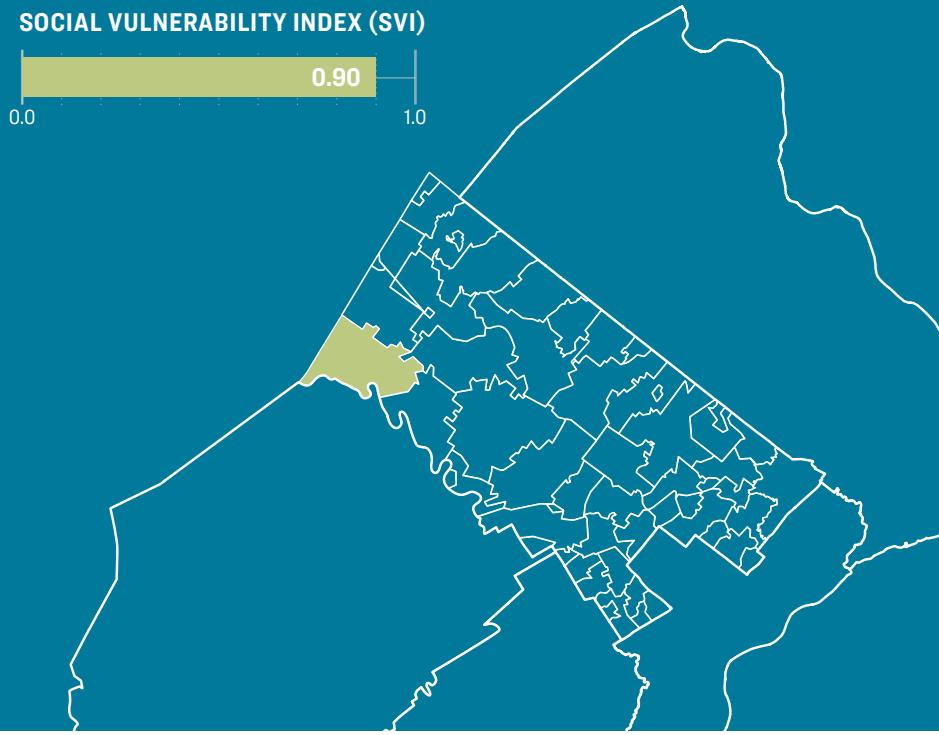
Transportation (getting to and from doctor's visits and appointment)

Pottstown

ZIP Codes: 19464

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Montgomery Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Wills Eye Hospital



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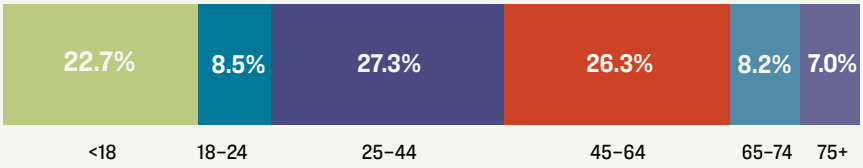
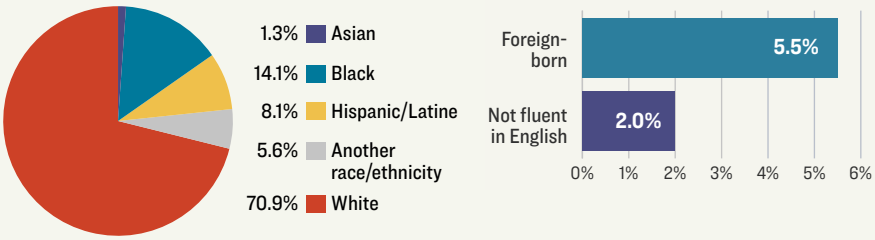


SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

48,084

MEDIAN HOUSEHOLD INCOME

$76,338

EDUCATIONAL ATTAINMENT

36.8% High school as highest education level

PEOPLE WITH DISABILITIES

17.0%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Accidents

SUMMARY HEALTH MEASURES

Category	Measure	Pottstown	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	1,079.0	883.5
	Life expectancy: Female (in years)	75.7	80.5
	Life expectancy: Male (in years)	70.7	77.4
	Years of potential life lost before 75	5,138	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	35.8%	30.2%
	Diabetes prevalence	10.9%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	475.0	152.0
	Hypertension prevalence	33.5%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	121.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	1,802.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	54.3	32.7
	Major cancer incidence rate (per 100,000)*	333.9	258.4
	Major cancer mortality rate (per 100,000)*	91.8	67.6
	Colorectal cancer screening (adults age 45-75)	65.7%	70.4%
	Mammography screening (women age 50-74)	75.9%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	9.7	4.2
	Percent low birthweight births out of live births	9.5%	8.3%
	Percent preterm births out of live births	10.3%	9.0%
	Child Opportunity Index**	76.0	67.4
BEHAVIORAL HEALTH	Adult binge drinking	19.5%	19.0%
	Adult smoking	16.7%	11%
	Drug overdose mortality rate (per 100,000)	68.9	21.1
	Opioid-related hospitalization rate (per 100,000)	492.6	180.5
	Substance-related hospitalization rate (per 100,000)	851.5	278.5
	Poor mental health for 14+ days in past 30 days	17%	13.9%
	Suicide mortality rate (per 100,000)	16.7	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,610.0	2,354.0
	Homicide mortality rate (per 100,000)	8.3	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	17.6%	8.4%
	Children <19 years with public insurance	48.4%	22.2%
	Population without insurance	4.3%	3.8%
	Children <19 years without insurance	1.3%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	11.7%	6.1%
	Children <18 years in poverty	17.7%	6.5%
	Adults 19-64 years unemployed	5.7%	4.2%
	Householders living alone who are 65+ years	30.3%	27.7%
	Households receiving SNAP benefits	16.1%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	15.1%	11.4%
	Vacant housing units	7.7%	4.9%
	Single parent households	45.3%	17.1%
	Commute greater than 60 minutes	10.0%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Central, Lower, and Upper Perkiomen Valley, and Pottstown communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 45

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obseity and maintaining healthy weight

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Substance use

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

No health insurance

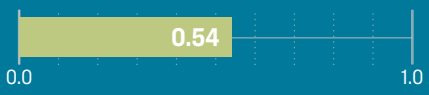
Upper Dublin

ZIP Codes: 19002, 19025, 19031, 19034, 19044, 19075, 19436, 19437, 19477

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Montgomery Hospital
- Jefferson Lansdale Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Temple Health - Chestnut Hill Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)



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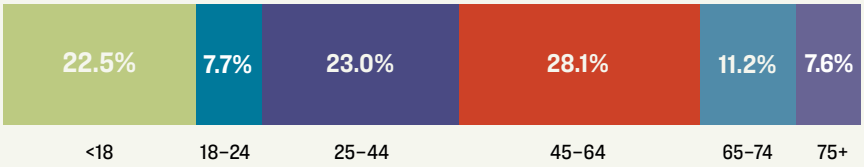
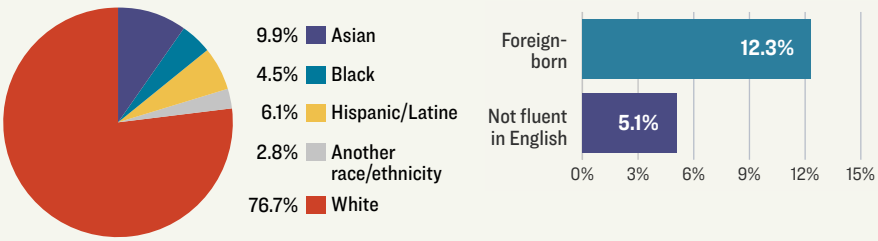


SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

77,430

MEDIAN HOUSEHOLD INCOME

$133,168

EDUCATIONAL ATTAINMENT

17.4% High school as highest education level

PEOPLE WITH DISABILITIES

9.1%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Upper Dublin	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	949.6	883.5
	Life expectancy: Female (in years)	82.1	80.5
	Life expectancy: Male (in years)	78.6	77.4
	Years of potential life lost before 75	3,018	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.5%	30.2%
	Diabetes prevalence	9.4%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	162.0	152.0
	Hypertension prevalence	32.5%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	38.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	759.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	25.9	32.7
	Major cancer incidence rate (per 100,000)*	302.7	258.4
	Major cancer mortality rate (per 100,000)*	67.3	67.6
	Colorectal cancer screening (adults age 45-75)	73.7%	70.4%
	Mammography screening (women age 50-74)	81.0%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	1.4	4.2
	Percent low birthweight births out of live births	7.0%	8.3%
	Percent preterm births out of live births	8.6%	9.0%
	Child Opportunity Index**	82.4	67.4
BEHAVIORAL HEALTH	Adult binge drinking	18.0%	19.0%
	Adult smoking	9.2%	11%
	Drug overdose mortality rate (per 100,000)	16.8	21.1
	Opioid-related hospitalization rate (per 100,000)	138.4	180.5
	Substance-related hospitalization rate (per 100,000)	175.9	278.5
	Poor mental health for 14+ days in past 30 days	12%	13.9%
	Suicide mortality rate (per 100,000)	9.1	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,138.0	2,354.0
	Homicide mortality rate (per 100,000)	1.3	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.8%	8.4%
	Children <19 years with public insurance	16.6%	22.2%
	Population without insurance	4.4%	3.8%
	Children <19 years without insurance	4.9%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.1%	6.1%
	Children <18 years in poverty	3.4%	6.5%
	Adults 19-64 years unemployed	3.1%	4.2%
	Householders living alone who are 65+ years	24.7%	27.7%
	Households receiving SNAP benefits	5.5%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	9.9%	11.4%
	Vacant housing units	4.0%	4.9%
	Single parent households	20.9%	17.1%
	Commute greater than 60 minutes	8.7%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 75

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Diabetes and high blood sugar

Mental health

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Anxiety

Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Injuries

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Good paying jobs

Affordable housing

Safe neighborhoods

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Don't know how to find healthcare services or providers

Scheduling problems (such as health services not open when available)

Upper Perkiomen Valley

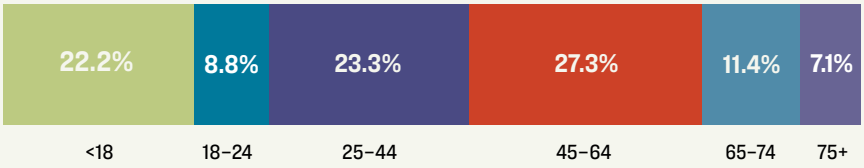
ZIP Codes: 18041, 18054, 18070, 18073, 18076

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Grand View Health
- Wills Eye Hospital

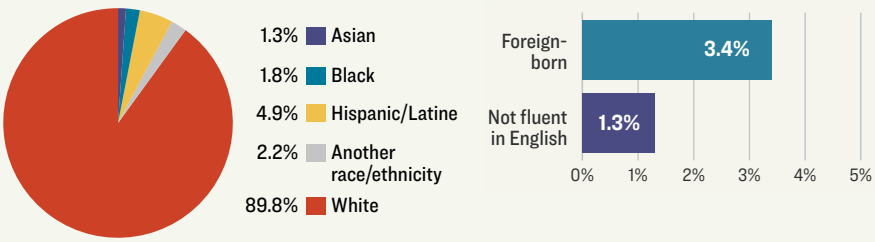
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

25,212

MEDIAN HOUSEHOLD INCOME

$101,785

EDUCATIONAL ATTAINMENT

36.1% High school as highest education level

PEOPLE WITH DISABILITIES

12.5%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. COVID-19

SUMMARY HEALTH MEASURES

*Estimates are unavailable or unreliable due to low sample size within a community

Category	Measure	Upper Perkiomen Valley	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	915.5	883.5
	Life expectancy: Female (in years)	80.6	80.5
	Life expectancy: Male (in years)	75.3	77.4
	Years of potential life lost before 75	1,561	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.9%	30.2%
	Diabetes prevalence	10.2%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	177.0	152.0
	Hypertension prevalence	32.7%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	46.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	699.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	47.4	32.7
	Major cancer incidence rate (per 100,000)*	327.5	258.4
	Major cancer mortality rate (per 100,000)*	71.0	67.6
	Colorectal cancer screening (adults age 45-75)	68.5%	70.4%
	Mammography screening (women age 50-74)	77.8%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	8.3	4.2
	Percent low birthweight births out of live births	7.9%	8.3%
	Percent preterm births out of live births	6.6%	9.0%
	Child Opportunity Index**	64.1	67.4
BEHAVIORAL HEALTH	Adult binge drinking	20.0%	19.0%
	Adult smoking	15.1%	11%
	Drug overdose mortality rate (per 100,000)	19.7	21.1
	Opioid-related hospitalization rate (per 100,000)	201.2	180.5
	Substance-related hospitalization rate (per 100,000)	244.7	278.5
	Poor mental health for 14+ days in past 30 days	16%	13.9%
	Suicide mortality rate (per 100,000)	11.8	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,598.0	2,354.0
	Homicide mortality rate (per 100,000)	--	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	8.6%	8.4%
	Children <19 years with public insurance	22.9%	22.2%
	Population without insurance	3.3%	3.8%
	Children <19 years without insurance	3.2%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.3%	6.1%
	Children <18 years in poverty	10.0%	6.5%
	Adults 19-64 years unemployed	3.7%	4.2%
	Householders living alone who are 65+ years	23.4%	27.7%
	Households receiving SNAP benefits	4.8%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	7.7%	11.4%
	Vacant housing units	3.5%	4.9%
	Single parent households	23.3%	17.1%
	Commute greater than 60 minutes	11.2%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

These results reflect responses from the Central, Lower, and Upper Perkiomen Valley, and Pottstown communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 45

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Obseity and maintaining healthy weight

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Substance use

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Safe neighborhoods

Affordable housing

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

No health insurance

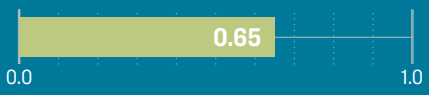
Willow Grove

ZIP Codes: 19001, 19038, 19090

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Temple Health - Chestnut Hill Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)



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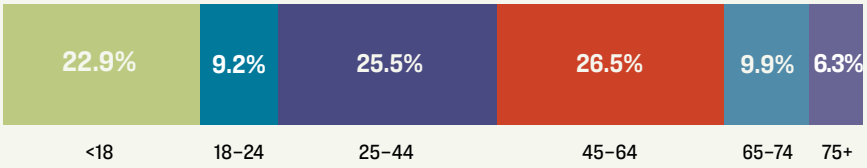
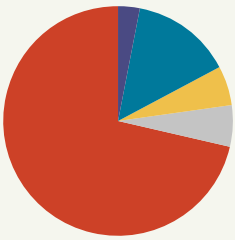
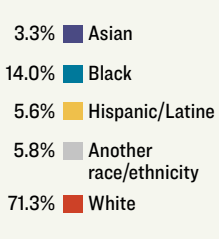
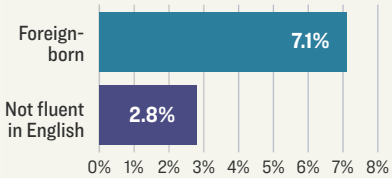


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

69,684

MEDIAN HOUSEHOLD INCOME

$106,645

EDUCATIONAL ATTAINMENT

21.0% High school as highest education level

PEOPLE WITH DISABILITIES

13.5%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Willow Grove	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	905.9	883.5
	Life expectancy: Female (in years)	80.1	80.5
	Life expectancy: Male (in years)	75.6	77.4
	Years of potential life lost before 75	3,930	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.4%	30.2%
	Diabetes prevalence	9.8%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	240.0	152.0
	Hypertension prevalence	31.6%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	44.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	1,048.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	38.4	32.7
	Major cancer incidence rate (per 100,000)*	280.2	258.4
	Major cancer mortality rate (per 100,000)*	68.3	67.6
	Colorectal cancer screening (adults age 45-75)	70.1%	70.4%
	Mammography screening (women age 50-74)	79.2%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	4.0	4.2
	Percent low birthweight births out of live births	8.3%	8.3%
	Percent preterm births out of live births	8.7%	9.0%
	Child Opportunity Index**	70.9	67.4
BEHAVIORAL HEALTH	Adult binge drinking	19.7%	19.0%
	Adult smoking	12.0%	11%
	Drug overdose mortality rate (per 100,000)	29.9	21.1
	Opioid-related hospitalization rate (per 100,000)	241.8	180.5
	Substance-related hospitalization rate (per 100,000)	328.5	278.5
	Poor mental health for 14+ days in past 30 days	15%	13.9%
	Suicide mortality rate (per 100,000)	15.6	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,025.0	2,354.0
	Homicide mortality rate (per 100,000)	2.8	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	8.5%	8.4%
	Children <19 years with public insurance	19.1%	22.2%
	Population without insurance	4.2%	3.8%
	Children <19 years without insurance	2.7%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.8%	6.1%
	Children <18 years in poverty	2.9%	6.5%
	Adults 19-64 years unemployed	4.7%	4.2%
	Householders living alone who are 65+ years	23.4%	27.7%
	Households receiving SNAP benefits	6.9%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.4%	11.4%
	Vacant housing units	4.6%	4.9%
	Single parent households	17.4%	17.1%
	Commute greater than 60 minutes	9.4%	9.0%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 97

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Chronic pain and pain management

Obesity and maintaining healthy weight

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Intellectual / developmental disabilities

Chronic pain and pain management

Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Bullying

Post traumatic stress disorder

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Services that support people as they age

Substance use services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Not enough health care services or providers

Scheduling problems (such as health services not open when available)

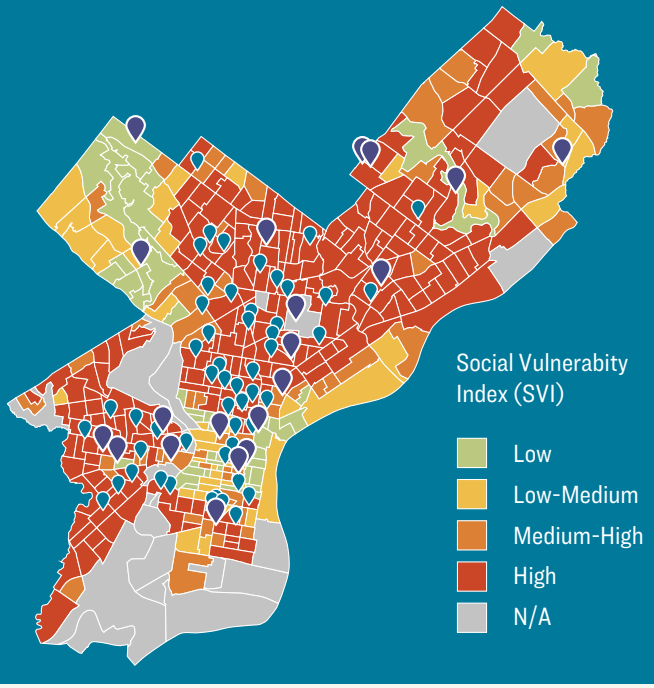
Philadelphia County

SOCIAL VULNERABILITY INDEX (SVI)*

*SVI is a measure developed by the CDC to identify communities that may need support before, during, or after disasters. This measure is made up of a combination of 16 different U.S. Census variables, which are grouped into four themes (socioeconomic status, household charateristics, racial & ethnic minority status, and housing type & transportation), and cover major areas of social vulnerability.

HOSPITAL HEALTH CENTER

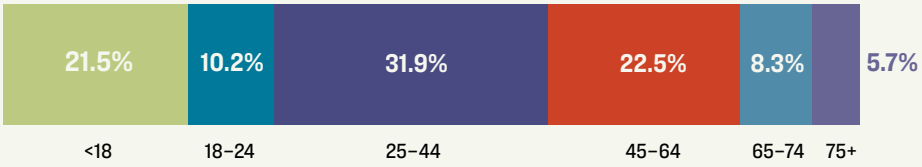
There are 21 hospitals and 23 health centers in Philadelphia County.



Demographics

AGE DISTRIBUTION

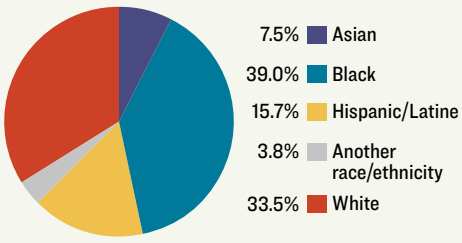
Philadelphia County has an estimated population of 1,582,432 with the largest proportion of residents between the ages of 25 - 44.



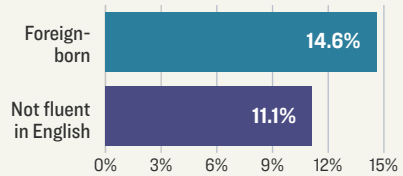
SEX

RACE/ETHNICITY/LANGUAGE

39% of residents are non-Hispanic Black. Non-Hispanic White residents make the next largest population, comprising 34% of the county's residents.



Nearly 15% of residents are foreign-born and about 11% speak English less than "very well."



HOUSEHOLDS

Median Household Income
$57,537

Homeownership
52.0%

Severe Housing Cost Burden
% spending >50% of household income
21.0%

High School as Highest Education
30.3%

Household Food Insecurity
15.2%

Single Parent Households
48.0%

Same Sex Couples
per 1,000 households
6.0

Commute Greater than 60 minutes
13.3%

Philadelphia County

Health

LEADING CAUSES OF DEATH- All Ages

1	Heart Disease
2	Cancer
3	Accidents
4	COVID-19
5	Cerebrovascular Diseases

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

13.2%

Depressed/Sad Most Days in the Past 12 Months

46.0%

Binge Drinking

9.6%

Cigarette Smoking

8.0%

Vaping

37.5%

Exposure

Lead Levels in Children (<16 years old)

5.6%

PEOPLE WITH DISABILITIES

Percent of Population

16.8%

Poverty Status in the Past 12 Months

39.0%

Percent who have difficulty with:

Hearing	3.1%
Vision	3.6%
Cognition	7.8%
Ambulatory	8.8%
Self-care	3.9%
Independent Living	6.9%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

31.3

Violent Crime Rate per 100,000

1,047.3

Gun-related ED Utilization per 100,000

34.7

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

2,111.9

This measure reflects limited access to primary care as individuals may rely on emergency departments non-emergency health needs due to barriers like insurance, trust, clinician shortages, etc.

Flu Vaccinations (Adult)

47.0%

This measure is a strong indicator of overall community vaccination levels because they reflect access to healthcare, public trust in vaccines, and the effectiveness of outreach efforts in promoting immunization.

Chlamydia per 100,000

1,082.5

This measure is a good marker for STIs in a community because it is the most commonly reported bacterial infection, often asymptomatic, and indicates the overall level of STI transmission, screening, and prevention efforts in a population.

Income Inequality

0.44

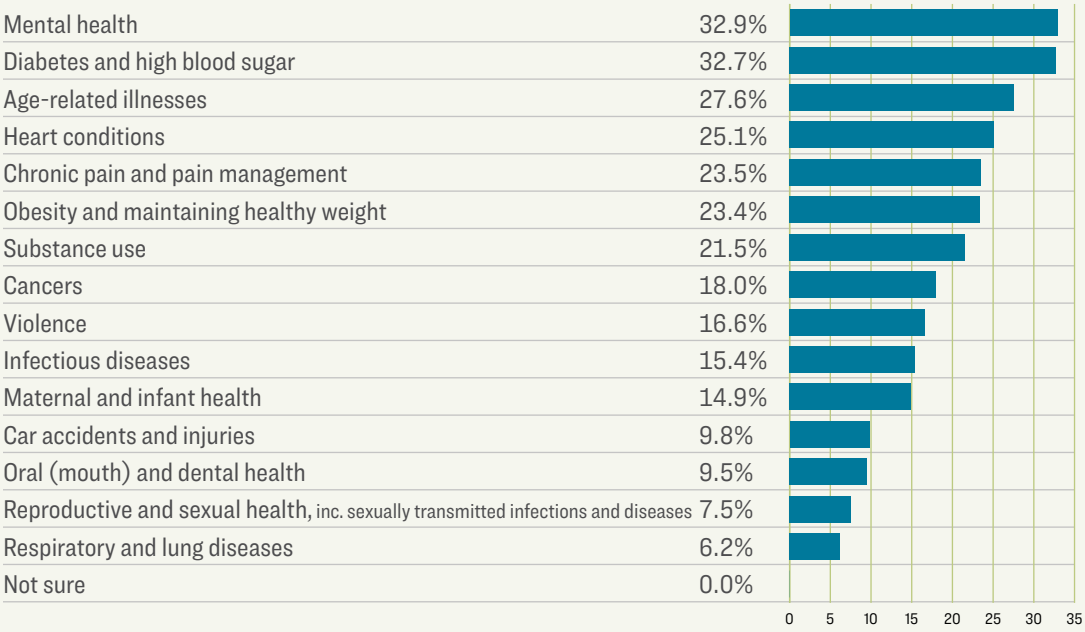
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Philadelphia County

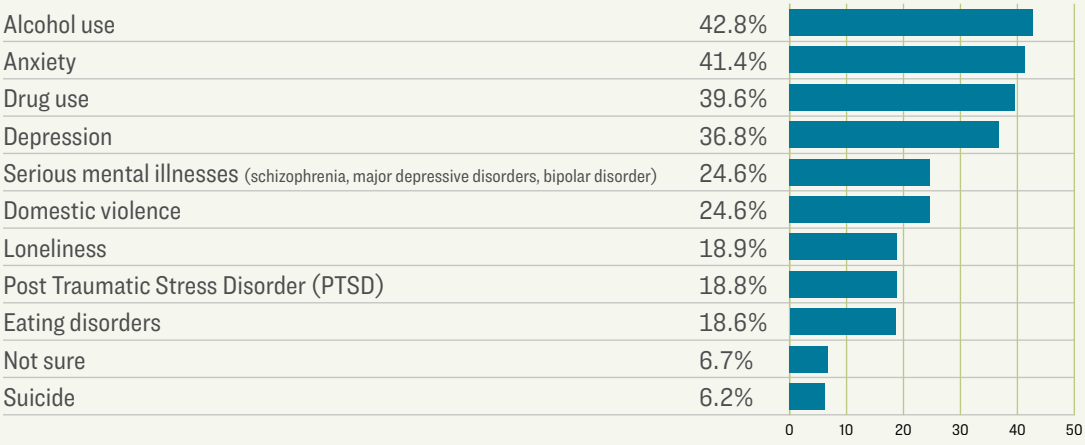
County Survey Results

Number of Respondents: 1,347

Thinking about yourself or other ADULTS in the community where you live, what are the top 3 HEALTH problems?



Thinking about yourself or other ADULTS in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?



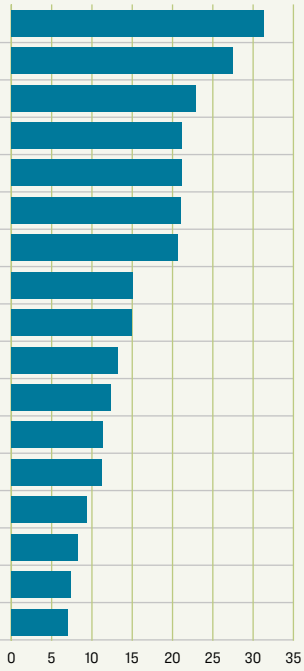
Philadelphia County

County Survey Results

Number of Respondents: 1,347

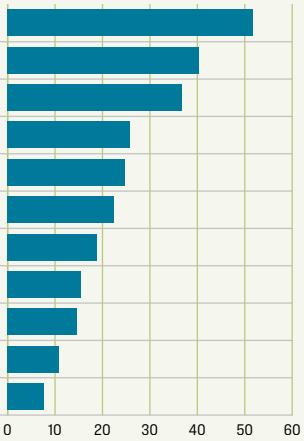
Thinking about your or other CHILDREN in the community where you live, what are the top 3 HEALTH problems?

Mental health	31.3%
Abuse or neglect	27.5%
Intellectual / developmental disabilities	22.9%
Injuries	21.2%
Obesity and maintaining healthy weight	21.1%
Infectious diseases	21.0%
Violence	20.6%
Blood diseases	15.1%
Infant / baby health	15.0%
Diabetes and high blood sugar	13.2%
Oral (mouth) and dental health	12.4%
Substance use	11.4%
Respiratory diseases	11.2%
Chronic pain and pain management	9.4%
Not sure	8.2%
Reproductive and sexual health, inc. sexually transmitted infections and diseases	7.4%
Cancers	7.0%



Thinking about your or other CHILDREN in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying	51.8%
Anxiety	40.4%
Depression	36.8%
Drug use	25.8%
Loneliness	24.7%
Eating disorders	22.4%
Post Traumatic Stress Disorder (PTSD)	18.9%
Serious mental illnesses (schizophrenia, major depressive disorders, bipolar disorder)	15.5%
Alcohol use	14.6%
Not sure	10.8%
Suicide	7.7%

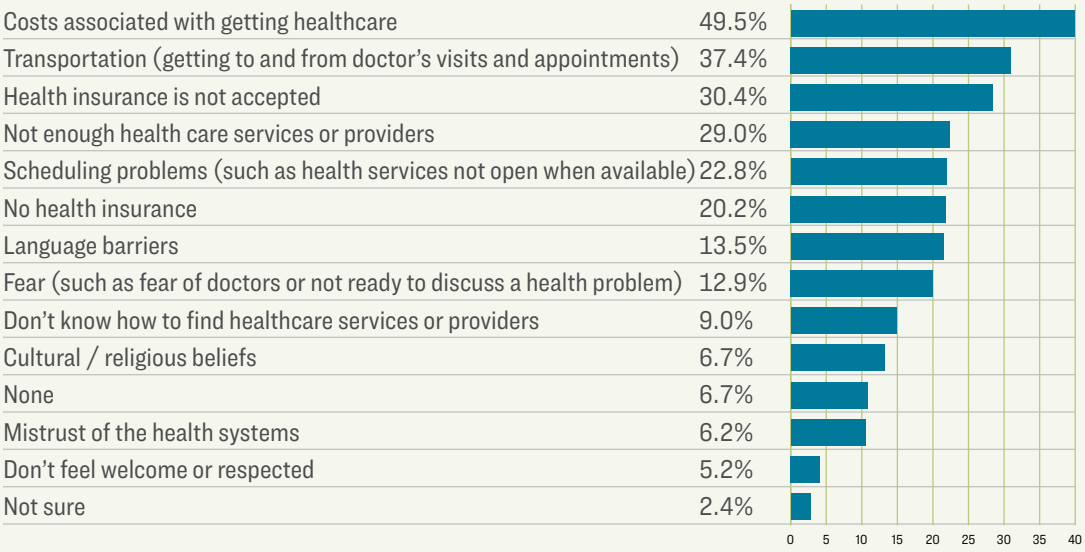


Philadelphia County

County Survey Results

Number of Respondents: 1,347

Thinking about the community where you live, which barriers prevent access to health care? (Select all that apply)



Thinking about the community where you live, how available are the following resources?

	Never Available	Rarely	Sometimes	Often	Always Available	Not Sure
Affordable healthy foods	4.2%	17.0%	31.0%	25.5%	18.5%	3.9%
Affordable housing	8.8%	23.6%	29.3%	19.8%	13.6%	5.1%
Clean outdoor environment	5.5%	18.2%	28.5%	26.9%	17.3%	3.6%
Good paying jobs	6.2%	17.9%	30.5%	26.0%	13.5%	5.9%
Good schools	3.4%	16.1%	28.8%	24.9%	20.9%	5.9%
Health care services	1.7%	6.5%	25.2%	34.2%	28.7%	3.8%
Mental health services	3.3%	18.6%	26.0%	25.8%	17.9%	8.5%
Places to be active such as parks	2.6%	10.0%	27.0%	27.8%	29.5%	3.1%
Safe neighborhood	2.9%	6.2%	20.9%	31.3%	35.2%	3.5%
Services that support people as they age	2.5%	11.1%	26.6%	26.4%	23.3%	10.2%
Substance use services	5.2%	15.1%	23.2%	26.1%	17.4%	13.1%

Philadelphia County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

Overall health, wellness, and physical activity were greatly attributed to the presence of parks, trees, and playgrounds. Recreation centers, gyms, fitness classes, and free health workshops improved quality of life, when made available.

ON GREEN SPACE AND RECREATION

"They're like walking groups... To like foster community for people that may be new, or... trying to live a healthier lifestyle and I noticed a couple of years ago that we didn't have anything like that in my area."

"The library near me offers nutrition workshops at times, or workshops that touch on health and wellness."

"Since I've been home like 2 months I've been trying to go on as many of the walks in different parks."

"I'm part of the CDC [community development corporation], they're offering free yoga and free Pilates classes."

FOOD RESOURCES

Community members noted the significance of food banks, community gardens, and community refrigerators. These resources increased access to produce and horticultural education.

ON FOOD RESOURCES

"I got five bags of spinach, they had unlimited corn. So, we got about eight [things] of corn and peppers. Tomatoes on the vine. I never buy tomatoes on the vine because they're expensive in the supermarket. And since that has been going on, and me and my family have been eating a lot healthy again."

"They have fresh vegetables and canned goods, meats, sometimes drinks, they get fruit cups. It's helpful for the community but not just there, there's other areas where they have food banks around."

A SENSE OF COMMUNITY

Camaraderie among neighbors was important for social support. Senior centers, generations of families within neighborhoods, and immigrant communities facilitated relationships.

ON A SENSE OF COMMUNITY

"I like their friendliness. People are friendly and friendly environment where everybody kind of happy."

"If I don't go to church, I don't feel good. But I'm very happy that every Sunday I'm able to go to church."

"I have to say as a hairdresser, a lot of [the older adults], their neighbors are very good to them. I have neighbors that will actually bring the ladies in to get their hair done."

COMMUNITY ASSETS

PUBLIC TRANSPORTATION

Residents in North and Southwest Philadelphia noted reliable and affordable public transportation options. Bike lanes and bike share programs helped people to transport themselves.

ON PUBLIC TRANSPORTATION

"It's one thing our neighborhood has — it may lack in other things, but we have awesome public transportation in the area."

"I don't catch the bus but a lot of people say the transportation is pretty good as far as with all the trolleys and the buses."

COMMUNITY CHALLENGES

LIMITED HEALTHCARE ACCESS

Several barriers to healthcare were noted, some related to insufficient insurance coverage and high out-of-pocket expenses. Other barriers included long waiting times for appointments, geographic distance, and the inconvenience of appointments being confined to normal business hours. It was also noted that sometimes available health resources were underutilized.

There were issues related to culture, such as language barriers between service providers and healthcare recipients, discrimination, a lack of cultural sensitivity, and poor customer service.

In North Philadelphia, there was concern raised regarding the succession of pharmacy closures over the course of several years, leading to delays in prescription fulfillment and unfavorable prescription delivery services.

ON LIMITED HEALTHCARE ACCESS

"Nobody has enough money anywhere really. And people have to work multiple jobs because their jobs don't pay enough or their jobs don't give them benefits."

"Doctor office is closing too early."

"But then it's also a hindrance because you have to stay within a certain type of income level to be able to like keep that. And that also holds people back from actually moving forward..."

"I think providers need to be more culturally responsive and competent when interacting with people... And unfortunately, a lot of them have a lot of biases and prejudice against people who are not Caucasian."

"...a lot of the people don't take advantage of the resources that you have in the area. It's a lot of resources and people just don't know or they're just not taking advantage of the resources. So, you got like the health clinic which is a few blocks from here. It's a free health clinic for... when you don't have, medical. And then, another thing is a lot of people don't have medical so they can't seek these options."

"...when I was working full-time, my biggest option was having availability on the weekends to go to a doctor... I didn't go to a doctor for years because I had to take off from work, and I didn't get holidays or anything. So, I just didn't go."

COMMUNITY CHALLENGES

BEHAVIORAL HEALTH ISSUES

Residents discussed the need for more resources dedicated to supporting mental health, people with substance use disorders, and homeless individuals. Personal safety concerns were related to crime in neighborhoods, loud street activity at night, and perceptions of significant rates of mental illness.

ON BEHAVIORAL HEALTH ISSUES

"Providers, when people have substance abuse challenges or mental health challenges, they're treated differently and I really don't think that's fair."

"...lack of safety, but it's also affecting your emotional health, not feeling safe, but also your physical health because you're not walking as much as you would like."

"And I mean, go to the subway station and you will see that there is not enough help for people, especially that are using heroin. And they are forced to live outside and use drugs outside and it's not safe for anybody involved."

FOOD DESERTS

The proliferation of fast-food restaurants and corner stores within walking distance to residents have been described as congruent with "concentrated poverty," grocery stores that are too expensive and too far, and a lack of financial literacy. Also, food stamp eligibility was described as too restrictive. In Northeast Philadelphia, they "don't have some of the ones that other neighborhoods have, that offer more healthy foods."

ON FOOD DESERTS

"Food is very expensive. Healthy eating is way more expensive than fast food."

"...at one point, I think the city had a project to have the healthy food in corner stores and I don't know if that's still going on or how successful that is."

"But they're so easy to access and a lot of kids, that's not just kids, adults too. They run in all the junk food and the greasy foods and all that at them corner stores."

ENVIRONMENTAL HAZARDS

Abandoned vehicles with overgrowth, delayed pick-up of piles of trash, and issues with infrastructure were noted. Aged buildings lacked air conditioning and uneven sidewalks were left in disrepair.

ON ENVIRONMENTAL HAZARDS

"And there's been a huge proliferation of wildlife raccoons, squirrels from all the trash that's left out... there's a big problem with raccoons in South Philadelphia right now. So, that's also a health issue."

"Terrible sidewalks, terrible streets. It impedes good walk ability and also the lack of canopy — trees to keep it from being so hot."

SPECIAL POPULATIONS

CHILDREN AND YOUTH

Concerns were raised about the need for better nutrition options. Convenience stores and limited access to school meals in the summer were identified as problematic. There was a need for extracurricular activities, outside of video games, with the goal of "keeping them out of trouble" – related to criminal activity, victimization, and drug use. The closures of recreation centers and libraries in southwest Philadelphia were cited as reasons. Although a West Philadelphia mother noted that the quality of a particular recreation center depended on the recreation leader and their level of community engagement. It also depended on the zip code. Single parenthood was believed to be a contributing factor to difficulties that youth faced, as well as social media use.

Community gardens were educational and nutritional resources for youth. Today's youth were more inclined to seek support for their mental health, although there was a need for more mental health providers, mentors for youth, and outreach mechanisms that can dissuade youth from fear of stigmatization.

ON CHILDREN AND YOUTH

"So, they shut down rec centers and parks and then the things that are available, no transportation."

"So, their caregivers allow them to eat this food. And I see a lot of overweight children and I know when I was younger, we weren't overweight..."

"Me going to therapy to deal with the things that had happened growing up to deal with the things that have been happening my whole life. That wasn't cool to say, you know what I mean? It was something that you talk to a certain sector of people about. It was taboo. At this point, I got young girls coming to me who are like who is your therapist? I need a therapist too."

"And as a Black boy mom, we need more men... services and we are lacking a lot of men, especially Black men working in the mental health field in the local Philadelphia area."

"Social media is a really big issue for young people now, especially in Philly because... beefs have moved on to social media and so kids are shooting each other because of something they posted on TikTok..."

"But I know there are a lot of programs as I won't mention opposition or whatever, but there are programs just for that, but a lot of kids aren't coming. So, they're not getting the numbers for the funding for them to continue"

"And it's also a part of the displacement... we've witnessed in our community has been systematic, regardless as to how much community effort is put forth. There is the elephant in the room that is working against community efforts... for example, the pools haven't been opened. This is the 4th maybe 5th year... so there's intentional disinvestment."

"...we have this awareness and we have this education and we are able to look at our own selves as parents and see when your child is struggling and being able to reach out, but not everybody is able to do that without education and resources."

"My daughter started in 6th grade going to therapy. We had a house fire over Cottman Avenue, so we were displaced for almost a year, and that triggered all of the mental health. You know? And so, no one in school did anything. They didn't offer anything... My daughter has all her diagnoses finally by the time she was in college... But it took all those years through middle school, high school."

SPECIAL POPULATIONS

OLDER ADULTS

Senior living options fostered a sense of community, as did senior recreational centers. And free meal delivery services proved helpful. In North Philadelphia, food banks, supermarkets, and banks were less accessible due to limited transportation. Limited transportation options made it difficult to access health appointments in a timely manner. But paratransit services were helpful. Crime and unsafe neighborhoods deterred older adults from using public transportation. Residents of South Philadelphia were encouraged by the various options for activities, including bingo, walking, running, and dancing. Indoor activities were important for hot weather days.

Technological advancements in healthcare sometimes served as barriers for older adults. But free community health clinics provide accessibility.

There were concerns that unkept sidewalks and older buildings with narrow halls could make wheelchair use difficult. Intersecting factors such as crime, noise pollution, dementia, trash build-up, and pests could limit their desire to go out and hinder having guests. The "social structure breakdown" of families have led to increased isolation and loneliness among older adults, compared to immigrant families where "...there's many generational families and generations live together, and which is very helpful for the older [adults]." A lack of advocacy in healthcare has had a disproportionately negative impact on older, Black Americans.

ON OLDER ADULTS

"Our phones are computers now. Right? And so depending on how tech savvy you are, it can be difficult..."

"And ladies play the drums and dancing and pool and even have a religious thing every once in a while but it's good, something to get the heck out of the house."

"...because of the crime and the violence... we don't wanna go out, we don't wanna go anywhere."

"...seniors need to have a place where they can get to easily, quickly... not to have to get on one or two buses to get where they need to go."

"...when we had whole blocks of occupied homes, we had more of a sense of family, and we knew who our elders were and checked on them. There's some... blocks where there's so few houses on the blocks that people are so disjointed and... far away from one another, and that makes you vulnerable."

"...very concerned to educate our elders... so that they're not victims of heat stress, or even heat stroke. And many of our elders don't have the financial wherewithal to purchase air conditionings."

"Usually they send them to physical therapy, or they bounce them around the different doctors, but they never get to the root cause of what may be the underlying health conditions."

"...for others it's like they have to rely on social security, because retirement funds weren't able to be built from a young age like mine up until they retire. Many people didn't have the financial education through their familial background to know that that's going to be a very big aspect of their life one day, but just retirement... I watched my grandmother right now, struggle in her retirement."

ADDITIONAL POPULATIONS

There were concerns among community members about the prevalence of homeless individuals, the hidden homeless – those with unstable housing who may not necessarily be found on the streets – and how their feminine hygiene and healthcare needs are met. More shelters are needed, as "multimillion properties being built" are juxtaposed with people on the street in South Philadelphia.

Immigrants required English language services and support with pursuing employment. Reliable financial and food resources were especially important for those who are undocumented.

People with disabilities (PWD) faced accessibility challenges, including recreational activities and community mobility. Community-based services for children with autism didn't match the need in North Philadelphia. Young adults with neurodivergence had unique needs that are more complex for families to meet. And community workshops were not accessible for the Deaf and hard of hearing.

Mental health services were needed for the LGBTQ+ community, "because of being afraid to be who they are." There were issues related to suicidal ideation, suicide, and hate crimes. This was especially true in the Black community. Societal stigma can also act as a barrier for pursuing healthcare services.

"

HOMELESSNESS

"And [the homeless] don't bother you but they're so prevalent that you just step over them..."

"But if I brought it up to my council person but what she said is that when the city has tried, these individuals don't wanna go to facilities because they feel like they're attacked."

FOOD BANKS

"...I can see the line, if this place gave out food, the line would be around the corner. Literally, that's how desperate people are just to get some decent food."

PWDS

"I wanted people with disability to be able to come to a fitness center that didn't look therapeutic. And the disability community was saying, we ain't going to the Carousel House. So, when I went to the Carousel House, I said, I don't blame them. It was bombed out with equipment that didn't even work."

"People with disabilities are definitely suffering the most... We need just more services."

"I've particularly noticed in this neighborhood that it's just something unaddressed. And in the 3 local elementary schools, there's so many autistic children that they've had to open autistic support classrooms in all the elementary schools around here. So I'm like, so if you guys know, there's this many children with this issue, why are we not, you know, talking about it on a larger scale?"

"There was a gentleman in Starbucks today that was coloring, and he had all his books and all his art supplies and everything, and every 15 minutes or so, he would get up, he would run around, he would yell, and you knew he was by himself. And I felt horrible... Somebody had to drop him off because he had all this stuff all over the whole big table, and nobody was there taking care of him... and people were looking, which I [couldn't] care less about, but I don't want to go up and ask if he needs me to help him. And the baristas are like, 'What do we do?'"

"

ACCESS TO CARE

Residents have experienced unanswered and unreturned phone calls to healthcare providers, making appointment-setting difficult. Differences in coverage between those with state sponsored and private insurance coverage made some services inaccessible. Co-pays and out-of-pocket expenses served as deterrents for those with limited incomes. Those with income limits also faced access issues. A lack of upfront transparency with healthcare costs was described as "a huge limiting factor." Also, appointments were set too far into the future for symptoms/ concerns that needed immediate attention, particularly when specialists were needed. There was a desire for more substance use treatment facilities that offered extended stays that were covered by insurance. Quality of care in rehabilitation centers and instances of re-traumatization from staff were a concern. North Philadelphia respondents were not aware of any mental health facilities in their area. Hospitals have been diminishing in number. Yet, telehealth services have provided more options, especially as residents found that many providers were not accepting new patients. Accessibility didn't always take into account neurodevelopmental disabilities and related accommodations in health settings.

ON ACCESS TO CARE

"...I don't get no answer. I want to give my new number so they can send me an email when my next doctor's appointment is and uh, nothing, no response or, you know, nothing I can't get through over there and, and even the, the specialist they sent me to up on Broad Street, they never returned my call and no answer. No answer. Nothing. It's terrible over there. That's the worst hospital in the city."

"If I gotta figure out whether I'm gonna feed me and my kids with this, my last $100 or I'm gonna go to the doctor's clinic tomorrow. I feed me and my kids... and try to heal myself and still showing up to work often. But because I gotta make sure that me and my family is ok."

"Some doctors is not available until like three months later. So, if you really need to go to the urgent care, there's a whole bunch of them in the city."

"I just think that the way the healthcare is set up, you can make a dollar or two cents over and you lose your health care..."

"...unfortunately, a lot of places are lacking workers, so they're just hiring anybody and nobody's being held accountable for the way they treat any patients."

"...it really just kind of depends on if you - where you work, if they have a good health care plan, then it's easy. If they don't, then it becomes very costly for you. And then when you go to retire, a lot of folks are stuff, but I can't retire because I need the medical."

"...we just need universal health care in this country..."

"A lot of pharmacies don't have a lot of the popular medications, especially like Metformin and stuff like that."

TRUSTWORTHINESS

Community members with established relationships with their providers and consistent communication tended to have more trust. This was also true of individuals with histories of serious medical conditions that had good outcomes. Others mistrusted providers through what they perceived as low-quality insurance plans, who were not good listeners, or because of historical, discriminatory health practices in America.

ON TRUSTWORTHINESS

"I say, yes, because I'm on my second pacemaker. And whenever I go to that local hospital, they're always great."

"Yeah, I feel there's mistrust to me like that everything wants to make money is not like really caring about people what's going on."

"It all depends on what kind of insurance you have. So, you might not get the best. It's a kind of like a tier thing. If you have this kind of insurance, you'll get this kind of health care. For me personally I won't say I don't trust any of my doctors, but I get a second opinion... It all depends on what your insurance is and whether or not a provider can make money off of that."

"...some doctors take time to explain. And so, at least you build that trust."

"I feel like my doctor is cool as an individual. But if I'm being honest like, I don't really have a lot of trust in the healthcare system overall. Just from personal experience. Studying history as a African American woman, and what the medical establishment has done..."

COVID-19 PANDEMIC

Post-COVID, respondents have engaged more with technology in health spaces (e.g., accessing health portals, virtual appointments). There were differing levels of comfort with this, based on technological savvy, habits, time savings, language proficiency, lack of trust, purpose of the visit, and convenience. But most appreciated the option and considered health services to be better post-COVID because of it. Some individuals felt that virtual appointments should cost less or have lower co-pays.

For the most part, COVID-19 was still a concern due to variants and personal experiences and losses. Although it was not considered as threatening, precautions should still be taken. Many individuals found security in repeated vaccinations/boosters. Generally, there was some awareness among respondents of Long COVID, either having heard of it or knowing someone with it.

ON COVID-19 PANDEMIC

"Don't ask me to go check my lab test and all this stuff. I ain't got time for that... that's driving me crazy trying to even understand."

"I do appreciate for like the follow up appointments, those being virtual..."

"Every single other week I'm getting a letter about my information being leaked. So, I know that with a lot of the telehealth, they say it's not recorded and it may not be, but who's to say who's watching on the other side..."

"Well, for me COVID took a family member from me and my mother had it. So, I don't think we're done with it. I really feel that it's not just getting started but it's going to be around for a while and we just got to learn how to contain it."

"...she has long term COVID. She almost died from it. Went to a coma for like three months."

"...in larger political spheres, myths and disinformation about what COVID precisely is and how different strains can continue to affect and disable people's efforts to regain normalcy..."

"My cousin had and it's been a year and he still had some respiratory issues and problems. And then a friend of mine's son, it's probably been almost a year, he still can't get his taste back."

"COVID is not a concern to me... I got all my shots, and then I don't work. I'm on disability. I don't go many places but to the doctor and back, so I'm good."

DIVERSE LANGUAGE PERSPECTIVES

Two community conversations were held in Spanish and Burmese to increase diversity and equity in the voices and perspectives shared in this assessment.

Burmese-Speaking Respondents

A clean environment contributes to overall well-being. Access to public health benefits is important. In the South Philadelphia area, residents appreciated the presence of food pantries, public transportation, and the convenience of resources that are geographically close (e.g., schools, grocery stores, places of worship, other Asian residents).

Language barriers can lead to loneliness, difficulty with self-advocacy, miscommunication, and decreased productivity at work – making it difficult to obtain and maintain employment. Respondents tend to have to rely on the help of others to community with health providers, including setting appointments. Interpreters are hard to find, leading to misunderstandings with healthcare professionals. Dentists most often do not provide interpreters. Community members are unaware of how and where to access services for substance use disorders or mental illness.

Respondents generally have trust in their providers. One person shared about an experience where she did not feel heard and decided to find another doctor. Providers also become impatient when there are language difficulties. These experiences can make them feel anxious about accessing healthcare. A lack of childcare limits access as well.

Technology-use has facilitated appointment scheduling, checking test results, and messaging providers. There are some difficulties, as most respondents had no experience with telehealth appointments and/or unreliable internet access. Most, and generally older, respondents would prefer to receive healthcare in-person.

Community resources that are working well include health literacy initiatives, nutrition education for older adults and parents, and relationships with neighbors. Suggestions for what is needed include community gardens, opportunities for recreation and physical activity, social activities, preventative health measures, and food resources.

Spanish-Speaking Respondents

Community centers offer activities for the whole family, including yoga, dance, and swimming. Someone mentioned programs offered by their church, including a 3-day camp. Local clinics and social services are accessible and have helped individuals with multiple health conditions. However, two local parks are considered unsafe, due to people using substances there and broken bottles. More recreational activities are needed to meet the needs of people who work during the day, that provide affordable childcare, and that cater to Spanish speakers. A concern was raised about trash build-up and related hygiene issues.

For some, healthcare has been accessible and with Spanish-speaking providers and social workers. For others, language does serve as a barrier and interpreters are not always provided. They've experienced a lack of empathy, lack of advocacy, and bullying. There's also a fear that sometimes health providers are not telling them the whole truth because of misconceptions about their education levels or biases against those perceived as being undocumented. There is a lack of trust when it comes to medical costs for those who do not have health insurance. Vision services are generally more affordable than dental. Individuals who are uninsured and underinsured tend to experience advanced health conditions that require treatments that they can't afford.

Regarding the integration of technology, most community members had mixed or negative feelings. Some perceived the technological applications to be more convenient for health providers than the consumers. Current community resources include smoking cessation programs. One respondent spoke to the need for HIV/AIDS prevention and education. Another discussed the need to address suicide prevention and depression (especially since COVID) in the Hispanic community. Culturally, there is a tendency to not ask for help with these kinds of issues because of shame. There is concern for individuals who are selling and using drugs and not getting help. There are "Block Captains" in place to provide community support. However, one respondent felt that residents aren't listened to unless they sound like they are American when they call.

Suggestions included having Spanish speakers in leadership within the municipality and soliciting representatives to meet with the city council. They acknowledged it would be beneficial to include American allies. The focus group itself was praised as a useful experience that should continue regularly.

SUGGESTED ACTIONS

Philadelphia County

What is already working well to improve health in your community?

Preventative health services in schools.	"I think that school-based clinics, health clinics are really promising direction to be moving. A lot of folks can't afford the healthcare, don't have the time or the access to it for whatever reason. So, if we can help young people stay healthier in the place they already are, that would be really helpful."
Health navigators.	"Pennie is the healthcare marketplace for Pennsylvania. They have been extremely helpful. They have people to help you navigate. They're all licensed..."

What are the most important issues to address to improve health in your community?

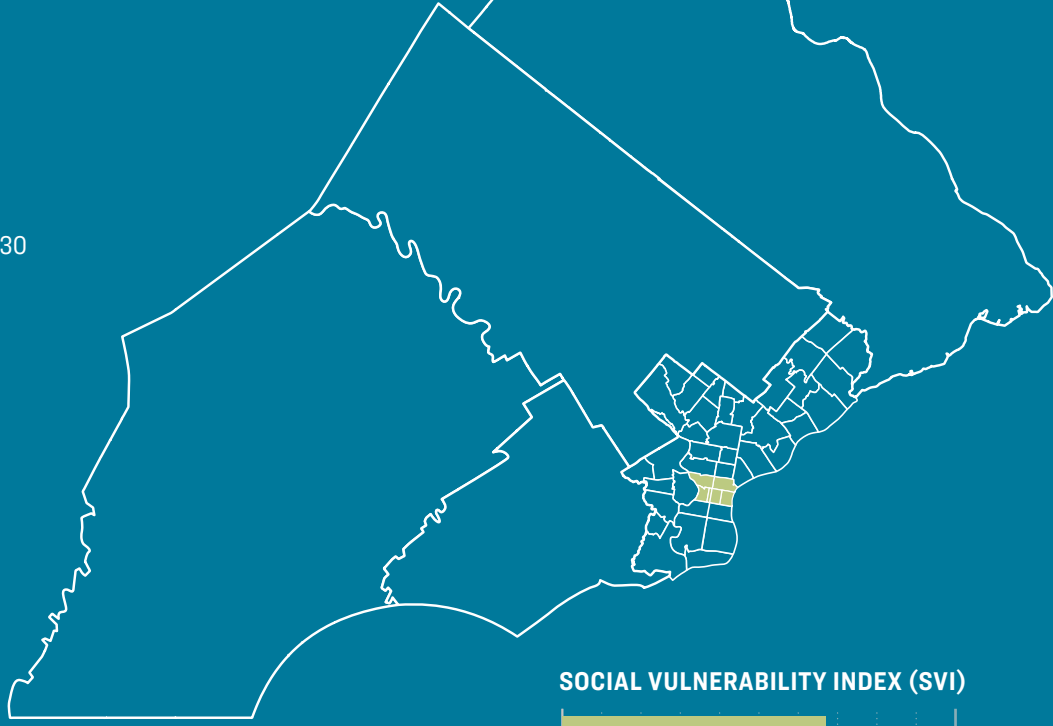
Genuine care.	"How about just listening to your patient? They so busy over talking and not actually listening to what the patient is saying."
Cultural diversity among health professionals.	"I would like to see the healthcare people in my neighborhood to look like me because I think culturally they would understand my culture..."
More efficient emergency services.	"Like when you go to an emergency system, you sit too long...The care is so slow."
Biopsychosocial and holistic health approaches.	"I would like a doctor that believes in more holistic health. Not just giving you a whole bunch of pharmaceuticals, but that doesn't mind giving me herbs or telling me what vitamin therapy to use or just even using food therapy and everything. Nutrition therapy."
Accessibility through community-based services.	"One of the key changes I would like to see. I would like to see the hospital instead of having the people in the community come to them. I think they should have more things come out into the community. And the reason why I say that is because they have no concept of the community in which they serve, because they don't come out the walls."
Effective programming for youth needs reliable funding, such as the library system.	"And, sadly, [the library] has had to cut a lot of programs, especially with funding. Our funding went way down, and that's a big draw for kids and families to come in and spend time together. They still have the after-school program where the kids can come in there and spend time, but the actual programs that we used to have, we just don't have, like, used to."

Center City

ZIP Codes: 19102, 19103, 19106, 19107, 19123, 19130

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Penn Medicine
- Thomas Jefferson University Hospital
- Wills Eye Hospital



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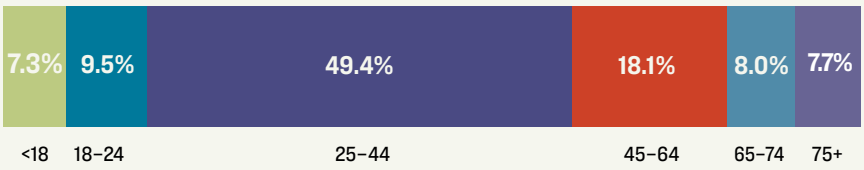
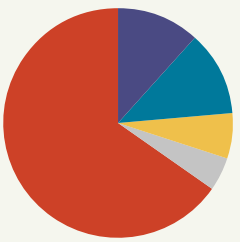
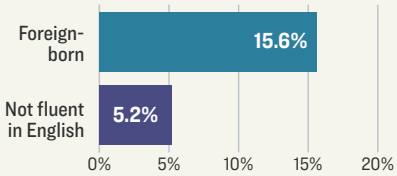


SEX

RACE/ETHNICITY/LANGUAGE



11.7% Asian
12.0% Black
6.6% Hispanic/Latine
4.5% Another race/ethnicity
65.3% White



POPULATION

109,338

MEDIAN HOUSEHOLD INCOME

$102,263

EDUCATIONAL ATTAINMENT

8.6% High school as highest education level

PEOPLE WITH DISABILITIES

10.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Center City	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	637.5	953.0
	Life expectancy: Female (in years)	79.9	77.1
	Life expectancy: Male (in years)	75.2	70.4
	Years of potential life lost before 75	6,476	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	23.6%	32.4%
	Diabetes prevalence	7.4%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	197.0	301.0
	Hypertension prevalence	21.0%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	52.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	888.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	30.2	68.0
	Major cancer incidence rate (per 100,000)*	194.8	218.9
	Major cancer mortality rate (per 100,000)*	51.2	69.4
	Colorectal cancer screening (adults age 45-75)	73.9%	66.7%
	Mammography screening (women age 50-74)	82.2%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	2,629.3	716.1
	Infant mortality rate (per 1,000 live births)	4.5	6.6
	Percent low birthweight births out of live births	8.8%	11.4%
	Percent preterm births out of live births	10.0%	11.2%
	Child Opportunity Index**	61.9	25.4
BEHAVIORAL HEALTH	Adult binge drinking	23.9%	18.9%
	Adult smoking	8.5%	16.2%
	Drug overdose mortality rate (per 100,000)	60.4	75.7
	Opioid-related hospitalization rate (per 100,000)	578.0	622.0
	Substance-related hospitalization rate (per 100,000)	969.5	1,017.9
	Poor mental health for 14+ days in past 30 days	14.8%	18.4%
	Suicide mortality rate (per 100,000)	11.9	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,027.0	1,929.0
	Homicide mortality rate (per 100,000)	8.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.2%	26.7%
	Children <19 years with public insurance	26.7%	61.5%
	Population without insurance	3.7%	7.3%
	Children <19 years without insurance	0.8%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	12.1%	22.1%
	Children <18 years in poverty	12.3%	27.0%
	Adults 19-64 years unemployed	3.1%	8.0%
	Householders living alone who are 65+ years	48.3%	36.9%
	Households receiving SNAP benefits	7.6%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	15.1%	19.3%
	Vacant housing units	11.2%	9.8%
	Single parent households	28.9%	48.0%
	Commute greater than 60 minutes	8.1%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 233

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Diabetes and high blood sugar
- Chronic pain and pain management

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Alcohol use
- Anxiety
- Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)
- Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Substance use services
- Affordable housing
- Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- No health insurance
- Transportation (getting to and from doctor's visits and appointments)

Far North Philadelphia

ZIP Codes: 19120, 19126, 19138, 19141, 19150

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)

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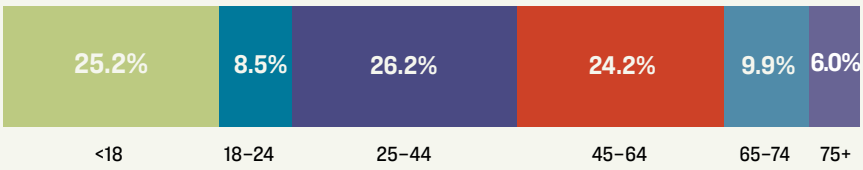
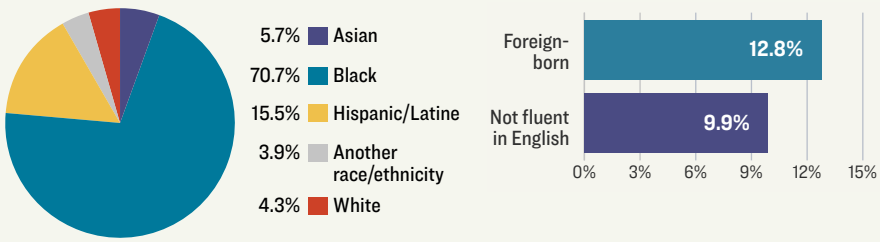


SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

178,629

MEDIAN HOUSEHOLD INCOME

$51,294

EDUCATIONAL ATTAINMENT

36.4% High school as highest education level

PEOPLE WITH DISABILITIES

21.8%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Far North Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,015.5	953.0
	Life expectancy: Female (in years)	77.2	77.1
	Life expectancy: Male (in years)	68.2	70.4
	Years of potential life lost before 75	20,857	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	39.6%	32.4%
	Diabetes prevalence	19.6%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	462.0	301.0
	Hypertension prevalence	41.9%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	153.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,848.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	72.8	68.0
	Major cancer incidence rate (per 100,000)*	251.4	218.9
	Major cancer mortality rate (per 100,000)*	79.5	69.4
	Colorectal cancer screening (adults age 45-75)	66.6%	66.7%
	Mammography screening (women age 50-74)	80.3%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,314.5	716.1
	Infant mortality rate (per 1,000 live births)	5.6	6.6
	Percent low birthweight births out of live births	15.9%	11.4%
	Percent preterm births out of live births	13.5%	11.2%
	Child Opportunity Index**	18.7	25.4
BEHAVIORAL HEALTH	Adult binge drinking	14.1%	18.9%
	Adult smoking	19.6%	16.2%
	Drug overdose mortality rate (per 100,000)	79.5	75.7
	Opioid-related hospitalization rate (per 100,000)	410.3	622.0
	Substance-related hospitalization rate (per 100,000)	844.8	1,017.9
	Poor mental health for 14+ days in past 30 days	19.1%	18.4%
	Suicide mortality rate (per 100,000)	10.1	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,132.0	1,929.0
	Homicide mortality rate (per 100,000)	36.9	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	32.9%	26.7%
	Children <19 years with public insurance	71.7%	61.5%
	Population without insurance	9.2%	7.3%
	Children <19 years without insurance	5.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	24.6%	22.1%
	Children <18 years in poverty	34.9%	27.0%
	Adults 19-64 years unemployed	11.5%	8.0%
	Householders living alone who are 65+ years	32.4%	36.9%
	Households receiving SNAP benefits	34.8%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	21.5%	19.3%
	Vacant housing units	7.1%	9.8%
	Single parent households	67.7%	48.0%
	Commute greater than 60 minutes	16.1%	13.3%

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COMMUNITY SURVEY

Number of Respondents: 102

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Diabetes and high blood sugar

Mental health

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Drug use

Alcohol use

Anxiety

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Depression

Anxiety

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

No health insurance

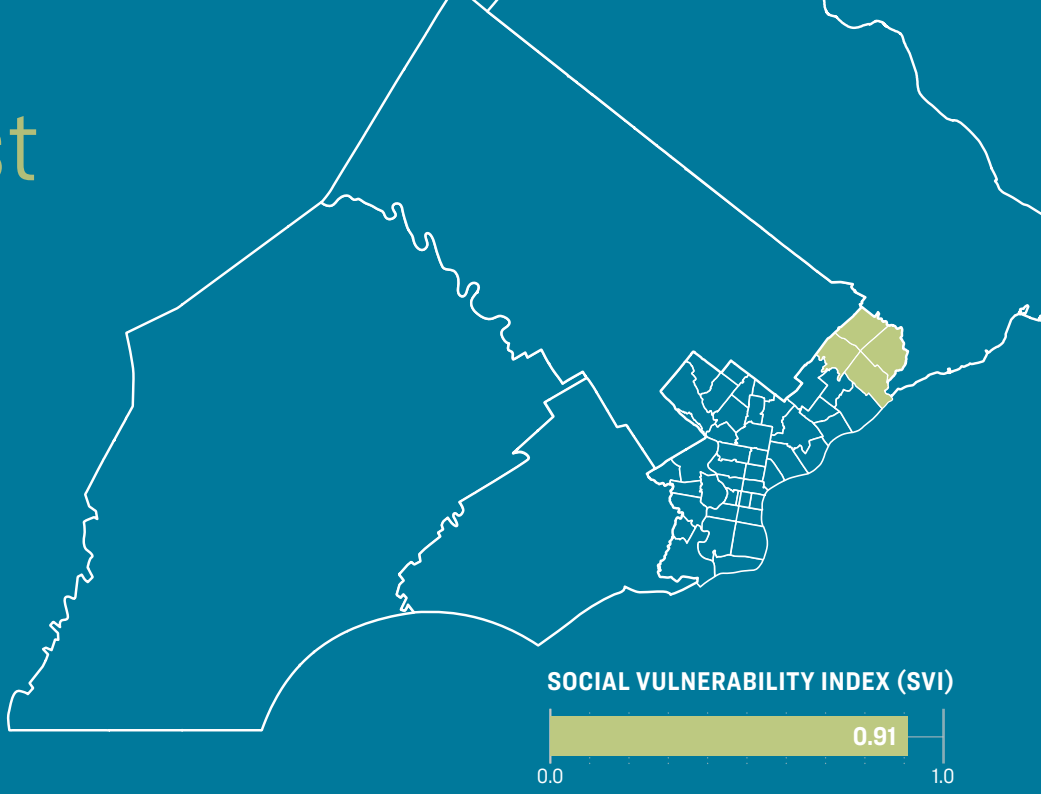
Transportation (getting to and from doctor's visits and appointments)

Far Northeast Philadelphia

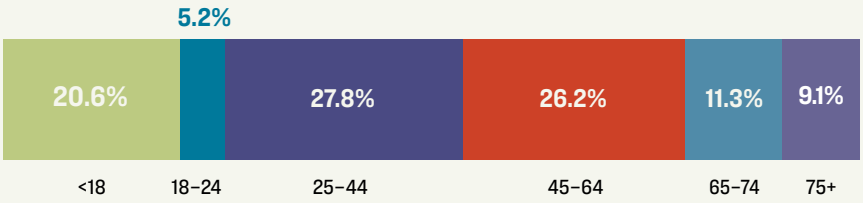
ZIP Codes: 19114, 19115, 19116, 19154

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

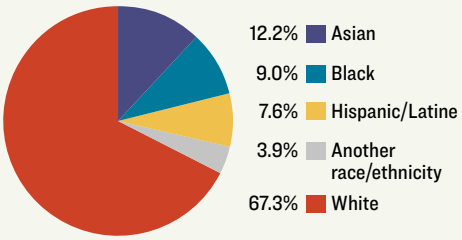


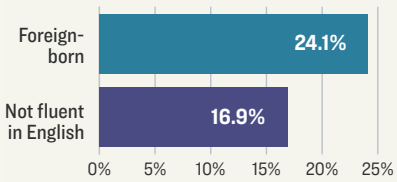
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

135,125

MEDIAN HOUSEHOLD INCOME

$76,469

EDUCATIONAL ATTAINMENT

35.6% High school as highest education level

PEOPLE WITH DISABILITIES

17.1%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Far Northeast Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,171.5	953.0
	Life expectancy: Female (in years)	79.7	77.1
	Life expectancy: Male (in years)	74.1	70.4
	Years of potential life lost before 75	10,111	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.6%	32.4%
	Diabetes prevalence	12.2%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	220.0	301.0
	Hypertension prevalence	30.4%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	45.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,119.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	45.9	68.0
	Major cancer incidence rate (per 100,000)*	313.0	218.9
	Major cancer mortality rate (per 100,000)*	88.8	69.4
	Colorectal cancer screening (adults age 45-75)	69.4%	66.7%
	Mammography screening (women age 50-74)	78.8%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	873.7	716.1
	Infant mortality rate (per 1,000 live births)	1.9	6.6
	Percent low birthweight births out of live births	8.4%	11.4%
	Percent preterm births out of live births	10.4%	11.2%
	Child Opportunity Index**	37.1	25.4
BEHAVIORAL HEALTH	Adult binge drinking	19.1%	18.9%
	Adult smoking	14.9%	16.2%
	Drug overdose mortality rate (per 100,000)	49.6	75.7
	Opioid-related hospitalization rate (per 100,000)	401.1	622.0
	Substance-related hospitalization rate (per 100,000)	486.2	1,017.9
	Poor mental health for 14+ days in past 30 days	16.2%	18.4%
	Suicide mortality rate (per 100,000)	12.6	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,878.0	1,929.0
	Homicide mortality rate (per 100,000)	8.9	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	16.2%	26.7%
	Children <19 years with public insurance	43.6%	61.5%
	Population without insurance	5.7%	7.3%
	Children <19 years without insurance	3.5%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	10.3%	22.1%
	Children <18 years in poverty	11.9%	27.0%
	Adults 19-64 years unemployed	4.7%	8.0%
	Householders living alone who are 65+ years	32.2%	36.9%
	Households receiving SNAP benefits	17.1%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	14.5%	19.3%
	Vacant housing units	4.1%	9.8%
	Single parent households	30.6%	48.0%
	Commute greater than 60 minutes	14.2%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 73

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Age-related illnesses
- Heart conditions
- Mental health

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Intellectual / developmental disabilities
- Abuse or neglect

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Affordable healthy foods
- Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Scheduling problems (such as health services not open when available)
- Health insurance is not accepted

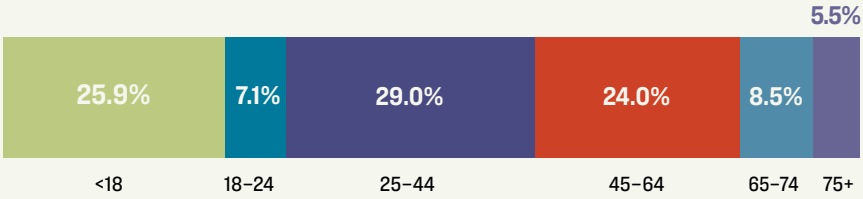
Lower Northeast Philadelphia

ZIP Codes: 19111, 19135, 19136, 19137, 19149, 19152

This community is served by:

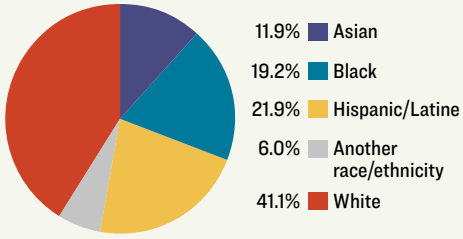
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

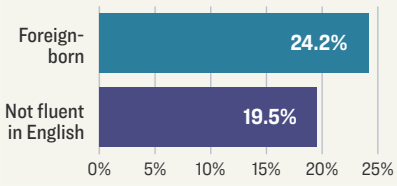
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

239,850

MEDIAN HOUSEHOLD INCOME

$58,399

EDUCATIONAL ATTAINMENT

37.6% High school as highest education level

PEOPLE WITH DISABILITIES

18.9%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Lower Northeast Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	943.5	953.0
	Life expectancy: Female (in years)	77.4	77.1
	Life expectancy: Male (in years)	71.0	70.4
	Years of potential life lost before 75	24,192	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.0%	32.4%
	Diabetes prevalence	13.4%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	364.0	301.0
	Hypertension prevalence	30.9%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	69.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,511.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	57.5	68.0
	Major cancer incidence rate (per 100,000)*	221.4	218.9
	Major cancer mortality rate (per 100,000)*	64.6	69.4
	Colorectal cancer screening (adults age 45-75)	62.2%	66.7%
	Mammography screening (women age 50-74)	76.0%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	2,354.3	716.1
	Infant mortality rate (per 1,000 live births)	5.2	6.6
	Percent low birthweight births out of live births	9.3%	11.4%
	Percent preterm births out of live births	9.3%	11.2%
	Child Opportunity Index**	20.1	25.4
BEHAVIORAL HEALTH	Adult binge drinking	18.7%	18.9%
	Adult smoking	18.8%	16.2%
	Drug overdose mortality rate (per 100,000)	75.5	75.7
	Opioid-related hospitalization rate (per 100,000)	527.8	622.0
	Substance-related hospitalization rate (per 100,000)	684.6	1,017.9
	Poor mental health for 14+ days in past 30 days	19.0%	18.4%
	Suicide mortality rate (per 100,000)	12.9	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,081.0	1,929.0
	Homicide mortality rate (per 100,000)	20.4	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	28.6%	26.7%
	Children <19 years with public insurance	62.0%	61.5%
	Population without insurance	9.2%	7.3%
	Children <19 years without insurance	5.2%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	18.9%	22.1%
	Children <18 years in poverty	25.2%	27.0%
	Adults 19-64 years unemployed	8.6%	8.0%
	Householders living alone who are 65+ years	30.7%	36.9%
	Households receiving SNAP benefits	37.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	18.1%	19.3%
	Vacant housing units	5.7%	9.8%
	Single parent households	51.1%	48.0%
	Commute greater than 60 minutes	15.8%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 134

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Chronic pain and pain management

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Drug use

Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Health insurance is not accepted

Transportation (getting to and from doctor's visits and appointments)

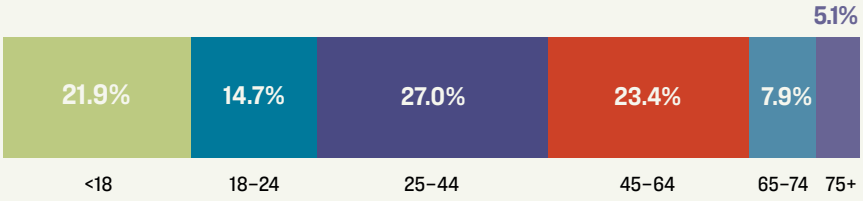
North Philadelphia-East

ZIP Codes: 19122, 19133, 19140

This community is served by:

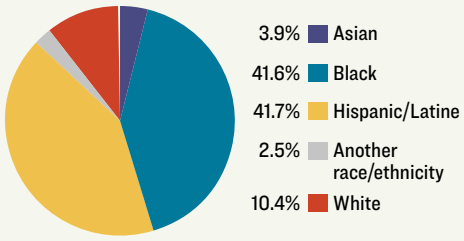
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

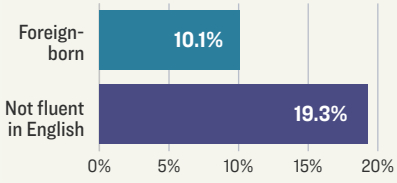
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

102,536

MEDIAN HOUSEHOLD INCOME

$38,555

EDUCATIONAL ATTAINMENT

37.1% High school as highest education level

PEOPLE WITH DISABILITIES

32.5%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	North Philadelphia-East	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,034.8	953.0
	Life expectancy: Female (in years)	76.5	77.1
	Life expectancy: Male (in years)	65.7	70.4
	Years of potential life lost before 75	13,660	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	38.8%	32.4%
	Diabetes prevalence	18.0%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	631.0	301.0
	Hypertension prevalence	33.8%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	162.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,553.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	84.8	68.0
	Major cancer incidence rate (per 100,000)*	187.3	218.9
	Major cancer mortality rate (per 100,000)*	59.5	69.4
	Colorectal cancer screening (adults age 45-75)	57.8%	66.7%
	Mammography screening (women age 50-74)	74.8%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	6,287.1	716.1
	Infant mortality rate (per 1,000 live births)	9.0	6.6
	Percent low birthweight births out of live births	14.3%	11.4%
	Percent preterm births out of live births	13.7%	11.2%
	Child Opportunity Index**	9.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	16.9%	18.9%
	Adult smoking	22.1%	16.2%
	Drug overdose mortality rate (per 100,000)	125.8	75.7
	Opioid-related hospitalization rate (per 100,000)	848.5	622.0
	Substance-related hospitalization rate (per 100,000)	1,550.7	1,017.9
	Poor mental health for 14+ days in past 30 days	23.1%	18.4%
	Suicide mortality rate (per 100,000)	11.7	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,244.0	1,929.0
	Homicide mortality rate (per 100,000)	53.6	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	46.0%	26.7%
	Children <19 years with public insurance	74.2%	61.5%
	Population without insurance	10.5%	7.3%
	Children <19 years without insurance	4.0%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	36.5%	22.1%
	Children <18 years in poverty	48.5%	27.0%
	Adults 19-64 years unemployed	12.4%	8.0%
	Householders living alone who are 65+ years	30.5%	36.9%
	Households receiving SNAP benefits	50.9%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	23.6%	19.3%
	Vacant housing units	12.1%	9.8%
	Single parent households	66.6%	48.0%
	Commute greater than 60 minutes	15.4%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 74

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Heart conditions

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Alcohol use

Anxiety

Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Abuse or neglect

Violence

Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Loneliness

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Good paying jobs

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Fear (such as fear of doctors or not ready to discuss a health problem)

Transportation (getting to and from doctor's visits and appointments)

No health insurance

North Philadelphia-West

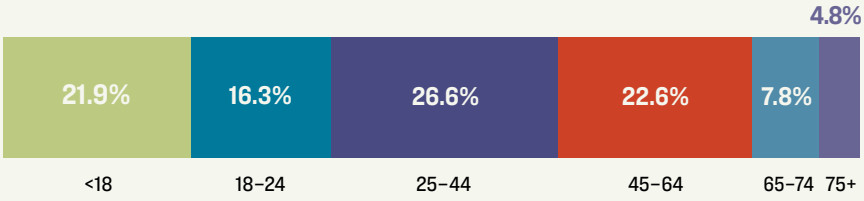
ZIP Codes: 19121, 19132

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

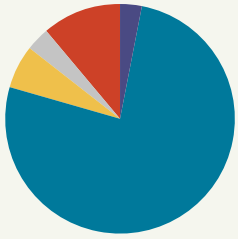
SOCIAL VULNERABILITY INDEX (SVI)

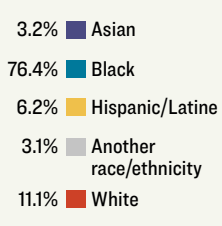
AGE DISTRIBUTION

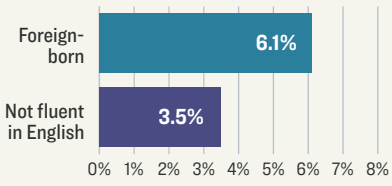


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

70,111

MEDIAN HOUSEHOLD INCOME

$33,817

EDUCATIONAL ATTAINMENT

37.8% High school as highest education level

PEOPLE WITH DISABILITIES

25.6%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	North Philadelphia-West	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,270.8	953.0
	Life expectancy: Female (in years)	71.4	77.1
	Life expectancy: Male (in years)	62.5	70.4
	Years of potential life lost before 75	11,777	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	40.1%	32.4%
	Diabetes prevalence	17.5%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	717.0	301.0
	Hypertension prevalence	37.7%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	197.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,963.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	122.7	68.0
	Major cancer incidence rate (per 100,000)*	225.4	218.9
	Major cancer mortality rate (per 100,000)*	87.0	69.4
	Colorectal cancer screening (adults age 45-75)	64.0%	66.7%
	Mammography screening (women age 50-74)	78.4%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	6,403.2	716.1
	Infant mortality rate (per 1,000 live births)	15.6	6.6
	Percent low birthweight births out of live births	16.4%	11.4%
	Percent preterm births out of live births	15.6%	11.2%
	Child Opportunity Index**	8.8	25.4
BEHAVIORAL HEALTH	Adult binge drinking	15.6%	18.9%
	Adult smoking	22.1%	16.2%
	Drug overdose mortality rate (per 100,000)	122.7	75.7
	Opioid-related hospitalization rate (per 100,000)	747.4	622.0
	Substance-related hospitalization rate (per 100,000)	1,700.2	1,017.9
	Poor mental health for 14+ days in past 30 days	23.3%	18.4%
	Suicide mortality rate (per 100,000)	4.3	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,991.0	1,929.0
	Homicide mortality rate (per 100,000)	67.0	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	40.6%	26.7%
	Children <19 years with public insurance	77.5%	61.5%
	Population without insurance	6.6%	7.3%
	Children <19 years without insurance	5.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	36.7%	22.1%
	Children <18 years in poverty	49.5%	27.0%
	Adults 19-64 years unemployed	14.7%	8.0%
	Householders living alone who are 65+ years	48.0%	36.9%
	Households receiving SNAP benefits	44.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	26.8%	19.3%
	Vacant housing units	18.4%	9.8%
	Single parent households	84.0%	48.0%
	Commute greater than 60 minutes	16.1%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 62

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Diabetes and highblood sugar

Violence

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Alcohol use

Anxiety

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Abuse or neglect

Mental health

Violence

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Drug use

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Good schools

Clean outdoor environment

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

No health insurance

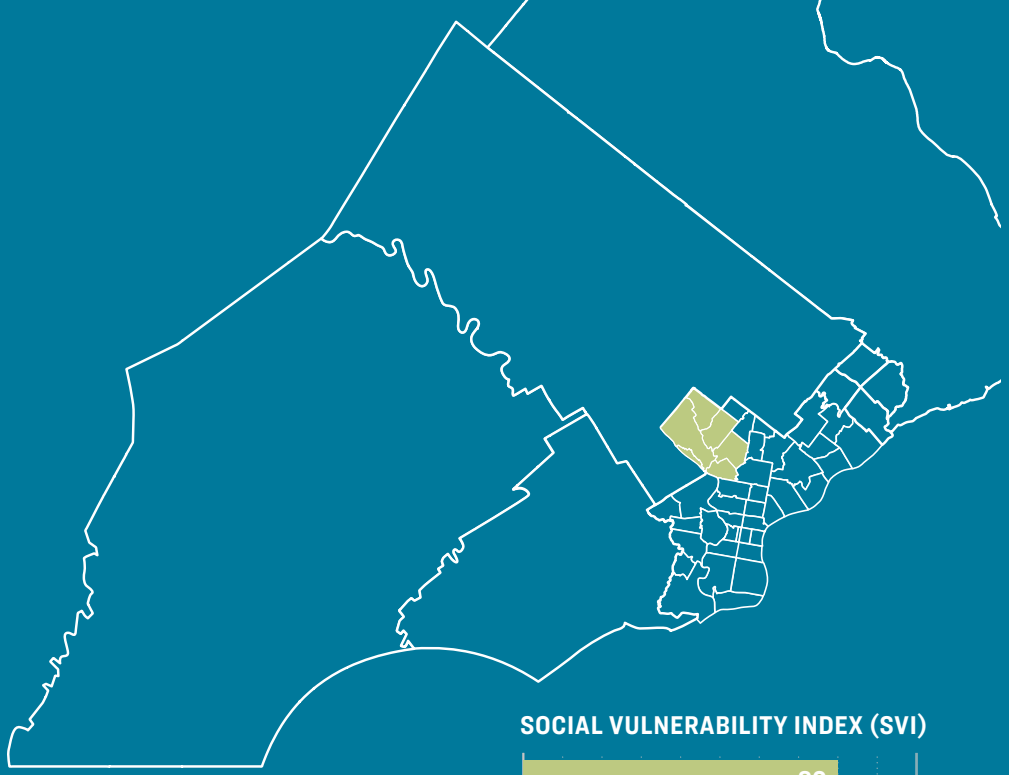
Transportation (getting to and from doctor's visits and appointments)

Northwest Philadelphia

ZIP Codes: 19118, 19119, 19127, 19128, 19129, 19144

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital



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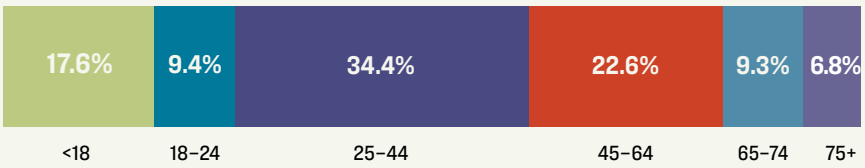
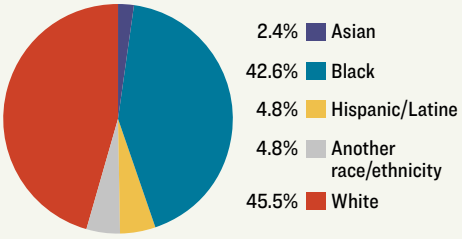
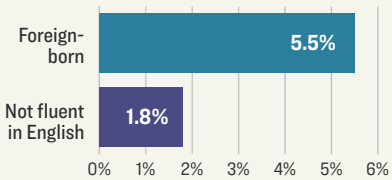


SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

142,506

MEDIAN HOUSEHOLD INCOME

$74,333

EDUCATIONAL ATTAINMENT

20.5% High school as highest education level

PEOPLE WITH DISABILITIES

18.2%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Northwest Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	884.9	953.0
	Life expectancy: Female (in years)	79.6	77.1
	Life expectancy: Male (in years)	72.5	70.4
	Years of potential life lost before 75	11,856	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.0%	32.4%
	Diabetes prevalence	10.7%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	337.0	301.0
	Hypertension prevalence	28.2%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	89.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,410.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	59.6	68.0
	Major cancer incidence rate (per 100,000)*	209.8	218.9
	Major cancer mortality rate (per 100,000)*	60.3	69.4
	Colorectal cancer screening (adults age 45-75)	72.1%	66.7%
	Mammography screening (women age 50-74)	82.1%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	2,113.0	716.1
	Infant mortality rate (per 1,000 live births)	3.2	6.6
	Percent low birthweight births out of live births	10.1%	11.4%
	Percent preterm births out of live births	9.1%	11.2%
	Child Opportunity Index**	39.9	25.4
BEHAVIORAL HEALTH	Adult binge drinking	21.3%	18.9%
	Adult smoking	11.8%	16.2%
	Drug overdose mortality rate (per 100,000)	44.2	75.7
	Opioid-related hospitalization rate (per 100,000)	747.4	622.0
	Substance-related hospitalization rate (per 100,000)	1,700.2	1,017.9
	Poor mental health for 14+ days in past 30 days	16.3%	18.4%
	Suicide mortality rate (per 100,000)	11.2	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,991.0	1,929.0
	Homicide mortality rate (per 100,000)	30.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	18.2%	26.7%
	Children <19 years with public insurance	45.9%	61.5%
	Population without insurance	3.8%	7.3%
	Children <19 years without insurance	2.3%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	14.4%	22.1%
	Children <18 years in poverty	15.9%	27.0%
	Adults 19-64 years unemployed	6.7%	8.0%
	Householders living alone who are 65+ years	38.3%	36.9%
	Households receiving SNAP benefits	19.0%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	16.1%	19.3%
	Vacant housing units	7.6%	9.8%
	Single parent households	48.6%	48.0%
	Commute greater than 60 minutes	13.4%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 103

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Diabetes and high blood sugar

Mental health

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Alcohol use

Drug use

Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Intellectual / developmental disabilities

Injuries

Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Depression

Anxiety

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Good paying jobs

Affordable housing

Substance use services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

Health insurance is not accepted

River Wards

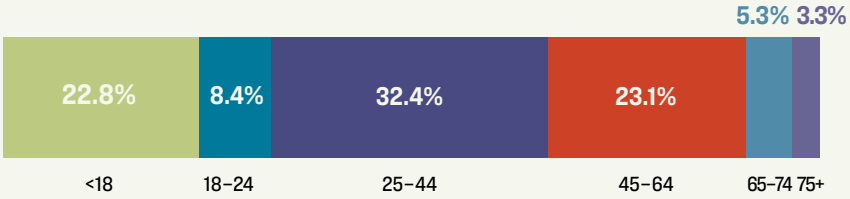
ZIP Codes: 19124, 19125, 19134

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

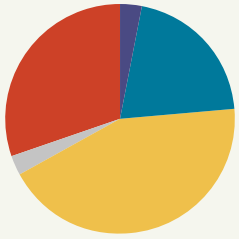
SOCIAL VULNERABILITY INDEX (SVI)

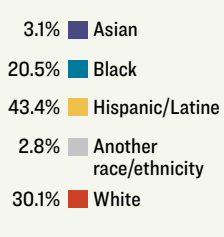
AGE DISTRIBUTION

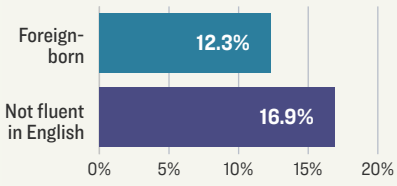


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

157,749

MEDIAN HOUSEHOLD INCOME

$57,816

EDUCATIONAL ATTAINMENT

35.9% High school as highest education level

PEOPLE WITH DISABILITIES

27.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Accidental poisoning** (including unintentional drug or alcohol related use)
3. **Cancer**

SUMMARY HEALTH MEASURES

Category	Measure	River Wards	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	843.1	953.0
	Life expectancy: Female (in years)	74.4	77.1
	Life expectancy: Male (in years)	67.5	70.4
	Years of potential life lost before 75	21,612	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	34.8%	32.4%
	Diabetes prevalence	13.5%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	508.0	301.0
	Hypertension prevalence	28.4%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	86.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,214.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	87.5	68.0
	Major cancer incidence rate (per 100,000)*	188.9	218.9
	Major cancer mortality rate (per 100,000)*	56.4	69.4
	Colorectal cancer screening (adults age 45-75)	59.0%	66.7%
	Mammography screening (women age 50-74)	74.9%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,914.9	716.1
	Infant mortality rate (per 1,000 live births)	9.1	6.6
	Percent low birthweight births out of live births	10.8%	11.4%
	Percent preterm births out of live births	11.4%	11.2%
	Child Opportunity Index**	14.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	20.3%	18.9%
	Adult smoking	19.8%	16.2%
	Drug overdose mortality rate (per 100,000)	119.8	75.7
	Opioid-related hospitalization rate (per 100,000)	1699.5	622.0
	Substance-related hospitalization rate (per 100,000)	2,188.3	1,017.9
	Poor mental health for 14+ days in past 30 days	20.5%	18.4%
	Suicide mortality rate (per 100,000)	13.3	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,736.0	1,929.0
	Homicide mortality rate (per 100,000)	41.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	37.6%	26.7%
	Children <19 years with public insurance	74.5%	61.5%
	Population without insurance	8.9%	7.3%
	Children <19 years without insurance	4.6%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	31.9%	22.1%
	Children <18 years in poverty	45.9%	27.0%
	Adults 19-64 years unemployed	6.7%	8.0%
	Householders living alone who are 65+ years	36.2%	36.9%
	Households receiving SNAP benefits	40.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	20.6%	19.3%
	Vacant housing units	9.0%	9.8%
	Single parent households	68.7%	48.0%
	Commute greater than 60 minutes	11.5%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

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COMMUNITY SURVEY

Number of Respondents: 112

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Substance use

Mental health

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Drug use

Alcohol use

Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Blood diseases (such as lead poisoning, anemia, and sickle cell)

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Depression

Drug use

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Clean outdoor environment

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

No health insurance

Health insurance is not accepted

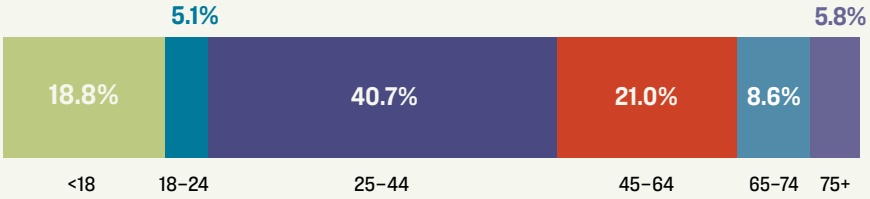
South Philadelphia-East

ZIP Codes: 19147, 19148

This community is served by:

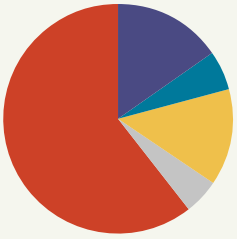
- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Penn Medicine
- Thomas Jefferson University Hospital
- Wills Eye Hospital

AGE DISTRIBUTION

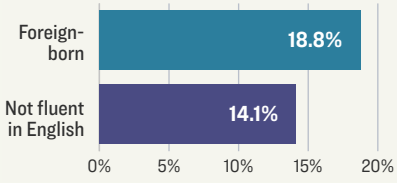


SEX

RACE/ETHNICITY/LANGUAGE



15.4% Asian
5.7% Black
13.5% Hispanic/Latine
5.0% Another race/ethnicity
60.5% White



POPULATION

89,242

MEDIAN HOUSEHOLD INCOME

$91,809

EDUCATIONAL ATTAINMENT

21.1% High school as highest education level

PEOPLE WITH DISABILITIES

14.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	South Philadelphia-East	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	828.6	953.0
	Life expectancy: Female (in years)	79.0	77.1
	Life expectancy: Male (in years)	72.8	70.4
	Years of potential life lost before 75	6,991	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	26.5%	32.4%
	Diabetes prevalence	9.9%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	272.0	301.0
	Hypertension prevalence	24.9%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	43.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,062.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	36.9	68.0
	Major cancer incidence rate (per 100,000)*	219.2	218.9
	Major cancer mortality rate (per 100,000)*	74.9	69.4
	Colorectal cancer screening (adults age 45-75)	66.7%	66.7%
	Mammography screening (women age 50-74)	78.9%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	1,698.1	716.1
	Infant mortality rate (per 1,000 live births)	2.7	6.6
	Percent low birthweight births out of live births	7.3%	11.4%
	Percent preterm births out of live births	8.5%	11.2%
	Child Opportunity Index**	52.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	21.7%	18.9%
	Adult smoking	13.3%	16.2%
	Drug overdose mortality rate (per 100,000)	52.6	75.7
	Opioid-related hospitalization rate (per 100,000)	463.0	622.0
	Substance-related hospitalization rate (per 100,000)	630.7	1,017.9
	Poor mental health for 14+ days in past 30 days	16.2%	18.4%
	Suicide mortality rate (per 100,000)	16.8	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,356.0	1,929.0
	Homicide mortality rate (per 100,000)	19.0	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	14.9%	26.7%
	Children <19 years with public insurance	44.8%	61.5%
	Population without insurance	8.3%	7.3%
	Children <19 years without insurance	4.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	14.8%	22.1%
	Children <18 years in poverty	20.8%	27.0%
	Adults 19-64 years unemployed	5.9%	8.0%
	Householders living alone who are 65+ years	35.0%	36.9%
	Households receiving SNAP benefits	16.7%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	14.2%	19.3%
	Vacant housing units	8.2%	9.8%
	Single parent households	33.4%	48.0%
	Commute greater than 60 minutes	9.7%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 106

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Substance use

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Violence

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Clean outdoor environment

Substance use services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Language barriers

No health insurance

South Philadelphia-West

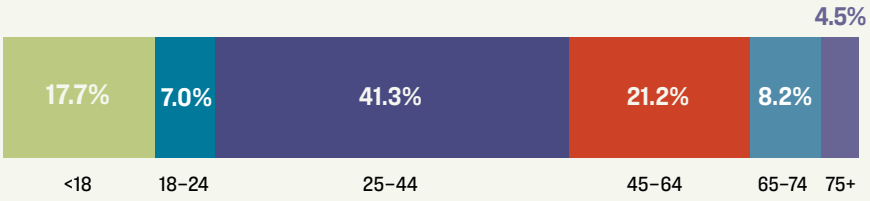
ZIP Codes: 19145, 19146

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Penn Medicine
- Thomas Jefferson University Hospital
- Wills Eye Hospital

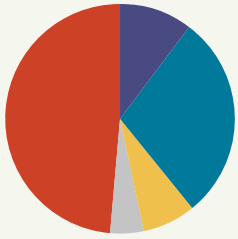
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

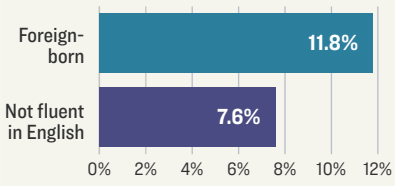


SEX

RACE/ETHNICITY/LANGUAGE



10.5% Asian
28.9% Black
7.5% Hispanic/Latine
4.6% Another race/ethnicity
48.5% White



POPULATION

84,410

MEDIAN HOUSEHOLD INCOME

$84,996

EDUCATIONAL ATTAINMENT

24.0% High school as highest education level

PEOPLE WITH DISABILITIES

15.2%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	South Philadelphia-West	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	907.5	953.0
	Life expectancy: Female (in years)	74.9	77.1
	Life expectancy: Male (in years)	71.9	70.4
	Years of potential life lost before 75	8,231	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.1%	32.4%
	Diabetes prevalence	10.9%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	374.0	301.0
	Hypertension prevalence	27.5%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	70.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,606.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	69.9	68.0
	Major cancer incidence rate (per 100,000)*	252.3	218.9
	Major cancer mortality rate (per 100,000)*	77.0	69.4
	Colorectal cancer screening (adults age 45-75)	68.3%	66.7%
	Mammography screening (women age 50-74)	80.9%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,292.4	716.1
	Infant mortality rate (per 1,000 live births)	5.4	6.6
	Percent low birthweight births out of live births	8.6%	11.4%
	Percent preterm births out of live births	8.4%	11.2%
	Child Opportunity Index**	40.3	25.4
BEHAVIORAL HEALTH	Adult binge drinking	21.0%	18.9%
	Adult smoking	13.8%	16.2%
	Drug overdose mortality rate (per 100,000)	61.6	75.7
	Opioid-related hospitalization rate (per 100,000)	588.0	622.0
	Substance-related hospitalization rate (per 100,000)	888.5	1,017.9
	Poor mental health for 14+ days in past 30 days	17.0%	18.4%
	Suicide mortality rate (per 100,000)	11.8	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,503.0	1,929.0
	Homicide mortality rate (per 100,000)	22.5	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	17.5%	26.7%
	Children <19 years with public insurance	45.0%	61.5%
	Population without insurance	5.7%	7.3%
	Children <19 years without insurance	3.3%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	15.4%	22.1%
	Children <18 years in poverty	22.6%	27.0%
	Adults 19-64 years unemployed	7.9%	8.0%
	Householders living alone who are 65+ years	37.7%	36.9%
	Households receiving SNAP benefits	19.7%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	14.4%	19.3%
	Vacant housing units	11.5%	9.8%
	Single parent households	45.6%	48.0%
	Commute greater than 60 minutes	10.0%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 82

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Diabetes and high blood sugar

Substance use

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Violence

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

Fear (such as fear of doctors or not ready to discuss a health problem)

Southwest Philadelphia

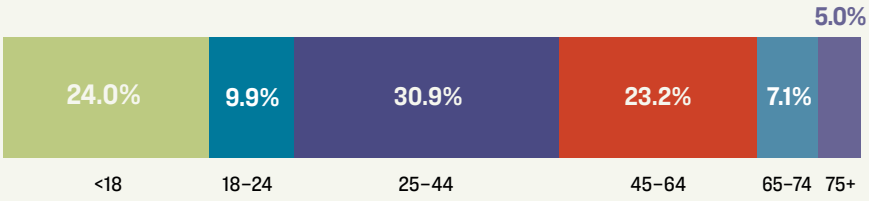
ZIP Codes: 19142, 19143, 19153

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Penn Medicine
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

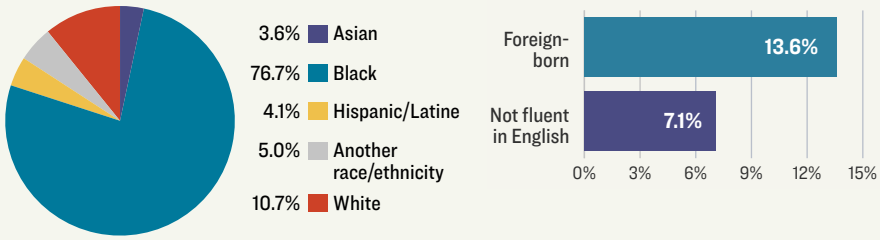
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

106,427

MEDIAN HOUSEHOLD INCOME

$47,309

EDUCATIONAL ATTAINMENT

35.1% High school as highest education level

PEOPLE WITH DISABILITIES

20.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Southwest Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,010.1	953.0
	Life expectancy: Female (in years)	75.3	77.1
	Life expectancy: Male (in years)	68.1	70.4
	Years of potential life lost before 75	12,098	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	39.3%	32.4%
	Diabetes prevalence	17.9%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	584.0	301.0
	Hypertension prevalence	39.1%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	173.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,364.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	89.3	68.0
	Major cancer incidence rate (per 100,000)*	187.0	218.9
	Major cancer mortality rate (per 100,000)*	85.5	69.4
	Colorectal cancer screening (adults age 45-75)	64.7%	66.7%
	Mammography screening (women age 50-74)	78.8%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	4,630.9	716.1
	Infant mortality rate (per 1,000 live births)	5.3	6.6
	Percent low birthweight births out of live births	14.7%	11.4%
	Percent preterm births out of live births	13.5%	11.2%
	Child Opportunity Index**	14.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	15.1%	18.9%
	Adult smoking	20.5%	16.2%
	Drug overdose mortality rate (per 100,000)	66.7	75.7
	Opioid-related hospitalization rate (per 100,000)	492.4	622.0
	Substance-related hospitalization rate (per 100,000)	1,018.5	1,017.9
	Poor mental health for 14+ days in past 30 days	20.0%	18.4%
	Suicide mortality rate (per 100,000)	12.2	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,503.0	1,929.0
	Homicide mortality rate (per 100,000)	43.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	34.9%	26.7%
	Children <19 years with public insurance	68.2%	61.5%
	Population without insurance	7.2%	7.3%
	Children <19 years without insurance	4.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	26.4%	22.1%
	Children <18 years in poverty	33.2%	27.0%
	Adults 19-64 years unemployed	10.9%	8.0%
	Householders living alone who are 65+ years	41.8%	36.9%
	Households receiving SNAP benefits	34.5%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	23.8%	19.3%
	Vacant housing units	11.8%	9.8%
	Single parent households	66.1%	48.0%
	Commute greater than 60 minutes	15.7%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 117

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Diabetes and high blood sugar

Mental health

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Alcohol use

Depression

Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Violence

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Good paying jobs

Affordable housing

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

No health insurance

West Philadelphia

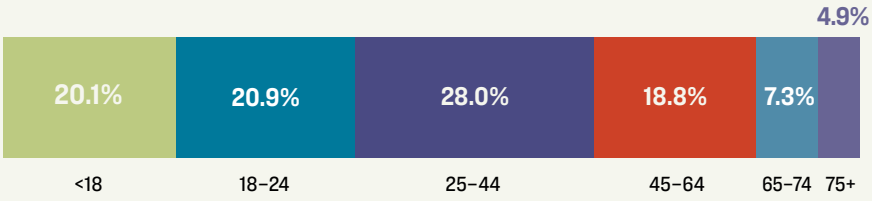
ZIP Codes: 19104, 19131, 19139, 19151

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Penn Medicine
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

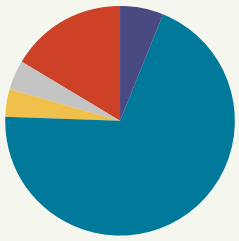
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

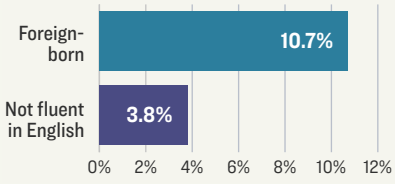


SEX

RACE/ETHNICITY/LANGUAGE



6.3% Asian
69.3% Black
4.0% Hispanic/Latine
4.2% Another race/ethnicity
16.2% White



POPULATION

177,389

MEDIAN HOUSEHOLD INCOME

$44,460

EDUCATIONAL ATTAINMENT

30.0% High school as highest education level

PEOPLE WITH DISABILITIES

20.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	West Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	958.9	953.0
	Life expectancy: Female (in years)	75.4	77.1
	Life expectancy: Male (in years)	68.5	70.4
	Years of potential life lost before 75	19,080	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	36.2%	32.4%
	Diabetes prevalence	15.4%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	540.0	301.0
	Hypertension prevalence	35.6%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	149.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,300.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	77.2	68.0
	Major cancer incidence rate (per 100,000)*	178.7	218.9
	Major cancer mortality rate (per 100,000)*	63.7	69.4
	Colorectal cancer screening (adults age 45-75)	67.0%	66.7%
	Mammography screening (women age 50-74)	80.3%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,929.4	716.1
	Infant mortality rate (per 1,000 live births)	14.4	6.6
	Percent low birthweight births out of live births	13.0%	11.4%
	Percent preterm births out of live births	13.0%	11.2%
	Child Opportunity Index**	17.0	25.4
BEHAVIORAL HEALTH	Adult binge drinking	16.4%	18.9%
	Adult smoking	17.5%	16.2%
	Drug overdose mortality rate (per 100,000)	63.7	75.7
	Opioid-related hospitalization rate (per 100,000)	437.5	622.0
	Substance-related hospitalization rate (per 100,000)	980.3	1,017.9
	Poor mental health for 14+ days in past 30 days	20.5%	18.4%
	Suicide mortality rate (per 100,000)	8.5	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,780.0	1,929.0
	Homicide mortality rate (per 100,000)	41.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	27.4%	26.7%
	Children <19 years with public insurance	58.9%	61.5%
	Population without insurance	6.2%	7.3%
	Children <19 years without insurance	2.9%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	26.6%	22.1%
	Children <18 years in poverty	34.1%	27.0%
	Adults 19-64 years unemployed	8.2%	8.0%
	Householders living alone who are 65+ years	46.1%	36.9%
	Households receiving SNAP benefits	29.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	25.2%	19.3%
	Vacant housing units	15.7%	9.8%
	Single parent households	73.2%	48.0%
	Commute greater than 60 minutes	12.6%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

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COMMUNITY SURVEY

Number of Respondents: 188

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Chronic pain and pain management
- Diabetes and high blood sugar
- Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Anxiety
- Alcohol use
- Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)
- Blood diseases (such as lead poisoning, anemia, and sickle cell)
- Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Good paying jobs
- Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Health insurance is not accepted
- Transportation (getting to and from doctor's visits and appointments)

PHILADELPHIA COUNTY
Neighborhood Perspectives

Far North Philadelphia

COMMUNITY ASSETS

Respondents spoke of support for one another by engaging in organized **physical fitness activities**, that also helped to foster a sense of community. “They’re like walking groups. Or you know, there’s groups of people they get together. To like foster community for people that may be new, or maybe new, to trying to live a healthier lifestyle…” Other community-based recreational activities and resources, including bike lanes, were valued as well. “The library near me offers nutrition workshops at times, or workshops that touch on health and wellness. And they’re free, so if I can take advantage of it, I try to.”

One community member acknowledged the **incentives** (e.g., gift cards, movie screenings) provided by her health insurance, although she “NEVER” took advantage of them.

COMMUNITY CHALLENGES

Work obligations—even on weekends—can make it hard to stay motivated to exercise or cook at home. One respondent spoke of limitations due to not having a car, especially when needing to grocery shop, and compared her experiences to her home country. “And one day I’d walk like a mile plus. And then one of the hottest days, carrying like 3 bags. And it was, it was hard.” **Public transportation** was not available.

- “And when we get to the healthcare system it’ll be the kind of the same issue, whereas in the country that I’m in, I go to one place, and all my doctors are like in two buildings next to each other. Whereas if I’m here and I had the same healthcare needs, I’d have to go to like all over the city to get the same.”

Healthcare barriers also included cost, particularly for residents with complicated health needs. “Access to specialists, and I’d be broke before I got halfway through.” There was also discussion of **mental health resources** being insufficient in the area. “I do know, in my neighborhood and surrounding areas mental health is not adequate, as it is in other zip codes, because I live in a zip code of low poverty is what they call it… things like that is not here.” Some residents complained of red tape, difficulty changing **insurance companies**, and complications with having to appeal bills with their health insurance companies. “It can be really, really messy.”

CHILDREN AND YOUTH

Community members agreed on the importance of having **activities** readily available for youth. Recent programming that youth have actively participated in include free ice skating, karate, and programming at the local library. Activities like this are perceived as significant protective factors against **criminal activity**. Yet these resources can be improved upon. “Some rec centers in philadelphia are trash.” Conversely, “…it can be complicated, based on where you’re at. But I’ve seen really nice recreation centers that may also be in unsafe zip codes. So that can be a problem, too. You’ve got this gem in your neighborhood, but you’re afraid to let your child walk to the recreation center.”

Concerns were raised about **neglected parks** and their abandoned renovations.

- “…we have a playground that was high on the rebuild at one point and somehow fell off. It’s not high on the list now, so I don’t know… The bathroom hasn’t worked since I’ve lived in the city… I think 30 years.”

OLDER ADULTS

Older adults need to be a part of the conversations about their **own well-being and their needs**.

- "I think one of the things that can really help support their population is like actually canvassing or like listening to what that group wants... I think a lot of times like it's easy to make assumptions."
- "If you're not affiliated with a church or a recreation center, there really isn't a lot for folks."

Resources and activities should reflect the **cultural preferences** of the community members that they are targeting.

- "...like my dad, he's in his seventies, and he loves line dancing as well... Like in my neighborhood there's a lot of people from the Caribbean and things like that. So getting together like maybe cooking classes. Or, you know, like we mentioned, like the line dancing."

Some concerns about older adults included their **limited access to transportation**, subsequently having to walk in areas that are not safe, taking the bus at night, and isolation. Regarding one recreation center, "It's not like it's in front of a bus or a trolley route like you really need to drive. So, I guess accessibility is a thing as well..."

ADDITIONAL POPULATIONS

People with disabilities face **mobility and accessibility** challenges due to structural issues in their physical environments.

- "But we kind of realized that... people that... have walking issues where they use like any kind of like motorized [chairs] or vehicles, or even people that use... walking sticks and things of that nature. There were so many things that are deemed accessible because of distance. But when you look at, okay, like are the curbs level...? Can a wheelchair come up on this ramp...?"

Attitudinal and structural barriers in healthcare spaces can limit access and effective service provision for patients with disabilities.

- "And there's also the issue, too, again, like going back to the special needs community like, I've had issues with my son when he was younger where it's like, okay, we set the appointment to get the blood drawn. But you know he's in such a frenzy because the lights are so bright. And you know, I think like there's just not a lot of accommodations for all walks of life. So sometimes it seems like the access is there but when you really get to these appointments, or you're trying to get to these appointments that's when there are all these other barriers."

Members of **ethnic minority groups** shared how shame and stigma can deter people from seeking assistance with their mental health.

- "A lot of different communities [won't be] seen going into going to a mental health setting. Both in all the Asian cultures we dealt with, but [also] in the African American community."

Respondents identified a need for mental health support among **LGBTQ+ residents**, suggesting webinars as a method of information-sharing. Stigma may also discourage their pursuit of health-related services because of a fear of being judged at doctors' offices.

- "Webinars that can speak on the LGBTQ community, which I see there's a great need for mental health services in my community, because of being afraid to be who they are. And it causes suicidal ideation."

TRUST AND COMMUNICATIONS

Regarding their **sense of trust** of healthcare providers, one community member responded skeptically, lacking faith in providers' cultural sensitivity. But trust can also be fostered after navigating a health system, with positive experiences, over a long period of time.

- "I feel like my doctor is cool as an individual. But if I'm being honest like, I don't really have a lot of trust in a healthcare system overall. Just from personal experience. Studying history as an African American woman, and what the medical establishment has done in terms of... our reproductive rights, and you know, experimentation on African Americans in general. But I will say also that you know medical malpractice is one of the leading causes of death in the country, too. So, you know, I just think that, like our medical system, really needs to be revamped."
- "I think there's a discrepancy between the way uninsured patients are treated and patients with insurance. I remember my younger days when I was a struggling student, and I was treated like a number. But there's a lot of people in this country who are against the idea of universal healthcare."
- "... I'm at a stage in my life where I actually like the doctors that I have. And I trust them. So, with that said, I have had virtual meetings. I see a nutritionist on Zoom, with the hospital that I choose to see, for most of my appointments."

ADDITIONAL CONSIDERATIONS

Children and families addressing **neurodivergence** faced challenges with trying to find sufficient community-based resources.

- "...we've been able to like reach a lot more families that have been affected by autism, and really any kind of developmental disability. But I've particularly noticed in this neighborhood that it's just something unaddressed in the three local elementary schools. There's so many autistic children that they've had to open autistic support classrooms in all the elementary schools around here. So, I'm like, so if you guys know, there's this many children with this issue, why are we not, you know, talking about it on a larger scale?"

Respondents shared concerns about having to sometimes wait months for medical appointments, especially when a specialist needs to be seen. **Long waits** in the emergency room, canceled appointments, and interruptions in continuity of care were also named as barriers to healthcare access.

- "I had to go sit in the emergency room, in which I ended up sitting there for five hours and they never called my name."
- "You would get a different dentist every time you went. So... every time you went you would... have a different plan for how to solve the major problems. So nothing ever really got solved because you know there wasn't any continuity in the care... you're sort of limited to going to somebody."

Some community members were still concerned about **COVID-19**. And one was familiar with Long COVID. "But from what I know about it, it's kind of like where you have perpetual COVID." Post-COVID, health services have improved, in part due to the convenience of telehealth.

SUGGESTED ACTIONS

Perhaps recreational programming that is geared toward the **whole family** will appeal to more community members.

- "I think parents are willing to drive their kids there and wait, or pick them up, depending on... what the circumstances are."

More **transparency** is needed from healthcare providers.

- "I would say, for like doctors to be more transparent when it comes to informed consent. Like when you're going through like different procedures and things like that. I think like a lot of things are kind of just especially if it's routine, they're kind of just like pushed on the general public."

Appointment-setting can be made easier, by allowing patients to do so virtually.

- "Being able to access and make appointments through a portal instead of having to go through a call center. I mean they have a portal that theoretically has that capability, but they don't have them."

North Philadelphia, East of Broad

COMMUNITY ASSETS

Recreational centers, such as the "Y" and health centers, were named as valuable community resources. **Public transportation** was described as "AWESOME" for the area. One respondent noted the presence of new "**senior buildings**" and related programming.

- "I'm going to say the local fitness centers... they're open to accepting the health insurance... so that helps."

COMMUNITY CHALLENGES

Limitations in access to health services were the prevailing topic of discussion around challenges. Doctors' offices closing early, limited proficiency across various languages among health providers, and an overall lack of cultural responsiveness were mentioned. For instance, French, Spanish, Arabic, and "different language(s) from Africa" are important. Additionally, respondents spoke of **poor customer service and bias** against certain consumers, especially those who lack self-advocacy. "...When people have substance abuse challenges or mental health challenges, they're treated differently and I really don't think that's fair... if a person is receiving substance abuse treatment when they go to the doctor and if they're in severe pain, they won't give them the full of the pain medication. And I've witnessed that myself..." there is a perceived lack of education among community members about **matters of mental health**, which may limit the pursuit of services. And some residents lamented **slow receipt of health benefits** and inadequate support for **homeless individuals**. "I want to say we're also lacking a lot of shelters. We don't have shelters." One respondent had trouble having her mother's prescription filled in Philadelphia but was able to find the medication in another county and for hundreds of dollars cheaper.

- "The big thing it was like I applied and then it was like for four months, I had no benefits at all. Because they said they didn't receive my information. They just took me off completely. I had nothing, no benefits, no income, no nothing, social security, everything was just like wiped out the whole thing. No medical, no nothing and it was like for four months and it was like the only saving grace was the senior building that I lived in and friends that I knew that helped me."
- "I've noticed with the health system... they want you to turn this paperwork on time, half the time when you get that letter, it arrives after the due date and then you're not aware that it was due. You know, back in the day they used to give you a call, they would be in the morning and sometimes you're calling this number constantly. No one answers the phone... it's like nobody is being held accountable for their actions, but yet they're penalizing the consumer in a sense."
- "...So lack of education and also cultural biases on the whole health care system itself and how mental health is looked at as something negative. So, I think there needs to be a lot more coverage on that and on the education of that."
- "...I think providers need to be more culturally responsive and competent when interacting with people because unfortunately some of them are still operating from the old medical model, old books 20 years ago. And unfortunately, a lot of them have a lot of biases and prejudice against people who are not caucasian."
- "The intake people, the people that greet you at the door, they're not nice... I'm always speaking up but if you don't have somebody there with any heart to speak up, they treat you like crap."

Neighborhood challenges were named, including the presence of **crime and lack of safety**, an abundance of **trash** on the streets, and **crumbling infrastructures**. "...Health-wise like there's asbestos in these schools and it affects these students' health and where they can't even show up to school anymore and they have to do online school. And it's kind of a challenge for parents, for families where they have to keep watch of those children and keep them." **Addiction-related homelessness** also contributed to feelings of being unsafe and evoked empathy among respondents.

- "Terrible sidewalks, terrible streets. It impedes good walkability, and also the lack of canopy, trees, to keep it from being so hot."

CHILDREN AND YOUTH

Gun violence in Philadelphia neighborhoods and schools were of great concern, personally impacting one respondent. "I've had three of my sons shot, the oldest one was murdered but I think that we have to do a better job at protecting our youth." The impact of **social media** was also discussed by a college student, as having a negative impact on mental health and being used to **cyberbully**. There is a need for **role models** for youth, as some can look to older adults who are setting poor examples. "For me, like I said, I grew up watching a lot of the old guys. I looked up to selling drugs and stuff so they made it seem cool. That plays a big factor on the kids today too, just trying to fit in."

Respondents expressed gratefulness for the availability of meals in schools that are of good quality, especially for those students who do not have reliable, **healthy sources of food** at home and in their neighborhoods. Perhaps there is also a need for **parenting support**, as respondents discussed issues around discipline and structure in the home. "I look at the children now, coming home 10:00 o'clock or 11:00 o'clock... a baby in the stroller and she was holding one waiting for a bus. Those kids should have been washed and in bed by 8:00 o'clock." There is also a concern about families' knowledge of health issues and insufficient **health education programs** on mental and physical health matters. Children are using and abusing stronger drugs at younger ages.

Extracurricular, summer, and job **programs for youth** and families are present but underutilized. "So, the plus is we have programs available, but some of our kids aren't buying into the program that's available."

OLDER ADULTS

Recreational programs, such as Tai Chi, are a necessary resource. But not all programs are affordable, covered by health insurance, or available by public transportation. **Public transportation** to doctor visits is also needed. Another issue of health access is directly related to **language barriers** and disproportionately impacts older adults. "...especially for the Latino community in this area, the older generations, a lot of them don't even speak English."

- "Having a way for seniors to be able to communicate abuse or any type of mistreatment because they're definitely a vulnerable population."

Food banks provide necessary access to sustenance, but the quality of the food is sometimes questionable. "...a lot of places that's giving food to seniors and to even the young, but I feel like... some of the foods that they're getting that are not necessarily healthy foods. It's like, yeah, it's free but it's bad."

Older adults, who are also **immigrants**, face additional barriers related to accessing personal records from their countries of origin, which can delay qualification for different types of health and social services. "...getting their documentation, getting their birth certificate, trying to run down a baptismal certificate to say this is who I am trying to get school records. so, seniors need a lot of help with that..."

ADDITIONAL POPULATIONS

Respondents raised concerns about the **LGBTQ+** population, **homelessness**, **substance use**, and being poorly treated in their community. Regarding those experiencing homelessness and substance use, "...they get moved from one place, then they go to another. it seems like the problem is not being solved." Gentrification was named as a related problem, because "there's all the people that are being pushed out of the area so that is a big health issue also..." and it's due to their **disadvantaged socioeconomic backgrounds**.

- "Same sexual preference. Sometimes those group of folks are mistreated... I think there needs to be some more training for the providers, that access to health care... shouldn't be based on someone's sexuality."
- "...racism is really big in the Latino community."
- "To add to that I actually heard someone homeless that said that they had to really commit a crime so they could get locked up so that they would have access to the insurance."

Medical deportation was identified as a violation of rights and barrier for immigrants who are undocumented and hospitalized, which can deter them from seeking necessary treatment.

ADDITIONAL CONSIDERATIONS

Accessing **dental care** can be difficult, depending on the type of coverage. "...try to find a dentist and that's a real big one. My mom's been trying to find an insurance company for the past two years. Every time she finds one, 'oh we don't take that card no more.' So, that's a challenge... no warning." A college student spoke of being covered under her parents' health insurance, but not their dental insurance. "Based off of my parents' insurance, I get everything but I don't get dental and they said like, you have to find that on your own. So, now I'm wondering should I transfer for my own insurance?"

The limited availability of general health **appointments** can lead to worsening health conditions. "So, if you need something like right away, sometimes you don't get an appointment until maybe four months down the line, five months down the line and then the condition has gotten worse."

Regarding the concept of **trustworthiness** among health professionals, perspectives were generally negative. There's a lack of trust related to perceived biases against patients based on insurance type, concerns about being unethically motivated by incentives from pharmaceutical companies, and billing for unneeded services. This issue came up again regarding experimental treatments and feeling like a "GUINEA PIG."

- "For me personally I won't say I don't trust any of my doctors, but I get a second opinion."
- "But they're not telling you in the beginning what these side effects, what can happen to you and all of this. But it's like you're their Guinea pig and you're helping and putting money in your pockets and they're not helping you."

Post-COVID experiences in healthcare were varied, with some community members preferring in-person services and others appreciating the convenience and resource-savings of virtual appointments. Comfort with telehealth services was positively correlated with **technology** savviness. COVID-19 is still concerning for some, it "did not go away." And respondents believe that people should still take "common sense" precautions.

- "What I don't like is the virtual doctor appointment. How they want to diagnose you over the...phone. Make it make sense... Don't ask me to go check my lab test and all this stuff."
- "I do appreciate for like the follow up appointments, those being virtual because sometimes when you have to go in person... it's almost like those meetings where... you could have just sent this in an email. So, that's a plus for the virtual being able to do like the follow up appointments."
- "Well, for me COVID it took a family member from me and my mother had it. So, I don't think we're done with it."
- "COVID doesn't worry me as much as crime does. The crime that's going on to it affects me worse than thinking of any disease."

SUGGESTED ACTIONS

Some suggestions offered to improve community health and conditions included **expanded doctors' visits** through evenings and weekends, **cultural sensitivity**, more **affordable housing** options, and fully covered **universal healthcare**. Medical **social worker**s were recommended for patients to have a "person talk to them one on one," along with **mentors** for youth. Youth programming should also be informed in part by input from youth themselves. Lastly, patients could benefit from clearer information regarding the explanation of benefits and **costs** incurred.

- "So, nutritional education for parents to help those kids I think it is a priority and going back to what you were saying, peer pressure is a big thing."
- "What I would love to see sometimes when they come to the doctor. I would love to see drug education. I would love to see sexual education... I would love for providers besides having... a 800 number. I would love to see more behavioral services if needed for the child and the family when they come in to teach them."
- "So, I think we need better like role models out there—especially the men because the young men tend to follow older men..."
- "I know we don't say good touch, bad touch, anymore, but this is appropriate and this is not appropriate. And I think that providers can play a pivotal role in that because you can have a health educator."

North Philadelphia, West of Broad

COMMUNITY ASSETS

An **urgent care facility** was recently built in the area, although more would be helpful. "We recently had an urgent care that opened in the area we could have used, that we can use more urgent care centers in the area that people can actually get to, they can actually reach…" Some respondents also reflected on **positive healthcare experiences**.

- "I personally stay pretty healthy, because I'm able to get to the health resources that I need. I'm able to get there. So for myself and my family we stay pretty healthy."
- "I think the other amazing thing for the 21 and 32 ZIP code areas is that we have two public health centers… these health centers have accommodated the needs of generations of people in our communities."

Outdoor recreational spaces were valued, such as the nearby zoo, Fairmount Park, and the Schuylkill River. "…The playgrounds we have. I feel as though [we have] some of the better playgrounds in our neighborhood…" There's also a local reservoir that children in the community enjoy, and a track where **neighbors meet**. "…we put neighbor back in neighborhood…" Residents also share information with one another, such as upcoming health screenings and yoga classes.

- "Fortunately, like on my block, there's still a lot of folks who've been there generations, and we still tight, we still look out for each other."
- "I do like the community gardens that that develop. I like the community green spaces that begin to develop in the different neighborhoods where people can learn how to grow food…"

Food pantries providing boxes of food have proven beneficial to community members, especially older adults. "…we also have agencies throughout the neighborhood that will supply food at certain times during the month…"

COMMUNITY CHALLENGES

Community members desired easy **access to health centers** that were local to them, but they're no longer available in their neighborhood. Health centers and doctor visits required **public transportation**, which was deemed inconvenient.

Financial limitations made it difficult to prioritize **healthy foods**, even though the desire was there, and local supermarkets were described as subpar. **Environmental conditions** were also described as unfavorable.

- "…just the financial wherewithal to have the right kinds of food to eat. And the environment around us sometimes is just not healthy…There are not as many trees as there are in some other areas of the city where the area was planned with trees."
- "I have vouchers from PCA for vegetables and things of that nature, but we don't have anywhere around us where we can use those vouchers, we don't have a farm. We don't have a Produce Junction in our area. If we had something along those lines where we have access to healthier foods, maybe people would, I don't know, be healthier…"
- "You get a lot of old meats and frozen, you know, nothing fresh… generic brands!"

Distance was not the only barrier to adequate health care but **cost** as well. **Acquiring medication** was also difficult because pharmacies were rare in their area. Chain **pharmacy** stores used to be in the community, but sometimes didn't carry the prescription medications that were needed. "…a lot of times they didn't have the medicine that the patients need or the residents. So, it was a lot of negative things with the pharmacies."

- "I can simply say a lack of health insurance can be a barrier for sure."
- "I remember when we had many, many small family-owned pharmacies. Many of them were even Black-owned pharmacies…"

Unsafe neighborhoods contributed to poor mental health. And local **mental health** resources were either unavailable or not well known.

- "Just seeing what's going on in the neighborhood, I mean, when you don't feel safe in your own area. That can contribute to your mental health…I mean, I'm not aware of any place in the area that you can go to, where you can get help."
- "We don't have any place to go or call for mental health services."

CHILDREN AND YOUTH

The issues of **youth mental health** were raised, along with limited access to mental health support that has been a problem for many years. "... just nowhere for you to feel safer when you can go talk to someone. And I think that's the problem with a lot of the youth. They have nowhere to go." There may be discrepancies between actual services available and awareness of these services.

- "I'm not sure that the youth are aware of the free programs that are available at the local recreation centers in the neighborhood."
- "... in the rec centers here, they're old buildings, lack air conditioners, lack activities for the kids... they need to be tore down and rebuild again."
- "... the pools haven't been opened. This is the 4th, maybe 5th year."

OLDER ADULTS

Older adults needing access to banks or healthy grocery options required **transportation**, which was problematic for them. "It really means traveling. And for seniors that would mean getting access to someone to take you where you need to go." **Comprehensive support services for older adults** were lacking. "...what I've been seeing they are building a lot of senior complexes and things like that. But they don't offer them anything they need."

People moving out of the neighborhood contributed to the **isolation of older adults**, which has made them vulnerable.

- "But when we had the population of people, when we had whole blocks of occupied homes, we had more of a sense of family, and we knew who our elders were and checked on them. There's... some blocks where there's so few houses on the blocks that people are so disjointed and far further and far away from one another, and that makes you vulnerable."

Concerns were raised about **medical care** not being thorough enough, with health professionals treating symptoms instead of the actual causes of conditions. "Usually, they send them to physical therapy, or they bounce them around the different doctors, but they never get to the root cause of what may be the underlying health conditions."

SOCIAL DETERMINANTS OF HEALTH

Historical and systemic legacies in the community were found to create hardships for residents, past and present. Those who had lived in the neighborhood for decades also spoke of how some **social conditions worsened** over time with "intentional disinvestment", while others had improved with recent development. Hospitals and schools closed, drugs became pervasive, and safety deteriorated. "...institutional racism in my perspective is a big barrier. A lot of the legacies from like redlining and poverty and lack of jobs that kind of create a lot of problems. The schools are poor in some regards and... now you have gentrification coming in."

- "...for maybe like 20 something years, there was no supermarket... There's nowhere people can get no food. And then it went through a period where it was a lot of vacancy."

Community members have inadvertently jeopardized their health benefits by **earning too much in wages**, making gainful employment counterintuitive. "...when her income went up a little bit, she was no longer eligible for health coverage!"

ADDITIONAL POPULATIONS

Medical **appointment times** were too far into the future, with some waiting for 3-6 months to be seen. Switching health systems didn't seem to solve this issue, as respondents have also faced barriers due to high co-pays, insurance premiums, and ambulance costs. "...between June and July, $1,500 just for co-pay."

- "...when you're offended by one healthcare system, and you say, well, I'm not going to go back there anymore, and you shift to go to another health system. And [the] Philadelphia region has many health systems. But things happen at all of them. And and that's really really unfortunate..."
- "I think it doesn't matter if you have healthcare or not. There's always a wait, no matter where you go. That's why people choose urgent care..."

When questioned about levels of **trustworthiness** for healthcare providers, respondents associated trust with the length of time spent in waiting rooms and how much time and attentiveness their health providers invested in them. Trust was also correlated with providers who fostered safe spaces, "feeling like you can tell your health provider anything."

ADDITIONAL POPULATIONS (continued)

Regarding post-COVID **integration of technology** into healthcare, most respondents agreed that technology use has been helpful. Some, particularly older adults, have had a more difficult time adjusting. "I'm trying to keep up with the technology, even though I'm 68." The latter would prefer to have providers explain test results verbally, rather than accessing results independently through a portal. Most respondents were still concerned about **COVID-19**. And four people were somewhat familiar with **Long COVID**. "It occurred to me within the past couple of weeks that maybe that's part of what I'm experiencing. I may have to have a conversation with my doctor about that."

- "Not for me, because I always make sure, well, I'm going to put this way - I got my 6th shot."
- "COVID is a great concern for me, because I only had the first two shots. When I went to get the second, I reacted horribly... So it is a concern for me, because I'm not able to get a booster shot."
- "...it's a great concern for me, too, because I've had COVID 4 times, and I have a breathing disorder."

SUGGESTED ACTIONS

Services and activities for older adults require greater organization and follow-through. They need **advocates**.

- "...we got five senior buildings in our neighborhood and all they do like [to] sit outside... They don't have anybody... so a social worker in there who could help them with some of the problems they might have... that's one of the things that they always complain when they come into our office is that they have nothing to do"
- "I'm gonna stress that I think we gotta do way more investment and bring in health services to directly to people houses directly to the places where our seniors are living at. Gotta have a more door-to-door approach."
- "I had a situation where I had to, you know, really put my foot down to get my mom a CAT scan. And he didn't want to do it."

There's an expressed need for more providers from diverse, ethnic backgrounds.

- "...free tuition for Black students starting, targeting them in middle school. They start a partnership with the local universities, the local hospitals, and they be placed on a track to become doctors."

Northeast Philadelphia

COMMUNITY ASSETS

Free access to **physical fitness and recreation programs** and spaces were valued by community members, especially when there were options for both indoor and outdoor activities.

- "...one of the things that the CDC just did and I'm part of the CDC, is they're offering free yoga and free Pilates classes... And so, we have pop-up events, and we have a lot of people that have been coming to them. So, we're hoping that if it grows, we're going to continue doing that."
- "Riverfront North is building a trail... when it's all said and done, you'll be able to drive all the way to King of Prussia on a bicycle. It's going to be a 30-mile bike trail. So, it's slow coming, but people are starting to use it more."
- "Just about every playground around here has been redone or in the process of being redone."

Philadelphia's non-emergency inquiries and service requests line, via 311, has provided residents with a mechanism for addressing environmental issues efficiently. General efforts toward neighborhood cleanliness were appreciated. "The cleaning of the neighborhood was really nice when they came around."

- "I called for five things, at least for a couple vehicles that were out here. They came, they did all of them across the street, they cleaned up. So, it is working..."
- "So she's [the mayor] trying to push for cleaning the neighborhood and, which increases our health."
- "We had street cleaners come down the street for the first time..."
- "...the CDC pays for Ready, Willing, and Able. It is a group that, you may have lost your job, you've got divorced, you're just getting out of jail, you're recovering, and they teach you finances, cooking, how to maintain a job, what to do. We pay for them three times a week, and they clean from Cottman Avenue all the way to Harvest Avenue."

Respondents spoke of the availability of free, community-based **behavioral health and self-help groups**. Those mentioned were affiliated with local churches. "There's so many different ones for people who don't have insurance."

COMMUNITY CHALLENGES

Community members cited **limited healthy food options** as a barrier to optimal health. Apparently, efforts to establish healthier options in their neighborhood did not meet success. And **affordable supermarkets** with quality food items are limited.

- "We did have one store open that had healthy things. It was a juice bar, but they closed down. So, there's really not a lot of healthy options in the area unless you make it yourself."
- "And recently, a bakery opened up, so it's really a lot of good stuff. They're only open one day a week, and that's probably because they're uneasy about keeping it open the whole week..."
- "There's nothing in the 19135."

Lacking a sense of safety in their neighborhood, respondents limited their physical activity outdoors.

- "I want to say that staying healthy would be walking, walking the neighborhood, and there's a walk path and all that other stuff around them, but if you just want to walk outside of your house, which I do my whole life, it appears like there's a danger factor now. And that affects my health, because I'm not as free to walk as I do."
- "So, we walk every day, me and my niece, and some days we don't walk because I get done too late. So, we don't want to walk when it's dark, because of that reason, we'll walk when it's light."
- "And also not being able to walk alone, where I used to always walk alone, never think about it. And even carrying mace and stuff, I still don't feel safe."

COMMUNITY CHALLENGES (continued)

Substance use was cited as a visible problem. And "a lot of it goes along with being houseless."

- "Drug abuse. Substance, you want to call it. That's affecting everyone."

Access to **mental health services** was challenging. Community members felt that health insurance companies did not regard mental health as important as physical health. And those who had sought out services locally were not satisfied. Concerns were raised about the mental health status of people in their community experiencing homelessness. Some participants were aware of the 988 hotline, and some were not.

- "There aren't really many walk-in places other than, like, when my husband had to go to a hospital. Which was sort of traumatic for him."
- "And unfortunately, the mental health facilities, when you go there and you tell them, look, this is what's happening, they tell you there's nothing left we can do for you. And my daughter had a friend who committed suicide..."
- "That's why my daughter stayed at the main hospital in the city, because she's so afraid to try to switch somewhere around here because she doesn't think that she'll get help in a timely matter."

CHILDREN AND YOUTH

Recreational areas in the neighborhood have recently been renovated and utilized by local youth. But more support is needed to lead organized activities.

- "...we just had in the 19135 area, Keystone and Tyson, they just redid the basketball courts. And it's nice that every night, there's somebody there. And there's been no trouble. The only thing, we need the lights on later because they're pulling their cars in there... So, we need to get the lights on. They're redoing Vogue, which is again in the 19135 area. So, they are trying. There's a soccer group that they're looking for coaches to have kids and adults play soccer at Roosevelt Playground. Again, that's through Parks and Rec. So, Parks and Rec does a lot around here for us."
- "Plus a lot of the rec centers when my children were younger, they could go and play different sports. But now nobody wants to get the sports teams together. The kids don't show up. They don't want to play. So, the younger kids now, it's really hard for them to belong to a group."

Concerns were raised by participants about **inadequate mental health services** for young people, not following through with comprehensive treatment when needed.

- "I don't think the health care system understands mental health. And they treat it as a cold and it's not. And they really should do something where the children have a wrap around in school. You really do need somebody to follow you. Family can only do so much, and it's hard."
- "My daughter started in 6th grade going to therapy. We had a house fire over Cottman Avenue, so we were displaced for almost a year, and that triggered all of the mental health. You know? And so, no one in school did anything. They didn't offer anything."
- "My daughter has all her diagnosis finally by the time she was in college, she got all the right diagnosis. But it took all those years through middle school, high school."

Respondents spoke of youths' **overreliance on technology**, and how it has limited social interactions. There were also concerns that this behavior was being modeled by young parents.

There was an expectation for **local political leaders** to have more of a vested interest in supporting youth, similar to how community members felt they were advocating for older adults. "I noticed when we have a community meeting, the politicians always be there and always talk about, 'we're doing this for seniors, we're doing that for seniors'... and I know they're doing it probably to get votes from the seniors, but I never hear them say, 'we're doing this for the kids.'"

Respondents also mentioned a recent loss of **funding for local libraries**, which negatively impacted youth programming. "We've had to cut a lot of programs, especially with funding. Our funding went way down, and that's a big draw for kids and families to come in and spend time together. They still have the after-school program where the kids can come in there and spend time, but the actual programs that we used to have, we just don't have, like, used to."

- "So, the library really does a lot for the kids, not as much as pre-COVID, but they're still doing it."

OLDER ADULTS

Residents felt that older adults were supported by local politicians.

- "The politicians do a lot of senior expos, and they help them… and they go to the senior meetings and give them money so that they can get out and do things like that. So, I think the politicians help the seniors."

Physical fitness programs were available in the community at a low cost or for free for older adults.

However, older adults could benefit from enhanced transportation services. For instance, the free SEPTA service that transports them to medical appointments was not efficient. "If you're coming to doctor's appointment, you're either getting to the doctor and sitting there for two hours or getting done your appointment and sitting there for two hours." A resident who used a similar service through her insurance had the same experience. "And it's not a big bus that I have to wait three hours for. And I'm a senior."

SOCIAL DETERMINANTS OF HEALTH

The proximity of **neighbors who smoke** was identified as problematic, limiting use of shared outdoor spaces in order to minimize exposure to second-hand smoke.

- "… living in a row home and having renters come in continually and evolving door of renters, it seems every renter we've had in the last 10 years has smoked. And we're a smoke-free home. And my husband's mom died of lung cancer. So, that's a big issue for me having to shut my windows, because they're constantly out on the deck that adjoins and they're constantly smoking… don't want it in my home."

The disparity in cost between healthy food options and **unhealthy food options** was directly correlated with health outcomes, such as diabetes. This was true for pricing in local restaurants and supermarkets.

- "… French fries are a $1.99 for extra-large, but if you want a cup of fruit, it was $5.99 for the fruit."
- "And our large supermarkets, I believe. Also, we don't have some of the ones that other neighborhoods have that offer more healthy foods."

ADDITIONAL CONSIDERATIONS

Access to **mental health** services appeared to be based in part on the type of health insurance that someone had, which also created issues with affordability. "I only know when I tried to go to one, it was really hard to get one with regular [insurance company] because I belong to a private group. So if you get it at work, it's a different thing. Nobody wanted to take me because my [insurance company] was an individual plan… and I paid $1,500 a month to [insurance company]… And then my copay with them was $60 a time."

As some respondents shared about different resources that they were familiar with locally, others seemed to be hearing about them for the first time, indicating a need for better **dissemination of information**. "Well, that sounds like a barrier to health then… the lack of knowledge of what resources are even available." A local, printed newsletter was accessible to some but not others and has been used to share information about community-based resources. This was cited as a tool that needed enhancement, such as widespread delivery.

Respondents had mixed thoughts about services at **local hospitals**. There were concerns raised about hospital **staffing issues** since COVID, that have contributed to longer wait times and lower quality services. **Urgent care centers** were reliable for fast service. "… If I have to go to a local emergency room, I will not go to one in our neighborhood, which is a horrible thing to say. I will travel out of our neighborhood to go to an emergency room, and I don't like having to do that. But I've been overnight in an emergency room in the past. That's how busy they've been, because of the lack of staff." Another community member shared a different experience. "And I've been to some of the local ERs that were wonderful… it depends on what you're there for."

ADDITIONAL CONSIDERATIONS (continued)

When asked about feelings of **trustworthiness** regarding relationships with health providers, respondents were positive. Two referenced critical health needs related to pacemakers, mammograms, and the significance of longevity in relationships with healthcare providers.

- "...the one hospital I am established with, they're very good with their care."
- "I say, yes, because I'm on my second pacemaker. And whenever I go to that local hospital, they're always great. I was like, test everything. I think they're really good."

Participants were asked about their post-COVID experiences with the **integration of technology** in health services, and responses were mixed. This was based on convenience, whether someone had questions to ask of their provider, and comfort with technology use.

- "I love it. Having a portal, I like being able to get my results before my doctor."
- "I'm not very happy, and it's not their fault, but I have difficulty with portals. But that's me. I just like to know that there's a person at the other end speaking."
- "I'm fine with the portals because you do get your information. Sometimes the doctor doesn't get back to you, so then you can call them. I'm not fine with the [telehealth] appointments because if there is something wrong, they don't see you, they're not taking your blood pressure."

Respondents were still concerned about **COVID-19**, staying current on booster shots. "I'm nervous because I can't get any vaccines. So, if I get it, I have customers that are in their 90s. So, I'm very afraid that I'm going to give it to them." One community member indicated that they had experienced "effects from **Long COVID.**"

SUGGESTED ACTIONS

The option of having medical appointments outside of **traditional business hours** would improve accessibility for community members who cannot afford to take time off of work for doctor visits.

- "I know when I was working full-time, my biggest option was having availability on the weekends to go to a doctor... I didn't go to a doctor for years because I had to take off from work, and I didn't get holidays or anything. So, I just didn't go."

The frustration with long **emergency room waits** can be alleviated with better communication from health providers and access to healthy food during late hours.

- "I think when you're waiting in the ER, it would be nice for somebody to communicate with you. I was in there, and the guard actually was coming and telling me because he saw that I was very upset."
- "...in the ERs at night, a place to go eat... their cafeterias are closed at 6 o'clock. And you're in an ER, you have the vending machine. ... last time, I had a $20 bill. The machine wouldn't take it, and nobody would give me change."

A suggestion was made for **co-located physical and mental health services**, in order to facilitate access. "I think they should include mental health in the hospitals instead of having to go separately to different locations."

Respondents discussed the need for day programs for **adults with intellectual disabilities** in their community.

- "...what do you do with somebody that has the mentality of a five-year-old when if you could take them to a place during the day... like a camp, and there's nothing in that age group. [Person's name] is like, 40 and above, there's nothing there. That's why, I guess, they end up on the street."
- "There was a gentleman in [a coffee shop] today that was coloring, and he had all his books and all his art supplies and everything, and every 15 minutes or so, he would get up, he would run around, he would yell, and you knew he was by himself. And I felt horrible, because you just dropped him off there. Somebody had to drop him off because he had all this stuff all over the whole big table, and nobody was there taking care of him. Nobody was helping him, and people were looking, which I could care less about, but I don't want to go up and ask if he needs me to help him, and the baristas are like, 'what do we do'"?

River Wards

COMMUNITY ASSETS

Neighborhood aesthetics played a positive role in respondents' perspectives of their communities. **Green spaces** and periodic **street cleaning** were noted as examples of this. **Relationships** with neighbors, churches, community health workers, and the presence of police officers contributed to positive health outcomes. **Community gardens** provided a "healing tranquility" for families to convene and get away from the typical noise of the city.

COMMUNITY CHALLENGES

Challenges within the community included the **unhoused population's** insufficiently met needs, poor air quality, litter, and access to **unhealthy food** options. Not all respondents feel **safe** in their neighborhoods, and some noted a "lack of transportation," and "difficulty finding jobs."

- "How is the quality of the housing? So even, you know, some people are not necessarily houseless, but the quality of the place where they live may not be great."
- "...they don't have any trash cans out there. Everyone else throws stuff on the ground."

CHILDREN AND YOUTH

A local **playground** is unsafe to access because of the need to cross multiple major roads to reach it. However, the number of youth sports and sports-related **activities** have increased, "keeping them out of trouble and giving them something to do." One resident raised concerns about the implications of **parents** working outside of the home with older children lacking supervision. "...in today's society they got to work when they got to work. With kids who are grown, they got too much free time." Parents may benefit from more support. "...A lot of parents they talk about, 'I'm your best friend.' You not my best friend. You are, you're my son. I'm your mother." And concerns were raised about youth spending too much time playing **video games** and on **social media**.

- "...single parents. [If] they work from home... they're trying to focus on kids but trying to do their jobs..."

OLDER ADULTS

Issues raised regarding older adults included **unaffordable health insurance** and **insufficient income** in older adulthood. Accessing doctor appointments with **physical disabilities** have proved challenging. "I was here seven months, and my service coordinator was supposed to set me up with medical transport... she still ain't do her job. I had to buy a truck. I got to go on a stretcher to go to the doctor's. I called up and complained, she won't give me a supervisor's number." Being placed on hold for 30 minutes or more and facing confusion with transitioning health benefits at retirement age, residents expressed that older adults might need support with **accessing community services**.

- "...because now you living off of one income or, you know, a, a set monthly income and that's barely enough to take care of just yourself..."
- "I don't know what to do. I don't want to pay the premium. It's so overwhelming to me right now. I don't know what to do."

Respondents acknowledged the need to be **technologically savvy** nowadays, and that older adults can have a harder time with this.

SOCIAL DETERMINANTS OF HEALTH

Concerns about the inefficiency of **substance use disorder programs** were raised. The length of stay and geographic settings of behavioral health programs should be reconsidered to encourage long-term recovery. Respondents acknowledged how **poor mental health** coincides with **substance use disorders** and that it can serve as a form of coping for certain life circumstances. And high treatment cost can serve as a barrier.

- "...they need drug treatment or better drug treatment. Not only... about whether the person get clean but they don't keep them long enough. What is 30 days? What is 60 days? Give me six months, nine months a year and get them away from the area... You see that repeated behavior? So, what are you going to do to change it?"

ADDITIONAL CONSIDERATIONS

Poor customer service that limits healthcare access was noted by respondents. “I can’t get through over there and, and even the, the specialist they sent me to up on [ ] street, they never returned my call and no answer. No answer. Nothing. It’s terrible over there.” Lack of affordability of **deductibles and co-pays** was another issue raised.

Most respondents spoke positively of their telehealth experiences, using technology to check for follow-up appointments, to access medical records, and for the convenience of not having to leave home.

Post-COVID, community members expressed a persistent concern about the virus. Although, there was a general lack of awareness of Long COVID.

- “...everybody coughing and sneezing, you just don’t know. It could be COVID...”
- “...COVID is real, it was real when it came out. Um, it is real now, a lot of people don’t just because you’re not hearing about it. It’s still different, rare variants.”

SUGGESTED ACTIONS

The community would like to see “more libraries. Yeah, I used to always hang out with the library.”

Residents acknowledged the need to be more civically engaged for their own well-being and to vote for policies that support their interests.

- “What I’m noticing when it comes to getting things done in your community, we need to come together in numbers.”

South Philadelphia

COMMUNITY ASSETS

There's a **sense of community** cultivated by community activities, such as neighborhood holiday celebrations and time spent together at local parks. **Cultural ties** related to countries of origin and religion also support the sense of community among residents.

- "What's going down in FDR Park is wonderful. Try to get down there. There's a great sense of community. They're doing a great stuff with youth and different cultures and communities and just to get that rust bit and see grass and see trees, it's very important for your mental health. And it also helps your physiological, your breathing your lungs. So, whenever you can try to immerse yourself in nature."
- "I agree with community. I think that's one of the strengths of South Philly specifically is we have so many groups of immigrants that have, I think in general, stronger community ties than what mostly white suburban neighborhood would have. And so I see a lot of my neighbors spending time together and looking out for each other. I live next to a church that is really active with people. And I see a lot of programs happening there that seem to all be helping people stay healthy."

There was an appreciation for resources and organized activities to **promote physical fitness** among community members, such as a Philadelphia bike share program that offered free trial periods. And efforts by the mayor to clean every part of the city raised community members' spirits about their surroundings. "So, last week, I don't know if anyone is talking about the **cleanliness of the city**, which also adds to health outcomes. Mayor Parker almost finished this one city initiative cleaning every neighborhood very deeply for one week. I've been following it very closely and it's really been successful really at the street cleaning program."

Gaining **access to healthcare** was deemed "easier than in other places," because "we have a lot of major medical systems, hospital systems..." **Community health navigators** facilitated access for those who faced complications. "where you get your care, you can ask for a community health worker. They are pretty much the liaison between a mixture of what a social worker and a doctor can do... they can work with you with language barriers, health literacy."

COMMUNITY CHALLENGES

Stated challenges to obtaining and maintaining optimal health included barriers to **healthy eating and physical activity**, such as cost, "time, not having enough time to go to the gym or to exercise," and fast-food restaurants and discount stores where "you can get stuff really cheap but it tends to be cheap and unhealthy. And what seems to be healthy tends to be too costly."

For one respondent, the reliance on **technology to navigate health services** and insurance policies caused an immense amount of stress, after her insurance was canceled and needed to be "reinstated retroactively" or she would have to wait for open enrollment several months later. Related concerns and sentiments of mistrust were raised from the perspective of Spanish-speaking **immigrants**. "There are folks from Guatemala who have moved to the area in the last few years and when they come here because they can't communicate and they try to speak to them in Spanish... But also there's not cultural sensitivity for the most part, almost everywhere. The systems are made not for the community to use it, but for the corporations who want them not to use to make more money, unfortunately."

The problem of **food insecurity** resonated with residents, as the cost of healthier food options and geographic distance served as obstacles. And poor food choices were recognized for their long term, negative impacts on physical health. "I work with a community group that has community fridges and pantries around South Philly. And every time I go there to put food in, it's gone in 30 seconds. Every time I walk in that, there's a really long line. Affording food, having enough food, being able to get to even a grocery store is really hard."

- "People are stressed out, they're trying to make ends meet, inflation is out of control. Good food, healthy food is very expensive. So, what's the default setting? People go to McDonald's for $2 to get a hamburger and fries. And what's the default of that? Hypertension and diabetes and obesity, which causes all kinds of issues. So, it's just a spiral."

Substance use within the community raised concerns about the mental health of community members and overall neighborhood safety. These were also contributing factors to feeling less inclined to engage in physical activity outside of the home, along with feelings of anxiousness.

- "And I know, personally I don't walk on certain blocks because I know that gun violence is an issue there. So, it makes me more likely to stay home or just not to walk around. And I mean, go to the subway station and you will see that there is not enough help for people… And they are forced to live outside and use drugs outside and it's not safe for anybody involved."
- "I run at 5:30 in the morning but I run with the group. So, that's an issue if you have to run or do something early before you can go to work, it's usually going to be dark so that you're going to be concerned about the safety."
- "I mean, you're accosted if you don't have your wits about you every second of every moment you're out on the street or on the sidewalk, you can be killed by anyone at any time. And it never was like that before. People had empathy. People had self-respect. People had respect for each other, and they had respect for where they live. So, it's like the breakdown in society. And I hate to say it, the political climate has normalized hate and has normalized divisiveness and that's where we are on our side today. I've never seen this in my life. And it's sickening and it has become a health issue because the anxiety that you feel every day…"

Communities were criticized for **discarding trash** carelessly, creating a public health concern. "So, if people had more pride of where they lived, I don't think we would have… trash, it really leads to poor, bad health outcomes, trash maggots, mosquitoes. And there's been a huge proliferation of wildlife raccoons, squirrels from all the trash that's left out. So, there's a lot of - there's a big problem with raccoons in South Philadelphia right now. So, that's also a health issue."

CHILDREN AND YOUTH

Youth have been observed engaging in **high-risk behaviors**, such as smoking "all sort of things" in subway stations and in parks. Underfunded and under-resourced schools and **social media** were also topics of concern. "Kids end up then without a mentor when they really need one or they just need someone that they feel like cares about them because they can't always get that at home if their parents have to work multiple jobs or if they don't live with their parents."

Also, "Beefs have moved on to social media and so kids are shooting each other because of something they posted on TikTok."

There appeared to be a disconnect between **youth programming** available in the community and the type of programming youth wanted or needed, which can affect future funding within their community. "There are more programs for the youth… but it's hard to reach them. So, it just has to be a change in how they're making the approach or at least sending out the invitation. But I know there are a lot of programs, but… a lot of kids aren't coming. So, they're not getting the numbers for the funding for them to continue."

- "In my experience in people that I've talked to, especially for younger people of color. The increased funding and presence of police has led to negative life outcomes and thereby negative health outcomes. Because often that is different from community care and turns more into just like frequent incarceration, unnecessarily, frequent violence against a lot of people but particularly young people of color…"

OLDER ADULTS

The need for **recreation spaces** in the community was a recurring theme for older adults. "I kind of like the fact that they have the senior centers for the older folks… they can get out to bingo, a lot of them doing line dancing… They have a lot of walking groups now that they can go on a walk. They have some running groups."

- "But that's positive that Philadelphia really has a nice big budget set aside for aging and PCA - Philadelphia Corporation on Aging."

Meal delivery services were also important for older adults who faced mobility and transportation issues that varied as the seasons changed. In addition, "the only thing is the heat. They're not coming outside, they're staying in their homes, they're not venturing outside at all which is, that's not good for health."

- "I think a difficulty that I notice especially amongst older adults has to do again with **accessibility**, especially for wheelchair users. Most I guess particularly on sidewalks that are sometimes broken and craggy or which have bumps and levels that are just not accessible and then in buildings themselves which have too narrow alleys to be used by a wheelchair person…"

Distinct differences were noted between older adults in immigrant families and those in American families, related to the propensity to have **family support**. "...The social structure breakdown that [person's name] had said about the families... I've seen the Indonesian communities are more tight knit and there's many generational families and generations live together and which is very helpful for the older... and if that's a great thing and I see the cultures, the Mexican culture Spanish speaking, the Indonesian community, Asian community, I feel they're more tighter knit."

ADDITIONAL POPULATIONS

Various intersecting social factors were identified for negatively impacting health outcomes in the community.

- "...with **queer and trans people** being considered less employable, incomes are lower and accessibility to health services are thereby diminished."
- "Health care is being debated by old white men. I mean, they took away **women's right to choose** out of the majority of states and left it to the states. And now women who don't have transportation or they can't afford it, it's going to cost them more money to go to another state to get an abortion."
- "And I see it every day and then all of my **neighbors are very lonely** because their kids live so far away and there's no one there to help them with the day to day."
- "There are multimillion properties being built but there is over 10 to 20,000 **homeless people** in the street..."

For members of the community who are **not American citizens**, eligibility for health insurance could be difficult because they no longer had access to identification documents that they needed.

- "...for a lot of people that aren't citizens, it's very difficult for them to obtain birth certificate, social security cards and stuff. So, it's almost impossible to get insurance if you don't have an ID, so that could be a challenge."

ADDITIONAL CONSIDERATIONS

Described as a "huge limiting factor" was the lack of transparency with **healthcare costs**. This impacted community members' ability to make informed choices about their health. "You might be able to get to the doctor, but it's going to put you in debt. And then potentially keep you from continuing care you need because you can't afford it because insurance is terrible in this country. So, I think that it would help if we could do something about health care costs." Some individuals with "good jobs" still had trouble affording insurance. And older adults of retirement age couldn't retire because of health care costs.

The demand for **mental health services** outpaced the availability of mental health providers. "...My insurance covers mental health, which has been great... but again, everybody needs it right now especially. And so there's not enough people accepting new patients."

Community members expressed that the **fear of experiencing discrimination** in healthcare settings was a reason for a lack of trustworthiness. These biases were perceived to indicate a need for more **cultural sensitivity training**, with an increase in staff numbers. "...People tend to express a fear of micro or macro aggression even within health care settings where there should be more competencies. And further, I think with the utmost empathy as fear of mistreatment by people who are overworked and under supported..." Although one respondent shared a contrasting perspective about her experiences. "I've always felt heard, valued, respected. I never had an instance, I guess I'm fortunate. I never had an instance where I did not feel that way."

Regarding post-COVID use of **telehealth and technology** integration into health communications, the reviews were mostly unfavorable among this group. A lack of tech savviness and accessibility issues were cited as hurdles.

- "Yeah. I'd rather talk to a live person. It is helpful to be able to go into the portal. Sometimes when you don't want to have to be on the phone... sometimes it's a little difficult for me to navigate..."
- "It's only negative because I'm not tech-savvy."
- "And so in addition to not being exactly tech-savvy, the way that websites are designed is not always the most accessible... so many websites are just not built in a way that is conducive to softwares like that, which are extraordinarily helpful for people with different disabilities."

ADDITIONAL CONSIDERATIONS (continued)

Seven respondents were still concerned about **COVID-19**. This was due to persistent viral mutations and fears of contagion, pre-existing conditions, the spread of misinformation about COVID-19, and perceptions of insufficient safeguards on the part of the government.

- "...especially in larger political spheres, myths and disinformation about what COVID it precisely is and how different strains can continue to affect and disable people efforts to regain normalcy which just seek to continue putting people back into workplace to be laborers in dangerous situations, making people expendable. Yeah. A lack of value on the human life at stake."
- "The original form of vaccine is still not strong enough... It's hard to keep track of what's happening..."

Three respondents were familiar with **Long COVID** and discussed its implications on quality of life. "My cousin had and it's been a year and he still had some respiratory issues and problems. And then a friend of mine's son, it's probably been almost a year, he still can't get his taste back. And he's a cook so it's really challenging. So, that's the thing that's going to interfere with his mental health, his livelihood that can affect him, his finances and stuff."

SUGGESTED ACTIONS

Some thoughts from respondents on how to implement improvements in healthcare experiences included school-based health services, enhancements to housing services, universal healthcare, and further development of a diverse healthcare workforce.

- "...community centers after school time would be really important to help kids just have something that makes, that is a good use of their time that keeps them safe, makes them feel cared about, makes them feel confident and just keeps them from getting mixed up and some less pleasant stuff."
- "I think that school-based clinics, health clinics are really promising direction to be moving. A lot of folks can't afford the healthcare..."
- "But I feel that a really big issue, the major warehouses that can be turned into shelters with simple funding..."
- "...we just need universal health care in this country... not everybody has a job and your health care should not depend on that. So, that would make a huge difference."
- "...overhauling insurance in general is prescribing food as medicine. I think that health care providers should heavily subsidize healthy foods for folks and deliver it to them and make it as low barrier as possible."
- "Workforce development programs... they don't really exist anymore. But if there are workforce development programs for healthcare assistants along with the school, you can get a student to... become staff..."

Southwest Philadelphia

COMMUNITY ASSETS

Friendly neighbors (i.e., being welcomed, inviting small talk), **family support**, and **clean neighborhoods** contribute to overall good health. This includes community members attending church together. Being able to "sleep in peace," not being stopped on the street, and no seemingly random knocking at the door provide a sense of safety. Violence in the neighborhood seems to have subsided. A wide variety of public transportation options and access to an abundance of free produce were noted as well. "So, we got... tomatoes on the vine. I never buy tomatoes on the vine because they're expensive in the supermarket. And since that has been going on, and me and my family have been eating a lot healthy again." Community members also obtain free produce through community gardening. There is also a walk-in clinic open to all (including undocumented individuals) that provides a variety of services additional to those that are health-related, such as assistance with filing taxes, food, and for a short while, bus passes sponsored by a local councilperson.

- "The church is very good... If I don't go to church, I don't feel good. But I'm very happy that every Sunday I'm able to go to church."

COMMUNITY CHALLENGES

On the other hand, options for purchasing **healthy foods** are limited and not as convenient as the corner stores in the neighborhood. "I don't do the corner stores per se. I don't even let my children do the corner stores. But they're so easy to access and a lot of kids, that's not just kids, adults too. They run in all the junk food and the greasy foods and all that at them corner stores... some people don't drive. So, they don't have anywhere to get to but the corner store or maybe their children, grandchildren go to the store for them."

- "I just wanna add, that's another thing that people do need food. And some people do, like when I go, I wait an hour before they open so that once they open, I'm getting in and out... But if you don't go when they first giving out the food, it can be three hours, so that's how hungry people, or at least for the food banks in my area... But when I'm driving back, I can see the line, if this place gave out food, the line would be around the corner. Literally, that's how desperate people are just to get some decent food."

A respondent described their apartment building as "fine," but their neighborhood as "high crime." Although she is within walking distance to a local discount store, she prefers to drive to ensure safety and acknowledged that this has an adverse effect on her physical and mental health. Access to proper grocery stores requires a vehicle, which makes them inconvenient to most.

- "...there's a lot of access to fast food."

Concerns were raised about "mental health, alcoholism and the second-hand smoke and high blood pressure. That's a big issue in the community." **Access to health services** is impeded by a lack of knowledge and inadequate health coverage. "...A lot of the people don't take advantage of the resources that you have in the area. It's a lot of resources and people just don't know... so, you got like the health clinic which is a few blocks from here. It's a free health clinic for... when you don't have, medical."

Some **neighborhoods have been neglected**. "A vacant house right next door. 40 years vacant... I'll complain about it to no avail. I got a school bus at the corner. It's been here for two years. I called 911 or wherever it is to no avail."

CHILDREN AND YOUTH

Parks and libraries have been closing, along with vocational training programs. Youth would have to access programming, but at a greater geographical distance. "So, it's a lot of stuff in the area, but it's just the point of getting to there or getting the kids involved in there. I don't know because they're so used to going to the rec centers and all in the area." There were concerns raised about children being less active nowadays and eating **unhealthy foods**. A positive observance was the extended school lunch programs, to provide young people with better options.

- "And the unhealthy eating options are, I guess affordable. So, their caregivers allow them to eat this food. And I see a lot of overweight children and I know when I was younger, we weren't overweight, that and things to do, but I don't know why their guardians won't, I guess, make them go because I was made to go to activities at least until I got to college, and I could do my own thing. But an after-school activity was mandatory whereas there are things to do."

OLDER ADULTS

Senior living options and the provision of **transportation** for older adults are helpful resources. They also appreciated the **meal delivery** service for older adults and people with disabilities, covered by healthcare. There are also several local **recreational programs**, accessible by bus. "Bingo. And ladies play the drums and dancing and pool and even have a religious thing every once in a while, but it's good, something to get the heck out of the house."

ADDITIONAL POPULATIONS

Homelessness was mentioned by respondents as being an issue in the area. "So, where I live at there's a high homeless population... I do see the homeless outside."

ADDITIONAL CONSIDERATIONS

Experiences regarding access to healthcare were mixed. Factors impacting decision-making included **long appointment waits**, **unaffordable co-pay** amounts, and doctors' walk-in policies for **patients without appointments**. Long-time residents lamented the on-going **closure of hospitals**. "When I first came to Philadelphia, [I used to see] hospitals all over the city."

- "For me, if I can't see my primary care, then I'll just go to urgent care. So, it's good that they have them around everywhere and I could just get in and get out."
- "It's not difficult for me. It's pretty easy."
- "Some doctors is not available until like three months later. So, if you really need to go to the urgent care, there's a whole bunch of them in the city...Not to wait months and months to be seen, that's too long."

Regarding access to mental services, **social stigmas** serve as a barrier. But for some, **virtual visits** help to combat this issue.

- "...it's like a pride thing, like a lot of people that I know they like, no... they won't seek their help and that's not good because if you know you need the help, you're worrying about what people think about you or what they gonna say about you instead of getting that help."
- "And you also have some of the doctor's offices do virtual. They do Zoom. So, it's not always about going into the facility."

Respondents were asked about levels of **trust** for their healthcare providers. One person indicated that there was a lack of trust, although others identified issues related to trust. Trust is built when "doctors take time to explain," when they don't make patients wait in their waiting rooms for hours past their appointment times, and when there are open lines of communication.

Telehealth services post-COVID had been utilized by respondents and described as "very convenient." They prefer the convenience, compared to having to go into the office and pay for transportation. All but one of the participants still considered **COVID-19** to be a concern. In addition to being sick, concerns were raised about missing work and having lost several neighbors to the disease. No one in the group was familiar with Long COVID.

SUGGESTED ACTIONS

Having healthcare providers from more **diverse backgrounds** was important to community members. "I would like to see the healthcare people in my neighborhood to look like me [African American] because I think culturally they would understand my culture..."

A need for improvements to **emergency services** was mentioned, particularly related to long wait times. "Like when you go to an emergency system, you sit too long and sometime people line them all over. The care is so slow."

Lastly, respondents requested general support for **housing** and low-income households that is more expedient. "I feel like if they have a job and they're looking to move, they should work more with people like that, that want to have low income, like housing and stuff like that instead of making them wait years and years. It's like they need something now. Why do they have to wait 3-4 years just to move and stuff like that?"

West Philadelphia

COMMUNITY ASSETS

Most community members who participated in this discussion had lived in the area for decades and reflected a lot on community assets from years ago. Generally, they found it **difficult to highlight community assets**. But they also expressed a **sense of pride** in where they live and its history and hoped that conditions would improve. One participant mentioned that community members would come together, "people like gym teachers, personal trainers and everything that would teach you..." and engage youth in **physical activities**.

- "...they're about to revamp that whole playground, which they really need to do. Because like some of the stuff was there like when I was a kid and we're talking about that, I'm talking like 1980s. So, the only thing that was really worthwhile going there was just a swimming pool and the basketball court."

COMMUNITY CHALLENGES

There is a lack of **green space and trees**, and that was not always the case. "I'm 74 years old and we used to have trees. We had a tree line for a mile, we didn't cut them down, the city did."

Respondents also expressed concerns about the **lack of grocery stores** and **unhealthy food options**. And a teacher lamented that **schools needed to improve**. "So, if you talk generational, our schools in West Philadelphia are not the best." Students in West Philadelphia do not always have access to opportunities that are comparable to those in other schools. Lost opportunities can perpetuate dangerous cycles. "Our children, our young people aren't working and if they are, they're selling, okay, because that's what they feel they need to do to be in the neighborhood or to be a part of the community and no one is offering them and our young mothers [support]..."

- "I mentioned earlier about how there was so much excitement around a grocery store coming into the neighborhood that I had been living in for maybe four years we had a very low-quality store. The meat was decrepit. There was no fresh produce."
- "I'm just going to be candid and honest. And looking and observing our communities, our communities are not healthy. Our communities are sick. Our communities are toxic."

Public transportation was regarded as unreliable, and particularly unsafe for bus drivers. There is a culture of individuals and whole families boarding buses and not paying. And there's a concern about the implications of these behaviors moving forward.

- "Oh, my God public transportation, what about it?... How will you get there and will you get there on time?"

CHILDREN AND YOUTH

There were disparities noted in the ways that families address **disabilities among their children**. "The one thing about autism on the spectrum is we that are African American, we put our people up in the room and we say, well, that's how he is and you go to the other side where you deal with our caucasians, they going to go get it, they're going to get the help." Parents and schools need more support for and education on such matters.

Some individuals noted that the taboo associated with **mental illness** may be fading.

- "At this point, I got young girls coming to me who are like who is your therapist? I need a therapist too. So, when you start thinking about actually healing, right? Then you want to do things that are better for you, then you want to eat better. You want to take care of yourself physically, you want to take care of yourself emotionally, because you're taking care of yourself mentally."
- "I'm seeking it for my six-year-old now, because gun violence nowadays is ridiculous. Lost her father to gun violence... We're losing a lot of kids and we just don't have, they don't count like grief counselors it's hard to find nowadays and I feel like mental health and grief counseling is a big thing nowadays in Philadelphia."

CHILDREN AND YOUTH (continued)

Efforts are being made to engage youth in **community gardening**, alongside their parents. This is helping to bring quality food into homes. Generally, perspectives about **recreational programs** for youth varied, and quality seemed to be based on specific neighborhoods, perceptions of biases on the part of local political leaders, and systemic discriminatory practices rooted in local history.

- "You know what I like and I see in West Philadelphia, they're starting to have a lot of farming programs for youth and I have seen them where youth become little farmers or entrepreneurs. And it's one group that's teaching a parent and a separate group, so they could continue to teach the child."
- "And I will say on a positive note, my rec center is definitely doing a better job with breaking all different types of programs for youth, sports, swimming. You know, it really depends on the rec leader and how much they really want to engage with the community. Because they do listen to the community if it's a good rec leader and determining what we need, what type of program we need."
- "We need more consistent mental health services for youth."
- "And as a Black boy mom, we need more men's services and we are lacking a lot of men, especially Black men working in the mental health field in the local Philadelphia area. And I can speak to this, because I had sought out services for my child, because we experience trauma, and it's not we have been assigned a lot of females. And my son can't relate to them and that's what we're lacking."
- "I'm going to say the representatives and even some council people of the communities, they finger pick who they are going to help. When it comes down to the schools and the youth in our community you don't see no gardens or nothing else in some of our community...I've been employed for the Philadelphia school district. And I watched them categorize the children. I watched them place the children and I watched them label the children."

OLDER ADULTS

The **paratransit** services for older adults and people with disabilities were described as unreliable, with drivers arriving late and with no mechanism of communication existing between drivers and customers. "I guarantee these seniors and now they having a fit, because most time they got to go to dialysis..." Drivers sometimes do not assist customers with boarding and de-boarding. "We had to start reporting them to tell put in the ride. Please tell the driver to get off... but they're supposed to get off anyway, even if they may not need help. You have to tell them to get off the vehicle. Come to the door... you're not supposed to be even riding for more than 50 minutes, people on there two hours."

Other transportation services have proven helpful for facilitating activities of daily living. "I just am so excited that the advantage insurance that you pay after Medicare and Medicaid or whatever they have the insurance where you get your ride to your doctor's appointment and you get your ride back and the senior citizens are so excited... it's just so exciting to me to see them excited about something, because they can go right next two doors down to... Shoprite and buy their groceries..."

But one respondent got emotional as she spoke of **isolated older adults** with dementia, "They're not coming out of their homes, because they are afraid and I get that but trash has built up on Ludlow Street... but the trash is running over to the point where we can't even walk down the street. It's embarrassing." Several weeks of uncollected trash, and unauthorized dumpster use, prohibited residents from opening their windows in the summer heat.

Concern was raised about the comprehensive way that **technology** is being integrated into health services and the fact that many older adults may not have the necessary equipment or skills and may also lack the motivation to learn.

- "...we're not going back to paperwork. So, in order to continue to navigate in this world, you're going to have to conform to change."

SOCIAL DETERMINANTS OF HEALTH

Some individuals may be disincentivized to earn a **livable wage** because of a fear of losing their health benefits. "I just think that the way the healthcare is set up, you can make a dollar or two cents over and you lose your health care and people can even the working class cannot afford the copayments."

Whole health was acknowledged for its importance in fully capturing a person's wellness needs and social determinants of health. For instance, one respondent mentioned that "isolation has to do with food deserts." In other words, a lack of social support, inaccessible transportation, and/or geographic location have limited access to healthy food options.

ADDITIONAL CONSIDERATIONS

People with disabilities were described by respondents as being "left out." More services and resources are needed for people with a variety of functional limitations in their community.

- "...people with challenges and disability, because they are the voiceless hidden community and they are not ready, in the community there is not readily services [for] them. I tried three years to bring about a state-of-the-art fitness center for people with disabilities. And I got turned away..."
- "...they seem as expendable. Which is so crazy."

Substance use concerns included unwillingness by those in need to seek out services and low-quality services that need improvement.

- "We have people that get hospitalized, and they are re-traumatized from the hospitalization... a lot of places are lacking workers, so they're just hiring anybody and nobody's being held accountable for the way they treat any patients... And I got to be honest, this is what I did for a living. I was a mental health worker and I was also an admission counselor."

When asked about how **healthcare experiences have changed** since the COVID-19 pandemic, most respondents spoke about improved access through telehealth. One shared concern related to recent security breaches, and another expressed pleasure with more attentive and person-centered care.

- "I'm getting a letter every day, whether it's from my health insurance, my phone telling me there has been a [breach] of information... I opened one last week for my health insurance company. Every single other week I'm getting a letter about my information being leaked. So, I know that with a lot of the telehealth, they say it's not recorded and it may not be, but who's to say who's watching on the other side, because these hackers, they are amazing. And so, that's the concern I have about just the breach, the confidentiality."
- "...there are new things that make sure that they spend more than five minutes with the patient. So, they're spending more equitable time, they're spending the time more equitably when they're listening to them. So, I'm finding that it has gotten better. I don't know if that's across the board, I just know that in the market segment that I work in the providers that we work with that has been finding that across the board that the patients are feeling more equitable with the time that the doctor is spending with them to really go through like whatever the health care needs and their concerns are.

SUGGESTED ACTIONS

Respondents discussed the importance of **advocacy and self-advocacy** for patients of all ages, but especially older adults and people with disabilities who may not be able to speak up for themselves when needed.

- "And I know when I go to the meetings just like with something like this, the room should be packed. This is our neighborhood, but we want to change things, but we want to talk about it. I don't talk to anybody that don't vote. Because the bottom line is that's the only way it's going to change. But showing up and saying, they've been talking about this bus revolution for so long."
- "I think it's important to have a doctor that listens to you, because they have doctors when you go and you're complaining you're there, because for a reason. Well, anyway, and it's for a reason and you tell us for some type of pain you might have like, recently I had pain in my shoulder, they would wake me up. So, I went to the doctor. He said you slept on it. No, no, I said that's not it. So, I went to [an] orthopedic doctor, she took the X rays. I got spur in both of my shoulders."

More **holistic and non-pharmacological approaches** to healthcare were requested. "not just giving you a whole bunch of pharmaceuticals, but that doesn't mind giving me herbs or telling me what vitamin therapy to use or just even using food therapy and everything, nutrition therapy."

- "...back in December, I was diagnosed with a tear in my right shoulder. And the first thing they said, you want the shots? Absolutely none. What's your next choice? They said physical therapy, I said I'll do physical therapy."

SPOTLIGHT TOPICS

As part of the Regional Community Health Needs Assessment (rCHNA), a series of focus group discussions were conducted across each county with representatives from community-based organizations, local government agencies, healthcare providers, and community leaders. These discussions centered on a set of "spotlight" topics selected by the Steering Committee. Topic selection was guided by previous rCHNA priorities and shaped by input from community partners, ensuring alignment with pressing regional health needs.

In addition to general focus groups, key informant interviews were conducted to explore the topics in greater depth. The Steering Committee also revisited a set of community-driven solutions identified in the previous CHNA cycle to understand progress made and barriers encountered since that time.

Given the critical importance of maternal health in the region—and recognizing the sensitivity of this issue, which often limits open discussion in larger forums—a dedicated focus group of pregnant people and new mothers was convened to better understand the lived experience of maternal health in the community.

The Spotlight Topics discussed included:

- **Caring for Uninsured & Undocumented Community Members**
- **Culturally Appropriate Mental Health Care**
- **Housing**
- **Maternal Health**
- **Older Adults & Aging in Place**
- **Primary Care Access**
- **Community-Identified Solutions:**
  - Better Integration of Health and Social Services
  - Increasing Community Member Capacity to Serve as Care Navigators
  - Integrating Preventative Care and Education into the Community
  - Involving the Community in Decision-Making and Implementation

SPOTLIGHT TOPIC

Caring for the Uninsured and Undocumented

Uninsured and undocumented individuals in Southeastern Pennsylvania continue to face significant and intersecting barriers to health care access. While local clinics and community-based organizations strive to meet the needs of these populations, they do so within the constraints of limited funding, workforce shortages, and a fragmented safety net.

To better understand the current landscape, the Health Care Improvement Foundation conducted a series of group discussions and key informant interviews in 2024 with leaders and staff from community-based organizations across Bucks, Chester, Delaware, and Philadelphia Counties. These conversations explored how challenges have evolved, which strategies are working, and what solutions should be prioritized moving forward.

These findings build upon the 2022 Regional Community Health Needs Assessment (rCHNA), which highlighted the complex and varied barriers to care experienced by immigrant, refugee, and heritage communities across the region. The 2022 assessment identified key issues including language barriers, lack of culturally responsive care, fear related to immigration enforcement, and economic hardships exacerbated by the COVID-19 pandemic. It also underscored the critical role of trusted community-based organizations in navigating these challenges and the under-resourced nature of many of these groups. The 2024 conversations reinforce and expand on these findings, offering updated perspectives on current needs and strategies from those working most closely with undocumented and uninsured populations.

Challenges and Barriers

Uninsured and undocumented individuals in Southeastern Pennsylvania face numerous, intersecting barriers to accessing care. Delayed treatment due to cost, fear of deportation, and limited system knowledge often results in preventable health crises. Language and cultural mismatches further complicate care, especially for mental health and Indigenous language speakers. Even when resources exist, families are deterred by confusing eligibility rules, limited interpretation services, and a pervasive fear of immigration consequences. Providers report that individuals often turn to emergency rooms or unsafe alternatives after prolonged avoidance of care, reflecting a fragmented and overburdened safety net.

DELAYED AND EMERGENCY-ONLY CARE

Over the past few years, barriers to care for uninsured and undocumented residents have not only persisted but, in many cases, worsened. Participants reported more severe delays in care, increased fear among immigrants, and systemic issues that limit access to preventive services.

Many individuals are arriving at emergency departments with advanced illness or severe dental issues after avoiding care for years. In some counties, emergency Medicaid approvals have become more restrictive post-pandemic, making it harder to treat even eligible children.

Access to eye care is another unmet need, especially for children and adults whose work depends on good vision.

One participant from Bucks County said,

"They're not seeking care until it's dire. I see it a lot also with dental. I can't imagine the amount of pain some of the individuals are in until they're actually seeking care. I hate to bring this up, but there's also underground dentist that they just pull teeth and make things so much worse."

A Delaware County participant explained,

"I just processed some emergency medical assistance for a woman who now has terminal cancer. It probably would have been treatable. She probably could have survived this diagnosis. It is now very likely that she will not."

Another participant from Bucks recounts,

"Someone comes into our office and they need help navigating, enrolling a child in school or getting eyeglasses for a child. It's hard enough to navigate in English, let alone with all these additional barriers."

LANGUAGE AND CULTURAL BARRIERS

Language and cultural barriers continue to limit access to care. Even when interpretation services exist, they're often deemed too expensive or unavailable for outpatient behavioral health.

Even when interpretation services are technically available, cost remains a significant obstacle. Hospitals and inpatient facilities often avoid using services like LanguageLine due to expense, which in turn restricts access to care for those who are not English-speaking.

Regional dialects can further complicate communication, particularly for Indigenous language speakers from Central and South America, where even Spanish-language interpretation may fall short.

One participant from Delaware County said,

"We cannot get people in...we have made the decision to start bringing in folks to do just basic mental health education as a stop gap for the ability to get people into actual talk therapy treatment."

A Bucks County participant explains,

"The inpatient facilities, they won't take them majorly because if they only speak one language and they don't want to use the language line because it's too expensive for the hospital."

A Chester County participant shares,

"The migrant population is not just Spanish speaking... in places like Guatemala, they speak Mayan. So we've increased usage of LanguageLine, but you really need bicultural staff who carry a different kind of sensitivity."

FEAR OF IMMIGRATION CONSEQUENCES

Fear plays a significant role—many families avoid applying for programs they may be eligible for due to concerns about immigration status or public charge consequences. This mistrust prevents people from accessing even basic preventive care.

According to one Philadelphia participant,

"There is still that fear... that if they submit something, that there will be repercussions for that."

A Chester County participant explains,

"Fear of applying for insurance because of deportation concerns."

SYSTEM NAVIGATION CHALLENGES

Understanding how to navigate the health care system is a major challenge. People are often unaware of what services exist, what they qualify for, or how to access them. This confusion can lead to paying out-of-pocket unnecessarily or going with-out care entirely.

Many undocumented individuals work physically demanding jobs in construction, agriculture, food ser-vice, and domestic labor. These roles often result in preventable injuries or chronic pain, yet workers fre-quently forgo care due to cost, lack of transportation, or fear of exposing their immigration status.

Unfamiliarity with U.S. health sys-tems—compounded by language, documentation, and cultural barriers—leads to missed opportunities, unnecessary costs, and worsened health.

A Chester County participant said,

"They don't know what questions they ask. They don't know what they're eligible for."

A Bucks County participant added,

"It's hard enough to navigate in English and it's even harder when you have all these additional barriers on top."

Another Bucks County participant explained,

"We have to send them to the hospital instead because they need care and the hospital can't really turn them away... It's often a crush injury or diabetic foot wound that's been festering for who knows how long."

Special Populations

Certain groups—including children, youth, people with disabilities, and those with serious mental illness—face unique vulnerabilities. Preventive care, dental, mental health, and physical therapy services were all cited as high-need areas for these groups, services that are often not available through emergency Medicaid or free clinics.

CHILDREN AND YOUTH

For children, delays in dental and medical care can lead to long-term health issues and exclusion from school due to missing records.

A provider in Delaware County shared,

"We are seeing kids with heart conditions from lack of dental care. At 16 years old, they have high blood pressure, and it's due to poor dental care."

In another example from the same county,

"Kids are being forced out of school because they can't provide timely dental records."

ADULTS WITH DISABILITIES OR MENTAL ILLNESS

For adults with disabilities or mental illness, a lack of guidance around in-surance eligibility and disability doc-umentation often results in gaps in care.

"They have a family member who's an adult who no longer can be covered on their family insurance plan… they really don't know what to do."

What's Working Well

Despite the barriers, community-based providers continue to deliver impactful care through a variety of locally driven strategies.

FREE AND SLIDING-SCALE CLINICS

Free and sliding-scale clinics are the most consistently used resources. Free community clinics were frequently cited as trusted places that treat patients regardless of status.

The free medical and dental clinic in Doylestown

"Can accommodate individuals. They have a psychiatric nurse practitioner who still volunteers at the clinic."

A Chester County participant adds,

"It's a totally free clinic…they'll serve them completely free, including all the way up through and to surgery."

STRATEGIC USE OF EMERGENCY MEDICAID

Even within the safety-net landscape, documentation status often deter-mines access to care. Some participants noted that individuals who are documented, even if experiencing homelessness, are more likely to re-ceive timely care or qualify for assistance.

In some counties, Emergency Medicaid or mental health funding is used strategically to serve undocumented patients with urgent needs—particularly children in need of dental care.

A Bucks County participant says,

"If they're a citizen… even if they're homeless, it's pretty straightforward. We usually just apply and get the insurance within a month."

Another Bucks County participant explains,

"Our funding isn't prioritized whether they're documented or not. Let's say they can get 10 days, and I preauthorize it for that."

A Delaware County participant adds,

"We are very focused…to qualify for emergency Medicaid so they can get their full mouth done in one visit."

BILINGUAL BENEFITS COORDINATORS

Organizations that have hired bilingual staff, especially for benefits coordination, report improved follow-through and reduced fear.

A Philadelphia participant asserts,

"We onboarded somebody, a bilingual benefits coordinator a few months ago, and he's been super helpful. He does basic screenings with people to see if they're eligible for medical assistance, and then he assists them in putting through the application."

COLLABORATIVE PARTNERSHIPS SUPPORT ACCESS TO LABS AND PREVENTIVE CARE

Collaborative relationships with private partners and public health entities help fill critical service gaps. In some communities, partnerships with organizations like LabCorp enable free lab testing, while the state Department of Health supports vaccination and pharmacy supplies.

Two Chester County participants share:

"LabCorp is great... there's some type of relationship between Saint Agnes and LabCorp and they get their lab work done. That's a great channel."

"We work with the Department of Health in administering flu shots... they bring those. We give them to everybody."

COMMUNITY SUPPORTS

Community-Based Programs Support Programs that are tailored to vulner-able groups like adolescent mothers, offering comprehensive wraparound services including prenatal care and transportation—both of which are often inaccessible to undocumented and uninsured families. Such community-rooted solutions offer a life-line for pregnant teens and young mothers navigating complex systems without traditional support.

Most patients rely on word-of-mouth and trusted organizations for healthcare information. Community groups, churches, and clinics serve as primary entry points into care.

Participants also highlighted prescription assistance as one of the few widely used financial support tools.

A Chester County participant explains,

"YoungMoms of Kennett Square works with women between 16 and 21 with an unplanned pregnancy... they provide transportation to their prenatal appointments. It's an incredible organization."

A Philadelphia participant says,

"Most of it, as usual, is word of mouth."

"The nurse practitioners go on to -- I think it's GoodRx, and they get all kinds of coupons and things. And they'll print it out and give it to them."

Suggested Actions and Solutions

Participants offered several concrete recommendations for improving access and sustainability. Many emphasized the urgent need for more navigators, care coordinators, and community health workers, especially those who speak the languages of the communities they serve.

EXPAND AND SUSTAIN COMMUNITY-BASED NAVIGATION AND CARE COORDINATION:

Participants overwhelmingly called for an increase in navigators, community health workers (CHWs), care coordinators, and promotoras who reflect the communities they serve—linguistically and culturally. These roles are essential for helping individuals navigate complex healthcare systems, apply for benefits, and access resources. Sustained funding and the ability to bill for these services are critical for long-term impact.

- **"We need someone to help with all of the above in the home language with transportation, getting to appointments, accessing... benefits for their children... and being able to understand and navigate."**
- **"We need to find a way... how about we start being able to bill for services when we're helping people to get insured?"**
- **"So, one grant once a year... is not going to solve this problem... What's going to be a more realistic solution is a grant every couple of years... and insurance companies covering and allowing health systems to bill."**
- **"Programs like promatoras, programs like community health workers... that can help people navigate are two good things."**

INTEGRATE HEALTH INSURANCE AND SYSTEMS EDUCATION INTO TRUSTED COMMUNITY NETWORKS:

Many participants noted that people often lack foundational knowledge about health insurance, eligibility, and coverage options. Traditional education efforts—like flyers—are insufficient. Education should be embedded within trusted community institutions and delivered by peers or local advocates who can explain concepts in accessible, relevant ways.

- **"We need to be doing education around health insurance and what plans are... the problem is they don't know the questions to ask."**
- **"That information is not readily accessible... all the health literacy stuff... we need to target the community at large."**
- **"Trusted community members... providing the care is really, really important."**
- **"We onboarded somebody, a bilingual benefits coordinator... he assists them in putting through the application... a really long process, a really confusing process."**

STRENGTHEN CROSS-SECTOR COLLABORATION AND REFERRAL SYSTEMS:

Improving access requires better coordination among hospitals, schools, and community-based organizations. Clear, proactive referrals to food, housing, dental care, and other supports must become standard practice, especially for uninsured or underinsured individuals.

- **"It would be great if hospitals had a brochure listing food cupboards, dental help, and prenatal care in the area."**
- **"Referrals go from community health workers… they're usually agency agnostic."**
- **"Warm handoffs to housing resources, food resources, other healthcare institutions, making specialty appointments…"**

ADDRESS FINANCIAL BARRIERS AND ENHANCE AFFORDABILITY.

High out-of-pocket costs, even for insured individuals, remain a major barrier to care. Participants emphasized the need for financial assistance with copays, deductibles, pharmaceuticals, and self-insured plan costs. Policy solutions could include subsidies, expanded eligibility, and support for Pennie (the PA Health Insurance Marketplace).

- **"Finding ways to provide financial assistance for copays, deductibles, and for pharmaceuticals is a really important component."**
- **"If we can get some assistance to bring down the cost of being self-insured through the Pennie system… that would also be a benefit."**
- **"We've got folks choosing to be uninsured and then choosing to utilize services based on being uninsured."**

INVEST IN LONG-TERM INFRASTRUCTURE AND POLICY CHANGE.

Finally, sustainable impact requires investment in workforce development and policy changes that support billing, staffing, and accountability. Short-term grants or pilot programs are insufficient. A long-term strategy to embed equity-focused services into the healthcare infrastructure is needed.

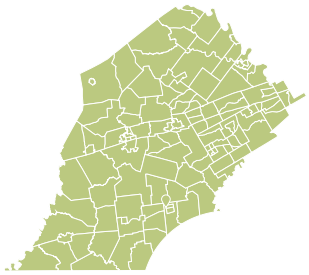
- **"If we're talking about all these health systems in our county… how about we start being able to bill for navigation services where we're getting people out of poverty and into housing."**
- **"So, placing AmeriCorps workers in community-based healthcare settings… calling [patients] and telling them, 'Hey, do you know that you're eligible for Medicare?'"**

County-Specific Perspectives

BUCKS

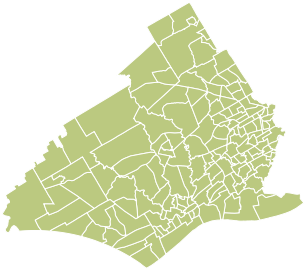
In Bucks, access to mental health care is a major concern, especially for individuals needing culturally competent, bilingual providers. There is also significant fear around seeking help, including domestic violence, due to immigration status. Preventive care is underutilized, and individuals often turn to emergency departments for primary care needs. There are reports of people seeking unsafe dental care from unlicensed providers. Major barriers include language access, transportation, and lack of patient navigation services, especially in a client's home language.

CHESTER



Chester County is home to a large migrant workforce in the mushroom industry, many of whom are undocumented and live with chronic fear of deportation, which discourages care-seeking. Working conditions were described as physically taxing, with individuals in the mushroom industry experiencing chronic health issues tied to repetitive labor, poor ventilation, and long hours. Yet without insurance or documented employment, many avoid care entirely—even when vision problems, injuries, or pain interfere with their ability to work. There is a lack of prenatal care, contributing to poor maternal and infant health outcomes. High demand for preventive and maternal health services outpaces the capacity of local clinics. The cost of caring for the uninsured places significant strain on providers, who are unable to bill for essential services like navigation and social support. The lack of insurance literacy and difficulty navigating programs like Medicaid or Pennie further contribute to unmet needs.

DELAWARE



Dental health was described as a public health crisis among undocumented children, many of whom suffer from severe decay, pain, and related school absenteeism. The state's restrictions on Emergency Medical Assistance (EMA) and the complexity of the application process delay urgently needed care. Access to mental health services is extremely limited, particularly for Spanish-speaking clients, with few bilingual providers and long waits. Some families face Child Protective Services threats over delayed school-required health records. While nonprofits attempt to fill gaps, demand often overwhelms available resources.

MONTGOMERY

The Montgomery County Office of Public Health's 2024 Community Health Assessment (CHA) noted that language access, immigration concerns, and workforce shortages remain critical barriers for immigrant and undocumented residents. Faith-based and volunteer-run clinics like Saint Agnes Nurses Center are vital resources, but operating hours are limited, and capacity is low, often turning people away. Mammograms and other preventative screenings are hard to obtain for undocumented patients, and volunteers report reliance on word-of-mouth to find care, leading to misinformation and frustration. Interpretation and navigation support is inconsistent, and referral options are limited despite strong community need.

PHILADELPHIA

Philadelphia has a relatively robust network of safety-net providers, yet demand outpaces supply. Many uninsured and undocumented residents fear that applying for benefits could jeopardize their immigration status, a belief that persists despite outreach efforts. There are federally qualified health centers (FQHCs) and community health worker models that are effective but under-resourced. Access to preventive care, housing, and employment services remains critical. Housing insecurity, fear of documentation requests, and poor system navigation persist as major barriers.

SPOTLIGHT TOPIC

Culturally Appropriate Mental Health Care

Access to mental health care that respects a person's culture, language, and background is a growing concern in Southeastern Pennsylvania. The COVID-19 pandemic, hospital closures, and changes in the health care system have made it harder for people to get the help they need. These challenges have especially affected Black, Brown, LGBTQ+, immigrant, disabled, and low-income individuals, who often face more barriers when seeking care.

To better understand these issues, four county-based group discussions and five key informant interviews were held with local leaders who know their communities well. This work builds on the 2022 Regional Community Health Needs Assessment (rCHNA), which explored mental health and substance use across Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This spotlight focuses on Culturally Appropriate Mental Health Care and shares insights, challenges, and community-driven solutions to improve access across the region.

Challenges and Barriers

Many people in Southeastern Pennsylvania face challenges when trying to get mental health care that respects their culture, language, and background. There are not enough diverse providers who understand the unique needs of different communities, including Black, Brown, LGBTQ+, immigrant, and disabled individuals. Language barriers, high costs, long wait times, and lack of insurance coverage make it even harder to access care. Some people feel judged or misunderstood by their providers, while others are unsure where to go or how to start. Cultural stigma and fear can also stop individuals from seeking help. For many, transportation, limited clinic hours, and hard-to-navigate systems add more stress. These barriers make it difficult for people to get the care they need in a way that makes them feel safe, respectful, and supportive.

LACK OF DIVERSE MENTAL HEALTH PROVIDERS

Many participants shared that their communities do not have enough Black, Brown, LGBTQ+, bilingual, or culturally informed mental health providers.

Individuals noted that they often feel they must explain their culture to their provider, instead of receiving care that already understands and respects their background.

One participant from Chester County said:

"We do not have enough Black and Brown providers, providers who speak languages other than English, providers who are LGBTQ+. And so, there are folks who are finally getting to a space where they're ready to engage in the service, and they have to if they can even communicate with their provider, they then are in a position where they have to educate their provider about their lived experience instead of actually be a service recipient, which is what they're doing. It's an issue that we've heard about. We don't provide clinical services. We are partnering with an organization in the Coatesville area to try to start doing some different things."

Another participant from Chester County mentioned:

"What I hear over and over again is a lack of providers that look like me, that speak the same language as me. And, yeah, I just, I think that that's been a huge issue."

LANGUAGE BARRIERS

Many participants shared that it is hard to find mental health professionals who speak the same language. This can make it difficult to build trust and get the right support.

Some said that interpreters are sometimes used instead of bilingual therapists, but this can be a challenge, especially when talking about sensitive or emotional issues.

While virtual care was seen as helpful, participants noted that it is not always available in multiple languages.

There was also a clear need for mental health materials and referral lists translated into other languages, especially Spanish, to help individuals better understand and use available services.

One participant from Philadelphia County said,

"No. In general, just no. I mean, our behavioral health consultant right now, he has to use a translator. Luckily, he's one of the only ones here that doesn't speak Spanish, so our providers are able to provide that linguistically competent care, but we have had a really hard time finding bilingual providers. And there are still some people that come in with languages that we don't have any providers that speak Haitian Creole or any Asiatic languages. We don't have any, actually, we have one person that speaks Telugu, and that is it. But, yeah, there are definitely gaps in that. And I think interpretation services have gotten super advanced, but we are still using a telephonic interpretation system, which is also a barrier to both mental health care and primary health care. It's just kind of what we're working with now."

COST AND INSURANCE ISSUES

Many participants shared that some mental health providers do not accept insurance due to low reimbursement rates and the amount of paperwork required. This often leaves individuals to pay out of pocket, which many cannot afford.

Even those with insurance may struggle to cover the cost of regular therapy, especially since mental health care often involves weekly or biweekly sessions.

Participants noted that people with hourly jobs, agricultural work, or tip-based incomes often skip care because they cannot afford to miss work or pay for services themselves.

Families with employer-sponsored insurance expressed frustration when they are unable to use their coverage for mental health care.

One participant from Chester County said,

"Cost is a huge issue. So the majority of Chester County residents are -- I know, uninsured and undocumented is another topic, but on this topic, I will say majority of Chester County residents are insured, and the majority have private or commercial insurance. However, a lot of providers in Chester County do not accept insurance because they're not being reimbursed at a rate that is affordable, and the amount of paperwork that is required to complete to get a really low reimbursement rate, they don't accept insurance."

SHORTAGE OF PROVIDERS

Many participants said that a major barrier to mental health care is the shortage of providers. With too few providers and more people seeking care, wait times can be long—sometimes weeks or even months. This is especially hard for individuals who must take time off work to attend appointments.

Some participants shared that people often stop trying to get help because it is so difficult to find care that fits their needs. Even when services are available, there are very few providers who reflect the culture, language, or lived experiences of the communities they serve.

In rural and underserved areas of Southeastern Pennsylvania, the shortage is even worse. Participants also noted a serious lack of bilingual therapists, and many of the trained providers leave for higher-paying jobs in nearby cities.

One participant from Chester County mentioned:

"There aren't any mental health facilities that are counselors that are available. I mean, it's crazy. It's become a specialty field, I guess, and people have to wait a month, two months for care. And, again, it it and then you have to get to the care, because it's not anywhere near where many other clients are. There are barriers all over the place."

One participant from Bucks County said:

"I think we just don't have the providers available. I can't think on the top of my head who I could refer a client to. It's language, yes, but also culturally appropriate services even in the English language. We lack a lot of diversity, I guess, in our service providers and it's a challenge but it's our area where we live."

CULTURAL STIGMA

Some participants shared that in many cultures, mental health is still stigmatized. It is not openly talked about, and people may feel afraid or embarrassed to ask for help.

Others noted that mental health is not always viewed as a real health issue. In some families or communities, it is not taken as seriously as physical health.

Cultural beliefs can also prevent people from seeking care. Some individuals feel that mental health services are not meant for them or their community, which creates a barrier to getting support.

Participants also highlighted that trusted community members, such as church leaders, teachers, or peers, can play a big role in reducing stigma and encouraging people to seek help when needed.

One participant from Philadelphia County said:

"I think one of the biggest issues that we find here is just sort of the cultural acceptance of mental health as a significant issue or something to seek care for."

Another participant from Philadelphia County mentioned:

"But I do think that a barrier to that is just the cultural sort of stigmas and the cultural sort of ideas about mental health and about people that maybe struggle with mental health issues. Again, speaking as somebody who is not Hispanic or Latino, not a person of color, those are the things that I think I've observed in our patient population, and it's really helpful to have culturally competent staff members as well as staff members that are potentially from the same culture, so they're able to kind of sit down and have those conversations. I think it's a deeper issue than just sort of access to mental health care. I think it's more about the acceptance of that care as well. And I don't know if there is an easy or quick fix to that, but that's sort of how we've been navigating it, and navigating that barrier in particular."

One participant from Chester County said:

"I think when we talk about cultural, there is still a hesitation to seek out mental healthcare."

LACK OF TRANSPORTATION AND LOCATION ACCESS

Many participants shared that getting to mental health care is a major barrier. Challenges included limited public transportation, lack of walkable routes, and difficulty accessing offices, especially for people with disabilities.

Mental health services are often far from where people live, particularly in rural or low-income areas. This makes it difficult for those without a car to reach care. Even when public transportation is available, it can take too long, especially for people who work or care for children.

Participants also noted that transportation is a bigger challenge for vulnerable groups, such as older adults, people with disabilities, and those without a driver's license.

To improve access, participants suggested creating one-stop clinics that offer mental, physical, and dental care in a single location. This would make it easier for people with limited transportation to receive the support they need.

One participant from Chester County mentioned:

"I mean, we've had to send people to Philly to get a mental health treatment. It's ridiculous."

One participant from Bucks County said:

"I just think it would be so much more comprehensive for individuals who have transportation issues and other socio-economic needs to have everything centralized and in one location."

LACK OF SUPPORT TO NAVIGATE THE SYSTEM

Many participants shared that the mental health system is confusing and difficult to navigate. People often struggle to find care, understand what services are available, and know how to get started.

Some individuals said they do not have clear referral options or enough information on where to go for help. This can lead to delays or people giving up on seeking care.

Participants suggested the need for system navigators or liaisons, trusted individuals who can guide families and help connect them to the right services.

In addition, insurance adds another layer of difficulty. Checking coverage and finding providers who accept certain plans is challenging, especially for those who are not familiar with how insurance works.

One participant from Bucks County said:

"I'd love to see roles that are specific to just helping people navigate the system, just navigators. In school districts, outside of our area, I know they have parent liaisons or just kind of these point people that can really help people navigate through the system because it's complex. It's so complex."

LACK OF INTEGRATION WITH TRUSTED COMMUNITY SPACES

Participants shared that schools, churches, and community centers are trusted by families but are not always connected to mental health services. These familiar spaces are often underused for outreach and support.

Bringing mental health providers into trusted places can help reduce stigma and make it easier for people to ask for help. When care is offered in locations where people already feel safe, they are more likely to use it.

Stronger partnerships between health systems and local organizations are important. These connections can help build trust and improve access to care, especially in underserved communities.

One participant from Philadelphia County said:

"I've seen success and if you bring providers, mental health providers to trusted sites."

One participant from Chester County said:

"I mean that making sure that the schools have resources to refer out. Maybe making sure that maybe we can go in and do education at the schools because the school is the trusted resource by the parents and by the families. And so, the more they're able to learn about services in the area and then have that as a resource for referral is really important."

UNDERINVESTMENT IN CULTURALLY TAILORED PROGRAMS

Participants shared not enough mental health programs are designed for specific cultural groups. This means many people do not receive care that feels welcoming, relevant, or respectful of their background.

Community-led programs like NAMI's *Sharing Hope* and *Compartiendo Esperanza* were praised for being culturally specific and led by trusted local leaders. However, participants noted that these types of programs are still limited and need to be expanded.

Many culturally tailored programs remain small or in early stages because they lack the funding to grow and reach more people.

Participants also shared that alternative care options—like yoga, acupuncture, and mindfulness—are helpful but often only available to people who can afford to pay out of pocket. These services are rarely covered by insurance, making access limited for lower-income individuals.

Two participants from Chester County mentioned:

"I think when we talk about cultural, there is still a hesitation to seek out mental healthcare. And so having partnerships with really important organizations like NAMI, making sure that places that are trusted community resources, so think about the schools, right?"

"For us, it's just we're still building our capacity to create those relationships so that because we don't know. I'm not a member of those communities. And so ensuring that really building the trust there so that if folks want to use that resource, they're welcome to do so."

Special Populations

Certain groups—including children, youth, older adults, people with disabilities, and those with serious mental illness—face unique vulnerabilities when trying to get culturally appropriate mental health care. Many of them struggle with finding providers who understand their background or can speak their language. Others face problems like stigma, fear of judgment, or not being able to afford care. Some live in areas without nearby services or don't have transportation to get to appointments. These challenges make it harder for special populations to get the right support, which can lead to more serious mental health problems over time.

CHILDREN AND YOUTH

Youth face challenges with provider shortages, cultural stigma, and a lack of school-based referrals.

There's a critical need for youth-focused, trauma-informed care, especially in schools and vulnerable communities.

One participant from Delaware County mentioned:

"Yeah, we we don't have enough therapists out there. And then when you get into -- in Delaware County, I can just use the example of Upper Darby. Upper Darby has over -- just in the high school alone, people who speak over 300 different languages just in the high school. So, then you bridge that out to the larger community of people who are maybe undocumented or whatnot, and they don't speak English, and they're not able to assimilate into the American English speaking therapy or community. As far as therapy, that access is basically going to be a very, very difficult way to navigate."

PEOPLE WITH DISABILITIES

People with disabilities face physical, cultural, and communication barriers to accessing appropriate care.

There's a lack of therapists trained in disability culture and few who know American Sign Language.

Accessibility of transportation, buildings, and therapy platforms remains a major issue.

One participant from Philadelphia County mentioned:

"I think there's definitely issues when it comes to disability culture. We view disability as part of somebody's identity, not a diagnosis. And there's nowhere near enough mental health professionals that understand disability culture. There's also a lack of accessible, physically accessible places for folks with disabilities to go. There's a lack of folks that are mobile. And there's also a lack of folks that know American sign language, which is incredibly difficult to receive services through an interpreter who is learning about the individual's mental health issues. And there's significant gaps, especially on the Medicaid and Medicare side."

IMMIGRANTS AND UNDOCUMENTED INDIVIDUALS

Language barriers, cost, and fear of deportation or system involvement create major access issues.

Many are uninsured or underinsured, and few programs are culturally and linguistically tailored.

There's a deep need for trust-building and culturally sensitive outreach.

One key informant mentioned:

"Well, I would say these folks, the Latino, the undocumented noncitizens, uninsured, they will express -- we go through the intake. Have you ever felt depressed? Do you feel like you have no energy to get out of bed? And that's hard to translate with the interpreter."

PEOPLE WITH SERIOUS MENTAL ILLNESS

People in crisis face limited treatment options after initial contact, resulting in only partial support.

There's a lack of continuity of care beyond initial intervention or suicide prevention efforts.

One participant from Bucks County said:

"You can recognize when somebody is suicidal, take them to crisis. But if they can't get the treatment, then they're still suicidal. We've got half of the equation."

Another participant from Bucks County mentioned:

"We're putting Band-Aids on open giant wounds. All we got is Band-Aids at the moment. But yes, that continuum of care. It's so necessary."

OLDER ADULTS

Older adults often face stigma around discussing mental health and limited access to geriatric psychiatry.

Programs aimed at reducing isolation have shown promise, but access is still limited.

One participant from Philadelphia County said:

"Also, with older adults, we hear that there is certainly stigma around talking about mental health, mental health treatment, etcetera, and that it can be hard. It's difficult to find providers who can support older adults specifically. Geriatric psychiatry, etcetera, it can be difficult to find the right people."

What's Working Well

Despite the barriers, community-based providers continue to deliver impactful care through a variety of locally driven strategies.

COMMUNITY-LED PROGRAMS AND PEER SUPPORT

Programs like NAMI's *Sharing Hope* and *Compartiendo Esperanza* were praised for being led by trusted community members who share cultural backgrounds with participants.

These programs use storytelling, discussion, and peer leadership to build trust and reduce stigma.

One participant from Philadelphia County mentioned:

"So I think there's opportunities to leverage community-based organizations to do that and also start to put effort behind it where we can show the results. So, I think working together collaboratively is one way to do that."

TRUSTED COMMUNITY PARTNERSHIPS

Bringing services into schools, churches, and local nonprofits was seen as a major strength because people already trust these places. This helps reduce stigma and makes it easier to connect families with care.

CBOs are trusted and serve as key bridges between health systems and hard-to-reach communities. They help reduce barriers by offering advocacy, outreach, and system navigation.

One key informant said:

"Go to a church. After the church service, do an education. You got a capital crowd. You got them right where you want them. Bring some food, call the day. I think things like that. More of that stuff needs to happen. We really wanna reach into the community. Same in the southern part. And, again, we have to make sure we're doing things bilingual. We have to make sure we're reaching everybody."

FREE OR ACCESSIBLE TRAINING FOR PROVIDERS

Free, local training like QPR (Question, Persuade, Refer) suicide prevention and trauma-informed care were appreciated and seen as essential for improving care.

One participant from Bucks County said:

"I'm going to throw in too, how about free training for trauma-informed care. I know there's a wonderful suicide prevention training that was done through the county. Just more of those types of things for providers and I think that's my wish list."

USE OF VIRTUAL MENTAL HEALTH OPTIONS

Telehealth services helped expand access for people who live far from providers or face transportation barriers.

Virtual therapy is especially helpful for hourly workers, young people, and parents who need flexible options.

One participant from Delaware County said:

"Thank goodness that virtual mental health care is a thing, so we're able to accommodate more folks in that way. But if we want bilingual health care to be an issue, we've got to incentivize folks to stay."

Suggested Actions and Solutions

Issues with accessing culturally appropriate mental health care are vast in the Southeastern Pennsylvania region, impacting every county and diverse community populations. To address these challenges, discussion participants offered targeted solutions and highlighted some successful approaches already implemented in their communities. Solutions reflect opportunities for partnership between hospitals and health systems, community organizations, health clinics, and government.

INCREASE DIVERSITY AMONG MENTAL HEALTH PROVIDERS:

Many participants suggested hiring and training more Black, Brown, bilingual, LGBTQ+, and culturally aware mental health providers. This would help clients feel more understood and supported by someone who shares or respects their background.

They also recommended offering incentives—such as higher pay, loan repayment programs, or bonuses for bilingual skills—to help keep diverse providers working in their local communities.

- **"We can't be paying them $40,000 at a base clinician salary when they speak two or three languages. Because if I go to Philadelphia, I'm making $80k. And that's just the reality. And where I think we haven't caught up is really appreciating the need to create that infrastructure and funding for people to stay. Because students will say to me, I want to stay in the county. I want to serve my community, but I also have to pay off loans. And they can do that because bilingual therapists, especially experienced ones, should make more."**

EXPAND COMMUNITY-BASED AND SCHOOL-BASED OUTREACH:

Many participants suggested bringing culturally competent mental health services to trusted community places like schools, churches, and local clinics.

They also recommended partnering with community organizations to help educate families, reduce stigma, and improve access to care.

- **"I've seen success and if you bring providers, mental health providers to trusted sites."**
- **"Community advocates are the ones who are gonna get the message out way more than a provider or a person from one of the health systems. I think you really need to start -- we need to start getting some advocates in the community and empowering them, not just giving them a flyer."**

IMPROVE NAVIGATION AND REFERRAL SUPPORT:

Many participants suggested creating navigator or liaison roles to help people understand and access mental health services, especially for immigrant families and individuals who do not speak English.

They also recommend supporting schools and social service agencies in building stronger and more effective referral pathways.

- **"I want to use my health insurance, I do not wanna pay out of pocket. So, people can't afford to pay out of pocket or people don't want to pay out of pocket or both. And it's a huge issue that we don't have, our behavioral health providers are not being reimbursed at a rate that is appropriate for the care that they are providing, and so they are not taking insurance. And it's that's a big, again, maybe not a cultural, but it's definitely a financial barrier for a lot of people."**

IMPROVE TRANSPORTATION AND ACCESSIBILITY:

Many participants suggested offering transportation to and from appointments or bringing services to places where people already go, like schools or community centers.

They also recommended increasing the use of mobile units and offering more after-hours appointments to improve access.

- **"I just think it would be so much more comprehensive for individuals who have transportation issues and other socio-economic needs to have everything centralized and in one location."**

DEVELOP AND FUND CULTURALLY APPROPRIATE MENTAL HEALTH PROGRAMS:

Participants suggested supporting and expanding mental health programs that are designed for specific racial, ethnic, and language groups.

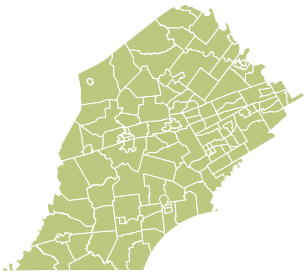
- **"The more partnerships, I guess, hospitals can make, will make it better for in the community also. I mean, it may drive down costs a little bit too, which is good. Again, we need to do it differently. We can't. The hospitals can't. So, they don't have all the answers, and I know that. And I know they don't have all the money. Although they have a lot, they don't have all the money."**

County-Specific Perspectives

BUCKS

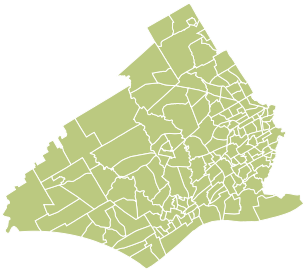
People in Bucks County say there aren't enough mental health providers, especially those who understand different cultures or speak other languages. Transportation and cost are big problems, especially for people with lower incomes. There was also a strong wish for one-stop clinics where people can get mental, physical, and dental care in one place. More training for providers and system navigators was also suggested.

CHESTER



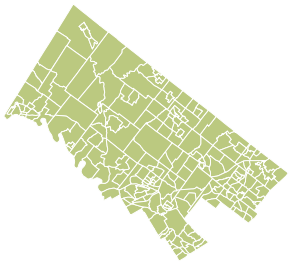
Chester County struggles with a lack of diverse providers, especially for Black, Brown, and immigrant communities. Many residents feel like they must explain their culture to their therapist. Cost is a major issue because many providers don't accept insurance. Community members also pointed out that cultural stigma prevents people from seeking help. Trusted spaces like schools and churches were seen as good places to connect people with care.

DELAWARE



Language barriers are a serious problem in Delaware County, especially in places like Upper Darby where many languages are spoken. There is a lack of bilingual therapists and not enough pay to keep them in the area. Virtual care has helped, but it's not a perfect solution. Transportation, cost, and long wait times also make it hard to get help..

MONTGOMERY



In Montgomery County, people shared that waitlists for mental health care are long and there are very few culturally appropriate options. People want more providers who understand their background and experiences. There is also a need for more support around navigating services and insurance systems.

PHILADELPHIA

Philadelphia faces many of the same issues, too few bilingual providers, long waitlists, and high costs. People with disabilities and older adults have even more trouble finding the right kind of care. Some providers are trying to help by visiting trusted places like churches or health centers. Community-based support and education are seen as important ways to reduce stigma and improve access.

SPOTLIGHT TOPIC

Housing

To assess the needs and opportunities to address housing issues across all five counties, focus groups were conducted with representatives from area organizations that address housing and related social services. In-depth information was also gathered via key informant interviews with community-based organizations, researchers and policy makers throughout the region; relevant comments from each of those discussions are included below. Across all groups, participants discussed a range of issues related to housing insecurity (the risk of losing one's home) and homelessness, habitability, and their intersections with mental health and substance use disorders.

"Housing is health care. You have a place to live. You'll take your medicines. If you have a place to live, you'll get your kids up and get them to school. You'll eat food. You have a base of operation. When you're without housing, you basically are unsafe."

This powerful statement, shared by a Chester County participant, underscores the central theme of this spotlight summary: stable housing is foundational to health, safety, and overall well-being. Drawing from focus groups and key informant interviews across the region, this report explores the interconnected challenges of housing insecurity, habitability, and homelessness—particularly as they intersect with health, social supports, and systemic inequities. The insights gathered here reflect both the urgency and the complexity of the housing crisis in our region and highlight community-driven strategies, health system roles, and policy opportunities to advance housing as a critical social determinant of health.

Housing Insecurity and Homelessness

In most counties, lack of affordable housing, limited access to resources, and compounding social drivers of health serve as key barriers for adults experiencing housing insecurity. Participants identified the need for more affordable and available housing as a priority.

Referring to the lack of resources, one Philadelphia-based participant shared:

"I think that families or individuals need access to rental assistance. We're fortunate that we can provide some of those services, but we have a waiting list of over 2,000 people for that service and not nearly enough resources to provide it."

Another participant from Delaware County underscored the challenges related to rental assistance:

"The other issue that we see time and again is that even when folks get their housing vouchers, there are limited landlords that will accept the housing vouchers. And the quality of the housing stock in some communities…is so low that they won't pass inspection even if the landlord will rent the folks."

Participants from Montgomery County also discussed other social drivers of health, such as transportation, as a raising concern.

"…I'm thinking about a client that walked in recently and she said she's looking to find a place that's near a bus system. Because she's unemployed or she only gets seven hours a week, so it's not enough, she wants to find a better job and she doesn't have transportation. So, she really needs to be near a bus. So that's the other challenge is it can't just be any place, not an isolated place. Place with resources."

COMMUNITY SAFETY

Community violence and safety were also cited as barriers in Chester County, making affordable housing a significant concern.

During the key informant interviews, a participant from Chester County detailed the notable gap in the housing market:

"…there are particular pockets of the community where crime is more prevalent. So, if I cannot afford certain housing, then…I'm restricted to where I can live. I probably have to find a house in a more crime-ridden area which might be deemed as less safe. There is a growing concern for attainable housing because the types of houses that are being built are not in the attainable housing price range."

EXISTING HEALTH ISSUES

Individuals with new or existing health issues and low income are disproportionately impacted, highlighting the urgent need for better housing solutions and systemic support.

A participant from Chester County accentuated the need to safeguard challenges faced by individuals with health problems:

"I've gotten a couple of calls…one was persons with a health problem, somebody who just recently had been stable working, recently diagnosed with kidney issues, on dialysis, income has significantly reduced, now they cannot afford their rent."

"Not only is their health in jeopardy, their houses in jeopardy, and all of that just kind of snowballs."

"…maybe family took them for a period of time, right? But that's not their home…and then because there has been recorded that somebody has helped them in the past, they may not be necessarily identified as homeless, right?"

HOUSING AND HEALTHCARE SYSTEM GAPS

Participants also highlighted a major gap in the housing and healthcare systems. Unstably housed individuals who get hospitalized often have nowhere to go post-discharge.

While one participant touched on the ethical aspect, another acknowledged the competing challenges for hospitals:

"I've recently spoke with someone from an organization that said there are hospitals that once a patient is medically stable, they drop them off…on the streets without housing. And I believe that's completely unethical."

"…they're also competing against, I guess, is the insurance and how long they'll cover something. So, a lot of times, the thing that would help is a longer timeline if there is a need for a home mod or something to be set up or even rehab care, and the insurance is denying it. So, the hospital is up against kind of their funding source for some things that could help for longer planning."

LOW WAGE JOBS

Low-paying jobs are another barrier to housing, leaving individuals homeless or living in precarious situations.

As one participant detailed during a key informant interview:

"I'm not even going to say there isn't a job, because there are plenty of low paying jobs in this area, and the low paying job doesn't give you enough to afford to live. That's the problem. So, if you're living here and you have a low paying job, you need…a couple of different jobs…or you're still living in your car, or you're still living in the backyard of a church."

THE HIDDEN NATURE OF HOMELESSNESS

The conversations also mention the hidden nature of homelessness, the struggle to access shelters, and how some individuals rely on indefensible conditions for temporary refuge. While resources are available, challenges remain with access, restrictions, and agencies being understaffed and overwhelmed.

A participant stressed how homelessness is becoming increasingly visible and urgent in Chester County:

"This stuff is rampant. People are living in hotels or in the backyard of our little church because…there's no home…But what, what do we do? What are the resources for those that are homeless? What are the plans for them?"

"…there's several places around that we have referred people… but I've heard that many times. They don't take certain ones. Don't take men, or they only take women and children. So, there's all these extra little things you have to be out by this time, and you have nowhere to be until nighttime."

A participant shared the unique trends related to housing insecurity in Delaware County:

"Most of our folks that are housing insecure are couch surfing… [They] are finding creative, but challenging circumstances to rehouse themselves."

"From a health perspective, what that leads to is all of these folks with great need that are very hidden from the system and not showing up in metrics and not having access to social workers and care providers."

SHELTER ACCESSIBILITY

While services are available, shelter accessibility and uptake remain a challenge.

In Philadelphia County, homelessness and shelter access has its own set of challenges. As one participant discussed:

"The housing system is a beast, whether it be transitional housing, recovery housing, finding apartments, it takes time."

"…it's also important for the hospital systems to understand that many people go to the emergency room who are homeless, Thursday, Friday, Saturday because they can survive during the week because they can go sit in a mall or sit in a waiting room or do other things because businesses are operating during the week. "

"…for the Northeast, I think the closest shelter is eight miles. For somebody that doesn't have transportation, trying to get their life back together to commute back and forth to a shelter -- and that's just one of the close ones."

KENSINGTON CHALLENGES

Participants also shared their concerns regarding the Kensington encampments and rehousing programs, citing it as a challenging issue with no easy solutions.

"We're trying to connect these people to resources. However, I get it, they don't want to leave their area. They're not going to take the chance going to a shelter that they may or may not have had a good or bad experience at previously and so trying to engage them and empower them to make decisions…is very hard."

"You know it's just back the way it was…I think that you would have to have a small army in place to help."

"We have the initiative in Kensington that's taking place, which is displacing people further out from that epicenter. So, we're seeing upticks in homelessness throughout different areas of the city where it wasn't as bad. Like, I know up in the Northeast, we have giant encampments in the woods. They're almost self-surviving cities."

Habitability

Conversations across the region highlight concerns about unsafe, unhealthy, and uninhabitable housing conditions that disproportionately affect low-income individuals, families, older adults, and other vulnerable populations. Key issues include lead exposure, lack of maintenance by landlords, structural hazards, and poor sanitation, all of which have serious implications for residents' health and well-being.

LEAD EXPOSURE

In Philadelphia, lead exposure in rental homes remains a public health concern, particularly for children.

In Delaware County, older housing stock presents a high risk for lead contamination.

"The Philadelphia houses, like they all end up facing with the lead…our client kid [got] sick because of the house, is all that kind of problem."

"In 2022, a study was done in Upper Darby Township…that estimated 50% of housing have a potential for elevated lead risk."

"…the county is working closely with the Department of Health to relocate lead poisoning families that have been identified… and work also with the landlords to ensure that they're not re-renting to the individuals."

LANDLORD NEGLECT

In Chester County, renters experience unsafe and poorly maintained housing due to landlord neglect. The participants emphasized on more accountability for landlords "and how they show up in the community."

"A lot of people are unhappy with their current housing. They have a slumlord or someone that isn't taking proper care of their properties, safety, security, and just affordability."

"So, when we don't stay in a good environment, we discover that some people might be exposed to, let's say, what they eat might be affected, the environment, they cannot air. The temperature at the moment is on the things that will affect them."

"Last week I was at a client's house who has infested roaches. And he sprayed and all the other stuff. The landlord does very little to assist that. [My client] was afraid to cook food, because bugs were falling in his food."

Housing and Mental Health

The spotlight conversations across the region highlight the intersection between housing instability and mental health, emphasizing that without stable housing, individuals struggle to access and maintain mental health care. Similarly, mental health challenges make it more difficult to secure and maintain housing, creating an unfortunate cycle of homelessness and crisis. Mentions of housing instability affecting mental health were more frequent in suburban county conversations.

MENTAL HEALTH

Community participants noted mental health as a major barrier to stable housing. The interconnection of mental health with physical health and other invisible factors, make mental health a critical aspect of addressing homelessness

A participant from Bucks County detailed:

"...once someone is suffering from that whatever mental situation that they're dealing with, and they are unhoused, there's other barriers that are surrounding them, invisible barriers that do impact their ability to kind of move into the shelter and then move into housing."

Another participant from Chester County focused on addressing the mental health needs of unhoused individuals before "putting them back out on the streets":

"...they're just on the streets trying to be a member of society but are struggling because of their mental health issues."

SUBSTANCE USE

Substance use was another point of concern in relation to mental health and homelessness for many commu-nity-based organizations. Stable housing is one of the biggest issues for people dealing with substance use disorders, leading to an increased risk of relapse. Other concerns included difficulty engaging clients in treatment and limited housing options, especially for men.

As one Bucks County participant noted:

"No one is going to stay sober, living homeless. It's just not a realistic possibility."

A Bucks County participant shared:

"It's really hard to engage them in any mental health or drug and alcohol treatment because they're worried about where they're going to lay their head at night or where their next meal is coming from."

With respect to the recovery houses, a Philadelphia-based participant added:

"...they're very minimal, like for the city, we have the office of addictive services that handles the recovery houses that are funded through, like CBH and OAS...and that's a broken system. It's hard to get into them, there's a waiting list that's enormous."

Another Bucks County shared struggles specific to men:

"At any given moment, we're full with women and children if you have a male and he needs assistance there's no way. You have to get him into a recovery house."

Additional mentions of specific subpopulations struggling with mental health and housing instability are highlighted later in this section of the report.

Older Adults

Older adults face significant housing challenges that impact their health, safety, and overall well-being across the region. The spotlight conversations highlighted several key concerns affecting older adults, including aging out of their homes, lack of affordable housing, poor living conditions, and barriers to accessing support services. Mentions of older adults facing housing difficulties were more frequent in suburban counties.

HOME MAINTENANCE

Many older adults struggle to maintain their homes as they age and develop mobility issues. Older adults losing the ability to maintain their homes often becomes a crisis before intervention happens.

"...with the older population, what we're seeing with housing is they age out of their current house, or their house is no longer appropriate for them. And then that location becomes a healthcare risk."

"They don't have the money to fix it up or keep it clean. So usually when we get a report of need, it is beyond the point because they're either in the hospital, or they're reported to the county because there's a hoarding issue."

AFFORDABLE HOUSING

Lack of affordable and accessible housing was another point of concern across counties. Older adults on fixed incomes often struggle to find affordable housing that meets their needs.

"We work a lot with seniors which is a real struggle to find appropriate housing for them. Accessible and affordable; it seems to be very little in the area."

"...when you talk about conducive environment, it's one of the factors that can cause so many illnesses. So, it is very important for communities where we have people who have aged that cannot be able to, maybe they are no longer working, those who are handicapped, they are not spending less."

ACCESSIBILITY

Temporary housing and shelter access is a challenge for older adults as well. Accessibility remains an added barrier for older adults with disabilities facing home insecurity.

"...there is a homeless issue with older adults too and it's very difficult because of their age to find temporary housing. So, it's usually in a hotel and that's not a great welcoming place for an older individual to be housed."

"It's funny how at that age, you have to worry about a mortgage, you have to worry about having a conducive environment to live in. It's quite saddening to know that emergency in a 55 year old, 60, 65 year old battling with housing issues because that's the age you have to relax and enjoy whatever is left of your life."

"...not all of them are accessible for their needs. So it makes it harder to encourage them to go into shelters that may help them get rapid rehousing."

Children and Youth

FAMILY HOMELESSNESS

Participants from most counties identified family and youth homelessness as a major concern leading to family separation.

"Unfortunately, we have very little capacity for family-based shelters, so families are being separated and segregated."

"...a lot of families and child welfare involve families that are looking for housing or that need housing in order to reunify with their children."

MENTAL HEALTH

The interconnection of mental health and housing insecurity for youth was also highlighted in the conversations. Youth in unstable housing often lack access to mental health support, especially after aging out of care.

"87% of our young people [who] self-identify as having some sort of a mental health challenge...49% of them have a history of being in foster care, and about 26% are survivors of domestic violence."

"Behavioral health piece is something that we try to address in house, but once they transition out of our care, it can be very difficult for them to connect to services outside in the community. Waiting lists are extremely long, and it can be hard to find a provider."

FINANCIAL AND EMPLOYMENT BARRIERS

Financial and employment barriers also limit access to affordable youth housing. Many young adults can only find low-wage jobs, making independent living difficult. Some youth experiencing homelessness are also young parents, which adds another layer of difficulty. Youth often struggle to secure housing due to a lack of rental history as well.

"...we're trying to do more on connecting them to career path employment because they can find jobs at...or other retailers, but those are not jobs that are able to help them sustain housing long-term, especially on their own."

"Childcare is another important piece. Waiting lists for childcare are long as well. And childcare, as we all know, is very, very expensive."

"And then for our young people, I think not having the history can make it hard for them to get an apartment."

Special Populations

Many minoritized communities, such as immigrant populations, individuals with disabilities, survivors of crime and human trafficking, face significant barriers in accessing stable and safe housing.

IMMIGRANT COMMUNITIES

Participants detailed nuanced issues related to immigrant communities. While strong community networks help ease the transition for migrants, challenges such as housing instability, healthcare access, and language barriers remain significant obstacles.

"Indians, we are so tight community. So even then if somebody is migrating from India to here and in the beginning, they don't have a lodging or boarding, there is always a friend or a relative who can -- support system and they just stay with them till they find a job and then they are on their own."

"There's other struggles that come along with it, so a lot of little ones and trying to get them enrolled in school, doctor's appointments and [inaudible] has become an issue, because now there's only the one address and they're definitely not listed on the lease."

"We have 82 languages I'm told, that are spoken in our schools. So that becomes a very huge challenge for our population. The language barrier can preclude a number of our citizens from participating in the various services because of the language."

PEOPLE WITH DISABILITIES

People with disabilities (PWDs) face significant challenges in finding housing that meets their needs; accessibility remains a concern in many counties. While some progress has been made, many other issues remain unaddressed, such as limited access to housing vouchers, extended waiting lists, and difficulties in securing accessible housing.

"For our participants that have disabilities, a lot of things are called accessible where they might not be accessible enough, and they're slow for landlords to make any of those accommodations."

"And it's getting better, but there is a lot of issues with people being allowed into shelters based on their disability, service dogs not being allowed into shelters, wide variety of ableist views that we've experienced with our folks at the shelters."

"Also, people who maybe have vouchers who find an accessible home or apartment, but the landlords will not become a PHA-affiliated landlord, which I didn't know until pretty recently is considered discrimination..."

SURVIVORS OF CRIME AND HUMAN TRAFFICKING

Survivors of crime and human trafficking often struggle to find housing outside of domestic violence shelters. In addition to housing assistance, case workers in a human trafficking shelter often play a key role in supporting survivors with medical care including mammograms, OB-GYN, and other and programs like CHIP.

"We do get a number of callers that are calling about a crime, but their immediate need is housing. We're not a domestic violence shelter, but we do have victims of sexual assault and other violent crimes. And sometimes the crime is forcing them to leave or move as soon as possible. And oftentimes we're giving them housing resources, but we can't give them the domestic violence center if it's not a domestic violence issue."

"A lot of them generally haven't had health care at all. Seeing doctors, anything in a long time…although we initially help with just housing, we also have to try to provide any type of medical care because some of them aren't from here in the US. So, they're not really familiar with healthcare, any different doctors we can offer here versus where they lived abroad."

What's Working Well

SMALL-SCALE HOUSING SUPPORT

Small-scale housing support programs – such as Friends Association's eviction prevention, new initiatives by Kennett Area Community Services and Safe Harbor – have been effective in some parts of Chester County. Despite these efforts, some argue that broader solutions remain inadequate, and county initiatives, such as plans to develop 1,000 housing units in a decade, fail to address the existing housing shortfall.

One participant noted:

"…we're already 10,000 houses to be left behind now…and you know it's gonna get worse."

Participants seek more innovative strategies to create a lasting impact rather than repeating the **"exact same thing."**

IMPROVED PROGRAMS

Philadelphia's housing support programs such as the Basic Systems Repair Program (BSRP), have improved with more contractors. The Home Modification Program also helps residents age in place by adding accessibility features like grab bars. Supportive housing efforts, such as a program that provides housing to individuals with criminal histories and a temporary housing initiative, have shown success in reducing emergency room visits and saving health system costs.

One participant shared:

"You had to be on the list for forever. But now they're turning it around pretty quickly, so that when people do have problems then they're addressed pretty quickly."

Montgomery County has initiated a program matching older adults with spare rooms for housing in exchange for services, though it faces challenges with limited funding and the time required for outreach.

One participant noted:

"Since January, I think we have had four matches, which is not bad for Department of Aging, but that's a lot of time and effort for four matches."

Suggested Actions and Solutions

Recognizing that housing insecurity directly impacts patient care is crucial for hospitals and health systems in the region. Collaboration between hospitals, businesses, and community organizations is essential to address affordable housing as a workforce and public health issue since "all of these needs go together, and that housing is really a key piece of it," as one participant shared. Solutions are categorized below into hospital-driven structural changes and community-based interventions, emphasizing the need for collaboration between both sectors:

Hospital Driven

Strengthen multidisciplinary teams to better plan patient discharges, especially for people with disabilities.	**"We need to get back to... a multidisciplinary team that would meet prior to an individual being discharged from a hospital. And I know that that does exist philosophically and literally, but I think it could be tightened up and a better job could be done..."** **"A lot of the hospitals, there's a lack of education on transition programs that could possibly help a person not have to go into a nursing facility...People with disabilities get various services, so...working with all those service providers to get them transitioned from the hospital back to home if it's somewhere that could easily be modified within a short period of time."**
Assist unhoused individuals in obtaining essential documents to help them access housing-related resources.	**"...a lot of people who are unsheltered or unhoused, don't have an ID, they don't have a social security card, they don't have a birth certificate. So, if we're talking about perhaps ways that hospitals can...help somebody be document ready or to apply for any other resources."** **"The hospital system can help us prove that people are homeless because people need documentation to get some of these vouchers. So, the hospital systems can do a better job of providing that documentation for us that somebody frequents the emergency room, and they experience homelessness."**
Provide community education on the health consequences of homelessness as well as the importance of maintaining clean living conditions.	**"If we educate the community through the hospital that there are medical consequences of being homeless, then our community will feel empowered to call 211 as they would for 911."** **"It's very necessary to take health awareness in West Chester to make sure that those that are having housing challenge, making sure that we'll enlighten them on how to try to keep the environment clean."** **"One concern is that sometimes we're putting out people in houses or apartments, and they really don't understand what it's like to care for an apartment. So, I think the part of that education piece that we need to do to support people in doing better."**

Enhance case management and supportive services to prevent missed treatment opportunities and hospital readmissions.	**"I think really that case management piece is critical…questions like even if they're going home, do they have a refrigerator that works if they're going to be having insulin? is there potable water?"** **"…putting someone in a recovery house that can't hold down a job because they have no short-term memory is absolutely a setup for disaster. That person is going to wind up homeless, they're going to wind up back on drugs. So, if hospitals can maybe do a little bit more just to check for TBIs when they get the clients that come in, do some cognitive checks…"** **"If a person is experiencing homelessness and…there's not that availability, but we meet the level of care criteria for detox or rehab…they have to leave the assessment site in hopes to maybe come back the next day…there's that window of opportunity when a person wants to seek treatment."**
Increase presence and capacity for hospital social workers to facilitate stronger connections with outpatient agencies and reduce workplace burnout.	**"… this is where I think hospital social workers are horribly undervalued and why there needs to be a stronger presence for the social workers in the hospitals…"** **"It would be helpful to have more social workers in the healthcare system and to tighten that bond between outside agencies and the healthcare system."** **"I used to work at a hospital. The social workers often feel constrained because they're getting pressure from administration. We aren't getting paid for this person anymore."** **"It's not enough people…the caseworker that from my church used to tell me what her load was…it's unrealistic to expect. So, it's getting people qualified, training them in the right way to deal with the real-life situations that are out there."**
Improve resource navigation by collaborating with organizations to uncover and expand awareness of existing services through clear guidance or support.	**"We talk about expanding access to resources, but we can't expand access to resources that don't exist… having to navigate these hidden resources is definitely an issue."** **"Some hospitals are better at that system than others where people have said that they have left with absolutely nothing and then have to get through this network of so many hidden resources. And all of these organizations would be willing to educate the hospitals and be part of that planning."**

Collaborate with community-based organizations to finance affordable housing, explore alternative models, and leverage community assets for creative housing solutions.	**"A hospital and a health system have given us money to start to develop those [housing] units, and I think that the health systems need to think about doing that more, helping finance, helping support, because I do believe we save them tons of money."** **"...there really does need to be some new models...given the multitude of health issues that many of our constituents are living with, hospitals can play a role in helping to develop those other models."** **"Churches have tons of land...you can buy full houses they put together for $10,000... all these houses that are abandoned or behind in taxes and getting those houses and developing those...All this space and no one -- the hospital's not coming back here, unfortunately. You could develop this space..."**
Engage in policy, advocacy, and research dissemination to promote affordable housing solutions and prevent displacement.	**"From a hospital standpoint, engaging in policy advocacy, working with other housing coalitions and organizations...sharing the research findings, promoting affordable housing to prevent displacement...would be really important."** **"It would be nice to see if there was some advocacy from the hospital administrations in collaboration with the community entities to look at making changes in housing so that container housing could be established or tiny houses could be established, where they're much more affordable for folks."**

Community Driven

Build a community network to organize community events and fundraisers, provide services, collect resources, and build a collaborative community network.	**"If we could really support them in beefing up those social services and get those individuals connected to all of these outpatient services..."** **"My organization...bring community together by organizing picnics and bowling and go to the game and have Valentine's Day parties...we had a fundraising...and sometimes one day of the polling event also be designated as a fundraiser. And we collect money and then provide whatever services we can."** **"...we collect a lot of clothes and a lot of money for Ukraine and Afghanistan... It's not only through the organizations, but it's a wide Indian community in this Montgomery County."** **"That's something to do, build some kind of community network."**
Investigate successful shared housing programs as potential models and consider blended housing communities that mix low-income families, foster families, and older adults, with on-site case management for support.	**"...if there's a way to have some volunteer base where neighboring families or people can volunteer a space in their home...maybe it could be a temporary thing or there needs to be a network of people. I'm wondering if there's a way to duplicate that..."** **"It's housing for seniors combined with housing for foster families or low-income families, and they sort of create a blended community with case management like right there in the community."**

SPOTLIGHT TOPIC

Maternal Health

The Maternal Health Spotlight was created to better understand the challenges, strengths, and opportunities surrounding maternal and child health in our region. To do this, focused conversations were held with a diverse group of stakeholders, including community-based organizations, healthcare providers, support groups, and policy leaders.

Recognizing that the voices of birthing people themselves are often missing from broader conversations, space was made to speak directly with individuals who have lived experience with pregnancy, childbirth, and postpartum care. By listening to both professional and personal perspectives, this spotlight offers a more complete and human-centered picture of maternal health needs and solutions across our communities.

Challenges and Barriers: Access to Care

GEOGRAPHIC DISPARITIES

Participants emphasized the inequitable distribution of birthing facilities in Bucks County. While Middle and Upper Bucks are served by hospitals like Doylestown and St. Luke's, Lower Bucks is limited to a single birthing hospital, requiring many residents to travel outside the county. This disparity results in decreased accessibility for marginalized populations.

A Bucks County participant said:

"Well, for starters, we don't have a lot of birthing hospitals in Bucks County, particularly in lower Bucks. … So Lower Bucks does not have the resources that Upper Bucks has. Now, there are resources across the bridge…, but again, if we're doing a Bucks County needs assessment, there are a resource but not necessarily fully accessible to Bucks County."

TRANSPORTATION AND PHYSICAL ACCESS

In Philadelphia, participants described how a lack of transportation makes even existing resources like food pantries and fresh produce inaccessible. This challenge disproportionately impacts low-income pregnant individuals who are already juggling multiple stressors and responsibilities.

"Yeah. Like, folks, especially people without a car, I know that comes up a lot. Because there are so many food pantries and things and but a lot of people are like, hey, but it's still really hard to get there and pick up my box of food and do all of that. So I think I have heard that specifically from some families I know that have pregnant people in their families, that it's been really hard, and especially for folks who are making just too much so they don't have SNAP benefits, and they're in that pinched place, and they're just trying, they're not eating the healthy fruits and vegetables and things that they know they wanna be eating for their pregnancy."

INSURANCE AND IMMIGRATION STATUS BARRIERS

Participants noted that undocumented and uninsured individuals frequently arrive at health centers during late pregnancy having received no prior prenatal care. This is especially prevalent in Bucks County, where financial, language, and immigration barriers intersect, compounding health inequities for immigrant communities.

"A lot of our clients that we serve are undocumented or uninsured and they tend to come in having had no prenatal care at advanced stages of pregnancy."

LACK OF REPRESENTATION AND CULTURAL COMPETENCY

The absence of racially and culturally representative providers creates a disconnect between pregnant patients and their care teams. This affects trust, communication, and whether individuals feel safe and understood in medical settings.

A Chester County participant told us:

"I didn't see many people that looked like me in the hospital room. I didn't feel when I was in discomfort that I was tended to… especially as a Black woman as well, I have twins, and obviously, I had a high risk pregnancy… I just felt like I wasn't monitored as much as I felt like I needed to be."

QUALITY OF CARE AND PROVIDER BIAS

Participants shared concerns about how healthcare providers treat pregnant individuals experiencing homelessness or substance use disorder. These patients were often treated as if they did not care about their own well-being or that of their baby, leading to feelings of judgment and inadequate care. This stigma erodes trust and discourages engagement with care.

Mothers' concerns during and after labor are sometimes dismissed by clinical staff, even when symptoms suggest complications. This contributes to avoidable maternal deaths and is especially alarming for women of color, who often report not being believed when they express that something feels wrong.

A Bucks County participant said:

"Yeah, treating them like they're less and that they don't care about their babies and social services, it's been not super great there when they're doing removals and everything else. So it just is better at [hospital], they're more sensitive to clients who have mental health and substance use and also treat them with a lot more dignity."

A Chester County participant explained:

"There isn't a lot of advocacy for when women are actually going through the labor and process and they're having issues. They're not really heard, I think. I've heard that several times… someone that I knew that passed away actually at a local hospital from her expressing she wasn't feeling well, literally right after birth. And the nurses were saying, 'Everything is fine. You're reading fine on the monitors. Everything is okay.' But she was, like, physically, she knew her head didn't feel well… ultimately, that night, she passed away."

MENTAL HEALTH AND EMOTIONAL STRESS

Postpartum mental health is often overlooked, with many patients struggling to access appropriate support. Language barriers and lack of warm handoffs to behavioral health providers further alienate patients from needed care.

"There are challenges that come out of being a birthing parent… there is a whole person that is behind that. It has to be support that's just not, 'I'm going to hand you a phone number.' This has to be to a caseworker or a social assistance person… if you just give them a phone number and say, 'Call this number,' they may not answer… they may not trust that that person's going to hear them when they're heard."

What's Working Well

Across counties, participants identified promising practices that support maternal health, including trusted community clinics, culturally responsive programs like CenteringPregnancy, and embedded behavioral health services. These approaches foster trust, promote early engagement in care, and provide meaningful support for diverse and underserved populations.

COMMUNITY-BASED CLINICAL SERVICES

Participants noted that some clinics provide more respectful, culturally sensitive care for undocumented, uninsured, and vulnerable pregnant populations. These institutions were praised for building trust and treating patients with dignity.

"I switched over to a clinic, [Clinic] and that was majorly Spanish speaking population who were undocumented. Probably about 85% of individuals are still majorly Spanish-speaking and undocumented."

SUPPORTIVE PROGRAMMING MODELS

The CenteringPregnancy model was cited as an effective program that blends education, peer support, and clinical care in a group format. Patients appreciated the chance to connect with others and receive anticipatory guidance in a way that felt less intimidating and more empowering.

"CenteringPregnancy program seemed to be very positive. Our patient population really enjoyed it… there's a community part to it as well… it does prompt great discussion between the parents to be able to say, 'Oh, this is how I do it.' And then you're guided by a healthcare professional."

EMBEDDED BEHAVIORAL HEALTH AND NAVIGATION SERVICES

Co-located behavioral health providers and navigators in community health settings made a tangible difference for high-risk populations. These services included proactive outreach, education, blood pressure monitoring, and support before and after pregnancy.

"The navigator was doing follow-ups for appointment reminders, follow-ups after to see how the appointment went… there was a connection to the behavioral health consultant on site to do screening and to do resources… groups throughout the pregnancy… all of those were really critical and important services."

TRUSTED COMMUNITY-BASED ORGANIZATIONS (CBOS)

Organizations like Catholic Social Services and Maternity Care Coalition were described as trusted, nonjudgmental hubs for community members of all backgrounds. Their ability to meet material needs (e.g., diapers, car seats) while offering culturally sensitive support was especially helpful for low-income and immigrant families.

"Catholic Social Services does have many agencies in the area. I just want everyone to know because some people think, oh, they're Catholic. We do service everyone. We do not discriminate against race, gender, religion, any ethnicity. We actually, our population has increased in diversity because of all the immigrants that are coming in."

NAVIGATION SERVICES (EVEN IF UNDERUTILIZED)

While underused, BCHIP's navigation services were identified as a valuable, no-cost option for helping patients access appointments, transportation, and interpretation — especially for reproductive and family planning care.

"BCHIP provides navigation services for people who need help securing family planning. We can provide transportation, we can accompany the person to an appointment, we can help schedule an appointment, we can help with translation services… they are available and underutilized."

DIRECT FINANCIAL SUPPORT PROGRAMS

Participants highlighted programs like the Philly Joy Bank and baby supply closets as practical, immediate support. These efforts reduced stress, helped parents prepare for birth, and allowed them to afford essentials like food, diapers, and car seats.

"Programs like the Philly Joy Bank and stuff like programs that will try to give people money are very helpful, especially when you're trying to do all of those things, like eat healthily and not have to maybe work as many hours or worry about paying rent or bills."

"We have here a baby cupboard, a baby boutique that they can utilize the ladies locker for feminine hygiene products because we know how expensive that is too."

Suggested Actions and Solutions

To address persistent maternal health inequities, participants recommended concrete actions such as expanding cultural competency training, increasing language access, strengthening mental health handoffs, and restoring reproductive care options. These strategies aim to improve care experiences and outcomes by centering dignity, trust, and accessibility.

INCREASE CULTURAL COMPETENCY AND REDUCE STIGMA:

Participants strongly recommended formal training for providers and hospital staff in cultural competence and trauma-informed care, especially for populations facing homelessness, mental illness, or substance use disorders. These trainings were seen as essential to reducing harmful biases.

- **"Training for staff around stigma and meeting the needs of our most vulnerable patients… whether they're someone experiencing substance use disorder or experiencing homelessness while pregnant… meeting the needs of our most vulnerable pregnant patients in a culturally competent way, would be important."**

EXPAND REPRESENTATION AND LANGUAGE ACCESS:

There was consensus that patients feel safer and more heard when providers reflect their community. Hiring bilingual staff and individuals who share cultural or lived experiences with patients improves trust, communication, and engagement.

- **"Having bilingual folks on staff is very, very helpful, and hiring people from the communities with which those systems reside."**
- **"They feel more engaged, they feel more cared for, and the patients feel that they can trust their healthcare provider much more than without having that as an opportunity."**

IMPROVE CONTINUITY AND ACCESSIBILITY OF MENTAL HEALTH CARE:

Rather than simply giving patients a phone number for services, participants stressed the need for case managers or social workers to facilitate the connection to mental health care. This was especially crucial for patients with language barriers or distrust in institutions.

- **"It has to be support that's just not, 'I'm going to hand you a phone number.' This has to be to a caseworker or a social assistance person… they may not answer. They may not take that phone call. They may not trust that that person's going to hear them when they're heard."**

FUND COMMUNITY HEALTH CENTERS AND OUTREACH:

Participants advocated for greater funding to community health centers and programs like CenteringPregnancy. By supporting parents early, before delivery, these programs can proactively address challenges and promote better outcomes.

- **"If there were opportunities within the health systems to be able to fund community health centers or other centers that are caring for those patients prior to them having that birthing experience at one of the hospitals, that would be fantastic… to address challenges, concerns and needs that they may have through that type of a model."**

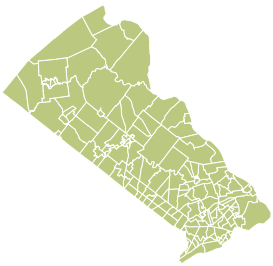
ACKNOWLEDGE AND RESPOND TO RACIAL DISPARITIES IN CARE:

There was strong emphasis on the need to directly acknowledge racial disparities in maternal health care, particularly for Black women. Without confronting these inequities, trust in the healthcare system will remain low and outcomes will continue to reflect systemic racism.

- **"Just the racial disparities around this topic too... there is still a true feeling of concern with their health systems, like trusting their providers, having providers that don't necessarily look like them, who might not take them seriously when they're talking about certain concerns or pains that they're having."**

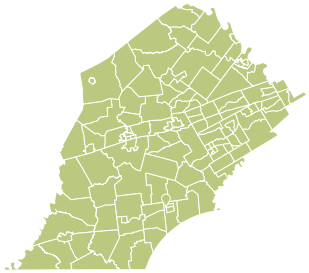
County-Specific Perspectives

BUCKS



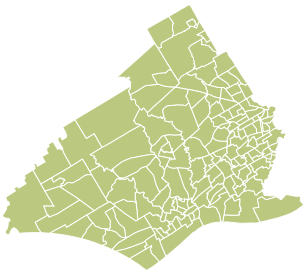
In Bucks County, community providers highlighted stark disparities in maternal care access, particularly in Lower Bucks, where the closure and consolidation of health centers has left many residents without nearby birthing services. Residents described cultural and linguistic barriers to care, especially for Spanish-speaking, Russian-speaking, and undocumented patients. These groups often arrive with little to no prenatal care due to systemic and financial barriers. Some respondents emphasized stigma and discriminatory treatment toward vulnerable populations, including people experiencing homelessness or substance use. Loss of reproductive health services, particularly abortion access, has deepened these inequities. Nonetheless, there are some safety net services in place, such as navigation support for family planning at a local community health center, although these services are underutilized.

CHESTER



Chester County participants underscored a troubling lack of patient advocacy, particularly for Black women and ethnic minorities during labor and postpartum care. A recurring theme was the feeling of not being heard or taken seriously, even when patients presented symptoms that later proved life-threatening. Mental health needs, both for birthing individuals and their partners, were noted as under-addressed, especially among those with limited English proficiency. Despite these challenges, community-based programs like prenatal monitoring initiatives and culturally tailored support groups have made positive impacts for populations such as West African immigrants and Black Americans. Providers stressed the importance of funding culturally relevant group care models and hiring staff reflective of the communities served.

DELAWARE



In Delaware County, participants had limited firsthand insight into local maternal and child health conditions. However, concerns were raised about the need for integrated dental health education during early pregnancy and the complexities of advising patients who are managing mental health conditions with psychotropic medications. The lack of broader commentary suggests a possible gap in awareness or engagement with maternal health initiatives among providers in this area.

MONTGOMERY

Montgomery County has been viewed as a resource-rich area, but disparities still exist, especially for residents in Norristown and other lower-income areas. Community voices emphasized challenges such as the affordability of care, language barriers for immigrant populations, and gaps in mental health services for pregnant and postpartum individuals. Assets include a network of providers committed to cross-sector collaboration and several hospital-based initiatives focused on improving outcomes for birthing individuals. Community stakeholders expressed optimism about current efforts to increase culturally competent care and improve access to maternal health resources, though work remains to ensure equity across the county.

PHILADELPHIA

Philadelphia providers described the need for comprehensive, long-term support from pregnancy through early childhood, particularly for families facing poverty, food insecurity, and limited childcare options. Cardiovascular issues and mental health struggles were recurring concerns, exacerbated by financial strain and lack of trust in the healthcare system. Providers noted that many patients—especially Black women and people with disabilities—experience bias and lack culturally sensitive care. Nonetheless, several programs offering direct financial support, prenatal education, and postnatal resources like baby supplies and mental health check-ins have proven effective. Some participants reported significantly better experiences during subsequent pregnancies, attributing improvements to more responsive providers, expanded community programs, and the integration of digital resources like telehealth and breastfeeding apps.

Community Conversation on Maternal Health

The Maternal Health Community Conversation provided critical insight into the experiences of birthing people across the region, surfacing gaps in education, care, and support throughout the prenatal and postpartum journey. While broader community health conversations often acknowledge maternal health as a key issue, personal stories and lived experiences related to pregnancy, childbirth, and postpartum care are rarely shared in general public forums. Recognizing this gap, we created a dedicated and supportive space for birthing individuals to speak openly about their experiences. This intentional approach allowed us to hear firsthand about the systemic challenges they face—ranging from lack of culturally competent care and disrespectful treatment to unaddressed mental health needs and barriers to postpartum support. These conversations not only shed light on the current state of maternal health in the region but also underscore the urgent need for more compassionate, equitable, and person-centered care systems.

Challenges and Barriers

The community conversations revealed a wide range of concerns and challenges faced by birthing individuals, particularly those from marginalized communities. Participants described feeling under-informed and unsupported throughout their pregnancy journeys, with limited prenatal education and rushed visits that left them unprepared. Many reported experiencing disrespect or bias from healthcare providers—often tied to their race, income level, or cultural preferences—which negatively impacted their sense of safety and trust in the health system. Mental health needs, particularly postpartum depression and anxiety were frequently overlooked or inadequately addressed.

In addition, some mothers shared that they were excluded from essential services simply because they were not teen parents, while others recounted experiences where medical complications were poorly managed or inadequately explained. Gaps in care extended beyond delivery, with some feeling abandoned after NICU discharge or when needing culturally competent, trauma-informed support. Collectively, these narratives reflect a need for more inclusive, informed, and compassionate maternal health systems that center patient voice, lived experience, and holistic care.

LACK OF PRENATAL EDUCATION & SUPPORT

Comprehensive communication and education efforts, especially for new mothers with pregnancy complications, were not always provided.

"I wasn't never really made aware of like the whole journey of pregnancy."

BIAS AND DISRESPECT IN CARE

A lack of support systems and mechanisms for self-advocacy further marginalized mothers with co-morbidities and who were ethnic minorities.

"... if you're poor and uneducated, that's exactly how they treat you at the hospital. Be mindful of where you get your care. When you have money they will treat you better. I work in a hospital, so I know how it goes. It's really unfortunate."

LIMITED ACCESS TO SERVICES FOR OLDER FIRST-TIME MOTHERS

Programs for "new moms" who are not teenagers appeared to be hard to access or were fewer in number.

"...when my sister was fresh out of high school, she was offered those programs to where, as though that you can go to like the [community resource] or the welfare office and sit down and take like a mother, a parenting class, and I wasn't never offered that."

COMPLICATIONS NOT ADEQUATELY MANAGED

Mothers with health issues such as preeclampsia shared they were not properly informed or supported during their pregnancies.

"I had preeclampsia, so I had a lot of check-ups, but this is my 1st child, so I didn't know like other like other ways to kind of go about [it]... I thought I was eating healthy. I didn't actually have a midwife. I think I was like, offered somebody that I could talk to on the phone because it was like right after COVID. So, things were kind of getting back to normal. So for me, I just kind of felt like I didn't know if there were other like other resources for pregnant people who were dealing with like preeclampsia... like they just told me I had high blood pressure and gave me medication. And then I wind up having to have my daughter like at like 33 weeks instead of what they originally planned for, which was like 37, and... I felt like because I didn't have like, I guess, more family support they kind of... I just was going to the appointments, not really getting like or not knowing what questions to ask. I didn't really feel like it was informative. I just kind of felt like I was being told what to do."

LACK OF TRANSPARENCY AND INFORMATION DURING PREGNANCY

Participants shared that important information like fetal size and potential complications were not communicated clearly.

"...my 1st pregnancy was not a good experience either. I had to have an emergency C-section. My baby was too big. They did not tell me how big the baby was during the pregnancy. I could have been careful with my diet..."

LACK OF POST-NICU

Some mothers felt abandoned after NICU care began, without ongoing support or resources.

"I kind of just felt like I didn't really have support after the NICU, because they was just like, 'Oh, well, you know we take care of her. You can come visit.'"

RELIGIOUS AND TRAUMA-INFORMED NEEDS IGNORED

Some participants reported that their religious or trauma-related care preferences were not honored by providers.

"I didn't want a man in the delivery room with me, due to my religion as well as sexual trauma, and I felt as though I was treated differently, because I only wanted women in the room with me."

BIRTH PLANS DISREGARDED

Participants expressed that their choices during delivery were ignored when unexpected changes occurred.

"... so I was transferred. I had to do an emergency transfer from the birthing center to the hospital, and the hospital didn't honor my birthing plan at all. So they just completely disregarded my wishes."

RUSHED AND IMPERSONAL PRENATAL VISITS

Short appointments left patients feeling dismissed and uninformed.

"...prenatal visits are too short. They rush you and do not appear to want to educate you."

UNMET MENTAL HEALTH NEEDS

Post-natal mental health needs were not always met, and limited support led to misunderstandings about one's own mental status.

"I guess I had postpartum, but it wasn't like, I guess, as severe as other women's postpartums can be. It just was like, I just feel like I can't take care of my child, or it was something wrong with me... I couldn't produce milk because I didn't make it to 40 weeks. It was just a lot of different things that wasn't broken down to me or explained to me."

What's Working Well

Participants also reflected on positive experiences and meaningful moments of support that stood out in their experiences. While challenges persist, many birthing people shared stories of improvements such as more responsive providers during subsequent pregnancies, helpful follow-up care, access to financial and material support, and culturally respectful treatment. These experiences underscored the value of person-centered care, consistent communication, and access to practical resources that reduce stress and promote well-being during the perinatal period.

IMPROVED CARE IN SUBSEQUENT PREGNANCIES

Although one participant felt that her initial labor and delivery experience could have been much better, she appreciated her health providers' pivot the second time around to ensure that previous health issues could be deterred.

"...the 1st pregnancy. They didn't take it as serious. It wasn't as serious until, you know. I found out I had preeclampsia towards the end, and they had to do emergency C-section. So, the second time around, they took it really serious. I had constant checkups, constant emails from my doctor, so they and I didn't have a midwife. I had an actual doctor, the 1st time around. I had a midwife."

EXPANDED RESOURCES AND ACCESS OVER TIME

While some participants lamented barriers to resources, others noted improvements over the years through successive experiences with labor and delivery.

"Yeah, maybe it was like a time where there wasn't a lot of things, but I feel like all the things that are offered. Now, I definitely appreciate it."

VARIABILITY IN SERVICES BY LOCATION

Greater knowledge and access may be correlated with specific health centers, and the availability of resources still varies depending on where care is received.

"... I think that there are things you do have to search a little bit. But I think it also depends on where you're actually getting your care. Because, like I said, there's things that I'm like, oh, really like I didn't know that was a service. I didn't know that that we could get that type of help. So it definitely is where you are."

PATIENT FEEDBACK AND HOSPITAL ENGAGEMENT

Some hospitals actively survey patients and seek input about care experiences, which participants felt made a difference.

"... my hospital that I received treatment from. They do a lot of surveying of the patients, asking our input as far as how was our experience? Not only with the provider, but the hospital in general as a whole. And that that helped out a lot actually."

IMPROVED BREASTFEEDING SUPPORT

Participants noted an increase in breastfeeding resources and support over time, including the availability of apps and other tools.

"Breastfeeding support has grown drastically like there's an app called pacify, that helps out... I had my 1st child years and years ago. I didn't receive any assistance, and I ended up quitting breastfeeding."

POSTPARTUM RESOURCE NAVIGATION AND VIRTUAL SUPPORT

Some hospitals provided comprehensive resource connections and scheduled postpartum appointments through video chat, which was appreciated.

"They had people come in after I delivered the baby and gave me lots of resources and sometimes can be a little overwhelming postpartum. But they set up appointments. That I thought that was really good, because appointments were set up just a little video chat like, you don't have to come into the office."

RESPECT FOR BIRTH PLANS AND PREFERENCES

Participants valued being asked about their preferences and supported in expressing their birth plans.

"I was asked several times just like about a birth plan, like, what would you like to do? So that was really helpful. Even was given the option to like, write up something while I was actually there laboring like anything that I wanted. So I thought that was really helpful."

CULTURALLY RESPECTFUL AND TRAUMA-INFORMED CARE

Positive experiences included being treated with respect for cultural and religious preferences, and receiving consistent mental health screening.

"I was lucky with the 2 different hospitals. I had my babies. They respect everything. If my my scarf, they respect that... my doctor was a woman, as my religion... I feel comfortable with a woman with a doctor female doctor... and also my kids' doctor. She's always let me fill a questionnaire every visit, that I'm not depressed... I'm doing well."

PREGNANCY AND INFANT LOSS – LACK OF OPEN DIALOGUE

When it came to the topic of pregnancy or infant loss, a few respondents were able to offer some insight through observations in their communities. But questions around the circumstances of the losses, how to engage in conversation about the topic, and how to offer support were raised.

"Working in the field. I've seen instances of it, but it was all like never a clear reason why, like, you know, was just unexplained pregnancy loss. o I don't have much information on it, and I do think it's one of those things that you don't talk about much. Because it's like, you don't want to talk about that to a pregnant lady. Because who wants to have those thoughts, you know?"

ENVIRONMENTAL, COMMUNITY AND HEALTH-RELATED CONTRIBUTORS TO LOSS

Participants reflected on how weight, comorbidities, nutrition, and domestic violence may contribute to poor pregnancy outcomes.

Broader community-level issues such as violence and drug use were identified as contributing factors to pregnancy loss.

"...one of the girls in my neighborhood, she was pregnant, but she was so overweight and then she has also had some other health issues with which kind of led to her losing her baby. I'm not exactly sure what was her underlying health issues. But I know we were excited one week, and then I seen her 2 weeks later, and she had told me she had lost the baby. And then also other environmental issues like not being able to fully give yourself the nutrition that you need, or maybe people are in domestic violence sit..."

"... unfortunately, I live in a very high crime rate and [there] are lots of drugs. I know a lot of pregnancy loss."

Suggested Actions and Solutions

Participants offered a vision for what a more supportive and equitable maternal health system could look like. Many called for holistic and preventative care approaches that address mental health, physical health, and social needs together. Participants emphasized the importance of early education about pregnancy and complications, culturally sensitive care, and improved communication from providers. There was also a strong call to include men and partners in education efforts, address the emotional and financial toll of infertility, and create more accessible, community-based resources throughout the pregnancy and postpartum journey.

A proactive and **holistic approach to maternal and child health** could help to offset potential health issues and support those who are less experienced in childbirth. Additionally, **limited financial resource**s contributed to undue stress while pregnant.

- **"... a midwife that was like more holistic. That would be like, 'Oh, eat these type of herbs or and this will help bring your high blood pressure,' down so that I didn't have to sit in the hospital for like 3 weeks with trying to figure out if they were going to give me a C-section or not."**
- **"We need more resources for physical and financial help for birthing people. It's a lot of stress on the mother during pregnancy and then having to raise children in this economy... Insurance is a big factor, because I see like a lot of like moms who don't have insurance. And they need different medications or needs during their pregnancy and it's stressful when they can't afford to get it because insurance is so expensive."**
- **"In a perfect world, if during those prenatal visits in the beginning, if every woman could be set up with some type of like therapy or like, ask, you know, if you would like to talk to somebody, even during the pregnancy, because you can become depressed during the pregnancy..."**

Complexities related to infertility were identified and are nuanced, requiring a strategic approach to problem-solving – such as addressing the high costs associated with treatments and the emotional toll that it takes on parents.

- **"I am thankful I did not struggle with infertility, but I would share that I know some people who do struggle with this day by day and due to the cost of going through the fertility treatments they stop trying or they move to their country of origin for help. Due to this matter, there are couples who would like to adopt after trying and cannot due to their immigration status."**
- **"It should automatically be covered through your insurance."**
- **"One of my close friends, same sex marriage, had a good and bad experience with infertility treatments. The process and expense of the treatments to become pregnant was troublesome with one loss but they now have a one-year-old."**

Maternal and child health-related information and support to help people understand and cope with their health and emotions, including opportunities and information-sharing, need to be improved. Men and fathers need support and education as well.

- **"There should be like a lot of people have smartphones now, maybe like a QR code, and it just pop up with like a bunch of resources that's like accessible to the patient."**
- **"I think NICU resources should be, I guess, talked about when they tell you, you have preeclampsia. And this is the opportunity like this could be something that could happen, or when you do hear your baby is in the NICU..."**
- **"I just think people don't... People aren't always honest with their physicians about the things that they know they shouldn't be doing, or the things that you know they may, they may be scared to admit that they do."**
- **"The fact that they want to, you know, push to ban abortion and not also consider other things outside of harming a woman's body. To end a pregnancy or to prevent a pregnancy is a little disturbing. I think they should push more sex conversations to boys, because they ultimately are, you know, the ones that are impregnating the females. So, I think the condom thing, or some type of more education for men on. Why, it's more important to use condoms rather."**
- **"I think that should be something that they talk about with the children. Like, women are getting pregnant and if you guys choose not to go through with the pregnancy, she might be affected by that. And I think that should go for the female and the male to know that the female will go through these certain things. So, maybe they'll think like, dang, maybe we really can't do this or we'll try and protect ourselves a little bit more because she's gonna go through hell in the long run. It might cross a couple of kids' minds before they do certain things. Not like a scare tactic, but I do think it's vital information..."**
- **"I would suggest more education on the possible complications that can occur during pregnancy and what to do to prevent and how to overcome them before they happen. More education on the test they perform when there are complications."**
- **"I feel this is a topic we don't really talk about. I feel the many amounts of birth control aren't spoken about and due to the lack of education, research, and cost many aren't able to have access to this. I also feel women should have some kind of anesthesia for birth control since it can be very painful."**

SPOTLIGHT TOPIC

Older Adults and Aging in Place

Across Southeastern Pennsylvania, older adults, caregivers, and community members emphasized the need to support aging in place through coordinated housing, health, and social systems. Participants voiced a clear preference for remaining in their homes and communities as they age, underscoring the importance of having accessible, reliable supports in place.

As one participant shared,

"I think that most adults want to age in place if they're able. As long as they know there are supports around them, and they know what they are and how to access them, and if we do a better job of that as a community, people will be more actively engaged in their community. But if we don't, we kind of leave them until they can't live alone or they can't stay by themselves, and they can't afford to have someone come in and help them out a little bit or whatever. It's a crisis."

To encourage the physical, emotional, and economic benefits of allowing older adults to remain in their homes and communities, structural barriers, such as inadequate housing accessibility, limited in-home care options, and underfunded services, need to be addressed. These challenges are often compounded by the complex realities many older adults face.

"For older adults, obviously, there's comorbidity," another participant noted. **"You're dealing with somebody who may be having physical health issues as they age, they're also trying to age in place and keep their independence and have to manage all the dynamics of all their doctors and specialists if they have multiple issues, mental health issues, et cetera, et cetera."**

Despite these challenges, promising examples of local programs, cross-sector partnerships, and innovative housing models show how older adults can thrive with the right support in place. Participants shared practical strategies to advance independence in aging, including improving access to home modifications, expanding caregiver support, strengthening transportation networks, and investing in community-based services that promote connection and well-being.

Challenges and Barriers:
Access to Healthcare

Older adults face significant barriers to healthcare, from navigating insurance complexities and scheduling appointments to accessing hands-on support for paperwork and medical equipment. Language and technology challenges make it harder to use online portals or follow medical instructions, while limited Medicare-accepting providers and poor integration between health systems delay essential care. Those with serious mental illness often struggle to secure placement in senior facilities, which may refuse them or send them to hospitals without allowing them to return. Transportation issues, including unreliable public transit and long paratransit wait times, further restrict access, contributing to worsening health outcomes.

NAVIGATING HEALTHCARE SYSTEMS

Seniors and older adults face significant barriers in navigating healthcare systems, including language difficulties, tech challenges like using MyChart, struggles with appointment scheduling, and the need for hands-on support with tasks like filling out forms or using medical equipment, as well as understanding instructions for self-monitoring tools.

A participant from Philadelphia stated:

"Navigating the system continues to be a massive barrier. People figuring out which insurance they need to do and, things like that, yeah."

Another Philadelphia participant said:

"It is getting more difficult to get a staff member and make an appointment there. It takes a longer time, at least 30 minutes. And many places now only accept appointments for a month in advance, so we cannot make it at the moment. So, they say clients should call them every day to get an appointment, but it's not feasible for the seniors, especially speaking other languages. They cannot use the phone, or they are afraid to make phone calls. And this can be a particular challenge for seniors who speak other languages. So, they're not going, so their health issue is getting worse."

A Philadelphia participant added:

"And also, not fully understanding the instructions. One of the people I worked with was given a tool to monitor his blood pressure at home, and he got home, and he didn't understand how to use the machine."

A participant from Delaware County expressed a similar sentiment:

"There are some people that do require hands-on help as far as like, 'can you please come to me and help me fill out this form?' 'Can you please come to me and take these papers that I've gathered, and fax them for me?', because they might not be able to get to a fax machine, they might not be able to get to the post office. So, I feel like when it comes to aging, a lot of times, we think, oh, this is enough for some people. But it is not quite enough for them."

MENTAL ILLNESS

Older adults with serious mental illness struggle to find placement in senior living facilities, which sometimes refuse them or send them to hospitals during crises without allowing them to return, contributing to rising behavioral health issues, suicide rates, and unnecessary hospitalizations, all worsened by gaps in integration between Medicaid, Medicare, and behavioral health systems.

A participant from Bucks County has experienced this with clients, stating:

"We have difficulty getting placement for older adults who may have a serious mental illness and cannot live independently, and so they need to go into a senior living facility. A lot of facilities will not accept those folks, they just, they can't, or they won't for different reasons."

A Chester County participant said:

"We are definitely seeing, I believe, an increase in older adults who are experiencing behavioral health crises and who are completing suicide, especially older men. So, there's something that we're missing there, right?"

A Philadelphia participant expressed:

"And also, not fully understanding the instructions. One of the people I worked with was given a tool to monitor his blood pressure at home, and he got home, and he didn't understand how to use the machine."

A participant from Delaware County expressed a similar sentiment:

"I think one of the biggest issues we've seen is the lack of integration, especially between Medicaid, Medicare, and the health systems, and behavioral health. We see a lot of issues on our end where folks are -- there's significant gaps in behavioral health and cultural competency on the mental health side, where folks end up being institutionalized because of the lack of addressing those needs."

TRANSPORATION CHALLENGES

Older adults face significant transportation challenges in accessing medical care and attending appointments, including unreliable public transit, long wait times for paratransit services, difficulties navigating insurance barriers for specialized transport, and a lack of accessible infrastructure like sidewalks and sheltered bus stops.

A Bucks County participant shared:

"For our clientele, access to transportation, getting to their doctors, even access to paying for their medications. Those are all big barriers to care for them, unless they're working with us, where we can help them with those barriers."

A participant from Philadelphia has experienced the same transportation barrier, stating:

"Public transportation is an issue. For those who can get on and off a trolley or a bus, you know, those things are pretty good. But if you require something like paratransit, that goes door to door, they might get you to the doctor an hour ahead of time, and then you wait an hour before you see your doctor. You spend a minute with the doctor, and then you might wait an hour for it to come back and get you. It's long."

MEDICARE

Finding Medicare providers is challenging, and there's a lack of integration between Medicaid, Medicare, and health systems. While Medicare programs provide essential support such as socialization and care management, access is often limited by financial barriers and the requirement to switch doctors.

A Chester County participant said:

"It's very difficult to find providers who are accepting Medicare for mental health services and that includes outpatient therapy."

A participant from Delaware County shared their perspective on Medicare programs, saying:

"LIFE (Living Independence for the Elderly) is this one stop shop kind of program where they have centers in the county, and at those centers you get that, you know, socialization, but also all you can get all your care. You can have therapy there, they have haircuts and dentistry that come in at times. They manage your medications, your doctor's appointments. The barrier with that one, is you also have to change your doctor, and some people aren't into that. And some people might not meet the, they're over the limitations financially."

Aging in Place

Aging in place presents significant challenges for many older adults, as homes are often not designed to meet their changing needs, and necessary supports can be difficult to access. Barriers such as limited mobility, lack of awareness about available resources, and social isolation can make it hard for individuals to remain safely and comfortably in their homes as they age. These challenges can lead to declining physical and mental health, especially when older adults lack strong support systems or struggle to stay connected to their communities.

ACCESSIBILITY

Many homes are not designed for aging in place, often lacking first-floor bedrooms or bathrooms, accessible entrances, or wide hallways for mobility devices. In-home supports and home modifications can help, but they're often expensive, hard to navigate, and not well known, leaving many older adults without the resources to safely remain in their homes.

A participant from Chester County expressed:

"This idea of aging in place is really challenged by the fact that most of us live in houses that are not built, designed to do that. There's not a full bedroom on the 1st floor. There's not a full bathroom on the 1st floor. We don't have hallways that are wide enough to accommodate walkers and wheelchairs and other mobility devices."

A Philadelphia participant agreed, stating:

"Accessibility is by far one of the biggest issues. You know, and depending on the style of rowhome, you know, Southwest Philly has the type of house where the basement is on ground level, and they build up the front lawn. So, you have to go up a flight of stairs, you're essentially going up a flight of stairs before you get into the front door. That can be a hardship for people. Then other style rowhomes, they're smaller, right on the sidewalk. There's no room for ramps or any sort of equipment to help people get into the house."

IN-HOME SUPPORTS AND REPAIRS

In-home supports can be expensive. While one participant noted a successful experience receiving aid for the cost and labor of installing the supports, other participants stated that it's unclear where to look or how to begin the process of receiving similar help.

Home repairs can also be expensive, and complicated to coordinate. One participant shared that there are programs to assist with this, but they need to be marketed more.

A participant from Philadelphia County said:

"I think it was PHDC or one of the home repair programs where they needed a stair lift put in, and to get their bathtub fixed and someone did comment and do that for them for free. So, I think there was a long waiting list, but I did hear success."

A Delaware County participant added:

"We need kind of a general overall social service support and an organization to kind of connect and help people specifically with in-home supports, affordability for in-home support. Many people need them, they have no way to pay for them. Don't even know where to begin, how to start the process"

A Philadelphia County member said:

"I think the, I think it's called the Home Modification Program, could be marketed more. That is designed to help people age in place. And so, if that's a public program, people should be taking advantage of it."

LONELINESS AND ISOLATION

Older adults aging in place often experience loneliness and isolation due to a lack of support, limited mobility, and barriers to accessing community resources. These challenges can lead to mental and physical decline, especially when individuals are disconnected from social engagement and support systems.

A participant from Delaware County said:

"It's the ones that maybe we don't know about who may be homebound or a little more isolated or, for whatever reason, don't know or aren't accessing these services."

A Delaware County member added:

"There is an epidemic of loneliness because people are in their house. They don't have the ability to get out of their house."

A Bucks County member said:

"Lots of times older adults are put through the process of a 302 [involuntary commitment for psychiatric placement] because they have a change in mental status that comes on quickly that is likely related to an organic dysfunction of the brain, whether it's dementia, Alzheimer's or something of the like. It really doesn't fall under the mental health purview but there's individuals who don't have their natural supports, or their only natural support, for example, a spouse or somebody else, is unable to care for that individual. So, a lot of times we see an emergency situation where an individual might be isolated alone or lack of natural support and they're really decompensating."

Resources for Older Adults

ACCESS TO PROGRAMS AND SERVICES

Senior centers play a crucial role in supporting older adults by offering opportunities to stay active, socially connected, and engaged, yet many of their programs and services go underutilized. This underuse is often due to stigma, limited awareness, or barriers to access, such as difficulty navigating complex systems, leaving some older adults unaware of available resources or hesitant to seek help, ultimately missing out on services that could enhance their well-being.

A participant from Bucks County said:

"With any population that's vulnerable, I think lack of access to services, lack of social support or connections is an issue. Talking about elder abuse or intimate partner violence in later life, not even recognizing what's happening to them as abuse, or that there are places like A Woman's Place that they can contact for help. So, I guess that would be education and awareness."

A Delaware participant stated:

"We do have an ongoing grief and loss support group, and we have a caregiver group that's run by a social worker, like, off-site in the library. And we can refer people to these, but it's hard to get people to show up. It's not a fun group that they're excited to go to."

Planning

WILLS

Senior centers play a crucial role in supporting older adults by offering opportunities to stay active, socially connected, and engaged, yet many of their programs and services go underutilized. This underuse is often due to stigma, limited awareness, or barriers to access, such as difficulty navigating complex systems, leaving some older adults unaware of available resources or hesitant to seek help, ultimately missing out on services that could enhance their well-being.

A Delaware County member said:

"In the case that they're not able to age in place, they have to be moved, or the family has to move them somewhere. Instead of finding an option where they can stay, and have supports put in place, and that can they be paid for. We just don't have that developed safety net. So, I wish there was that. I wish it was better and wasn't just crisis mode. I feel like, in general, people wait until, you know, it's too late for everything."

Another Delaware County member added:

"We've had programs to help people plan all of their living wills and understanding all of their long-term care insurance and policies and how that works. And they're very, very beneficial, you know, very necessary. But in general, we found that most people who were coming to these programs in their 70s or 80s had not done any preplanning, and really still did not have any clue or plans for budgeting, for saving, for what's available. They just did not know."

A member of Philadelphia County said:

"A lot of people don't have wills, you know? We did a will workshop in our office a couple of months ago, and I was shocked by the amount of seniors that came in for the workshop, who did not have a will. They had gotten so far in life without having anything. They had children. They had a home. But yet they didn't have a will."

What's Working Well

Senior centers and faith-based organizations are effectively supporting older adults by offering inclusive programs that promote physical activity, social connections, and overall well-being. Senior centers provide a range of services, including health, wellness, nutrition, and benefit programs, helping reduce isolation and enrich lives. Some faith-based organizations offer targeted outreach through elder care social workers who assist older adults with navigating systems, finding in-home care, and accessing low-income housing. These services are widely available and inclusive, benefiting older adults regardless of background.

SENIOR CENTERS

Senior centers offer inclusive programs that help older adults stay active, connected, and supported, and can reduce isolation.

A participant from Delaware County stated:

"There are a lot of resources for people to get out, be active, have a full range of health, wellness, socialization, nutrition, eating programs, connecting them to benefits, etcetera. There are a lot of things. You just have to, like, look and get yourself there. There's a lot around here, and I think they most do take advantage."

A Philadelphia participant said:

"Being part of a senior center enriches people. Enriches their lives."

FAITH-BASED ORGANIZATIONS

Faith-based organizations provide a variety of social services to older adults.

A member from Philadelphia County stated:

"Catholic Housing and Community Services, which is under the archdiocese of Philadelphia, they work specifically with seniors. They have outreach to different parishes and locations in the area. So, they have an elder care social worker in each area that helps to navigate the system, helps to find good in-home care or housing benefits if they qualify. And they also have built up their housing for seniors, low-income housing for seniors as well. But they have a specific program all throughout the city and the county specific for senior care. And again, nondiscriminatory, any senior that needs it."

Suggested Actions and Solutions

Participants offered solutions to improve care and health outcomes for older adults, spanning both hospital systems and community-based organizations. A central theme was the need for stronger collaboration among providers, many of whom are doing meaningful work independently but without alignment. Suggestions included better coordination of resources, improved hospital discharge planning that considers patients' social needs, and stronger referral pathways between health systems and community support. Participants also pointed to successful models, like one-stop shops for older adult care, and suggested their replication. Other ideas included investing in affordable, health-integrated housing and promoting will creation to prevent future property issues like tangled titles. These solutions highlight the need for a more integrated and proactive approach to aging services.

Improve coordination and resource sharing among organizations and hospitals, along with creating a centralized access point for resources, could help eliminate duplication of efforts and ensure individuals fully benefit from available programs.

- **"We're all working in our own silos. We're all doing great programming, and everybody's meeting a lot of needs, but we're not pooling our resources and sometimes I feel like we're duplicating the same resource and missing another one. And it's just sometimes when we have tried, you know, partnerships, it seems very difficult. It is difficult."**
- **"I think [hospitals] have a lot of the roles and abilities in place. I just think they use it only internally. They have social workers. They have social services. It's just really for admission and discharge, or creating their own programs. And when somebody's discharged, they refer them to their own program that they want them to go to, which is fine, but I just don't know why we're not pooling. You know, everybody has their own kind of expertise. And so, they certainly would be the ones I would say that would be appropriate to do the pain management group. But maybe we're more appropriate to do a caregiver's group. But that it's all kind of coordinated and centralized somehow. So, I think they can definitely do a lot more out in the community."**

Hospitals should provide patients with discharge information and ensure they have access to necessary resources, such as food, housing, and a safe living environment.

- **"If someone's getting discharged from the hospital, it's important to send them home with information on what they're supposed to be doing next to monitor their health, and for the hospital to be aware as well of what kind of environment are they going back to? Do they have food? They need meals to be delivered? What is their housing situation? Is it a safe, secure place for them to live? Just working with people as they're being discharged, for example, from hospitals to be set up in a healthy and safe way."**

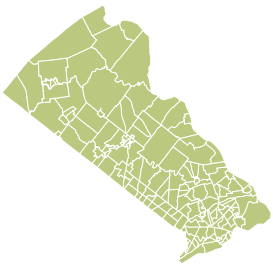
Replicate a "one-stop shop" model for older adult care, where multiple services are integrated into a single location with added support like transportation and comfortable spaces, could enhance convenience and accessibility for older adults in all healthcare practices.

- **"There is a doctor's office in a shopping center in West Philadelphia, and they have couches, they have coffee stations. They pick you up to bring you there, and take you home afterwards. They encourage people to hang out there if they want to. They have multiple doctors on site. So, there's a podiatrist, there's an optometrist. And they'll organize your appointments so they're back-to-back to back, so it's only one trip to the one-stop shop. They specialize in older adults. I think that is ingenious and should be a model for all practices that focus on older adults."**

Expand and invest in affordable housing programs, particularly through prescriptive housing initiatives that link healthcare and housing, could improve community health outcomes and leverage funding opportunities like Pennsylvania's PHARE Program to create more accessible housing solutions.	• **"Looking at innovation, we know in other parts of the country, and I think some places in PA, they've done what they call prescriptive housing. The idea of investing in housing from the health care side. We'll have a return on investment by keeping people healthy, and in the community. Also looking at funding opportunities, I know PA Housing Affordability Fund's PHARE Program just released an update where there's additional funding available for capital construction if it's tied to a health care entity. So, looking at that as an option to help create more affordable accessible housing."**
To prevent future tangled titles, there should be a greater focus on promoting will creation and proactive planning among organizations who work with older adults.	• **"A lot of people don't have wills, you know? ...So, I think that this could be something that is marketed and done way more of. The city's been focused on tangled titles, you know, houses where there's not a clear owner. They're doing all this outreach to get all of these tangled titles cleared. But there's no effort to prevent future tangle titles. It's so much harder to fix the problem than it is to prevent the problem. Get wills. I know community legal services are doing wills. But there should be such a bigger effort."**
Reframe activities for older adults to focus on shared interests and social engagement, rather than labeling them as support groups, can address the stigma often associated with support groups while still fostering strong participation and connection.	• **"So we did actually create a men's group, but we didn't call it a support group. We called it like a "lunch bunch." Like, just a group for men to have lunch together in a separate space led by the social worker. It was just you know, guided, structured, focused topics. It was just, hey, what's life like after you retired, how are you spending your time, and what advice do you give? It took off, and it really surprised us. We actually have a core group of men who come twice a month, have lunch together, and really look forward to just kind of eating and hanging out with each other.** **So, I just think its finding the hook to get people to try these things, because once they do, you know, they love it and they find meaning. I think, whether it's hospitals or social communities, we have to work together to kind of make it more appealing and enticing. And anything with food is going to be a big perk."**

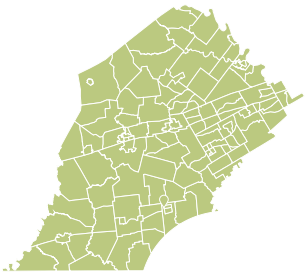
County-Specific Perspectives

BUCKS



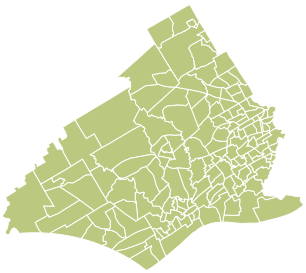
Participants in Bucks County highlighted significant barriers to healthcare access and transportation for older adults, with many emphasizing the financial difficulties that prevent older adults from affording essential medications. Mental health services were a major concern, particularly the stigma around seeking help. Several participants noted that the complexity of navigating systems for benefits and services posed a challenge, especially for older adults who lack digital literacy. A key issue for Bucks County was the increasing unaffordability of both housing and healthcare, which many residents on fixed incomes find increasingly out of reach.

CHESTER



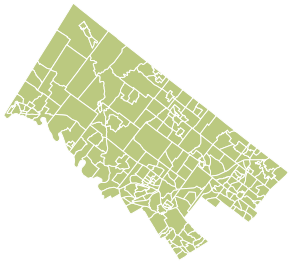
In Chester County, participants stressed the growing need for services that are culturally and linguistically appropriate, reflecting the county's shifting demographics. Digital literacy was a significant barrier, preventing older adults from accessing telehealth and online resources. A common concern was the fragmentation of services, with residents unsure of where to go for help or how to qualify for assistance. The lack of affordable in-home care options was a central issue, making it difficult for older adults to age in place and putting additional strain on families.

DELAWARE



Delaware County participants emphasized the importance of community-based supports, such as senior centers and local food access programs, as vital resources for older adults. Transportation remained a key barrier, particularly for low-income older adults in more rural or isolated areas. The growing challenges around mental health and substance use among older adults were frequently mentioned, along with concerns about elder abuse and financial exploitation. Many participants called for stronger protective services and educational programs to support families and prevent mistreatment.

MONTGOMERY



In Montgomery County, discussions centered around the need for enhanced caregiver support, as many families felt overwhelmed by the demands of caring for aging loved ones without adequate outside assistance. Affordability of housing and long-term care was a pressing issue, with many older adults feeling the financial strain from rising costs. Social isolation was another key concern, particularly among older adults living alone and without nearby family support. Participants also called for better coordination between healthcare providers and social services to streamline care and improve overall service delivery.

PHILADELPHIA

Conversations in Philadelphia County reflected the unique challenges of urban living, with concerns around neighborhood safety and the suitability of housing structures for older adults. Rowhomes, often with stairs at the front door and narrow hallways, were noted as particularly difficult for older adults. Access to primary care and in-home health services was also limited, especially in lower-income neighborhoods. Participants emphasized the need for more affordable and accessible services, both in terms of healthcare and housing, to better meet the needs of older adults in the city.

SPOTLIGHT TOPIC

Primary Care Access

The lasting impacts of the COVID-19 pandemic, coupled with recent hospital closures and health system mergers, have altered the landscape of primary care provision in the Southeastern Pennsylvania region over the past 3 years and will likely continue to shift going forward.

To understand ongoing and emergent needs and identify opportunities to improve access to primary care across the Southeastern Pennsylvania region, four county-based discussions and four key informant interviews were conducted with leaders and staff from with knowledge of local healthcare needs across Bucks, Chester, Delaware, and Philadelphia Counties. In the 2022 rCHNA, the topic of "Access to Care" discussed with Delaware County community-based organization representatives. This spotlight represents an expansion of that discussion, with a focus specifically on primary care access, offering updated perspectives on current needs and strategies.

Access to primary care is influenced by myriad factors – social and cultural (language, connectedness, trust, citizenship), economic (income, employment, insurance status), physical environment (transportation, walkability), and local health care infrastructure (hospitals, primary care physicians). These factors, and more, are reflected in the insights shared below – as well as reflected in the county and geographic community profiles.

Challenges and Barriers:
Scheduling and Availability

The most common responses to questions about barriers to primary care access were connected to the perceived lack of available appointments – particularly long wait times to schedule appointments.

SIGNIFICANT WAIT TIMES

Participants shared that although there is generally good awareness of the importance of having a primary care physician and regular checkups and screenings, community members experience significant wait times when trying to schedule appointments. This experience is increasingly common for current patients and has been exacerbated for new patients.

A participant from Philadelphia said:

"They're just overwhelmed…like they want to find a PCP. But their PCP, you know, they had one year ago, but that person retired or left, and they were told that the rest of the primary care providers weren't taking new patients, and so it just kind of fell off their plate."

STAFFING SHORTAGES

This is also a challenge for hospitals, health systems, and clinics as many have experienced staffing shortages following the pandemic, an increase in physician retirements, and decreasing interest in primary care as a profession (many medical students are choosing specialties). Certain areas in the region have fewer providers than others – particularly the more rural areas. Certain types of clinics and centers experience unique challenges either related to their patient population or their organizational structure – such as Federally Qualified Health Centers (FQHC).

A participant who works at a local FQHC shared the following:

"…I've been trying to advocate for caps on our providers' new patient intake because that is causing us to be booking patients out for six months in the future because we can't turn people [away]…we're a safety net provider. And so there's sort of this weird dichotomy or tension between, well, we wanna serve everybody, but at the same time, if we serve everyone, then we can't provide quality or quick care, if you will, to anyone, really, even our patients that have been coming here for years. And I don't know what the answer is to that, but it is just as frustrating from the inside as it is from the outside, unfortunately."

Delaware County-based participants highlighted:

"We rely heavily on the clinics. We do not have, in Delaware County, many options. I feel like a broken record. We are sending people into Philadelphia."

A participant from Chester County also shared the varied availability of providers throughout the area:

"Chester County is a big county. So, it really depends on where you're asking. I know there are not enough [providers] in the general greater Coatesville area. There are very few private practices there. There's some urgent care in Downingtown. There's some urgent care in Parkesburg. But as far as a primary provider, there's almost nothing."

SCHEDULING

With fewer providers, and more people seeking primary care, wait times at appointments can present additional challenges, especially for people who may be taking time out of their workday for the appointment.

A participant from Chester County shared:

"And now you're waiting an hour and a half to see your doctor, and that's really hard. It's especially hard for people who have a hard time getting paid time off for a doctor's visit, and they really can't afford to sit around for an hour and a half. They've got to get back to work."

Use of Emergency Departments and Urgent Care

In response to barriers with wait times and scheduling appointments, many participants shared that their community members and clients are increasingly using emergency departments and urgent care in place of primary care.

URGENT CARE USE

Although costs may be higher at urgent care or emergency departments, the perception is that "at least they'll be seen" as opposed to waiting months for a primary care appointment.

Wait times at hospitals and urgent cares continues to increase as more people utilize these services instead of primary care.

Additionally, seeking care from providers who do not know your medical history can result in increased costs (such as unnecessary or redundant tests).

A participant from Chester County addressed this:

"Even if you have insurance and a primary care physician, it can be really challenging to get in and get an appointment. And so then, you end up going to urgent care, which is a lot more expensive."

One participant from Philadelphia shared:

"I think the hospitals are overrun because they know they can go there...Unfortunately, I have the opportunity several times to experience different hospitals, and their waiting rooms are just [packed]. So you're talking, almost waiting a whole day just to get care."

"You don't necessarily have the same comprehensive health history with them that you have with your regular provider. And so it costs more money. There's not the same necessary knowledge of your history or something, and that just makes it very -- nobody's benefiting from that, except maybe someone who's getting paid more."

MISCONCEPTIONS ABOUT PRIMARY CARE

Misconceptions about the role of primary care – and the need to be seeking care regularly – result in the persistent usage of urgent care and emergency departments. This may also stem from concerns related to health care costs – not knowing what's covered and what isn't.

Participants from Chester County discussed the need for community education about the different roles that primary care and urgent/emergency care serve:

"What ends up happening too is there's an education challenge for folks. So, some people, because healthcare is expensive, they just don't go when it could be something that could be solved by seeing your primary care provider before it became an emergency. And then you ended up in the emergency room or urgent care....because folks don't see necessarily their primary care provider as someone to go to before it becomes urgent...That is something that our health systems could help our community to understand, is that the emergency room should not be your first line of defense, it should be used for emergencies and that when you are first experiencing a challenge to go see your primary care provider."

AVOIDANCE IN SEEKING CARE

Community members' negative experiences (bias, discrimination, historical injustices) with certain hospitals and health systems diminished overall trust, leading to avoidance in seeking care with those systems or only using hospital emergency rooms, not primary care.

When describing the closure of a local hospital, a participant from Chester County described community members' reluctancy to seek care:

"...because when they had an emergency, they needed to use the hospital for emergency care...even if they had access to the resources to go to the hospital, because of cultural competency or other comfort levels...but otherwise, they tended not to go to that hospital."

"One of the issues is that many of our lower income and particularly minoritized lower income folks do not feel quite as comfortable going to some of the other hospital options in the county just due to due to issues of again race and cultural competency."

A participant from Delaware County echoed a similar sentiment:

"But what I would say is that it was interesting when the hospital closed, many of our lower income community members, when asked, you know, 'what the negative impact of that hospital closing would have on them', they said 'very little', because they didn't interface with that hospital for a variety of reasons, many of which would be cultural comfort, and so they use the hospital for emergency care."

Accessibility

The inability to physically and logistically access primary care providers was frequently shared as a barrier to care. Issues ranged from the availability and reliability of public transportation, lack of walkability, and the accessibility of offices themselves for people with disabilities.

GREATER DISTANCES

Parts of the region have experienced hospital and office closures, resulting in greater distances to reach care. Additionally, areas with limited or no public transportation, and lower numbers of community members with access to private transportation, face increased barriers to accessing primary care.

A participant from Chester County described:

"Because many of our clients cannot get to the nearest hospital in any direction. And so that becomes a significant limiter. If they have private transportation, it's still a distance, but they can get there at least whenever they need to, I think. Sometimes people forget that there's issues with public transportation, right? One is time, the other one is cost, right? But we usually solve for cost, but you can't solve for time."

ACCESS TO PUBLIC TRANSPORTATION

Proximity to, and reliability and cost of, public transportation impacts accessibility to care across the region, with some counties such as Bucks and Chester experiencing significant challenges. Community-based organizations continue to identify solutions to reduce these barriers.

A participant from a community-based organization in Bucks County described collaborating with SEPTA:

"[SEPTA] can provide you up to 50 SEPTA key cards for free. So that's something we've been using for our clients because we had clients that really wanted to go to Northeast Philadelphia or Philadelphia for care and we'd be like, listen, we can only transport you through Bucks. So that has been really helpful when they can't use BCT or can't use us. We're now giving them SEPTA passes and they can get to and from whether it's for an infusion or whatever they have going on."

LONG ROUTES TO CARE

In some counties although the area lacks comprehensive public transportation, there are services available such as Chesco Connect, Coatesville LINK, and SCCOOT. However, these routes can be long and indirect, depending on where a patient needs to go.

Participants from the Chester County region shared:

"So TMACC, who is the organization that runs the SCCOOT bus and the Chesco Connect, they're working on a new route system. So, I can't speak for them, but there is a new route system where they're trying to combine their long route, which runs from Southern Chester County. It runs from Westchester through Oxford and then back again... for a patient to jump on in Westchester to get something out in Oxford, I think -- I don't remember what the ride time is... but it's a very long route."

PROXIMITY TO PROVIDERS

Community members prefer local, neighborhood primary care options, particularly for those who use public transportation or who have limited physical mobility. In addition to variations in accessibility across the region, proximity to primary care providers varies within the same county, such as Philadelphia, with providers concentrated in specific neighborhoods as op-posed to being dispersed throughout the county.

A participant from Philadelphia described this here:

"There are so many health resources in Center City and places like that but just having things that are more on a neighborhood level is very important and especially people who rely on transportation or can't walk very far to get to where they need to go."

BARRIERS FOR PEOPLE WITH DISABILITIES

In addition to the accessibility of an office's location, the accessibility of an office itself such as the width of hallways and doors or the limitations of medical equipment present significant barriers. This issue is particularly pronounced for people with disabilities and those who are caregivers to people with disabilities.

A participant from Delaware County shared:

"I can tell you that from what I know, my wife uses a wheelchair, and it was incredibly difficult. And we have to use pretty much hospital-based or hospital-affiliated practices because a lot of the smaller practice physicians, they're in small offices."

Additional mentions of specific subpopulations struggling with accessibility are highlighted later in this section of the report.

Fear

In addition to logistical and accessibility barriers, participants across discussions expressed fear as a common deterrent to seeking primary care services. Issues related to fear ranged from not wanting to know "what's wrong", fear of how much care/services will cost, to fear of not having insurance or documentation. Fear may be more prevalent in minoritized communities.

FEAR OF DIAGNOSIS

The fear of not wanting to know what's wrong, and hoping "it goes away," frequently results in significant health situations.

A particularly profound example of the extent to which "fear" impacts care was described by a participant from Delaware County:

"And you know we had a situation where a woman had skin cancer on her leg, and she just ignored it until one day at our after-school program, her leg started to bleed, and she couldn't get it to stop. And you know that she had, she had, like the front of her shin removed...And it was all fear. She knew something was terribly wrong, and when she first knew something was terribly wrong, or something was wrong, you know. That situation would, you know, could have changed, could have been much more minor than go out on disability, you know? Because you couldn't walk, and you had, you know, air oxygen being pumped onto the front of your leg. You know those kinds of situations, and that was the extreme situation. But that is happening in my office, and I think is very prevalent in the African American community."

COSTS

Uncertainty about costs is a common reason to delay care, often resulting in overutilization of emergency departments, or advanced health situations. Subsequent costs may be even more than necessary if care had been sought earlier, when issues arise. The need for clarity and education around costs, insurance coverage, financial support are necessary to reduce delays in care.

A participant from Delaware County described this experience:

"What folks tell me is they're worried about that back-end bill. But then they wait and wait and wait. Like a person who just admitted herself to the emergency room, turns out she just has very, very severe acid reflux. Well, now she has an almost $20,000 bill because she went to the hospital and they did a workup, whereas she could have been seen by a primary care doctor, and I think that that would have alleviated that. But some clarity in what the charges are...I think, would be huge."

Care Coordination

Challenges with care coordination were another common barrier among the discussion participants. This was frequently mentioned in relation to community events, health fairs, and pop-up screenings – specifically confusion regarding what someone should do after a screening or test, where do they go next, and whether that's primary care or a specialist.

LACK OF COORDINATION

Although there is great benefit to community health outreach, without proper care coordination, community members are left without knowing what to do next or may not receive the proper follow up care in a timely manner.

A participant from Philadelphia shared:

"We also are seeing it a lot with specialty care where people go to the like neighborhood health fairs and health screenings and find out that they need a colonoscopy, or, you know, they [have] high blood pressure. So, they really need to go in and see their PCP. And maybe get referred to a cardiologist and all of that. They get these tests, and the health systems go to them and say you need to come see us, and then they say "We're actually not scheduling, because that's a year out.'"

INSURANCE BARRIERS

When community members seek out primary care, they may be using inaccurate or outdated lists of providers who accept their insurance even within the same system or office. Often these are the lists shared through insurance portals, which can cause confusion and delays in care.

A discussion participant from Philadelphia, who also works at an FQHC, shared how this impacts both health centers and patients:

"We're finding out that insurances also sometimes cause barriers because they will list certain primary care doctors. And then if someone tries to come to us for primary care, we're like, 'Well, we're not your primary care doctor.' And they're like, 'Why? I've been going to you for so many years.' It's like, well, they listed someone else, and now there's this whole snafu we have to go through with insurance."

Special Populations: People with Disabilities

LACK OF ACCESSIBLE EQUIPMENT

In addition to barriers related to physically accessing primary care spaces (such as halls and doorways wide enough for wheelchairs), participants shared that at smaller, more local practices, the medical equipment cannot accommodate people with disabilities. This can lead to increased utilization of hospitals or specialty care because those facilities may have more accessible equipment. One participant mentioned that finding accessible dental care is particularly challenging.

Describing this experience, a Delaware County participant shared:

"And the other thing is very difficult to find, because I accompany my wife when she goes for primary care, because a lot of times, even if you can get in and they have wide enough hallways, they do not have medical tables or chairs that somebody using a mobility device can get into... So it leads to a lot more of hospital visits than if there were appropriate facilities to get her into — X-ray machines, MRIs, stuff like that. We wouldn't have to go to the hospital but in a lot of cases, the hospital's the only accessible place."

KNOWLEDGE OF RESOURCES

Compounding the physical barriers faced by people with disabilities are issues related to cultural competency and the need for more providers and care teams to "understand the principles of disability and the independent living philosophy" which are critical to providing compassionate and quality care to this community. Additionally, there needs to be greater education and awareness amongst providers about the resources available to people with disabilities, and the role providers play in securing those resources – such as Medicaid waivers.

A representative from Philadelphia County highlighted:

"We think that community first should be always the option, keeping people in their home, instead of in an institution. I also think there's opportunities to educate the health care systems, including the PCPs on, in particular folks that are enrolled in Medicaid waivers, on what services are available. As an example, I know home modifications were mentioned earlier through the city program, but the Medicaid waivers also cover some of those things. So, if a doctor deems somebody, [it's] a medical necessity for them to be able to continue to stay in their home and live independently, the waivers could cover the cost of a Stairglide or a vertical platform lift or extra lighting in the home. And there's an array of services that are available under these waivers, that the physicians just don't know about, and can help improve and reduce the risk that they're facing today in their own home."

Language and Health Literacy Access Issues

LANGUAGE BARRIERS

Many medical offices and clinics use translation services, such as LanguageLine, but this service is costly, is not always implemented with fidelity, and its usage may be accompanied by discrimination or frustration. These barriers can alienate patients who do not speak English.

A participant from Delaware County shared the following:

"But that said, I have advocated long for the ability to have LanguageLine available. LanguageLine is costly…but the ability to have it as a county-sponsored resource or something like that would go a long [way] — but partnered with that needs to be training on how to use it. So, a lot of places have LanguageLine, but the people are greeted with, 'Oh, you need that?'"

HIRING CHALLENGES

Certain clinics primarily hire bilingual staff in order to best serve their community – which can present challenges in hiring physicians and maintaining enough staff to serve growing needs. Participants also expressed that community members would be more likely to seek out services if they knew the staff was bilingual.

Discussing this dual barrier and opportunity, a participant from Chester County noted the experience at their organization:

"It's very difficult to find primary care providers who are able to work in our setting. It's a community health setting. So, if you're able to accept the position, and then, for us, we also have [to] hire bilingually. So, again, we're going back to that, not about us without us, right? So, hiring from within your community."

LOW LITERACY SUPPORT

Support is needed for individuals with lower literacy levels — in both verbal and written communication/education. The use of infographics was shared as a potential solution.

A participant from Chester County explains:

"It's a health literacy challenge, right? So, if I am not of a high education level, so if I have challenges with literacy, you have to say things very, very simply. You need to use infographics; you need to use 4th to 6th grade language. And it's very difficult for us to do that in the healthcare arena. It's really hard to take these really difficult concepts and make them something that you're not too high of an education level, but you are also not so simple that you're not getting the full concept."

Solutions to Address Primary Care Access Issues

Issues with primary care access are vast in the Southeastern Pennsylvania region, impacting every county and diverse community populations. To address these challenges, discussion participants offered targeted solutions and highlighted some successful approaches already implemented in their communities. Solutions reflect opportunities for partnership between hospitals and health systems, community organizations, health clinics, and government.

IMPROVE TRANSPORTATION OPTIONS:

Encourage partnerships with transit providers to subsidize costs, provider vouchers, include transportation as part of health navigation, or innovate new solutions such as healthcare system-specific shuttles or individual drivers employed by the systems. Additionally, identify if routes need improvement (specifically related to time and distance) and if routes adequately connect community members to health care locations.

- **"Again, pie in the sky, right? If we had all this money in the world, if somehow Chester County could create, and through TMACC or another organization, some type of healthcare shuttle service, 'Uber Health', that kind of a thing, but that the drivers are part of an organization or system, not just, 'I'm Kate. I drive for Uber. I'll go pick up.' Because patients don't always trust that kind of a resource. So, it has to be built in such a way that it's a trusted resource for the patients to utilize in order to access primary care and the hospital systems. If we were able to do that, that would be huge."**
- **"One solution would be to have stronger transportation and have more things covered by insurance or generally just having navigators who at a nonprofit level and all kinds of levels, but just help people to navigate accessibility through transportation to their health provider."**

FOSTER STRONGER RELATIONSHIPS BETWEEN HOSPITALS/ HEALTH SYSTEMS AND COMMUNITY CLINICS:

As noted above, increased usage of emergency departments and urgent care for issues better suited to be addressed by primary care is an ongoing challenge. To address this, participants recommended hospitals and health systems and community clinics and FQHCs work more closely to connect community members with local primary care providers. This could be particularly impactful for those with Medicaid insurance, who may have limited options based on their insurance status. Additionally, community members may be more comfortable seeking care with local, community-based providers – especially those who distrust large systems, speak a language other than English or who have limited transportation options. Shifting usage of emergency departments and urgent cares to primary care will also reduce the burden on emergency departments – both in terms of patient volume and patient needs.

- **"The community health centers could be an opportunity for health systems, to maybe lessen the burdens in their emergency room by making sure that they're partnering with primary care providers like a community health center. Community health centers, if you are an FQHC, which is a federally qualified health center, you're able to accept Medicaid, and there are other primary care providers who do not accept Medicaid. So, if you are a person who is in poverty or you have a chronic health condition and you rely on Medicaid for your insurance, then making sure that the health systems are partnering with providers, like community health centers that are able to accept Medicaid, is really important. It does help, not only the patient, but then helps the health system as well. And that does, I think, increase access at your emergency room because you're preventing and using primary care as a preventative service."**
- **"We see a lot of folks there that don't have, you know, regular PCPs, and that that is a potential target for contacting people who have left, you know, been discharged from the emergency department that we could do work to try to connect them to a primary care provider within the system."**

ENHANCE HEALTH NAVIGATORS & COMMUNITY HEALTH WORKER PROGRAMS:

Participants expressed the value of health navigators and community health workers as successful strategies to foster community engagement, encourage prevention, and support patients' complex needs. These roles should be well-positioned to coordinate screening follow-ups and connection with primary care providers.

- **"More investment in community health worker type programs, especially for at risk populations, to target opportunities to reduce that risk again. Like, the example about you go to a blood pressure monitoring [event] and there should be a follow-up, but the follow-up never occurs. Perfect opportunity where a navigator or community worker can fit in to make sure that there's follow through, and coordination."**

FOCUS ON EQUITY AND ACCESSIBILITY:

Participants offered examples of what's working well for their communities and clients around equity and accessibility – such as community-based clinics and diverse language services. When discussing solutions, participants shared the need to continue offering services and resources (or expanding existing services) in multiple languages, address building layouts and physical accessibility, invest in accessible equipment, train staff in practices and concepts such as trauma-informed care and cultural humility, and hire diverse staff to reflect the local communities.

- **"I think that what is working, in Southwest [Philadelphia] there's a large African, West African population, and there's an organization that has a health clinic and I think that you know that the West African population, you know, is way more comfortable going to that clinic. Even though it's a little rough around the edges, and it's not in a pristine building. And you know that kind of thing, I think that there's more of a trust because they're going to somebody like them than there is to go to a brand [new] facility that, you know, is all pristine, but has a mix or of ethnicities working there."**
- **"Every office has a bilingual staff member, and we have a very, very nice and expensive translation system. So, we have these monitors that will directly talk to them in pretty much any language you can possibly think of."**
- **"So I think with LanguageLine, we always want to pair the training about how and why it's important to use it. But if we are asking small organizations…small practices that are in existing office buildings to adapt, we need to be providing them some ability to do so. There needs to be funds to widen those hallways. I shouldn't be surprised, but I am. And LanguageLine should be available."**
- **"I think in terms of solutions, there are educational resources out there to equip health care professionals to understand the principles of disability and the independent living philosophy and what that means."**

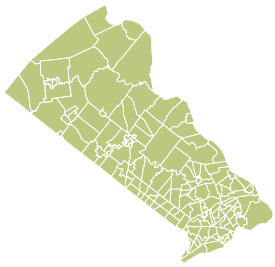
INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS IN THE REGION:

Participants recommended offering incentives or an alternate type of financial funding (either from healthcare systems or federal funding) to encourage medical students and residents to go into the field of primary care, in coordination with education around the benefits of the field itself. With providers retiring across the region, and fewer clinicians moving into primary care, without funding or incentives to close the gaps in providers, primary care access for community members will continue to suffer.

- **"It's hard to afford primary care providers. They're not specialty providers. Their income is maybe a little bit less than some of the specialty folks. So, education and encouraging education of primary care providers would be wonderful. Providing some kind of an incentive for someone to become a primary care provider would be amazing. I don't know that that's something that we would be able to get specifically from the health systems. However, there could be opportunities to encourage healthcare providers to become primary care providers, in some federal funding or partnership funding way of doing things so that we can have more providers from our community to provide care."**

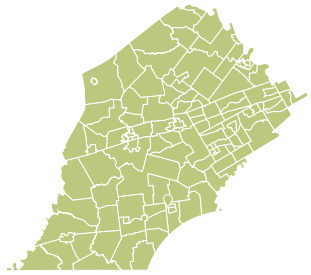
County-Specific Perspectives

BUCKS



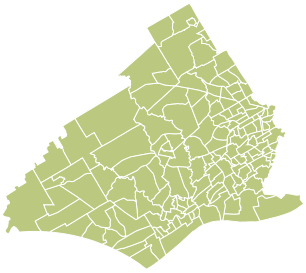
In Bucks County, transportation and logistics to primary care offices and hospitals remains a significant barrier to care – especially when community members seek care in Philadelphia. A partnership between community-based organizations and SEPTA to provide free key cards for clients has proven to be successful and should be expanded to additional organizations. Appointment wait times for new patients is an additional barrier to care. Participants felt that accessing primary care is easier for individuals with insurance, and that community-based organizations can connect patients with care at local hospitals and clinics such as Lower Bucks Community Health Center.

CHESTER



Chester County is geographically and demographically diverse, resulting in unique challenges for community members' ability to access primary care. Southern Chester County is home to a large immigrant population and migrant workforce, many of whom do not speak English, are undocumented, or who do not receive insurance through their employer – all of which may discourage community members from seeking care. Community health centers play a crucial role in filling these gaps by offering integrated services and multilingual services and accepting Medicaid. However, hiring providers, particularly bilingual ones, remains a challenge. The availability and accessibility of care is uneven across the county – with some areas in close proximity to medical offices and hospitals and others with little to no providers nearby, often mirroring seriocomic demographics. This has been exacerbated by hospital closures in recent years. Although public transportation is limited and underutilized, services are available, offering routes along main corridors and to and from health system offices and hospitals.

DELAWARE



In Delaware County, access to primary care remains a significant challenge despite insurance coverage, particularly for Medicaid recipients and immigrant populations who struggle to secure timely appointments at community clinics. Due to recent hospital closures in this area, limited healthcare options force many patients to seek care in Philadelphia. Dental care and accessible healthcare facilities present additional barriers, especially for individuals with disabilities, as small practices often lack the necessary equipment to accommodate their specific needs. While resources like Kids Smiles and hospital-affiliated practices help mitigate some gaps of these, improvements to accessibility should be universally addressed.

MONTGOMERY

Montgomery County's Office of Public Health's 2024 Community Health Needs Assessment featured key insights on community members' perceptions on access to care. Community survey summary results showcase disparities in healthcare access among different demographic groups. While most respondents (78.2%) reported having a personal healthcare provider, access varied widely across racial and ethnic backgrounds. Hispanic or Latino respondents were the least likely to have a personal provider, with only 45.8% reporting access, compared to 82.3% of non-Hispanic/Latino respondents. Additionally, healthcare accessibility was relatively high, with 88.6% of respondents stating that they were "always" or "mostly" able to receive medical care when needed. However, younger adults face greater challenges, with those aged 18 to 34 most likely to report difficulty accessing care. Barriers were also higher for refugee and asylum seekers, immigrants, people experiencing homelessness, and single parents.

PHILADELPHIA

Although Philadelphia is home to multiple major health systems and hospitals, community members still experience barriers to primary care – primarily long wait times, inconsistent care based on insurance status, and disparate access based on geographic location – resulting in systemic inefficiencies disproportionately affecting marginalized communities. Due to significant wait times for primary care appointments, more community members are seeking care from emergency departments and urgent cares. Federally Qualified Health Centers serve as crucial safety nets, but their capacity is often stretched thin, limiting timely access to care. Additionally, fear and mistrust of the healthcare system deter some from seeking necessary preventive care, sometimes leading to severe health complications. Community-based organizations, local clinics, and houses of faith are key connection points in Philadelphia – and are often perceived as welcoming and accessible for many community members.

SPOTLIGHT TOPIC

Community-Identified Solutions

Introduction

The following topics represent community-generated solutions shared during the 2022 rCHNA discussions. Recognizing the value of these insights, the Steering Committee sought to understand how these ideas are being implemented today. To do so, we spoke with a broad cross-section of individuals—including leaders from community-based organizations, civil servants, government officials, and other trusted community voices—who offered firsthand reflections on both progress and persistent gaps.

Shared Challenges Across Topics

Across all themes, stakeholders described enduring systemic barriers that prevent meaningful change. These include fragmented systems of care, lack of transportation, language and cultural barriers, community mistrust, and burnout among both professionals and volunteers. Many noted that services exist but remain out of reach due to inaccessible formats, poor communication, and inadequate outreach. Community members frequently shared feelings of frustration from being excluded from decision-making or asked to participate without seeing meaningful follow-through. Even in well-resourced areas, inequities persist when trust is broken, systems don't communicate, or services fail to meet people where they are at.

What's Working Across Topics

Despite these barriers, there is momentum toward progress. What's working is rooted in relationships, trust, and creative local partnerships. From mobile clinics and warm handoffs to faith-based health events and peer-led care navigation, community-driven strategies show promise. Organizations that embed services in trusted places—like churches, libraries, and barbershops—and those that compensate and support local leaders are achieving greater engagement and impact across the region. Transparent communication, culturally aligned outreach, and investments in lived-experience leadership have helped shift systems toward equity and inclusion, even amid resource constraints.

Invitation to Learn More

The following sections represent a deeper look into each topic area. Each section provides detailed insights into community-identified solutions, what's working locally, and actionable steps toward better health and social outcomes across Southeastern Pennsylvania.

Better Integration of Health and Social Services into the Community

Across Southeastern Pennsylvania, community stakeholders, including social service providers, healthcare professionals, and nonprofit leaders, are calling for stronger integration between health systems and community-based social supports. Interviews conducted in Bucks, Montgomery, Chester, Delaware, and Philadelphia Counties revealed common challenges in coordinating care for individuals whose health outcomes are deeply influenced by social factors like transportation, housing, food access, language, and trust.

Despite a shared commitment to improving community health, the region faces systemic barriers which prevent effective collaboration. Chief among these are information silos, fragmented referral systems, inconsistent infrastructure, and persistent inequities in access. These barriers disproportionately impact vulnerable populations, particularly immigrants, people with disabilities, older adults, and those living in underserved or rural areas.

At the same time, promising practices are emerging. Stakeholders highlighted successful food access initiatives, mobile health services, and warm handoff strategies as examples of what's working. These models demonstrate that integration is possible when health systems take a community-centered approach, communicate across sectors, and build long-term relationships with both patients and partners.

Looking ahead, community leaders envision a more connected landscape—one where referral systems are unified, transportation and technology are leveraged for equity, and healthcare institutions are fully engaged as partners in social well-being. While the region's challenges are significant, so too is the willingness among its professionals to collaborate, innovate, and advocate for change.

What follows is a closer look at how these dynamics play out in each county, identifying local challenges, existing strengths and potential solutions as described by those working on the front lines of health and social care.

Challenges and Barriers:

Participants across all counties highlighted persistent and systemic barriers preventing better integration between health and social services. These include fragmented systems, logistical hurdles like transportation, and deep-rooted cultural, structural, and communication issues.

INFORMATION SILOS AND GATEKEEPING

Professionals described an inability to access or share information across organizations, even when services exist. This siloing leads to duplication of efforts, confusion, and missed opportunities for patients.

One Bucks County participant states:

"Really the biggest thing is the information gatekeeping and just not knowing what everybody else does, not knowing what agencies are out there. So I would really love to see some collective resource that we could all communicate through even if it was like the old Yellow Pages - made life a lot easier."

TRANSPORTATION ACCESS

Lack of reliable transportation, especially in rural and suburban areas, was one of the most universally cited barriers to care access.

According to a Chester County participant:

"Transportation is a very big issue that most people from the rural areas find it difficult to transport themselves to location where there is a hospital is a very big challenge."

CULTURAL AND LANGUAGE BARRIERS

Participants explained that interpretation alone is not enough. Without cultural understanding, services can miss their mark entirely.

A Chester County resident explains:

"Not only is the need is for language barrier to be broken, but also cultural barrier. It is two different things to speak one's language, which is great, which is a need, but also understand why culturally this health behavior or this service is not reached out to."

DISCONNECTED REFERRAL AND DATA SYSTEMS

Multiple incompatible referral platforms force clients to repeat their stories and disrupt continuity of care.

Another Chester County participant said:

"Could we all agree to use the same thing? Because if different hospital systems are making referrals out of different systems, and if the county is working out of yet a third system, and then some of the agencies are working out of maybe a fourth system, we don't need people retelling their story over and over. We need people getting help."

BURNOUT AND WORKFORCE CAPACITY

While often implied, the strain on both healthcare and social service workers emerged as a subtle but critical barrier. Multiple participants mentioned overworked staff, high turnover, and limited time for collaboration—even when the will exists.

A community-based organization participant from Delaware County explains:

"I don't know a single person in our profession who truly has bad intentions, but they all have limited time."

MISMATCH BETWEEN SCREENING AND SERVICE AVAILABILITY

Several interviewees described a tension where health systems are now required to screen for social needs but lack meaningful referral options when people screen positive.

One participant from Philadelphia described it this way:

"We screen folks for housing or transportation insecurity… then we have no up-to-date referrals to help people."

THE NEED FOR BIDIRECTIONAL INTEGRATION

While much of the conversation focused on health systems referring into social services, some key informants raised the reverse challenge: CBOs also need more formal pathways to connect clients into healthcare systems.

A participan from Philadelphia shared:

"Typically, we refer patients in healthcare into social services, but we could be doing more to create a full loop."

IMPORTANCE OF TRUST AND CONTINUITY IN RELATIONSHIPS

Trust came up repeatedly, not only as a cultural concern but also in terms of how systems build or break community confidence. Several participants emphasized that short-term pilots or programs that disappear leave communities more skeptical and harder to re-engage.

According to a participant from Chester County:

"It's very hard when a company or agency comes out saying they're doing these wonderful things for the community to trust them... because it's been their experience that they're not going to be there that long."

What's Working Well

While challenges remain, participants pointed to several bright spots in integration efforts. Effective areas include food access programs, mobile and street medicine services, and personalized approaches to client handoffs and care coordination.

FOOD ACCESS AS AN EFFECTIVE ENTRY POINT

Food access, especially those tied to health systems, was widely viewed as successful and replicable models.

A member of a Philadelphia CBO said:

"Food and nutrition is actually one of the areas where health systems are doing a pretty good job. Not all of them, not all the time, but many health systems in the region have either developed their own food pantries or they have referrals to food pantries. They're connected to Philabundance and MANNA and other organizations, and I think food is an area where we're doing better."

MOBILE AND COMMUNITY-BASED SERVICES

Mobile units and outreach programs (e.g., mammograms, dental vans, street medicine) increase access by meeting people where they are.

One Montgomery County participant explains:

"Over in Pottstown, they do street medicine now. And a lot more mobile units like their community health and dental or the mobile mammogram and things like that where they're really getting the doctors out to either other sites in the community. And I think that that's been really successful in that area and I'm not sure if any of that occurs in this part of the county."

WARM HANDOFFS AND RELATIONAL REFERRALS

Building trust through person-centered care and warm handoffs was seen as more successful than transactional referrals.

According to a Chester County participant:

"It really doesn't make a difference. If you hand that person a number and the person still can't access the service. It's still a problem. So, it has to be more involvement in just making sure that that person actually was able to get into that service if in fact that's what's supposed to meet their needs,"

Suggested Actions and Solutions

Participants offered tangible strategies for improving system integration. Suggestions focused on improving communication infrastructure, embedding services in communities, utilizing technology for independence, and institutionalizing long-term support roles.

Multiple stakeholders advocated for routine cross-sector meetings and infrastructure for sharing updates and connecting services.

- **"There needs to be a group of people, whatever they're called, kind of a team that meets regularly. Some frequency about kind of, I guess representatives that know what's happening in the community can take it back and are just educated about, oh, you're doing a program on this. Okay. That's great. We're going to get the word out."** – Delaware County

Embedding hospital outreach within churches, senior centers, and trusted spaces can build visibility and credibility.

- **"Go to a church. After the church service, do an education. You got a captivated crowd. You got them right where you want them. Bring some food, call the day. I think things like that. More of that stuff needs to happen. We really wanna reach into the community."** – Chester County

In-home technology was seen as a cost-effective tool to prevent unnecessary institutionalization and support independent living.

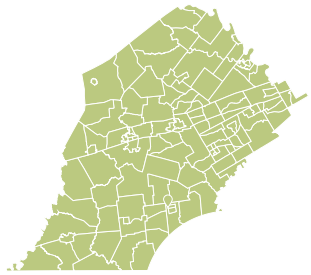
- **"We have about five people who are using in-home medication dispensers, and they would not be able to stay housed if they didn't have those in-home -- it's high-tech. When they're supposed to take medication, they press this button on this machine, the medication drops into a cup, and then they take it. If they don't press the button and they don't pick the medication off the tray, our nurses get a message on their phone and can call them and help them deal with it or go to the apartment."** – Philadelphia County

County-Specific Perspectives

BUCKS

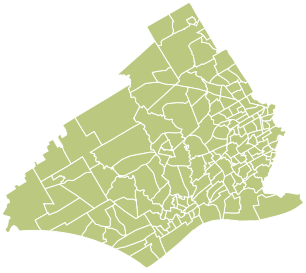
In Bucks County, one of the most pressing challenges is widespread information gatekeeping and lack of cross-agency awareness. Despite being a resource-rich area, participants noted that agencies often do not know what services others provide, leading to missed opportunities for collaboration and fragmented care. Newer staff entering the field expressed frustration at the inability to connect freely with other organizations—even within the same building—due to administrative restrictions and a lack of centralized communication tools. Another major issue is that clients are typically connected to only one agency, even when they have multiple, intersecting needs, which leads to frustration and disengagement. Additionally, clients are often not empowered to make independent decisions, especially when many providers are involved. Yet, there is strong enthusiasm among professionals in the county to bridge these gaps. Some described Bucks County as offering "more services than anywhere" they had worked before, suggesting that the infrastructure exists, but better communication and coordinated referral tools (such as a county-wide directory or Yellow Pages-style system) are essential. Participants also recommended county-wide training focused on fostering client independence and clarifying eligibility across programs as practical solutions to reduce client attrition.

CHESTER



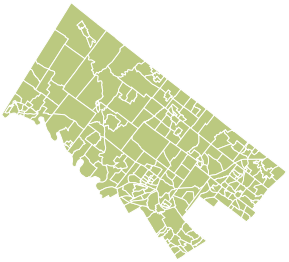
Chester County's integration challenges are defined by geographic and jurisdictional fragmentation. Participants from Southern Chester County noted that while services may technically exist, transportation and awareness remain substantial barriers. Compounding this is the fact that many communities in Chester span multiple county lines, meaning access to services changes depending on where a resident lives, even for people with the same condition or need. A major systems-level challenge is the lack of unified referral infrastructure. Hospitals, counties, and nonprofit agencies all use different platforms, forcing clients to retell their stories repeatedly and often leading to service gaps. Language and cultural barriers were also highlighted, particularly among the county's growing Spanish-speaking population. Nevertheless, Chester County benefits from engaged coalitions like Communities That Care (CTCs) and a strong recognition among local providers of the importance of warm handoffs and trauma-informed communication. Solutions proposed included hospital participation in local coalition efforts, co-locating social service staff in hospital spaces, and institutionalizing long-term navigators to help patients stay connected to services. Participants also stressed the importance of consistent community presence, noting that short-term or underfunded programs erode trust over time.

DELAWARE



In Delaware County, the major barriers to integration stem from organizations being territorial, privatized health systems, and inconsistent access to programs based on residency. Interviewees expressed frustration with large hospital systems whose leadership operates outside the region, noting a disconnect between decision-makers and community needs. Additionally, community-based organizations (CBOs) and churches often limit their programming to internal groups, which restricts collaboration and creates inefficiencies. Some township-level programs are also only available to residents of specific municipalities, further fracturing access across the county. Despite these barriers, Delaware County has shown promise with its 211-call system and a strong network of grassroots organizations eager to collaborate. Participants emphasized that regional coordination teams, including representatives from medical, social service, and community sectors, could help break down silos. They also recommended greater hospital investment in local social infrastructure, funding for mental health services, and a place-based strategy that tailors solutions to the diverse sub-regions within the county (e.g., Wayne vs. Upper Darby). The need for hospital systems to see themselves as community health leaders, not just clinical care providers, was a key theme throughout.

MONTGOMERY



Montgomery County stakeholders identified transportation barriers and language access challenges as two of the most significant obstacles to better integration of health and social services. Although telehealth is available, many clients lack devices, internet access, or digital literacy, making remote care inaccessible. Similarly, language services are insufficient for the county's diverse population, with most bilingual capacity limited to Spanish. Interpreter services exist but are inconsistently applied, and some—like LanguageLine—fail to adequately capture patients' concerns. Still, the county has several promising practices in place. Some participants praised the usage of GLOBO, an interpretation service offering over 240 languages, including ASL and video. There was also enthusiasm around existing mobile health initiatives, such as street medicine and dental vans in Pottstown and Norristown, which were seen as successful models of community care. As a solution, participants recommended partnerships with transportation services like Uber Health, investment in volunteer-based ride coordination, and clearer post-discharge transportation planning at hospitals. To better serve multilingual and multicultural populations, stakeholders emphasized expanding interpreter access and improving cultural responsiveness across systems.

PHILADELPHIA

Philadelphia's integration challenges center on mistrust of healthcare institutions, fragmented systems, and institutional bias toward congregate care for people with disabilities. Many residents are hesitant to seek care in large health systems that feel overwhelming or unwelcoming. Community-based organizations reported that health and social services operate in parallel but disconnected silos, which is especially problematic for people with multiple, overlapping social needs. A recurring concern was the "nursing home default" for patients with disabilities—where hospital discharges lead straight to institutional care due to lack of community-based alternatives. Yet Philadelphia was also highlighted as a leader in food access programs, with health systems running food pantries, food-as-medicine programs, and partnerships with organizations like MANNA and Philadabundance. In-home technology, such as automated medication dispensers, was also noted as a promising innovation that enables people to live independently. Interviewees emphasized the need for holistic, long-term approaches to care that treat food, housing, and health as interconnected. They recommended expanding waiver-based home and community care programs, training hospital staff on disability cultural competence, and developing long-term referral systems with built-in feedback loops. Many felt that the success of food integration could serve as a model for other social determinants of health.

Increasing Community Members Capacity to Become Care Navigators

Across Southeastern Pennsylvania, community members and providers articulated a deep commitment to expanding the capacity of individuals—especially those with lived experience—to serve as care navigators.

These individuals often serve as trusted guides through complex systems of health and social care, but their ability to do so effectively is shaped by entrenched challenges, current successes, and creative grassroots solutions.

Challenges and Barriers:

Participants across all counties highlighted persistent and systemic barriers preventing better integration between health and social services. These include fragmented systems, logistical hurdles like transportation, and deep-rooted cultural, structural, and communication issues.

FRAGMENTED SYSTEMS & ACCESS BARRIERS

Participants highlighted the systemic fragmentation in health and social services, where siloed funding streams (e.g., substance use vs. mental health) hinder coordinated care.

A Bucks County participant said:

"We should be able to refer a client in all those directions in one shot and you get to pick one and hope that you get funding for it."

A Montgomery County participant further explained this challenge:

"I'm thinking about community connections through the county and that they are, I guess intended to be that central hub for resources. But again, I feel like, I don't know if everybody knows about them and then I think one of the challenges is how things are just constantly changing. So, keeping up with the change and what services are available, that's just hard. You could make a resource guide and six months from now it's not going to be current. So, I think that's a challenge of that, but maybe more types of —or a really known community connection. This is here for everybody to use."

LANGUAGE & CULTURAL BARRIERS

Language emerged as a recurring theme across counties, with service navigation often falling to children or overburdened staff.

A Bucks County participant shared their experience:

"I think of like capacity and navigators is our family standard coordinators speak all different languages. I don't know, if your guys – healthcare, if they provide many different languages, we have a bunch of Middle Eastern languages like Arabic, Hindi, Russian, Ukraine, Spanish. So not only are coordinators focusing on funded programs through our agency. People come to them asking what does this mean? What's that? It's like they have to spend so much time explaining in different languages and we're not funded for a lot of that time. So, they have to squeeze where they can to help people, but I know that language is -- as much as transportation language is definitely up there with barriers for our staff to advocate for them or steer them in the right direction."

LACK OF AWARENESS AND OUTREACH

Despite longstanding programs, many residents and even providers remain unaware of available services.

A Philadelphia participant shared:

"So, in starting work in the Northeast, one of the first things I did was to get a grasp of the area, even though I live up there as well, was going to civic meetings, trying to — hey, we might start doing work up here. What's going on? Getting feedback from community members, different civic groups. And one thing I noticed is that most people like some of us in the field, we don't communicate outside of what we're doing. So, the community members that are there want to help, they're at a civic meeting. They obviously have some inclination to do something for their community, but they don't have the resources."

One Montgomery County participant summed up their experience with a longstanding community organization:

"We celebrated our 125th year. I can't tell you how many times we were like … 'Never heard of them'. For real."

VOLUNTEER BURNOUT AND AGING WORKFORCE

Participants described burnout among care navigators and an over-reliance on a small group of aging volunteers.

A participant from Philadelphia shared:

"And I think the biggest thing with the burnout - just in some of community organizations that I have volunteered in and been a part, we ask the same people, we don't go outside of our usual. And there's so many other individuals out in the community that may be open to supporting and volunteering, but they just don't know, and no one's asking."

One Chester County participant further highlighted the challenges with volunteer burnout and engagement:

"It's really challenging to get someone that's going to commit to that on a weekly basis, on a long-term sustainable basis. I think a lot of times we see, like, volunteer pushes and volunteer initiatives that last, you know, months, and then it sort of phases out and fizzles out."

DIGITAL LITERACY & TECHNOLOGY ACCESS

Many participants, especially those working with older adults, flagged digital navigation as a growing barrier. As healthcare systems increasingly rely on patient portals and online systems (e.g., MyChart), some community members struggle to access or understand digital tools essential for care.

A participant from Chester County expressed:

"There needs to be some training…how to navigate on your computer is all the MyCharts and MySpaces that the hospitals have. Everyone can't navigate those things."

To mitigate this barrier, a participant from Philadelphia offered this solution:

"That sort of preparedness is something we can focus on…we can make trainings virtual and on-demand and asynchronous, so we can reach more people."

CRISIS-LEVEL ENTRANCES TO CARE

Participants shared that people often access care only when in crisis, and frontline staff or community members are left trying to interpret needs that are not clearly articulated. This leads to miscommunication, inadequate care, or even criminalization.

A Delaware County participant shared:

"Because this is an issue, it can cause the consumer…to act a certain way, which then triggers them to possibly have somebody called on them…they want services… but there's not someone there on-site that knows a little bit of what's happening."

What's Working Well

What's working to support community members as care navigators' centers on trust, relationships, and culturally rooted approaches. Faith-based organizations, libraries, and grassroots spaces are stepping in as reliable access points where people feel safe seeking help. Community-led efforts—like informal mental health support, Narcan training at civic meetings, or barbers trained to identify and refer clients for care—demonstrate that navigation doesn't have to be clinical to be effective. These approaches are grounded in everyday environments and speak to the lived realities of the communities they serve.

Collaboration is also a key success factor. Interagency gatherings like Kensington's "huddles" create space for problem-solving and sharing resources across sectors. In parallel, organizations that uplift peer leaders with lived experience—like community health workers or caregivers—build deeper trust and reach. Simple efforts like tabling at local events or resource fairs also go a long way in boosting visibility and awareness. Together, these practices highlight that when communities are engaged authentically and given the right tools, they can lead the way in navigating care systems that often feel overwhelming or inaccessible.

TRUSTED COMMUNITY ANCHORS

Faith-based organizations, libraries, and grassroots groups have built strong trust within their communities.

A participant from Chester County said:

"When we needed, at the library, a new lactation room, a Facebook group of moms volunteered to furnish a whole room, plus one year of free diapers and wipes to other moms at the local library, just because I presented this under a community effort that had a name, a space, trust built."

INFORMAL MODELS OF SUPPORT

Programs such as the "Friendship Bench" and Narcan trainings at civic meetings showed the value of low-barrier, community-grounded interventions.

A participant from Chester County expressed:

"It was called Friendship Bench. And it started, I believe, in Africa, and is just coming into the United States. But they had community grandmothers sitting on a bench where people could come and they train these grandmothers in mental health services and things like that. And people could come and sit with the grandmother, and tell them their problems, tell them their issues, have a sort of therapy in this safe space with this grandmother."

A participant from Philadelphia County said:

"So, what ended up happening, inadvertently, is that I was going there to fish for information for a program that we're doing, but what ended up happening is I ended up doing impromptu Narcan trainings and filling in people on different social services in different areas depending on where they live at."

INTERAGENCY COLLABORATION AND LEARNING HUBS

Interagency collaboration and community-based learning hubs emerged as powerful mechanisms for strengthening care navigation, particularly in communities where needs are complex, and traditional systems often fall short. In both formal and informal spaces, participants described how bringing multiple organizations together fosters real-time problem-solving, relationship-building, and shared accountability.

Together, these examples illustrate how collaborative ecosystems, whether in clinical settings or barbershops, build stronger, more responsive networks for care navigation by valuing shared learning, trust, and community-rooted knowledge.

A participant from Philadelphia County said:

"It's just a bunch of people that meet up, and anything happens down there because in that area, you just got to figure it out. So, you're going to come across some of the craziest cases and some of the craziest things to try to figure out. And if you're willing to do the job, you can get into some crazy stuff that you're figuring out, which you bring it there, and you put it on the table like, 'Hey, I don't know what to do. I got this crazy case that's just a mess.' And there's always people there willing to at least brainstorm with you."

A participant from Chester County said:

"We partnered with community care, behavioral health, and provided our hair training where we trained barbers and hairstylists in Black communities to understand mental health diagnosis and referrals for mental health treatment… it was a great process, a great experience for the barbers and stylists."

PEER-LED AND LIVED-EXPERIENCE APPROACHES

The importance of navigators with lived experience—not formal education—was raised repeatedly, especially in communities where trust in formal systems is low. Community Health Workers (CHWs) with shared backgrounds can connect more effectively.

A member from Philadelphia County said:

"There are many, many robust, well-run CHW programs…We can have CHWs train other healthcare workers…I think it's actually been a very straightforward, successful system for places that have invested in it."

LEVERAGING RESOURCE TABLES AND PUBLIC EVENTS

Resource tabling at community events emerged as a valuable, simple mechanism to increase visibility and awareness of services. These efforts help address the challenge of outreach without requiring deep infrastructure.

A paricipant from Montgomery County said:

"We do resource tabling and people come up like, 'Oh wow, I never knew this.' How long have you been around?' '50 years.'"

Suggested Actions and Solutions

Across counties, participants emphasized that increasing community capacity for care navigation requires **intentional investment, inclusive recruitment, and structural support**. Solutions center on **training and compensating individuals with lived experience**, ensuring that those most connected to the community are also empowered to lead. Organizations are working to **standardize care navigation protocols** across sites to ensure consistency, while also developing **virtual and on-demand training** to make learning more accessible.

To prevent volunteer burnout and ensure sustainability, participants advocated for **expanding the volunteer pool**—especially by **engaging youth and young adults** through schools, service requirements, and internships. There is also strong support for **intergenerational mentorship**, pairing experienced older adults with younger volunteers to build mutual learning and long-term capacity. Finally, many called for **compensating volunteers through stipends, gift cards, or workforce development opportunities**, recognizing that the economic realities of many potential navigators must be addressed to make service accessible for all.

There is a strong consensus that organizations must provide funding, training, and recognition for navigators.	• **"There are many, many robust, well run CHW programs within health systems. And really, all it takes is the, you know, desire to fund the position and provide the training, and that training can really come now from the distributed network of CHWs that already exist within the city. So we can have CHWs train. Other healthcare workers, you know, provide their perspectives and things like that. But I think it's actually been a very straightforward, successful system for places that have invested in it."** • **"There is a woman in the Coatesville community that does a caregiver…she used to care for her husband with Parkinson, and so she does a survey just about like what their experiences with caregiving, and she didn't even know that she could have been reimbursed for the caregiving that she was providing…There is an opportunity for that sort of transition."**
Several participants emphasized the need to intentionally include high school and college students, tapping their lived experiences and leadership potential	• **"Have we gone in and had conversations in the high schools and talked about some of the great work that's being done in their very own community and backyard and the gaps of that volunteer need with all of this work that's being done. and we may be surprised how many? We may say yes."** • **"So, learning those pieces of because if they're not asked and they're not put in situations where they have the opportunity they may not know where to go to look to ask, or they just, you know, they're in their own world."**
Bridging youth with older adults who have decades of experience can both preserve knowledge and create continuity.	• **"The older generation has a wealth of knowledge. We need to partner the older ones with the younger ones. The younger ones are now willing and able because they're going to get credit for it. The older ones usually love to spread information, love to share knowledge."** • **"I was just thinking this morning about going to vote, and it was like everyone who was working the polls was an older Black woman from my neighborhood. There was no like that was the only demographic, you know, there were like 10 women there doing it."**

Several interviewees spoke explicitly about economic hardship is a major deterrent to volunteering. Stipends, flexible schedules, and structured programs can mitigate this and increase equity in participation.

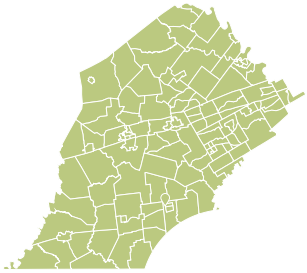
- **"There's like an economic barrier that we don't always think about — that like volunteering does tend to fall to older people because they're no longer, you know, working full time, or they're not trying to do like three gig economy jobs, you know, in between doing whatever else. So, I think any financial support we can give to people, the more the better. And I think that's probably like one of the major ways of doing it. So, in projects that we're working on where we're trying to engage younger people to be a part of it, we're trying to pay like monthly stipends for the hours that they volunteer for us to cover things like what it takes to volunteer."**

County-Specific Perspectives

BUCKS

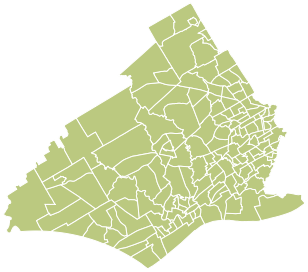
Bucks County faces pronounced challenges related to siloed services, especially for individuals with co-occurring mental health and substance use issues. Providers feel powerless when funding streams dictate care options, regardless of client need. Despite resource availability, navigation remains difficult without centralized, updated directories. Nonetheless, staff are deeply dedicated and eager to refer clients, if only the tools existed.

CHESTER



Chester County has demonstrated innovation through local adaptation of global models like the Friendship Bench and grassroots mobilization at libraries. Participants emphasized the importance of placing care navigation in comforting, familiar community settings. There is a strong local willingness to volunteer when efforts are framed as collaborative, named, and intentional.

DELAWARE



Despite abundant services, accessibility remains a major barrier in Delaware County, complicated by staffing shortages and lack of responsiveness from agencies. Language and cultural mistrust—especially among Latino and Asian communities—compound the problem. However, existing interpreter services and a commitment to outreach offer a foundation to build on.

MONTGOMERY

Montgomery County benefits from longstanding institutions and community clinics, including faith-based vaccine distribution and nutrition services. However, many residents remain unaware of available resources due to limited marketing and constant service changes. The "Community Connections" hub has potential but needs greater visibility and integration.

PHILADELPHIA

Philadelphia stands out for its informal, embedded outreach strategies. Civic meetings, Narcan trainings, and Kensington's "huddles" serve as organic sites of engagement and information sharing. Participants emphasized the need for systems to better support community volunteers, financially and structurally, to avoid burnout and improve continuity.

Integrating Preventative Treatment, Care, and Education in the Community

Across Southeastern Pennsylvania, community stakeholders emphasized the urgency of shifting from reactive to proactive approaches to health.

The conversations revealed persistent challenges in reaching marginalized populations with preventative care, while also highlighting community-driven innovations and solutions. Participants underscored that trust, access, and culturally appropriate outreach are pivotal in successfully delivering health education and preventative services.

Challenges and Barriers:

Community leaders described persistent structural, cultural, and logistical barriers to accessing preventative care. These included transportation, cultural stigma, lack of language-appropriate resources, health system complexity, and socioeconomic conditions.

TRANSPORTATION AND ACCESS ISSUES

Transportation barriers were one of the most commonly cited logistical challenges across multiple counties. Stakeholders noted that even when preventative services exist, unreliable or unavailable transportation renders them inaccessible. These issues not only deter initial appointments but also negatively impact future health-seeking behavior.

Two Philadelphia participants explained:

"If people can't get to where they need to go to get the preventative care or to access something, then [it] doesn't matter that it exists because they can't get there. Or if they can get there, say there is a program that schedules rides for them, maybe a paratransit type program or motive care or something, but those rides are consistently late or no shows or just unreliable, then that's pointless too."

"Transportation not only to get to your preventative care, but then transportation access, the healthiest food that you need to then prevent chronic disease and illnesses. That is a huge barrier."

CULTURAL BARRIERS AND STIGMA

Providers discussed how cultural trauma, and norms prevent many immigrant women from seeking mental health care. Shame, secrecy, and fear of judgment or exposure in their own communities are significant deterrents. These issues often remain invisible to mainstream providers who may lack nuanced cultural understanding.

A Bucks County participant told us:

"They've been raped and it's not something you talk about, you don't get help with. They don't want to be labeled as a victim with needing mental health help… being able to talk about — through counseling, what they went through because they don't want their — maybe their husbands don't know what happened or their friends, they just don't want people to know… it is definitely a barrier for clients to even consider going for help."

A Montgomery County participant shared:

"Nobody thinks they have any problems and they hesitant going to doctor and talk about their problems. They just want to hide all this thing till it really explodes."

SOCIOECONOMIC STRESS AND CRISIS LIVING

A theme across counties, particularly Bucks, was that generational poverty leaves people in constant crisis mode. Preventative care falls by the wayside because people lack the bandwidth to prioritize anything beyond immediate survival needs like food and shelter.

Another Bucks County participant said:

"What happens is when real crisis strikes... that's when we see folks come through and say, hey, what's available?... So, I think that a lot of the barriers that exist in preventative care is we're not getting in front of the folks because we don't know where they are until they're in crisis."

LACK OF HEALTH LITERACY

Despite available services, participants shared that many residents—especially in Chester—lack foundational understanding about why preventative care matters. This "education gap" prevents community members from engaging in health services until a crisis occurs.

A Chester County participant explained:

"To this day, 2024, regardless if the resources out there, if it's accessible, the concept still today is not there. Why would I want to do a preventative effort? And I think that is a huge, huge gap to fill simply by health literacy and health education of the why."

LANGUAGE ACCESSIBILITY

Language access was flagged as a key barrier. Resources, even when available, are often only in English, which makes independent learning or navigation of services nearly impossible for clients with limited proficiency.

A Philadelphia participant said:

"We don't have, not much to give them, flyer or brochure. We just like, search our own, you know, like, online... No. It's a lot of English."

A Delaware County participant said:

"Not everyone is computer literate, knows how to fill it out. It may not be offered in other languages, and the language is not probably usually reader friendly."

COMMUNITY MISTRUST AND HISTORICAL DISCONNECTION

Across counties, there's a thread of longstanding mistrust in institutions—particularly healthcare systems—rooted in cultural disconnection, lack of representation, or perceived elitism. While this overlaps with "challenges," it deserves its own framing because it is more than a logistical or awareness gap—it's a relational and historical one.

A Chester County participant explained:

"I think you still have to have people who look like me in order for me to want to hear what they have to say."

MENTAL HEALTH AS BOTH A BARRIER AND AN UNMET NEED

Mental health came up repeatedly—not just as a standalone need, but as a barrier to engaging in any kind of preventative care. This includes stigma, depression-related inaction, and post-pandemic trauma, especially among youth.

Two Montgomery County participants shared:

"Mental health... post-pandemic, the teenagers, oh Lord. Everything they've had to go through... prevention for mental health would be really important."

"There's not enough providers, and the providers that are there, the waitlists are crazy."

INFORMATION OVERLOAD OR FRAGMENTATION

Several stakeholders—particularly in Delaware and Philadelphia—spoke about the difficulty of navigating too many disconnected systems, where information is either overwhelming, inaccessible, or not presented in ways that encourage uptake.

"I'm inundated with information... And since that takes up 90% of my energy, I don't have an opportunity many times to see what's going on in other communities and see what other people are doing throughout Delaware County."

What's Working Well

Innovative programs and local partnerships were highlighted, especially when rooted in trusted community institutions or tailored to specific populations. Examples include mobile health clinics, faith-based outreach, and home visits from insurers.

COMMUNITY-BASED EDUCATION AND MOBILE CARE

Mobile health clinics and pop-up services were praised as accessible, effective methods of reaching underserved populations. By removing the burden of travel and integrating care into community spaces, these models filled a crucial service gap.

A Montgomery County participant told us:

"What I've seen in Pottstown with the mobile clinic... that seems to be really hitting a population that was not getting any treatment before. It's not preventative, but it's treatment that is working there."

IN-HOME CHECKUPS BY INSURERS

Health insurers were commended for offering in-home health assessments. These check-ins not only improve convenience but also serve as reminders and motivators for patients to complete outstanding screenings and care.

Another Montgomery County participant told us:

"Once a year, [health insurance company] sends a nurse at home. Even though I have my physical once a year, they still want to come. 'Til you let them come, they keep on calling you... So the nurse comes and she takes your blood pressure and what not and asks questions about you had your mammogram and colonoscopy and all that... That reminds you that this one you haven't done it, so you have to get it done."

RESOURCE SHARING AMONG TRUSTED ORGANIZATIONS

Trust in organizations like SEAMAAC was high among community members. When healthcare systems partner with known and respected community organizations, especially those embedded in ethnic or immigrant communities, people are more likely to engage.

A Philadelphia participant told us:

"I think like, if you give to SEAMAAC, I think SEAMAAC will be a good to share information to client community. Because mostly all the community, when they need help, they come to see me."

FAITH-BASED HEALTH EVENTS

Faith institutions were seen as a powerful, though underutilized, vehicle for health outreach. By hosting wellness events and clinics, they bring health information into familiar and trusted spaces. Still, participation remains an issue.

A Montgomery County participant explained:

"This temple, they take care of not only religious, but they have a lot of health clinics. They have yoga clinics, they have a dentist coming and diabetic specialist comes and give lectures and all. But the participation is again a problem."

Suggested Actions and Solutions

Participants proposed clear strategies to strengthen community health education and prevention, such as improving outreach through schools, tailoring messaging through community champions, and integrating culturally relevant communication in familiar settings.

Plain language and representation matter. Participants suggested using relatable, culturally aligned messaging delivered by trusted messengers—not necessarily health professionals—to improve community engagement in prevention education.

- **"I look at those lists all the time, and I think they could be nice, but they don't look like they would be the language or whatever that I want to hear. Right? And then I have to go back to you still have to have people who look like me in order for me to want to hear what they have to say."**

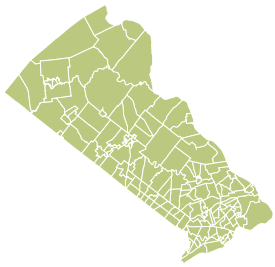
Participants emphasized early intervention through schools and pediatricians as essential to long-term prevention efforts. Children's health habits start early, and so must educational messaging.

- **"How can we better educate our children on eating healthy foods versus eating Takis and Doritos all the time… So how can we do that with the schools, with the hospitals, with the PCPs?"**

Rebranding health education as social, fun, and interactive can help reduce stigma and draw broader audiences. Events like cooking demos or "family fun nights" were named as ways to slip prevention into appealing formats.	• **"So they're not admitting maybe that things could be done differently, because it's not even wrong. It's just that you could do it better. Like nutrition, to have cooking classes, not necessarily a lecture on diabetes, but to be like, let's make these fun snacks and to get people in that way."** • **"There are 70 kids that come to a library story time three times a week. So, think outside the box, go to public spaces like a public library, do health literacy in public libraries."**
A recurring request was for a centralized, user-friendly tool that filters resources based on need and eligibility. A digital or county-specific "one-stop shop" could significantly reduce access barriers and information gaps.	• **"I am by no means IT inclined, but one of my bigger goals is to have a resource... where you can go in and enter certain criteria like... age address, and maybe insurance and that's it, and it populates the list of resources based on that criteria... there's not really like we've talked about a couple of times like a one-stop shop where we can search for things specific."**
Advocacy is needed to shift funding, eligibility, and systemic rules—especially around housing, language access, and documentation. Some interviewees, especially in Philadelphia, touched on policy-level solutions (e.g., adjusting area median income (AMI" guidelines for housing aid) and the importance of systemic change to meet prevention goals—not just programs or messaging.	• **"There's actually legislation that — I'm in a coalition called the Philadelphia Coalition for Affordable Communities, and we're trying to get legislations passed to have the city council allocate 50% of all housing funds that come in, whether it be state, local, or federal, to people who make $32,000 or less, a family of four to the appropriate AMI associated with Philadelphia."**

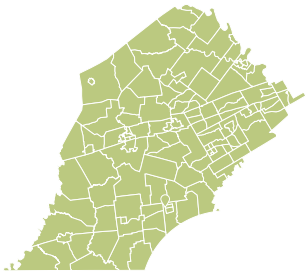
County-Specific Perspectives

BUCKS



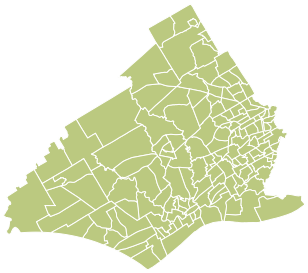
Bucks County is grappling with major cultural and awareness gaps in reaching non-traditional settings for prevention education, such as daycares. Barriers like stigma, generational poverty, and cultural trauma inhibit access to mental health and substance use support. However, success in engaging unlikely partners (e.g., daycare centers) and suggestions for a centralized, digital resource hub point to creative, community-rooted solutions.

CHESTER



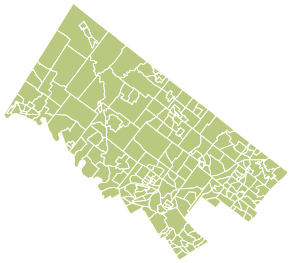
In Chester County, a persistent lack of health literacy underpins many prevention gaps. Community leaders emphasized the need for plain-language messaging, culturally aligned education, and child-focused wellness. Trust and relatability—especially from people who "look like me" and settings outside the clinical space—are vital. Participants called for stronger partnerships between health systems and grassroots organizations to shift public perception of prevention.

DELAWARE



Delaware County stakeholders identified systemic reactivity as a root issue—services only activate once a person is in crisis. Key barriers include language, literacy, and lack of culturally competent outreach. Although there's general awareness of available resources, they're inconsistently used. Solutions focus on proactive outreach, community forums, and multilingual communication to make people feel seen and heard.

MONTGOMERY



Montgomery County highlighted challenges in parental engagement, mental health waitlists, and the undervaluing of adult preventative care. Still, residents recognize the value of mobile care, insurer-initiated check-ins, and informal wellness events through faith institutions. Suggestions included making prevention fun and accessible—such as incorporating education into family-friendly events and hands-on activities.

PHILADELPHIA

Philadelphia's challenges are deeply structural—transportation, housing instability, and the mismatch between available resources and those most in need. Community voices underscored the importance of location-based and trusted messengers, such as CDCs and SEAMAAC. Solutions include partnering with community development entities, tailoring funding models to match actual neighborhood AMIs, and sustaining lessons learned from COVID-era outreach.

Involving Community in Solutions and Implementation

Across Southeastern Pennsylvania, community leaders and health stakeholders emphasized the importance of meaningfully involving residents in designing and implementing health solutions. While there is widespread recognition of the value of lived experience and community voice, many structural barriers—such as staffing shortages, inaccessible formats, and lack of feedback loops—limit meaningful engagement.

At the same time, there are powerful examples of grassroots initiatives, community-driven events, and collaborative task forces that demonstrate what works when institutions partner with residents authentically. Participants offered concrete ideas to advance equity, inclusion, and sustainability through more intentional power-sharing, clear communication, and strategic collaboration.

Challenges and Barriers:

Participants identified a wide range of challenges that undermine authentic community involvement in health solution development. These include systemic issues like transportation and staffing shortages, as well as less visible barriers such as community burnout, fear of not being heard, and inaccessible or overly academic messaging. Power imbalances—where decisions are made without true representation—further weaken trust. Even when community input is gathered, it often goes unacknowledged, leaving residents feeling unheard and excluded. These barriers combine to create a landscape where participation is limited not by disinterest, but by fatigue, frustration, and lack of structural support.

LACK OF TRANSPORTATION AND ACCESSIBILITY

Many communities, particularly older adults, people with disabilities, and those in rural or underserved urban neighborhoods—struggle to access services or participate in forums due to inadequate transportation.

Although Philadelphia has a relatively robust public transit system, gaps in access and connection exit.

A Bucks County participant shared:

"It is hard to eradicate social isolation if you can't get anywhere because there is no public transportation or the transportation that we do have is very limited or very rigid in the timing."

One Philadelphia County participant highlighted:

"Transportation is a problem. And it's not always easy as you would think to get the managed care entity or the hospital to coordinate transportation to and from appointments."

UNDERSTAFFING AND WORKFORCE BARRIERS

Social service organizations are severely understaffed, creating burnout and limiting capacity to innovate or collaborate meaningfully.

A Bucks County participant shared:

"Every social service division is short-staffed… When you're asking people to think beyond their agency, there's a barrier to that as well."

A Delaware County participant echoed this sentiment:

"We're just absolutely overwhelmed with just doing what we do. And trying to do that while doing the work becomes very, very, very challenging."

COMMUNITY BURNOUT AND LACK OF TRUST

Repeated community engagement efforts without follow-through have led to fatigue and skepticism about their potential for sustained impact.

A Chester County participant described this challenge:

"We especially heard at the most recent one in mid-October that the community is, like, happy to provide feedback on health services, and happy to be a part of and sitting at the table of the creation of some of those solutions. But that they do, especially in minority communities like Coatesville, feel really burnt out and sort of left out of the outcome of those conversations and the solutions."

A Philadelphia participant reiterated:

"A lot of people that I know, they say they usually don't come out to community involvements because of lack of knowledge and sometimes still confidence. A lot of them feel like we're going to put them down or we're just generally not going to listen to them."

OVER-SURVEYING WITHOUT FEEDBACK

Surveys are common, but rarely followed by communication or action, reducing credibility. Participants expressed the need to talk to people, not automated systems or surveys.

A Bucks County participant shared:

"So, I think it's not just doing the survey and asking the questions. It's what you do with the information you get and sometimes what you get, you think oh, dear Lord that's huge we can't possibly tackle that right now, or whatever. So, it can be a bit deflating, but it's what we do with that and how we partner and pull other people into the information we get."

A Delaware County participant saidt:

So, when people can see, the people say, 'Hey, I'm a person, and I have this cell phone number, and you can call me. And when you contact us, there will be no automatic service.' They're more inclined to say, yes, I need a person, not a computer, not a survey. I need to speak to a person."

LACK OF FOLLOW-UP AND ACCOUNTABILITY

There is a strong desire for institutions to close the loop when soliciting feedback. Community members expressed that input is often collected but not shared back, leaving people feeling used or ignored. Transparent communication about what is being done with feedback—even when the answer is "not yet"—builds trust.

A Chester County participant described a recent feedback and follow-up experience:

"And so, we've tried to be really intentional about, like, following up with folks and making sure that you know, even from our October event, we got a lot of really good feedback that sort of left us with, like, okay. So, there's things that we have to do like, run down this to do list of, you know, a hundred things that the community wants and it's just not timely or realistic. But being honest with that with the community and saying like, 'Listen, we know that you keep saying that you want this ER reopened in the Brandywine Hospital, and we are hearing you, and we are going to continue to advocate for that.'"

MESSAGING AND INFORMATION ACCESSIBILITY

Reports and communications from health systems are often too complex, academic, or culturally inaccessible. Participants called for more plain language, visual, and multilingual communication, including for those with disabilities. Accessibility isn't just about translation—it's about equity in comprehension and usability.

One Philadelphia participant shared:

"Particularly, we work closely with the deaf and hard of hearing community, and a lot of folks in the community want to be more involved in making decisions or a group like this. But not having ASL offered is a problem for them, obviously. And ASL is not the same as English, so closed captions aren't going to cut it. So, I think not only offering multiple languages, but if it's not able to be offered because of funding, and we all know how that works especially with nonprofits, then offering it as an accommodation that people need to request by a certain date. At least it's being offered as something that they can request,"

What's Working Well

Despite numerous obstacles, participants across counties shared examples of initiatives that are making a difference. What's working includes community-led programming grounded in lived experience, cross-sector partnerships, and culturally responsive events that blend fun with wellness. Programs that provide personal outreach, meet residents where they are, and offer tangible supports like food or childcare have seen stronger participation. Transparent, honest communication about limits and next steps also helps build trust—even when resources are constrained. These successes point to the importance of centering the community not just in message but in method, structure, and leadership.

COMMUNITY-LED AND LIVED EXPERIENCE-DRIVEN INITIATIVES

Groups led by community members with lived experience—such as addiction support volunteers and grassroots wellness efforts—show high commitment and trust.

A Bucks County participant said:

"This group of volunteers... had not had a call in a year and they still showed up to the meeting."

A member from Chester County added:

"The individual that was leading those conversations with the support group was someone with lived experience."

CREATIVE LOCAL EVENTS AND HOLISTIC APPROACHES

Multi-sector events like "Family Fun Help Day" and integration of clinical with non-clinical services (e.g., air fryers and healthy cooking) are drawing engagement.

A Bucks County participant said:

"Different hospitals come out, local farmers bring free vegetables... That is one way we try to increase people's participation

A member from Chester County added:

They gave them an air fryer and said here are healthy recipes you can make. It really worked for the senior population."

COMMUNITY FORUMS AND TRANSPARENT COMMUNICATION

When feedback loops are closed and participation is made accessible (childcare, food, multiple formats), community voices emerge more powerfully.

A Chester County member said:

"We offered childcare. We offered dinner. We offered it after work hours... The direct personal invitation is so powerful."

A Philadelphia County member added:

"We did a lot of listening sessions to find out what people thought the top issues were before setting the topic areas."

Suggested Actions and Solutions

To move forward, participants offered thoughtful, actionable strategies to strengthen community participation in health initiatives. These include forming diverse task forces, co-designing programming with residents, simplifying data and reporting formats, and closing the loop after feedback is collected. Many called for better pathways to hire and train individuals from the community, as well as stronger partnerships with educational institutions to address workforce gaps. By reducing the burden of engagement and redistributing decision-making power, institutions can transform participation from symbolic to strategic—laying the groundwork for more equitable, effective health outcomes.

Task forces that include representatives from various organizations and directly from the community can foster shared goals and planning.

- **"Some kind of task force and the task force would set up forums like this and have different platforms, not just in person and throughout different parts of the community, so that transportation or travel isn't necessarily a barrier. Virtual or even phone conversation, something accessible. So multiple options to contribute to your voice."**

Solutions include integrating social service pathways in higher education, paid internships, and relaxing unrealistic educational expectations.

- **"So maybe we need to work better with universities and create more of a channel directly promoting – 'Hey, come join healthcare.' Look, there's 9 million jobs you can choose from, and letting people know what the options are. I know when I graduated college with my psych degree. I had no idea what I qualify for or what I could do and I didn't know there were that many agencies available in different directions I could go in."**

Tapping into corporate giving, local businesses, and simplifying messaging around impact (storytelling) can unlock new sources of financial support.

- **"But here you go, you need money. Right? So we need to tap into these resources that have money, these for-profit companies, the banks, the communities, the credit unions, whatever it is out there. And I have learned through my work on different boards and different local communities agencies and groups, that there is a lot of businesses out there that want to give back to the community, and want to give back financially so that you can do more. And I'm like, let's tap into them some more to support us in all of these causes and to get the hospital to connect to and just build this bridge, just build this ladder of support, interconnecting."**

Community members emphasized that true involvement means having a seat at the table—not being asked to contribute midway or just for optics. This includes hiring from the community, involving lived experience in leadership roles, and ensuring residents are not just consulted, but co-designing solutions.

- **"I'd say invite them in to hear their stories. It's one thing for us to tell their stories, but it's another thing for the actual person going through the situations to tell their stories, to tell how they feel, to share their experience, because we can speak for them, but it's better if they would speak for themselves. So inviting them in and hearing their voice, I think, would establish some a little bit more compassion as well because there's a story, but then there's a person behind the story as well."**

Engagement efforts often end at data collection. Community members expressed frustration with the lack of updates on outcomes from forums and surveys—leading to feelings of being "used" and disillusioned about impact.

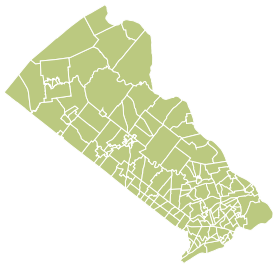
- **"It's so easy for us to to gather information, to come up with feedback and to keep folks updated via like a newsletter or a blog post. And the community is not engaging with our email newsletters, and so as much as we can. you know, through personal relationships. And that extra work of like, yeah, we had people attending the event, and we're gonna call every one of them back and say, like, 'Just wanted to touch base and see, you know, if you had anything else to say.' And here's what we've been working on, and here's what you know. Here's what we think and believe for the next what the next steps are gonna look like as much as we can directly communicate with them and keep inviting them back to events and organizing and being present at existing community events like not necessarily hosting something new, but going to things like 1st Friday, or football games, or whatever it might be, and just continuing to be a presence. I think, helps, even if we're not providing them like a really thorough update on like significant progress. They're still happy to know that we are still engaged with the community still available. To answer questions or give updates as as they become available."**

Communities want to understand the data that informs decisions and be part of interpreting it. But often, data is used to justify decisions already made. When shared meaningfully, it becomes a tool for partnership.

- **"I think the hospitals and the managed care entities can do a better job at sharing data with the community. For example, there might be certain sections of the city where the national average of diabetes is this, but the national average of diabetes in this neighborhood is this. What do you think we can do about it? The community should know, this is happening in our community or there's cancer rates or whatever it is. I just don't feel like they share data in a way that could engage people."**
- **"Data doesn't tell the whole story... But when you're talking to individuals groups, you can get these little nuggets of information that can that may be able to pivot everything and create something that is more suited to what your mutual goals are. So, we're working on it. So, stay tuned 2025, 2026, there's a lot coming."**

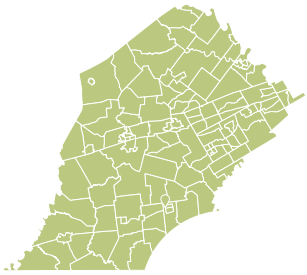
County-Specific Perspectives

BUCKS



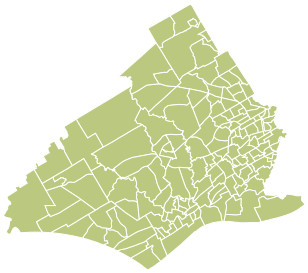
Bucks County faces significant challenges around post-COVID social isolation, particularly among elderly populations and those disconnected from child-centered events. Despite that, dedicated volunteers and creative event models like Family Fun Days offer bright spots. Staffing shortages and systemic workforce barriers remain a key concern, with emphasis on changing education-to-career pipelines.

CHESTER



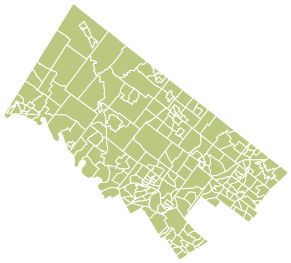
Chester is resource-rich but challenged by coordination and engagement fatigue. Local stakeholders emphasize the need for collective prioritization, intentionality, and transparency. Innovative mobile wellness units and hyper-local support groups show promise. Transparent communication around limitations and real timelines has built trust even amid resource constraints.

DELAWARE



Funding scarcity and organizational siloing dominate Delaware's landscape. Despite high motivation, limited staff capacity hinders outreach and coordination. Community members voiced the need for direct contact, outreach beyond mail/surveys, and cross-sector volunteerism to avoid duplication of efforts.

MONTGOMERY



Montgomery participants emphasized infrastructure solutions—like accessible forums and collaborative task forces. Community members proposed concrete mechanisms like shared committees and multi-modal participation strategies (virtual, in-person, phone) to deepen inclusion.

PHILADELPHIA

Philadelphia's challenges include transportation barriers, trauma and engagement fatigue, and linguistic or cultural disconnects. However, initiatives like pre-pilot studies and community-driven design efforts (e.g., Well City Challenge) offer strong models. Success depends on closing feedback loops and reframing data and reports in community-accessible language and formats.

FOCUS AREAS AND COMMUNITIES

This section features primary and secondary data focused on health needs associated with conditions requiring specialized care (cancer, people with disabilities, vision), as well as communities whose needs have historically been less understood or adequately addressed (older adults and youth).

Cancer

Cancer is one of the leading causes of death in Southeastern Pennsylvania (SEPA), and a concern for local community members, and hospitals and health systems – particularly cancer centers.

To better understand the state of cancer care in this region, key sources of information are presented below – including county-level quantitative data and qualitative findings from public community discussion and cancer care specific conversations held across the region.

A dedicated cancer care focus section was first featured in the 2022 rCHNA to address the specific concerns and needs associated with the topic, as well as to serve as an important data source for participating health systems and in particular, local cancer centers. This section closely mirrors the 2022 report and features new data indicators and additional qualitative inputs.

While the discussion guide used for the public community conversations did not include questions specific to cancer care, the topic did arise organically in multiple instances. These comments have been combined into the "common themes" section below.

A critical source of qualitative data used in this section was gathered by three cancer centers and one hospital affiliated with participating health systems:

- Abramson Cancer Center at University of Pennsylvania (Penn Medicine)
- Fox Chase Cancer Center (Temple Health)
- Jefferson Einstein Montgomery Hospital (Jefferson Health)
- Sidney Kimmel Comprehensive Cancer Center (Jefferson Health)

Lastly, findings from a PCORI grant-funded program — Philadelphia Communities Conquering Cancer, led by Abramson Cancer Center, Fox Chase Cancer Center, and Sidney Kimmel Comprehensive Cancer Center, and community partners across Philadelphia — are included in this section, with consent from participating cancer centers.

Representatives from each of these cancer centers and hospitals conducted focus group discussions with community advisory board (CAB) members in September 2024, using a standardized discussion guide developed jointly, with a focus on building upon the discussions held during the previous rCHNA. Representatives were particularly interested in hearing CAB members' recommendations and strategies for what hospitals can do to improve their experiences across the cancer spectrum (prevention, screening, treatment, survivorship, caregiving, etc.) Discussion guide questions reflected this focus.

The cancer centers facilitated the meetings, which were attended by individuals representing the communities they serve. Some participants were also cancer survivors and shared insights based on lived experience. All sessions were recorded and transcribed for analysis. The HCIF team used the discussion guide to develop a preliminary set of themes, which informed the coding process.

A team of three coders independently applied these pre-developed codes to the transcripts. Intercoder reliability meetings were held to ensure consistency in code application, with particular attention to identifying references to special populations and emergent themes not explicitly captured in the original guide.

There was a great deal of agreement across all discussions – common themes are presented below, followed by the unique insights gathered through individual center/hospital discussions.

Findings

County-level data for several cancer-related quantitative indicators previously presented in the geographic community profile tables are shown below for ease of reference:

QUANTITATIVE DATA

	Bucks	Chester	Delaware	Montgomery	Philadelphia
Major cancer incidence rate (per 100,000)*	323.0	260.2	263.3	258.4	218.9
Major cancer mortality rate (per 100,000)*	82.0	60.8	80.3	67.6	69.4
Cervical cancer rate (per 100,000)	6.4	6.1	6.1	6.6	8.8
Cervical cancer screening (among adults ages 21-65)***	84.3%	85.3%	83.6%	85.0%	80.5%
Colorectal cancer screening (among adults 45-75 years)**	71.2%	70.3%	68.6%	70.4%	66.7%
Mammography screening (among adults 50-74 years)**	78.4%	79.6%	79.3%	79.5%	79.2%

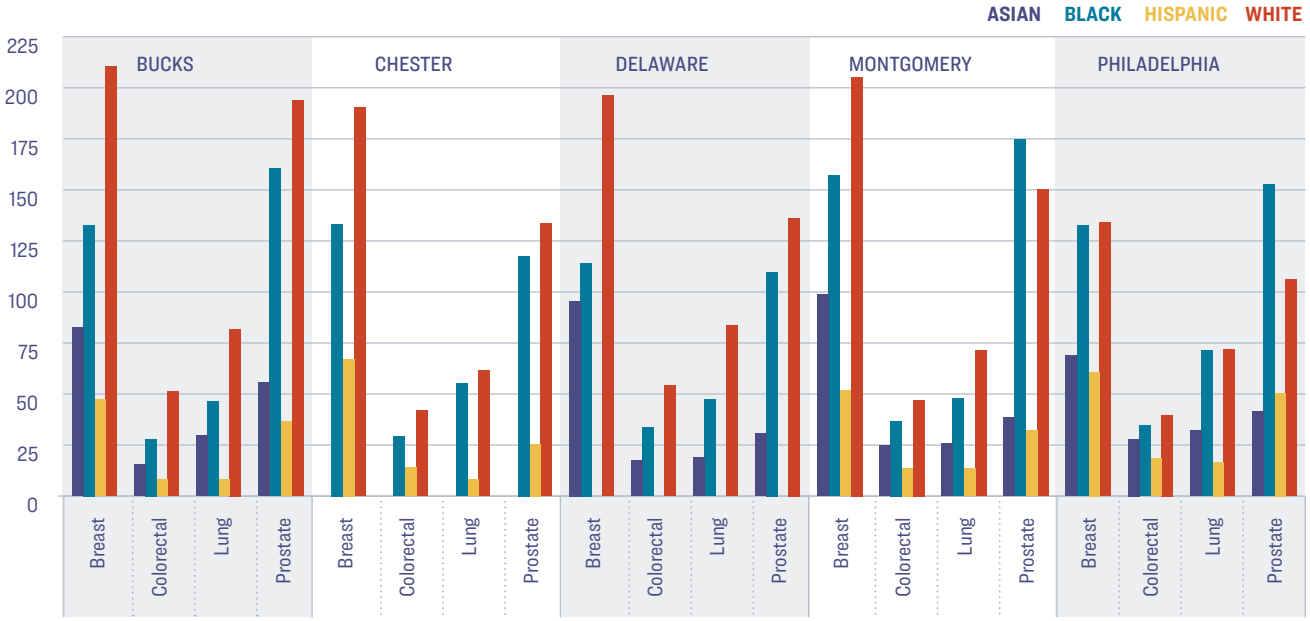
* "Major" cancer defined as: prostate, breast, lung, colorectal cancers; crude rate per 100,000; Vital Statistics, EDDIE (PA Department of Health)

** 2022 Behavioral Risk Factor Surveillance System

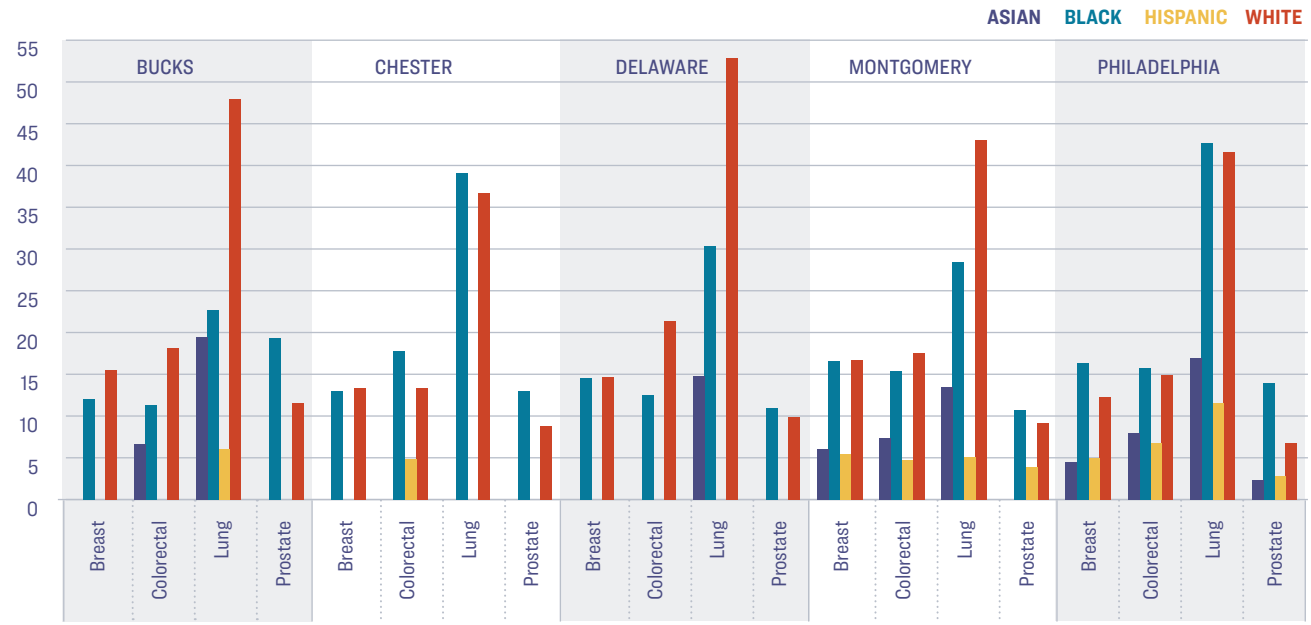
*** CDC PLACES

Age-adjusted incidence and mortality rates by race in each of the five counties, according to data from the Pennsylvania Department of Health's Vital Statistics are presented below:

Age-Adjusted Major Cancer Incidence by Race, 2017-2021



Age-Adjusted Major Cancer Mortality by Race, 2019-2023



NOTE: No bar indicates estimate that is unreliable due to low numbers.

These data show not only the extent of cancer's impact on SEPA communities, but also the variation and scope of racial/ethnic disparities in each of the five counties.

Common Themes

Cancer care is a deeply personal and complex journey, shaped by diverse experiences, systemic challenges and barriers, and unique opportunities for improvement. Across conversations and reflections, patients, caregivers, advocates, and community members shared recurring themes which demonstrate the cancer care experience. These themes not only highlight critical areas for improvement but also serve as examples of lived experiences, shedding light on the pressing needs and opportunities within the cancer care continuum for patients and advocates in the Southeastern Pennsylvania region.

EQUITY AND ACCESS TO CARE

Participants shared individual experiences across discussions, highlighting the differences in access and availability of high-quality cancer care – despite living in a region served by multiple hospitals, health systems, and cancer centers. Various geographic disparities, socioeconomic limitations, and systemic inequities create significant barriers to treatment. Patients who live outside of Philadelphia shared their struggles with long travel times to reach specialized care and expressed a desire to receive care closer to home.

"One of the big things is we don't want to go to Philadelphia for treatment. We want to be in our communities where we live and where we have support... I had the experience of losing someone to cancer and part of it was just so onerous for her to leave Chester County and go all the way into Philadelphia for the treatment that she needed."

Regarding socioeconomic barriers and limitations, participants expressed how uncertainty around the cost of care – particularly for those with lower incomes, or who are under- or uninsured, who live on fixed incomes, or who are undocumented – keeps community members from receiving screenings (whether proactively or based on medical guidelines, family history, etc.), seeking out care following positive screenings or diagnoses, and agreeing to undergo treatment. One participant discussed feeling "lucky" because their insurance covered their care, describing their family situation:

"He's taking some unbelievably expensive medications and they've paid for it. So, we're lucky. He actually told one doctor, he said, 'I can tell you right now, if that drug you want me to take is not covered, I'm not going to take it because I want to leave money for my children.' And I said, 'That's not your decision. Whatever it costs, we'll pay for it.' But, fortunately, we were covered. But I can see that that's a major issue for people."

Additionally, the normalization of "office hours" (9am-5pm, no evening or weekend hours), unreliable access to transportation, and long wait times at appointments, present significant barriers for community members with limited ability to take time off from work, those who need childcare, or live in an area with no public transportation options.

"How can we work around the working person? Because we gotta stop assuming people have...they're sitting around doing nothing from 8 to 5, they got money for transportation. We assume a lot of these things in the communities that we>re working with ... we're very far from the truth. With that we do not tend to meet people where they are."

To address these barriers, participants recommended the implementation of new (or expansion of existing) services and resources to reduce the financial and logistical obstacles to care such as telemedicine services, investment in mobile clinics, vouchers for transportation, support with childcare, open more "local" offices, expand office hours, and offer financial navigation assistance.

FEAR

The role of "fear" was consistently shared through each discussion. Its influence in the cancer care continuum manifested as: fear of diagnosis, fear of treatment side effects, fear of financial impacts, and the fear of mortality. For many, the fear attributed to "not wanting to know what's wrong" was the most pervasive. One participant, when discussing low numbers at outreach events, reflected on this specific fear.

"I think for a lot of people, is more, it's like a fear base, right? If I don't get tested, and if I don't do the work to know, then it's not there."

Avoiding screenings can translate to more advanced diagnoses, while fear of the unknowns related to treatment can result in potentially preventable death. Participants shared this specific type of fear can be more pronounced in certain communities and populations – such as older adults and Black/African Americans.

A unique take on the concept of "fear" emerged in connection with the COVID-19 pandemic. Certain communities experienced higher death tolls than others during the pandemic and participants shared that this experience was particularly impactful and that it sparked a sense of proactiveness in community members — taking screenings and overall health more seriously.

"I think it's a willingness, and it I think it comes out of some fear again attributed to what so many people saw with COVID, especially in the communities of color. It hit us really tremendously, and all the stigma around getting the vaccine and and various things. I think it kind of scared people more which can be good even if you're scared, at least you're willing to go get a test done. You're willing to get [a] physical done. You're willing to do something, even if it's out of fear."

Participants – some of whom are survivors themselves – noted the fear of recurrence can linger long after successful treatment, deeply impacting survivors and their families. They shared that although primary treatment may be complete, each subsequent check-up elicits fear and anxiety.

"Survivors are not always okay. Even after being in remission, there's always the fear that when they go for their checkup, it will show up again."

CULTURE AND LANGUAGE

Participants were asked to reflect on how cultural and spiritual beliefs, and language (including literacy) impact their communities' experience with cancer care.

Cultural beliefs about illness and healing influenced community members' willingness to seek care or adhere to recommended treatments. This was particularly pronounced when participants referred to religion and faith, and the belief that faith will heal or cure cancer.

"I am in total agreement with my sister and brother, because in the church there's just such a belief that Jesus can fix it. Yes, Jesus can fix it, but we also need to seek medical attention."

Alternatively, many expressed the importance of the community and social support that faith and religion can provide to those with cancer such meal sharing, support groups, transportation, childcare and caregiver relief. These beliefs and behaviors were often shared in connection with Hispanic and Black/African American communities. Additionally, the reliance on traditional remedies, hesitancy to discuss illness openly, or the avoidance of medical intervention altogether due to historic mistrust in healthcare were shared as well when reflecting on cultural beliefs.

"There's a lot of conspiracies because…we do work with individuals that are…unfortunately, we have really bad history with medical systems. So there are a lot of conspiracies in regarding of especially like cancer diagnosis and cancer treatment."

The lack of language diversity in cancer materials (written and verbal), in discussions with care teams (including support staff), in the instructions and guidance from providers were noted as examples of how language barriers create challenges in accessing care, understanding diagnoses and treatment options, and navigating the complexities of the healthcare system. Although Spanish was the most common language mentioned during conversations, participants noted an increase in diversity in their communities and subsequent language needs – such as languages spoken by "Asian cultures", Spanish dialects (particularly those from Guatemala), French and Creole (common amongst Caribbean cultures). The use of LanguageLine was mentioned as a tool to support diverse language needs. However, participants prefer to see more language diverse staff embedded into offices and care teams to foster greater community representation, in-person communication, and language support as soon as possible.

"We can head it off when they come in a door, so it's good to go out in the community, but once they're in the door, and they come into the facility, we can address that, have protocols in place to to address that."

Beyond diverse languages, participants shared the need for health care providers to acknowledge challenges related to literacy and comprehension, and how it impacts patient-provider communication. This included not understanding certain medical terminology, navigating the shock of a diagnosis, not feeling certain what questions to ask, and the experience of those with cognitive disabilities.

"And you know, I always say to my people, 'Don't leave the room if you don't have a full understanding. And if the conversation is over your head, you can say I need you to explain it to me as if I'm a 2 year old, and I need you to slow it down and and just give it to me, where, in plain language, plain language is language that I understand, however plain it is.'"

Participants indicated that addressing these barriers requires a culturally competent approach, bilingual healthcare providers, educational materials tailored to diverse needs – both language and literacy, and meaningful cooperation between health systems, community-based organizations, and houses of faith.

PREVENTION, SCREENINGS, AND EARLY DETECTION

Despite increasing knowledge about the importance of cancer prevention and screenings as method for early detection, barriers to education and action around these topics persist. Through all conversations, participants shared the value of focusing cancer education and outreach around prevention by discussing annual physicals, nutrition and physical activity, sun protection, etc. Multiple participants referenced interest in these topics from their community members.

"When I brought the cancer prevention person, there's a lot of questions, there's a lot of interest."

Participants also shared that framing cancer screenings as a form of prevention is beneficial to their communities, particularly as a means to destigmatize "the C word."

"You see them wanting to be more preventive. And I like that. I mean, we've been in health field, you've been wanting that for so long…So it kinda, it's like they're still a little, they're scared of that C word, but they're getting past that and saying, 'I'm going to go get care and get checked and do screening.'"

A lack of awareness or confusion around changing guidelines, socioeconomic barriers, and competing priorities were three primary challenges related to screenings shared across discussions. Participants shared that community members expressed confusion and frustration around changing screening guidelines, which can cause distrust in medical institutions and insurance companies.

"Is this just because the insurance companies don't want to pay for it? So, there is kind of always that question, whenever a guideline changes."

This kind of confusion, and resulting mistrust, may cause delays in screenings.

"It was it the cervical cancer screening that's, that went from like one year to 2 years or one year to 3 years. Kind of like, 'Well, maybe I don't need to worry about it then.' Kind of does that lessen the importance of that screening if it, if it now seems to need to be less frequent. So, I think there is kind of just general confusion when the guidelines change."

Socioeconomic constraints included transportation, limited or no paid time off from work, childcare, insurance coverage, finances, etc. Discussion participants connected these constraints to the reality that community members may deprioritize screenings – not necessarily because they are not aware of the importance or the necessity for screenings, but because existing priorities outweigh the future benefits.

"So, when you got all this going on and you're working, you don't have someone to maybe watch your child. You don't have someone to come with you to help you. You don't have money for transportation. It gets to a point where folks may just say that's it. And then what happens is, it progresses, and they end up in the ER."

Participants underscored the critical importance of screenings for early cancer detection.

"You know you've already pushed that cart down the hill. It's a little harder to slow it down."

Screenings for prostate, breast, and skin cancer were said to be the most well-known, while more emphasis should be placed on colon cancer screenings as colonoscopies tend to be particularly sensitive and stigmatized.

When recommending solutions, participants overwhelmingly suggested the continuation of existing community outreach and screening programs (such as mobile vans) – bringing the information and resources to people **"where they're at,"**particularly evenings and weekends. Education and awareness should focus on screenings as prevention, explain screening guidelines – especially when there are changes, and inform community members of how maintaining a healthy lifestyle impacts cancer risk. One innovative approach – **"reverse referrals"** was shared by a participant. Instead of solely relying on patients to schedule their screenings after receiving a referral from their primary care provider, the screening facility is also notified. This way, the facility can proactively reach out to the patient to help facilitate the appointment. This approach could improve follow-through, as some patients may deprioritize referrals or forget to schedule them. By having both the provider and the screening facility engaged in the process, it may increase the likelihood that patients complete their recommended screenings.

INTERPERSONAL COMMUNICATION

Open and honest communication about cancer was highlighted as essential for awareness, early detection, and social support. A common refrain in conversations was the struggle in discussing health histories and diagnoses among family members – whether due to stigma around the topic or the belief that they are "protecting" their family by disclosing what's happening. Many participants shared heartfelt and direct examples of this experience – attending funerals or hearing about deaths without knowing the deceased had cancer.

"I think the thing that really grieves me is that I just went to a home going service on Saturday of a very good friend of mine, who passed away of cancer, and the sad thing that broke my heart is that she never even told her daughter that she had the cancer, and her daughter was devastated."

Understanding one's genetic predisposition to cancer can be lifesaving. Sharing family history allows individuals to take preventive measures, undergo recommended screenings, and make informed healthcare decisions.

"So, if I'm the mother and I have daughters at home, or sisters or mother, beginning to have that conversation as being automatic, of getting hereditary risk assessment for the patient who's the newly diagnosed, but also that that surrounding nucleus."

Many participants felt more community members were becoming comfortable discussing cancer – as one participant put it **"there's less whispering."** Various reasons were theorized to be driving this shift, such as the perception that as more people are diagnosed (or know someone who's been diagnosed) more people are discussing it openly, the success of community health outreach, advances in screening and treatment lead to more survivors discussing their experience, and certain groups feeling more comfortable discussing health in general (i.e. LGBTQ+, women). Participants share that while men may be less comfortable talking about cancer – particularly prostate cancer – they do notice some more openly discussing it, which has a ripple effect on others.

"So, with them being diagnosed, you're seeing more of a discussion. Now, if there's anything of a positive that is coming out of it, they're being more open with their discussion around other men 'cause they tend to be 'No, I'm gonna keep this close to the vest. No one needs to know anything.' So, if they are in certain men's group, whether they're in community groups, fraternities, or the case may be, they're more open to talk about it because it's a sign of being vulnerable. But now they're more open so, and then learning more about it and they're listening to more discussions."

Discussing cancer openly helps reduce stigma, provides emotional support, and fosters a culture where seeking medical advice is normalized. Hospitals can reinforce this through ongoing community outreach, offering support groups for cancer patients and their families, and collaborating with community-based organizations – particularly those whose clients or communities may be less inclined to discuss this topic.

PATIENT-PROVIDER COMMUNICATION

When discussing challenges with patient-provider communication, participants commonly expressed frustration at not feeling seen or heard – either personally or reflecting on community member experiences. A common sentiment was that providers often appear distracted—avoiding eye contact, staring at screens, rushing through appointments, keeping a hand on the doorknob or glancing at the time. Although participants understood the challenges providers face with packed schedules and limited time per patient, this lack of engagement creates an environment where patients feel their concerns are dismissed or not taken seriously. Others described feelings of being pushed **"through the system"** without providers taking the time to truly understand their needs.

Another recurring issue was the absence of diversity among medical professionals. Many patients shared that not seeing providers who **"look like them"** contributed to feelings of judgment or misunderstanding. While some had positive experiences in their care, the lack of representation in professional roles remained a barrier to building trust. In contrast, encountering doctors, nurses, or other healthcare staff from similar backgrounds often helped ease anxieties and foster a sense of connection, particularly during medical crises.

"They are all positive experiences. I'm still alive. But it's rare that at the professional level I'm seeing someone who looks like me. And so that can, that can sometimes make a difference. And when you are showing up in a crisis."

Beyond feeling unheard, some patients struggled to ask questions or voice concerns. Fear, shock, and the overwhelming nature of a diagnosis often left them uncertain about what to ask or how to navigate their care. One participant highlighted how providers may assume they are offering clear guidance, forgetting that for many patients, this is their first encounter with a complex and unfamiliar process.

"So sometimes the physicians, you know, that's their job. They see hundreds of patients all the time. And so, they're on a roll, and they're saying, they're giving good information. But they're forgetting that this person, this is their first go around, and they don't understand that verbiage, and they may not know that next step. And so just taking each case as an individual case and explaining it until they understand it."

Addressing these challenges requires a more community-centered approach to healthcare. Participants emphasized the importance of providers engaging with communities outside of clinical settings. By attending community events, not just as medical professionals, but as active participants, healthcare workers can build relationships and develop a deeper understanding of patient needs. This level of engagement fosters trust and ensures that when a medical issue arises, patients feel more comfortable seeking care.

Equally important is ensuring that patients feel heard during medical visits. Extending appointment times, simplifying medical language, and encouraging patients to advocate for themselves can help bridge the communication gap. One participant stressed the importance of patients asking for explanations in "plain language," ensuring they fully understand their diagnosis and treatment options before leaving the room. Small but meaningful changes in how providers listen, explain, and connect with their patients can lead to a more compassionate and effective healthcare experience.

SURVIVORSHIP AND LIFE BEYOND CANCER

Survivorship is often framed as a celebratory conclusion to the cancer journey, but for many, it is a new chapter filled with its own unique challenges and opportunities. When discussing this topic, participants shared both physical and emotional challenges. Physical effects from treatment, such as fatigue, neuropathy, or issues with fertility, all of which were mentioned in these discussions, can persist long after the disease is in remission. Many of these effects are "invisible" and therefore survivors and their family members take on the role of reminding others how their lives have changed and the lingering physical impacts. Emotionally, participants described how survivors grapple with lingering anxiety, fear of recurrence, and the struggle to reintegrate into their daily lives. Many discussed trying to redefine who they are after cancer.

"People think just because you had that last infusion, now get back to work. You have to do everything. Your life is normal again. Well, it's not. You have side effects. You face fertility issues if you're young. Maybe you're dating. Maybe you've got other issues that are going on that create all these other things. So, I just think that's such a big point that you all say that just because I'm not in active treatment doesn't mean I don't have the cancer, for sure."

Additionally, the loss of the structured support system provided during active treatment can leave survivors feeling isolated. One of the most common themes around this topic focused on the need for survivorship plans – many of whom felt they were provided with limited or no support following their treatment. They identified the need for such plans to feature methods to reduce the risk of recurrence, particularly lifestyle changes (nutrition, physical activity) and to offer resources for social and emotional support (survivor groups, therapy). Some participants noted taking this responsibility on themselves – doing their own research, asking questions of their providers, and seeking out their own support.

"But I think there needs to be more communication about what happens in survivorship because that's not part of the current dialogue. And I'd say as a survivor, what I finally realized is, I was going to be a survivor for the rest of my life. When you're done with those five weeks, you're not done. I'm a cancer survivor, but I'm going to be a cancer survivor until I'm no longer on this earth. And there isn't any conversation about that."

Addressing these challenges requires a long-term, holistic approach that includes survivorship care plans, mental health resources, and community support. Participants also recommended hospitals use storytelling and public awareness campaigns featuring survivors to highlight the opportunities and outcomes which are possible with comprehensive care.

CANCER KNOWLEDGE & AWARENESS

Participants were asked to share their perceptions of cancer knowledge and awareness in their communities and to describe any changes in the past two to three years. Specific cancers, such as breast, skin, prostate, lung, and cervical cancers were among the most recognized within participants' communities. However, awareness of colon cancer, prostate cancer (despite some familiarity), and rare cancers remain lacking.

Several factors influenced community knowledge and awareness about cancer. Concerns were raised about HPV vaccine uptake, with hesitancy growing due to experiences with COVID-19 vaccinations. Many older adults, who are beyond the eligible age for vaccination, struggle to understand the risks associated with HPV-related cancers and what preventive steps they can take.

"They're thinking about 'What do I do? How do I understand this? Why can't I be protected?'"

Additionally, misconceptions around family medical history continue to shape community behaviors. People who believe cancer does not "run in their family" may not take the risk seriously, overlooking the fact that many cancers are not hereditary.

Older adults tended to have greater awareness, often due to personal experiences with cancer over time - having either battled the disease themselves, supported friends and family through treatment, or gained more knowledge through increased exposure to healthcare systems and screenings. Similarly, participants felt women demonstrated a higher level of awareness, particularly regarding breast and skin cancers.

In the digital age, the internet was thought of as the first stop for those seeking cancer-related information.

"The first thing they do is grab their phones, right? And start Googling. And what does the Internet say? What does ChatGPT say?"

However, there is growing concern about the reliability of online sources, particularly as misinformation and conflicting messages are easily spread. While organizations like the American Cancer Society and major cancer research institutions provide trustworthy information, individuals often turn to family, religious leaders, and local community health workers as their most trusted sources. This is especially true in immigrant communities, where information is often shared within close-knit networks.

Building trust remains a central theme in effective cancer awareness and education efforts. Strong relationships within communities foster confidence in the information being shared, particularly when shared by local community health workers, community leaders, survivors, or a faith-based leader. Consistency was cited as a crucial element, with communities needing reliable, comprehensive and culturally meaningful access to resources, screenings, and educational opportunities.

"But people have to understand that this is an ongoing process. It's not a once a year, you know, prostate cancer month, and then after September, I'll see you the year from now. It has to be continuous, continuous, ongoing outreach that build trust, and then out of that I believe that we'll start to see greater levels of participation."

Special Populations

BLACK/AFRICAN AMERICAN

Participants highlighted the influence of religion and faith in this community, which can reinforce beliefs in the power of prayer as a means to heal cancer and downplay the importance of seeking medical care; participants expressed the need for balance with both. Conversely, participants also shared the benefits of social support provided through faith-based communities. They additionally noted reluctancy to seek care due to historical injustices, negative experiences with hospitals/providers. Many participants referred to "fear" as a deterrent to screening, treatment, communication, etc. They expressed wanting to feel respected and welcomed by providers and care teams.

"The fears could just prevent someone from even going in and engaging with a doctor because I was treated this way the last time. So, I'm just going to self-medicate. So, I'm speaking of African American communities."

Participants shared the belief that prevention and early detection saves lives, and that they would like to see more efforts directed toward their communities given the barriers to care, mistrust, and disproportionate rates of cancer in Black/African Americans.

MOTHERS & FAMILIES

The unique challenges faced by mothers and families were mentioned in many conversations, including the barriers to seeking care such as managing competing priorities, obtaining childcare and the importance of including families in discussions related to cancer spectrum – from screening to diagnosis, treatment, and survivorship.

"As somebody who recently had a cancer diagnosis in my family, having the facility or just the departments that are diagnosing or working with families. How easy they are to explain the process and showing their willingness to be able to walk through what the next year or 2 years of chemo may be, for a family is really helpful."

Additionally, the importance of communication among families as it relates to family history was frequently highlighted. Knowing if and how cancer has impacted your family can support early detection in younger family members. This is particularly important with regards to cancers which may be hereditary.

HISPANIC/LATINE

Participants shared common barriers faced by this population – particularly connected to language and culture. These barriers can be heightened depending on the type of cancer, or who's having the experience with cancer.

"I think, for Hispanic population. It's sometimes difficult to speak about. For example, speak about colon cancer or prostate cancer. Particularly among men, this is something related to like the macho culture that sometimes it's difficult to tell a man that they need to follow certain treatments. That implies something. So, it', it's, I think it's something cultural."

The benefits of community outreach and education, as well as the engagement from the community in these events, were mentioned with positive feedback. However, participants shared the need for even more Spanish language education, literature, and overall health care support. This can be especially helpful to ensure community members know their rights when seeking care, any documentation that may be needed (i.e. insurance), and to increase trust overall in local providers.

"I think that something very important among Hispanic and Mexican population is that they don't have insurance, and they tend to believe that if I don't have insurance a medical insurance there's no chance to get those resources that there are in the community."

LGBTQ+

For many in this community who have experience with HIV and AIDS, there are parallel experiences with cancer. The perception is that many people in this community, particularly those who are older, are more open to discussing their health and health care.

"I'm in kind of a specific community of LGBTQ peeps and also older people. So, older people talk about their health more, I've noticed. Here we are. But I think because of the HIV thing, there's more openness to speaking about it. It comes up. Although there are some still, in general, when I tell people that I've had treatment, there's still people [who] think, oh, you didn't lose your hair, or you say the word cancer. I mean, myself. I mean, I didn't even really, I think, admit to myself that it was cancer until halfway through my treatment. It was kind of weird to say that."

Additionally, participants shared that the progress and innovation from HIV and AIDS treatments gives them hope as it relates to cancer research.

MEN

While there is still hesitancy and stigma among men related to cancer, many participants mentioned increased willingness and openness to discussions on the topic in the past 2 to 3 years. This was seen in conjunction with an increase in support groups specific for men and may be connected to an increase in diagnoses, especially related to prostate cancer.

"I know there's been a lot of discussion around education, and men's group with cancer. But the discussion has been pretty much created because of increased diagnosis. And that uptick of men with prostate cancer. And it goes across socioeconomic lines."

Participants emphasized the importance of outreach to men in their own communities – "meeting them where they are at." Examples included barbershops and sporting events. Education should focus on prevention and early detection.

MID-LIFE ADULTS & YOUNG FOR CANCER

There was an overwhelming concern related to the perception that more people are being diagnosed at younger ages, such as 30s and 40s. One participant shared that young people are often dismissed when expressing concerns related to cancer. And because insurance may not cover a biopsy or screening for someone young, diagnoses may be delayed under the assumption that is must be "something else."

"I think this is true for all ages, but particularly for young folks who eventually are diagnosed with cancer. I was dismissed for six months. So, during very active advocacy for myself, told multiple times by multiple providers that I just had a virus and was placated because I was so young and convinced something was wrong. They're like, 'Fine. We'll finally give you a bone marrow biopsy.' And at that point, I had pretty advanced leukemia."

Participants shared the importance of understanding screening guidelines and understanding hereditary considerations for this age group. Those who are younger expressed themselves as finding camaraderie in social media as a means to find social support, share their experience, and to reduce stigma.

"Social media was my opportunity to talk about cancer after I was diagnosed, despite having people in my real life who were impacted and treated at [HEALTH SYSTEM]. I think that as a former 30-year-old, I'm no longer a 30-year-old, but even when I was diagnosed, I was 30, and no one I knew my age had cancer, and actually that turned out to be wrong. One of my friends had been diagnosed, and I met her after she had went through treatment, so I did not know that about her life."

OLDER ADULTS

Overall perception is that older adults have more experience with cancer – both from their own personal experience and with friends and family members. They may also be more aware of screening guidelines based on increased engagement with health care providers.

"There are a lot of grandmothers who have been around the block with this."

Many older adults are also adept at utilizing technology and the internet, which can be both positive and negative in terms of the reliability of the information they're consuming.

"All my seniors are on the Internet now. We're as dangerous as teenagers...they are all, you know, with very, very few exceptions, well into their, you know, eighties and nineties. These people are doing searches."

WOMEN

Participants expressed a belief that women are aware of importance of screenings related to breast and cervical cancer and that they are often more actively engaged in their health care. This can also translate into women encouraging each other to be screened, ask questions, and advocate for themselves.

"I think for me, I've had people that were like, 'I have not done a self-breast exam until I knew that it was possible, until I heard that you were diagnosed with breast cancer.' And so, for me, it's been as much of a personal connection that I can make with people to be like, 'I went through this thing. It was terrible. But it would've been a lot terrible had I not touched my boobs for a few more months before I found it.' And so, for me, it is just like having someone that you know who's just up front and like, 'Yo, you should really do self-exams for that and for other things.' It sucks to be the person that reminds people to touch their boobs, but I would like to do that for them."

Although women seem to be more engaged with their care, many participants shared the belief that it seems as though women are being diagnosed younger and dying from breast cancer. Women experience unique physical and emotional challenges related to breast cancer – specifically when considering, or following, mastectomies and the need for additional support related to this experience.

"Because you have some women that have had a double mastectomy, or something of that nature. You know. They may not want to go through reconstructive surgery. I mean, I don't know. Some, some choose not to do so, and some choose to do so, but there needs to be somebody there that they can really really get to the meat of whatever decision that they're trying to make."

Participating Cancer Center Insights

In addition to the common themes shared across community discussions, each participating cancer center surfaced insights that were uniquely shaped by the populations they serve, their engagement strategies, and the local context in which conversations occurred. These reflections offer valuable nuance, and in some cases, point to emergent needs and opportunities for more tailored responses across the cancer care continuum.

ABRAMSON CANCER CENTER

Abramson Cancer Center hosted one virtual discussion with seven members of their community advisory board members.

At the **Abramson Cancer Center**, participants reflected on an evolving cultural shift in how cancer is discussed—particularly among men. There was a sense that conversations are becoming more open and proactive, with community members, especially those impacted by prostate cancer, beginning to share their experiences and encourage others to seek care. This shift was attributed in part to the impact of the COVID-19 pandemic, which brought health concerns to the forefront and, for some, shifted perspectives around the importance of prevention and screening. The role of storytelling emerged as a powerful force—participants shared that hearing about others' experiences helps reduce stigma and creates opportunities for dialogue in families and communities.

Despite these gains, participants emphasized the need for health systems to do more to demonstrate presence and accountability. Several reflected that hospitals can feel like "occupying forces" rather than trusted partners—particularly when they are visible only during events or outreach efforts, rather than embedded in ongoing community life. To build trust, participants called for more consistent presence and greater investment in the "whole person"—including support with food access, transportation, and other practical needs. Faith and spirituality also featured prominently in these discussions. Some participants noted persistent beliefs in divine healing as a sole path to recovery, which can delay or deter engagement with medical care. Others highlighted promising shifts within the faith community, where partnerships between churches and healthcare institutions are gaining ground. Participants emphasized the importance of continuing to build these bridges and ensuring they are grounded in mutual respect and shared purpose.

FOX CHASE CANCER CENTER

Fox Chase Cancer Center (FCCC) hosted two virtual discussions with 10 members of their Community Advisory Board (CAB).

The conversation hosted by **Fox Chase Cancer Center** reflected strong connections between the center's outreach efforts and community trust. Participants spoke positively about the impact of Community Health Workers and Community Ambassadors, who serve as consistent, credible messengers for cancer education and prevention. There was a notable sense that these efforts are resonating and leading to increased interest in prevention—not only to avoid cancer altogether, but to prevent treatment side effects and recurrence. One area of discussion focused on colorectal cancer screenings—particularly hesitancy around colonoscopies. Participants raised the question of whether alternative screening tools like Cologuard should be more widely promoted to those who are unlikely to undergo more invasive procedures. Environmental health concerns were also shared, with participants pointing to specific buildings in the Frankford area of Philadelphia where they believe occupational exposure (e.g., to asbestos) may be linked to elevated cancer rates. These concerns highlight the importance of incorporating environmental context into cancer education and prevention strategies. While Fox Chase's language access efforts were generally seen as robust, participants underscored the importance of early and ongoing language support as part of routine care—not just during key touchpoints or upon request.

JEFFERSON EINSTEIN MONTGOMERY HOSPITAL

Jefferson Einstein Montgomery Hospital hosted one in-person discussion with 10 community members – representing both caregivers and survivors.

Participants at the **Jefferson Einstein Montgomery Hospital** felt that cancer diagnoses are becoming more common, especially among younger individuals, and there's greater openness in discussing it today than in the past. While social media and Google are often used to gather general information, community members overwhelmingly trust their oncologists and care teams for medical guidance. Faith communities provide crucial emotional and practical support, leading to suggestions that hospitals partner with places of worship for education and outreach. Participants expressed the need for clearer, earlier communication about cancer risks, symptoms, and screening guidelines—especially at routine doctor visits—and emphasized barriers such as language access, transportation, and appointment delays. Low-income communities face even greater challenges due to lack of resources and education. Survivors wanted more support for wellness, like nutrition, exercise, and appearance-related tips (hair, skin, massage), as well as emotional and financial assistance. There was a strong desire for more localized, accessible support groups, mentorship programs, and partnerships between healthcare systems and public organizations to better serve vulnerable populations.

SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER

Sidney Kimmel Comprehensive Cancer Center (SKCCC) hosted two virtual discussions with 29 members of their Patient & Family Advisory Board and their Community Advisory Board.

At the **Sidney Kimmel Comprehensive Cancer Center**, participants reflected a dual reality: an increase in cancer-related outreach—especially within the Hispanic/Latino community—and ongoing challenges rooted in stigma, fear, and mistrust. While outreach was appreciated, participants expressed concern about the inconsistency of engagement efforts, noting that when programs or events are discontinued without explanation, it can reinforce long-standing skepticism of health systems. The importance of sustained, visible presence was a recurring theme. Participants also spoke to the powerful role of representation in shaping awareness and comfort—particularly the value of seeing people "who look like me" in advertisements, on social media, or in public education campaigns. These moments of recognition not only provide information but help reduce feelings of isolation for those undergoing treatment. Conversations also surfaced the reality that for many, cancer occurs in the context of broader life stressors—including caregiving responsibilities, economic hardship, and lack of access to supportive services. These challenges underscore the need to address cancer as a community-wide concern, with tailored responses that reflect the full scope of people's lives.

Solutions and Suggested Actions

BUILD TRUST TROUGH CONSISTENT COMMUNITY PRESENCE

Participants emphasized that trust is built not through one-time outreach but through ongoing, visible engagement. Cancer centers and health systems should be seen as authentic partners in community wellbeing—not just providers of clinical services.

"We've got to give people something they leave with... not just show up and then disappear again."

PARTNER WITH FAITH-BASED COMMUNITIES TO REDUCE STIGMA

Faith leaders and congregations play an influential role in shaping beliefs about illness and healing. Collaborating with them offers a pathway to balance spiritual beliefs with medical advice and to build bridges with harder-to-reach groups.

"So we ministers have finally gotten past this idea... that it's all Jesus and no medicine. Now we partner hand-in-hand with the institutions in our community."

EXPAND AND INTEGRATE COMMUNITY HEALTH WORKERS AND AMBASSADORS

Community Health Workers (CHWs) and Ambassadors are viewed as trusted, credible messengers. Their involvement helps reduce barriers to care and fosters greater understanding and trust.

"So I love the Community Ambassador program... that helps get the word out and educates people. When we show up in the numbers, it goes directly to treatment."

NORMALIZE AND EXPAND SCREENING ALTERNATIVES

Participants suggested offering non-invasive alternatives for cancer screening, especially for procedures with low uptake like colonoscopies. Meeting people where they are—without judgment—can improve screening rates.

"Should we stop fighting that battle? Maybe we need to encourage folks to use a different tool if they're never going to do a colonoscopy."

EMBED LANGUAGE AND LITERACY ACCESS THROUGHOUT CARE

While services like LanguageLine are helpful, participants recommended early, in-person support and expansion into languages beyond Spanish. Literacy needs should also be addressed through plain language and clearer explanations.

"We can head it off when they come in the door... have protocols in place to address it right away."

ADDRESS ENVIRONMENTAL AND OCCUPATIONAL RISK FACTORS

Environmental exposures—like asbestos in older buildings—were flagged as a health concern. Cancer centers should acknowledge and investigate these concerns to ensure they're responding to the full spectrum of community risks.

"Everybody in that building had a different type of cancer. And I think it's from the asbestos... breathing that in every day."

ENSURE CONTINUITY IN PROGRAMS AND OUTREACH

Communities expressed frustration when programs were discontinued without explanation. Maintaining consistency or clearly communicating changes is essential for preserving trust and momentum.

"These are groups that have been disappointed time and time again by healthcare systems."

SUPPORT SURVIVORS BEYOND TREATMENT

Survivors often feel unsupported after treatment ends. Participants called for more structured survivorship planning—covering everything from nutrition to emotional wellbeing—to help navigate life after cancer.

"Just because I'm not in active treatment doesn't mean I don't have cancer. I'm a survivor until I'm no longer on this earth."

Tailor OUTREACH TO SPECIFIC COMMUNITIES

One-size-fits-all outreach is not enough. Participants urged health systems to bring education and services to places where people already feel safe and seen—such as LGBTQ+ centers, barbershops, and community centers.

"If you're in men's groups, fraternities, community groups... they're more open to talk about it. It's a sign of being vulnerable, and now they're listening."

Disability

Disability affects the lives of millions of people in the United States, shaping not only health outcomes but also experiences with care, independence, and community participation. According to the Centers for Disease Control and Prevention (CDC), "a disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them." As of 2025, approximately one in four adults—an estimated 67 million people—live with some form of disability. In the five-county southeastern Pennsylvania (SEPA) region, about 14 percent of residents are currently living with a disability. Understanding the diverse needs, barriers, and strengths of this population is critical to advancing equity and ensuring that services are inclusive, accessible, and empowering. This report draws on both survey and qualitative findings to paint a fuller picture of life with a disability in SEPA—capturing challenges in care access, mental health, daily life, social connection, and the importance of advocacy and community support.

A survey was developed to assess the health needs of people living with disabilities in the SEPA region (see online Appendix for results and a copy of the survey itself). This survey retained core questions included in the 2022 rCHNA disability survey, with the addition of several evidence-based items addressing quality of life, experiences with microaggressions, trust in health care providers, and feelings of isolation. The original questions explored respondents' disabilities, general health status, health care access, health behaviors, non-medical needs, employment status, use of technology and assistive devices, community participation, resource needs, and demographic characteristics.

A committee composed of representatives from Bryn Mawr Rehab Hospital, GSPP Rehabilitation, Jefferson Moss-Magee Rehabilitation - Center City and Jefferson Moss-Magee Rehabilitation - Elkins Park, and St. Mary Rehabilitation Hospital reviewed and approved the final survey instrument. The survey was fielded online in two waves: August–September 2024 and again in April 2025 to support focus group recruitment. The survey link was distributed through committee-generated contact lists, which included partner organizations, community programs, and support groups across the region. Committee members also shared the link through their own networks of current and former patients. All survey participants who provided an email address received a $10 gift card as a thank-you.

Descriptive analysis was conducted on 140 unique submissions. Where appropriate, open-ended responses were coded by the project team to identify key themes. For "check all that apply" questions, percentages may exceed 100 percent due to multiple selections.

In addition to the survey, two focus groups and four individual interviews were conducted to explore topics such as access to care, experiences with clinicians, community assets and barriers, and the isolation and loneliness associated with having a disability.

Human Subjects Protection

The focus group protocol was reviewed and approved by Advarra Institutional Review Board (IRB). All participants provided informed consent, and procedures followed institutional and federal guidelines to ensure the protection of human subjects.

Survey Results

RESPONDENT CHARACTERISTICS

The table at right summarizes the demographic characteristics of respondents. Respondents who are over 40, white, or had earned bachelor or graduate degrees made up a majority of the sample. Given this sample profile, it is important to note that the findings may not generalize to the larger community of adults with disabilities when interpreting survey results.

Characteristics		N	%
Gender	Man	75	48%
	Woman	75	48%
	Nonbinary	2	1%
	Transgender Man	1	<1%
	Prefer Not to Answer	3	2%
Age	18-24	5	3%
	25-44	31	20%
	45-64	81	52%
	>65	38	24%
	Prefer Not To Answer	1	1%
Race/Ethnicity	American-Indian/Alaskan Native	1	<1%
	Asian	9	5%
	Black/African-American	22	13%
	Hispanic/Latine	7	4%
	Native Hawaiian/Pacific Islander	1	<1%
	White	116	70%
	Some other race	2	1%
	Prefer Not To Answer	5	3%
Education	High school degree or equivalent	18	12%
	Some college	19	12%
	Associate degree	14	9%
	Bachelor degree	46	29%
	Graduate degree	53	34%
	Prefer Not To Answer	6	4%
Sexual Orientation	Straight	134	85%
	Gay or lesbian	10	6%
	Bisexual	6	4%
	Not Sure	2	1%
	Pansexual	1	<1%
	Prefer Not To Answer	6	4%

Additionally:

- Almost half the sample is **currently not working (43%), 24 percent are retired, 16 percent are working full-time and 10 percent are working part-time**. The remaining 7% include students, people who volunteer, care givers and those able to work but unable to find employment. About half of those working part-time do so because earning more puts them at risk for losing disability or attendant care benefits.
- **About 85 percent are residents of the five-county SEPA region (Bucks: 13%, Chester: 7%, Delaware: 9%, Montgomery: 26%, Philadelphia: 30%)**, with an additional 10 percent from other parts of Pennsylvania, collar counties in New Jersey and Delaware. The remainder are largely from outside the Greater Philadelphia region.

Disabilities and Limitations

- Most respondents **(92%) reported their disability as permanent**.
- Using the Center for Disease Control's standardized disability questions:
  - 9% are deaf or have serious difficulty hearing.
  - 12% are blind or have serious difficulty seeing even with glasses.
  - 41% have serious difficulty concentrating, remembering or making decisions because of physical, mental or emotional conditions.
  - 64% have serious difficulty walking or climbing stairs.
  - 44% have difficulty bathing or dressing.
  - 53% have difficulty doing errands alone because of a physical, mental or emotional condition.
- For those reporting more than one health condition or disability:
  - **24%** report **chronic pain**.
  - **19%** report **chronic disease**.
  - **12%** have **trouble speaking**.
  - **11%** report being **neurodivergent** including being on the autism spectrum, having ADHD, dyslexia, dyspraxia or Tourette syndrome.
- More than half of respondents **(68%) reported having their disability or condition for over five years**.
- About a quarter of participants **(26%) indicated that their mobility is impacted** by their condition. **Another 27%** reported difficulty with interactions such as making friends, being around others and communicating with others.
- Of those respondents who indicated that they **require personal assistance for life activities (92% of the total sample)**, 50% indicated that unpaid family and friends provide this care.
- **49% of the sample reported needing help for certain activities but not being able to get it.** These included daily activities such as self-care, mobility-related or physical activity, social interactions, and therapy or other health care.

Current Health

- Most prevalent **health conditions** were as follows:
  - **47% reported falling** within the past 12 months.
  - **17% reported having diabetes or high blood sugar.**
  - **13% reported having been diagnosed with asthma.**
  - **37% had been diagnosed with high blood pressure or hypertension.**
  - **54% reported being diagnosed with a mental health condition.**
- **About half of the sample reported good (35%) or very good health (12%).** An additional 35% reported fair health.

Accessing Health Services

- When asked about health services that had been utilized in the past 12 months, the most frequently selected options were **primary care (27%) and dental care (18%)**. About 11% of respondents reported using emergency care and about 15% reported use of psychological and/or counseling services.
- Of the almost 60% of respondents who indicated that they could not get the medical care that they needed in the past 12 months, the most frequently selected barriers were: **participants could not get an appointment, could not find a clinician who understood my condition, have difficulty identifying a doctor or clinic or had too much difficulty getting to the doctor's office or clinic**.
- Almost all participants who indicated they **take medication (98%) were able to regularly get the medication they needed (96%)**.
- Of the nearly 50% of respondents whose insurance status impacted their ability to get care, **the most frequently selected barriers included insurance did not pay for what was needed, could not afford care needed, could not find clinician that accepted insurance**. Of those reporting insurance barriers only **2% indicated they had no insurance at all**.
- About two- thirds of participants **(66%) reported that they have used telehealth services** in the past 12 months, and a majority of these respondents found **services beneficial (96%)**.
  - Those who had not used telehealth services indicated that they either did not have a need for such services or preferred in-person care.
  - While many found the services **convenient** (especially for particular types of appointments), others expressed **preference for in-person appointments or cited challenges related to technology and limitations of what could be done virtually**.
- The majority of participants **(82%) reported using a portal, website or app to see health information, communicate with their health team or make an appointment** in the past 12 months, and a majority of these respondents found **services beneficial (93%)**.
  - Those who had not used telehealth services indicated that they prefer to speak to someone on the phone or had difficulty with digital access.

Disability-Related Resources

- **27% of respondents reported needing special equipment or assistive devices**, with factors such as cost, insurance-related issues, and lack of knowledge posing barriers to acquisition. Needed equipment included:
  - Lifts, chairs, or other mechanized assists (7%)
  - Stair access supports (5%)
  - Railings, bars, or other non-mechanized assists (6%)
  - Vehicle big enough for a wheelchair, cart, or scooter (5%)
- Nearly half **(43%) reported that they currently participate in support groups**, with an additional 22% indicating that they are not currently participating but would be interested. A variety of resources were not widely used, but some respondents indicated interest in using:
  - Transportation support (28%)
  - Peer mentors (19%)
  - Support for caregivers (relief support or respite) (15%)
  - Care navigation (15%)
  - Complementary therapy (8%)
  - Adaptive sports programs (7%)

Non-Medical Needs

- With respect to housing, the biggest challenges were related to **home access and safety**:
  - **About a quarter of respondents (24%) with a physical disability indicated that they cannot enter or leave their home without assistance from someone else.**
  - **Almost 30% indicated that their current housing does not meet their needs.** Most commonly shared issues included those related to accessibility, safety, need for repairs, and cost.
- **Twenty-three percent of respondents shared that their primary means of transportation does not meet their current needs.** Most cited reasons included cost, need for assistance or equipment, and lack of reliability or convenience of transportation mode.
- **More than a quarter of the sample expressed significant financial needs:**
  - Almost 20% reported that there was a time in the last 12 months when they were **not able to pay mortgage, rent, or utility bills**. **Forty-four percent** of participants reported that **housing costs were somewhat or very difficult in the past year**.
  - Approximately **38% experienced food insecurity and 47% were often or sometimes worried about food insecurity**.
  - Twenty-seven percent needed the **services of an attorney but were not being able to afford one**.

Lifestyle

- While 33% of respondents shared that they exercise at least 30 minutes three or more days per week, **28% indicated that they never participate in such activity**. Most frequent barriers to physical activity were: not having the physical capability to participate in exercise, inability to afford a gym membership or no places near their home to exercise and lack of knowledge of exercises appropriate for their condition.
- **A majority of respondents (81%) reported eating at least one serving of fruits and vegetables in a typical day.**
- **Substance use was not prevalent in the sample:** 92% indicated that they do not currently use tobacco; 95% stated that they either do not use or do not feel that drug use impacts their daily life; and 86% stated that they either do not use or do not feel that alcohol use impacts their daily life.
- The survey asked about typical social interactions and activities:
  - A majority of respondents indicated that they **socialize with close friends, relatives, or neighbors (82%) and feel there are people they are close to (88%)**.
  - **Over a third (36%) indicated that they do not feel that their daily life is full of things that are interesting to them.**

Quality of Life and Connection

- More than **two-thirds of respondents (67%) rank quality of life as 'so-so'**, neither good or bad.
- Despite almost 80% of participants indicating they regularly socialize, more than half of participants experience some form of isolation often or some of time including:
  - **Twenty-two percent of participants feel they often lack companionship** and 32% lack companionship some of the time.
  - **Thirty percent of participants report often feeling left out** and an additional 33% feel left out some of time.
  - **Twenty-eight percent of participants feel isolated from others often** and another 33% feel isolated some of the time.

Experience with Disability Microaggressions

Microaggression	% Applicable	% Impacted
People feel they need to do something to help me because I have a disability.	91%	62%
People express admiration for me or describe me as inspirational simply because I live with a disability.	91%	67%
People express pity for me because I have a disability.	88%	35%
People do not expect me to have a job or volunteer activities because I have a disability.	85%	31%
People offer me unsolicited, unwanted, or unneeded help because I have a disa-bility.	88%	38%
People are unwilling to accept I have a disability because I appear able-bodied.	79%	31%
People minimize my disability or suggest it could be worse.	90%	44%
People act as if accommodations for my disability are unnecessary.	89%	36%

While the survey provided valuable insight into trends in access, resource use, and unmet needs across the SEPA disability community, the lived experiences behind the numbers reveal even deeper truths. To better understand how people with disabilities navigate daily life, interact with health and social systems, and define quality of life, two focus groups and four in-depth interviews were conducted.

These conversations explored issues such as mental health, caregiving, social connection, systemic trust, and self-advocacy—shedding light on the emotional, relational, and structural dimensions of living with a disability. Participants' voices brought richness and nuance to the data, elevating the themes from statistics to stories.

Access to Care

Access to care encompasses a broad range of experiences that shape whether, and how, people with disabilities are able to get the healthcare and support they need. Participants described numerous barriers, from delayed appointments to inaccessible clinic environments. One person shared that post-pandemic delays were widespread: **"There's always a long wait for any doctor nowadays,"** especially for specialists and therapies. Even when appointments happened, the facilities were sometimes unprepared. One participant recalled arriving in respiratory distress only to learn the provider **"didn't have oxygen or anything in his office,"** and he was sent home with no help.

Transportation and logistical hurdles were major subthemes. **"I need rides, I can't drive myself now… that can be really difficult to coordinate,"** one woman explained, describing how unreliable paratransit and agency transport often caused her to miss care altogether. Financial barriers also emerged as key obstacles—especially costs not covered by insurance. One man noted, **"The cost of home care… it's just one of those things that's often not covered,"** leaving people to pay out of pocket for essential support. Others shared stories of navigating confusing insurance denials or delays for treatments they needed.

Communication was another critical piece of access. A participant with a neurological condition explained, **"It's gonna take me a longer time to process what you're saying, and I'm not leaving until I understand."** Without time, clarity, or written instructions, even having an appointment didn't guarantee appropriate care. True access meant being treated as someone who deserved to fully understand and participate in care decisions.

Alongside these barriers, some participants shared moments of supportive, well-designed care. One person compared experiences at two therapy sites: at the hospital, he received attentive, concierge-like service—**"staff met me with a wheelchair and escorted me"**—but not at the same health system's affiliate site. This highlighted how responsive systems can make care accessible, while inattentive ones leave patients struggling.

Participants also emphasized **respect** as a vital part of access. Disrespect or dismissiveness—especially tied to invisible disabilities—eroded the quality of care. **"Sometimes I feel like they assume I can't read or write,"** one woman said, highlighting how stereotyping can undercut a patient's credibility. Others described being talked over or not accommodated in exams, leading to frustration and missed information.

Power in decision-making was closely tied to access. Many participants felt they had to push hard to be heard. **"If I don't question them, who will? It's my health,"** one said. This advocacy was sometimes misunderstood as being "difficult," but participants saw it as necessary to ensure their needs were met. One woman described how she has to educate every new provider about her condition: **"Why don't you all know about aphasia? If I say I have aphasia, I need you to speak slowly."** These acts of advocacy—even switching providers or dictating how a visit should go—were about claiming a rightful voice in their care.

Experiences of **discrimination in care** further complicated access. A wheelchair user described a snowy day when **"they plowed all the snow into the handicap spot,"** leaving her unable to reach her doctor's office. Her complaint was ignored. Others described being denied care or questioned unfairly due to disability-related insurance or visible conditions. These stories revealed how both policy-level and interpersonal discrimination shape whether patients receive equitable treatment.

At the broader systems level, **trust and mistrust** shaped how participants approached access. Many described healthcare and insurance systems as adversarial. **"You look at the [denial] letter… and go, 'Were they even on the same phone call I was on?'"** one participant asked. Still, some found pockets of trust in individual providers who took time and advocated for them.

Transitions from pediatric to adult care added another layer of complexity. **"Moving from the school age, transitioning into adulthood becomes this vast scope of unknown things,"** a mother said, describing how her son lost the coordinated services he relied on. While adult systems often expect individuals to be independent, they frequently fail to provide the necessary guidance to support that independence. Simply turning 18 does not automatically equip young people—or their families—with the tools to navigate complex adult systems. Without intentional transition planning and continued support, families are left feeling overwhelmed and unsure of how to move forward.

Outside of clinical settings, participants also pointed to **broader health-related barriers** in their lives. Unsafe housing, poor public infrastructure, and limited access to food or community services made it hard to stay healthy. **"If you don't have a car to get to the food pantries… obviously the people in need of these supports can't get them,"** one said. These environmental and economic factors directly influenced health and reinforced the need for community-level changes.

Still, many highlighted the value of **community supports** that worked. **"There have been a lot of resources available,"** one person said, referring to local nonprofits and peer groups. Accessible transportation, wellness activities, and advocacy organizations were often described as game-changers. **"There's a lot of peer support out there if you look,"** another noted.

Finally, **health and digital literacy** challenges were cited as modern barriers to care. From navigating telehealth to deciphering insurance forms, many participants felt overwhelmed. One man shared, **"I see now, because everything is connected to the phone… I need a phone."** For others, peer support and self-teaching helped bridge the gap, but they emphasized the need for better tech training and more accessible provider communication.

In sum, participants' stories made clear that access to care is about much more than scheduling appointments—it's about transportation, respect, power, discrimination, trust, and navigating complex systems. Where supports were in place, care felt possible. But too often, the fight for access was exhausting and unjust, underscoring the urgent need for more inclusive, responsive systems.

Solutions for Access to Care

Participants identified several key strategies to improve access to care for people with disabilities. First, they emphasized the need for more **disability-competent providers**—clinicians who understand various conditions, communicate clearly, and are equipped to accommodate different needs. Ongoing provider training in accessibility and respectful care was strongly recommended. Second, **transportation support** emerged as critical. Suggestions included expanding paratransit services, offering travel vouchers, and developing shuttle programs for medical and social needs.

Third, participants advocated for **simplified insurance processes** and stronger care coordination, including patient navigators who can assist with scheduling, referrals, and insurance appeals. Lastly, participants called for **more integrated telehealth and digital access tools**—paired with training and support to ensure that technology enhances rather than hinders access. These practical solutions reflect a desire not only for medical services, but for systems that recognize and respond to the full scope of disability-related barriers.

The Experience of Being Disabled: Emotional, Social, and Support Dimensions

Living with a disability deeply impacts emotional and social well-being, not just physical health. Participants spoke openly about how their mental health was affected by both their conditions and the systems they had to navigate. Many experienced **depression, anxiety, and chronic stress**, often triggered by loss of independence, pain, or the emotional toll of feeling misunderstood or devalued in daily life and healthcare settings. **"I am statutorily blind, and that has also affected my mental health,"** one participant said, explaining how the progressive loss of vision slowly closed off the world she once knew. Others spoke about how physical limitations chipped away at their identity: **"After a while, you get into a funk because you can't do what you used to."** These expressions of grief and frustration were common, especially from those who had recently experienced a major shift in health or ability.

The emotional toll wasn't limited to the disability itself—it was **compounded by negative experiences with healthcare providers, insurance companies, and public systems**. Several participants described being dismissed or misunderstood by doctors, which triggered anxiety and made them dread appointments. Others linked their mental health struggles to systemic barriers like job insecurity or housing instability. One woman noted that the stress of nearly losing her job due to health-related absences **"kept me up at night and worsened my health overall."** These reflections show how navigating a difficult or disrespectful system can intensify mental health issues, creating a cycle that affects both physical and emotional well-being.

Despite these struggles, there were signs of **resilience and growth**. A participant with aphasia described how she used to beat herself up when her speech faltered: **"I used to get so… it would just depress me more."** Over time, she shifted to a more compassionate inner dialogue: **"Now I've learned to be gentler with myself."** Others shared that seeking therapy or joining a support group helped them cope and reconnect with others. For many, mental health care wasn't just helpful—it was transformative. **"I finally felt understood,"** one said about joining a group. Participants also emphasized the need for integrated mental health services, such as being referred to counseling automatically after a diagnosis or trauma. As one person put it, **"Mental health is very important, especially when you have [a disability],"** advocating for it to be treated as an essential part of care, not an afterthought.

Closely tied to mental health was the theme of **isolation and loneliness**. Participants described how social disconnection was both a cause and effect of their health challenges. Many shared that they no longer had strong support networks; illness had chipped away at their social lives. **"I don't work anymore… your communication isn't like it was,"** one woman said, describing how losing the routine and relationships of work left her adrift. Others noted that friends gradually stopped inviting them to events, assuming they couldn't attend. Over time, this erosion of contact created a sense of being forgotten.

Importantly, isolation wasn't always about physical solitude—it often stemmed from **feeling misunderstood or "othered."** One woman explained that having multiple disabilities made people treat her as fundamentally different: **"My long span of having many disabilities… I personally experienced a lot of isolation."** Others shared that even when they were with others, they felt emotionally alone, especially if their communication needs weren't respected. A participant with a speech impairment described the frustration of people trying to finish her sentences: **"They don't understand the frustration when I don't want you to feed the words for me."** These seemingly small moments created a disconnect that added to her loneliness.

Physical barriers played a role too. Several participants said they avoided social outings because of the effort required to get there—transportation challenges, poor infrastructure, or inaccessible buildings. **"Even though I'm grateful for public transportation, it's a challenge… I don't want to socialize sometimes because it's such an ordeal to get out,"** one person shared. Others who had relocated for care or housing reported being surrounded by strangers, unable to build new connections.

Yet again, **peer support emerged as a lifeline**. Whether through Zoom groups, community centers, or faith communities, participants found comfort in shared experience. **"It's nice to hear you're not alone in this… we're part of the world,"** one person said during a focus group session. This moment of recognition—of mutual understanding—served as a powerful antidote to isolation. People described how support groups, even if virtual, helped them feel included and valued. Others took proactive steps to build community, like forming informal networks with neighbors or becoming peer mentors.

Independent living and relationship support emerged as a fragile balance. Participants wanted autonomy but often lacked help with everyday tasks—transportation, housework, companionship. One person reflected, **"God knows I would love to have more help… even to the point of, oh my gosh, having the dude who does my lawn."** Those without a partner or family nearby faced steeper challenges. Pride and shame were emotional barriers to asking for help, particularly among men. Some built informal networks—neighbors, church friends—to fill the gap, showing resilience and creativity in maintaining independence.

Caregiver support and burden was another side of this conversation. Participants deeply valued family caregivers but were also keenly aware of the strain. **"My mom has been amazing, but I feel like it's taken a toll on her,"** one person said. Others were caregivers themselves while managing their own disabilities, leading to compounded stress. Financial strain, lack of respite options, and emotional fatigue were common, and many worried about the future if caregivers became unavailable.

Finally, **advocacy and self-advocacy** stood out as powerful tools for navigating all of these challenges. Participants described filing complaints, organizing support groups, joining hospital advisory boards, and founding nonprofits. **"I am always wearing my advocate hat,"** one participant said, illustrating how advocacy became a way of life—protecting their own rights while improving conditions for others. These acts, large and small, fostered a sense of agency and purpose, even in the face of overwhelming systems.

In sum, the emotional and social dimensions of disability are as significant as the medical ones. Mental health support, connection, autonomy, caregiver balance, and advocacy all shape how people live and thrive with disability—and when those elements are missing, they carry heavy costs.

Solutions for Connection

Solutions for Connection revolves around ideas and initiatives to reduce loneliness and build community among people with disabilities. After many participants shared their struggles with isolation, this theme captured the hopeful turn: what can we do about it? Participants had a chance to brainstorm and endorse various solutions – some they've experienced working, and others they wish to see implemented.

One overwhelmingly supported solution was **increasing the availability of support groups and peer gatherings**. **"I like the idea… more support groups publicly available. I think that's a great idea,"** one participant said, jumping off another's suggestion. There was a consensus that support groups (whether for specific conditions or more general disability social groups) help people connect, share experiences, and feel less alone. Participants discussed how these could be made more accessible – for instance, held in community centers or libraries (public, neutral places), possibly facilitated by a counselor or volunteer, and better advertised so people know about them. **"A lot of people either don't know or don't have access to those groups,"** the participant continued, noting that awareness is key. The idea of doctors or clinics referring patients to local support groups was floated; essentially, integrating social support into the care plan. The group clearly felt that structured settings where disabled individuals can meet each other are invaluable. Several people had personal anecdotes: one mentioned a stroke survivors group that "saved" her from deep depression, another talked about a virtual group for young adults with disabilities that became her friend circle. These examples reinforced the point – **organized peer support** is a lifeline, and expanding it would directly combat loneliness.

Technology as a tool for connection came up as well. Even though earlier there was frustration over technology, here participants noted its positive side. **Zoom gatherings** were cited: **"We do weekly support groups on Zoom… there's lots of folks from anywhere who join in,"** one participant mentioned. This was seen as a great solution for those who can't easily leave home or who live far apart. People can bond online and perhaps occasionally meet in person when possible. Social media groups specific to disability interests were also mentioned (with caveats about sometimes misinformation, but for socializing they can be good). One participant said he found a Facebook group for people with his rare disease and now has friends across the country from it – even traveling to meet one in person. Participants agreed that **digital connection** is a powerful solution, as long as people are comfortable with the technology (looping back to digital literacy and accessibility efforts).

Another major idea was **community events and activities designed to be inclusive**. Participants thought communities should create more opportunities for people with and without disabilities to socialize in a comfortable way. One person suggested a monthly game night or movie night at the local recreation center that specifically welcomes individuals with disabilities (providing needed accommodations but also open to all, to encourage integration). **"I think it was number 3 who threw out… more support groups…,"** another said, building on earlier comments, **"but also maybe like social events – like mixers where people can just hang out."** They imagined things like an adaptive sports day, art classes adapted for various abilities, or disability-friendly festivals. The key is these events would be well-publicized and normalized, not just one-off special occasions. Some noted that organizations do exist that host such events (like Easterseals, Centers for Independent Living, etc.), but they wished for more funding and frequency for these.

Participants also touched on **transportation solutions** as a prerequisite for connection. All the events in the world don't help if people can't get there. So, some suggested expanding shuttle services or volunteer driver programs for those with mobility issues to attend social gatherings. One person said her community started a free shuttle that **"goes to different parts of town that are important."** Such transit options, possibly funded by local government or nonprofits, were seen as enabling solutions for connection.

Interestingly, a participant with significant mobility limitations said that even just **phone calls** make a difference: **"They do have activities here… they've led me down the path of prayer,"** he said about his assisted facility residence, **"and we pray a lot. We also have folks who call to check on us."** This highlighted those simple interventions, like a scheduled call from a volunteer or staff just to chat or say hello, can brighten someone's day and make them feel cared about. Another participant mentioned "friendly visitor" programs where volunteers visit homebound older adults or individuals with disabilities regularly — she thought expanding those programs would be beneficial.

A few participants brought up the idea of **buddy systems or peer mentoring**. For example, pairing someone who's newly disabled with a peer who's been living with disability for a while – not only to provide practical advice but also friendship. One man said when he first became a wheelchair user, an older gentleman who also used a wheelchair took him under his wing through a local program, and that bond was crucial to his adjustment. They remained friends beyond the formal mentoring period. Standardizing such buddy programs (maybe through hospitals or community organizations) was seen as a great way to ensure no one falls through the cracks after a life change.

Advocacy and community education were mentioned as long-term solutions to change attitudes that cause isolation. For instance, teaching school kids about disability inclusion, or having community workshops to "demystify" disabilities, so that the general public is more comfortable interacting with and including people with disabilities. Over time this type of programming and education could reduce the social barriers and make organic connections more likely. While this is more preventative and cultural, the participants did see value in it.

Finally, it was noted that **the conversation we were having right now is part of the solution**. By coming together in this survey/focus group and sharing, they were already lessening isolation. One participant said, **"These conversations… give us an opportunity to differentiate care from quality care… and to be heard."** This comment highlighted the value of creating space for disabled individuals to define what quality care means beyond basic services. Through collective discussion, participants could identify shared priorities, articulate what a meaningful quality of life looks like, and feel a sense of connection and validation by being heard within a supportive group setting.

In conclusion, the **Solutions for Connection** theme was uplifting because it focused on positive action. Participants clearly believe that loneliness is not an inevitable fate – there are concrete steps to be taken. They championed **support groups, inclusive events, better transportation, buddy systems, and leveraging technology** as ways to bring people together. Importantly, those with firsthand experience in some of these solutions vouched for their effectiveness: **"We're not alone, and we're trying to fit in… it helps to hear each other,"** as one said. The collective wish was for these types of programs to be more widespread, consistent, and integrated into community offerings. There was a sense of empowerment: having identified solutions, participants seemed motivated to pursue them or at least to voice that these changes are needed. In a way, this theme tied the narrative together on a hopeful note – yes, there are many challenges, but also many ways to foster connection, and the participants are eager to see those ways expanded.

Intersectionality

Intersectionality in this context refers to how disability intersects with other identities or social factors (such as race, gender, socioeconomic status, incarceration history, etc.) to shape a person's experience. Although fewer participants spoke directly about this theme, those who did provided insightful examples of how their disability experience is compounded by other aspects of who they are.

One participant highlighted the importance of **cultural and linguistic background** in her healthcare. She struggled for years to find mental health providers who could understand her context – a woman of color and an immigrant. Eventually, she succeeded: **"I managed to find some providers from my particular background – so this would be women from minority backgrounds or from immigrant backgrounds."** This made a tremendous difference to her comfort level in care. **"There's a lot that I can tell them that they intuitively understand,"** she explained, **"[I don't have] to explain too much."** In other words, sharing gender and cultural identities with her providers meant she didn't have to constantly translate or justify her experiences; they "got it." Her story shows how **race/ethnicity and gender** intersect with disability in care settings – when these are aligned, the care feels more supportive, and when they're not, patients may feel misunderstood. It was an important reminder that a one-size-fits-all approach in healthcare can leave people from minoritized backgrounds feeling lost or alienated, whereas a provider who shares aspects of their identity can alleviate that burden.

Another powerful example of intersectionality came from participants who had been involved with the **criminal justice system**. One gentleman shared his experience of being incarcerated while managing mental health challenges. **"I was like in [prison] with a bunch of men, and I just didn't socialize that much,"** he admitted. It was only when he **"became a peer support and then the block tutor for the special needs unit"** that he found a sense of community. In helping other inmates with disabilities, he connected deeply: **"I could relate with those guys because I am them."** Here, his identity as a formerly incarcerated person and as someone with a disability converged. He felt "othered" both as a person with a disability in society and as an ex-prisoner, but in that role as peer mentor, those pieces of his identity combined to give him purpose and belonging. After being incarcerated for 20 years, reentering society was extremely challenging for him – he mentioned feeling "empty" coming home to a changed city and struggling with everyday technology, such as self-checkout machines. In addition to dealing with his health and disability, he bore the label of "ex-offender," which carries its own stigma. When two store employees laughed at him for not knowing how to use a self-checkout kiosk and joked, **"old head, you been locked up?"** it illustrated the prejudice he faced. That intersection of **disability and incarceration history** made his transition doubly hard: he had to catch up with societal changes and find people who would accept him. His story emphasizes that for some, disability can't be separated from contexts like incarceration – the two interlock to influence their challenges and needs.

Participants also touched on **mental health stigma and sexual orientation** as intersecting factors. One man described feeling judged in the past when seeking help for depression because some providers – or even friends – would say dismissive things like **"we all get sad, come on."** That lack of understanding was partly due, he felt, to a cultural stigma around mental illness. One participant shared, "I identify with the LGBT community," and reflected on past healthcare experiences where certain questions from providers made him "feel weird." Although he did not specify the questions, it can be inferred that they may have been phrased insensitively or based on assumptions about his sexual orientation, contributing to discomfort and a sense of exclusion in the care setting. **"That was in the past… typically now I don't experience that,"** he noted, implying that healthcare has become more aware of LGBTQ+ concerns over time, but it was clearly an issue he remembered. This shows an intersection of **disability, mental health, and LGBTQ+ identity** – any one of those can invite bias, and together they can complicate finding supportive care. For him, knowing that element of his identity might affect a provider's attitude was an extra worry layered on top of managing her health.

Interestingly, one participant reflected on intersectionality from a position of relative privilege. He introduced himself by acknowledging, **"I have my privilege, you know, as a white male,"** and yet he described a particular kind of fear. Despite his privilege, he said, **"I'm scared of doctors in a way… I don't want to ask for maybe a certain medication, or I don't want to admit… that I'm having a problem."** This reluctance to show vulnerability, which he partly attributed to being a man in our society ("a macho thing"), intersected with his mental health needs.

Fortunately, he found a psychiatrist who was "very open" and supportive, and **"that experience with that particular person has been wonderful."** His perspective is telling: even someone who does not face racial or economic disadvantage still experiences a kind of intersectional barrier – in this case, the societal expectations of masculinity affecting how he engages with healthcare. It underlines that intersectionality isn't only about marginalization; it's about **how all facets of identity interact**. For him, being male made it harder to admit he needed help (due to stigma around men and mental health), and being disabled made that help necessary – a tricky combination he had to navigate.

In summary, the **Intersectionality** theme illuminated that people with disabilities are not monolithic – their other identities significantly shape their experiences. Whether it's finding refuge in a provider who shares your culture, or struggling with societal reintegration after prison, or ensuring a safe space as an LGBTQ+ individual, these additional layers can either buffer or intensify the challenges of living with a disability. Participants' narratives here call for a more nuanced understanding in services: cultural competence in healthcare, support systems for those with disability and a criminal record, sensitivity to gender and sexual orientation in treatment, and acknowledgment that disability intersects with issues of race, class, and beyond. Recognizing these intersections is key to addressing the full person, not just their disability in isolation.

General Population Perspectives

The **general population perspectives** theme captures insights from community members—caregivers, advocates, and concerned residents—who may not identify as disabled but are aware of disability-related issues. These comments emerged from a broader series of community conversations about health and well-being, offering an important outside-looking-in viewpoint that often validated and reinforced the voices of people with disabilities.

Across the board, general population participants expressed empathy and concern, especially for older adults who lose mobility and face financial strain. **"Many people lose their driver's license when they are older,"** one participant said, noting the lack of affordable alternatives: **"They need a person to take care of them, and some people don't have the money to pay for that [help]."** Others pointed to community efforts—like meal delivery services—as examples of what's working but acknowledged that services for medical transport or social needs remain insufficient.

A recurring theme was the **invisibility of the disability community**. One passionate advocate who tried for years to improve a local adaptive fitness center said, **"The disability community to this day, in my opinion, is left out… the voiceless hidden community."** His frustration with bureaucratic inaction showed how even non-disabled allies are aware of systemic neglect—and are sometimes stonewalled when trying to help.

Many echoed the need for **expanded services and inclusion across all ages**. **"People with disabilities are definitely suffering the most… from the youth all the way up to our seniors,"** one person observed. Another shared pride in witnessing inclusive community behavior: when a blind woman attended a local event, **"everybody was so attentive… her needs were met."** That moment stood out as rare and commendable, subtly highlighting that such inclusion is not yet the norm.

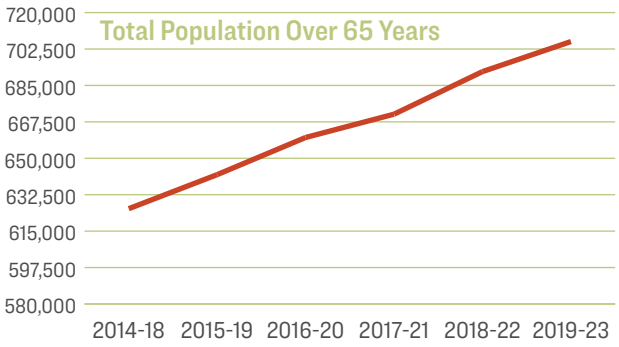
General population voices also revealed awareness of **technical and systemic challenges**—from poorly run paratransit programs to the financial burdens of caregiving. One participant described how unpredictable ride services leave people stranded: **"You never know when your rides are coming… if they're late, they don't even know they're late."**

In sum, general population community members served as powerful allies in these discussions. They saw and echoed many of the barriers described by discussion participants with disabilities—transportation, affordability, social exclusion—and added their own frustrations and hopes. Their perspectives highlight that disability access is not just a personal issue; it's a community one. They called for improved services, infrastructure, and inclusion, expressing solidarity and a willingness to act. Their voices added strength to the overall message: people with disabilities should be seen, heard, and supported—by everyone.

Together, the survey and qualitative data presented above highlight the complex and multifaceted experience of living with a disability in southeastern Pennsylvania. While many participants expressed resilience and described meaningful support systems—ranging from peer groups to trusted providers—there were also clear and persistent barriers: inaccessible services, financial hardship, social isolation, and deep mistrust in institutions. Emotional and mental health impacts were intertwined with structural challenges, and personal stories of exclusion often paralleled broader systemic failures. Yet participants also offered solutions—calls for more inclusive community programming, better caregiver support, integrated mental health care, and expanded opportunities for connection and advocacy. The findings underscore the urgency of addressing disability not just as a clinical condition but as a social and policy issue requiring comprehensive, person-centered strategies. This report aims to inform that work—by ensuring that the voices and needs of people with disabilities are central to planning, policy, and community health initiatives across the region.

Older Adults

As the older adult population continues to grow in size, it is essential to assess their distinct health, social, and economic needs, which differ from those of the general population. This report examines key issues affecting older adults in the community, including health care access and socioeconomic support. Their care needs are often more complex, requiring specialized services and coordinated support systems.



To identify existing challenges and areas for improvement, we used several methods to gather community perspectives. We analyzed community survey results, stratifying responses to compare the differences in priorities among the group aged 65 and older with the general population (18-64). This survey had a total response of 3,146 individuals, with 14% (451) being over 65 years old. We also collected qualitative data through community conversations with older adults at aging organizations, including Brandywine Valley Active Aging, Bethel Deliverance International Church, and Wayne Senior Center. We also gathered perceptions of older adults' health through targeted questions in community conversations with the general public (adults over 18) across the five-county region.

According to the community survey, people 65 and over reported:

Top 5 Barriers	Top 5 Health Problems	Top 5 Mental Health Problems
Costs associated with getting healthcare	Age-related illnesses	Depression
Transportation	Heart conditions	Anxiety
Health insurance is not accepted	Mental health	Alcohol use
No health insurance	Diabetes and high blood sugar	Loneliness
Scheduling problems	Cancers	Drug use

Compared to the general population, the aging population expressed significantly greater concern about health insurance coverage as a barrier, likely related to their dependence on Medicare and supplemental plans. Age-related illnesses and challenges of loneliness and social isolation were also rated as more significant concerns by older adults. They reported lower levels of willingness to discuss their health problems and a diminished sense of feeling welcome or respected in healthcare settings. Finally, the availability of affordable housing has emerged as a particularly prominent challenge for this population.

We will now explore these themes in greater depth through qualitative data collected from in-person community meetings at aging organizations, highlighting the personal experiences and perspectives shared by older adults.

Resources for Older Adults

SENIOR CENTERS & PROGRAMMING

There is a variety of programs available for older adults, emphasizing **education, arts, social engagement**, and overall well-being. Older adults have access to free educational opportunities at local schools and universities. **Arts and cultural programming**, including theater performances and concerts at outdoor venues provide entertainment and enrichment. Senior centers play a vital role in **fostering community** by offering diverse activities such as exercise classes, games, language courses, and arts programs.

"The senior center is really a wonder and one of the things I really like about it, the obvious things are exercise, different exercise classes. But somebody could say, well, they don't need anything beyond that. They don't need the ukuleles, they don't need music, they don't need art. Those things have been so valuable to the center as well as food and the obvious things"

Beyond traditional senior centers, churches and libraries serve as important **social hubs** where older adults can connect with others and access additional resources. While many programs are free or low-cost, affordability remains a concern for some individuals. In addition to recreational and educational programming, senior centers also address public health needs by providing nutritious meals, socialization opportunities, and extended hours during extreme heat, ensuring older adults have safe and comfortable spaces when needed.

AWARENESS & ACCESSIBILITY

Participants expressed concern about a widespread **lack of awareness** among older adults regarding available services, particularly as more essential tasks move online. Many older adults struggle with **technology**, yet accessible training opportunities are limited, making it difficult for them to order groceries, access resources, or navigate digital platforms.

"A lot of people, probably the vast majority of people don't know how to order food from the grocery store and have it delivered to their house."

They also feel left behind due to a **lack of patience and guidance** from service providers. While helpful food access programs exist, such as **meal delivery trucks and community produce distributions**, many older adults remain unaware of these options or how to use them.

"So, there are areas that still need help, and a lot of people don't know that the help exists, so they need to be educated as to what's out there and what's available to them."

Some nonprofits and senior centers have started offering training on ordering groceries online, which could be especially beneficial for those with mobility challenges or health concerns. Additionally, while Social Security benefits vary based on career and earnings, some older adults **struggle to make ends meet** and are ineligible for programs like SNAP benefits. Resources such as free SEPTA passes and discounted farmer's market coupons are available to older adults, but many are **unaware of these benefits**. Without broader outreach and education efforts, many older adults could continue to miss critical resources that could improve their quality of life and support their independence.

HOUSING

Participants highlighted the positive impact of **aging housing developments**, noting that these residences have significantly improved the quality of life for many older adults. These apartments with features like **elevators and accessible transportation options**, such as nearby bus stops, have provided **safer and more convenient living arrangements** for those who may struggle with stairs or other physical barriers in traditional homes. However, some participants shared the challenges of securing affordable housing, pointing out that **income restrictions** often disqualify individuals from low-rent options, leaving them with limited alternatives. In such cases, older adults may need to **rely on family for temporary shelter** while searching for stable housing.

"The lady I'm staying with, so the house is going to be sold. So, I have to get out of the house. Now, I tried to apply for the low rent housing. They said my income is too high. I have to go to my son's house and crowd him up until I find a place to go."

Despite these obstacles, participants acknowledged the availability of various resources that **support independent living, including mobility aids and home modifications**. Some credited state-funded initiatives, such as lottery-funded services, play a key role in making these services more accessible. While gaps remain, participants recognized the progress made in ensuring that older adults have access to the housing and resources necessary for safe and comfortable living.

Access to Care

ADVOCACY & CARE NAVIGATION

Participants expressed concern about older adults who **lack family support** and emphasized the need for community members to step in as advocates. Many struggle to **navigate medical decisions**, often not fully understanding what doctors tell them or what they are signing. Having someone to check on them, help them comprehend their medical care, and ensure they receive appropriate treatment is crucial. Participants also highlighted the risks of both overmedication and undermedication, stressing the importance of **advocates who can monitor prescriptions** and ensure medications are taken correctly. With rising rates of dementia and Alzheimer's, the need for such support is even more urgent. They suggested that individuals or groups could "mentor" an older adult, much like one would mentor a younger person, offering guidance, companionship, and assistance in navigating healthcare decisions.

Participants also expressed frustration with the **complexity of the healthcare system**, particularly when trying to **access primary care**. Some shared experiences of long wait times just to establish a primary care relationship, even when dealing with urgent health concerns.

"It takes too long to get a doctor's appointment... A person has to wait over two months to see a doctor? And then what they do when they tell you that. So, if you have a problem they say, go to the emergency room, which is like triple the cost of seeing a doctor, a regular appointment."

The requirement to see a primary doctor before being **referred to a specialist** was a common challenge, particularly in fields like dermatology, where delays could worsen existing conditions. Others noted that while some individuals had no issues getting a primary doctor, others faced systemic obstacles, such as miscommunications within health networks that prolonged the process.

MEDICARE

Older adults expressed frustration over the **lack of clear education** about Medicare options, particularly as they approach age 65. Many feel that some benefits are confusing or misleading, with key restrictions, such as limited provider networks and required specialist referrals, often not fully disclosed.

"There's a bigger issue here and that is that there is inadequate education as people are nearing the age of 65 to learn from an unbiased source about all options necessary that the government requires for when you sign up for Medicare. What level of care? What kind of prescription drug plan? How do you even analyze any of this? Someone who is nearing the age of 65 needs to know how far in advance to start doing research. If they are unable to do that themselves, then who else is available?"

Navigating the complex system without sufficient guidance is challenging, and while some community volunteers provide assistance, their availability is limited." There is also widespread **confusion about coverage details**, with many older adults unaware of their entitlement to certain benefits, such as annual check-ups, or what aspects of care are covered. Some have even found themselves educating healthcare providers on these issues. While some senior centers offer **monthly counseling sessions** to assist with Medicare decisions, many older adults remain **uninformed about their choices**, leaving them vulnerable to gaps in care and unexpected expenses. Participants emphasized the urgent need for comprehensive, accessible, and unbiased Medicare education to help older adults make informed healthcare decisions.

TELEHEALTH

Participants shared a range of experiences with telehealth, with many praising its convenience and accessibility. Virtual visits were appreciated for allowing easy access to healthcare professionals through portals, enabling patients to track their medical history and communicate with their doctors from the comfort of their homes.

"I think it's nice we can access our lab work, because then I can look up what I don't know. I can look up what I don't understand, and I don't have to ask as many questions. I'm more concise when I ask questions at the doctor's office."

The ability to access lab results and other medical information online was seen as an advantage, empowering patients to review their health data and ask more informed questions during follow-up office visits. Some participants also highlighted the value of telemedicine during the COVID-19 pandemic, particularly for high-risk individuals, as it provided a safer alternative to in-person visits while still ensuring ongoing care.

Despite the benefits, several challenges with telehealth were raised. A major issue for older adults was **difficulty navigating platforms**, which made it harder to engage with healthcare providers.

"The system that we live in now is becoming more computer. So it kind of fans out with our elderly having them, accessibility to understand how that works. So, no one has the patience anymore to sit there and dialect with you. They want you go online, go on your computer. So, my heart now says, how does that affect our older people to make sure that that information and resource that they're being taught that there's a system set up for them to be able to do that."

Participants also shared frustrations about unclear communication from medical offices regarding how to access portals and delays in receiving help. One participant struggled to **access medical records online**, requiring multiple attempts for assistance. Additionally, interpreting medical information online caused stress and confusion, as one participant misinterpreted a lab result, leading to **unnecessary panic**.

"Well, I had the mammogram and all the other testing that you get for your yearly. Well, when it came over my computer, got my trusty phone, I said, oh, wow. I'm in there reading it, I was almost in tears, I thought I was dying. Because I don't know what I seen. It was horrible."

The lack of in-person interaction was another point of contention, with several participants preferring face-to-face consultations for a **more personal experience** and effective symptom assessment. **"Certain specialties and certain problems are more compatible with telemedicine. If it's a cardiology problem, they have got to listen to your heart if there is a problem or there's got to be a visit so an EKG can be done,"** shared one participant, highlighting the limitations of virtual visits for more **hands-on care**. Despite these challenges, there was recognition of the growing importance of telehealth, with many calling for improvements in accessibility, communication, and support to make it more effective for everyone.

TRUSTWORTHINESS

Trust in healthcare providers among older adults varies significantly, with some individuals expressing **strong confidence** in their doctors, hospitals, and specialists, particularly when the **healthcare system is well-established and transparent**.

"Especially when you're ill, you're vulnerable and you need some sense of, I will be okay. They will take care of me. And I've always had it."

However, there are instances where trust is compromised, including skepticism around sharing and privacy of electronic health records, or when treatment recommendations lead to **negative health outcomes**.

Additionally, negative experiences with medical professionals, ranging from doubting quality of care to **poor communication from providers**, can severely affect trust. These experiences often lead to a preference for doctors that are familiar, even if out-of-network, due to past negative experiences. Some participants also voiced frustration over high healthcare costs, particularly for services not covered by insurance, which adds to their **dissatisfaction with the healthcare system**. Expansions of health systems into communities has also raised red flags, with one participant questioning, **"So what I'm going to say is, what is like every health system who goes in community - you have certain ones who target certain geographic areas - what are their responsibility to the community that they are building and that they basically taking over? Like what are they doing as a way how they are helping the community that they keep building in?"** Overall, while many feel confident in their providers, there is an undercurrent of skepticism in the health care system, and the accessibility and affordability of care.

MENTAL HEALTH

Participants highlighted the significant issue of isolation among older adults, particularly those who live alone and **lack access to social activities**.

"Is isolation an issue? Of course. Sure. Most seniors live alone and if they don't have access to outside activities, isolation sets in and then it becomes their norm. It's what they become accustomed to."

Over time, isolation becomes a routine way of life for many, and without regular social connections or support, these individuals can be left vulnerable and **disconnected from essential resources**. Moreover, participants noted that older adults may face communication barriers, such as using outdated technology or having hearing difficulties, making it harder for them to stay connected with others and **seek help when needed**. While some hospitals and police departments have systems in place to check on older adults, many are unaware of or unable to access these services. These proactive efforts, such as volunteer programs and wellness checks, aim to ensure the safety and well-being of older adults, but without broader outreach and education, many individuals remain isolated.

Beyond isolation, participants also emphasized the **stigma** surrounding mental health.

"I think that there's still such a stigma that comes with many mental health issues, even though we've made great strides in trying to accept that overall. But I still think that a lot of people are embarrassed or ashamed to come forward and admit to people that they have these issues."

This stigma can prevent older adults from discussing their mental health needs or accessing necessary care, exacerbating feelings of loneliness and distress. Additionally, the **intersection of mental health and socioeconomic status** presents further challenges.

"There are mental problems. We have so many individuals with mental problems that have nowhere to go. They have nowhere for housing. There are some community housing groups where they stay in. But when [state mental institution] went, they just were distributed wherever, dropped off or whatever."

These sentiments underscore the need for more accessible mental health services, stronger community outreach, and efforts to reduce stigma so that older adults and those with low incomes can receive the care and support they need.

COMMUNITY ASSETS & CHALLENGES

Participants highlighted several community assets that support their well-being. Many residents appreciate the **availability of parks, playgrounds, and walking trails** in their areas, encouraging physical activity.

"I think just having accessibility to green space ties in with being able to shop at local farmer's markets and things like that. That really encourages a healthy lifestyle."

Some noted feelings of safety and a strong sense of community in their neighborhood, with people of all ages, including older adults, participating in walking and running activities. Additionally, local **houses of faith offer programming** that addresses physical, mental, emotional, and financial well-being. The availability of recreational centers was also mentioned as a key asset for both youth and older adults, helping to keep people active and connected to the community.

Many participants raised concerns about **traffic safety**, pedestrian accessibility, and transportation infrastructure. Near-miss incidents and hit-and-run accidents highlight the need for improved crosswalk visibility, clearer pedestrian signals, and additional signage. Participants raised frustration about specific locations throughout their communities, one saying, **"That's a great danger."** Some crosswalks are poorly designed, with obstructions or flooding that force pedestrians into unsafe situations. **Pedestrian safety** is especially critical for older adults and individuals with disabilities, as some signals lack auditory cues, and certain streets need better signage to alert drivers.

Beyond transportation, there are concerns about **access to public services, social support, and healthcare**. Overflowing trash bins, inadequate infrastructure maintenance, and accessibility barriers make it difficult for individuals with mobility challenges to navigate their surroundings. **Food insecurity** is another pressing issue, with disparities in access to fresh, nutritious food affecting lower-income residents. **"The amount of unhealthy food centers that are of course in certain communities. It's predominantly in certain ethnic areas, lower income areas. The type of food services that are provided in those areas are accessible, easy and it's the poorest food for people to eat. We need more fresh foods, more accessibility so people can get to the market, those same places where there's a fried food place or whatever, we need some healthy areas for people to eat."** Social isolation, particularly among older adults, is also a concern, as some lack transportation or awareness of local programs that could provide assistance.

COVID-19

Participants expressed concerns about the resurgence of COVID-19 and the emergence of new variants in Pennsylvania. Some participants were worried about the lack of vaccines and expressed frustration with neighbors who refuse vaccinations, highlighting the risks this poses to vulnerable individuals like older adult family members. Several noted that COVID-19 **exacerbated underlying health conditions**, with some reporting new respiratory issues attributed to long-COVID. Others shared concerns about inconsistent mask-wearing in healthcare settings, advocating for clear guidelines to protect high-risk individuals. Despite these concerns, some participants continued to take precautions, such as wearing masks in public and utilizing social distancing options such as curbside pickup at grocery stores to avoid crowded spaces.

"If I go into any large area like that where there's a lot of people, I'm wearing a mask. I carry a mask all the time. Usually there's one in my pocket."

Telemedicine was seen as a helpful tool, especially during the pandemic, for minimizing exposure to high-risk groups. While some participants expressed reluctance to receive further boosters, others were hopeful for new vaccines to address the latest strains.

Suggested Actions and Solutions

Older adults have proposed several solutions to address health issues, emphasizing the importance of accessible and comprehensive care. Many suggested that health care should be **fully covered** for older adults, as well as prescription medications. Increased awareness about available health benefits, such as the annual check-up under Medicare, was also highlighted as essential. Some participants advocated for more widespread **use of community resources**, such as Meals on Wheels and senior center programs, which proved invaluable during the pandemic.

There was also a strong desire for **better communication and education** about available resources. For example, using **printed newsletters** to inform residents about community health resources could reach those without internet access.

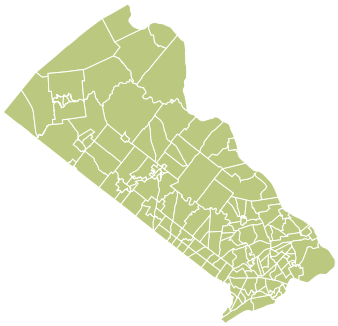
"With our township, they have a newsletter. I get it electronically. I went to the website and signed up for it, but if every resident or household received a paper copy and it contains some community resource phone numbers, that could be a way of reaching people who don't have computers and do read their mail. And I think that some of the health resources, community health resources and ways to reach these agencies or whatever could all be put somewhere in these monthly newsletters."

Participants also suggested **improving access to preventative care and healthy lifestyle education**, with an emphasis on nutrition and exercise. Addressing inefficiencies in emergency rooms, such as long wait times and unclear admission decisions, was another area of concern. Overall, participants emphasized the need for more consistency in healthcare policies, better outreach to older adults, and continued support for health and wellness initiatives.

Next, we examine insights from in-person community meetings held across various counties, where participants of all ages shared their perspectives on the challenges older adults face in accessing healthcare and resources for aging in place.

County-Specific Perspectives

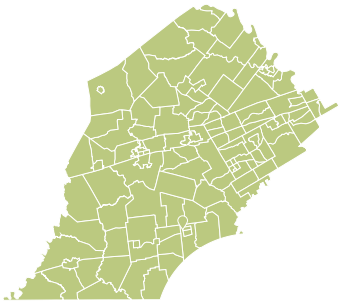
BUCKS



Community members highlighted several key challenges that older adults face, particularly in mobility, financial stability, cultural expectations, and access to care. Transportation emerged as a significant concern, with many older adults losing their ability to drive and relying on limited public transit options or assistance from churches and community organizations. Financial insecurity was another prominent theme, especially among immigrant populations, where individuals who had spent their working years supporting families abroad found themselves with little to no savings and were forced to continue working well past retirement age. Some interviewees noted stark differences in approaches to elder care, comparing systems where older adults often live independently or in nursing homes with those where family members provide care within multi-generational households.

Other barriers included language and technological limitations, which made it difficult for some older adults to access health services, understand medical information, or utilize available resources. Concerns about the quality of care in nursing homes and the financial burdens associated with long-term care were also raised, with some participants describing predatory practices and loss of assets upon entering such facilities. Despite these challenges, community members also pointed to existing support systems, such as senior day programs and local organizations that provide transportation and assistance. However, many stressed the need for better outreach, communication, and culturally competent services to ensure older adults are aware of and can access these resources.

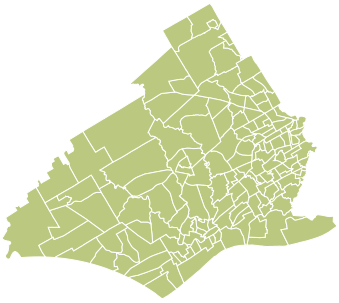
CHESTER



Participants highlighted the significant challenges faced by older adults, especially in terms of isolation, access to healthcare, and community support. The COVID-19 pandemic exacerbated these issues by limiting social interaction and access to essential services. Many older adults struggle with transportation and navigating the fragmented healthcare system, often facing long wait times for specialty care. There is also concern over financial strain, with many older adults unable to afford retirement homes or sufficient in-home care, which adds to their stress. The isolation felt by older adults can also lead to decline of physical and mental health, making it critical to address these needs in a more efficient and accessible way.

Community resources like senior centers and peer support programs are seen as valuable solutions, providing both social interaction and essential services. However, not all older adults take advantage of these resources due to stigma or lack of awareness. Some interviewees suggested creating more opportunities for peer-driven support, such as tech-savvy older adults helping others or teens assisting their peers. Improving the accessibility of services, such as clearer communication about benefits and better transportation options, is essential to support older adults. Overall, fostering a more cohesive community network can help address the complex needs of this population, promoting better health and well-being.

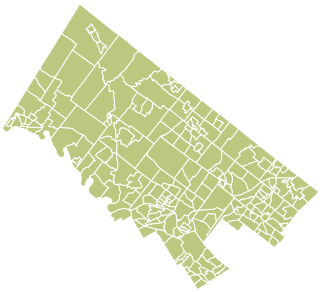
DELAWARE



Participants shared their perspective on resources available for older adults and the challenges they face. Interviewees highlighted the benefits of local services like the YMCA, which has programs that offer free, accessible exercise classes for older adults. However, the costs of gyms and the lack of transportation for some older adults were also concerns. Additionally, some participants emphasized the importance of social interaction for older adults, as it helps combat loneliness. They mentioned community centers offering free classes and the need for more caregiving support, especially for those living alone or with Alzheimer's.

The conversations also touched on the struggles of family caregivers and the challenges of providing home care for elderly parents. Interviewees noted the difficulty of balancing personal needs with caregiving responsibilities, as well as the emotional toll it can take. There was also concern over the lack of support for caregivers and the isolation that many older adults experience. Suggestions included increasing caregiver support groups and community services to help older adults remain engaged and independent. Participants stressed the importance of fostering community connections and providing more accessible resources for both older adults and their caregivers.

MONTGOMERY



Participants highlighted the benefits of senior centers, emphasizing that they provide valuable programs for healthy older adults, such as exercise and line dancing, along with meals served a couple of times a week. Senior centers also collaborate with local senior transportation services, making it easier for people to access the center. They expressed a positive view of senior centers, noting that they offer a supportive environment where older adults can receive care and social interaction. They believe that accepting care can help reduce stress and improve the quality of life for older adults, fostering a sense of community and happiness.

PHILADELPHIA

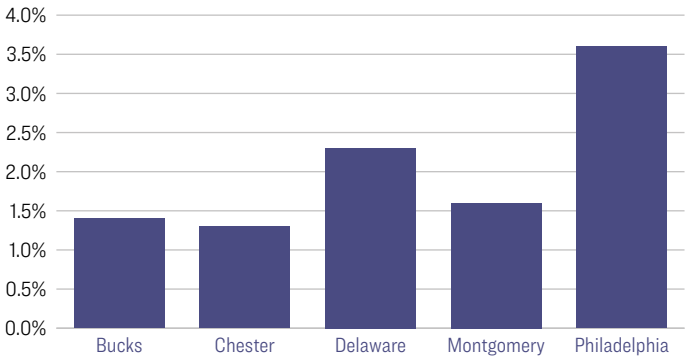
Participants emphasized the significant challenges older adults face in maintaining financial stability, accessing healthcare, and securing nutritious food. Many older adults live on fixed incomes, making it difficult to afford essential services such as housing, medical care, and groceries. The reduction of emergency SNAP benefits has worsened food insecurity, and complex eligibility requirements, confusing renewal processes, and limited mobility create additional barriers to assistance. Healthcare access is a pressing issue, with long wait times for specialty care, high prescription costs, lack of transportation, and fragmented systems making it harder for older adults to receive adequate care. Additionally, there is an unmet need for in-home support due to workforce shortages and affordability concerns.

Social isolation is another major concern, often exacerbated by mobility issues and the lingering effects of the COVID-19 pandemic, leaving many older adults with few social connections. Though community resources like senior centers, peer support programs, and home-delivered meal services are available, many older adults are unaware of these options or hesitant to use them due to stigma. Participants suggested expanding transportation services, simplifying public assistance applications, and increasing awareness of existing resources. Strengthening community-based programs, such as intergenerational support initiatives, was also seen as a promising solution to improve the well-being of older adults and ensure they receive the support they need.

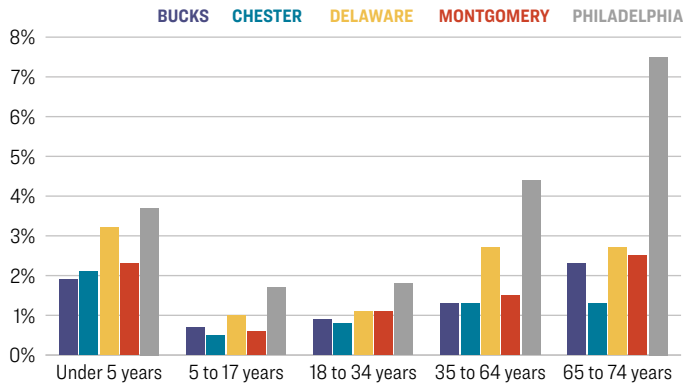
Vision Care

The following discussion explores the needs and opportunities for addressing vision health in Philadelphia, with a focus on Wills Eye Hospital as a specialized facility for treating patients with vision impairments and ocular pathologies. Three focus groups were conducted with individuals receiving preventive and ongoing eye care, representing a diverse range of populations – from middle-class, college-educated professionals to those with low or no income and varying levels of insurance coverage.

Percent of Total Population with Vision Difficulty



Vision Difficulty, by Age



A dedicated section on vision care is new to the 2025 Community Health Needs Assessment (CHNA), reflecting a growing recognition of eye health as a critical component of overall well-being and equity. Quantitative and qualitative data are provided below.

Relevant insights were drawn from broader community and town hall discussions held in Bucks, Delaware, and Philadelphia counties, highlighting concerns specific to older adults, immigrants, and individuals with disabilities. These forums illuminated deep-seated disparities in access to vision care among older adults, immigrants, and people with disabilities, with vision concerns often cited as a top unmet need. Participants highlighted structural gaps in screening, treatment availability, and specialist access, particularly for low-income and uninsured residents. Across the region, individuals face similar themes—delays in care, lack of awareness of existing resources, affordability challenges, and limited culturally competent services. These challenges are intensified for those managing chronic conditions, vision loss, or navigating care as non-English speakers.

Across all groups, participants discussed key issues related to vision health, including access and barriers, impact of cost and insurance on care, provider interactions and trust, knowledge and resources, and potential solutions.

ACCESS & BARRIERS TO VISION CARES

Questions about access and barriers to vision care yielded most responses, with participants sharing their experiences of seeking services in their community and the challenges they encountered.

Many participants experience inconsistent care, long wait times, and systemic barriers when accessing vision services. Some report varying treatment quality depending on the provider, while others express frustration with rushed appointments in government facilities. Free clinics are seen as unreliable, and some patients avoid seeking help until their condition becomes severe.

> **"I go to the same place all the time, and even though I get different clinicians, or whatever it is, you get treated differently each time. It all depends on who it is."**
>
> **"I go to a government facility, and there'd be so many veterans...they just realized brush it through and everything."**
>
> **"I have those glasses, and I can't really see out of them that well, I barely I hardly ever use them. So now I still got to wait another year before I can get glasses again."**
>
> **"I go to the free clinic. A lot of people, when they go to these clinics...they're not getting service or treatment like at other doctor's office or other clinics...and they don't care until something happened to them with a point where they're going blind, or they develop cancer or something like this."**

Long appointment wait times raise concerns about the consequences of delayed care. Additionally, challenges with medical record-sharing between different facilities create inefficiencies, while changes in insurance coverage disrupt continuity of care.

> **"Looking at my son's condition. and then having to wait that long to meet...you don't know what might happen between now and then for a kid of that age. We wish that would have been like immediate, but they said, that's the earliest that they could arrange."**
>
> **"You have to book pretty far out in advance to get appointments, and they are very busy when they're there. But they're pretty good about...moving people through my experience like efficient."**
>
> **"There's not always great communication between like the different parts of hospital. So, the retinal office doesn't like to share the records with the primary eye office, even though they're all part of the same institution... It's just a lot of having to repeat things and ask for things to be faxed overnight."**
>
> **"One issue I had was that my insurance changed last year, and so the doctor that I went to was no longer covered, so then I switched."**

People with disabilities face significant barriers in accessing necessary services, including fitness facilities, vision care, and educational resources. Specialized healthcare and support services are also limited, with long wait times for therapists and difficulty finding Braille instructors.

"I tried three years to bring about a state-of-the-art fitness center for people with disabilities. And I got turned away...I came with my little stuff...the equipment had visual, had sound, braille and on and on. I wanted people with disability to be able to come to a fitness center that didn't look therapeutic."

"I was proud of the lady that just left for even attending and having that visual impaired disability and just caring, just showing up and her needs was met here because everybody was so attentive. So, I definitely want to see more services and things for people with disabilities, all disabilities."

"Access is hard... with my visual impairment, I'm having trouble finding... somebody to teach me braille."

While telehealth has advantages, participants express concerns about the effectiveness of remote diagnostics for conditions requiring direct examination. Accessibility also remains a challenge for individuals with disabilities, as many websites are not designed to accommodate assistive technologies, making it difficult for blind or visually impaired individuals to navigate telehealth platforms independently.

"Yeah, they are like, show me your eye. Do you see it? No, I'm in your chest, it's okay. Put the camera in your ear, let me examine you. How are you gonna do that?"

"It has its advantages...I've done the teleconferencing with the doctor and everything, but I feel better if I'm one on one with the physician...so, that way when it comes time for them to examine if they want for my lungs, eye and everything, you can't do it tele [health]."

"I have an older friend who is blind, and so, in addition to not being exactly tech-savvy, the way that websites are designed is not always the most accessible...I found in helping her that so many websites are just not built in a way that is conducive to software's, which are extraordinarily helpful for people with different disabilities."

EXPERIENCE WITH MANAGING VISION HEALTH

The initial conversation focused on personal experiences with vision issues, how individuals manage their conditions, and the support or challenges they encounter. Participants shared frustrations with healthcare coverage, difficulty accessing necessary treatments, and concerns about long-term vision health.

Some participants seek clarity on vision insurance coverage as they struggle to maintain prescription glasses, while others are curious about potential treatments for severe dry eyes.

"...at the time I got my glasses I had medical coverage, now and I don't. And my glasses chipped, and they told me that I would have to bring in another pair of paper for it to be included under insurance."

"There's only one eye I can partially see a little bit out of my right eye...it's been since I was a young young girl, so, but I've never been able to do anything about it."

"...I have bad dry eyes, and I want to try that transplant that you can get. And you don't have to worry about wearing glasses anymore."

Significant vision challenges, including fluctuating eyesight, sometimes leave participants unable to perform daily activities safely. Some worry that medical treatments could worsen their condition rather than improve it, while others express concerns as newly relocated parents navigating care.

"...with me some days I can get up, and everything is blur, and I can't see nothing, so I just lay in a bed all day, and then other days, if I'm in the house, I don't want to be using any knives or anything like that to that nature, because if my eyes are blurry I end up cutting myself, and I end up in the ER and I ain't trying to be there either."

"...I have no sight in my left eye and some vision in the right...when the weather changes and the time fall back it's dark so I really can't see."

"...you have people sitting in the emergency room with two eyes. They said I came in with one eye and then now my other eye is bothering. So, what it is, is they're treating symptoms, making them worse, and then curing them back so you can't really get where you need to be to get better. So, I'm afraid of that."

"But then lately it appears my 1st born could have a vision issue...I'm new in the in the neighborhood."

More participants share their experiences with prolonged vision issues, including macular degeneration, high myopia, and retinal concerns, requiring routine checkups, treatments, and specialist visits. Some follow long-term treatment plans to prevent further vision deterioration, while others undergo annual monitoring due to family histories of eye conditions.

"About 14 years ago I was diagnosed with macular degeneration which was stable, and I was referred to...my retina specialist, and I've been seeing him now for the last 14 years. Otherwise...seeing the ophthalmologist every couple of years."

"I see a retinal specialist...mostly just yearly monitoring retinal, primary sort of eye doctor and keeping watch for things that, like I have a family history of like cataracts and macular degeneration."

"I need annual vision care. I'm nearsighted...I get checked every year for general eye health and then check and make sure that my retina is okay, because my eyeball is long."

IMPACT OF COST AND INSURANCE

Financial burdens, insurance limitations, and systemic challenges tied to economic and community factors significantly restrict participants' ability to obtain necessary vision care.

Partial insurance coverage makes it difficult to purchase and maintain consistent prescription glasses. High cost is an even bigger concern for those without medical insurance.

> ""And right now I do have insurance, but...it only pays for a certain amount, and then you have to come up with the rest of the money."
>
> "...with all the stuff that I need for my glasses it's gonna cost run me like $500, and I didn't got no job, and I sure ain't got no money to pay for. And that's why I don't get them."
>
> "My vision fluctuates and it's hard for me to stay with one pair of glasses...now that I don't have no medical, the other doctor wants to charge $150 just for the prescription."

Many feel that vision centers prioritize payment over patient needs, while free clinics do not offer vision services, making it difficult to access eye exams and prescriptions.

> "Sometimes when I go, I get this experts look at me. Then somebody else looks at me, and then somebody else...they're like, okay, we're only paying for this amount of money so this is what you get..."
>
> "...they don't have free eye service at the free clinic, either. They have everything else, but they don't have that."
>
> "Some of them don't even take your insurance, so you can't go close to your home, which would be much better."
>
> "Or if you don't have a good insurance, they're not going to take you."
>
> "I shouldn't pay to have my eyes examined because I have a pre-existing condition which I've had since I was 7 years old."

Systemic factors such as location, race, immigration status, socio-economic background, and age shape access to vision care. Financial and racial dynamics are perceived to influence service availability. Immigrants often forgo treatment due to cost or legal concerns. Many delay care, hoping Medicare will cover costs, while older adults report gaps in coverage for essential services.

> "Is it...something to do with, my opinion, race, and the community? You know whether you live high up on a hill, or you live low on a hill, it has that plays a part of it..."
>
> "Well, it depends on the socio-economic status, because I met a lot of people that are coming with sickness from our countries to work here. For example, one guy hit his leg crossing the border. He had an accident, he couldn't see by one eye, but he was like, I just need to make money, don't take me to the hospital. And I'm like, you cannot work like that."
>
> "I have an issue with my eyes. But I know for my glasses. It's like $500 top. And maybe once I turn 65, the insurance will pay for it, but I don't know."
>
> "Senior citizens don't have dental. Or vision or hearing..."

VISION CARE INTERACTIONS

Trust in medical providers is a consistent theme across many conversations detailed in this report. To assess its impact on patients' willingness to follow recommendations, participants were asked whether they trust the information from their vision care providers and feel involved in their care decisions.

Clear communication about treatment, costs, and insurance is key to having trust in medical professionals. While most participants trust their doctors, financial constraints limit their options, and some feel taken advantage of due to their income. There is a wider appreciation for doctors who are transparent and informative, particularly those who take time to explain conditions and treatments. However, long waiting times, unexpected charges, and perceived unequal treatment cause frustration. Despite challenges, participants generally feel comfortable with their care and value having knowledgeable specialists.

> **"I trust him because he is saying similar to what the other doctors were saying before I got the insurance I have now. But it's still a situation where if you can't afford it, you just can't afford it."**
>
> **"I don't believe that he's doing things just for the money. He'll tell you the truth... but like I say, it's too much money for me to be able to afford."**
>
> **"I don't really know these doctors...because I get a different one every time...but as far as deciding my care yes, I do decide how I want to be, how I want to the session to go like..."**
>
> **"They give me all kinds of information...and I felt like I was sort of part of the team..."**
>
> **"I just started with this new office, and they gained my trust really quickly, because the way they treated me and answered all my questions..."**
>
> **"...they billed me one time for something that I did that I thought was like I said that extra care thing...I didn't pay it because they didn't tell me they were going to bill me for it."**
>
> **"I have to go get my eyes checked because I'm a diabetic... But I don't wanna go...at 8 and get out at 12 because I don't know what this doctor is doing...if you have no income, they assume that you don't have anything to do."**

KNOWLEDGE OF VISION HEALTH

To assess the general understanding of eye health, participants were asked about the importance of regular eye exams, their contribution to overall health, awareness of common eye conditions (such as glaucoma, diabetic retinopathy, age-related macular degeneration, and cataracts), and their ability to prevent or manage these issues.

Several participants emphasized the importance of eye exams, particularly for those with serious eye or vision problems. Generally, participants are aware of conditions like glaucoma, cataracts, and macular degeneration, and feel comfortable with their understanding of eye conditions and the information provided during regular screenings and exams.

"I would say, if you have a serious eye problem or you have a serious sight problem, you should go to the doctor at least once or twice."

"I think, it's important to get eye exams because your eyes, your vision does change."

"So, I do know what glaucoma is...I don't have cataracts, because every time I go, what they say to me is that you know you're this close to like maybe a cataract. But I'm not there yet."

"I also feel comfortable kind of my understanding of those issues we do regularly talk about."

"Yeah, I feel confident in understanding eye conditions. Doctor tells me what potentially could happen and how it could get treated and all that."

There's an acknowledgment that aging, environmental factors like air pollution, and lifestyle habits like smoking can affect eyesight.

"Yeah, okay. I know there are two, first the age related, which is almost obvious..."

"I do believe that the older you get different things happen to your eyesight and the environment and the air pollution. And all these drugs, people are smoking. It is killing everybody, and they don't realize it."

While there's comfort in the information provided by doctors, several participants express uncertainty about preventing eye conditions, recognizing that only doctors can provide guidance. Some question if treatments are more profit-driven than focused on curing conditions.

"The other part of that question is, do you feel you have the knowledge to prevent or deal with those issues...how would we know that like we're not doctors...that's why we go to the eye doctor to find those things out."

"...I'm afraid of those ones. I don't know much how to avoid those first two [diseases]..."

"I don't think I have the power to prevent anything, because it's all based on the doctors and what they prescribe, unless I find a natural cure. Because it seemed like it's more money and not curing people than it is curing people."

SUPPORT AND RESOURCES FOR VISION HEALTH

Many community members are unaware of available free vision care resources. Participants suggest better outreach through flyers, emails, and doctor's offices. Some feel resources are selectively shared, making word-of-mouth crucial. However, past disappointments make community engagement difficult.

"Nothing I know of around the neighborhood yet."

"I've never used any community resources and haven't heard about too much. I think I might have seen a study, or a program advertised in an office once..."

"...if there are free services, then people in the community should be getting some kind of correspondence, saying that it's free, so people can know."

"They can hand out flyers. And they can email you when they have these resources."

"...that information should be in your doctor's office as well."

"...they rarely share certain things with certain people, because they want certain people to benefit from it, and not everybody."

"...a lot of times people in the community been burnt so many times. They don't come out."

Accessibility challenges, including restroom shortages and lack of braille instruction, also deter participation. While some do not need community programs due to good insurance, others stress the need for structured programs and hands-on assistive device training.

"...when I go out farther in the suburbs for help, there is more help like they have Porta potties when they do inner city...there's no way to go to the bathroom. So, a lot of times when they had these things for senior citizens, elderly, and other people they don't attend..."

"I need someone to teach me braille and it's urgent for me. I cannot find that resource anywhere...the library, I get free stuff from them...and I'm feeling on it and all I can read is bumpety bump bump because I don't know what I'm doing."

"...I think they're important...I haven't had to use them...with the privilege I have of having such good insurance."

"...when you use those [assistive] devices, you still need something to feel like, okay, this button here and that button there..."

IMPACT OF VISION CARE ON DAILY LIFE

Vision issues cause anxiety, uncertainty, and fear for parents and older adults, as it relates to children and adults with mobility issues. Specialized resources, such as high-powered magnifiers, prove to be invaluable for tasks like reading, while regular vision care and updated prescriptions remain essential for maintaining independence and quality of life.

> **"...I'm now in a situation like, what's the problem with my son's vision, or I as I'm waiting anticipating, is it that he can't see me as I look like? Maybe he can't explain that this is the way things look like. Maybe he has always seen things like that, and thinking that's the correct way they appear...I keep asking, can you see what I'm seeing like? Can you read there...can you see the color?"**

> **"I'm always afraid of falling. I have mobility issues and visual impairment. So, the pavement, our communities need to be very aware of holes and what do you call them, potholes and the sidewalk cracked and things like that."**

> **"...when my retina specialist referred me to this low vision place in Media, [I] ended up with a extremely high-powered magnifying glass, which I have found extremely useful and obviously reading is an issue for me."**

> **"It's...necessary for me to wear glasses to do pretty much anything. So, you know, definitely been important for me to have regular vision care and get updated prescriptions."**

AWARENESS AND UNDERSTANDING OF TREATMENT OPTIONS

Clear and comprehensive information is essential for individuals managing vision conditions. While some participants report receiving clear explanations and ongoing care, others experience uncertainty due to a lack of available treatment options or unclear next steps.

> **"Meanwhile the only source is what the doctors will say, otherwise I don't have another option..."**
>
> **"...throughout the years that I was being treated before the vision started to deteriorate. I was very reassured...they would explain everything that was going on, and then, once my vision started to slow down...they were very helpful in explaining what was going on, and how at that point there was no treatment..."**
>
> **"I feel like. I also definitely had time. good explanations of treatment options, for it was nice."**
>
> **"Yeah, I understand my treatment options well because I don't think they're that complicated. But they are explained to me well, also."**

ACCESS TO SPECIALIZED VISION CARE

Participants share mixed experiences with accessing specialized vision care. While communication and navigation are generally easy, challenges include the lack of a patient portal and difficulty scheduling appointments due to provider availability.

> **"It's very easy to talk to people...my only complaint about them is they don't have a portal, but they do have a very active phone number."**
>
> **"The ophthalmologist I see...he's gotten so busy he's it's hard to make an appointment."**
>
> **"I've had no problems at all... I have nothing but praise for my ability to navigate the system with them."**
>
> **"I really haven't had issues with my ability to access the specialized [care]."**

Suggested Actions and Solutions

Access to quality eye care is essential for overall well-being, yet many individuals face barriers to vision health services. Raising public awareness about eye health, improving accessibility to care, and ensuring support for visually impaired individuals can help address some of these challenges. By utilizing media and public outreach, reinstating school vision screenings, enhancing pedestrian safety, and advocating for healthcare reforms, hospitals can work with communities toward better eye health for all.

Educate the public about eye health through newspapers, radio, television, social media, and mobile clinics targeting places where people gather. Make public service announcements to raise awareness about specific eye conditions and the importance of regular eye exams.

- "Street corners where people gather crowds just make some noise about the eye issues and stuff. I mean it would be more direct to people, and getting close to where people stay..."
- "...you know those are things that you don't necessarily are going to know you have until you've been diagnosed. So, I don't know if they could do more public service announcements on that."

Improve access to vision care by minimizing wait times and better continuity of care. Expand vision tests in schools to make eye care more accessible for children.

- "...try to maintain decent access and not have super long wait lists to get in."
- "...I remember being a child, having my eyes checked by the school nurse...there's some merit to that, because it's hard to take time off sometimes, and your children has to come first of course, but life gets in the way sometimes."

Collaborate with relevant agencies to enhance safety and accessibility for visually impaired, disabled, and older adults, fostering confidence and social engagement.

- "On the crosswalk business, they say it pauses and then it goes, you see a person walking, but there's no verbal cue for any older person [or visually impaired] and it's very difficult."
- "And the other thing is better lighting at night because I'm visually impaired due to glaucoma..."
- "If they make things a little comfortable for the senior or disabled person's environment and community, they can feel a lot more confident in going out and socialize. I love to socialize and... if they just make it comfortable so we can be confident, I think we'll be out more."

Advocate for healthcare reform to improve consistent access preventing disruptions due to insurance changes.

- "...healthcare reform or access to universal healthcare because I had to switch doctors due to health insurance changing, and I would have stayed with the same doctor that I was with if I didn't have to."

Access to comprehensive vision care is not just a matter of convenience, it is a matter of public health, equity, and dignity. The findings across Southeastern Pennsylvania, especially in the voices of those managing vision impairment alongside socioeconomic hardship, reflect a deeply fragmented system in which cost, insurance status, provider availability, and physical accessibility routinely disrupt care. Participants' stories reveal how the consequences of these systemic issues ripple through daily life, affecting everything from independence and employment to emotional well-being and trust in healthcare institutions.

Addressing these disparities requires a multi-layered approach. Solutions must go beyond service provision to include systemic reforms: better insurance coverage for vision services, increased funding for community-based resources, renewed investment in early detection through school and public health screenings, and consistent outreach that makes care visible and welcoming, especially to communities historically excluded from quality eye care. Vision health, as described by participants, is integral to quality of life and long-term health outcomes.

Youth Voice

The 2025 Regional Community Health Needs Assessment (rCHNA) takes a youth-centered approach to better understand the health needs of young people ages 11 to 26 across Southeastern Pennsylvania. Youth are the experts of their own experiences, and their voices offer important insight into what's working, and what's not in their communities. This report shares their stories, concerns, and ideas to help hospitals, health systems, and community partners create programs that truly meet their needs.

Between August and October 2024, the Health Care Improvement Foundation (HCIF), along with the rCHNA Youth Voice Sub-Committee and local organizations, hosted 15 focus group discussions with 154 youth across five counties: Bucks, Chester, Delaware, Montgomery, and Philadelphia. Led by Dr. Briana Bronstein from Widener University, these conversations gave youth a safe space to reflect on their health, surroundings, and future. A separate community survey also gathered adult perspectives on youth issues.

Youth spoke about the strengths in their communities, like supportive relationships and access to parks and schools. They also shared serious concerns, such as, bullying, gun violence, mental health challenges, and lack of access to food, safe transportation, and equal education. Youth also shared solutions: more mental health support, safer neighborhoods, better schools, and programs that prepare them for success.

This report highlights the priorities, challenges, and ideas youth shared. By centering their voices, it offers a roadmap for building healthier, safer, and more supportive communities.

Methods

The 2025 Regional Community Health Needs Assessment (rCHNA) used a youth-centered approach to gather input from young people ages 11 to 26. The goal was to understand what youth see as the biggest health needs and challenges in their communities.

To do this, the Health Care Improvement Foundation (HCIF), with guidance from the rCHNA Youth Voice Sub-Committee, worked closely with trusted community organizations that serve youth. A total of 154 youth were engaged in this process across five counties in Southeastern Pennsylvania:

- Bucks County: 6 youth
- Chester County: 9 youth
- Delaware County: 10 youth
- Montgomery County: 12 youth
- Philadelphia County: 113 youth

Youth were invited to take part in 15 focus group-style discussions, held both in person and online between August and October 2024. These sessions were led by Dr. Briana Bronstein, Ph.D., from Widener University. Dr. Bronstein is an expert in special education and community-based learning. Each session lasted about 60 minutes, and youth received gift cards for participating. Each community organization that hosted a session also received a donation.

The following community-based organizations helped engage youth and hosted discussion sessions:

- Abington Township Public Library
- Awbury Arboretum
- Congregation Temple Beth 'El
- Esperanza College
- Garage Youth Center
- Greener Partners
- Middletown Free Library
- Netter Center
- Northeast Family YMCA
- Philadelphia Chinatown Development Corporation

Major health systems also supported this effort, including:

- Children's Hospital of Philadelphia (CHOP)
- Doylestown Health
- Jefferson Health
- Main Line Health
- Penn Medicine
- St. Christopher's Hospital for Children

Each session followed a discussion guide developed by the rCHNA Steering Committee. The guide included nine key questions to help youth share their thoughts on community strengths, health concerns, and possible solutions. Dr. Bronstein was supported by note takers, and sessions were recorded to ensure that youth voices were accurately captured.

After the discussions, a thematic analysis was used to look for common ideas and patterns across counties. Special populations were also considered to make sure all voices were included.

In addition to youth focus groups, a general community survey was shared with adults to gather their perspectives on youth health needs. The survey was available in English and seven other languages and was supported by local hospitals and community organizations.

All of this information helped identify the top health priorities in the region. These findings will guide how hospitals and health systems develop plans to address the most important needs, both on their own and in partnership with others.

MENTAL HEALTH

Across all focus group sessions, youth clearly stated that mental health is the most important health issue affecting their lives and communities. Their stories and insights revealed several key mental health challenges:

DEPRESSION, ANXIETY, AND SUICIDE

Many youth shared personal experiences with **depression, anxiety**, and even **suicidal thoughts**. They said that these struggles are often ignored or misunderstood, especially by older generations, teachers, and school staff. Some youth felt like they had no one to turn to and were afraid to ask for help due to **stigma** or fear of being judged.

Youth said more resources like coping skills groups, peer support, and open conversations about mental health would help them feel less alone.

> **ON DEPRESSION, ANXIETY, AND SUICIDE**
>
> **"I feel like depression, because at the same time, most kids, they don't know what depression is. I went through depression, where I was staying in bed, I didn't eat, and I didn't know what was happening until after I got out of it. I thought I was the only person going through what I was going through."**

BULLYING, HARASSMENT, AND ONLINE HARM

Youth across the region shared that bullying, both in person and online, is a major concern in their lives. Many talked about being picked on for how they look, what they wear, or simply for being different. Cyberbullying, in particular, was seen as especially harmful because it can follow students outside of school and into their homes.

Young people reported experiencing body shaming, online harassment, and having personal or inappropriate images shared without their consent. Some young people also said they faced racial discrimination and felt unsupported when they reported these incidents to school leaders. Many described situations where teachers or administrators failed to take action, which made them feel unheard and unsafe.

These experiences were closely tied to youths' mental health. Youth expressed how bullying lowers self-esteem, increases anxiety and depression, and makes school a stressful environment. They also said schools and communities don't always offer enough support or resources to help students cope.

According to the general population survey, **bullying was the most commonly reported mental health-related issue for youth (51.8%)** in the region.

Overall, youth called for stronger accountability, more supportive adults, and better systems in schools to prevent bullying and protect youths' well-being.

ON BULLYING, HARASSMENT, AND ONLINE HARM

"Kids talking to strangers online, or even just like bullying."

"And another thing about harassment, people will do the craziest things to other people and not care about it at all. Especially guys in my school, they're very immature. And they will disrespect people, like other ladies and just think it's okay."

"I think what we want to change in our community is just the amount of people just bullying. Some people do bullying [to] someone for no reason."

COMMUNITY VIOLENCE AND SAFETY

Many youth shared deep concerns about gun violence and safety in their neighborhoods. They talked about feeling unsafe doing everyday things like walking to school, going to the park, or even heading to work. Youth described how the constant threat of violence, especially from guns and gang-related activity, affects both their mental and physical health.

Some youth said they avoid going outside because they're afraid of being caught in a shooting. Others said gun violence has made places like parks and playgrounds unusable, especially for younger kids. A few mentioned that their communities used to feel safe, but violence has increased, and now even quiet neighborhoods are seeing things like drive-by shootings.

Youth expressed that safety and mental health are connected. The fear of violence adds to daily stress, and many feel like adults and systems meant to protect them aren't doing enough. They called for more support, including gun safety education, a stronger presence of trusted adults, and programs to prevent violence before it happens.

ON COMMUNITY VIOLENCE AND SAFETY

"I live in Philadelphia, and it's like parks on every corner. But because of gun violence, kids aren't able to play and do what they wanna do because it's unsafe."

"I've heard so much talk and we keep seeing this on the media about how people are really just worried about school shootings, and parents are scared to send their own kids to school. And kids are scared to be in school, because they're worried that someone will break in and kill them."

"And there's also, you know, the about the gun violence that I can't go more than a month without hearing something that I can't tell was that a fire truck or a gunshot? I'm just gonna choose the ladder, and I'm terrified to get out of my, I never wanna leave my house after sundown. I don't care what reason, if the sun is down, I'm not leaving by myself and there has to be at least two more people with me."

SUBSTANCE USE AND ADDICTION

Young people shared serious concerns about substance use in their communities, especially in schools. They talked about vaping, smoking, underage drinking, and drug use being common and often starting at a young age. Many said these behaviors are used to deal with stress, mental health struggles, or problems at home when other support isn't available. Some youth also said that drugs and alcohol are too easy to access and are becoming too normalized among their peers.

They shared that peer pressure plays a big role. Some feel left out or judged if they don't participate in smoking or drinking. Others mentioned that being surrounded by substance use, especially in social settings or even in their own families, makes it harder to avoid.

Youth believe more needs to be done to educate people about the real harm of addiction. They suggested hearing stories from people who have struggled with addiction might make a bigger impact than just hearing "don't do drugs."

ON SUBSTANCE USE AND ADDICTION

"Alcohol, smoking, the fentanyl issue in Kensington, depression for kids my age."

"Like sometimes people ask for money and they don't ask for food but, and a lot of people stay addicted to the drugs and then end up overdosing."

"I've seen a few people die through the drugs."

"I feel like a lot of vapes are targeted towards young children, because when you think about it, it's like banana, bubble gum, like, all these Fruity Pebbles. I've seen people smoke Fruit Loops or whatever. And so, I feel like those aren't really flavors targeted towards adults. They're targeted towards children…

"And then, also in the media, they portray vaping as something that cool people do."

EATING DISORDERS AND BODY IMAGE

Many youth shared that social media and unrealistic beauty standards can lead to eating disorders and poor body image. They explained that online trends—like extreme dieting, gym culture, and "pretty privilege", create pressure to look a certain way. This pressure can lead young people to skip meals, count calories, or follow unhealthy diets without realizing they may be developing an eating disorder.

Youth also pointed out that platforms like TikTok often promote harmful weight-loss advice. They noticed that some teens even build their identity around harmful behaviors, including disordered eating, because of how these issues are shown in pop culture.

Some youth shared that stress from school, sports, or family life can also affect both mental and physical health.

They said depression and anxiety often go hand-in-hand with eating disorders, and that many young people are struggling with these challenges quietly.

Overall, youth made it clear that body image and eating disorders are serious mental health concerns, and they want more support, education, and awareness around these issues.

ON SUBSTANCE USE AND ADDICTION

"I feel like the Internet and models and everything has this pretty privilege thing, and it says the same as on how people think they should be and how they should look and put a certain way, and because of that it causes young teenagers today to, oh, well, I have to lose 25 pounds by next week, so I only can eat one meal, or without even noticing that they slowly gain an eating disorder from calorie counting, or all juice diets, which the Internet just only ups and promotes, especially Internet things like TikTok."

These conversations show that youth are deeply affected by mental health struggles and want more support, resources, and safe spaces to be heard. Their voices are a powerful call to action for schools, health systems, and community l eaders to respond with care and urgency.

YOUTH HEALTH ISSUES

Youth across the region also shared their concerns about health problems affecting themselves, their families, and their communities. Their input helped highlight several areas of concern:

CHRONIC DISEASES AND UNHEALTHY LIFESTYLES

Many youth said they see serious health problems like diabetes, heart disease, obesity, and cancer happening often in their families and neighborhoods. They linked these issues to unhealthy eating, limited physical activity, and not having access to healthy food or safe places to exercise. Some youth explained that even when they want to be healthy, it's hard to make good choices when they feel unsafe outside or don't have the right resources.

> **ON CHRONIC DISEASES AND UNHEALTHY LIFESTYLES**
>
> **"My family is plagued with diabetes, obesity, and heart problems. I'm like one of the few in my family where I don't really have to deal with any of those problems, but a lot of my family members have died from it too."**

SEXUAL HEALTH AND EDUCATION

Youth also talked about the lack of quality sex education in schools. They said many students do not get enough information about safe sex, relationships, and emotional well-being. As a result, they noticed high rates of teen pregnancy and sexually transmitted diseases (STDs) in their communities. Youth explained that when these topics are ignored in school, misinformation spreads, and young people don't always know how to protect themselves.

> **ON SEXUAL HEALTH AND EDUCATION**
>
> **"Sex education is kind of neglected nowadays. People say that there's more sexual education in schools, but honestly, the kids are not gonna pay attention, especially when they feel like you don't care."**

MENTAL HEALTH, ABUSE, AND DEVELOPMENTAL CHALLENGES

In addition to the focus group conversations, a general population survey showed that the top three health concerns for youth in the region include mental health (31.3%), abuse or neglect (27.5%), and intellectual or developmental disabilities (22.9%). These issues reflect the need for more mental health support, protection from harm, and better access to services for youth with special needs.

These concerns show that youth are not only aware of the health challenges around them, but they are also eager for better education, safer environments, and more support to lead healthier lives. Their voices provide important direction for programs and policies that aim to improve youth health across the region.

YOUTH HEALTH TRENDS

Youth also discussed health trends, both positive and negative, that are becoming more common in their everyday lives.

GROWING AWARENESS AND ACCEPTANCE OF MENTAL HEALTH

Youth shared that mental health is being talked about more openly than in the past. Many said they've seen a positive shift, more people are going to therapy, speaking up about their struggles, and learning how to take care of their emotional well-being. While some stigma still exists, youth feel that mental health is starting to be taken seriously by their peers, families, and schools.

This trend shows hope for stronger support systems and earlier help for those who are struggling.

ON GROWING AWARENESS AND ACCEPTANCE OF MENTAL HEALTH

"I feel like it's about mental health. In some way, it's good that people are talking more about it. That has become more normalized."

"When other people take mental health more seriously, I feel like more people are inclined to speak up."

"people are getting the help they need earlier on, and finding diagnosis that they need or just helping themselves, because some kids that do know what mental health is and realize something's wrong and slowly helping themselves to fix them."

THE IMPACT OF SOCIAL MEDIA ON HEALTH AND WELL-BEING

Youth also talked a lot about the influence of social media. While they acknowledged that it could help people connect and learn, many also shared concerns about cyberbullying, body image pressure, explicit content, and unrealistic standards that harm mental and emotional health. Some mentioned that too much time online can negatively affect relationships and self-esteem.

Youth said they want more education about healthy social media use and more support when online harm happens.

ON THE IMPACT OF SOCIAL MEDIA ON HEALTH AND WELL-BEING

"Social media is such a big thing with our generation."

"Social media has a big influence on the youth. I don't think a lot of youth realize what you post online never goes away. People have seen it, people aren't going to just forget about it. That can cost you your job, that can cost people's lives, and I think it's just really important for the youth and other people just to be educated on social media etiquette."

"Over usage of technology. Now it's a lot more common for relationships to be online, which can obviously harm somebody's mental health or harm relationships internally."

These trends, the normalization of mental health care and the powerful role of social media, are shaping how youth view their health and the world around them. Listening to their insights can help schools, parents, and communities support youth in more effective and meaningful ways.

CHALLENGES AND BARRIERS

Youth shared many serious challenges and barriers in their communities that impact their daily lives and well-being. Through focus group discussions, several key concerns were identified across the region:

LITTERING AND ENVIRONMENTAL ISSUES

Youth across counties voiced frustration about pollution and trash in public places. Many talked about how hard it is to enjoy parks and community spaces because of litter. They saw this as a sign that their neighborhoods are not being cared for properly and said it affects how safe and proud they feel about where they live.

ON LITTERING AND ENVIRONMENTAL ISSUES

"But I also feel like a barrier, I feel like for the community as a whole would be the litter. It's just so absurd. You can't even go outside into a park without seeing piles of trash. And it's like, if it's your community and you're living in it, and you're living in this neighborhood, why wouldn't you want to take care of it?"

"I'm starting to see a lot more trash in the playgrounds, and that's even like the younger generation just not being disrespectful but not respecting the community they live."

ACCESS TO HEALTHY RESOURCES AND HEALTHCARE

Another common challenge was lack of access to basic resources. Youth said it is often hard to find healthy food, get affordable healthcare, or use reliable transportation. These barriers can make it difficult for families to stay healthy and for young people to get the support they need.

ON ACCESS TO HEALTHY RESOURCES AND HEALTHCARE

"Access to resources. Well, definitely access to health in general."

"Probably, like, the prices in, like, grocery stores where, like, people have, like, less access to income, like, their own income."

These challenges show that while youth feel connected to their communities, they also face daily struggles that impact their health, safety, and quality of life. Their voices help guide future efforts to create safer, cleaner, and more supportive environments for all young people in the region.

ACCESS TO CARE ISSUES

Young people shared several concerns about getting the care and support they need. The top issues they mentioned are explained below.

ACCESS TO MENTAL HEALTH RESOURCES

Mental health was the most common concern among youth. Many said it's hard to get the help they need. They shared that behavioral hospitals often provide poor quality care, and there is still a lot of fear and stigma around asking for help. Some youth don't know where to go or feel uncomfortable talking about their problems. Others said the resources available don't feel anonymous or supportive enough.

ON ACCESS TO MENTAL HEALTH RESOURCES

"I'm not sure about, like, statistics and stuff like that, but usually, access to health care and stuff like that, in the younger generation, they're usually savvy in there. They usually are good about going to the doctors and stuff. I would say, mental health and finding resources for mental health is usually a struggle. Or just having a stigma against utilizing resources for mental health, like therapy or meditation or just talking to someone usually get utilized."

"I was going to say there are a bunch of resources at my school, especially for people who are struggling with mental health. There's always safe to say, which we always have, but a lot of kids have realized, as we continue to use these resources that are anonymous, that they're not really anonymous. And there are consequences to using it, and so people have relied on it less, and it just becomes this backward thing where people don't even want to access this resource, because for sure, there are safeguarding issues and legality of not -- that you can't really remain anonymous like that. But now that just makes people want to use it less."

ACCESS TO HEALTHY FOOD AND NUTRITION

Many youth said healthy food is too expensive or hard to find. They talked about how junk food is everywhere, but fruits and vegetables are harder to get, especially in neighborhoods without good grocery stores.

ON ACCESS TO HEALTHY FOOD AND NUTRITION

"Access to fresh healthy foods."

ACCESS TO CARE ISSUES

ACCESS TO TRANSPORTATION AND SERVICES NEARBY

Young people often struggle to get to the services they need because of long distances or unreliable transportation. Some said buses are unsafe or don't run often enough. If services are far away or hard to reach, many youth go without the help they need.

ON ACCESS TO TRANSPORTATION AND SERVICES NEARBY

"I think having a wider access in transportation would be nice."

"I think public transportation is a problem. Going back to the money thing, a car is expensive, the bus isn't always the safest route to go. And in the North-East the buses are not super easy to -- there's like maybe three buses, there's like 84, the 67, and the 20."

OTHER CONCERNS: EASY ACCESS TO DRUGS AND VAPES

While not a care barrier, many youth said it's too easy to get drugs, alcohol, and vapes. This raises safety and health concerns and shows how access can sometimes work in harmful ways.

ON EASY ACCESS TO DRUGS AND VAPES

"Not really related to what anyone else said, but still related to health, I think that I would change how easily kids our age have access to vapes and such, especially in our high schools and even middle schools kids have such easy access to drugs, to vapes, to all these things that are bad for your health. And it's so normalized, and there I feel like not much is being done in schools."

These issues highlight the importance of improving care systems so that all youth can get the help and support they need, when and where they need it.

GOOD SCHOOLS

Youth shared their ideas for improving their schools and communities. Their feedback focused on the need for more useful education, better mental health support, and community-based solutions to keep youth safe and healthy.

MORE RELEVANT AND PRACTICAL EDUCATION

Many youth said that schools should focus more on real-life skills like financial literacy, health education, and career preparation. They feel that while traditional subjects are important, schools don't always teach them how to manage money, take care of their health, or get ready for the workforce.

ON MORE RELEVANT AND PRACTICAL EDUCATION

"And I think-- oh, sorry. Going off of like in the schools of the life someone skills of like, in this generation, a lot of people order food because they were never taught how to cook, they were never taught how to make things. And so, that inevitably you're spending a lot of money and stuff, and. And I think too with the college, -- my school did an okay job, but I feel like they could have done a lot better of, like, okay, you kind of have an idea of where you want to go for school, I mean, not everybody does, and that's okay, but will this job, will you be able to pay back your schooling? Will you be able to pay back those loans with the job that you want to get in the future and stuff like that? And it's like, they don't teach you those life skills of how to think about that stuff or how to get there, how to find those scholarships, how to outreach. They'll send you a link, but then it's like, are you able to answer these questions or this essay, was education enough to teach you how to do all of that stuff on your own and things like that?"

BETTER MENTAL HEALTH AND SOCIAL SUPPORT

Youth also talked about the need for stronger mental health support in schools. While some schools have counselors, many students said they don't feel comfortable using these services or worry about privacy. They want more safe spaces, group support options, and counselors who feel approachable and trustworthy.

ON BETTER MENTAL HEALTH AND SOCIAL SUPPORT

"Also having counselors at school that you can go to at any time. Because know at my old school there wasn't a counselor there."

"I was going to say there are a bunch of resources at my school, especially for people who are struggling with mental health. But a lot of kids have realized they're not really anonymous, and now people don't even want to access t his resource."

These insights show that youth are thinking seriously about their futures and their communities. They want schools and neighborhoods that help them grow, support their mental health, and give them the tools they need to succeed in life.

ACTIVITIES FOR YOUTH

Youth shared how they stay involved and connected in their communities. Many spoke about activities that help them build friendships, feel supported, and give back.

SPORTS AND EXTRACURRICULAR CLUBS

Youth shared that being part of sports teams, dance groups, and school clubs gives them a strong sense of community. These activities provide a safe space to have fun, make friends, and feel included. Whether it's school sports, church-based activities, or after-school programs, youth said these experiences helped them stay active and build lasting social connections.

ON SPORTS AND EXTRACURRICULAR CLUBS

"Having access to local sports teams and community centers makes it easy to stay active and meet new people."

"I'll definitely say, us, the YMCA. I think a lot of the younger community that live in this area access this facility as much as possible and they use it to their advantage. And I think it creates a better life for them."

"Oh, I consider the dance team my community. I feel like it's a safe space, I feel like we have a great time, easy for us to get along and talk about things, that's where my community is at."

COMMUNITY SERVICE AND VOLUNTEERING

Many youth said that volunteering and giving back to their neighborhoods is a big part of their lives. They enjoy helping others and said it brings people together. Volunteering also gives them a sense of purpose and allows them to support communities that may not have many resources.

ON COMMUNITY SERVICE AND VOLUNTEERING

"For me, it'd be the Philadelphia Suns where we do - where we volunteer, we play sports, get to know each other like we're family."

SOCIAL AND CULTURAL IDENTITY GROUPS

Youth talked about how important it is to be part of cultural and identity-based groups, such as Black Student Unions, Asian cultural clubs, or LGBTQ+ support groups. These spaces help them feel seen, supported, and understood. They also provide education and community around shared experiences and identities.

ON SOCIAL AND CULTURAL IDENTITY GROUPS

"Seeing yourself represented in the community and having an entire safe space in the case that it feels really nice to just be able to see yourself and have a place to go if you really want to."

These activities show how youth connect with their communities through sports, service, and cultural identity. They also highlight the need for more safe, inclusive, and accessible spaces where young people can grow, feel supported, and lead positive changes.

YOUTH LEADERSHIP

Many youth shared how they are taking on leadership roles in their schools, communities, and workplaces. These opportunities help them build confidence, gain experience, and prepare for their futures.

VOLUNTEER AND COMMUNITY SERVICE LEADERSHIP

Youth spoke proudly about their involvement in volunteer programs, community service projects, and youth-led outreach efforts. Whether helping at food drives, caring for animals, or starting their own projects, many youth said these hands-on experiences helped them become more responsible and feel more connected to their communities.

ON VOLUNTEER AND COMMUNITY SERVICE LEADERSHIPS

"For my community and my congregation, specifically the youth, I'm in leadership with that. So being able to take the lead, being a guide and help as best as possible. And also creating opportunities for us to give back to the community."

"I feel like there are a lot of opportunities. I think it's also much easier now that we have online. We have the opportunity to go online and just search up volunteering opportunities, like charities we can attend, just all our resources. But I feel like sometimes it's hard to really get into it because of requirements like you have to be in a wait list for a couple of years or -- okay, not a couple, but a year, or you can only attend if you're 18 or older in that sense."

SCHOOL-BASED LEADERSHIP ROLES AND CLUBS

Many youth said they developed leadership skills through school clubs, student government, and academic programs. These roles gave them the chance to speak up, plan activities, and represent their classmates. Clubs like HOSA (Health Occupations Students of America), GSA (Gender and Sexuality Alliance), and others were mentioned as key places for youth leaders.

ON SCHOOL-BASED LEADERSHIP ROLES AND CLUBS

"We volunteer all the time. We're in almost every after school program."

"At my school. We just recently, like in the last few years, we started a GSA club. Gender and sexuality awareness like, yeah, that."

"But to go on the leadership thingy, the HOSA Club is a really big one. I was vice president for a year for it and my friend was also, my friend actually was the president for a year. There are also other leadership roles within that, not just president, vice president, there's treasurer and other roles such as that. But I think that is a stepping stone for something a lot bigger, because it showed me that there are so many different things, so many different opportunities you could take a hold of, not just in the HOSA club, but also through the trips we would take in, state and international."

CAREER DEVELOPMENT AND EARLY WORK EXPERIENCE

Youth also talked about internships, job training programs, and early college experiences that helped them build real-world skills. Through programs like Counselor-in-Training (CIT) at camps, hospital internships, and college credit courses, youth learned responsibility and leadership in work settings.

ON CAREER DEVELOPMENT AND EARLY WORK EXPERIENCE

"For me, it was leadership roles when I did. I was an intern, and I helped kids out, which is hoping them engage and interact, I think in the summer of 2023. So, that was one of the leadership roles I obtained. There's other places and other programs where I was in the leadership role, but that helped me interact more with different age groups, and things like that."

These youth-led experiences, whether in the community, at school, or through job programs, are helping shape the next generation of leaders. Youth shared how important it is to have opportunities to lead, grow, and give back, and they want more support to continue building those skills.

WHAT'S WORKING WELL

Although youth shared many challenges and barriers in their communities, they also talked about what is working well. In conversations held across five counties, young people shared what they believe are the biggest strengths in their communities. They described what makes their communities feel strong, supportive, and positive.

STRONG SENSE OF COMMUNITY AND SUPPORT

Many youth said that the people in their communities are their greatest strength. They shared how neighbors, friends, and even strangers look out for each other. Support systems like mentors, counselors, and social groups help them feel connected and cared for. Youth also said they feel proud of how their communities come together during tough times.

ON STRONG SENSE OF COMMUNITY AND SUPPORT

"I like to see when people like, random strangers be helping other random strangers. I just love it. It warms my heart."

COMMUNITY EVENTS AND INITIATIVES

Youth spoke highly of local events that bring people together, such as block parties, gardening programs, and community cleanups. These activities give people a chance to work together, meet new friends, and build stronger neighborhoods. They also help youth feel like they belong and can make a positive difference.

ON COMMUNITY EVENTS AND INITIATIVES

"Two months ago, we actually had like this block party where we cleaned up our whole block. And honestly, I would say like that's our biggest strength is the fact that we know how to communicate with each other, when we see a problem, we know how to deal with that."

ACCESS TO RESOURCES AND FACILITIES

Young people shared how important it is to have easy access to things like parks, schools, community centers, mental health support, and public transportation. These resources help youth stay active, healthy, and connected to others. Youth also mentioned how small businesses and local programs help make their communities feel close-knit and supportive.

ON ACCESS TO RESOURCES AND FACILITIES

"The access we have out here, like urgent care, all the stuff around here, we've got stores, we've got markets, we've got we've got restaurants, places. So that way there's still produce and resources that you can go around and you don't have to drive, maybe hour or 30 minutes away. Just so you can go to the grocery store or get food, as long as it's just in the area. That's how I like some areas that have all the resources in just one place and not all spread out."

These insights show how youth value connection, community effort, and access to helpful resources. Their voices highlight the strengths that already exist and can be built upon to support healthier, more united communities.

SUGGESTED ACTIONS AND SOLUTIONS

Youth were asked to share ideas on how to improve their schools and neighborhoods. They offered thoughtful, community-focused solutions to help young people feel safer, healthier, and more supported.

INCREASED MENTAL HEALTH AND SUBSTANCE USE SUPPORT

Youth emphasized the urgent need for better access to mental health care and substance use recovery programs. Instead of punishing youth who are struggling, they suggested workshops, group meetings, and community services that provide support and healing. Many believe that early help can prevent bigger problems later on.

ON INCREASED MENTAL HEALTH AND SUBSTANCE USE SUPPORT

"I also think that the way that we shift our resources is a solution. Instead of the city putting millions of dollars to A, let's put some of that money towards youth mental health and youth education."

"To get help just without being penalized maybe"

ENHANCED PUBLIC SAFETY AND GUN VIOLENCE PREVENTION

Many youth shared that they don't always feel safe in their neighborhoods or schools. To improve safety, they suggested having more trained staff on campus, gun safety education programs, and metal detectors in schools. These ideas came from a desire to prevent violence and protect students from harm.

ON ENHANCED PUBLIC SAFETY AND GUN VIOLENCE PREVENTION

"And I think it should be more safety around, so people could be more safe going outside. I need to see police at every corner, you know. Cause I ain't about to be going to my job, and I think I'm about to get my head blown off seconds later. I don't want to feel like that. I need the police to be more active and aware, everyone are surrounded."

"I'd say maybe a stronger enforcement. Maybe more police or something like that."

"I would say, I wanna introduce more gun safety laws to my community and then, education on how to deal with firearms and stuff like that. But definitely more, making it harder for people to get guns."

BETTER ACCESS TO EDUCATION, COMMUNITY PROGRAMS, AND CAREER READINESS

Youth said they want more opportunities to build real-life skills through education, extracurricular programs, and career training. They highlighted the need for community centers, mentorship programs, and resources for underprivileged youth to help them grow and succeed in life.

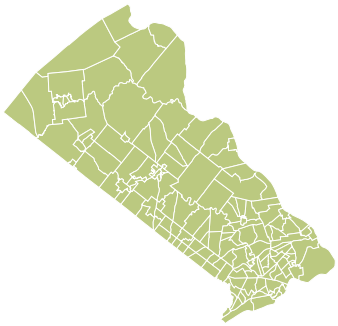
ON BETTER ACCESS TO EDUCATION, COMMUNITY PROGRAMS, AND CAREER READINESS

"And another one was introducing more, like, outreach programs that help young people in inner-cities and stuff like that. Explore job fields and stuff. Like, they get to really see different career paths that they can go into. Something like that."

These youth-led solutions show a strong desire for prevention, education, and support. Youth across the region want to be part of creating safer, more inclusive, and opportunity-filled communities, and they're ready to lead the way.

County-Specific Perspectives

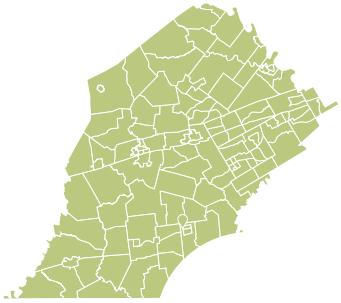
BUCKS



Youth in Bucks County identified two major concerns impacting their health and well-being: substance use and academic and social pressures. Many youth shared that vaping, alcohol, and drug use are common and start as early as middle school. Flavored products were seen as targeting teens, and students felt schools were not doing enough to address the issue. They recommended stronger prevention efforts using real stories and clearer messaging about health risks.

Youth also described feeling overwhelmed by school demands, pressure to succeed, and stress from social media. They called for more mental health support, access to therapy, and programs that help prepare them for life after high school, such as job shadowing and workshops. Despite these challenges, many youth spoke about strong community support, safe neighborhoods, and quality school programs. Their feedback can help shape future programs that better support youth in Bucks County.

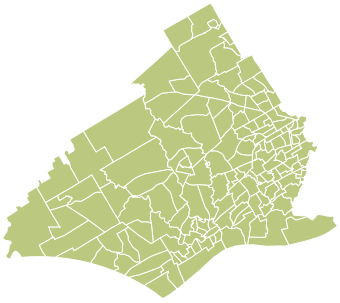
CHESTER



Youth in Chester County identified two key concerns affecting their well-being: mental health and substance use, and the need for stronger community connection and inclusion. Many youth reported high stress, family issues, and peer pressure, leading some to use vaping, alcohol, or drugs as a way to cope. They said they need more trusted adults, better mental health education, and easier access to support services.

Youth also spoke about the importance of feeling accepted and included. Bullying, cyberbullying, and social isolation were common concerns. They want more opportunities to connect through school clubs, volunteering, and community events. Clean, safe spaces and respectful environments were seen as essential to helping youth feel valued and supported.

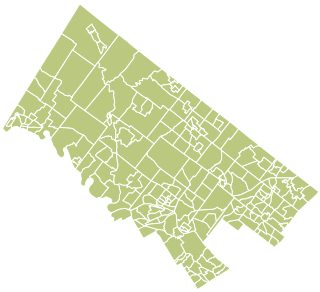
DELAWARE



Youth in Delaware County shared concerns about mental health, school pressure, and inclusion. Many reported feeling overwhelmed and said school counselors and mental health resources often feel unhelpful or hard to access. Youth called for more trusted adults, better mental health education, and services that fe.el real and focused on their needs

Students also described high academic pressure and a lack of understanding from teachers when they struggle. They want more practical classes like financial literacy and more time to rest. While some youth felt supported through clubs and leadership roles, others shared concerns about bullying, peer pressure, and lack of diversity. They asked for safer, more inclusive spaces where all students feel welcomed, respected, and able to lead.

MONTGOMERY



Youth in Montgomery County shared concerns about mental health, school safety, and substance use. Many reported feeling stressed, anxious, or depressed, often without trusted adults to turn to. Bullying, online harassment, and the pressure to support friends added to their struggles. Youth said stigma and a lack of early mental health education make it harder to ask for help

Youth also described feeling unsafe at school due to bullying, threats, and sexual harassment, often worsened by social media. They said schools don't always respond effectively and called for stronger safety measures and accountability. Substance use, especially vaping and marijuana, was another concern, with youth noting increased peer pressure and misleading online messages. They asked for more honest, age-appropriate drug education. Despite these issues, youth recognized the value of supportive clubs and inclusive community programs.

PHILADELPHIA

Youth in Philadelphia County identified mental health, community safety, and limited access to youth opportunities as key concerns impacting their health and well-being. Many youth reported high levels of stress, anxiety, and trauma related to school pressure, bullying, social media, and lack of trusted adults. They also highlighted easy access to vaping, alcohol, and drugs—especially flavored products targeting teens, and called for more youth-friendly mental health services and education.

Safety was another top issue, with youth expressing fear in public spaces due to gun violence and bullying. Many said safety concerns keep them from joining programs or using community resources. Youth also noted a lack of accessible jobs, internships, and support services, particularly for those under 16. They recommended better outreach, use of social media, and stronger community connections to increase access and improve safety and mental health support.

Community Health Needs

All quantitative and qualitative inputs were organized into 12 community health needs that were categorized across three domains:

HEALTH ISSUES

Physical and behavioral health issues significantly impacting the overall health and well-being of the region

- Chronic Disease Prevention and Management
- Healthy Aging
- Substance Use and Related Disorders

ACCESS AND QUALITY OF HEALTHCARE AND HEALTH RESOURCES

Availability, accessibility, and quality of healthcare systems and other resources to address issues that impact health in communities across the region

- Access to Care (Primary and Specialty)
- Culturally and Linguistically Appropriate Services
- Food Access
- Healthcare and Health Resources Navigation (Including Transportation)
- Mental Health Access
- Racism and Discrimination in Health Care
- Trust and Communication

COMMUNITY FACTORS

Social and economic drivers of health as well as environmental and structural factors that influence opportunity and daily life

- Housing
- Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.)

An additional list represents youth specific priorities:

- Substance use and related disorders
- Youth mental health
- Access to Physical Activity
- Lack of Resources/ Knowledge of Resources
- Access to Good Schools
- Activities for Youth
- Bullying
- Gun violence

Participating institutions' ratings of the community health needs were aggregated and are listed below in order of priority: Potential solutions for each of the community health needs, based on all qualitative data collection and evidence interventions, are also included.

PRIORITY

1 Trust and Communication

KEY FINDINGS:

- National surveys indicate declining patient trust in healthcare institutions, often due to provider burnout, high turnover, disparities in treatment, and financial barriers, which disproportionately affect uninsured and minoritized communities. Community conversations reinforced this issue in the region.
- **Challenges in Provider-Patient Communication:** Patients feel rushed during short appointments and unheard by providers, leading to concerns about potential medical errors, particularly with conflicting prescriptions.
- **Emergency Room (ER) Communication Gaps:** ER staff have the most pronounced communication issues, which are closely linked to long wait times and patient frustration.
- **Administrative & Customer Service Concerns:** Poor front-desk interactions, including last-minute appointment cancellations and unprofessional behavior, contribute to negative patient experiences and decreased trust.

POTENTIAL SOLUTIONS:

- Desire for **more empathetic, respectful, and culturally responsive care** and support staff.
- Suggestions included **more social workers** in hospitals and **improved communication** about healthcare changes.
- **Transparent, Timely Communication:** Ensure benefit notices and appointment information are received on time, not after due dates and provide regular updates on healthcare changes and medication protocols.
- **Accountability Mechanisms** for Healthcare and Social Service Staff to provide consequences when institutions or workers drop the ball on paperwork or communication.
- A dream solution expressed by multiple participants was a system where **everyone receives the same quality of care, regardless of insurance status**.
- Implement **team-based care**, including patient navigators, care coordinators, and longer appointments for complex cases.
- Expand and improve **training of healthcare providers in active listening, shared decision-making, and cultural competency** for all healthcare staff.
- Implement **standardized communication tools** and patient status boards to enhance transparency.
- Require **front-desk staff to complete standardized training** in customer service, de-escalation, and empathy-based communication.
- **Expand appointment availability, reduce financial barriers** for uninsured patients, and **improve transparency** in billing and treatment options.

PRIORITY

2 Racism and Discrimination in Health Care

KEY FINDINGS:

- People of color, immigrants, people with disabilities, people with mental illness, people with substance addiction, LGBTQ+ individuals, and other minority groups continue to **experience discrimination and institutional barriers to health care**.
- Insufficient health care staff from diverse and representative backgrounds play a major role in this issue – people do not see themselves reflected in the healthcare workforce; can lead to not "feeling seen."
- **Intersecting identities** lead to exponential impacts on discrimination and racism, and subsequent trauma.
- The **political climate** in the United States contributes to feelings of vulnerability within marginalized communities.

POTENTIAL SOLUTIONS:

- **Cultural Competency and Anti-Bias Training for Providers:** Participants called for healthcare professionals to update their knowledge and attitudes beyond outdated textbooks.
- **Bilingual and Multilingual Staff and Services:** Strong calls for in-person translation services and recruitment of bilingual providers. Languages mentioned: Spanish, Arabic, French, several African languages.
- **More Representation in Healthcare Staffing:** Participants suggested that providers should reflect the communities they serve — racially, culturally, and linguistically.
- **Trauma-Informed, Non-Stigmatizing Behavioral Health Care:** Address the way patients with substance use or mental health needs are often denied full treatment, especially pain management.
- **Systemic Reform for Equity in Access:** Recognize and address structural racism — such as how funding, communication, and service offerings exclude or deprioritize certain communities.
- Expand and improve **training of healthcare providers around anti-racism**, structural racism, implicit bias, and trauma-informed care.
- Increasing number of people of color in healthcare leadership positions.
- Ensure diversity, equity, and inclusion efforts and plans at healthcare institutions include explicit focus on racism and discrimination.
- **Create and fund ongoing forums for community leaders** to work with health system partners to address issues of racism and discrimination in health care.
- Targeted, specialized services to meet culturally specific needs.

PRIORITY

3 Chronic Disease Prevention and Management

KEY FINDINGS:

- **Community gyms and recreation spaces that are well maintained and free/affordable**, were recognized as desirable neighborhood resources, along with safe neighborhoods, and support disease prevention & management.
- **Limited access to healthy food options and limited food education** were noted as some of the greatest barriers to maintaining health and preventing or improving health conditions.
- Some participants shared about knowledge of and experiences with **Long COVID**, while a significant number were unfamiliar with the condition. Millions of adults in the U.S. have been affected by Long COVID. Participants are still generally concerned about acute COVID-19 infection.
- **People with disabilities, who are not all older adults, face barriers to disease prevention and management** due to accessibility issues and require greater advocacy.

POTENTIAL SOLUTIONS:

- Increase **access to local fitness centers** and programs that accept health insurance.
- Promote **community gardens and green spaces for physical activity** and healthy eating.
- Provide consistent access to **nutritional education** for both children and adults.
- Offer more accessible **chronic disease screenings and follow-up care**, especially for older adults.
- Ensure health centers and providers are open during evenings/weekends to improve access.
- **Engage trusted community leader**s to spread key messages (for example, promoting cancer screening).
- Expand successful innovations from the pandemic, such as **virtual and mobile wellness programs**.
- Bring screenings and health education to **faith-based institutions** or where people are.
- Provide screening, referrals, and **"warm hand-offs"** to community-based health and social services.
- Offer support and services to people with Long COVID, providing education on this condition as well.

PRIORITY

4 Access to Care (Primary and Specialty)

KEY FINDINGS:

- Prevailing barriers in accessing care include: **inadequate health insurance coverage** (insurance not accepted, high out-of-pocket costs, no dental coverage), **limited transportation/accessibility of offices/hospitals** (primarily an issue in non-urban settings and amongst older adults), **extended wait times** for appointments (prompting use of ER and urgent care more often), **closures of local hospitals**, and specialists not covered by insurance or not available for appointments/too far.
- In addition to hospital closures, **pharmacy closures** present challenges related to obtaining prescriptions, resulting in increased utilization of prescription deliveries.
- Some pandemic-era changes to access have persisted, including more **pervasive telehealth services, increased interaction with health portals, and virtual health-related programming.**

POTENTIAL SOLUTIONS:

- **Extend clinic hours** to evenings and weekends.
- **Reduce wait times** for appointments, especially for urgent needs.
- **Simplify the referral** and authorization process, which often delays care.
- Provide local **urgent care and dental options**, especially in rural or underserved areas.
- Address **insurance instability** (frequent changes to accepted plans or providers).
- Establish comprehensive health centers addressing physical and mental health, as well as dental care. Provide low-cost or free care options.
- **Expand services** in areas which have experienced closures.
- **Embed social workers** and patient navigators in primary care practices; continue utilization of community health workers (particularly focusing on sharing of community resources and health information)
- Provide **on-site language interpreters** and health education materials in diverse languages.
- Increase racial, ethnic, language diversity of staff and providers to better reflect communities served; offer increased training related to culturally appropriate care.

PRIORITY

5 Healthcare and Health Resources Navigation

KEY FINDINGS:

- Community members' **lack of awareness of resources** is reflective of both community needs and a lack of knowledge.
- The perception of a lack of resources where some might exist is indicative of a need to **improve information dissemination** and methods of accessing that information. Participants frequently felt compelled to share resources and experiences with one another, when needs and complaints arose about health services among the focus group members.
- **Navigating insurance policies**, coverages, web platforms, related resources and healthcare costs prove challenging – especially for older adults who feel less confident with technology use and the transition to Medicare.
- **Mentorship for medical decision-making**, particularly for older adults who live alone, can promote social support, advocacy, and safety.

POTENTIAL SOLUTIONS:

- **Expand non-emergency medical transportation options**, particularly for older adults and rural residents.
- Provide **help navigating insurance plans, applications, and renewals** (e.g., in-person or phone-based support).
- Create **centralized, updated lists of services** and locations (e.g., food vouchers, clinics).
- Provide **tech support** or training for those who struggle with using healthcare portals or telehealth.
- Increase public awareness of **community resource directories** that local health systems have invested in and support community members with using them.
- Increase the capacity of healthcare staff to assist community members with navigation by regular education on available resources.
- Grow the numbers of professionals serving as community resource or **healthcare navigators**.
- Create permanent **social service hubs** that serve as "one-stop-shops" for commonly needed resources.
- Expand low-cost transportation options.

PRIORITY

6 Mental Health Access

KEY FINDINGS:

- Community members shared the quantity and availability of **mental health providers are insufficient to meet ever increasing needs** (particularly post-pandemic).
- Additionally, health **insurance coverage for mental health services and providers is inadequate**.
- **Stigma** around this topic was cited as a barrier – especially in ethnic minority communities.
- The **intersection of mental illness, substance use, and/or homelessness** was recurring concern.
- The general population expressed significant concerns related to **youth mental health** – which is reflected in the youth prioritization.
- **Mental health needs for older adults** focus on grief support and opportunities for community-based social engagement.

POTENTIAL SOLUTIONS:

- Increase the number of **behavioral health providers**, especially in rural areas. Increased behavioral health workforce diversity (e.g., language, racial, and ethnic).
- **Reduce wait times** and eliminate long delays between referrals and services.
- Normalize seeking help by reducing cultural stigma around mental health through community education.
- Offer **telehealth mental health options** for those without transportation.
- Provide **trauma-informed mental health** support tailored to children, youth, and families.
- Improved **care coordination** in integrated care model.
- Co-located prevention and behavioral health services in community settings (**"one stop shop"**).
- Increased training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence.
- Increased individuals with lived experience in the behavioral health workforce.

PRIORITY

7 Substance Use and Related Disorders

Key Findings:

- Community members shared concerns about substance use in their communities, co-occurring mental illness, the potential implications on youth, and the association with poor neighborhood safety.
- **Drug overdose** rates continue to be high due to opioid epidemic.
- **Community-based services** to treat substance use are perceived as **insufficient in number** by some, and/or are not well-known by others.
- **Prevention and education measures** can serve as protective factors against misuse and abuse; questions arose regarding the usefulness and impact of policing related to substance use.

POTENTIAL SOLUTIONS:

- **Expand community-based rehabilitation programs** as alternatives to incarceration.
- Provide **trauma-informed care** and education during health visits, especially for youth.
- Increase provider training to **eliminate bias toward individuals with histories of substance use**.
- Offer drug education at the provider level (not just in schools) with resources for both youth and families.
- **Reduce stigma** through culturally competent and empathetic behavioral health care.
- Sustain and expand prevention programs, ranging from school-based educational programs to community **drug take-back programs**.
- Expand **Narcan training and distribution**.
- Increase **medical outreach and care for individuals living with homelessness and substance use disorders**.
- Encourage use of **Certified Recovery Specialists and Certified Peer Specialists** in warm handoffs for drug overdose and other behavioral health issues.
- Enhanced utilization of **medication-assisted treatment initiatives**, in coordination with behavioral therapies and social support.

PRIORITY

8 Healthy Aging

KEY FINDINGS:

- Community members raised concerns about older adult **isolation, impacting mental health, food access, and healthcare interactions**. Senior centers and community services were frequently mentioned.
- **Transportation barriers** contribute to food insecurity and limited community engagement. Free ride programs often involve long waits, indirect routes, and lengthy travel.
- **Limited digital literacy** and unfamiliarity with technology restrict older adults' access to healthcare and social services.
- **Medicare transitions are often confusing**, causing missed benefits.

POTENTIAL SOLUTIONS:

- **Improve transportation services** for older adults to attend appointments, social events, and access groceries.
- Provide free or subsidized **exercise classes** (e.g., Tai Chi) to support mobility and wellness.
- Increase **availability of nutritious food** through filtered senior food distribution programs.
- Establish or **re-open senior centers** and day programs for social engagement and resource access.
- Offer help with documentation and paperwork (e.g., birth certificates, benefits forms).
- Create anonymous and accessible **reporting systems for elder abuse** or neglect.
- Expanding **services to help older adults age in place**, including affordable home health care, home repairs, food delivery, and utility assistance.
- Increase access to **safe, affordable housing**, including subsidized options.
- Train community health workers to support vulnerable older adults aging in place.
- Create **more opportunities for social interaction** at home and in community spaces.
- Develop **intergenerational programs for socialization** and technology assistance.
- Improve methods of communicating available resources and benefits to increase awareness and utilization.

PRIORITY

9 Culturally and Linguistically Appropriate Services

KEY FINDINGS:

- **Language barriers** are the greatest contributing factor to healthcare access issues for immigrants and ASL speakers. Language issues lead to misunderstandings between patients and healthcare providers or can dissuade patients from attending appointments altogether.
- Provision of high-quality **language services** (oral interpretation and written translation) is critical for providing equitable care to these communities; inquiring of patients at the time of appointment-setting about interpreter needs is ideal.
- Beyond language access, **cultural and religious norms** influence individual beliefs about health; stigma can make seeking help objectionable, particularly mental health services.
- **Fear and not having health insurance discourage** undocumented individuals from seeking medical help.

POTENTIAL SOLUTIONS:

- **Hire bilingual/multilingual providers and translators** (languages mentioned: Spanish, Arabic, French, African dialects).
- Provide **in-person interpreters**, especially during complex or urgent health interactions.
- Ensure all **signage, forms, and digital tools are translated into key community languages**.
- Train providers in culturally responsive care that respects beliefs and traditions of immigrant communities.
- Increase racial, ethnic, and language diversity of staff/**providers to better reflect communities** served.
- Develop organizational language access plans with protocols for identifying and responding to language needs.
- Explore development of **formalized programs to train and credential bilingual staff** (employed for other roles) to serve as medical interpreters.
- Provide on-site language interpreters and health education materials in diverse languages.
- Develop strong **partnerships with community organizations** serving diverse communities that involves providing financial support.

PRIORITY

10 Food Access

KEY FINDINGS:

- Maintaining diets consisting of **fresh produce and healthy foods is consistently difficult** and cost prohibitive. Cheaper fast food and corner store options are also more convenient, readily accessible, and more prevalent – particularly in urban neighborhoods. Likewise, large grocery stores may require transportation to access them.
- A **lack of food literacy** and longevity of poor dietary habits over time also contribute to food choices.
- Local food banks/pantries serve as an indispensable community resource. When available, community gardens offer neighborhoods opportunities to grow their own food in the company of neighbors.
- Older adults have enjoyed **meal delivery services**, as a part of their benefits.
- Immigrants and ethnic minorities face challenges with finding **foods that are culturally relevant** to them.

POTENTIAL SOLUTIONS:

- Maintain and **expand community gardens**, fresh food access, and local markets.
- Offer **nutritional education** for both children and parents.
- Increase **oversight of food stamp benefit security** (e.g., prevent theft and fraud).
- Improve **quality of food provided at pantries** or senior meal programs – not just quantity.
- Ensure more **equitable access to food assistance programs/resources** in region by collecting data.
- Before patients are discharged from the hospital, providing **"warm handoffs" to connect them with community health and social service organizations that address hunger and other needs**.
- Increase collaboration and resource-sharing between hospitals and community groups working on healthy and culturally relevant food access.
- Increase **outreach to raise awareness** and utilization of food assistance programs.
- Provide services that distribute food directly to people where they live.

PRIORITY

11 Housing

KEY FINDINGS:

- Homelessness was indicated to be a concern at 17% of the qualitative community meetings. The overall health of homeless individuals was also of concern to community members, feeling as though **resources were not readily available and that homeless individuals** contributed to sentiments around neighborhoods being unsafe.
- A growing lack of **affordable housing** has led to a year's **long waiting list for subsidized housing**, as well as evictions, and individuals sleeping in places not meant for human dwelling (e.g., cars, outdoors). This phenomenon is pervasive across counties, but particularly in Philadelphia.
- Housing for certain sub-groups, such as **older adults and veterans**, was also noted as priorities

POTENTIAL SOLUTIONS:

- Invest in **affordable housing and shelters**, especially for people experiencing homelessness or with substance use challenges.
- **Improve transitional housing** and reentry programs to prevent homelessness post-incarceration.
- Ensure **stable housing for vulnerable groups** to support health management (e.g., medication, food access).
- Increase investments by hospitals, managed care organizations, and others in **supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness**.
- Explore strategies that aggregate funds to **support rental assistance** or develop an equitable acquisition fund to preserve and create affordable housing.
- Expand **programs supporting habitability** and raising awareness of resources for **housing repair assistance**.
- Increase **Rapid Re-housing Programs**.
- Invest in respite housing for individuals in urgent need of **transitional housing**.

PRIORITY

12 Neighborhood Conditions

KEY FINDINGS:

- Availability of **greens spaces**, dog parks, libraries, and health centers (with parks, walking trails, gyms, pools) contribute significantly to positive perceptions about neighborhood conditions; named as desired neighborhood features.
- Lack of overall neighborhood safety, caused by criminal activity, **community violence**, or **road conditions**, are risk factors for poor mental health and limited physical activity outside.
- **Uncollected trash** build-up and littered streets negatively impact neighborhood morale and contribute to air pollution that can prevent some from opening their windows.
- Community events were praised as opportunities to foster neighborly connections and cohesion.
- **Local pride** from residents who have lived in the area for several decades, particularly in Philadelphia County, contribute to vested interests in improvement, and informed perspectives on neighborhood history and nature of changes.

POTENTIAL SOLUTIONS:

- Increase **investment in neighborhood clean-up efforts** (e.g., trash removal, illegal dumping).
- Expand **tree canopy and green spaces** to reduce heat and support walkability.
- Maintain and **rebuild parks and rec centers** to offer both safety and engagement for youth.
- **Improve sidewalks and streets** for better mobility and pedestrian safety.
- Recognize the mental health impacts of environmental stressors like blight and noise.
- Support **neighborhood remediation** and clean-up activities.
- Collaborate with local advocates engaged in campaigns to improve air quality, especially in areas that have increased exposure to emissions.
- Invest in **infrastructure improvements** to support active transit near hospitals.
- **Improve vacant lots by developing gardens** and spaces for socialization and physical activity.
- Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.

PRIORITY

1 Youth Mental Health

KEY FINDINGS:

- **Youth and adult community members recognize mental health as the primary health** concern in the region.
- Youth mental health was prioritized at 12 of 15 youth meetings.
- Top issues included: **limited access** to mental health services, **lack of coping skill** resources, harmful effects of **social media**, and widespread feelings of **loneliness**.
- Addressing youth mental health in Southeastern Pennsylvania requires a multifaceted approach, including early intervention, increased access to care, community support, and targeted programs within educational settings.
- **High Prevalence of Mental Health Issues:** In 2022, approximately 12.88% of Pennsylvania youth (around 117,000 individuals) experienced a major depressive episode. Alarmingly, nearly 60% of these youths did not receive any mental health treatment.
- **Impact of the COVID-19 Pandemic:** The pandemic exacerbated mental health challenges among teens. A 2022 survey revealed that 37% of responding teens reported poor mental health during the pandemic, and 44% felt persistently sad or hopeless. This suggests that upwards of 35,000 teens in Philadelphia may require mental health support.
- **Suicidal Ideation Among High School Students:** The 2021 Youth Risk Behavior Survey indicated that 22% of high school students nationwide seriously considered attempting suicide in the past year, with 10% having attempted suicide. These figures underscore the critical need for accessible mental health resources for youth.

POTENTIAL SOLUTIONS:

- **Integrate mental and behavioral health services into primary care and school settings:** Normalize mental health care and reduce stigma by embedding services where youth already go. Participants urged that schools have accessible mental health resources in schools beyond just overwhelmed counselors.
- **Embed trauma-informed and healing-centered care into all services and programming:** Recognize the impact of trauma and promote resilience in all youth-facing programs.
- **Increase education and awareness of youth mental health services for families and caregivers:** Equip trusted adults to recognize warning signs and access timely care. Participants recommended Parent/community education on youth mental health, potentially offered at school events like back-to-school nights. They also suggested mandated parenting education/training to better equip caregivers.
- **Support extracurricular and peer-group activities to enhance social engagement:** Reduce loneliness by fostering safe and inclusive environments for connection.
- **Collaborative Care Model:** Proven approach where primary care teams include behavioral health professionals to improve youth mental health outcomes.
- **Trauma-Informed Schools Model:** Builds supportive learning environments by training staff and embedding school-wide trauma practices. Programs like the Philadelphia school-based mental health initiative, supported by the Independence Blue Cross Foundation and Children's Hospital of Philadelphia (CHOP), have been implemented to train school staff in screening and referring students at risk of mental health issues. This approach aims to create a comprehensive support system within schools.
- **Mental Health First Aid Training:** Prepares educators and youth leaders to identify, understand, and respond to mental health crises.
- **Peer Support Programs (e.g., Youth MOVE National):** Promote youth leadership and mutual support for mental health advocacy. Participants advocated for peer-led support spaces in schools like "Relationships First" circles where trained student leaders facilitate discussions.
- **Community Resources for Youth:** Organizations such as The Lincoln Center for Family and Youth offer services including school-based mental health counseling and alternative education programs to support youth mental health in the greater Philadelphia area.
- **Community-Based Support Centers:** Community Evening Resource Centers (CERC) in Philadelphia provide free, safe spaces and activities for children and teens aged 10 to 17, offering structured activities, homework assistance, and opportunities to build friendships. Youth encouraged reducing stigma through community awareness and generational conversations.
- **Early emotional support:** Participants advocated for incorporating social-emotional learning (SEL) from a younger age, not just in high school.

PRIORITY

2 Lack of Resources/ Knowledge of Resources

KEY FINDINGS:

- 30% of youth meetings prioritized **help with navigating health resources**.
- Youth reported difficulty accessing services due to **lack of awareness, system fragmentation, and limited transportation**.
- Many felt they lacked trusted adults or safe reporting pathways.
- **Complex Healthcare Systems:** The intricacies of the healthcare system can be overwhelming for youth, making it difficult to identify appropriate services and navigate insurance processes.
- **Stigma and Fear of Judgment:** Concerns about stigma, particularly regarding mental health services, deter youth from seeking help due to fear of being judged or misunderstood.
- **Transportation Barriers:** Limited transportation options can prevent youth from accessing health facilities, especially in underserved areas.
- **Financial Constraints:** Even with insurance, out-of-pocket costs and uncertainties about coverage can discourage youth from pursuing necessary health services.
- **Limited School-Based Support:** While schools are pivotal in health education, not all institutions have adequate resources or programs to guide students toward appropriate health services.
- **Cultural and Linguistic Barriers:** Diverse populations may face challenges due to language differences and cultural misunderstandings within the healthcare system.
- **Digital Divide:** Not all youth have reliable internet access or digital literacy, hindering their ability to find and utilize online health resources.
- **Fragmented Services:** The lack of coordination among various health services can make it difficult for youth to receive comprehensive care.

POTENTIAL SOLUTIONS:

- **Engage healthcare providers and care coordinators:** Help youth navigate complex systems through warm handoffs and follow-up.
- **Partner with schools to enhance health education and resource sharing:** Ensure youth know what services are available and how to access them.
- **Community Health Worker (CHW) Models:** Train CHWs to support youth and families in navigating care and building trust.
- **School-Based Health Centers (SBHCs):** One-stop access points for physical and mental health care, especially in underserved areas.
- **Trusted Messenger Programs:** Utilize culturally and age-relevant community members to relay information more effectively.
- **Community Initiatives:** Organizations like CORA Services have launched programs such as the Family Navigation Center to assist families in accessing and navigating health services effectively. Participants also encouraged community events (e.g., Healthy Kids Day) that attract families with incentives (bounce houses, food) while sharing resources.
- **More community-based outreach** instead of just web-based referrals.
- **Increase transportation access** or bringing services closer to communities (e.g., having more rec centers or clinics locally).
- **Youth-friendly formats** like social media campaigns to spread resource awareness.
- **Cultural and language access:** Hiring bilingual staff and making materials culturally relevant.

PRIORITY

3 Substance Use and Related Disorders

KEY FINDINGS:

- Identified in 9 of 15 youth meetings as a major concern.
- Key concerns: **binge drinking**, increased **marijuana** and **vape** use, and **trauma due to drug exposure**.
- Youth reported a need for better navigation of behavioral and treatment services.
- In 2022 according to the National Center for Drug Abuse Statistics (NCDAS), approximately 7.22% of Pennsylvania adolescents aged 12 to 17 reported **using drugs in the past month**, with marijuana being the most commonly used substance. In the same study, 9.19% of Pennsylvania teens reported **using alcohol** in the last month, slightly higher than the national average for this age group.
- **Youth experiencing depressive symptoms are significantly more likely to engage in substance use** compared to their peers with a more positive outlook.

POTENTIAL SOLUTIONS:

- **Youth-focused recovery spaces:** Suggestion of AA-style meetings for adolescents.
- **Safe reporting systems** where youth can help others (e.g., call for overdose support) without fear of punishment.
- **Integrated recovery and workforce development programs:** Pairing mental health support with skill-building and community service.
- **CIT (Counselor-in-Training) programs** and volunteer work for youth as alternatives to substance use and ways to build confidence and responsibility.
- **Develop and expand substance use prevention and education programs:** Deliver age-appropriate, evidence-based curricula in schools and communities.
- **Promote prescription drug take-back initiatives:** Reduce misuse by encouraging safe disposal of medications.
- **Botvin LifeSkills Training:** Proven curriculum that builds personal and social skills to prevent substance use.
- **SBIRT (Screening, Brief Intervention, and Referral to Treatment):** Early intervention tool used in schools and health centers.
- **Communities That Care (CTC):** Data-driven framework engaging local stakeholders to reduce youth risk behaviors through tailored strategies.
- **Treatment and Recovery Programs:** Organizations such as the Anti-Drug & Alcohol Crusaders, Inc. (ADAC) provide substance misuse prevention and intervention services targeting youth and families in Philadelphia.

PRIORITY

4 Bullying

KEY FINDINGS:

- Youth cited **bullying**—especially **cyberbullying**—as a major issue impacting mental health.
- **Discrimination**, **harassment**, and **social media toxicity** were recurring themes.
- Among students aged 12–18 who reported being bullied during the 2021–2022 school year, 21.6% experienced cyberbullying, with a **higher incidence among females** (27.7%) compared to males (14.1%).
- The 2023 Pennsylvania Youth Survey (PAYS) highlighted a **strong correlation between being bullied and experiencing depression or suicidal behaviors** among youth in Philadelphia County.

POTENTIAL SOLUTIONS:

- **Social media etiquette education** starting at young ages to combat online bullying.
- **Safe spaces in schools** to talk about feelings, led by peers or trained youth facilitators.
- **Early interventions** to prevent verbal and cyberbullying from escalating.
- **Support for immigrant and bilingual children** facing bullying due to language barriers.
- **Build conflict resolution skills and outlets for emotional expression:** Empower youth to manage emotions and resolve issues constructively.
- **Provide digital citizenship education:** Teach responsible online behavior and how to respond to cyberbullying.
- **Co-create psychologically safe environments:** Ensure schools and programs promote inclusion, equity, and support.
- **Olweus Bullying Prevention Program:** Evidence-based schoolwide program shown to reduce bullying.
- **Second Step SEL Program:** Social-emotional learning curriculum that builds empathy, emotion regulation, and decision-making.
- **Restorative Practices in Schools:** Shifts discipline from punitive to healing by fostering accountability and connection.
- **Support for LGBTQ+ Students:** The National School Climate Survey by GLSEN reports on the experiences of LGBTQ+ youth in schools, highlighting the need for supportive environments to reduce bullying and harassment.

PRIORITY

5 Gun Violence

KEY FINDINGS:

- Youth recognize gun violence as a top concern, **driven by poverty and easy access to firearms**.
- **Immigrant and LGBTQ+ youth face additional risks**, including IPV and sex trafficking.
- Youth report trauma and **limited access to supports** for healing.
- In 2022, firearms were the **leading cause of death among children and teens aged 1 to 17** in Pennsylvania.
- Studies indicate that **Black youths and those residing in urban communities have higher rates of witnessing gun violence** (21.4%) and hearing gunshots in public (51.6%) compared to their non-Black and non-urban counterparts.
- Stories from local youth highlight the profound personal impact of gun violence, **emphasizing the need for community support and policy change to create safer environments**.

POTENTIAL SOLUTIONS:

- **Reallocation of city funding:** Instead of heavy spending in one area, directing more toward youth mental health and education.
- **Safe community spaces** where youth can express fears and ideas (e.g., community art like the "community plate" activity).
- **Community involvement and cleanup events** to reclaim and uplift neighborhoods.
- **Critical feedback on ineffective policing** and calls for greater investment in actual youth-centered prevention and safety measures.
- **Expand violence prevention and youth recreation programs:** Offer safe spaces and constructive alternatives to violence.
- **Integrate social and mental health supports:** Provide trauma-informed care in schools, clinics, and community programs.
- **Advocate for stronger gun safety and economic policies:** Address root causes like poverty, firearm access, and structural inequality.
- **Cure Violence Model:** Treats violence like a contagious disease, using credible messengers to interrupt cycles.
- **Trauma Recovery Centers (TRCs):** Holistic support for youth who experience or witness violence.
- **Youth Empowerment Solutions (YES):** Engages youth in civic action and community transformation.
- **City Initiatives:** In November 2024, Philadelphia's Office of Public Safety launched the Group Violence Intervention Juvenile (GVIJ) program, targeting individuals aged 12 to 17 who are at high risk of involvement in gun violence, aiming to foster positive outcomes and well-being.

PRIORITY

6 Access to Physical Activity

KEY FINDINGS:

- **Youth associate health with movement** and requested more opportunities for physical activity.
- **Limited access to safe green spaces, parks, and recreation** infrastructure in many neighborhoods.
- 13% reported parks or activity spaces are rarely or never available.
- Regular physical activity **enhances cardiorespiratory fitness, supports healthy bone and muscle development, aids in weight management, and reduces symptoms of anxiety and depression among youth**.
- The **pandemic led to a decline in physical activity** levels among children and adolescents, emphasizing the need for renewed efforts to promote active lifestyles.
- Challenges such as **financial constraints, safety concerns, and limited access to facilities can hinder youth participation** in physical activities. Addressing these barriers is essential to ensure equitable access for all communities.
- The American Public Health Association advocates for **enhancing physical activity opportunities in out-of-school programs and increasing accessibility to reduce disparities** and promote health equity among youth.

POTENTIAL SOLUTIONS:

- **Community gardens and step challenges** tied to school programs.
- **Block parties and community clean-ups** that include physical activity components.
- **Rec centers and gym access** where youth feel welcome and included.
- **Peer involvement at gyms** and modeling healthy physical routines in neighborhood spaces.
- **Teach behavioral strategies for physical activity:** Encourage small, daily changes to increase movement.
- **Invest in active infrastructure:** Expand sidewalks, bike lanes, and parks for safe and equitable access.
- **Foster social networks that promote movement:** Peer-led activities and group fitness can improve consistency and motivation.
- **Safe Routes to School (SRTS):** Enhances walkability and biking through community design and education.
- **Play Streets:** Temporarily convert streets into pop-up play zones in under-resourced neighborhoods.
- **SPARK PE:** Research-based program improving fitness and academic performance through quality physical education.

PRIORITY

7 Activities for Youth

KEY FINDINGS:

- 11 of 15 meetings highlighted a need for more extracurricular options.
- Though 92% of youth participate in some activity, **accessibility—particularly in underserved areas—is a major barrier**.
- Programs like **summer camps, leadership clubs, and STEM activities** were top priorities.
- **Promotes Mental and Emotional Health:** Regular engagement in structured activities like sports, arts, music, and mentorship helps reduce stress, anxiety, and depression. It gives youth a positive outlet and builds emotional resilience.
- **Prevents Risky Behaviors:** Youth with access to after-school and community programs are significantly less likely to engage in substance use, violence, or other high-risk behaviors. These programs offer supervision, structure, and positive role models.
- **Builds Life Skills and Confidence:** Participation in group activities teaches teamwork, leadership, time management, and responsibility—skills that are vital for success in school and life.
- **Provides Safe Spaces:** Especially in neighborhoods impacted by gun violence or under-resourced schools, community centers and rec programs can be sanctuaries where youth feel physically and emotionally safe.
- **Supports Academic Success and Future Opportunity:** Programs that blend academics, mentoring, and enrichment activities help close opportunity gaps, support college and career readiness, and connect youth with pathways to higher education and employment.

POTENTIAL SOLUTIONS:

- **Volunteer and leadership opportunities** like CIT programs, community cleanups, or school clubs.
- **Skills-based training with incentives** (e.g., small stipends or "training pay") even before official working age.
- **Reviving youth programs** (e.g., Girl Scouts, Boy Scouts) and emphasizing mentorship.
- **Creative expression projects** like community plates or mural work to connect youth to their environment and voice.
- **Offer activities that foster connection and purpose:** Design programs that build belonging and life skills.
- **Partner with community orgs to expand access:** Leverage existing networks to offer free or low-cost options.
- **Support youth leadership and intergenerational initiatives:** Promote mentorship and civic engagement across age groups.
- **Positive Youth Development (PYD):** Strengths-based approach helping youth thrive emotionally, socially, and academically.
- **21st Century Community Learning Centers:** Federally funded programs offering afterschool and summer learning.
- **Youth Mentoring Programs:** Build trusted, supportive relationships through structured mentor models.
- **Out-of-School Time (OST) Programs:** Philadelphia offers OST programs for young people in grades pre-K through 12, supporting working families and promoting children's academic, social, and personal development. Activities include arts, sports, and academic enrichment.

PRIORITY

8 Access to Good Schools

KEY FINDINGS:

- Youth emphasized disparities in school quality across counties.
- Needs include **improved mental health support, updated teaching methods, and equitable funding**.
- Desired school traits include **diversity, inclusion, quality educators**, and **modern facilities**.
- Students in the School District of Philadelphia have **demonstrated varied academic performance**. In the 2021-2022 school year, approximately 34% of third- to eighth-grade students met reading standards, a 2% decrease from 2018-2019. Math proficiency was at 17%, down 5% from the same period.
- Access to high-quality schools directly affects a young person's ability to learn, graduate, pursue higher education or vocational training, and secure stable employment. **Education is one of the most powerful tools for breaking cycles of poverty and inequity.**
- When students fall behind in reading and math—as is happening post-pandemic—they are more likely to struggle academically in later years, drop out of school, or face limited job prospects. **Early gaps often widen over time without intervention.**
- Schools are not just for academics—they **provide mental health support, meals, social-emotional learning, and connection to services**. Quality schools help meet the basic needs of youth and families, especially in under-resourced communities.
- Communities with strong public schools often have **lower crime rates and greater social cohesion**. Good schools attract families, increase civic engagement, and help neighborhoods thrive.

POTENTIAL SOLUTIONS:

- **Support for bilingual learners** and anti-bullying efforts to ensure comfort in school environments.
- **Creating welcoming and identity-affirming clubs** for students of all backgrounds.
- **Better sexual health and emotional learning programs** that students feel engaged in.
- **Training for teachers and school staff** to be culturally competent and approachable.
- **Advocate for fair funding and staffing:** Reduce disparities by directing resources to underserved schools.
- **Provide interdisciplinary mental health teams in schools:** Normalize mental wellness as part of academic success.
- **Support mentoring, counseling, and career readiness programs:** Prepare students holistically for life after graduation.
- **Community Schools Model:** Integrates academics with health, social services, and community engagement.
- **Multi-Tiered System of Supports (MTSS):** Data-informed framework addressing academic and behavioral needs at varying intensities.
- **School-Based Mental Health Services:** Aligns with pediatric guidance to offer accessible care within the school setting.

Resources

LOCAL HEALTH RESOURCES AND SERVICES

Many health resources and services are available to address the needs of SEPA communities. A list of organizations serving Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties was developed based on those included in the 2019 rCHNA report, as well as community organizations identified by Steering Committee members as partners. Organizations were coded into categories based on types of services provided, and contact information was verified in April 2022 for all included organizations. Descriptions of the categories are below, and a searchable list of organizations with contact information, organized by category and county, is included in the online Appendix.

CATEGORY	DESCRIPTION
Behavioral Health Services	• Services, including treatment, to address mental health or substance use issues
Benefits & Financial Assistance	• Assistance with enrollment in public benefits or provision of emergency cash assistance
Disability Services	• Services for individuals with disabilities
Food	• Food pantries or cupboards, as well as assistance with Supplemental Nutrition Assistance Program (SNAP) benefits
Housing/Shelter	• Assistance with emergency shelter, rental payment, or support services for individuals experiencing homelessness
Income Support, Education, & Employment	• Support for tax assistance, adult education, and employment
Material Goods	• Material goods including clothing, diapers, furniture
Senior Services	• Services for seniors
Substance Use Disorder Services	• Treatment for substance use disorders
Utilities	• Assistance with utility payment
Veterans Services	• Services for veterans

REFERENCES AND DATA SOURCES

The participating hospitals and health systems would like to acknowledge the following organizations for access to data and reports to inform the rCHNA.

ORGANIZATION/SOURCE	DESCRIPTION
Academy Health	• Building Trust and Mutual Respect to Improve Health Care
American Board of Internal Medicine (ABIM) Foundation	• Building Trust Initiative
Centers for Disease Control and Prevention	• Behavioral Risk Factor Surveillance System Data (PLACES) • CDC/ATSDR Social Vulnerability Index • WONDER • Youth Risk Behavior Surveillance System Data
County Health Rankings & Roadmaps	• Health Data by Location • What Works for Health
Feeding America	• Map the Meal Gap
HealthShare Exchange	• Emergency Department High-Utilizers • Gun-related Emergency Department Utilization
Institute for Health Care Improvement	• Organizational Trustworthiness in Health Care
Montgomery County Office of Public Health	• 2024 Community Health Assessment
National Center for Health Statistics	• NCHA Data Query System
National Equity Atlas	• Income Inequality
Pennsylvania Department of Health	• Vital Statistics (Birth, Cancer, and Death Records)
Pennsylvania Office of the Attorney General	• Pennsylvania Uniform Crime Reporting System
Pennsylvania Health Care Cost Containment Council	• Hospital Inpatient Discharge Data
Philadelphia Communities Conquering Cancer	• Listening Session Summaries
Philadelphia Department of Public Health	• Syndromic Surveillance Data
Pennsylvania Commission on Crime and Delinquency, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Education	• Pennsylvania Youth Survey Data
U.S. Census Bureau	• American Community Survey 5-Year Data Decennial Census
Walker Data	• Tidycensus

Notes

Vital records data were supplied by the Bureau of Health Statistics and Research, Pennsylvania Department of Health, Harrisburg, Pennsylvania. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions.

Data for selected indicators is provided by HealthShare Exchange (HSX), the Delaware Valley's health information organization, based on data contributed from its healthcare provider members.

The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency responsible for addressing the problems of escalating health costs, ensuring the quality of health care, and increasing access to health care for all citizens regardless of ability to pay. PHC4 has provided data to the Philadelphia Department of Public Health in an effort to further PHC4's mission of educating the public and containing health care costs in Pennsylvania. PHC4, its agents and staff have made no representation, guarantee, or warranty, express or implied, that the data—financial, patient, payer and physician specific information—provided to this entity, are error free, or that the use of data will avoid differences of opinion or interpretation. This analysis was not prepared by PHC4. This analysis was done by the Philadelphia Department of Public Health. PHC4, its agents and staff bear no responsibility or liability for the results of this analysis, which are solely the opinion of this entity.

ONLINE APPENDIX

An online appendix of resources used to inform and produce this CHNA is available at: RCHNA-SEPA.org