

SOUTHEASTERN PENNSYLVANIA  
**COMMUNITY  
HEALTH NEEDS  
ASSESSMENT**

**2022**



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This excerpt, taken from a report covering all of southeastern Pennsylvania, focuses on the service areas and populations served by Jefferson Abington Hospital and Jefferson Lansdale Hospital.

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## EXECUTIVE SUMMARY

Identifying and addressing unmet health needs of local communities is 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. 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.

Recognizing that hospitals and health systems often mutually serve the same communities, a group of local hospitals and health systems have again collaborated on a Southeastern Pennsylvania (SEPA) Regional CHNA (rCHNA), with specific focus on Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This continued collaboration enables continuity of approach, while also providing opportunities to expand and improve upon the last assessment process. Participants recognize that the CHNA is an important part of how health systems, multi-sector partners, and communities work together to achieve meaningful and positive community change. In addition to the shared learning, increased efficiencies, and reduced community burden offered by the collaborative approach, participants have derived particular benefit from mutual support in the face of the COVID-19 pandemic and its cascading impacts. In response to the crises of the past several years, the 2022 rCHNA is explicitly grounded in an approach that seeks to advance health equity and authentic community engagement.

## Partnering Health Systems and Hospitals

### Children's Hospital of Philadelphia

- Children's Hospital of Philadelphia
- Middleman Family Pavilion at CHOP, King of Prussia

### Doylestown Health: Doylestown Hospital

### Grand View Health: Grand View Hospital

### Jefferson Health

- Einstein Medical Center Elkins Park
- Einstein Medical Center Montgomery
- Einstein Medical Center Philadelphia
- Jefferson Abington Hospital
- Jefferson Bucks Hospital
- Jefferson Frankford Hospital
- Jefferson Hospital for Neuroscience
- Jefferson Lansdale Hospital
- Jefferson Methodist Hospital
- Jefferson Torresdale Hospital
- Magee Rehabilitation Hospital
- MossRehab
- 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

### Redeemer Health: Holy Redeemer Hospital

### 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

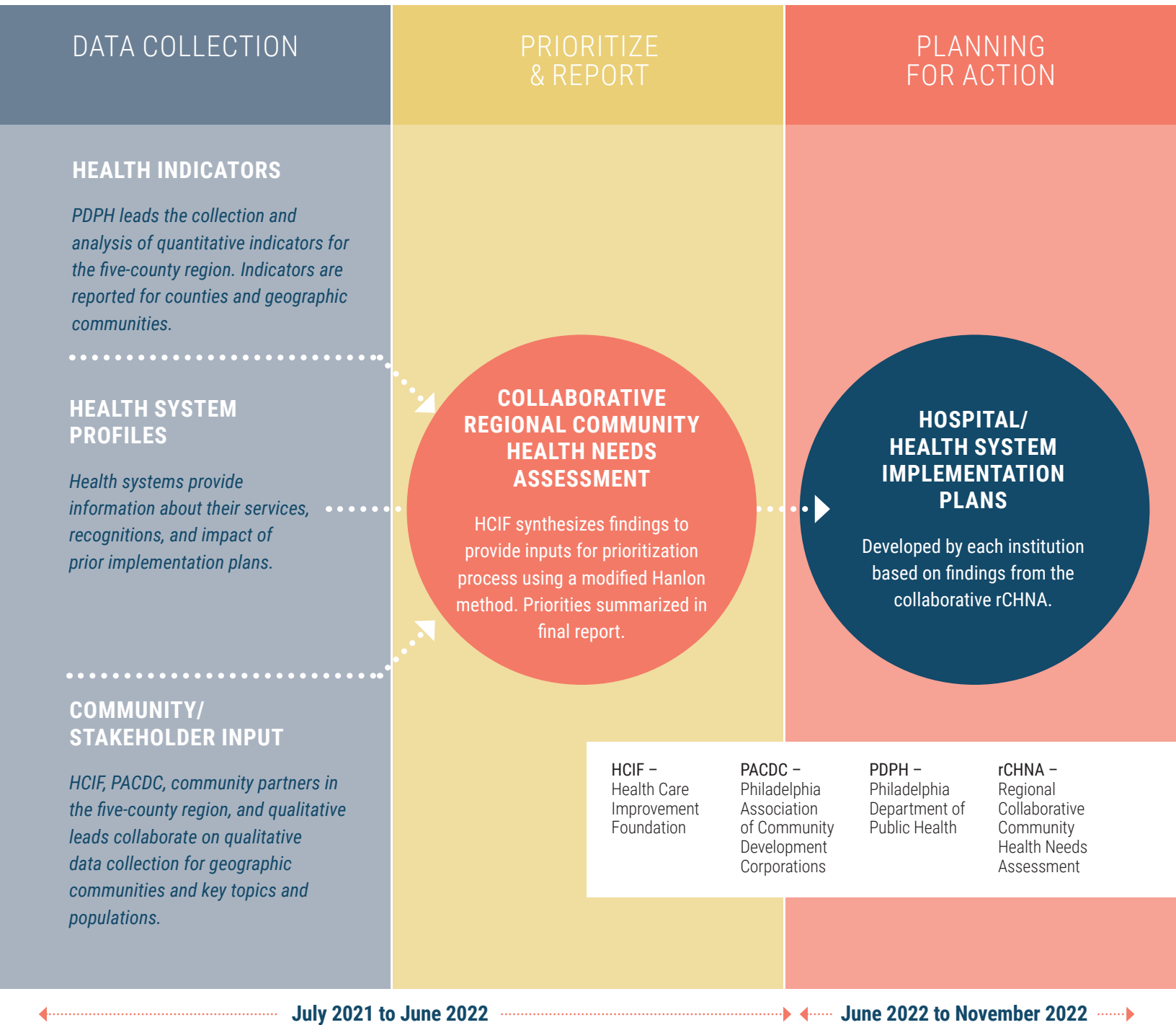
### Trinity Health Mid-Atlantic

- Mercy Catholic Medical Center, Mercy Fitzgerald Hospital Campus
- Nazareth Hospital
- St. Mary Medical Center and St. Mary Rehabilitation Hospital

**EXECUTIVE SUMMARY**

# 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, hospitals/health systems produce implementation plans to respond to unmet health needs. These plans may involve further collaboration or coordination to address shared priorities.



## EXECUTIVE SUMMARY

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

Quantitative data were acquired from local, state, and federal sources and focused on indicators that were uniformly available at the ZIP code level across the region. The PDPH team, which included experts in epidemiological and geospatial analyses, compiled, analyzed, and aggregated over 60 health indicators encompassing data on community demographic characteristics, COVID-19, chronic disease and health behaviors, infant and child health, behavioral health, injuries, access to care, and social and economic conditions.

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

- 26 virtual focus group-style “community conversations” held to gather input from residents of geographic communities across all five counties.
- 21 virtual focus group discussions centered on “spotlight” topics conducted with community organization and local government agency representatives. Topics covered included behavioral health, chronic disease, food insecurity, housing and homelessness, older adults and care, racism and discrimination in health care, substance use, and violence.

Two experts in qualitative data collection and analysis engaged as Qualitative Lead consultants facilitated all of these discussions, analyzed the qualitative data, and summarized key findings.

In addition, 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 either specific to different type of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) or reflected gaps in the 2019 rCHNA:

- Cancer
- Disability
- Immigrant, refugee, and heritage communities
- Youth voice

Finally, secondary data in the form of reports and summaries from other community engagement efforts were also incorporated into the report.

All data were synthesized by HCIF staff and a list of 12 community health priorities was presented to the Steering Committee. Using a modified Hanlon ranking method, each participating hospital and health system rated the priorities. An average rating was calculated, and the community health priorities were organized in priority order based on:

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

Potential solutions for each of the community health priorities, based on findings from the qualitative data collection, were also included.

# COMMUNITY HEALTH NEEDS

COMMUNITY HEALTH NEEDS	KEY FINDINGS	POTENTIAL SOLUTIONS
<p><b>1.</b> <b>MENTAL HEALTH CONDITIONS</b></p>	<ul style="list-style-type: none"> <li>• Youth and adult community members and community partners prioritize mental health as their top health need.</li> <li>• Significant mental health needs across the region are indicated by high rates of depression among youth and adults, frequent mental distress, and suicide mortality and suicide attempts/ideation among youth.</li> <li>• Trends exacerbated by social isolation, stress, and fear experienced due to the COVID-19 pandemic.</li> <li>• Pandemic-related trauma particularly compounded for those communities also contending with trauma associated with high levels of poverty, community violence, and racism.</li> <li>• Populations particularly affected include youth, older adults, immigrant communities, LGBTQ+ communities, those experiencing homelessness and housing insecurity.</li> <li>• There continues to be a significant lack of community-based, integrated mental health treatment options and a particular dearth of resources for youth with mental health needs and their families.</li> </ul>	<ul style="list-style-type: none"> <li>• Improve care coordination as part of an integrated care model.</li> <li>• Increase awareness of behavioral health resources and services.</li> <li>• Increase access to safe, structured afterschool activities for youth available on weekends and in the evening.</li> <li>• Create spaces for openly discussing mental health for youth to normalize/ destigmatize mental health issues.</li> <li>• Co-locate prevention and behavioral health services in community settings (“one stop shop”) where families live, work, learn, and socialize.</li> <li>• Increase access to support groups to address mental health and substance use.</li> <li>• Increase training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence/sensitivity.</li> <li>• Increase behavioral health workforce capacity and diversity (e.g., language, racial, and ethnic).</li> <li>• Increase individuals with lived experience in the behavioral health workforce.</li> <li>• Provide programming to prevent “burn-out” among behavioral health staff.</li> <li>• Support efforts to increase funding to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment.</li> </ul>

# COMMUNITY HEALTH NEEDS

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<p><b>2.</b> <b>ACCESS TO CARE</b> <b>(PRIMARY AND SPECIALTY)</b></p>	<ul style="list-style-type: none"> <li>• Supply of primary care providers across the region compares favorably to national data and trends with uninsured rates are improving regionally, but challenges remain with increasing provider acceptance of new patients with Medicaid coverage.</li> <li>• Barriers to access to primary care for communities are due to lack of providers in neighborhoods, issues of affordability, and language/cultural barriers.</li> <li>• Above issues exacerbated with specialty care, with added challenges posed by even more limited availability of appointments, high cost, and lack of care coordination/linkage with primary care.</li> <li>• Impacts of COVID-19 pandemic include increased enrollment in Medicaid, longer wait times for appointments (especially for specialty care), and gaps in access to preventive services.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide education and information about Medicaid (e.g., eligibility, coverage) and assist with enrollment.</li> <li>• Create high quality free or low-cost health care options to serve those who may be uninsured or underinsured.</li> <li>• Establish comprehensive health centers that would address not only physical health, but also mental health and dental care.</li> <li>• Bring more health and social services directly to underserved communities through health clinics in schools or mobile medical clinics.</li> <li>• Embed social workers in primary care practices, such as family medicine, pediatrics, and OB/GYN offices.</li> <li>• Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”</li> <li>• Provide on-site language interpreters and health education materials in diverse languages.</li> <li>• Increase racial, ethnic, and language diversity of staff and providers to better reflect the communities they serve.</li> <li>• Increase transportation assistance, including adding options for those not eligible for certain benefits.</li> <li>• Expand appointment availability and hours in low access areas.</li> <li>• Address barriers to telehealth (e.g., related to internet or device access or digital literacy).</li> </ul>

# COMMUNITY HEALTH NEEDS

COMMUNITY HEALTH NEEDS	KEY FINDINGS	POTENTIAL SOLUTIONS
<p><b>3.</b> <b>CHRONIC DISEASE PREVENTION AND MANAGEMENT</b></p>	<ul style="list-style-type: none"> <li>• Conditions like heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute majority of top 5 leading causes of death for all counties.</li> <li>• Rate of premature cardiovascular deaths significantly higher in Philadelphia County.</li> <li>• Cancer mortality rates highest in Delaware and Philadelphia Counties.</li> <li>• Hypertension-related hospitalization rates highest in Bucks, Delaware, and Philadelphia Counties.</li> <li>• Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, which disproportionately affects communities of color.</li> <li>• COVID-19 pandemic has negatively impacted chronic disease prevention and management. Notably, there have been delays in seeking care, as found in qualitative reports and indicated by lower health care utilization in 2020 as compared to previous years.</li> </ul>	<ul style="list-style-type: none"> <li>• Better inform, educate, and engage the public regarding chronic disease prevention and management.</li> <li>• Engage trusted community leaders to help spread important messages (for example, promoting cancer screening).</li> <li>• Expand successful innovations from the pandemic, such as virtual wellness programs.</li> <li>• Bring screenings and health education to faith-based institutions or where people shop, recreate, or work.</li> <li>• Integrate mental health services into overall care management for people with chronic diseases.</li> <li>• Before patients leave a hospital or clinic, provide screening, referrals, and “warm hand-offs” to community-based health and social services, as well as resources that assist with lifestyle changes for people managing chronic conditions.</li> <li>• Increase networking and collaboration among community organizations and health system partners to improve resource sharing and coordination of services.</li> </ul>

# COMMUNITY HEALTH NEEDS

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<p><b>4.</b> <b>SUBSTANCE USE AND RELATED DISORDERS</b></p>	<ul style="list-style-type: none"> <li>• Substance use disorders often co-occur with mental health conditions.</li> <li>• Substance use is associated with community violence and homelessness.</li> <li>• Drug overdose rates continue to be high due to the opioid epidemic. The drug overdose rates in Bucks, Delaware, and Philadelphia Counties exceed the overall Pennsylvania rate. It is the leading cause of death for young adults.</li> <li>• The opioid epidemic is associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS).</li> <li>• Use of other substances, especially during the COVID-19 pandemic, was of pressing concern to community members and partners. Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth, were raised as increasingly prevalent. High rates of marijuana vaping among youth in the four suburban counties.</li> </ul>	<ul style="list-style-type: none"> <li>• Sustain and expand prevention programs, ranging from school-based educational programs to community drug take-back programs.</li> <li>• Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs.</li> <li>• Broaden and intensify efforts to reduce vaping among youth.</li> <li>• Expand Narcan training and distribution.</li> <li>• Increase medical outreach and care for individuals living with homelessness and substance use disorders.</li> <li>• Encourage use of Certified Recovery Specialists and Certified Peer Specialists in warm handoffs for drug overdose and other behavioral health issues.</li> <li>• Develop texting support services that address underlying issues of substance use, provided by trained peers or qualified therapists to individual clients.</li> <li>• Streamline system navigation for providers and the population at large to facilitate access to outpatient services after discharge from inpatient facilities.</li> </ul>
<p><b>5.</b> <b>HEALTHCARE AND HEALTH RESOURCES NAVIGATION</b></p>	<ul style="list-style-type: none"> <li>• Community members and partners widely viewed navigating healthcare services and other health resources as a challenge due to general lack of awareness, fragmented systems, and resource constraints.</li> <li>• Healthcare providers, particularly in the primary and acute care setting, can play an integral role in linking patients directly to health resources or to community health workers or care coordinators.</li> <li>• Navigation includes information as well as transportation. Lack of accessible, affordable transportation options was raised in a large majority (70%) of qualitative meetings, with the need spanning urban and suburban counties.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase public awareness of community resource directories that local health systems have invested in and support community members with using them.</li> <li>• Increase the capacity of healthcare staff to assist community members with navigation by regular education on available resources.</li> <li>• Grow the numbers of professionals serving as community resource or healthcare navigators.</li> <li>• Create permanent social service hubs that serve as “one-stop-shops” for commonly needed resources.</li> <li>• Expand low-cost transportation options.</li> </ul>

# COMMUNITY HEALTH NEEDS

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<p><b>6.</b> <b>RACISM AND DISCRIMINATION IN HEALTH CARE</b></p>	<ul style="list-style-type: none"> <li>• Racism recognized as ongoing public health crisis in need of urgent, collective attention.</li> <li>• Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are examples of inequities stemming from structural racism.</li> <li>• Representatives of communities of color shared their mistrust of healthcare providers and institutions arising from seeing such disparities and personally experiencing discriminatory treatment in health care settings.</li> <li>• Such experiences can lead to forgoing of needed care, resulting in increased morbidity and mortality.</li> <li>• Anti-Asian hate crimes increased during the COVID-19 pandemic. Fear of violence among Asian older adults has led to reluctance in leaving their homes, resulting in increased social isolation and adversely affecting mental and physical health.</li> </ul>	<ul style="list-style-type: none"> <li>• Train and hire people with lived experience to work in communities that have been historically marginalized.</li> <li>• Increase hospital investment in grassroots community organizations that are working to address social determinants of health and related needs.</li> <li>• Expand and improve the training of healthcare providers around anti-racism, structural racism, implicit bias, diversity awareness, cultural competence, and trauma-informed care.</li> <li>• Increase the number of people of color in healthcare leadership positions.</li> <li>• Ensure diversity, equity, and inclusion efforts and plans within healthcare institutions include an explicit focus on racism and discrimination, with focus on policies, care practices, and ongoing measurement.</li> <li>• Create and fund ongoing forums for community leaders to work with health system partners to address issues of racism and discrimination in health care.</li> </ul>
<p><b>7.</b> <b>FOOD ACCESS</b></p>	<ul style="list-style-type: none"> <li>• Issues of food access focus primarily on food security. Many community members experience challenges obtaining sufficient food of any kind, as well as issues with accessing healthy food more specifically.</li> <li>• Financial challenges brought on by the COVID-19 pandemic has led to an increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits.</li> <li>• Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities.</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure more equitable access to food assistance programs and resources throughout the region by collecting data.</li> <li>• Before patients are discharged from the hospital, provide “warm handoffs” to connect them with community health and social service organizations that address hunger and other needs.</li> <li>• Increase collaboration and resource-sharing between hospitals and community groups working on healthy food access.</li> <li>• Increase outreach to raise awareness and utilization of food assistance programs.</li> <li>• Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food.</li> <li>• Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources.</li> </ul>

# COMMUNITY HEALTH NEEDS

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<p><b>8.</b> <b>CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES</b></p>	<ul style="list-style-type: none"> <li>• About 12 percent of the population across the 5 counties were not born in the U.S. As much as 45 percent of residents of some geographic communities report speaking English less than very well.</li> <li>• The need for culturally concordant providers and resources to address language barriers was raised in over 50 percent of qualitative meetings.</li> <li>• Provision of high quality language services (oral interpretation and written translation) is critical for providing equitable care to these communities.</li> <li>• Beyond language access, cultural and religious norms influence individual beliefs about health. Providers and systems equipped to engage patients about these beliefs and integrate them into care is needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase the racial, ethnic, and language diversity of staff and providers to better reflect the communities they serve.</li> <li>• Develop organizational language access plans that outline protocols for identifying and responding to language needs.</li> <li>• Explore the development of formalized programs to train and credential bilingual staff (employed for other roles) to serve as medical interpreters.</li> <li>• Provide on-site language interpreters and health education materials in diverse languages.</li> <li>• Develop strong partnerships with community organizations serving diverse communities that involves providing financial support.</li> <li>• Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”</li> </ul>
<p><b>9.</b> <b>COMMUNITY VIOLENCE</b></p>	<ul style="list-style-type: none"> <li>• Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties.</li> <li>• In 2020, Philadelphia lost 447 people to gun violence, the most gun-related homicides in 30 years. It is the leading cause of death for Black men ages 15-43 and Hispanic/Latino men ages 15-31.</li> <li>• Community violence driven by community disadvantage disproportionately impacts N, NW, and SW communities in Philadelphia.</li> <li>• Trauma associated with exposure to gun violence is widely felt in communities, especially among youth. Significant challenges exist with accessing necessary mental health supports to address negative impacts of such exposure.</li> <li>• Women, youth from immigrant communities, and LGBTQ+ communities are at higher risk of interpersonal violence, including intimate partner violence (IPV), sexual assault, and sex trafficking. Reports of increased risk of IPV associated with COVID-19 stay-at-home orders have been shared by local advocates.</li> <li>• Negative social media engagement, including cyberbullying, among youth can be a source of community violence.</li> </ul>	<ul style="list-style-type: none"> <li>• Increase awareness and availability of youth programs to prevent violence, including educational programs, sports, and other recreational activities.</li> <li>• Integrate social and mental health services into existing youth activities. Also provide training for individuals who are trusted by and work with youth (e.g., teaching artists, coaches, teachers, parents) in addressing trauma and other violence-related issues.</li> <li>• Build youth capacity for healthy conflict resolution and create positive outlets for arguments or anger.</li> <li>• Create more safe spaces for people to talk about the violence they experience.</li> <li>• Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”</li> <li>• Increase advocacy for policies to prevent or reduce violence, including initiatives to address poverty and other social determinants that contribute to violence.</li> <li>• Partner with community-based organizations to build on each other’s strengths and increase funding opportunities.</li> </ul>

# COMMUNITY HEALTH NEEDS

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<p><b>10.</b> <b>HOUSING</b></p>	<ul style="list-style-type: none"> <li>• Safe, stable housing is critical for physical and mental health and well-being. Lack of stable housing is associated with 27.3 fewer years of life expectancy.</li> <li>• Health issues associated with housing instability include behavioral health issues (mental distress, depression, developmental delays in children, falls among older adults) and medical conditions such as asthma and lead poisoning. Households may forgo needed health care due to financial strain.</li> <li>• In 2018, 40 percent of Philadelphia households were cost-burdened (when a household spends 30 percent or more of its income on housing costs, including rent, mortgage payments, utilities, insurance, and property taxes). This figure is expected to be higher as a result of the COVID-19 pandemic.</li> <li>• Poor housing conditions like old lead paint, asbestos, infestations, lack of running water or HVAC, and damaged infrastructure disproportionately impact communities with low incomes.</li> <li>• Lack of affordable housing is a major driver of homelessness.</li> <li>• People experiencing homelessness are at increased risk of mental health and substance use disorders and experiencing discrimination and bias in healthcare settings.</li> <li>• Homelessness experienced by youth and older adults are of particular concern for local advocates.</li> </ul>	<ul style="list-style-type: none"> <li>• Drive solutions that prevent homelessness, including advocating for livable wages, more affordable housing, and services that support aging in place.</li> <li>• Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.</li> <li>• Increase investments by hospitals, managed care organizations, and others in supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness.</li> <li>• Explore strategies that aggregate funds to support rental assistance.</li> <li>• Explore development of an equitable acquisition fund to preserve and create affordable housing.</li> <li>• Expand programs that support habitability and raise awareness of available resources for housing repair assistance.</li> <li>• Evaluate existing hospital housing programs for potential expansion, including those that provide home repairs and remediation for high risk youth (e.g., with asthma) and older adults.</li> <li>• Train and encourage health care providers to conduct regular housing insecurity assessments for patients and make referrals as appropriate. Train health professionals and social service providers to use a trauma-informed approach when caring for individuals experiencing homelessness or housing insecurity.</li> <li>• Increase Rapid Re-housing Programs.</li> <li>• Invest in respite housing for individuals in urgent need of transitional housing.</li> </ul>

# COMMUNITY HEALTH NEEDS

COMMUNITY HEALTH NEEDS	KEY FINDINGS	POTENTIAL SOLUTIONS
<p><b>11.</b>  <b>SOCIOECONOMIC DISADVANTAGE (E.G., POVERTY, UNEMPLOYMENT)</b></p>	<ul style="list-style-type: none"> <li>• Individuals living at or near poverty levels have higher rates of adverse health behaviors and outcomes; poverty resulting from structural racism is the underlying determinant for many racial/ethnic health disparities.</li> <li>• Inadequate education, limited opportunities, and unemployment are key drivers of poverty.</li> <li>• Poverty among children and adults tends to cluster in communities; these communities collectively experience trauma and toxic stress, lower life expectancy, limited access to healthcare and health resources, and greater exposure to unhealthy living environments.</li> <li>• Poverty rates are nearly 4 times higher in Philadelphia compared to suburban counties overall, but pockets of high poverty clusters are seen in suburban counties.</li> </ul>	<ul style="list-style-type: none"> <li>• Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs.</li> <li>• Partner with local community-based organizations who provide public benefits enrollment assistance to ensure that residents receive all the benefits (e.g., SNAP, Earned Income Tax Credit) for which they are eligible.</li> <li>• Collaborate with community colleges and universities to develop and expand programs focused on skills training and development to increase access to family-sustaining careers.</li> <li>• Train and employ returning citizens.</li> <li>• Advocate for improvements to the disability system to ensure that people with disabilities are able to work without losing attendant care services.</li> <li>• Provide workforce development/pipeline programs with schools.</li> <li>• Increase access to Science, Technology, Engineering, Arts, and Mathematics (STEAM) education for youth.</li> </ul>
<p><b>12.</b>  <b>NEIGHBORHOOD CONDITIONS (E.G., BLIGHT, GREENSPACE, AIR/WATER QUALITY, ETC.)</b></p>	<ul style="list-style-type: none"> <li>• Greater neighborhood blight (e.g., abandoned homes, vacant lots, trash) is more likely in high poverty areas and is associated with increased community violence.</li> <li>• Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards.</li> <li>• Access to outdoor greenspaces and recreation areas like parks and trails are lower in these neighborhoods. The negative impact of such lack of spaces on mental and physical health was shared by community members.</li> <li>• Communities expressed concerns about air pollution and climate change, particularly in S Philadelphia, Delaware County, and flood-prone SW Philadelphia.</li> <li>• Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity, and further racial segregation.</li> </ul>	<ul style="list-style-type: none"> <li>• Support neighborhood remediation and clean-up activities.</li> <li>• Collaborate with local advocates engaged in campaigns to improve air quality, especially in areas that have increased exposure to emissions.</li> <li>• Invest in infrastructure improvements to support active transit near hospitals.</li> <li>• Improve vacant lots by developing gardens and spaces for socialization and physical activity.</li> <li>• Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.</li> </ul>

# INTRODUCTION

Identifying and addressing unmet health needs of local communities is 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 certain health needs as significant and prioritizing those needs
- A description of resources potentially available to address the significant health needs identified through the CHNA

This assessment is central to not-for-profit hospitals and health systems' community benefit and social accountability planning. By 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 Philadelphia Department of Public Health (PDPH) and the Health Care Improvement Foundation (HCIF) convened an effort to collaboratively develop a regional Community Health Needs Assessment (rCHNA) for four counties of the Southeastern PA (SEPA) region in 2019. This effort represented the first joint CHNA in the region, providing a foundation for future collaboration on both needs assessment and implementation planning to better serve shared SEPA communities.

Once again, local institutions have collaborated on the 2022 rCHNA, enabling continuity of approach, while also providing opportunities to expand and improve upon the last assessment process. Participants recognize that the CHNA is an important part of how health systems, multi-sector partners, and communities work together to achieve meaningful and positive community change. In addition to the shared learning, increased efficiencies, and reduced community burden offered by the collaborative approach, participants have derived particular benefit from mutual support in the face of the COVID-19 pandemic and its cascading impacts. In response to the crises of the past several years, the 2022 rCHNA is explicitly grounded in an approach that seeks to advance health equity and authentic community engagement.

While the basic structure and format of the report are retained from the 2019 effort, the ways in which the 2022 rCHNA departs from the previous process is largely due to a significant increase in size and scope. With the inclusion of additional hospitals and health systems in 2022, the current report not only adds Delaware County to the included service area, but also features full coverage of all ZIP codes in the five-county SEPA region. This has led to the re-defining of geographic communities, as well as increases in the number and types of quantitative and qualitative data in response to the requests of the expanded participant group. Given such differences, as well as the unique impacts of the COVID-19 pandemic on data collection efforts, it is important to note that comparability with the 2019 rCHNA report (especially as related to quantitative data) is limited.



## Jefferson Health

### 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 nearly two centuries ago. These values are:

#### Put People First:

Service-Minded, Respectful & Embraces Diversity

#### Be Bold & Think Differently:

Innovative, Courageous & Solution-Oriented

#### Do the Right Thing:

Safety-Focused, Integrity & Accountability

Jefferson Health, in partnership with Thomas Jefferson University, 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 throughout the Delaware Valley; and educating tomorrow's professionals through transdisciplinary and experiential learning designed for new and emerging fields for the 21st century.

Jefferson Health includes 18 hospitals throughout southeastern Pennsylvania and southern New Jersey. They are: Einstein Medical Center Elkins Park, Einstein Medical Center Montgomery, Einstein Medical Center Philadelphia, Jefferson Abington Hospital, Jefferson Bucks Hospital, Jefferson Cherry Hill Hospital, Jefferson Frankford Hospital, Jefferson Hospital for Neuroscience, Jefferson Lansdale Hospital, Jefferson Methodist Hospital, Jefferson Stratford Hospital, Jefferson Torresdale Hospital, Jefferson Washington Township Hospital, Magee Rehabilitation Hospital, MossRehab, Physicians Care Surgical Hospital, Rothman Orthopaedic Specialty Hospital and Thomas Jefferson University Hospital.

In 2021, Jefferson Health finalized its ownership of Health Partners Plans (HPP), a health maintenance organization that provides CHIP, Medicare Advantage and Dual Eligible Special Needs plans, and a nationally recognized Medicaid plan. Through HPP, Jefferson can continue to advance its value-based care model while reducing costs of healthcare services, particularly among underserved patients and families of the greater Philadelphia region.

Combined, Jefferson Health and Thomas Jefferson University have more than 42,000 employees, which includes nearly 3,500 employed physicians/advanced practice professionals, 9,500 full and part-time nurses and more than 1,900 full and part-time paid faculty. Jefferson is the second largest employer in Philadelphia and the largest health system in Philadelphia based on total licensed beds. Jefferson Health includes over 50 outpatient and urgent care centers; 10 Magnet®-designated hospitals; the NCI-designated Sidney Kimmel Cancer Center; and one of the largest faculty-based telehealth networks in the country that began more than 10 years ago.

## JEFFERSON HEALTH

Thomas Jefferson University Hospital is one of only 14 hospitals in the country that is a Level 1 Trauma Center and a federally designated Regional Spinal Cord Injury Center.

In 2021, Jefferson Health earned *Digital Health Most Wired* recognition from the College of Healthcare Information Management Executives (CHIME). Jefferson scored in the top 5% of all participating organizations, earning recognition for its technology advancements in acute care, ambulatory care and long-term care.

Also in 2021, nearly 600 Jefferson physicians were named among the region's best by Castle Connolly in *Philadelphia* magazine's 2021 Top Docs™ issue.

### COVID-19 Response

Jefferson was able to treat more than 16,000 COVID-19 inpatients – ranking it as the busiest care provider in the Philadelphia region battling this global pandemic. Jefferson was the first health system in the Philadelphia region to institute universal masking guidelines, and at the peak of COVID-19, its infection rate among frontline staff was roughly 1% – a testament to the effectiveness of its safety protocols and the relentless commitment to sourcing adequate supplies of personal protective equipment for staff. This in turn translated to protecting thousands of patients from COVID-19 exposure.

Jefferson was also among the first in the region to arrange external Emergency Department triage tents and mobile-testing sites to keep patient screenings for COVID-19 outside of its hospitals. In parallel, Jefferson, with the largest faculty-based telehealth network in the country, treated more than 500,000 patients virtually throughout the pandemic – keeping both patients and physicians safe. Jefferson Health and the City of Philadelphia also worked closely together to open a COVID-19 testing site in Northwest Philadelphia to offer free, twice-weekly testing throughout the peak of the pandemic.

When the COVID-19 vaccine became available, Jefferson Health assembled a multidisciplinary COVID-19 Vaccine Task Force that worked tirelessly to develop its Real Talk Initiative and Trusted Messenger program to spread accurate and up-to-date information about the vaccine, particularly to Black and Brown communities that had concerns about the vaccine and mistrust of the medical and scientific community. In tandem, Jefferson initiated a mobile community vaccination program that has administered more than 5,200 vaccines in marginalized communities. More than 92% are people of color and 47% non-English speaking.

### In the Community

In FY20 Jefferson Health contributed more than \$448 million in charitable care and community benefit. Among Jefferson's many efforts in this area is the work of the Philadelphia Collaborative for Health Equity (the Collaborative), the community outreach and engagement arm of Jefferson Health charged with addressing the social and structural determinants of health in Philadelphia. Aligned with the CHNA and CHIP, the Collaborative partners with internal and external stakeholders to address the complex issues facing our communities by aligning resources, building partnerships, and forging trust and relationships that create sustainable change. The Collaborative builds on community strength to improve health and well-being in communities, fostering the local Ecosystem necessary to promote health equity and help every family in our targeted communities reach their full potential.

In 2020, Jefferson, in partnership with Temple, launched The Frazier Family Coalition for Stroke Education and Prevention, which is coordinated through the Collaborative to promote the health of North Philadelphia residents through a multifaceted program aimed at reducing the number of strokes. With its office located in the lowest-income zip code in the city, the coalition is countering the lack of access to providers, unmanaged chronic disease, and limited awareness of risk factors that has allowed the rate of stroke to swell in North Philadelphia.

Jefferson and Novartis also initiated a program called "Closing the Gap" to focus on reducing cardiac health disparities across the city's most vulnerable zip codes. Addressing social determinants of health, the program heavily utilizes Community Health Workers to screen, identify, and navigate individuals at high-risk for cardiovascular disease to the care and preventative services they need. The Jefferson Center for Connected Care was also launched to develop and test innovative approaches for a patient-responsive care delivery system. As part of its Reimagine fundraising campaign, Jefferson has set a goal of raising \$100 million for health equity initiatives in the greater Philadelphia region.

Jefferson is one of the largest providers in Philadelphia for refugee health care and is one of only four programs in the nation recognized by the Centers for Disease Control and Prevention as a Center of Excellence. In addition to its Center for Refugee Health, Jefferson opened the Hansjörg Wyss Wellness Center in 2021. The Center brings free medical and social services to immigrant and refugee communities. In the fall of 2021, Jefferson and other providers supported an extensive volunteer medical operation at the airport for Afghan evacuees. They offered urgent medical care for 1,600 on site, while providing family-centered testing and vaccinations.



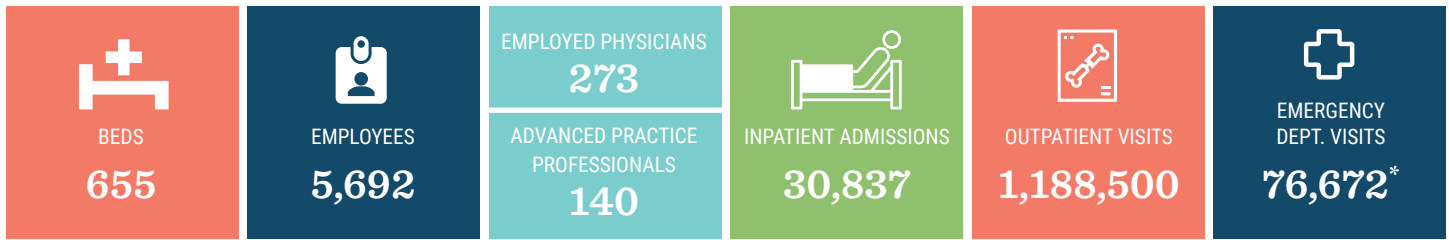
## Jefferson Abington Hospital

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 for over 100 years. Jefferson Abington Hospital offers comprehensive healthcare services at a level not often found in a community hospital, including 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, orthopaedic 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. The commitment to providing accessible care during the COVID-19 pandemic is what led the hospital to launch a COVID-19 Community Testing Site in March 2020 - the first of its kind in the Philadelphia area.

In 2019, the hospital opened its newest outpatient health center located in Horsham, Montgomery County. Jefferson Health – Horsham is the seventh outpatient facility of its kind that the organization operates in Montgomery and Bucks counties. The 20,000 square-foot, state-of-the-art facility includes three medical practices and a full service laboratory on site.

Also in 2019, Jefferson Health – Abington partnered with Nemours Children's Health to provide pediatric services to infants, children and adolescents of Bucks and Montgomery counties. Through this collaboration, Nemours pediatric hospitalists provide advanced medical care for children in Jefferson Abington Hospital's 15-bed pediatric unit, pediatric consultations in the hospital's Emergency Trauma Center and more.



\*FY21 Statistics

In addition to this collaboration, as a major regional teaching facility, Jefferson Abington Hospital also maintains associations with Philadelphia College of Osteopathic Medicine and Sidney Kimmel Medical College at Thomas Jefferson University.

In FY20 and FY21, Jefferson Abington Hospital received numerous awards and accolades for high quality patient care, excellence and safety, including recognition from the Institute for Healthcare Improvement as an *Age-Friendly Health System* (2019). Age-Friendly Health Systems work to implement a set of evidence-based interventions specifically designed to improve care for older adults.

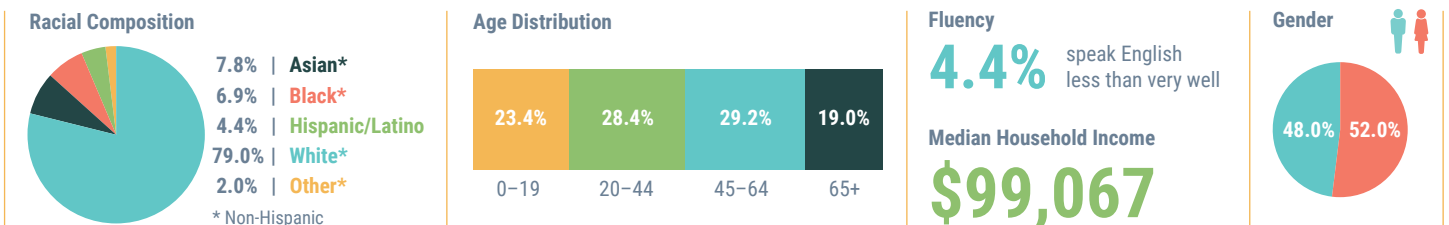
In the area of maternity care, Jefferson Abington Hospital was named to *Newsweek's* 2020 list of "Best Maternity Care Hospitals," one of fewer than 250 hospitals nationwide to receive this honor. In addition, the Hospital and Healthsystem Association of Pennsylvania (HAP) awarded Jefferson Abington Hospital the *2020 Excellence in Care Achievement Award*, one of three awards the hospital's maternity program earned for its work to reduce opioid use among women who give birth by cesarean section.

In FY21, Jefferson Abington Hospital earned the *Mission: Lifeline-STEMI Receiving Center – Gold Plus Quality Achievement Award* 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 Honor Roll* 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 2021. The Hospital scored high-performing in 10 categories: aortic valve surgery, congestive heart failure, colon cancer surgery, chronic obstructive pulmonary disease, diabetes, heart attack, hip replacement, knee replacement, kidney failure and stroke. Additionally, Jefferson Abington Hospital was rated high performing in one specialty area: Diabetes & Endocrinology.

### SERVICE AREA DEMOGRAPHICS

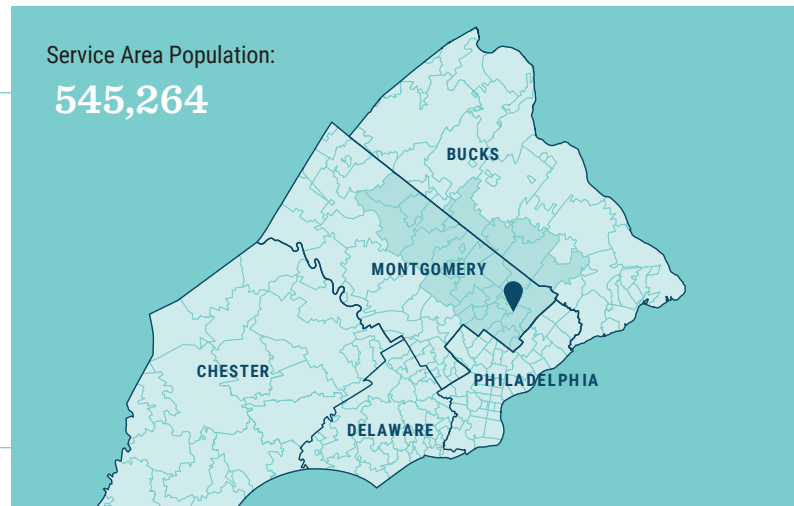


## TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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.

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

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



## 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 2020, Jefferson Abington Hospital provided over \$101.7 million to individuals in our communities seeking resources for care and education, in alignment with our Community Health Implementation Plan developed in response to our 2019 Community Health Needs Assessment:

- » Over \$76.2 million in financial assistance and subsidized health services was provided to 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 annually. 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. A faith-based advisory council, led by Jefferson Abington Hospital, works together to support and provide/coordinate programming at specific sites for over 300 members of Faith Community Ministries to address chronic disease management.
- » Partnering with the Montgomery County Public Safety and the Abington Health Foundation Women's Board, Narcan<sup>®</sup> kits were made available to patients in Jefferson Abington Hospital's Emergency Trauma Center.
- » Throughout fiscal year 2020, Jefferson Abington Hospital provided more than \$2.7 million 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 2020 Jefferson Abington Hospital provided over \$22.5 million 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/>.



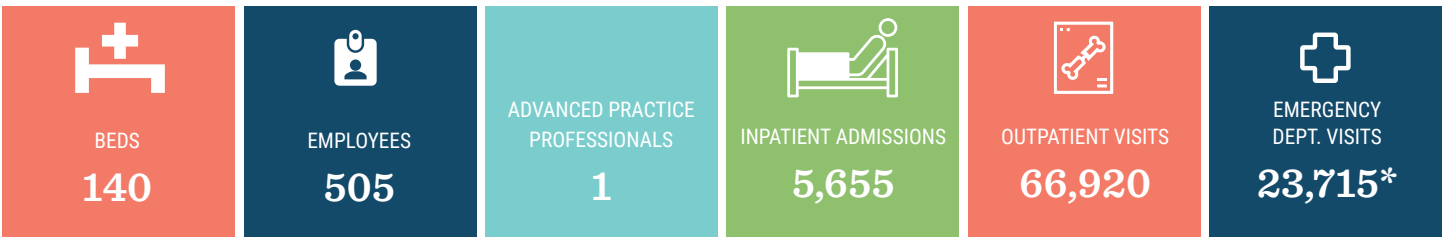
## Jefferson Lansdale Hospital

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 Orthopaedic and Spine Institute, a wound care center, gynecology, endocrinology, urology, pulmonology, gastroenterology, general surgery and more.

Jefferson Lansdale Hospital, part of Jefferson Health, is dedicated to improving lives and caring for the community. Jefferson Lansdale Hospital's commitment to the community was evidenced during the COVID-19 pandemic when it began offering COVID-19 vaccines as soon as they became available. A COVID-19 Vaccination Center opened at Jefferson Lansdale Hospital by mid-December 2020 in order to administer vaccines to both employees and community members.

Jefferson Lansdale Hospital is also home to three, impactful Community Health programs for children's health, dental care and elder care. All three programs provide easily accessible care to local underinsured or uninsured patients of all age groups:

- » The Children's Clinic provides a full range of affordable primary/preventive care services to children from birth to their 22nd birthday, and a social worker is available to assist families with insurance applications, charity care applications and more.
- » The Dental Access Program is designed to provide basic dental services to underinsured and uninsured residents of the greater North Penn community through a network of participating local dentists from the Montgomery-Bucks Dental Society.
- » 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.



\*FY21 Statistics

In FY21, Jefferson Lansdale Hospital began its pursuit of Age-Friendly status. Age-Friendly Health Systems is an initiative of the John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association of the United States. Age-Friendly Health Systems and facilities aim to follow an essential set of evidence-based practices and align them with what matters most to older adults patients and their caregivers.

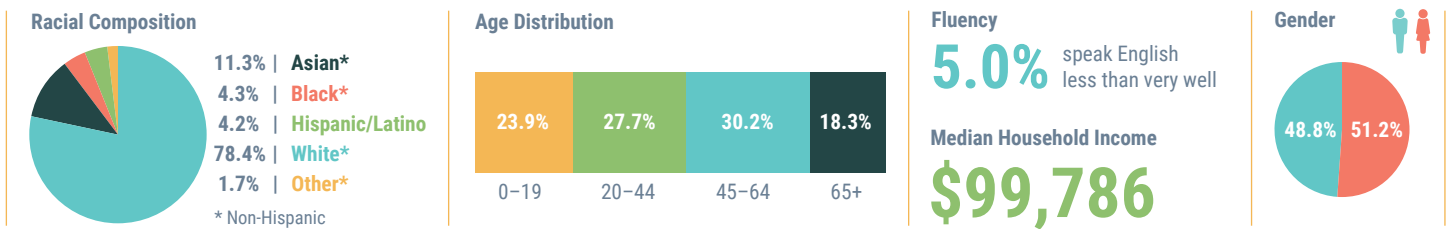
In FY20 and FY21, Jefferson Lansdale Hospital received numerous awards and accolades for high quality patient care, excellence and safety. In 2019, Jefferson Lansdale Hospital was the first in the nation to earn the Joint Commission's *Gold Seal of Approval*® and the American Heart Association's *Heart-Check mark for Acute Heart Attack Ready Certification* in recognition of its care of heart attack patients.

Also in 2019, Jefferson Lansdale Hospital's renowned stroke program earned The American Heart Association/American Stroke Association's *Get With The Guidelines Stroke Gold Plus & Target: Stroke Elite Honor Roll Award* for excellence in providing quality stroke care.

In 2020, Jefferson Lansdale Hospital earned Healthgrades' *Pulmonary Care Excellence Award* for superior clinical outcomes in treating COPD and pneumonia. Additionally, the Gift of Life donor program and Hospital and Healthsystem Association of Pennsylvania (HAP) honored Jefferson Lansdale Hospital with their *Platinum Award*.

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

### SERVICE AREA DEMOGRAPHICS

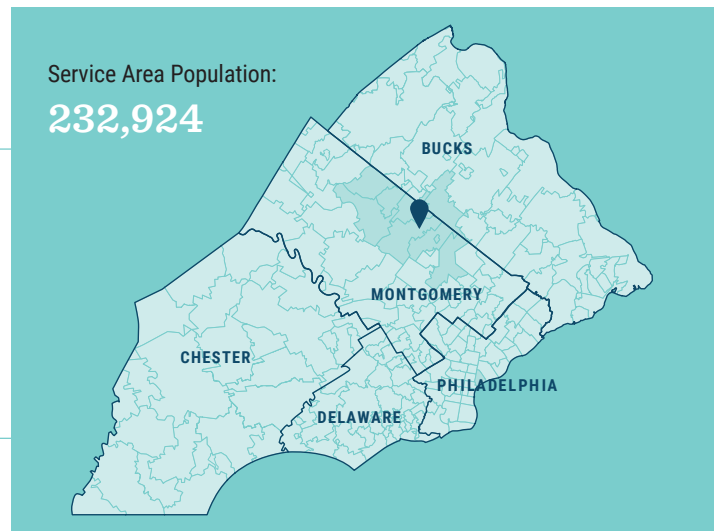


## TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

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.

**Bucks County:** 18914, 18932

**Montgomery County:** 18915, 18936, 18964, 18969, 19002, 19422, 19438, 19440, 19446, 19454



## 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 2020, Jefferson Lansdale Hospital provided over \$8.7 million to individuals in our communities seeking resources for care and education, in alignment with our Community Health Implementation Plan developed in response to our 2019 Community Health Needs Assessment:

- » More than \$7.8 million was provided to the community in uninsured and underinsured health services, including through 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 the 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 annually.

- » Jefferson Lansdale Hospital collaborates with many community organizations to support community health improvement initiatives. A faith-based advisory council, led by Jefferson Abington Hospital, works together to support and provide/coordinate programming at specific sites at over 300 members of Faith Community Ministries to address chronic disease management.
- » 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 2020, Jefferson Lansdale Hospital provided over \$79,000 in free health education, screenings, in-kind donations and other community support.
- » Jefferson Lansdale Hospital provided over \$87,000 in medical education programs in fiscal year 2020, 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/>.

# PARTNER ORGANIZATIONS

In addition to the participating hospitals and health systems, the organizations below provided support to the rCHNA process. More details about each organization's role are highlighted below.

## Chester County Health Department

The [Chester County Health Department](#)'s mission is to provide public health leadership as well as personal and environmental health services to residents and visitors so that they may grow, live and work in healthy and safe communities. Since its founding in 1968, Chester County Health Department has consistently provided exceptional public health leadership, programs and services to Chester County residents. The Health Department embraces the public health principle of "community as client," promoting the health of families, populations, and communities through coordinated efforts across the Bureaus of Administrative and Support Services, Personal Health Services, Environmental Health Protection, and Population Health. The Health Department provides a full range of public health programs, including nurse home visiting; immunization clinics; food supplements through the Women, Infants and Children program; sexually transmitted disease testing; restaurant inspections; sewage and water permits; disease investigation and surveillance; emergency planning and response; community health assessment and planning; health promotion; and much more.

*Chester County Health Department supported community engagement for focus group-style community conversations with Chester County residents and community organization representatives.*

## Delaware County Health Department

The central focus of the new [Delaware County Health Department](#) is to create thriving and healthy communities. Priorities such as health equity, education, safe and affordable housing, nutrition, green space, racial justice, and employment opportunities will lead to positive health outcomes for all Delaware County residents and have a meaningful impact on their quality of life. As the first health department established in Pennsylvania in 33 years, the Delaware County Health Department has the unique opportunity to provide public health leadership that embodies the principles of Public Health 3.0, a national model for public health in the 21st Century. Through coordinated efforts across the Environmental Health Division, Personal Health Division, Population Health Division, and with strong support from a dedicated Epidemiology Team, the health department will offer public health capacities and services for residents to achieve health equity, maintain healthy environments, support the health of moms and babies, control communicable diseases, respond to health emergencies, and promote safe and healthy lifestyles. The Health Department provides a full range of public health programs including Vaccines for Children (VFC), STI testing and education, retail food service inspections, emergency planning and response, disease investigation and surveillance, health education, and more. The Delaware County Health Department will partner with other government agencies such as municipal health entities, aging, mental health, and criminal justice agencies, non-profits, small businesses, and major employers, public schools, trade schools, colleges and universities, hospitals, and other healthcare facilities, community partners, groups, and individuals- to ensure an authentic community voice is present to drive the positive health outcomes every single resident deserves.

*Delaware County Health Department supported community engagement for focus group-style community conversations with Delaware County residents and community organization representatives.*

## Health Care Improvement Foundation

The [Health Care Improvement Foundation](#) (HCIF) is an independent nonprofit organization based in Philadelphia that is dedicated to the vision of healthier communities through equitable, accessible, and quality health care. HCIF seeks to drive superior health care through collaboration and shared learning. Using skills in program design, coaching, facilitation, measurement, and evaluation, HCIF's team of experts convenes diverse partners around common goals for healthcare improvement to implement solutions that no market participant could achieve individually. Since its inception, HCIF has been recognized as an outstanding example of how advances in quality care can be achieved through large-scale collaboration.

HCIF's population health work is grounded in collaborative initiatives advancing health literacy, chronic disease prevention and management, and community health improvement. HCIF facilitates the Collaborative Opportunities to Advance Community Health (COACH) initiative sponsored by the Hospital and Healthsystem Association of Pennsylvania. Through COACH and other initiatives, HCIF builds system capacity and cross-sector partnership opportunities to more effectively address social determinants of health and advance health equity in the five-county southeastern Pennsylvania region.

*HCIF provided overall project management and led qualitative data collection, synthesis, health need prioritization, and report development processes.*

## Montgomery County Office of Public Health

It is the Mission of the [Montgomery County Office of Public Health](#) (OPH) to provide public health services and foster collaborative actions that empower our community to improve its health and safety. Our Vision is to optimize the health and wellness of individuals and families through innovative practices. The OPH takes great pride in being ranked #1 in Health Factors and #4 in Health Outcomes in the state of Pennsylvania by the Robert Wood Johnson Foundation.

The OPH is Project Public Health Ready (PPHR) certified and recognized by the National Association of County and City Health Officials (NACCHO) for our capacity and capability to plan for, respond to, and recover from public health and other emergencies.

*OPH supported community engagement for focus group-style community conversations with Montgomery County residents and community organization representatives.*

## Philadelphia Association of Community Development Corporations

[Philadelphia Association of Community Development Corporations](#) (PACDC) works to create an equitable city where every Philadelphian lives, works, and thrives in a neighborhood that offers an excellent quality of life. As a membership association, we foster strong community development corporations and non-profit community organizations by enhancing their skills and advocating for resources and policies to create a just and inclusive Philadelphia.

The work of community development improves health outcomes by improving the context in which people live and the quality of lives that they lead. PACDC has played a leadership role in securing more than \$640 million for affordable homes and neighborhood economic development, and worked to reform the city's vacant property system to get blighted properties back in productive reuse. Our Community Development Leadership Institute has trained more than 3,000 people representing community development corporations, civic associations, and other practitioners looking to better understand issues affecting lower-income residents and neighborhoods, ranging from gentrification and blight to neighborhood-driven real estate development, and their intersection with arts, health, education, and community engagement.

*PACDC led community engagement efforts for focus group-style community conversations with Philadelphia residents.*

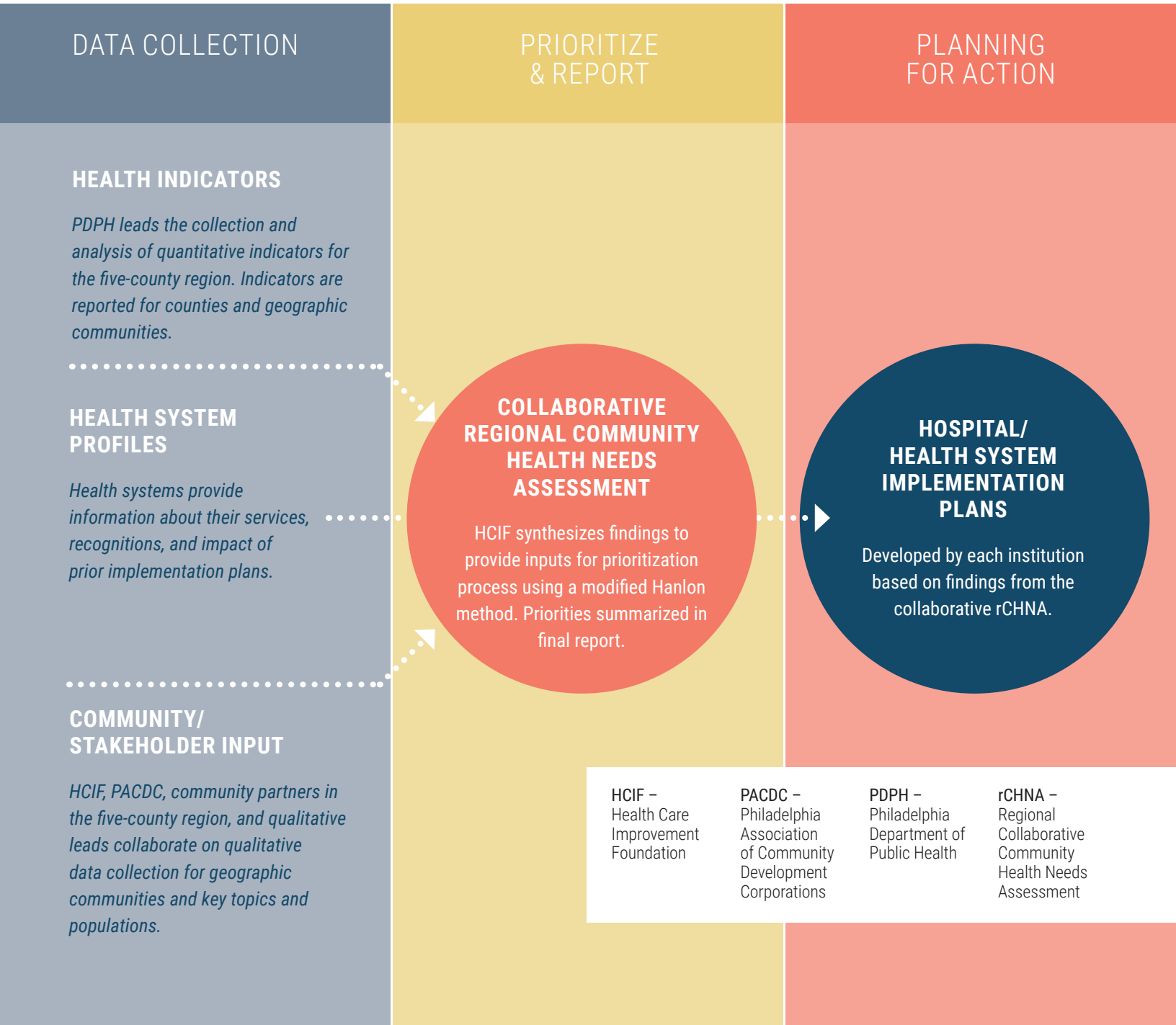
## Philadelphia Department of Public Health

The [Philadelphia Department of Public Health](#) (PDPH) promotes and protects the health of all Philadelphians and provides a safety net for the most vulnerable. The agency leads programs to prevent communicable diseases; prevent chronic diseases and promote healthy behaviors; prevent environmental health risks; investigate outbreaks of disease; respond to public health emergencies; and promote the health of women, children, and families. In addition, the department operates the eight City Health Centers that provide primary care to more than 80,000 Philadelphians. PDPH has been on the vanguard of public health, proposing policy solutions to problems like smoking and obesity, and intends to continue that tradition with creative solutions to both long-standing urban health problems and new crises.

*PDPH led the integration process to extract, transform, and load (ETL) data to a unified repository from multiple sources. PDPH also conducted analyses of quantitative metrics used to inform the status of health and well-being in the five-county region and contributed to the report's development.*

# 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, hospitals/health systems produce implementation plans to respond to unmet health needs. These plans may involve further collaboration or coordination to address shared priorities.



July 2021 to June 2022

June 2022 to November 2022

# GOVERNANCE

A Steering Committee, composed of representatives from participating hospitals/health systems and supporting partner organizations, guided the development of the regional community health needs assessment (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 Health Care Improvement Foundation (HCIF), Philadelphia Department of Public Health (PDPH), 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
Ashley Orr, MPH	Population Health Director	Chester County Health Department
Meghan Smith, MPH	Health Planning & Promotion Supervisor	Chester County Health Department
Falguni Patel, MPH	Manager, Community Impact	Children's Hospital of Philadelphia
Rebecka Rosenquist, MSc	Health Policy Director, PolicyLab	Children's Hospital of Philadelphia
Rosemarie Halt, MPH	Chair	Delaware County Board of Health
Monica Taylor, PhD, MS	Chair	Delaware County Council
Allyson Gilmore, MBA	Director, Marketing & Outreach	Doylestown Health
Kellye Remshifski, MS, CHES, NBH-HWC	Wellness and Outreach Manager	Doylestown Health
Joan Boyce	Senior Director, Government Relations & Public Affairs	Einstein Healthcare Network (Jefferson Health)
Brandi Chawaga, M.Ed.	Director, Community Wellness	Einstein Healthcare Network (Jefferson Health)
Donna Manning	Executive Director, Post Acute Care	Grand View Health
Cynthia Westphal, MSN, RN, NE-BC	Chief Nursing Officer/Vice President, Patient Care Services	Grand View Health
Susan Choi, PhD	Senior Director, Population Health	Health Care Improvement Foundation
Mojisola Delano, MPH, MS	Consultant	Health Care Improvement Foundation
Kelsey Salazar, MPH	Director	Health Care Improvement Foundation
Cassidy Tarullo, MPP	Project Coordinator	Health Care Improvement Foundation
Marianna Calabrese, MA	Manager, Community Benefit	Jefferson Health
U. Tara Hayden, MHSA	Vice President, Community Health Equity, Philadelphia Collaborative for Health Equity	Jefferson Health
Sasha Mendez	Program Manager, Community Health Benefits & Engagement, Philadelphia Collaborative for Health Equity	Jefferson Health

Yawei Song, MSW, LSW*	Former Community Benefits Coordinator, Center for Urban Health	Jefferson Health
Sharon Larson, PhD	Professor and Executive Director, Main Line Health Center for Population Health Research at Lankenau Institute for Medical Research	Main Line Health
Robert Lorenz*	Former Manager, Strategic Planning and Analytics	Main Line Health
Debbie McKetta, MS, CLSSGB	Manager, Strategic & Service Line Planning	Main Line Health
Ruth Cole, RN, MPH	Director, Division of Clinical Services	Montgomery County Office of Public Health
Nicole Rafalko, MPH, CPH	Epidemiology Research Associate	Montgomery County Office of Public Health
Laura Lombardo	Manager, Community Relations	Penn Medicine
Courtney Summers, MSW	Administrator, Division of Community Health	Penn Medicine
Garrett O'Dwyer	Health Programs & Special Projects Manager	Philadelphia Association of Community Development Corporations
Frank Franklin, PhD, JD, MPH	Deputy Health Commissioner	Philadelphia Department of Public Health
Jonas Miller, MGIS, PMP	Data Visualization Engineer	Philadelphia Department of Public Health
Claire Newbern, PhD, MPH*	Former Chief Epidemiologist	Philadelphia Department of Public Health
Anne Catino, RN, BSN, MS, NEA-BC	Vice President/Chief Nursing Officer	Redeemer Health
Barbara Tantum, MBA, MHA	Director of Planning	Redeemer Health
Andrew Kunka, JD, MPAP	Community Benefit & Special Projects Manager	Temple Health
Lakisha Sturgis, RN, BSN, MPH, CPHQ	Director, Community Care Management, Temple Center for Population Health	Temple Health
Laureen Carlin	Director, Community Health and Well-Being and Volunteer Services	Trinity Health Mid-Atlantic
Joann Dorr, RN, BSN	Regional Director, Community Health and Well-Being	Trinity Health Mid-Atlantic
Lisa Kelly, RN, MBA*	Former Director, Community Health and Well-Being and Volunteer Services	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

PDPH advised the Steering Committee on the selection of quantitative health indicators. The list of indicators for the 2019 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.** Indicators related to COVID-19 were added.

The PDPH team, which included experts in epidemiological and geospatial analyses, compiled, analyzed, and aggregated over 60 health indicators from varied data sources. The table below presents information about the included indicators.

Indicator	Details	Year(s)	Source
<b>ABOUT THE COMMUNITY</b>			
Population	Total population size	2019	American Community Survey, Census Bureau (5-yr)
Age distribution by gender		2019	American Community Survey, Census Bureau (5-yr)
Race/ethnicity		2019	American Community Survey, Census Bureau (5-yr)
Educational attainment	High school as highest education level (26+ years)	2019	American Community Survey, Census Bureau (5-yr)
Income	Median household income	2019	American Community Survey, Census Bureau (5-yr)
Social Vulnerability Index	Percentile ranking of 4 socioeconomic indicators	2018	CDC/ATSDR Social Vulnerability Index
Foreign-born status	Born outside of United States	2019	American Community Survey, Census Bureau (5-yr)
Ability to speak English	Speak English less than "very well" (5+ years)	2019	American Community Survey, Census Bureau (5-yr)
Disability status	With a disability	2019	American Community Survey, Census Bureau (5-yr)
Leading causes of death	Top 5 causes	2019, 2020	Vital Statistics, PA Department of Health
<b>GENERAL</b>			
All-cause mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Life expectancy by gender	Years	2019, 2020	Vital Statistics, PA Department of Health
Years of potential life lost before 75	Years	2019, 2020	Vital Statistics, PA Department of Health
<b>COVID-19</b>			
COVID-19 fully covered vaccination	Rate per 100,000 (as of 11/30/21)	2020-2021	Pennsylvania Department of Health
COVID-related emergency department utilization	Rate per 100,000	2020	HealthShare Exchange
COVID-related hospitalization	Rate per 100,000	2020	PA Health Care Cost Containment Council
COVID-related mortality	Rate per 100,000	2020	Pennsylvania Department of Health

CHRONIC DISEASE & HEALTH BEHAVIORS			
Adult obesity prevalence	Body mass index 30-99.8 among adults 18+ years	2018	Behavioral Risk Factor Surveillance System
Diabetes prevalence	Told by a doctor that they have diabetes	2018	Behavioral Risk Factor Surveillance System
Diabetes-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Hypertension prevalence	Told by a doctor that they have high blood pressure	2017	Behavioral Risk Factor Surveillance System
Hypertension-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Potentially preventable hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Premature cardiovascular disease mortality	Death before 65 years, rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Major cancer incidence	Prostate, breast, lung, colorectal cancers; rate per 100,000	2019	Vital Statistics, PA Department of Health
Major cancer mortality	Prostate, breast, lung, colorectal cancers; rate per 100,000	2019	Vital Statistics, PA Department of Health
Mammography screening	Mammogram in the past 2 years among women 50-74 years	2018	Behavioral Risk Factor Surveillance System
Colorectal cancer screening	Fecal occult blood test, sigmoidoscopy, or colonoscopy among adults 50-75 years	2018	Behavioral Risk Factor Surveillance System
Physical inactivity prevalence	No leisure time physical activity	2018	Behavioral Risk Factor Surveillance System
INFANT & CHILD HEALTH			
Asthma hospitalization	Children <18 years, rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Infant mortality	Deaths before age 1 per 1,000 live births	2019, 2020	Vital Statistics, PA Department of Health
Low birthweight births	Percent low birthweight (<2,500 grams) births out of live births	2019, 2020	Vital Statistics, PA Department of Health
Preterm births	Percent preterm (before 37 weeks gestation) births out of live births	2019, 2020	Vital Statistics, PA Department of Health
BEHAVIORAL HEALTH			
Adult binge drinking	5+ (men) or 4+ (women) alcoholic drinks on one occasion in past 30 days	2018	Behavioral Risk Factor Surveillance System
Adult smoking	Current smoker status	2018	Behavioral Risk Factor Surveillance System
Drug overdose mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Opioid-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Substance-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Poor mental health	Poor mental health for 14+ days in past 30 days	2018	Behavioral Risk Factor Surveillance System
Suicide mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
Youth binge drinking	5+ alcoholic drinks in a row on ≥1 days in past 30 days among teens, county-level only	2019	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey*
Youth ever attempted suicide	Suicide attempt ever among teens, county-level only	2019	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, county-level only	2019	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey*
Youth smoking	Smoked cigarettes in past 30 days among teens, county-level only	2019	Youth Risk Behavior Surveillance System
Youth vaping	Used electronic vapor products in past 30 days among teens, county-level only	2019	Youth Risk Behavior Surveillance System

INJURIES			
Fall-related hospitalization	Rate per 100,000	2019, 2020	PA Health Care Cost Containment Council
Gun-related emergency department utilization	Rate per 100,000	2019, 2020	HealthShare Exchange
Homicide mortality	Rate per 100,000	2019, 2020	Vital Statistics, PA Department of Health
ACCESS TO CARE			
Health insurance (public) status - Adults	Adults 19-64 years with Medicaid	2019	American Community Survey, Census Bureau (5-yr)
Health insurance (public) status - Children	Children <19 years with public insurance	2019	American Community Survey, Census Bureau (5-yr)
Health insurance status - Population	Population without insurance	2019	American Community Survey, Census Bureau (5-yr)
Health insurance status - Children	Children <19 years without insurance	2019	American Community Survey, Census Bureau (5-yr)
Emergency department utilization	Rate per 100,000	2019, 2020	HealthShare Exchange
High emergency department utilization	5+ visits in 12 months, rate per 100,000	2019, 2020	HealthShare Exchange
SOCIAL & ECONOMIC CONDITIONS			
Poverty status - Population	Population in poverty	2019	American Community Survey, Census Bureau (5-yr)
Poverty status - Children	Children <18 years in poverty	2019	American Community Survey, Census Bureau (5-yr)
Employment status	Adults 19-64 years unemployed (not in labor force)	2019	American Community Survey, Census Bureau (5-yr)
Household type	Householders living alone who are 65+ years	2019	American Community Survey, Census Bureau (5-yr)
Food insecurity	Population experiencing food insecurity, county-level only	2019	Feeding America
Households receiving food assistance	Households receiving Supplement Nutrition Assistance Program (SNAP) benefits	2019	American Community Survey, Census Bureau (5-yr)
Housing cost burden	Households who spend >30% of income on housing	2019	American Community Survey, Census Bureau (5-yr)
Housing lead risk	Homes with potential lead risk	2019	American Community Survey, Census Bureau (5-yr)
Housing occupancy status	Vacant housing units	2019	American Community Survey, Census Bureau (5-yr)
Violent crime rate	Rate per 100,000, county-level only	2018	PA Uniform Crime Reporting System

Note: Only crude rates are reported.

\* Youth Risk Behavior Surveillance System data only for Philadelphia County; similar items collected for Bucks, Chester, Delaware, and Montgomery County through the Pennsylvania Youth Survey (data limited to high school students only)

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.

The Steering Committee had a strong interest in examining how indicators varied by race, ethnicity, or other demographic characteristics to identify potential disparities. However, many geographic communities did not have a sufficient sample size for specific racial/ethnic groups to enable rigorous comparison for a given health indicator. In addition, the availability and quality of such demographic data was inconsistent across indicators. The health indicators are therefore not disaggregated by these characteristics for the current report. Wherever possible and appropriate, secondary analyses comparing health outcomes or factors by such characteristics are presented in relevant sections throughout the report.

# COMMUNITY INPUT

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. Though no formal written comments on the 2019 rCHNA were received upon solicitation, feedback from partners provided to Steering Committee and project team members informed the development of the current process. Building on the qualitative data collection approach developed for the 2019 rCHNA, the Steering Committee and project team sought to expand, enhance, and refine strategies to thoughtfully gather and incorporate community input into the 2022 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 two experts in qualitative data collection and analysis as consultants to serve as Qualitative Leads.

## Qualitative Team Members

Name	Title	Institution
Kathy Gorman	Sr. Vice President, Strategic Planning and Marketing	Chester County Hospital
Falguni Patel, MPH	Manager, Community Impact	Children's Hospital of Philadelphia
Rebecka Rosenquist, MSc	Health Policy Director, PolicyLab	Children's Hospital of Philadelphia
Kellye Remshifski, MS, CHES, NBH-HWC	Wellness and Outreach Manager	Doylestown Health
Allison Zambon, MHS, MCHES	Program Manager, Office of Community Outreach	Fox Chase Cancer Center - Temple University Health System
Keith Hammerschmidt	Executive Director, Grand View Healthcare Partnership	Grand View Health
Rickie Brawer, PhD, MPH	Qualitative Lead Consultant	Health Care Improvement Foundation
Susan Choi, PhD	Senior Director, Population Health	Health Care Improvement Foundation
Mojisola Delano, MPH, MS	Consultant	Health Care Improvement Foundation
Kelsey Salazar, MPH	Director	Health Care Improvement Foundation
Cassidy Tarullo, MPP	Project Coordinator	Health Care Improvement Foundation
Jean Wallace, PhD, MPH	Qualitative Lead Consultant	Health Care Improvement Foundation
Marianna Calabrese, MA	Manager, Community Benefit	Jefferson Health
U. Tara Hayden, MHSA	Vice President, Community Health Equity, Philadelphia Collaborative for Health Equity	Jefferson Health
Yawei Song, MSW, LSW*	Former Community Benefits Coordinator, Center for Urban Health	Jefferson Health
Deborah Mantegna, RN, MSN	System Director, Community Health and Outreach; Manager, Volunteer Services, Riddle Hospital	Main Line Health
Debbie McKetta, MS, CLSSGB	Manager, Strategic & Service Line Planning	Main Line Health
Heather Klusaritz, PhD, MSW	Director of Community Health Services, Penn Medicine Center for Health Equity Advancement; Associate Director, Center for Community & Population Health, DFMCH	Penn Medicine
Barbara Tantum, MBA, MHA	Director of Planning	Redeemer Health
Joann Dorr, RN, BSN	Regional Director, Community Health and Well-Being	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.

Special thanks to Michele Francis, MS, RD, CDCES, LDN, Director, Community Health & Wellness Services at Chester County Hospital and Maureen Hennessey, Ed.D., MPA, Manager, Community Health and Outreach at Bryn Mawr Hospital (Main Line Health) for invaluable assistance with community outreach and engagement.

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 that 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 geographic 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 October 2021 – February 2022. To ensure the safety of participants in light of the COVID-19 pandemic, all focus group discussions were held virtually, using the Zoom platform.
- Focus group-style, 90-minute “community conversations” were held to gather input from residents (and in some cases, those who provide services for those residents) of a subset of the 46 geographic communities. The Steering Committee guided the selection of communities, with higher need communities for whom recent qualitative data was not available being identified for inclusion. To accommodate the expanded service area, the number of conversations increased to 26: Bucks (3), Chester (4), Delaware (3), Montgomery (5), and Philadelphia (11). In addition, several interviews were conducted with key informants unable to join a session.
- To capture the insights of those who provide important health, human, and social services in each of the counties, 21 60\*-minute focus group discussions centered on “spotlight” topics were conducted with organization and local government agency representatives. (Again, a limited number of interviews were conducted with those who were unable to participate in the focus groups.) A list of potential topics was generated by the Steering Committee based on priorities from past CHNAs. From this list, four topics were selected per county through consensus vote by Steering Committee members whose organizations serve that county.

The topics selected for each county are as follows:

Topic	Bucks	Chester	Delaware	Montgomery	Philadelphia
Access to care			X		
Behavioral health	X	X	X	X	X
Chronic disease	X	X	X	X	X**
Food insecurity		X	X	X	
Housing and homelessness					X
Older adults and care	X				
Racism and discrimination in health care					X
Substance use	X	X		X	
Violence					X

\* For those counties opting not to have a separate substance use discussion (Delaware and Philadelphia), the behavioral health discussion was extended to 90 minutes, in recognition of the interrelationship between these topics.

\*\* Chronic disease was also discussed in a focus group discussion conducted in Philadelphia as part of data collection supporting the cancer focus area, to be addressed in the section below.

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 either specific to different type of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) or reflected gaps in the 2019 rCHNA:

**Cancer.**

New to the 2022 rCHNA. In addition to cancer-related information gathered from community conversation and spotlight discussions described above, partner cancer centers shared findings from focus groups with community advisory board members they conducted.

**Disability.**

HCIF worked with a subcommittee of rehabilitation facilities to develop and administer an online survey of people with disabilities.

**Immigrant, refugee, and heritage communities.**

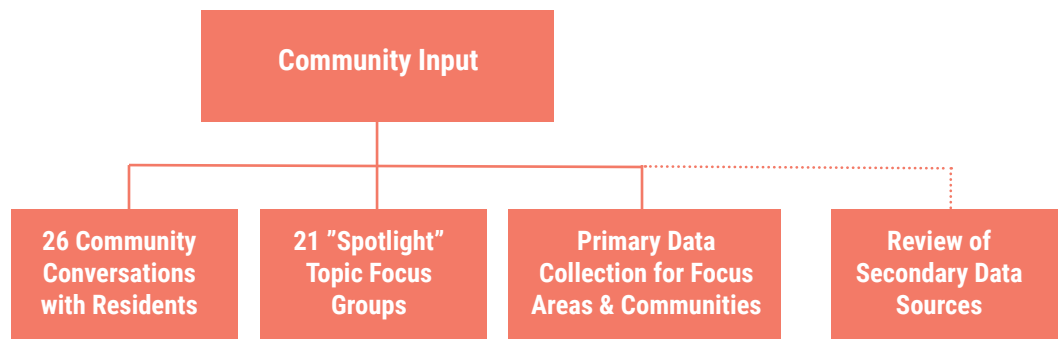
Community organizations were provided support and funding to collect data about health needs in their communities (through surveys, focus groups, and interviews) or share relevant secondary data.

**Youth voice.**

Recognizing the opportunity to grow from the small-scale effort in the 2019 rCHNA, HCIF supported youth-serving organizations with funding and resources to conduct discussions about health with youth and report back findings.

Secondary data in the form of reports and summaries from other community engagement efforts were important inputs for this report. For example, the 2020 Pennsylvania LGBTQ Health Needs Assessment served as a key data source for the LGBTQ+ Communities section. A full list of sources incorporated is included in the "Resources" section.

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



## 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 2019 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.

In light of the unique challenges posed by the virtual format of the discussions, the Qualitative Team provided critical feedback on the development of materials such as Zoom how-to guides and flyers to promote the discussions and facilitate online registration. Anticipating the challenges of the digital divide and potential discomfort with the online format, the project team and the Qualitative Team also prioritized strategies such as offering additional preparation sessions for interested participants needing technical support, as well as working closely with trusted community organizations who could facilitate community resident participation. Those organizations interested in serving in this role and more generally assisting with recruitment were offered funding to support their time. In Philadelphia, PACDC led community engagement efforts through its network of community development corporations and other partners.

Values guiding participant engagement included valuing 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 marginalized 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. Steering Committee members, PACDC, partner organizations, and HCIF used varied methods to promote the discussions, including phone and email outreach, social media posts, intranet outreach, listserv posts, and posting flyers in community locations.

In advance of discussions, HCIF fielded questions, assisted with registration, and provided regular reminders to registrants to maximize participation rates. Despite best efforts, it is important to note limitations to the data collection process:

- Ensuring sufficient numbers of participants (at least 5-6) for all sessions was challenging. Despite significant outreach, some meetings had lower registrations; feedback from community organizations indicated their own challenges with having enough time to devote to recruitment (owing largely to increases in their work due to COVID-19-related impacts) and community members' reluctance to join an online meeting (whether due to online meeting fatigue or unfamiliarity with Zoom). In addition, higher no-show rates relative to in-person meetings were observed, suggesting that registrants may have found it easier to forget or change their minds about participation.

- To begin to assess representation in the discussions, optional demographic questions were added to the online registration form for each session. Given the extent of missing data it is difficult to draw firm conclusions, but a lack of racial/ethnic diversity in the spotlight topic discussions with organization representatives was evident, suggesting important opportunities for intentional and thoughtful engagement in future data collection efforts.

The Qualitative Leads facilitated all discussions with technical support by the HCIF team. All discussions were recorded and transcribed for later analysis; only the project team and Qualitative Leads had access to the recordings and transcripts. Transcripts were imported as Word documents into NVivo software (release 1.5.1, QSR International) to manage, code, and interpret qualitative data from focus groups and interviews. Both Qualitative Lead consultants identified recurrent themes from the transcripts, agreed on 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.

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

- **Geographic communities** – County-level summaries for Bucks, Chester, Delaware, and Montgomery Counties; 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** – Topic summaries that aggregates across counties; given the overlap between Behavioral Health and Substance Use, these topics were combined into one summary.

Summaries are organized around key sections of the discussion guide. Within each section, themes are generally presented in order of greatest frequency of mention; in some cases, for reasons of flow, related topics may be presented together. Themes are accompanied by illustrative quotes to capture participants' voices as much as possible.

# DETERMINING AND PRIORITIZING COMMUNITY HEALTH NEEDS

The project team synthesized a full list of community health needs based on the health indicators and findings from the community engagement components. Related community health needs were consolidated to produce the final list of 12 high priority community health needs, representing three categories: health issues, access and quality of healthcare and health resources, and community factors.

A modified Hanlon rating method was used to prioritize the community health needs.

- For each health need, the project team assigned scores for both Criterion 1: Size of the Health Problem (based on relevant health indicators) and Criterion 2: Importance to Community (based on the frequency a given community health need was mentioned during qualitative data collection).
- Each participating hospital/health system scored the remaining three criteria (Capacity to Address, Alignment with Hospital/Health System Mission and Strategic Direction, Existing Collaborations/Interventions) using the below ranking guidance and with input from internal stakeholders and external partners. A final score was computed for each health need by weighting the score for each criterion (see percentages in table below) and adding the weighted scores.

	<b>Size of Health Problem</b> Magnitude of health priority based on size of population(s) impacted (15%)	<b>Importance to Community</b> Magnitude of health priority based on community input (30%)	<b>Capacity to Address</b> Availability of effective/feasible interventions (25%)	<b>Alignment with Hospital/Health System Mission and Strategic Direction</b> (20%)	<b>Existing Collaborations/Interventions</b> (10%)	
Ranking Guidance	9 or 10	>25%	>40	High Effectiveness/High Feasibility	Very consistent with mission AND strategic direction	Yes, strong existing partnerships AND initiatives
	7 or 8	10 to 25%	31 - 40	High Effectiveness/Moderate Feasibility	Relatively consistent with mission AND strategic direction	Yes, existing partnerships AND initiatives
	5 or 6	1 to 9.99%	21 - 30	Effective/Feasible	Consistent with mission AND strategic direction	Yes, existing partnerships OR initiatives
	3 or 4	0.1 to 0.99%	11 - 20	Low Effectiveness /Low Feasibility	Relatively consistent with mission NOT strategic direction	Yes, existing partnerships, no current initiatives
	1 or 2	0.01 to 0.09%	1 - 10	Low Effectiveness/Not Feasible	Consistent with mission NOT strategic direction	Weak, existing partnerships OR initiatives
	0	<0.01%	0	Not Effective/Not Feasible	Not consistent with mission OR strategic direction	No, existing initiatives or partnerships
Community Health Needs	Need 1	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
	Need 2	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
	Need 3	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
	Need 4	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10
	Need 5	Score 0-10	Score 0-10	Score 0-10	Score 0-10	Score 0-10

- An aggregate score for each community health need was calculated as an average of the scores for that health need across all participating hospitals/health systems. The health needs were then prioritized from highest to lowest final aggregate score.
- As a final check, the 'PEARL' test was applied to each health need to screen out any community health needs that did not meet the following feasibility factors:
  - Propriety – Is a program for the health problem suitable?
  - Economics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
  - Acceptability – Will a community accept the program? Is it wanted?
  - Resources – Is funding available or potentially available for a program?
  - Legality – Do current laws allow program activities to be implemented?

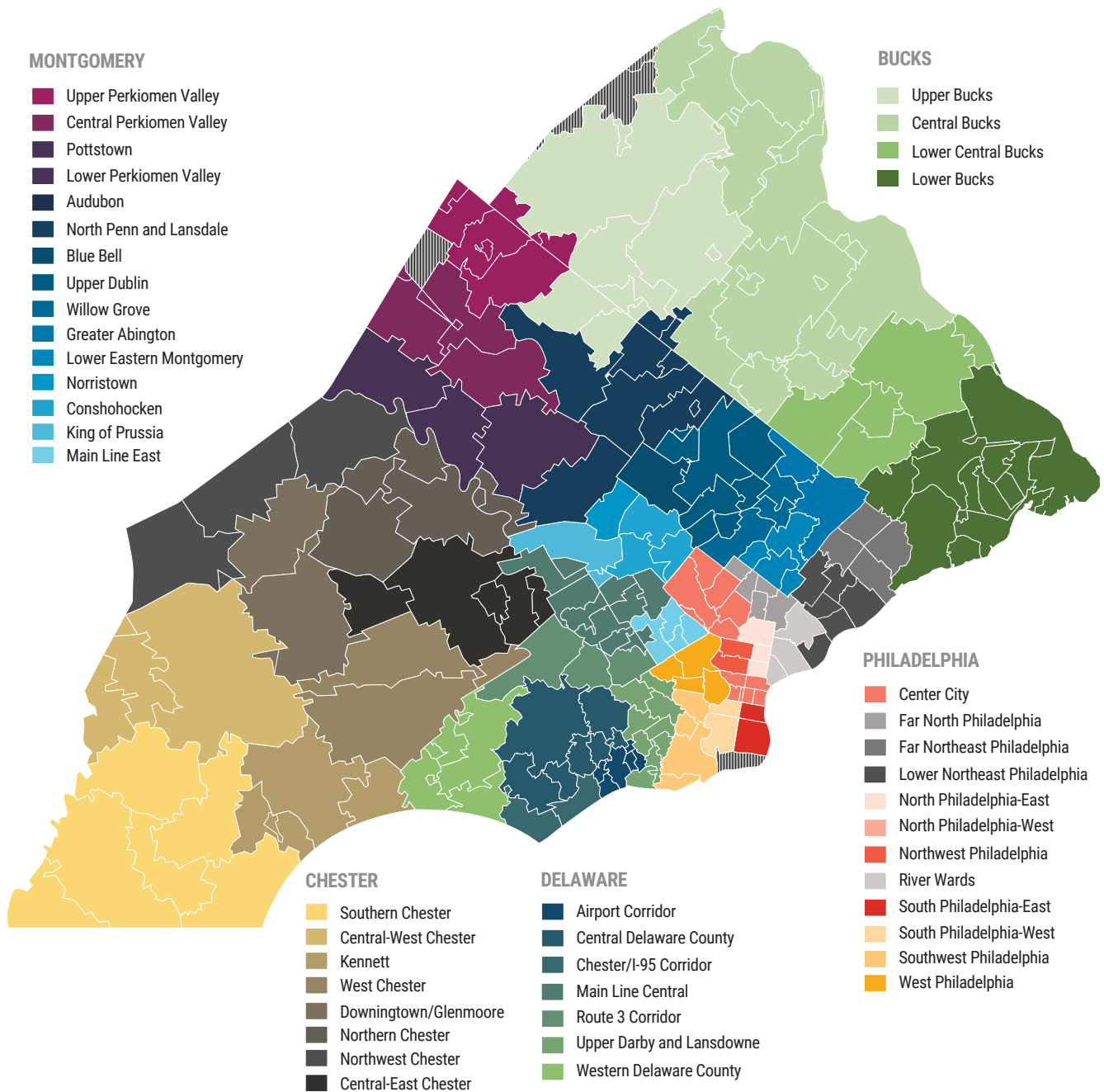
No health needs were eliminated based on the PEARL test.

# FINAL REPORT

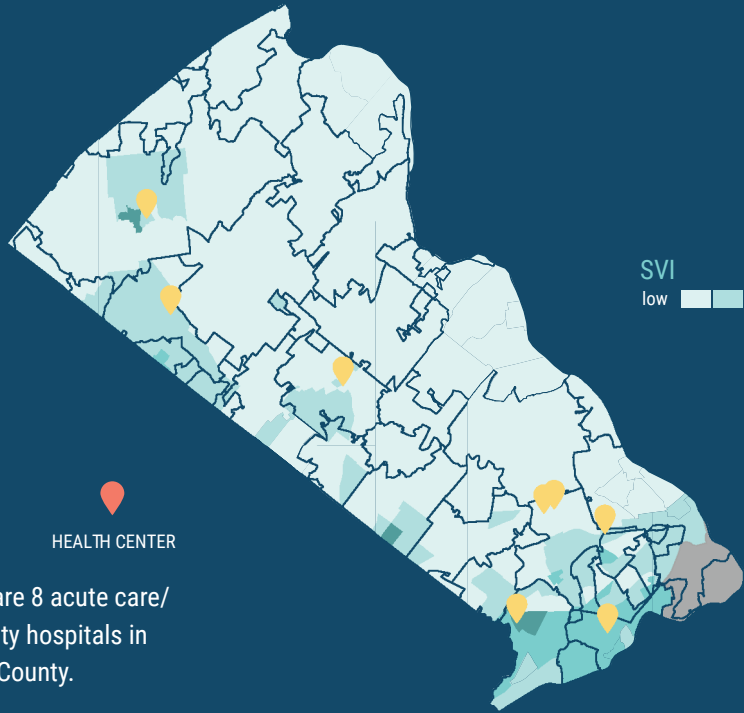
- The final CHNA report was drafted by the HCIF team and presented to the hospital/health systems for review and revision.
- This report was presented and approved by the Board of Directors of each hospital/health system.

## ABOUT THE SERVICE AREA

The overall service area includes Bucks, Chester, Delaware, Montgomery, and Philadelphia and represents a diverse population of 4,111,039. 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



HOSPITAL HEALTH CENTER

There are 8 acute care/specialty hospitals in Bucks County.

## Social Vulnerability Index (SVI)



Median Income **\$93,749**

High school as highest education **23.6%**

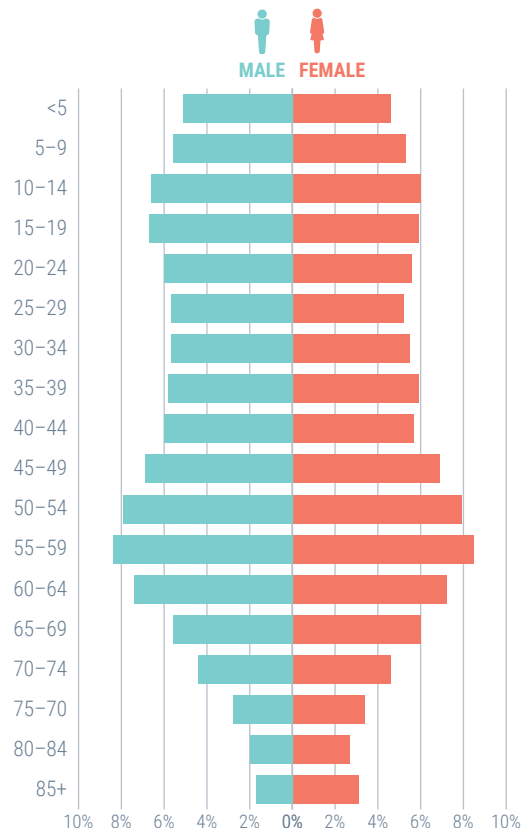
Food Insecurity **7.2%**

With a Disability **10.7%**

Violent Crime Rate **74.0** per 100,000

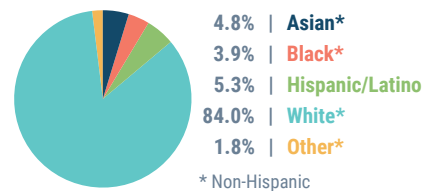
## AGE DISTRIBUTION

Bucks County has an estimated population of 614,495, with the largest proportion of residents between the ages of 50 and 59.

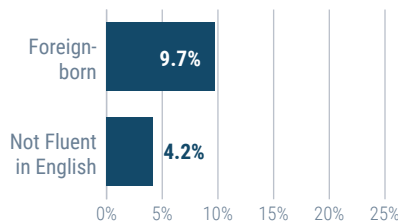


## RACE/ETHNICITY/LANGUAGE

84% of residents are non-Hispanic White. Hispanic/Latino residents make the next largest population, comprising 5.3% of the county's residents.



Nearly 10% of residents are foreign-born and about 4% speak English less than "very well."



## COVID-19 | Rates per 100,000

Fully Vaccinated **55,875.8**

COVID-related:

- Emergency Department Use **190.2**
- Hospitalization **398.9**
- Mortality **145.1**

## MORTALITY

Leading Causes of Death

- Cancer
- Heart disease
- COVID-19
- Cerebrovascular diseases
- Chronic lower respiratory diseases

## YOUTH BEHAVIOR

- Attempted Suicide **9.3%**
- Feeling Depressed/Sad/Hopeless **39.0%**
- Binge Drinking **15.9%**
- Cigarette Smoking **3.6%**
- Vaping **28.8%**

# COMMUNITY PERSPECTIVES



This summarizes focus group-style community conversations conducted with residents of three geographic communities: one each in Central Bucks, Lower Bucks, and Upper Bucks.

## Community Assets

Multiple participants from all three focus groups value the **built environment in their communities, especially parks, trails, and open space.**

- *“Walkability is, to me, very important. I can walk in town, I can walk to the post office, I can walk pretty much anywhere as opposed to have to drive all the time.”*
- *“Places like Peace Valley Park. I know through this pandemic just being able to go there, and just look at the water and just look at nature having open spaces, that is so important.”*
- *“There’s a big robust selection of state and public parks people can go to... you always go to Falls Township and see kids playing soccer... A lot of physical stuff going on there, a lot of fishing, getting close to nature.”*

A **strong sense of community and ample community organizations** were highlighted as assets by a majority of participants in all groups, as well as a “huge donation spirit” in the area.

- *“There is availability of services for people...whether it’s a pantry or home health or whatever else. I feel there is always somewhere I can refer a client based on their situation.”*
- *“We’ve so many churches, a synagogue, religious institutions, a stone’s throw from everything pretty much ... And I think that was something that carried a lot of our community--probably like a lot of other communities across the country--through the pandemic, especially. So, I think there’s a really large faith-based aspect to things that benefit the community.”*
- *“I live in a neighborhood where it’s not unusual to stop and talk to my neighbors on my way in and out. So, that provides that social aspect. Especially for my neighbor who’s like 90 years old, to be able to talk and knock on our door and make sure they’re okay, especially coming through COVID.”*

Across the groups, many participants commented on **convenient access to healthy food in grocery stores and from local farms**, such as a farmers market in Doylestown that’s “*extremely popular.*” However, several acknowledged that **access to nutritious, affordable food is challenging for many residents with low incomes and those living in rural areas of the county.**

**Good access to quality health care** was mentioned in two groups. “*We’re fortunate that around us there’s so many doctors right within a couple of miles,*” shared one participant. Several mentioned the availability of facilities for substance use recovery, although the demand for these services can exceed capacity. “*We have a surplus of providers here for drug and alcohol. The only issue with that is, is we have so much population that needs those services that sometimes there’s not enough beds in the area, especially at the detox level of care.*”

**Public transportation, such as SEPTA trains and Doylestown DART buses**, was mentioned as a valued resource, though these services may not be universally accessible (described below).



## Key Challenges

**A pandemic-related surge in behavioral health issues, including substance use, among youth and adults, was a top concern for participants in all three groups.** Participants noted difficulties with both accessing and affording behavioral health care, especially during the pandemic, along with ongoing stigma as a barrier to seeking care for these issues.

- *“I think something needs to be done about mental health. It’s an access issue to getting them help, because you can’t ... get through telephone lines, you can’t get appointments with therapists. And it’s not something that can always be put off for weeks, when you’re feeling like you need help.”*
- *“I can tell you that the people that need mental health that come into the ER can sit in that ER for days on end, waiting ... to be moved to a facility that can take care of their mental health needs,”* said a participant who works in health care.

Participants in two groups briefly mentioned that **obesity, cardiovascular disease, and diabetes** are major health concerns in their communities: “Women do not understand how heart disease is the number one killer, not breast cancer like they think. But it’s heart disease, and we should just do better again with the education of those things.” Another, commenting on diabetes, said: “People, you know, are not eating healthy and ... eating a lot of canned foods and processed foods, and all of these things ... are probably contributing to it.”

Across the three groups, participants discussed a **number of barriers to health care access, including difficulty navigating insurance policies and finding providers who would accept their coverage.** Lack of adequate insurance coverage for behavioral health issues was cited as a key concern in all three groups.

- *“Sometimes it’s hard for people to get the insurance; once you get the insurance, finding a provider that accepts your insurance [is difficult], and then trying to get an appointment on top of that. And if you’re a new patient, it’s a lot longer for you to be able to be seen.”*
  - *“A lot of the doctors in the area don’t take Medicaid; they take insurance companies like Aetna and Blue Cross,”* said a participant who could not find a provider to accept her child’s Medicaid policy.
  - *“Insurance is not good for mental health, it’s very much lacking in the health system. It’s never been a priority, and right now, it needs to be more of a priority than anything.”*
  - *“There’s just so little for it [behavioral health] under people’s insurance plans. ... I mean, if you’re looking at ... an out of pocket of \$100 a session, and that maybe they need a session every week ... it becomes a big stumbling block.”*
- Staffing shortages in the health care system, along with hesitancy among many to seek care due to fear of COVID exposure, are delaying medical appointments amid the pandemic.**
- *“As many healthcare providers are encountering, it’s very difficult to attract and keep healthcare workers. Folks are leaving. You know, pay is increasing, which is a good thing, but it is very difficult. Turnover has increased, I think across the board, and it’s just hard to maintain access and services when you are constantly struggling with staffing,”* said a participant who works in health care.
  - *“Sometimes [it’s] difficult to get in with specialists. I mean I think that’s just something that’s a problem across the board. It’s really hard to do that. ... I don’t think it’s specific to this community, but I know ... people have struggled with that, just trying to get appointments.”*



## Social Determinants of Health

Several participants who work in health care raised concern about **delays in preventive care** due to the pandemic, as many people put off scheduling checkups and other routine preventive care visits. One predicted that patients are going to *"be at least two, three years into this now before they even get in for their routine yearly exams, which is scary because what's gonna happen next year when everybody decides to come back?"*

The **shift toward telehealth during the pandemic has been a mixed blessing**, participants in the three groups said. *"I think telehealth does have its strong points, I do think it's very good in mental health, because you can actually speak to somebody and not have to get out for the appointments,"* said a participant. Another noted that *"show rates [attendance] for appointments actually increased when they switched to virtual. ... People actually kept their appointments a little better."*

However, virtual health care is a barrier for those who lack digital access or skills, including many older adults. Telehealth also may not be suitable for some types of medical visits or patients, such as mental health visits for young children. Some who have digital access simply prefer to see their providers in person. *"The first time I did it was over video chat, and it was nice, because I could do it from home,"* said a participant. *"But I prefer to go in person to everything. I like to be able to speak face to face with someone ... just like that human interaction and stuff like that."*

The **cost of living in Bucks County** was discussed by participants in several groups and, in the words of one participant, the county is a *"very expensive place to live for low wage employees."*

For some individuals, even those at 200% of poverty level, **finding affordable housing, paying for health care, and being able to meet other needs are major challenges**. A participant whose organization provides social services spoke of the hardships for workers with low wages and little or no job security. *"People who are in really dire situations ... tell us that they can't afford to take time off to address [mental or physical health issues] because they are concerned about losing a job."* Another noted, for many families: *"Struggling day to day to pay your bills and keep your family fed and all of those things ... it really puts an undue stress, strain on people."*

**Participants in all three groups discussed a range of housing concerns, including lack of affordable housing and issues related to homelessness and habitability.**

- Several commented on increasing development of high-rent luxury apartment buildings in their area, reducing options for affordable or subsidized housing.

- Homelessness was discussed in two groups, along with the need for more public awareness of resources to address homelessness and its associated stigma. A participant with relevant expertise noted: *"Most people are homeless not because of drugs and alcohol or even mental health. Sometimes it's because of lack of support...just trying to break down that stigma of homelessness in the first place... this stigma that says that in this wealthy county we don't have problems...Right now there are probably upwards of 800 kids that are about to be homeless or are currently homeless. The wait time to get into the shelter right now for single males or females is 10-12 weeks."*
- Housing safety and habitability issues were brought up in one group. Participants discussed a boarding house that had recently been condemned for health and safety violations, causing residents to be displaced.



## Children and Youth

**Food insecurity** exists in the county, but is often hidden from view, several participants said.

- *“Central Bucks ... does appear to be more affluent, but there’s definitely pockets that ... are struggling. And I do think that sometimes people are not aware of that. I think it’s hard for, especially, children, going to school in the district who may have food insecurity.”*

In addition, access to healthy food may be limited for those in rural areas or without a vehicle.

- *“When you get over towards Ottsville and Riegelsville ... there really aren’t a whole lot of resources up there for food,” said one participant. Another said: “If you live in some of those lower-income communities and you don’t have a car, it’s (food) not as accessible.”*

**Lack of reliable and affordable transportation, as well as the distance to primary and specialty health care services,** are barriers for some, especially older adults, commented multiple participants across the groups.

**Behavioral health issues among young people, including substance use problems,** were cited as key concerns by participants in all groups. Adding to these concerns are lack of affordable care, a shortage of behavioral health providers and crisis-care beds, and low awareness among youth and parents on how and where to seek care.

- *“I know numerous people ... that have overdosed, died, that I just graduated with [from high school a few years ago]. I feel like in some spots, like there’s not enough awareness about mental health and about getting help for like issues like that.”*
- *“When we try to get the mental and behavioral support for young kids in our site, we don’t, we don’t. There are not enough people out there doing that work.”*
- *“With COVID, there’s just been experience after experience after experience that I’ve heard first-hand where ... parents picking up the phone to call for a teenager or for somebody in their 20s cannot get anybody to call them back. And I know the mental health system is stressed with COVID. But when you’re not getting an answer, there’s discouragement and that doesn’t help people that are facing mental issues.”*

- One participant knew a young boy who had to travel to Florida to get treatment for depression. *“Like, that’s how far he had to go to try to get the help that he needs--which is really sad, because you should be able to stay with your family or close to your family. There’s just not enough resources.”*

**For children and adults, financial barriers also hamper access to behavioral health care, which is often not adequately covered by health insurance policies,** several participants noted.

- *“Insurance is, you know, it’s not good [adequate] for mental health, it’s very much lacking in the health system. It’s never been a priority, and right now, it needs to be more of a priority than anything,”* said a participant.
- A young adult added, *“I feel like some [young people with mental health issues], they just don’t know where to turn to. ... Like, we’re young. We don’t have a lot of money. ... They need more affordable options.”*

**Youth vaping was raised as a concern in two groups.**

- A participant who works for a behavioral health organization said that vaping not only is common among high school students, but *“we’re even seeing it as young as elementary school, but middle school, definitely. And even older teens are expressing concern about their younger peers in middle school that are vaping.”*
- Another said: *“One of the things that I keep hearing from the schools is that there’s a lot of kids that are vaping and they are vaping in the bathrooms...and out in the open vaping.”*

**Access to vaping products is too easy for young people**, a participant with expertise on this issue stressed.

- *“Even though now you have to be technically 21 to buy products, there are certain stores that sell to minors and kids know that. ... They’ll also get things from peers or share it with their friends, or they’ll get people to buy it for them. ... And a lot of them get it online, including ... the cartridges for marijuana. A lot of these devices are interchangeable, you can use them for vaping either one, so it’s easy to access.”*

**Lack of structured activities, along with increasing use of social media and other forms of screen time, is harmful for young people’s health and social development**, multiple participants across the three groups noted. Several also cited unhealthy eating and lack of physical activity as contributing to childhood overweight, obesity, and diabetes.

- *“I think cell phones and tablets are addictive for young kids. ... Right now, kids won’t get off the tablets, the phones. I think cutting out Wi-Fi for so many hours a day is something we as parents and grandparents need to do, and make the kids go outside and play.”*
- *“I agree with everyone on concerns about screen time and social media regarding youth. We see a correlation with the uptick in reported mental health concerns, which have increased since smart phones became largely available. Smart phones also contribute to very easy access to alcohol, tobacco, and other drugs. Kids can easily acquire drugs like marijuana in about 15-30 minutes by simply using their phones,”* said a participant who works for a behavioral health organization.

- *“There are a huge number of students...like one out of three that are obese, that are not eating...fruits, vegetable, and greens. During COVID, many of them came back and said they ate cereal for breakfast, cereal for lunch, cereal for dinner, and on the weekends they would eat together as a family kind of like celebratory pizza and cheese sticks...So like no education about how important it is to have those (healthy) elements of their diet.”*

A few **other issues related to the health of young people** were briefly noted:

One participant discussed the need to raise awareness among students, parents, and school staff about the **risk of human trafficking of youth, stemming from unsafe use of the internet**. *“I think a lot of time people don’t realize that even happens in Bucks County; they think it happens somewhere else. Especially online too, you know.”*

Issues with **bullying in schools, including of LGBTQ+ youth**, were mentioned.

Participants cited a range of other needs for some children, including glasses for those whose parents can’t provide them; dental health support, such as toothbrushes and referrals to dentists; and healthy snacks and other food in schools and afterschool programs, including for children with special dietary needs.



Note: For additional information on needs and opportunities to improve the health of older adults in Bucks County, please see the spotlight section on *Older Adults and Care in Bucks County*.

## Older Adults

As the county's older adult population grows, **more services in the community—and better awareness of existing services—are needed to help older people age in place, especially those on fixed or limited incomes**, participants said in all three groups.

- *"I think that we, as a county, need to be really prepared for this. ... As the numbers [of seniors] increase, are we going to have enough county services to provide ... for the needs of these people who choose to age in place?"*
- *"There are a lot of older adults who are growing older in their own homes by themselves, they're on a fixed income. Oftentimes, the income doesn't keep up with the taxes that they're having to pay. And the services that they need, they no longer can mow their lawn, plow their driveways, they become shut in... In part this is due to older adults brought up thinking that Social Security was supposed to support them and give them an income the entire rest of their life. So, we're seeing a lot of poor seniors needing supports and services that we just don't necessarily have, but they're not Medicaid eligible quite yet."*

- *"A lot of people don't know that there is the [Bucks County] Area Agency on Aging, and I've worked with some of those people in the past, and they're a great resource, and they want to help people, and they're really strong advocates. ... That's a big thing, too--not only having people that can provide those services, but also knowing that those services are available."*

### **For many older adults, increased social isolation during the pandemic has taken a toll on their mental and physical health,**

several participants shared. One who regularly helps her elderly mother said: "I do her bills ... everything for her now. I didn't use to, but you know, through the pandemic, I've just seen her decline and decline. She's not remembering things, because she was isolated for so long. So, I think our elderly that do not have family [to help care for them] are just very vulnerable right now." Another commented that COVID-related restrictions on hospital visitors have meant that some hospitalized older adults are unable to have a family member or friend present to help them understand their health issues and care plans.

**Lack of understanding about Medicare and covered services** is another concern. Older adults can be overwhelmed by the amount of Medicare information as well as phone or online insurance scams, leading to fear, distrust, and reluctance to act. In addition, older adults may not realize that hearing aids or vision and dental care may not be covered by their Medicare plan.

**Ageism can adversely impact the treatment of older adults**, both in health care and society in general. "Simple ageism; people assume that when you get older, you're constantly in decline, and then you're just going to simply pass away. And that's not necessarily a healthy way to look at the older adult population. Seniors have and still continue to contribute to the society, they can maintain their health, they can still thrive. So oftentimes the medical community and sometimes social service agencies [are] thinking that seniors have nothing else to give back."

Other health-care related issues, mentioned by one or more participants, include **a shortage of home health workers and lack of medical providers trained in geriatrics**. "There is a severe shortage of direct care workers to help people in their homes. So while we want to keep people out of the nursing home and keep them in the community, there's just not enough staff to do it. ... We often have the funds to pay for home care for some seniors through state-funded programs, but we cannot find the resources [home health workers] to do it. So, I'd have to say that is my number one issue and the issue we face on a daily basis."

The **need for assistance with transportation** was cited as a challenge to accessing health care and other services for some older adults. Older adults may have mobility issues that preclude them from public transportation and face concerns about being charged additional fees if they are late for or miss their scheduled appointment. In addition, family supports may not be available. Many adults need assistance in scheduling transportation for ongoing health care services such as post-surgery follow-up visits and physical therapy.



## Other Groups

Another concern raised is **the use of same-day surgery for older adults**, who may be sent home before they are able to function safely on their own. A participant who lives in a senior living development said she knows many older adults who've had same-day orthopedic surgery. *"Some of the problem right now with orthopedics is they have this 'fast track,' or whatever you want to call it. And they take the patient in, they do the surgery, and they send them home the same day. ... It's very problematic, and dangerous too, because they still have the anesthesia in them, and they're on pain meds. And if they don't have anybody at home, or if they have a spouse that's about the same age, it really causes a problem."*

The **digital divide and use of technology** pose additional problems for older adults trying to access services and information, many participants said. Barriers to telehealth and other uses of the internet may stem from lack of computer equipment or skills, or physical impairments that make it hard to use technology. *"My mom's 79 years old, legally blind, hard of hearing, she cannot make an appointment because she can't, when you say press one, press two, it's just overwhelming... So they're not user friendly for the older population. I just know, I have to make all our phone calls,"* said a participant.

**Immigrant communities.** Several participants noted the need to build trusting relationships with people who are undocumented or have limited English proficiency to facilitate their access to health and social services. *"Once we connect in and we build that relationship... and then trying to find the services that can consistently help them and then to feel safe with that. ... And that's for across the board, mental health, food, health, even with school, communications with school."*

**People who are neurodivergent.** Two participants spoke about the needs of adults who are neurodivergent, such as those with autism, attention-deficit/hyperactivity disorder (ADHD), dyslexia, or other neuro-developmental conditions. Housing and employment security are concerns for these individuals, commented one participant. *"Most neurodiverse adults live with their aging parents, and when those parents go, there's [not] a place where these adults can go. They typically go with another family member. ... There's just not a lot of options."* Another noted that, because many cannot drive, *"the opportunities for adults [who are neurodivergent] are not as plentiful as they are for their neurotypical peers."* A nonprofit was mentioned, [Neuro Diverse Living](#), that provides cohousing in Bucks, Lehigh, and other surrounding counties to help these individuals gain independence and integrate more fully into society.

**People with mobility limitations.** One participant brought up the need for improvements to public trails and local parks to promote equitable access for those with special needs, including better wheelchair and walker access.



## Pandemic Impacts

Several participants spoke about the **need for clearer public health communications as COVID-19 guidelines evolve during the pandemic.** One participant shared: *"Once the [COVID vaccine] booster started rolling out, I heard a lot of people say like, 'Oh, I didn't even realize that they were available that I could get them yet.' ... I think that's important, too, just the communication there and how information is disseminated, especially when it's such important health information."* Having to go online to access pandemic-related resources, such as to find COVID-19 testing sites or schedule a vaccination appointment, was cited as a challenge for those who lack digital access or skills.

Participants in two groups spoke about **the difficulty that masks pose for communication among people with hearing impairment** who rely on reading lips and seeing facial expressions to fully understand the meaning of what is being said.

# Suggested Actions

**Address the need for affordable housing in the county, including resources to help older adults to age in place.**

Suggestions offered by participants included creating more affordable senior housing through public-private ventures, working with organizations such as Habitat for Humanity and others to improve habitability, and building “tiny homes” to address homelessness. More county-wide planning to address affordable housing needs among residents with lower incomes and older adults also is needed.

**Raise awareness of community health and social services by providing information in settings where people commonly go, as well as online.**

“Promotion of all resources to all people,” said a participant. Creating and distributing a booklet listing available resources was suggested. One person noted that the Direct Services Coalition in Bucks County already publishes a resource [directory](#) but “I don’t think many people know about it, unless they are providers.”

**Especially, raise awareness of mental health resources in schools and the community, urged several participants in two groups.**

To increase awareness among youth, a young adult who graduated from high school a few years ago said: “I think high schools should address the issue. Guidance counselors should make kids aware and tell them it’s okay to need help.”

Another participant called for raising awareness of the [Pennsylvania Student Assistance Program](#), a free, state-mandated program in schools to help students with substance use or other mental health issues. “I don’t think a lot of people are aware of it, ... but it’s just a really good [program] as far as the youth population goes.”

Another suggestion was to post signs in the community to help direct people to mental health resources: “So, anybody who’s walking down the street can look at a sign hanging in a store. If you’re depressed or sad or you need help, you’re a drug addict or whatever the case may be, they can call this helpline to get some resources.”

**Increase access to affordable behavioral health care for youth and adults, including more robust insurance coverage.**

“Even if these kids have insurance on a parent’s plan, mental health in terms of insurance coverage is, to me, severely lacking,” one said. Another suggested that “health insurance is not the answer for mental health and maybe we need to look at mental health in a different way to fund it differently so that people have access.”

Participants in several groups also recommended **more efforts to reduce the stigma associated with seeking care for behavioral health issues**—for example, through education and support to encourage people to talk about their mental health issues.

**Bring more integrated health and social services directly into the community to reduce barriers to access.**

For example, create mini-resource centers in schools and other community settings with co-located services, such as health care, employment training and assistance, food resources, financial assistance, and care coordination. “It would be interesting to have a one-stop-shop place so if you need mental health assistance, need to talk with a doctor, food resources, it’s just easy access, so there isn’t a bunch of transportation needed.”

# Suggested Actions

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**Provide more structured activities to promote physical activity and healthy social development among children and youth.**

A participant noted the need for activities to enable *“non-athletic youth to socialize face-to-face not via devices.”* Another suggested *“more opportunities for youth to volunteer and this way they could be less on their devices and socialize more.”* Expanding social and emotional learning programs in schools to improve students’ social development and mental health was recommended: *“There’s more of a need for social emotional learning in schools [amid the pandemic].”* Another suggestion: create more intergenerational opportunities to address community needs, such as for older adults to mentor youth and young people to teach computer skills to older adults.

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**Expand community education programs to promote health and improve detection and prevention of common diseases.**

*“Some people just don’t have the knowledge to know how to take care of themselves,”* commented a participant. *“I just think there’s so much that we in the community can do, and maybe through the hospitals ... [for example], to know what the risk factors are for heart disease, to know about a stroke, what are the signs and symptoms?”*

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**Address various training needs to improve health care access and delivery, several participants said.**

One suggested training advocates to help people who are uninsured or under-insured apply for Medicaid or other subsidized health insurance, such as through [Pennie](#), the state’s health insurance exchange website. Another recommended more training for health and community service providers in trauma-informed care.

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**Several participants suggested strategies to fund community health initiatives.**

To help fund more health education, one advised creating *“focused partnerships with pharma and insurance companies in the area to invest more in community health and health outcomes.”* Another suggested working with foundations and other funders to support community collaborations and coalitions, and incentivizing staff from community organizations to participate in the coalitions.

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# CENTRAL BUCKS

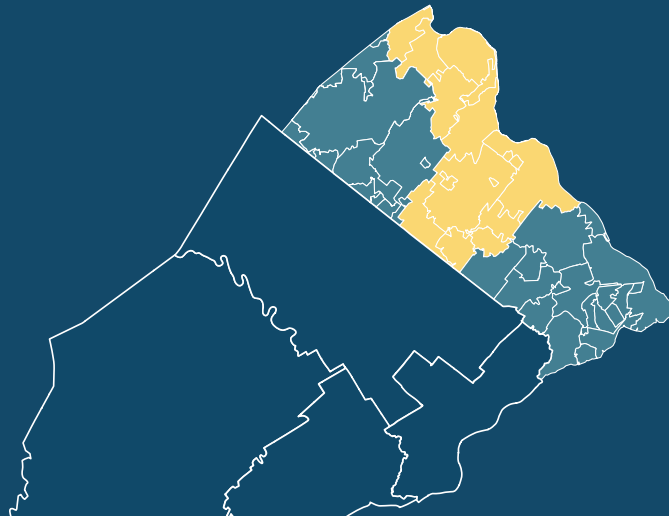
Central Bucks Social Vulnerability Index



**ZIP CODES:** 18077 , 18901, 18902, 18912, 18913, 18914, 18920, 18923, 18925, 18929, 18930, 18938, 18942, 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 Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital
- Trinity Health Mid-Atlantic



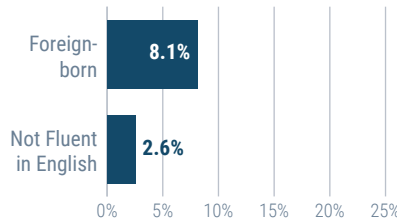
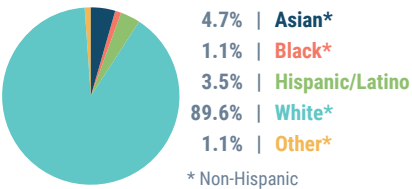
## POPULATION



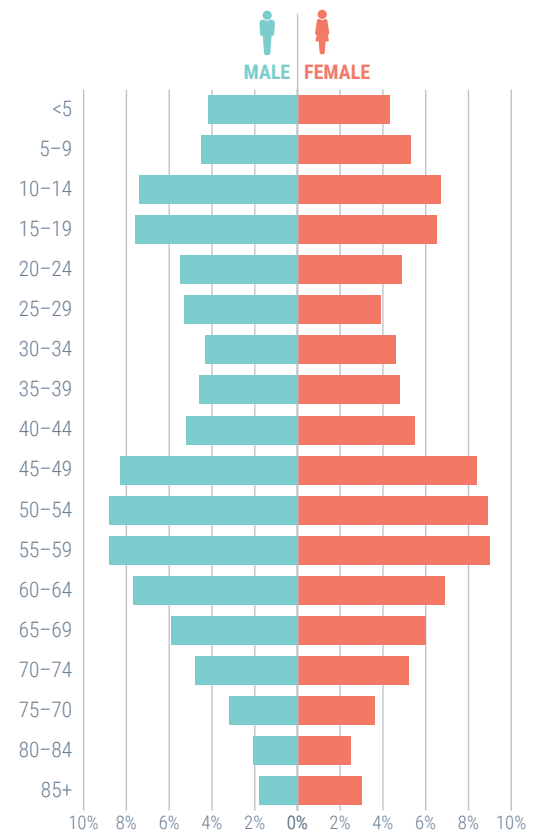
## MEDIAN HOUSEHOLD INCOME



## RACE/ETHNICITY/LANGUAGE



## AGE DISTRIBUTION



## LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Chronic lower respiratory diseases

## EDUCATIONAL ATTAINMENT

High school as highest education level **16.1%**

PEOPLE WITH DISABILITIES **8.1%**

## summary health measures

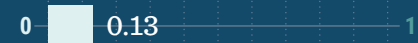
		Central Bucks		Bucks County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	801.6	966.2	962.0	1,126.0
	Life expectancy: Female (in years)	84.5	83.3	82.4	81.0
	Life expectancy: Male (in years)	81.1	79.1	78.0	75.8
	Years of potential life lost before 75	5,274	5,692	34,081	39,538
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	185.0	N/A	190.2
	COVID-related hospitalization rate (per 100,000)	N/A	259.2	N/A	398.9
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	29.2%		30.2%	
	Diabetes prevalence	9.1%		9.8%	
	Diabetes-related hospitalization rate (per 100,000)	79.8	63.6	134.2	129.7
	Hypertension prevalence	29.5%		30.2%	
	Hypertension-related hospitalization rate (per 100,000)	367.3	332.0	444.1	397.0
	Potentially preventable hospitalization rate (per 100,000)	952.8	659.0	1,092.4	875.1
	Premature cardiovascular disease mortality rate (per 100,000)	9.9	19.1	20.3	22.0
	Major cancer incidence rate (per 100,000)	287.5		308.7	
	Major cancer mortality rate (per 100,000)	69.9		91.4	
	Colorectal cancer screening	70.6%		68.6%	
	Mammography screening	77.3%		76.6%	
	Physical inactivity (leisure time) prevalence	18.2%		20.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	5.4	--	9.4	2.3
	Infant mortality rate (per 1,000 live births)	--	--	2.7	5.7
	Percent low birthweight births out of live births	6.4%	4.4%	7.6%	6.0%
	Percent preterm births out of live births	6.5%	5.7%	9.5%	8.4%
<b>Behavioral Health</b>	Adult binge drinking	19.8%		19.6%	
	Adult smoking	13.8%		16.0%	
	Drug overdose mortality rate (per 100,000)	10.6	14.1	30.8	31.1
	Opioid-related hospitalization rate (per 100,000)	11.3	9.9	57.8	41.1
	Substance-related hospitalization rate (per 100,000)	175.2	124.3	347.6	276.6
	Poor mental health for 14+ days in past 30 days	11.6%		12.8%	
	Suicide mortality rate (per 100,000)	16.2	10.6	15.6	11.6
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	5,105.3	5,964.9	3,098.0	3,124.5
	Gun-related emergency department utilization (per 100,000)	15.9	--	7.0	4.5
	Homicide mortality rate (per 100,000)	--	--	1.0	2.2
<b>Access to Care</b>	Adults 19-64 years with Medicaid	4.4%		7.8%	
	Children <19 years with public insurance	15.4%		22.5%	
	Population without insurance	2.4%		4.0%	
	Children <19 years without insurance	1.4%		2.4%	
	Emergency department utilization (per 100,000)	12,040.8	12,432.2	20,404.7	16,826.5
	High emergency department utilization (per 100,000)	66.5	254.7	389.4	311.2
<b>Social &amp; Economic Conditions</b>	Population in poverty	3.9%		5.6%	
	Children <18 years in poverty	4.1%		6.7%	
	Adults 19-64 years unemployed	1.3%		2.0%	
	Householders living alone who are 65+ years	37.9%		36.8%	
	Households receiving SNAP benefits	1.4%		4.1%	
	Households that are housing cost-burdened	11.0%		13.4%	
	Housing with potential lead risk	39.8%		45.8%	
Vacant housing units	8.9%		5.8%		

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

-- Estimates are unavailable or unreliable due to low sample size within a community.

# LOWER CENTRAL BUCKS

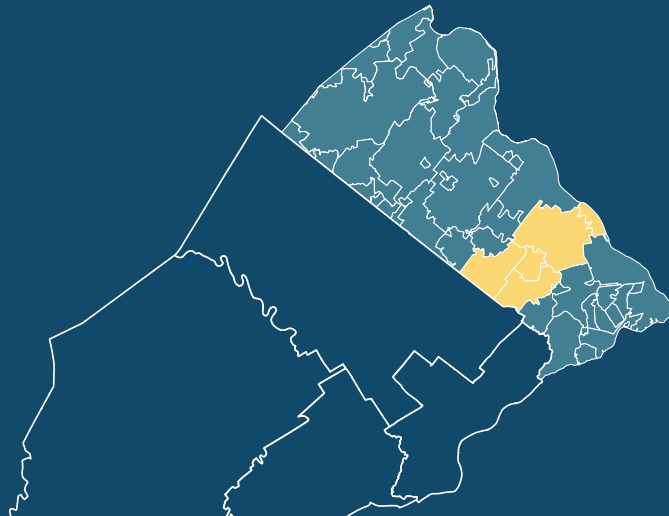
Lower Central Bucks Social Vulnerability Index



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 Health - Northeast
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital
- Trinity Health Mid-Atlantic



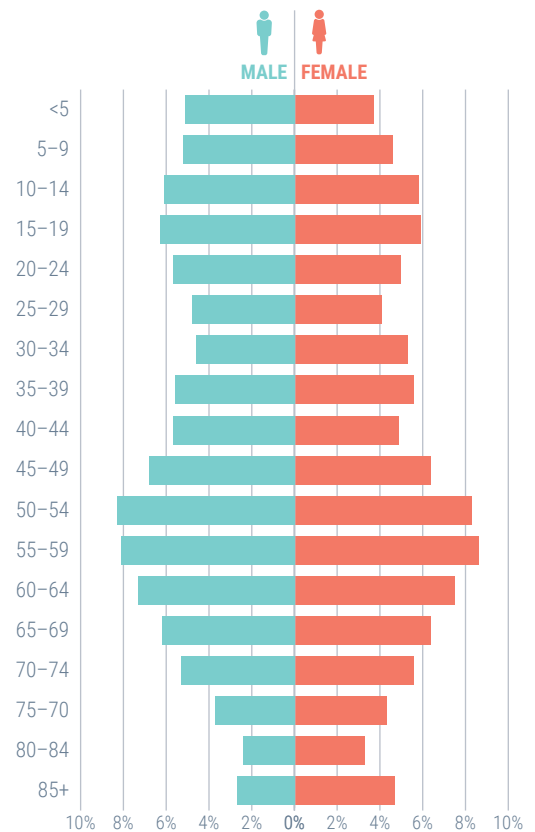
## POPULATION



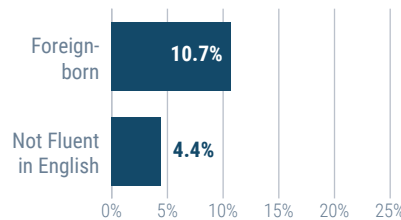
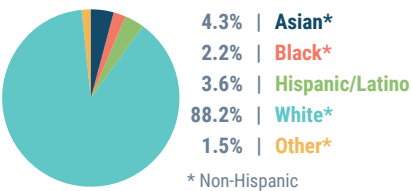
## MEDIAN HOUSEHOLD INCOME



## AGE DISTRIBUTION



## RACE/ETHNICITY/LANGUAGE



## LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer’s disease

## EDUCATIONAL ATTAINMENT

High school as highest education level **19.6%**

PEOPLE WITH DISABILITIES **9.9%**

## summary health measures

		Lower Central Bucks		Bucks County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	1,115.7	1,311.0	962.0	1,126.0
	Life expectancy: Female (in years)	84.3	82.2	82.4	81.0
	Life expectancy: Male (in years)	80.6	77.4	78.0	75.8
	Years of potential life lost before 75	4,392	6,204	34,081	39,538
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	215.2	N/A	190.2
	COVID-related hospitalization rate (per 100,000)	N/A	436.2	N/A	398.9
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	28.8%		30.2%	
	Diabetes prevalence	9.8%		9.8%	
	Diabetes-related hospitalization rate (per 100,000)	88.6	104.3	134.2	129.7
	Hypertension prevalence	31.1%		30.2%	
	Hypertension-related hospitalization rate (per 100,000)	515.6	415.5	444.1	397.0
	Potentially preventable hospitalization rate (per 100,000)	1,197.6	889.7	1,092.4	875.1
	Premature cardiovascular disease mortality rate (per 100,000)	9.1	15.7	20.3	22.0
	Major cancer incidence rate (per 100,000)	331.1		308.7	
	Major cancer mortality rate (per 100,000)	110.9		91.4	
	Colorectal cancer screening	70.8%		68.6%	
	Mammography screening	76.7%		76.6%	
	Physical inactivity (leisure time) prevalence	19.2%		20.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	3.9	--	9.4	2.3
	Infant mortality rate (per 1,000 live births)	--	7.8	2.7	5.7
	Percent low birthweight births out of live births	6.3%	6.8%	7.6%	6.0%
	Percent preterm births out of live births	5.9%	7.2%	9.5%	8.4%
<b>Behavioral Health</b>	Adult binge drinking	18.8%		19.6%	
	Adult smoking	13.8%		16.0%	
	Drug overdose mortality rate (per 100,000)	16.6	22.3	30.8	31.1
	Opioid-related hospitalization rate (per 100,000)	40.6	31.5	57.8	41.1
	Substance-related hospitalization rate (per 100,000)	239.2	198.6	347.6	276.6
	Poor mental health for 14+ days in past 30 days	11.6%		12.8%	
	Suicide mortality rate (per 100,000)	7.4	14.9	15.6	11.6
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	7,407.4	7,454.2	3,098.0	3,124.5
	Gun-related emergency department utilization (per 100,000)	3.1	3.1	7.0	4.5
	Homicide mortality rate (per 100,000)	--	--	1.0	2.2
<b>Access to Care</b>	Adults 19-64 years with Medicaid	4.5%		7.8%	
	Children <19 years with public insurance	13.9%		22.5%	
	Population without insurance	2.8%		4.0%	
	Children <19 years without insurance	1.6%		2.4%	
	Emergency department utilization (per 100,000)	21,914.9	16,764.6	20,404.7	16,826.5
	High emergency department utilization (per 100,000)	380.0	242.1	389.4	311.2
<b>Social &amp; Economic Conditions</b>	Population in poverty	4.0%		5.6%	
	Children <18 years in poverty	3.9%		6.7%	
	Adults 19-64 years unemployed	1.7%		2.0%	
	Householders living alone who are 65+ years	50.6%		36.8%	
	Households receiving SNAP benefits	2.2%		4.1%	
	Households that are housing cost-burdened	14.6%		13.4%	
	Housing with potential lead risk	31.8%		45.8%	
Vacant housing units	2.7%		5.8%		

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

-- Estimates are unavailable or unreliable due to low sample size within a community.

# UPPER BUCKS

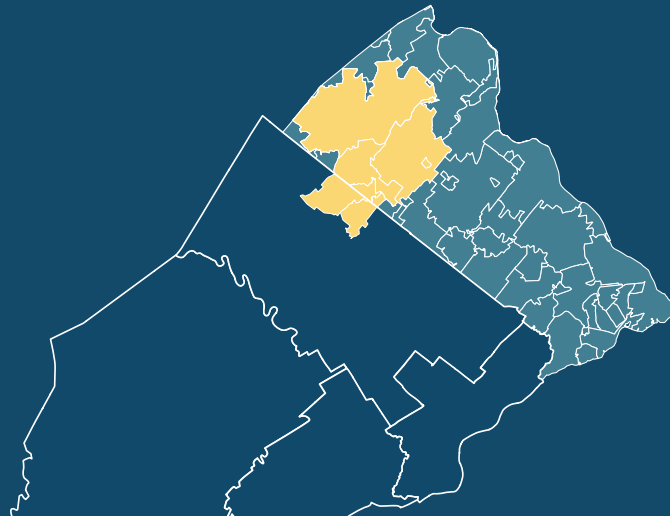
**ZIP CODES:** 18917, 18935, 18944, 18951, 18955, 18960, 18962, 18964, 18969, 18970

Upper Bucks Social Vulnerability Index



This community is served by:

- Children’s Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital



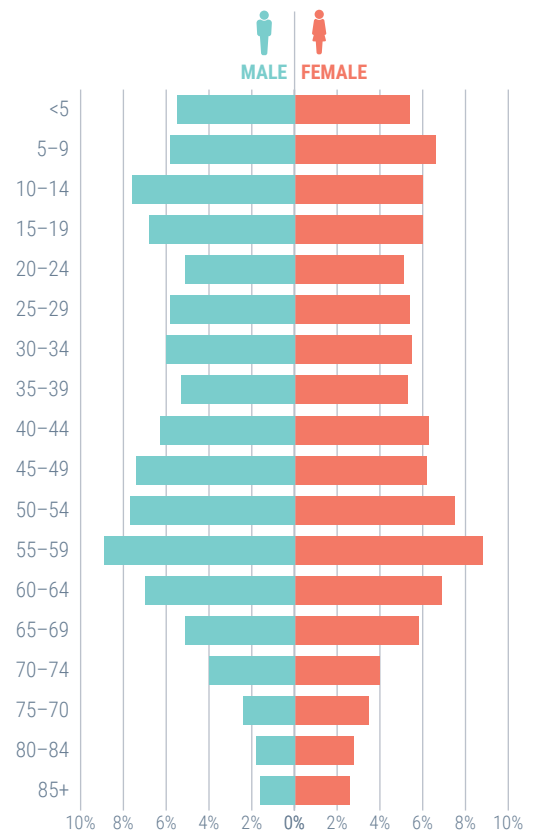
## POPULATION



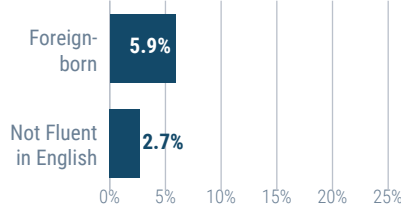
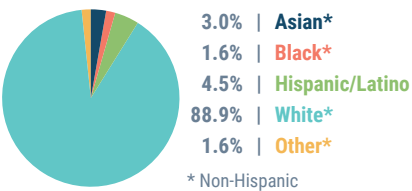
## MEDIAN HOUSEHOLD INCOME



## AGE DISTRIBUTION



## RACE/ETHNICITY/LANGUAGE



## LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer’s disease

## EDUCATIONAL ATTAINMENT

High school as highest education level **28.9%**

PEOPLE WITH DISABILITIES **9.6%**

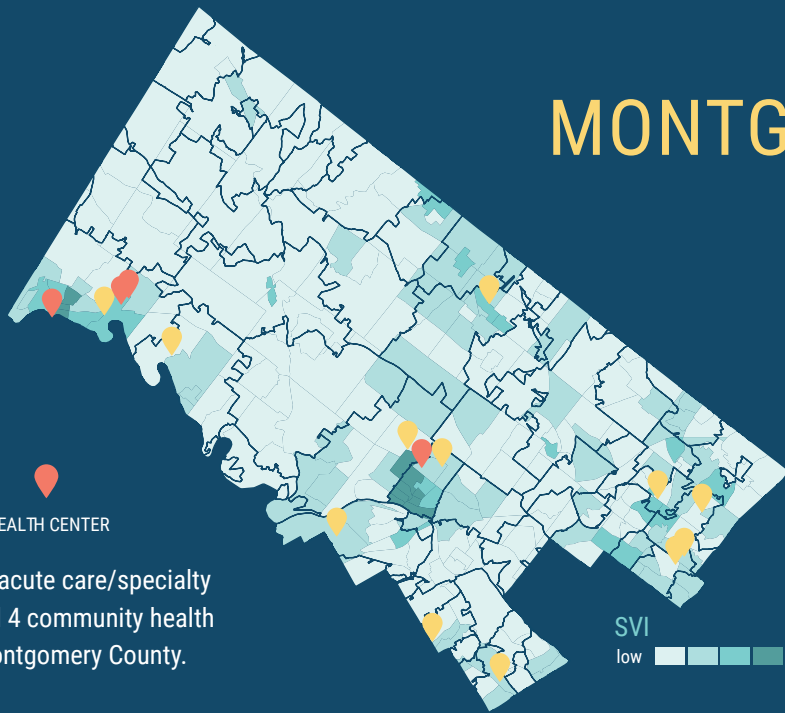
## summary health measures

		Upper Bucks		Bucks County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	967.8	1,075.3	962.0	1,126.0
	Life expectancy: Female (in years)	80.8	81.5	82.4	81.0
	Life expectancy: Male (in years)	78.0	76.8	78.0	75.8
	Years of potential life lost before 75	6,219	5,371	34,081	39,538
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	101.9	N/A	190.2
	COVID-related hospitalization rate (per 100,000)	N/A	307.6	N/A	398.9
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	30.9%		30.2%	
	Diabetes prevalence	9.6%		9.8%	
	Diabetes-related hospitalization rate (per 100,000)	112.2	92.6	134.2	129.7
	Hypertension prevalence	29.7%		30.2%	
	Hypertension-related hospitalization rate (per 100,000)	319.8	337.5	444.1	397.0
	Potentially preventable hospitalization rate (per 100,000)	910.7	769.5	1,092.4	875.1
	Premature cardiovascular disease mortality rate (per 100,000)	23.4	14.0	20.3	22.0
	Major cancer incidence rate (per 100,000)	273.0		308.7	
	Major cancer mortality rate (per 100,000)	79.5		91.4	
	Colorectal cancer screening	67.9%		68.6%	
	Mammography screening	75.7%		76.6%	
	Physical inactivity (leisure time) prevalence	21.7%		20.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	18.3	--	9.4	2.3
	Infant mortality rate (per 1,000 live births)	--	--	2.7	5.7
	Percent low birthweight births out of live births	5.4%	5.2%	7.6%	6.0%
	Percent preterm births out of live births	5.8%	5.1%	9.5%	8.4%
<b>Behavioral Health</b>	Adult binge drinking	20.0%		19.6%	
	Adult smoking	17.6%		16.0%	
	Drug overdose mortality rate (per 100,000)	25.2	23.4	30.8	31.1
	Opioid-related hospitalization rate (per 100,000)	14.0	12.2	57.8	41.1
	Substance-related hospitalization rate (per 100,000)	230.0	229.1	347.6	276.6
	Poor mental health for 14+ days in past 30 days	13.7%		12.8%	
	Suicide mortality rate (per 100,000)	20.6	16.8	15.6	11.6
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	6,231.2	6,131.1	3,098.0	3,124.5
	Gun-related emergency department utilization (per 100,000)	--	--	7.0	4.5
	Homicide mortality rate (per 100,000)	--	--	1.0	2.2
<b>Access to Care</b>	Adults 19-64 years with Medicaid	7.5%		7.8%	
	Children <19 years with public insurance	24.7%		22.5%	
	Population without insurance	4.5%		4.0%	
	Children <19 years without insurance	2.1%		2.4%	
	Emergency department utilization (per 100,000)	22,390.6	17,873.4	20,404.7	16,826.5
	High emergency department utilization (per 100,000)	294.9	237.5	389.4	311.2
<b>Social &amp; Economic Conditions</b>	Population in poverty	6.5%		5.6%	
	Children <18 years in poverty	9.1%		6.7%	
	Adults 19-64 years unemployed	1.8%		2.0%	
	Householders living alone who are 65+ years	30.2%		36.8%	
	Households receiving SNAP benefits	4.3%		4.1%	
	Households that are housing cost-burdened	13.6%		13.4%	
	Housing with potential lead risk	42.4%		45.8%	
	Vacant housing units	3.7%		5.8%	

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

-- Estimates are unavailable or unreliable due to low sample size within a community.

# MONTGOMERY COUNTY



HOSPITAL HEALTH CENTER

There are 12 acute care/specialty hospitals and 4 community health centers in Montgomery County.

SVI  
low high

Social Vulnerability Index (SVI)



Median Income **\$99,037**

High school as highest education **19.6%**

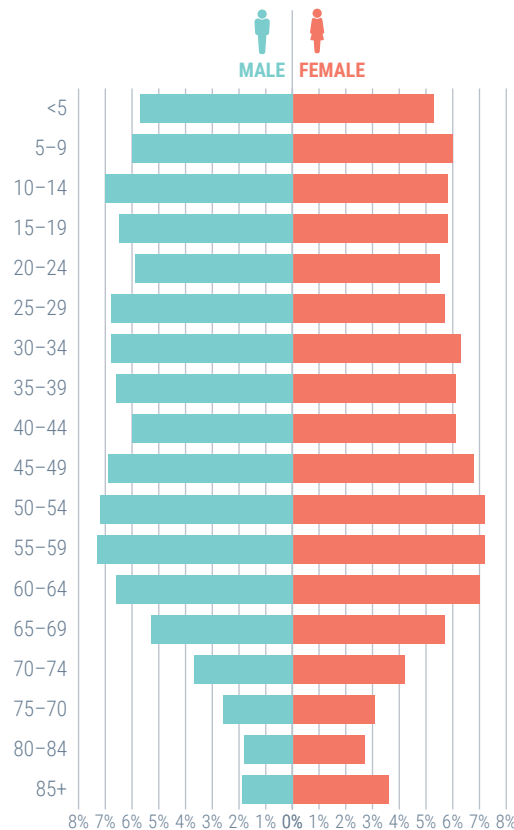
Food Insecurity **6.9%**

With a Disability **10.0%**

Violent Crime Rate **89.8** per 100,000

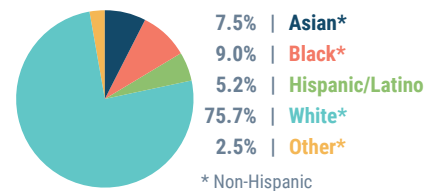
## AGE DISTRIBUTION

Montgomery County has an estimated population of 799,143, with the largest proportion of residents between the ages of 45 and 59.

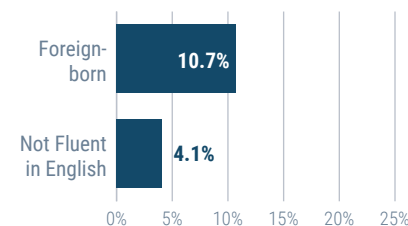


## RACE/ETHNICITY/LANGUAGE

75.7% of residents are non-Hispanic White. Non-Hispanic Black residents make the next largest population, comprising 9% of the county's residents.



Nearly 11% of residents are foreign-born and about 4% speak English less than "very well."



## COVID-19 | Rates per 100,000

Fully Vaccinated **56,857.4**

COVID-related:

- Emergency Department Use **853.5**
- Hospitalization **394.6**
- Mortality **144.2**

## MORTALITY

Leading Causes of Death

- Heart disease
- Cancer
- COVID-19
- Cerebrovascular diseases
- Chronic lower respiratory diseases

## YOUTH BEHAVIOR

- Attempted Suicide **9.0%**
- Feeling Depressed/Sad/Hopeless **37.8%**
- Binge Drinking **11.9%**
- Cigarette Smoking **2.6%**
- Vaping **25.2%**

# COMMUNITY PERSPECTIVES



## Community Assets

Throughout Montgomery County, residents spoke highly of **local organizations serving the community**, providing a wide range of services for youth, older adults, immigrant communities, and others. Important organizations include **faith-based institutions, public schools, and emergency food providers**. Among the many groups mentioned:

- *“I think the senior centers are a wonderful source of information. ... Through PALM [Center for Positive Aging in Ardmore], I was turned on to a diabetes prevention class that’s offered by Montgomery County Aging and Adult Services, and I signed up for that.”*
- *“I was thinking about the positives that we have in our faith community. Not only is there a church or synagogue or a mosque on every corner, they’re really invested in the community.”*

A Latina participant who attends Spanish mass at her church in Pottstown shared:

- *“When somebody is going through a rough time, I see people genuinely caring about the people that attend there. ... It makes me feel like it’s my happy place.”*

*This summarizes focus group-style community conversations conducted with residents of five geographic communities: one each in Main Line Central,\* North Penn/Lansdale, Norristown, Pottstown, and Willow Grove.\**

A participant commented on social services and health and wellness programs for Latinos and other community members:

- *“The community has organizations like ACLAMO that provide good information for the people.”*

A participant mentioned the Asian American Coalition for COVID-19, which includes members from Chinese, Vietnamese, Indian, Filipino, and other Asian American heritages.

In most groups, participants commented on the **strong sense of community** where they live.

- *“You have people in the community check up on you or checking in or making a phone call or dropping something off. They’re very supportive here, which is the beauty of this town.”*
- *“Abington’s a pretty close-knit community. There’s a lot of support groups within Abington, and there’s a lot of services available. Our library is very good at posting information for residents to see what they have available. Our township website, our Abington township, they host a lot of classes.”*

In Pottstown borough, community events and resources such as a local farmers market help to reinforce social connections and promote health.

- *“There’s a lot of things that the town has to offer that focus around your well-being overall.”*

In a majority of groups, participants mentioned the **value of local parks and other aspects of the built environment, such as playgrounds, walking trails, and YMCAs**.

- *“As a lifelong resident, Haverford College and their nature trail have been valuable for me. ... Just a place to be able to ... lift your spirits by experiencing the different seasons, walking through the woods, I love that.”*
- *“Pottstown is very outdoors friendly ... there’s a lot of things to do, like the [Schuylkill River] trail, that’s something that a lot of my friends do....It’s a good opportunity to kind of stay healthy, like exercise or whatever, take walks with your children and stuff with your dogs.”*
- *“In Lansdale [we have] a bunch of parks and public spaces, and it definitely helps me and my family stay healthy, and ... that’s what we [are] using mostly daily for ... fun, just breathe fresh air and walk around and relax, and look at greens and trees.”*

\* There are several ZIP codes that span Delaware and Montgomery Counties. The Main Line Central group included participants from both counties. Therefore information from this discussion is included in both Delaware County and Montgomery County geographic community meeting summaries.



## Key Challenges

Across Montgomery County, in every group, **multiple participants discussed a range of worsening behavioral health issues during the pandemic--from depression and anxiety to substance use disorders--as their top concern.** Amid this growing need for care, behavioral health clinics are increasingly short-staffed, leading to long wait times for treatment, especially for children.

- *“There’s a lack of availability for mental services 100%, here in Pottstown. I’ve had a really rough time finding mental health services for children especially,”* noted a participant from a social services agency.
- *“So, we have all these people calling [our] 24-hour crisis hotline who need services, and can’t get them, because either they don’t have coverage [or] the provider doesn’t take the insurance. The call volume has far exceeded anything we’ve ever experienced ever, to the point where we can’t even accept any new cases for children at all,”* shared a participant from a social services agency.

**Substance use issues are rising among youth and adults,** multiple participants said.

- *“We have seen an uptick in substance use, like we’ve never seen, with the kids being home and isolated and with them having access to the internet where they could buy drugs online. There’s been deaths in the community from kids that have been buying drugs that they thought were Percocet or Valium, but they’re being made in somebody’s basement and they have fentanyl. So, it’s an epidemic inside a pandemic, to say the least.”*
- *“It’s across the board, and also pandemic-related, with alcohol, and with ... a lot of substances ... I don’t see a lot of resources.”*
- *“I would definitely say substance abuse is a big challenge,”* said a participant whose nonprofit organization provides behavioral health services, including care for people experiencing homelessness. *“Unfortunately, substance abuse is a big contributor to that [homelessness], and goes along with mental health.”*

**Stigma remains a common barrier to seeking mental health treatment,** noted participants in two groups. *“They’re afraid to come forward because they feel that they’re already judged, or they already feel useless, they’re not loved,”* shared one participant, who noted people need to be educated that mental health challenges are health problems, not a sign of personal failure.

Within Asian-American communities,

- *“there’s such a big stigma around mental health counseling, that a lot of times, the Asian American community members will ignore it, or say it’s something that I have to deal with, or even if it’s dealing with their kids, the parents may reject that idea, and not get the support that they may need.”*

**Social isolation during the pandemic has worsened mental health for many, as has grieving and bereavement due to lives lost to the pandemic.** Some people who recovered have long-term complications and are unable to work, causing families to lose crucial income.

- *“We lost a lot of our clients, and the parents of our kids,”* said a participant who works at a social services organization. *“From March to May last year, we lost 15 parents, that so many of them got sick and they were in the hospital for three, four, five, six weeks. ... it’s just been very challenging.”*
- *“One thing that’s been really difficult is that they haven’t really had an opportunity to grieve,”* said another participant, who noted that traditional funerals and bereavement support services have been curtailed or hard to access during the pandemic.

**Heart disease, diabetes, asthma, and obesity are prevalent throughout the county,** noted participants in four of the five groups. *“Diabetes is something that is huge. ... that is something that it’s really present in the community,”* said a participant who works with Hispanic/Latino communities. Another commented on the high prevalence of hypertension, which many do not take seriously:

- *“There’s so many things that high blood pressure contributes to, and people take [it] for granted.”*

As is the case for accessing behavioral health services, participants discussed **long delays in scheduling primary or specialty care visits, due to fear of going out during the pandemic and staffing shortages in many health care facilities.**

A participant who works for a health care center spoke about the staffing shortage in her center:

- *“Recently, that has been a big issue for everyone, not having enough staff members to attend to the needs of everybody. And even the staff that you already have, and I say this openly, because it’s something that everybody knows is going on,...we are understaffed. So what happens is that each staff member ends up taking up more roles and more responsibilities, and that is a burden. As an employee, as a provider for services, you want to be able to put your full attention and be there 100% for the client that you’re assisting.”*

Several participants also expressed **concern about the well-being of health care providers during the pandemic, as well as health system capacity to meet demand for services.**

- *“We are losing so many providers because of COVID. How are all the people in the area going to receive medical care? If you have to wait two or three months to get a doctor’s appointment, what’s that doing to your health?”*

- *“Clearly, the hospitals lack capacity to deal with things that are non-COVID, right? I think the ICUs are pretty much packed if not near packed with COVID. ... I do wonder what is being done to care for the mental health of medical providers on the other side of COVID as well, because they’re just dealing with it day in and day out.”*

**Access to affordable primary care has been further reduced by some physicians shifting into concierge practices,** said participants in two groups. A participant shared:

- *“I just got a letter from my doctor saying that they’re becoming concierge practice, so basically, they’re opting to have less patients, and [now] I have to pay to be a member to access my primary care physician for \$1,800 a year, on top of my regular insurance.”*

She added: *“That’s not going to impact me as much as somebody who is on Medicaid”* and others who cannot afford concierge services and would need to find another doctor.

**High health care costs, such as co-pays and medication expenses, were mentioned as barriers to care in most groups.**

- *“I’m a middle-class person with a decent job, and [health insurance] coverage, and you know what, I haven’t been to a doctor since January 2019. Why? ... I have resources, but I don’t go, because I’m not going to make my deductible, everything’s out of pocket.”*
- *“It’s also the fear of going to the doctors, and them telling you: ‘You need a medication,’ and then you can’t afford it. So prescription costs as well.”*

**Just the fear of incurring medical expenses prevents some from seeking care.** A participant who works for a local social services organization commented that her clients “have told us ‘well, you go to the hospital and they charge you whatever they want, they never have prices they will tell you, this is how much it’s gonna cost you.’ If they go to an appointment, they never know, people charge you whatever they want.’ I don’t understand why everywhere [else] prices are posted, except in medicine.” She added:

- *“That’s one of the reasons why we had a lot of Latinos get very, very sick with COVID or die from COVID, because they were avoiding ... going to the hospital.”*

Another pandemic-related issue, mentioned by one participant, was **confusion and distress over COVID-related hospital bills:**

- *“A lot of people are getting stuck with bills that are related to COVID hospitalizations.”*

The problem was attributed to patients’ lack of awareness about emergency medical assistance and health system delays in processing assistance applications.

In every group, participants stressed **the need for better language services in healthcare settings, along with more culturally competent care for the region’s diverse immigrant population.**

- *“More language services, because we know language access is also a big issue.”*
- *“Speaking from the Asian American community, there’s not enough bilingual and bicultural or even multicultural providers. We have mental health counseling services, but the demand is high, it’s always been high for mental health counselors [but there are] not enough, [and] when you look for people who can speak different language, and have a cultural understanding, very, very few around.”*

- *“This is not just in mental health service, I feel like it’s the issue all across with physical therapists, OT, speech therapist, even nurses and doctors, there’s shortage of people who speak multiple languages and understand the cultural background that affects people’s mental and physical health. Language Line is not always a good solution. But sometimes, even the interpreting services that are put in place are not so easy to utilize from the community with language barrier, especially the seniors.”*
- *“I think there are two therapists right in Norristown who speak Spanish and that’s it--no more, that’s it, and you have a waiting list like forever, so it’s terrible.”*
- *“Language barriers can be a significant challenge. ... Whether that’s the police department or the hospital, there’s always some form of an element of a language barrier, for a variety of reasons I would say, can mean that maybe people are understaffed, or they don’t have bilingual bicultural staff, [or] maybe not enough resources to pay for ... a certified interpreter. I think it goes beyond Spanish speakers as well, I’ve encountered those who speak Chinese Mandarin, those who are Korean-speaking, and so I think language overall can be a challenge,”* said a participant who works for a victim services agency.



## Social Determinants of Health

From a patient's perspective, access to high-quality language interpretation services is important for *"empowering people to actually be part of what's happening to their lives and their treatment and their needs."*

Participants throughout Montgomery County generally agreed that the **shift toward telehealth during the pandemic has had benefits and challenges**. On the plus side, the increase in telehealth visits has provided greater patient convenience and **enabled some providers to meet the demand for their services during the pandemic**. *"We have had a decrease in no-shows and cancellations of appointments, due to the use of telehealth. Small silver lining,"* said a participant whose organization provides health and social services. On the other hand, the shift to virtual services during the pandemic has created **new barriers for many older adults, people with limited English proficiency, and those who need or prefer in-person visits**.

Participants across Montgomery County discussed a number of social determinants that create barriers to health for some:

**Transportation.** In every group, participants commented on the lack of adequate and affordable transportation options to access health care and other essential services, especially for homebound older adults and others who do not drive or cannot easily use public transit.

- *"Lack of transportation makes it very difficult for them [seniors] to get food, or get to doctor's appointments."*
- *Lack of transportation also "contributes to social isolation -- if you're afraid to walk out your door, or you can't get anywhere."*
- *"Transportation is a big barrier for seniors. I know that you can get a bus pass; I think it's over 65 you ride the bus for free, which is great. Not everybody can get to the bus."*

With regard to the paratransit system:

- *"We also see people waiting for very long time, some days to be picked up. So, I do think transportation is an issue there. Even if there's a million programs to help, it's not helpful if they can't get there, so I do think that transportation is a real challenge."*

An older adult participant commented:

- *"The regional line that goes through Philadelphia-- good luck climbing up the stairs on that thing, you know? And even though we ride for free on SEPTA, it's -- transportation is hard."*

**Healthy food access.** Lack of convenient access to affordable nutritious food, along with the need for nutrition education, was mentioned in most groups.

- *"Norristown is a what we call ... a food desert; it's recognized as a food desert. [In local bodegas, the food] "is not really appealing to anyone. They normally have like [bananas with] black spots like they're not fresh, so people tend to eat bread and soda because it's less expensive too."*

Lack of knowledge about healthy food choices is another factor, the participant added:

- *"People don't always either ... know how to use [healthy food], , they have no idea how to do it, so I think it's challenging."*

Another challenge for some, especially those without cars, is the ability to carry food home:

- *"I think that that's challenging when you can only go to one place [e.g., a pantry] to get one food, and you can only take two bags, because you cannot carry more."*

- *“There should be more places that have, you know, fresh produce at reasonable prices.”*
- *“They have a farmer’s market in Bryn Mawr, but the prices are pretty darn high.”*
- *“One of the concerns for me is school food, which I... think it’s super unhealthy.”*

Chronic disease management may be difficult for people experiencing food insecurity who are also contending with diabetes or other diet-related conditions and rely on the emergency food system. A participant who works for a food pantry mentioned:

- *“I have more families asking for lower sugar items, which are difficult, because we don’t normally get that stuff donated.”*

**Built environment.** While participants in four groups view their local parks and green space as assets, Norristown was a notable exception, with participants expressing safety concerns about using outdoor recreation spaces.

- *“My concern in Norristown, many times, is that we don’t have enough safe green spaces for people to exercise right or to go out ... We have trails, right, ... but this is the problem, the trails are [not marked], there’re [no] spaces where people can park ...they are not safe...there are no lights, there are no signs, it’s scary.”*

Participants in several focus groups also commented that their **communities lack sufficient walkability, bike lanes, and public transit routes.**

- *“There’s a bus stop right outside my house, [but] it’ll only take me to Philadelphia, which is not the only – not nearly the only place I want to go,”* noted a participant who does not drive.
- *“In Lower Pottsgrove, there are few, if any, sidewalks. So, it makes some of the walking very difficult. You really have to drive someplace or take a bus someplace in order to utilize the outdoor space.”*
- *“I used to ride my bike up Ardmore Avenue when I was younger, and last week, I tried to do the same thing, I almost got killed, you know? There’s no bike lanes or anything.”*

**Cost of living, including housing.** In most groups, participants commented on the high cost of living in many areas of Montgomery County, making it difficult for older adults and others with limited incomes to afford health care, housing, food, and other essential needs. Recent consumer price inflation also was noted.

- *“I definitely feel like I’m being priced out of my own home. The older neighbors are all passing on, and those of us who are left are really under the gun to try and keep our properties up to standard with a limited income.”*
- *“Health insurance is a big thing too for them [older adults]. It’s too expensive for them. Most of them are on fixed incomes.”*

- *“The medication issue is a nightmare, how much people are asked to pay towards their medication ... it’s an outrageous amount of money. And people are deciding [whether] to use less medication, or no medication, or less food or less heat.”*
- *“I see a lot of people that live alone, and then they have to decide where their money goes, if it goes towards groceries, or if it goes towards medical bills, and so that’s something that I don’t think should happen, but that’s the U.S. right, like, that’s the way that the health insurance is set up for seniors.”*
- *“The price of gas, the price of food, the price of everything has increased so much that it has put a strain on families, and it definitely has impacted the aging population.”*

**Violence.** A recent increase in community violence was discussed in the Norristown group:

- *“In Norristown, we all kind of know that there’s been a very big increase in violence, and especially gun violence, and so how are we going to address that? We can’t just keep saying, ‘oh, well that’s a city thing.’ It’s moving into our areas, it’s in Norristown, it’s in Pottstown, all of these things are impacting it.”*

Another added: “We can build as many green spaces as we want, but...if those spaces aren’t properly maintained, if they’re not safe, and it’s not a safe community to go out into, then that doesn’t make a difference as to how we’re helping the community.”



## Children and Youth

In every group, the pandemic's impact on mental health among young people was a major concern, along with limited and delayed access to care.

- *“The wait right now for mental health treatment for children is three to five months or longer for us to be able to get them connected to somebody who is trained, who can actually work with them on a fee that is affordable for the families.”*
- *“Having families that can't get the proper services that they need for their children is very distressing and puts a lot of responsibility on us as a community as to how we're going to help these children and these families, especially with the mental health needs increasing since COVID had started.”*
- *“Montgomery County has a lot of good resources, and yet, right now, the accessibility to these resources is very, very limited, especially within the behavioral health system.”*
- *“My daughter is in fifth grade, but some of her friends have talked about suicide. I mean, you're talking 11-years-old. Coming from the pandemic, from that social isolation, and also from parents trying to balance work, life, school, the pressure society puts on us is just – it's tough, and it's tough being a parent to manage.”*

Several participants also raised concern about the **high rate of substance use among children and youth**, which they said has increased during the pandemic:

- *“We've had kids as young as 11, 12 on cocaine. I think it's a contribution of the high pressure of mental health, the need to numb themselves and escape. And I think alcohol is somewhat normalized to a point where it's like, is it normal or is it alcoholism, right?”*

**Accessing mental health care for children and youth is especially difficult for families with limited English proficiency.**

- *“A lot of times it requires us to do a lot of searching and like looking into things and calling different agencies, trying to figure out what services they provide, but when it comes to children and mental health issues, ... they never have availability for new patients. ... And when the family doesn't speak English, or doesn't have an interpreter, then they choose to move the child to a waitlist.”*

**Lack of physical activity and healthy eating, and the associated increased risk of childhood obesity**, were raised as concerns in all groups:

- *“The lack of time they get to run around during the day, the recess. They're sitting, like so much, and their backpacks are like 35 pounds, and then they just sit all day. ... I always wish there was more movement, I guess that's my theme, movement.”*

With virtual schooling, youth miss out on extracurricular activities, which compounds their social isolation and physical inactivity:

- *“That's what I see as one of the struggles for keeping the kids moving. I don't think it helped that they [students] were completely virtual all last year, and many are having a very hard time adjusting to get back into school, and a lot of students have opted to stay virtual.”*
- *“I think a very big health issue in our community and nationwide is obesity, and the lack of education as far as healthy eating goes. I think maybe the lack of the ability to get healthy food, it's very, very cheap to eat unhealthy, but if you want to eat the healthy things, it's twice as much money to buy those things.”*



## Older Adults

Other barriers to physical activity for youth, discussed in one or more groups, include expensive fees to participate in local youth sports leagues, too few options for extracurricular activities outside of competitive sports, and lack of playgrounds and other recreational resources that are adapted for children with special needs. A participant also expressed concern about competitive pressures for youth to excel at one sport rather than learn to play many. *“They want you to be the best of the best,”* said the participant, adding that over-competitiveness in sports, plus pressure for youth to succeed in school can *“stress these kids out, and they don’t think of their mental health behind it.”*

### **Several participants noted the need for families to spend more time together – and away from their electronic devices.**

Concerns also were raised about children accessing adult websites, apps, and social media that are inappropriate or dangerous for them.

*“Parents are not necessarily being educated [and] up to date on all these technological changes that are exposing their children to danger,”* said one participant, who cited an app that allows children to talk to random strangers. *“Kids are exposed to a lot that I think ..., we could avoid with more education.”*

**In every group, multiple participants cited social isolation, which has greatly increased during the pandemic, as a major concern for the mental and physical well-being of older adults.**

- *“For seniors, it’s definitely a mental health issue that they’re so isolated, and they are afraid to reach out sometimes. They used to come into our centers and connect with people and be active and do healthy things, and they just were cut off [by the pandemic],”* said a participant who works at a senior center.
- In Asian-American communities, fear of discrimination has further increased isolation. *“With anti-Asian sentiments ... and fear of COVID, seniors are limiting going out of their homes, they’re staying home, which limits their movement, so physically, it’s not good for them. Also, because they’re staying isolated, it’s not good for their mental health, either.”*
- A participant who works at a senior center described seeing an elderly man she knows, who visited after a long absence: *“When I saw him, he looked so old, and he looked isolated. He looked unkempt and disheveled. So, the isolation aspect is, I think, first and foremost ...What COVID did do is expose the need for social interaction--that it is important to be able to speak and touch and have those relationships.”*

**Participants in all groups noted that social isolation has been worsened by lack of affordable transportation options, making it difficult for homebound adults to access essential services, such as groceries and health care.**

- *“A lot of them are remaining independent for a long time, and either their families take away their cars, or they decide “I’m not comfortable driving anymore,” and I don’t think there’s a lot of good, affordable transportation in this area. So, I see that just getting to doctor’s appointments a lot of times and getting out and so forth.”*
- *“The building I live in [has] a lot of seniors...they don’t have transportation, and they don’t have knowledge about what’s going on in the community, or how the world is changing and becoming more computerized.”*
- *“I have a population of older adults who walk here to get food. You know, and then you have to keep in mind that they have to figure out a way to get to doctor’s appointments, and then they have to prioritize if I’m going to ask somebody for a ride, what’s the most important thing, a doctor, or a food?”*



## Other Groups

Participants in all groups highlighted the **needs of immigrant communities living in the county, especially those who lack English proficiency**. With a growing number of Asian, Hispanic/Latino immigrants and refugees, participants cited the need for greater affordability and availability of health care that is culturally and linguistically competent, especially for mental health services.

The need for more community resources for LGBTQ+ individuals was also noted in one group.

### The shift to virtual services during the pandemic has further isolated some older adults:

- *“Technology is a huge barrier for seniors, as a whole world moving into virtual world, we need to make sure that we don’t leave them behind. For low-income seniors, that technology can be an issue...especially if during COVID they couldn’t get to libraries or senior centers.”*
- *“I live in a community where we have a number of old folks who just don’t access the internet, and they live in isolation.”*

### With fixed or limited incomes, many older adults also face challenges in affording health care and other essential services.

Difficulty navigating the health care system, especially Medicare policies, also was mentioned several times.

- *“For seniors who are on Medicare or whatever, the cost of co-pays prevents a lot of people from seeing different specialists and people that they need to see. ... If you’re not connected with the right health plan or supplemental plan, the co-pays can be prohibitive.”*

- *“I see a lot of seniors working part time at like Giant and Walmart and like different places that do minimum wage because they need the money...Because they won’t qualify for Medicaid, because their Social Security income is too high already, and so they have to compensate by working. And when you’re 75-80 years old, the last thing you want to do is be working at Walmart to make ends meet.”*
- *“I was a social worker for years and years and years, and [choosing] the appropriate Medicare plan is very, very difficult. It’s not just you look at a chart and say, oh, this one fits me. It doesn’t work that way at all.”*

**More resources are needed to help older adults age in place**, especially amid rising costs for housing and the need for convenient, affordable transportation, participants generally agreed.

- *“It’s a big deal to be able to have ... the resources in the community so that people can stay in their homes ... I mean, I think that’s crucial.”*

# Suggested Actions

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**Convene a coalition to increase communication and coordination among community groups to address common challenges.**

A participant spoke to the need to *“get everyone in the same room so that those client needs can get addressed in like a more holistic sort of way.”* Another suggested reconvening the Tri County Network, which had previously met periodically to improve coordination among agencies. Creating a centralized clearinghouse with easily accessible information about a wide range of health and social service resources in the area was also recommended.

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**Strengthen partnerships between hospitals and community service providers.**

Participants suggested increasing collaboration between senior living facilities and hospital discharge staff to better coordinate care when older adults are discharged from a hospital stay. Another noted the need for hospitals to better publicize their community health services, such as free seminars, screenings, and health fairs. Because many people lack digital access, hospitals need to include non-virtual communications to raise awareness of their services, another participant suggested. Smaller community organizations also could benefit from partnerships with hospitals that provide training, funding, or other support.

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**Expand access to primary care services**

A participant advocated for passage of statewide legislation that would allow nurse practitioners to establish independent practices to provide primary care. Another suggested creating a visiting nurse program or a once-monthly clinic in an easily accessible community location to provide basic care for older adults. A community health clinic that offers a wider range of primary care services than an urgent care center was also envisioned by a participant.

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**Expand access to behavioral health services.**

A participant suggested integrating screening for behavioral health issues as part of routine primary care exams. Another suggested training people with lived experience to provide peer support to others with behavioral health challenges, such as Certified Recovery Specialists and Certified Peer Specialists. Hospitals also could provide training to local social service organizations whose staff are often the first to encounter and support people experiencing behavioral health issues. As a longer-term solution, developing career pipelines to train more health and social service providers to address behavioral health staffing shortages was suggested. Similarly, a participant recommended *“investing in mental health structure and equitable pay for people that are working in that field, and also giving them things that are more valuable, in terms of [things] like more paid time off, more time off for them to spend and have family time with their children.”*

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**Increase affordable transportation options for older adults and create a way to regularly check in on those who are socially isolated.**

Free or inexpensive transportation options are needed to help older adults get to and from medical appointments and other community services. Creating a service, perhaps led by volunteers, to call on older and homebound adults to check in and assess their needs was suggested: *“An organized service where people could drop in on seniors to visit them in their homes, to help assess what they need, and care for them.”*

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**Provide more support services for older adults who wish to age in place.**

A participant suggested passing a local ordinance requiring that a certain percentage of units in new developments be offered at affordable prices for people living on fixed or limited incomes. A related suggestion: provide exercise coaches who visit older adults in their homes to encourage physical activity.

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# Suggested Actions

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**Increase community health education prevention programs to encourage healthy lifestyles for youth and adults.**

Participants stressed the need for more education in schools on healthy eating, internet safety, and sexual health topics. Another mentioned the need for education on gun safety and violence prevention. Education for adults on home safety issues, such as preventing falls and mitigating mold, is needed, another participant noted. As one participant put it: *"I think the key is the power of education. Education versus opinion, though."*

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**Improve access to healthy food and safe spaces for physical activity for youth and adults.**

Suggestions from participants included opening farmers markets and food co-ops, increasing public safety on trails and other open space, and providing more free or affordable access to recreation centers and other facilities for youth to play basketball or other activities.

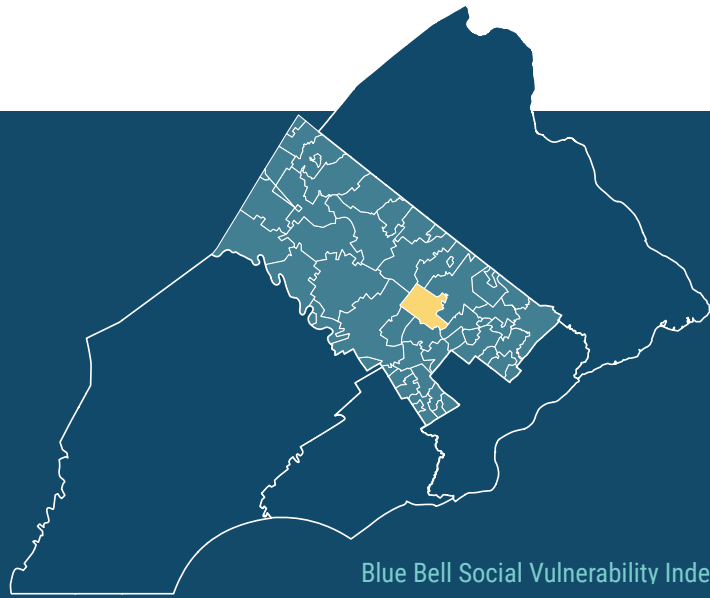
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# BLUE BELL

ZIP CODE: 19422

This community is served by:

- Children’s Hospital of Philadelphia
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital



Blue Bell Social Vulnerability Index



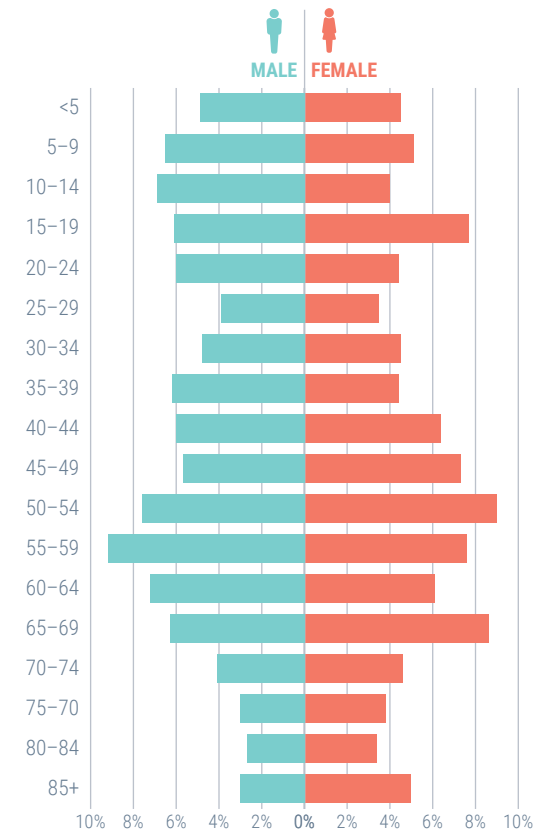
## POPULATION



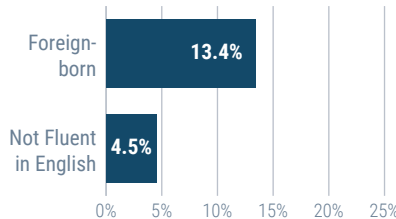
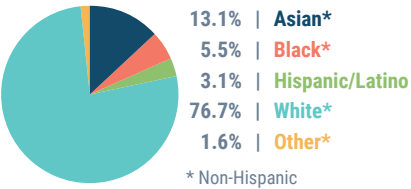
## MEDIAN HOUSEHOLD INCOME



## AGE DISTRIBUTION



## RACE/ETHNICITY/LANGUAGE



## LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. Cerebrovascular diseases
4. COVID-19
5. Diabetes

## EDUCATIONAL ATTAINMENT

High school as highest education level **11.6%**

PEOPLE WITH DISABILITIES **8.5%**

## summary health measures

		Blue Bell		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	976.0	1,167.0	939.0	1,072.8
	Life expectancy: Female (in years)	84.3	83.3	83.1	81.7
	Life expectancy: Male (in years)	83.0	81.3	78.3	77.0
	Years of potential life lost before 75	611	601	41,424	45,416
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	122.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	366.0	N/A	394.6
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	26.8%		29.1%	
	Diabetes prevalence	9.0%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	90.2	95.5	124.6	113.0
	Hypertension prevalence	28.7%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	403.1	307.7	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	917.7	673.7	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	--	--	26.3	30.1
	Major cancer incidence rate (per 100,000)	339.5		286.1	
	Major cancer mortality rate (per 100,000)	127.3		85.2	
	Colorectal cancer screening	73.9%		71.3%	
	Mammography screening	78.4%		77.4%	
	Physical inactivity (leisure time) prevalence	17.4%		19.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	5.9%	5.4%	7.2%	6.9%
	Percent preterm births out of live births	8.3%	3.6%	8.7%	8.0%
<b>Behavioral Health</b>	Adult binge drinking	17.1%		18.8%	
	Adult smoking	11.1%		14.4%	
	Drug overdose mortality rate (per 100,000)	--	--	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	42.4	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	233.4	175.0	265.9	223.8
	Poor mental health for 14+ days in past 30 days	10.4%		12.5%	
	Suicide mortality rate (per 100,000)	--	--	13.4	12.7
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	5,071.0	6,440.2	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	5.3	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
<b>Access to Care</b>	Adults 19-64 years with Medicaid	4.0%		8.0%	
	Children <19 years with public insurance	11.3%		21.5%	
	Population without insurance	1.6%		3.6%	
	Children <19 years without insurance	1.2%		2.3%	
	Emergency department utilization (per 100,000)	17,027.4	10,582.4	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	244.0	116.7	319.9	247.5
<b>Social &amp; Economic Conditions</b>	Population in poverty	2.4%		5.8%	
	Children <18 years in poverty	1.6%		6.9%	
	Adults 19-64 years unemployed	2.3%		2.0%	
	Householders living alone who are 65+ years	51.3%		43.5%	
	Households receiving SNAP benefits	1.8%		5.1%	
	Households that are housing cost-burdened	9.7%		12.7%	
	Housing with potential lead risk	29.8%		55.4%	
	Vacant housing units	6.9%		5.0%	

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

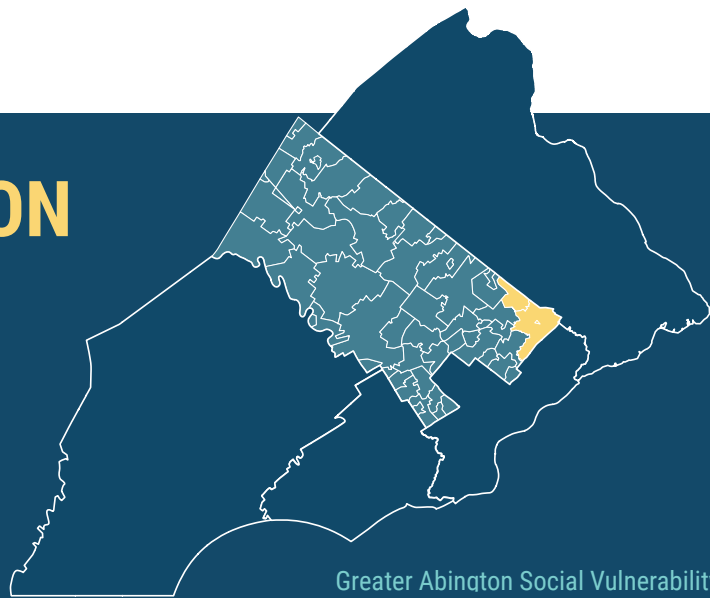
-- Estimates are unavailable or unreliable due to low sample size within a community.

# GREATER ABINGTON

ZIP CODES: 19006, 19009, 19040

This community is served by:

- Children’s Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Magee Rehabilitation
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital



Greater Abington Social Vulnerability Index



## POPULATION

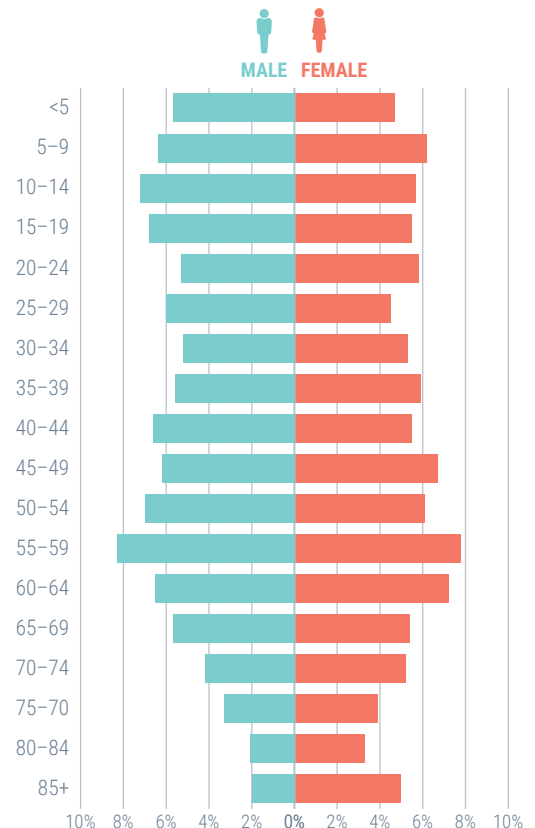
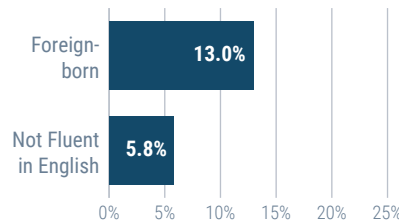
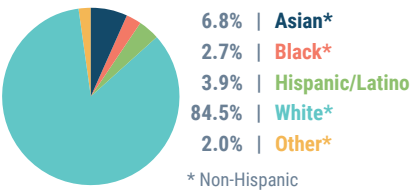


## MEDIAN HOUSEHOLD INCOME



## AGE DISTRIBUTION

### RACE/ETHNICITY/LANGUAGE



### LEADING CAUSES OF DEATH

1. Cancer
2. Heart disease
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer’s disease

### EDUCATIONAL ATTAINMENT

High school as highest education level **20.5%**

PEOPLE WITH DISABILITIES **9.3%**

## summary health measures

		Greater Abington		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	1,120.5	1,182.4	939.0	1,072.8
	Life expectancy: Female (in years)	84.1	83.7	83.1	81.7
	Life expectancy: Male (in years)	77.1	76.5	78.3	77.0
	Years of potential life lost before 75	2,257	2,281	41,424	45,416
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	293.3	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	515.6	N/A	394.6
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	28.4%		29.1%	
	Diabetes prevalence	9.4%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	114.6	112.3	124.6	113.0
	Hypertension prevalence	29.3%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	421.6	325.4	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,099.9	857.0	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	29.8	20.6	26.3	30.1
	Major cancer incidence rate (per 100,000)	263.5		286.1	
	Major cancer mortality rate (per 100,000)	91.7		85.2	
	Colorectal cancer screening	71.5%		71.3%	
	Mammography screening	76.4%		77.4%	
	Physical inactivity (leisure time) prevalence	20.0%		19.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	5.8%	6.2%	7.2%	6.9%
	Percent preterm births out of live births	4.4%	5.6%	8.7%	8.0%
<b>Behavioral Health</b>	Adult binge drinking	18.1%		18.8%	
	Adult smoking	13.9%		14.4%	
	Drug overdose mortality rate (per 100,000)	29.8	32.1	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	25.2	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	203.9	169.6	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.2%		12.5%	
	Suicide mortality rate (per 100,000)	13.7	--	13.4	12.7
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	8,179.7	7,350.2	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	4.7	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
<b>Access to Care</b>	Adults 19-64 years with Medicaid	6.6%		8.0%	
	Children <19 years with public insurance	21.8%		21.5%	
	Population without insurance	3.1%		3.6%	
	Children <19 years without insurance	2.3%		2.3%	
	Emergency department utilization (per 100,000)	17,554.8	12,934.6	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	242.3	186.9	319.9	247.5
<b>Social &amp; Economic Conditions</b>	Population in poverty	5.4%		5.8%	
	Children <18 years in poverty	6.7%		6.9%	
	Adults 19-64 years unemployed	2.0%		2.0%	
	Householders living alone who are 65+ years	51.7%		43.5%	
	Households receiving SNAP benefits	4.4%		5.1%	
	Households that are housing cost-burdened	14.5%		12.7%	
	Housing with potential lead risk	66.5%		55.4%	
	Vacant housing units	5.8%		5.0%	

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

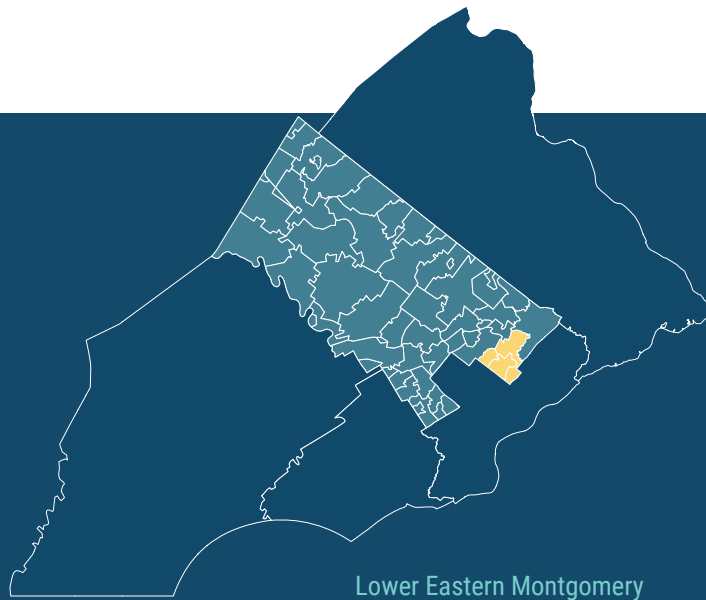
-- Estimates are unavailable or unreliable due to low sample size within a community.

# LOWER EASTERN MONTGOMERY

ZIP CODES: 19012, 19027, 19046, 19095

This community is served by:

- Children’s Hospital of Philadelphia
- Einstein Medical Center Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Magee Rehabilitation
- Redeemer Health
- Rothman Orthopaedic Specialty Hospital



Lower Eastern Montgomery Social Vulnerability Index



## POPULATION

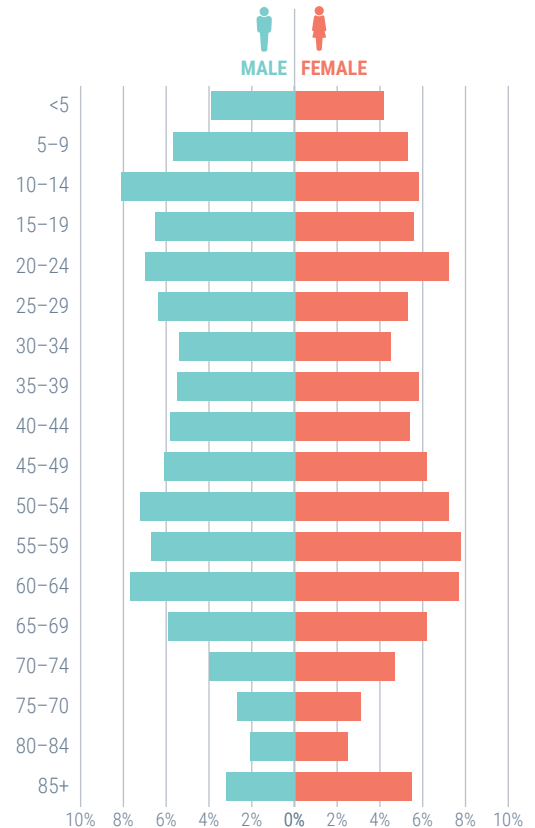
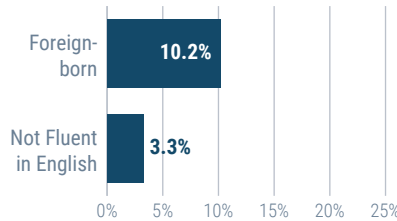
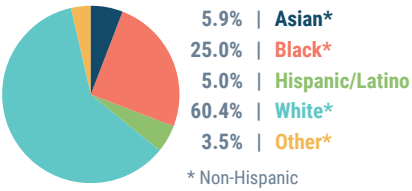


## MEDIAN HOUSEHOLD INCOME



## AGE DISTRIBUTION

### RACE/ETHNICITY/LANGUAGE



### LEADING CAUSES OF DEATH

1. Alzheimer’s disease
2. Cerebrovascular diseases
3. COVID-19
4. Cancer
5. Heart disease

### EDUCATIONAL ATTAINMENT

High school as highest education level **14.5%**

PEOPLE WITH DISABILITIES **12.3%**

## summary health measures

		Lower Eastern Montgomery		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	1,118.8	1,328.1	939.0	1,072.8
	Life expectancy: Female (in years)	82.4	79.2	83.1	81.7
	Life expectancy: Male (in years)	79.5	78.1	78.3	77.0
	Years of potential life lost before 75	2,479	2,909	41,424	45,416
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	313.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	588.7	N/A	394.6
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	29.4%		29.1%	
	Diabetes prevalence	10.0%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	158.4	129.1	124.6	113.0
	Hypertension prevalence	30.8%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	545.7	434.2	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,206.8	938.9	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	25.4	23.5	26.3	30.1
	Major cancer incidence rate (per 100,000)	299.3		286.1	
	Major cancer mortality rate (per 100,000)	99.8		85.2	
	Colorectal cancer screening	72.7%		71.3%	
	Mammography screening	78.8%		77.4%	
	Physical inactivity (leisure time) prevalence	19.5%		19.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	5.7	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	8.2%	7.5%	7.2%	6.9%
	Percent preterm births out of live births	7.3%	6.6%	8.7%	8.0%
<b>Behavioral Health</b>	Adult binge drinking	16.5%		18.8%	
	Adult smoking	12.3%		14.4%	
	Drug overdose mortality rate (per 100,000)	--	--	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	--	--	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	168.2	152.6	265.9	223.8
	Poor mental health for 14+ days in past 30 days	11.5%		12.5%	
	Suicide mortality rate (per 100,000)	--	19.6	13.4	12.7
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	7,286.8	7,144.3	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
<b>Access to Care</b>	Adults 19-64 years with Medicaid	8.0%		8.0%	
	Children <19 years with public insurance	20.5%		21.5%	
	Population without insurance	3.1%		3.6%	
	Children <19 years without insurance	2.4%		2.3%	
	Emergency department utilization (per 100,000)	24,093.7	19,122.7	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	409.2	332.6	319.9	247.5
<b>Social &amp; Economic Conditions</b>	Population in poverty	7.1%		5.8%	
	Children <18 years in poverty	7.1%		6.9%	
	Adults 19-64 years unemployed	1.8%		2.0%	
	Householders living alone who are 65+ years	42.8%		43.5%	
	Households receiving SNAP benefits	5.7%		5.1%	
	Households that are housing cost-burdened	20.2%		12.7%	
	Housing with potential lead risk	78.0%		55.4%	
	Vacant housing units	8.9%		5.0%	

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

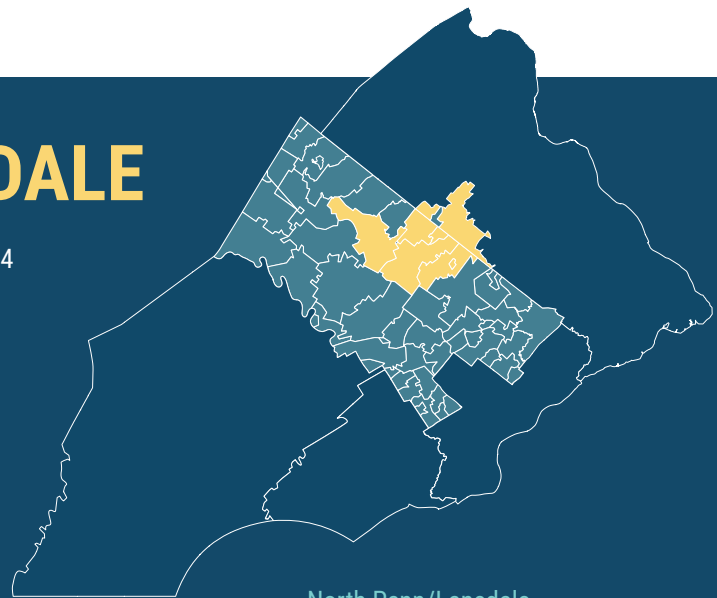
-- Estimates are unavailable or unreliable due to low sample size within a community.

# NORTH PENN/LANSDALE

ZIP CODE: 18915, 18932, 18936, 19438, 19440, 19446, 19454

This community is served by:

- Children’s Hospital of Philadelphia
- Doylestown Health
- Einstein Medical Center Montgomery
- Fox Chase Cancer Center
- Grand View Health
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Rothman Orthopaedic Specialty Hospital



North Penn/Lansdale  
Social Vulnerability Index



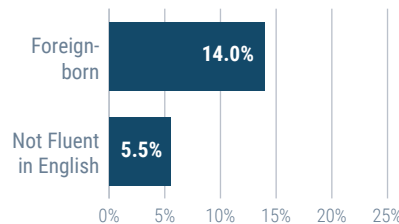
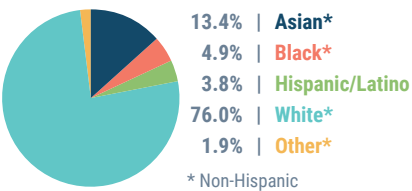
## POPULATION



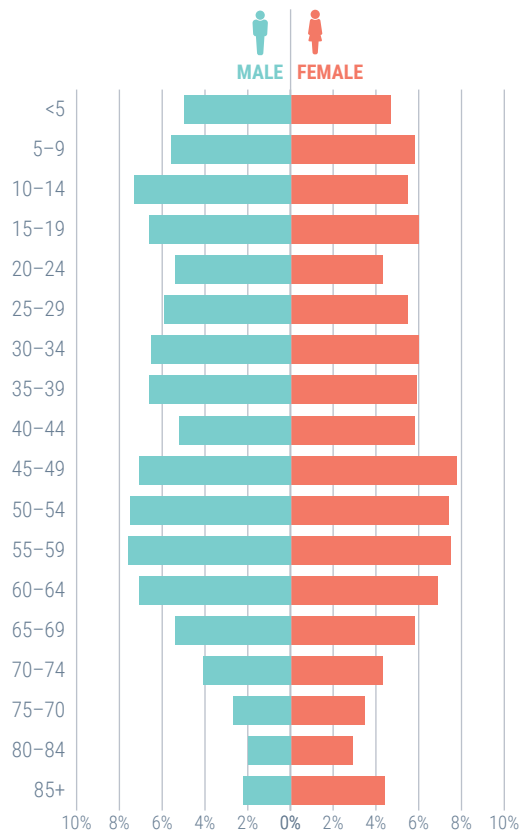
## MEDIAN HOUSEHOLD INCOME



## RACE/ETHNICITY/LANGUAGE



## AGE DISTRIBUTION



## LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Unintentional injuries (excluding drug overdoses)

## EDUCATIONAL ATTAINMENT

High school as highest education level **19.7%**

PEOPLE WITH DISABILITIES **9.6%**

## summary health measures

		North Penn/Lansdale		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	1,007.5	1,153.9	939.0	1,072.8
	Life expectancy: Female (in years)	83.6	82.4	83.1	81.7
	Life expectancy: Male (in years)	78.9	78.5	78.3	77.0
	Years of potential life lost before 75	6,210	5,984	41,424	45,416
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	151.0	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	398.1	N/A	394.6
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	27.7%		29.1%	
	Diabetes prevalence	8.8%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	117.4	109.1	124.6	113.0
	Hypertension prevalence	27.1%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	353.1	292.9	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,039.5	760.4	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	19.8	22.1	26.3	30.1
	Major cancer incidence rate (per 100,000)	263.1		286.1	
	Major cancer mortality rate (per 100,000)	77.8		85.2	
	Colorectal cancer screening	71.2%		71.3%	
	Mammography screening	77.3%		77.4%	
	Physical inactivity (leisure time) prevalence	19.3%		19.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	17.8	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	5.9	--	4.1	2.7
	Percent low birthweight births out of live births	6.0%	6.3%	7.2%	6.9%
	Percent preterm births out of live births	5.9%	5.9%	8.7%	8.0%
<b>Behavioral Health</b>	Adult binge drinking	18.4%		18.8%	
	Adult smoking	13.7%		14.4%	
	Drug overdose mortality rate (per 100,000)	22.1	18.3	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	20.6	19.8	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	178.5	160.9	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.0%		12.5%	
	Suicide mortality rate (per 100,000)	14.5	9.9	13.4	12.7
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	6,375.2	6,571.2	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	5.2	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
<b>Access to Care</b>	Adults 19-64 years with Medicaid	5.9%		8.0%	
	Children <19 years with public insurance	16.4%		21.5%	
	Population without insurance	3.3%		3.6%	
	Children <19 years without insurance	1.9%		2.3%	
	Emergency department utilization (per 100,000)	27,151.8	20,267.4	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	329.5	190.8	319.9	247.5
<b>Social &amp; Economic Conditions</b>	Population in poverty	3.9%		5.8%	
	Children <18 years in poverty	3.4%		6.9%	
	Adults 19-64 years unemployed	1.7%		2.0%	
	Householders living alone who are 65+ years	36.2%		43.5%	
	Households receiving SNAP benefits	5.6%		5.1%	
	Households that are housing cost-burdened	9.6%		12.7%	
	Housing with potential lead risk	32.0%		55.4%	
Vacant housing units	2.1%		5.0%		

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

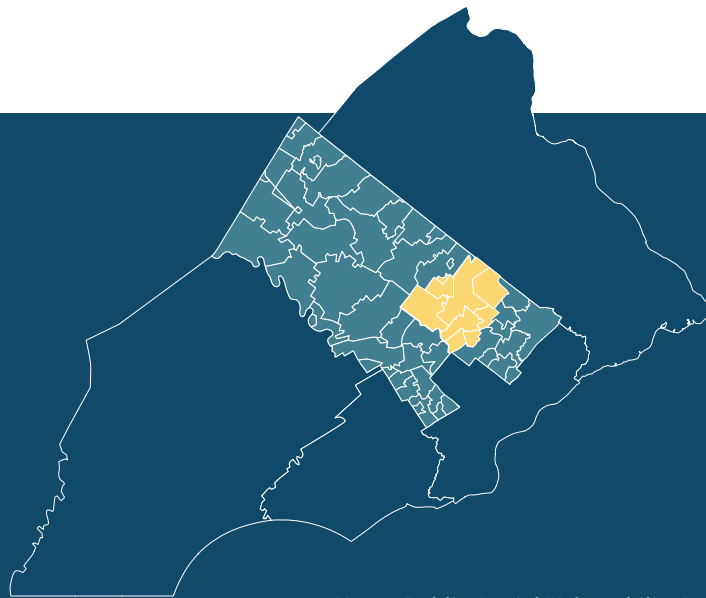
-- Estimates are unavailable or unreliable due to low sample size within a community.

# UPPER DUBLIN

ZIP CODES: 19002, 19025, 19031, 19034, 19044, 19075, 19436, 19437, 19477

This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Lansdale Hospital
- Magee Rehabilitation
- Rothman Orthopaedic Specialty Hospital



Upper Dublin Social Vulnerability Index



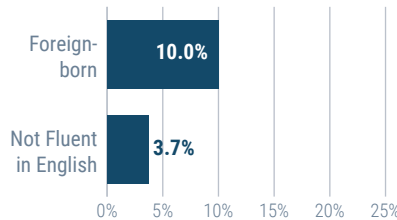
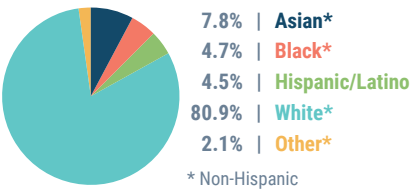
## POPULATION



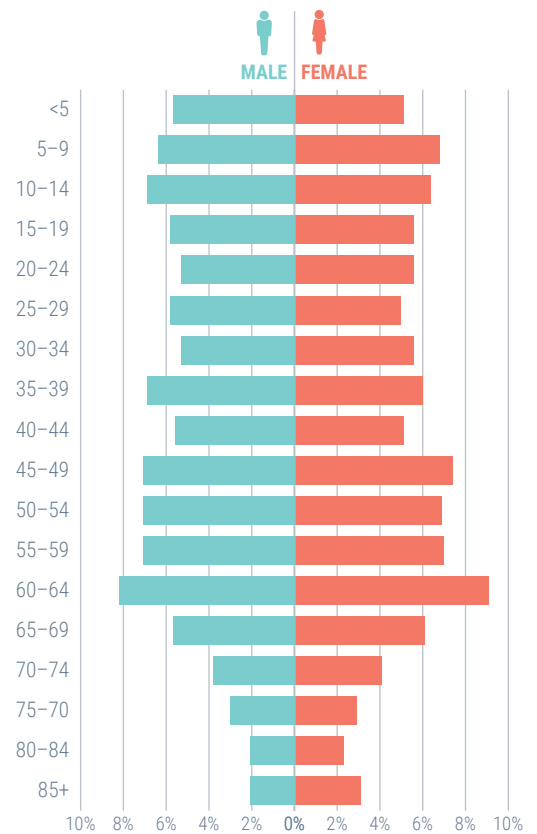
## MEDIAN HOUSEHOLD INCOME



## RACE/ETHNICITY/LANGUAGE



## AGE DISTRIBUTION



## LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer's disease

## EDUCATIONAL ATTAINMENT

High school as highest education level **14.4%**

PEOPLE WITH DISABILITIES **8.2%**

## summary health measures

		Upper Dublin		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	938.5	1,118.7	939.0	1,072.8
	Life expectancy: Female (in years)	83.7	82.4	83.1	81.7
	Life expectancy: Male (in years)	79.5	78.6	78.3	77.0
	Years of potential life lost before 75	2,969	2,961	41,424	45,416
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	217.8	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	372.5	N/A	394.6
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	27.8%		29.1%	
	Diabetes prevalence	8.5%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	94.1	87.4	124.6	113.0
	Hypertension prevalence	27.4%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	325.4	260.9	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	890.1	650.8	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	20.2	16.1	26.3	30.1
	Major cancer incidence rate (per 100,000)	255.5		286.1	
	Major cancer mortality rate (per 100,000)	82.0		85.2	
	Colorectal cancer screening	72.6%		71.3%	
	Mammography screening	77.9%		77.4%	
	Physical inactivity (leisure time) prevalence	17.8%		19.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	6.9%	6.1%	7.2%	6.9%
	Percent preterm births out of live births	5.2%	5.3%	8.7%	8.0%
<b>Behavioral Health</b>	Adult binge drinking	18.5%		18.8%	
	Adult smoking	12.5%		14.4%	
	Drug overdose mortality rate (per 100,000)	18.8	20.2	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	8.1	8.1	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	215.1	158.7	265.9	223.8
	Poor mental health for 14+ days in past 30 days	11.4%		12.5%	
	Suicide mortality rate (per 100,000)	14.8	8.1	13.4	12.7
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	7,972.4	7,679.0	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	--	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
<b>Access to Care</b>	Adults 19-64 years with Medicaid	6.0%		8.0%	
	Children <19 years with public insurance	14.9%		21.5%	
	Population without insurance	3.0%		3.6%	
	Children <19 years without insurance	2.5%		2.3%	
	Emergency department utilization (per 100,000)	21,068.4	15,895.1	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	489.7	169.5	319.9	247.5
<b>Social &amp; Economic Conditions</b>	Population in poverty	3.7%		5.8%	
	Children <18 years in poverty	4.0%		6.9%	
	Adults 19-64 years unemployed	1.8%		2.0%	
	Householders living alone who are 65+ years	59.9%		43.5%	
	Households receiving SNAP benefits	3.0%		5.1%	
	Households that are housing cost-burdened	7.7%		12.7%	
	Housing with potential lead risk	52.6%		55.4%	
Vacant housing units	3.4%		5.0%		

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

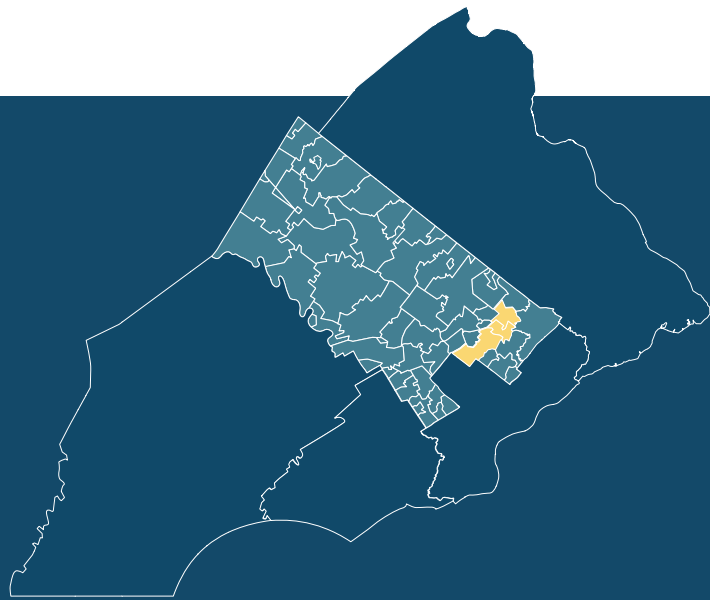
-- Estimates are unavailable or unreliable due to low sample size within a community.

# 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
- Magee Rehabilitation
- Rothman Orthopaedic Specialty Hospital



Willow Grove Valley Social Vulnerability Index



## POPULATION

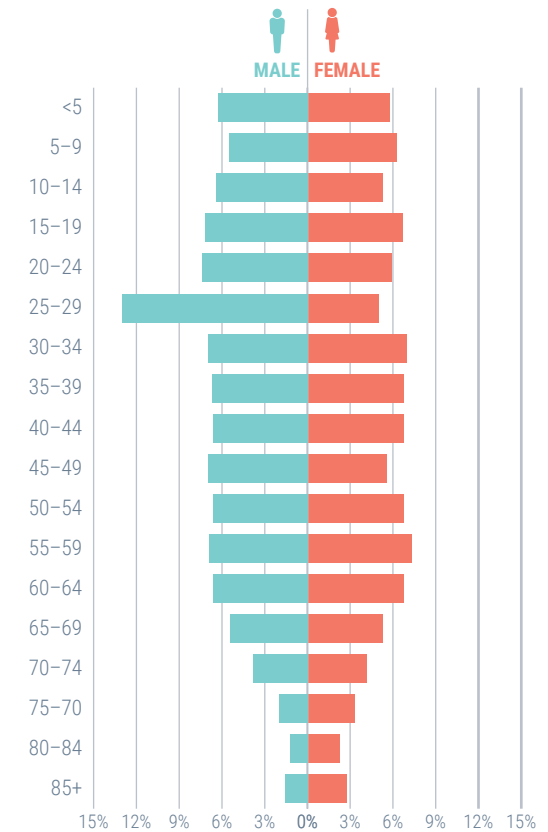
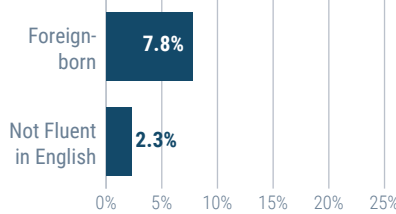
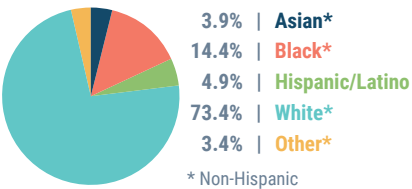


## MEDIAN HOUSEHOLD INCOME



## AGE DISTRIBUTION

### RACE/ETHNICITY/LANGUAGE



### LEADING CAUSES OF DEATH

1. Heart disease
2. Cancer
3. COVID-19
4. Cerebrovascular diseases
5. Alzheimer's disease

### EDUCATIONAL ATTAINMENT

High school as highest education level **17.5%**

PEOPLE WITH DISABILITIES **11.4%**

## summary health measures

		Willow Grove		Montgomery County	
		Pre-2020 Estimate*	2020 Estimate*	Pre-2020 Estimate*	2020 Estimate*
<b>General</b>	All-cause mortality rate (per 100,000)	916.1	1,088.0	939.0	1,072.8
	Life expectancy: Female (in years)	81.9	80.5	83.1	81.7
	Life expectancy: Male (in years)	76.7	73.9	78.3	77.0
	Years of potential life lost before 75	3,760	4,571	41,424	45,416
<b>COVID-19</b>	COVID-related emergency department utilization (per 100,000)	N/A	248.1	N/A	853.5
	COVID-related hospitalization rate (per 100,000)	N/A	572.4	N/A	394.6
<b>Chronic Disease &amp; Health Behaviors</b>	Adult obesity prevalence	29.5%		29.1%	
	Diabetes prevalence	8.9%		8.9%	
	Diabetes-related hospitalization rate (per 100,000)	142.0	109.1	124.6	113.0
	Hypertension prevalence	28.0%		27.7%	
	Hypertension-related hospitalization rate (per 100,000)	403.5	375.1	380.9	328.6
	Potentially preventable hospitalization rate (per 100,000)	1,001.3	787.6	979.3	763.1
	Premature cardiovascular disease mortality rate (per 100,000)	26.9	44.8	26.3	30.1
	Major cancer incidence rate (per 100,000)	331.8		286.1	
	Major cancer mortality rate (per 100,000)	103.1		85.2	
	Colorectal cancer screening	71.7%		71.3%	
	Mammography screening	78.2%		77.4%	
	Physical inactivity (leisure time) prevalence	19.0%		19.6%	
<b>Infant &amp; Child Health</b>	Asthma hospitalization rate <18 years (per 100,000 <18)	--	--	10.0	2.9
	Infant mortality rate (per 1,000 live births)	--	--	4.1	2.7
	Percent low birthweight births out of live births	8.8%	5.6%	7.2%	6.9%
	Percent preterm births out of live births	9.1%	6.1%	8.7%	8.0%
<b>Behavioral Health</b>	Adult binge drinking	19.0%		18.8%	
	Adult smoking	13.9%		14.4%	
	Drug overdose mortality rate (per 100,000)	29.9	23.9	24.3	23.7
	Opioid-related hospitalization rate (per 100,000)	37.4	37.4	43.6	34.2
	Substance-related hospitalization rate (per 100,000)	258.6	291.4	265.9	223.8
	Poor mental health for 14+ days in past 30 days	12.7%		12.5%	
	Suicide mortality rate (per 100,000)	12.0	13.5	13.4	12.7
<b>Injuries</b>	Fall-related hospitalization rate (per 100,000)	9,474.9	8,938.5	3,146.4	3,083.5
	Gun-related emergency department utilization (per 100,000)	--	3.2	9.4	9.9
	Homicide mortality rate (per 100,000)	--	--	2.5	2.5
<b>Access to Care</b>	Adults 19-64 years with Medicaid	9.4%		8.0%	
	Children <19 years with public insurance	24.5%		21.5%	
	Population without insurance	3.2%		3.6%	
	Children <19 years without insurance	2.5%		2.3%	
	Emergency department utilization (per 100,000)	22,508.1	19,407.8	19,958.7	16,419.9
	High emergency department utilization (per 100,000)	300.6	336.4	319.9	247.5
<b>Social &amp; Economic Conditions</b>	Population in poverty	6.4%		5.8%	
	Children <18 years in poverty	5.6%		6.9%	
	Adults 19-64 years unemployed	2.1%		2.0%	
	Householders living alone who are 65+ years	35.7%		43.5%	
	Households receiving SNAP benefits	7.9%		5.1%	
	Households that are housing cost-burdened	15.1%		12.7%	
	Housing with potential lead risk	81.5%		55.4%	
	Vacant housing units	5.2%		5.0%	

\* Estimates represent the most recent pre-2020 data available; 2020 estimates are shown if available.

-- Estimates are unavailable or unreliable due to low sample size within a community.



# COVID-19 PANDEMIC

The breadth, depth, and diversity of the impacts of the COVID-19 pandemic on the U.S. and the rest of the world are unprecedented.

While its effects have yet to be fully documented and understood, analyses of available U.S. data conducted over the past two years show:

- [Significant negative impacts on excess mortality and life expectancy;](#)
- [Widespread hardship affecting food access, housing, and employment; and](#)
- [Persistent racial/ethnic disparities in infections, deaths, disease severity, vaccination, and experience of economic distress.](#)

Local pandemic-related data for the five-county southeastern Pennsylvania (SEPA) region show patterns similar to national trends. For each of the five counties, COVID-19 is the third leading cause of death for 2020, following heart disease and cancer. Rates of COVID-19 mortality, health care utilization, and vaccination (see table below, which aggregates data featured in the county profiles; data for COVID-related health care utilization also available in tables for each geographic community<sup>1</sup>) are comparable to that of other metropolitan areas in the Northeast U.S.

	<b>Bucks</b>	<b>Chester</b>	<b>Delaware</b>	<b>Montgomery</b>	<b>Philadelphia</b>
<b>COVID-19 fully covered vaccination rate</b> (as of 11/30/21) (per 100,000)	55,875.8	61,756.4	55,860.1	56,857.4	58,072.7
<b>COVID-related emergency department utilization</b> (per 100,000)	190.2	445.0	713.4	853.5	701.4
<b>COVID-related hospitalization rate</b> (per 100,000)	398.9	274.1	564.8	394.6	851.0
<b>COVID-related mortality rate</b> (per 100,000)	145.1	110.2	177.9	144.2	165.4

<sup>1</sup> Due to the ongoing nature of the pandemic, these data are ever-changing so data incorporated into the report therefore represent snapshots at specific points in time. For more up-to-date information, please visit the [CDC COVID Data Tracker](#), the [COVID-19 Dashboard](#) maintained by the Pennsylvania Department of Health, or county health department resources (see [Bucks](#), [Chester](#), [Delaware](#), [Montgomery](#), [Philadelphia](#)).

As in other parts of the country, communities of color have been hardest hit by the pandemic, with Black/African American communities and Hispanic/Latino communities experiencing the [highest rates of COVID-19 infections, hospitalization, and death](#), as compared to other groups.

- An [analysis](#) of “interlocking systems of racism” encompassing employment, housing, neighborhoods, and transportation underscores the role of residential segregation in increasing risk of COVID-19 exposure and mortality for Black communities in Philadelphia.
- Though gaps have reduced over time, [COVID-19 vaccination rates](#) among African Americans continue to lag behind other racial/ethnic groups for every age group, especially among children aged 11 years and under. While [vaccine hesitancy](#) has often been cited as driving lower vaccination rates in communities of color, [building trust](#) through community engagement and [addressing barriers to access](#) are also important factors.
- Beyond COVID-19-related metrics, evidence is growing that racial disparities in other health outcomes (for example, [opioid overdose](#)) and health care access (such as [cancer care](#)) deepened during early phases of the pandemic.
- Directly contributing to and exacerbating such disparities are [pandemic-related job losses](#), experienced disproportionately by Black and Hispanic workers [at all levels of educational attainment](#) (but most starkly among those with less than a high school level of education, who are more likely to be in lower wage jobs in retail or hospitality). The cascading impacts of lost wages can be seen in hardships related to critical needs such as housing, as local [renters express challenges](#) with keeping up with rent and avoiding eviction during the pandemic.

The qualitative data collected for the rCHNA (see summaries of community conversations, spotlight discussions, and data collected for focus areas and communities) shed light on the lived experience of the pandemic on SEPA communities. Adults and youth alike experienced major disruptions to their lives, leading to negative impacts on mental health and physical health changes such as weight gain and sleep loss. For some communities, financial stress resulting from job loss contributed to experiencing higher levels of anxiety and depression.

Remote schooling was particularly challenging for youth, with many reporting difficulties with learning, lack of contact with peers, and feeling unprepared to socialize upon returning to in-person school. Impacts on older adults across the region were particularly acute, as heightened risks of COVID-19 morbidity and mortality contributed directly to significant social isolation. This had profound negative effects on their physical and behavioral health (e.g., reduced physical activity, food access challenges, delays in seeking health care, increased rates of depression and substance use).

A persistent theme across all rCHNA qualitative data collection efforts was the pronounced impact of the “digital divide,” reflecting increased awareness of disparities in digital access as a result of the pandemic. Lack of access to broadband internet services was universally viewed as a major barrier to employment (i.e., ability to telecommute), education (i.e., participation in remote schooling), and health care access (i.e., telehealth). Discussion participants particularly noted older adults as having the biggest challenges with digital access, owing to technology access issues (both broadband and device-related), as well as lower levels of digital literacy and comfort with using digital devices.

Local reports have delved into better understanding the digital divide in the region. One [regional analysis](#) mapped census tracts with below-average household broadband subscription rates for the region and found a positive association between higher COVID-19 infection rates and below-average household broadband subscription rates at the census tract level. A recent [report of the findings from a Philadelphia survey](#) identify other groups, in addition to older adults, with lower access to broadband or a working device, including Black communities, Hispanic/Latino communities, and households with lower incomes. Thirty-three percent of Philadelphians are considered to be “subscription vulnerable,” which is characterized by experiencing service interruption during the pandemic or having difficulty keeping internet service without a discount. Four in ten survey respondents cited affordability as a major reason for not having high-speed internet service, and 75 percent of residents with low incomes expressed that they are unable to afford paying \$20/month for access. A recently released [Digital Equity Plan](#) outlines potential strategies for addressing these issues.

# SPOTLIGHT TOPICS

Focus group discussions centered on “spotlight” topics were conducted with community organization and local government agency representatives in each county. A set of topics were selected for each county by Steering Committee members based in that county, taking into account prior CHNA priorities and key areas for input from community partners. (See “Our Collaborative Approach” section for details on topic selection by county.) Some topics were selected as a particular area of focus for a single county, while others were chosen by multiple counties. For topics discussed in multiple counties, discussions revealed a great deal of overlap in common themes across counties. To minimize redundancy in the report and highlight areas for potential shared regional action, summaries were written to aggregate insights across counties for a given topic.

The summaries included in this section are the following:

- **Access to care**  
*(Delaware County)*
- **Behavioral health** (including substance use\*)  
*(All Five Counties)*
- **Chronic disease**  
*(All Five Counties)*
- **Food insecurity**  
*(Delaware, Chester, Montgomery Counties)*
- **Housing and homelessness**  
*(Philadelphia County)*
- **Older adults and care**  
*(Bucks County)*
- **Racism and discrimination in health care**  
*(Philadelphia County)*
- **Violence**  
*(Philadelphia County)*

\* Given the significant overlap between the themes discussed in behavioral health and substance use discussions, these topics were combined in the summary.

# BEHAVIORAL HEALTH AND SUBSTANCE USE

## ALL FIVE COUNTIES

To better understand needs and opportunities to improve the prevention and treatment of behavioral health issues (including mental health and substance use) in southeastern Pennsylvania, focus groups were convened for each of the five counties with representatives from area organizations addressing these issues. In Philadelphia and Delaware Counties, both behavioral health and substance use topics were discussed in a single extended focus group. In Chester, Bucks, and Montgomery Counties, each topic was discussed in separate focus groups. Additionally, addressing behavioral health issues was identified as a major priority in focus groups conducted with community residents in all five counties; where relevant, comments from those discussions are included below.



## OVERVIEW

The terms mental and behavioral health are often used interchangeably. According to the [Centers for Medicare and Medicaid Services](#), behavioral health is defined as the emotional, psychological, and social facets of overall health; it encompasses traditional mental health and substance use disorders, as well as overall psychological well-being. This definition of behavioral health is used throughout this summary.

Substance use can include the use of illegal drugs; improper use of prescription and over-the-counter drugs; unhealthy use of alcohol, tobacco and vaping; and the continued use of drugs to alter mood, relieve stress and/or avoid reality. Many people will use substances at some point in their lives without any issues; substance use only becomes a problem when it starts to have harmful effects on someone's life. Substance use disorder (SUD) is the recurring use of a substance (legal or illegal) to the point that it interferes with the user's physical health and/or responsibilities at home, work, or school.

At some point during their lifetime, almost half of all people in the U.S. will be diagnosed with a mental health disorder.

According to the [National Institute of Mental Health](#):

- Nationally, nearly 1 in 5 adults live with a mental illness, but less than half (46.2%) received care for their condition in the past year.
- About five percent of U.S. adults reported having a serious mental illness (schizophrenia, bipolar disorder, or major depression); 64.5 percent reported receiving care for their condition in the past year.

In 2019, 7.7 percent of people 18 or older had an SUD per the [2019 National Survey on Drug Use and Health](#). Of those, 38.5 percent struggled with illicit drugs, 73.1 percent with alcohol use, and 11.5 percent with both illicit drugs and alcohol. Among people aged 12-17, 4.5 percent had an SUD in the past year. Only 10.3 percent of people over age 12 with an SUD in the past year received needed SUD treatment.

According to the [National Institute on Drug Abuse](#), people with a mental health disorder, such as anxiety, depression, or post-traumatic stress disorder, may use drugs or alcohol as a form of self-medication. **Multiple national population surveys have found that about half of individuals who experience an SUD during their lives will also experience a co-occurring mental health disorder and vice versa.** Similarly, research suggests that adolescents with SUD also have high rates of mental health conditions.

### **Behavioral health issues among youth have risen over the past decade.**

Even before the pandemic, behavioral health issues were the leading cause of disability and poor life outcomes in young people, affecting up to one in five aged 3 to 17 in the U.S., according to a recent [report](#) from the U.S. Surgeon General. This report cites data showing one in three high school students reported persistent feelings of sadness or hopelessness in 2019—an overall increase of 40 percent from 2009. According to the [Center for Disease Control's Youth Risk Behavior Surveillance Data Summary and Trends Report for 2009-2019](#), one in six youth reported making a suicide plan in the past year, a 44 percent increase from 2009. These data show that almost half of youth identifying as LGBTQ+ had seriously considered suicide, and the number of Black students reporting a suicide attempt increased by almost 50 percent.

Many adolescents with depression or other behavioral health challenges do not always get necessary treatment. According to the [National Survey on Drug Use and Health](#) and the [National Health Interview Survey](#), 26.7 percent with mental health problems (aged 4 to 17 years) did not receive treatment. Among adolescents with a diagnosis of depression (aged 12-17 years), 58.6 percent had not received treatment.

One in four older adults (aged 65 and older) are socially isolated, according to the [CDC](#). Lack of social connectedness (arising from social isolation and leading to feelings of loneliness) has been linked to depression, anxiety, cognitive decline, Alzheimer's disease, and higher rates of chronic diseases like high blood pressure, heart disease, and obesity. While drug overdose rates across the U.S. have been declining, rates of substance-related hospitalizations and overdoses have increased among older adults.

### **Access to care for behavioral health services was lacking prior to the pandemic and remains extremely problematic.**

In a recent [national survey](#) of mental health professionals conducted by the New York Times, nine out of 10 therapists said the number of clients seeking care is on the rise, leading to a surge in calls for appointments, longer waiting lists, and difficulty meeting patient demand. This trend has also been seen in southeastern Pennsylvania.

**Focusing particularly on the five-county region, selected behavioral health indicators for adults and youth that compare less favorably to state or national rates are highlighted below.**

(For more granular data on behavioral health indicators at the geographic community or county level, please see the geographic profiles.)

According to data on adults from [County Health Rankings 2021](#):

- As compared to Pennsylvania rates, Philadelphia County has higher rates of smoking, poor mental health days in the past 30 days, and more frequent mental distress.
- The drug overdose rate in Bucks, Delaware, and Philadelphia Counties exceeds the rate in Pennsylvania.
- Excessive drinking and alcohol-impaired driving deaths are higher in Bucks and Chester Counties in comparison to the rest of Pennsylvania.

**Behavioral Health Indicators for Youth**

Relevant behavioral health indicators for youth are collected through the Youth Risk Behavior Surveillance System (grades 9-12, collected in Philadelphia only) and the Pennsylvania Youth Survey (grades 6, 8, 10, 12, administered in Bucks, Chester, Delaware, and Montgomery Counties). Based on 2019 data from both data collection efforts, a selection of indicators in which rates in the five counties compare less favorably to state-level data are presented below:

- Philadelphia youth reported feeling sad or hopeless two or more weeks in the past year at a higher rate than the national rate (40.3% compared to 36.7%). The rate among those identifying as LGBTQ+ was considerably higher (59%).
- Compared to a national rate of 8.9 percent, 14.6 percent of Philadelphia students had attempted suicide. Among those identifying as LGBTQ+, this rate was 25.7 percent.
- Use of substances in the past 30 days was highest for marijuana (21%), followed by alcohol use (17.2%), and vaping (7.1%) among Philadelphia students.
- Bucks County youth had higher rates of reporting alcohol (17.8%) and marijuana (11.2%) use, as compared to Pennsylvania (16.8% and 9.6%, respectively). Of those who reported vaping, youth in Montgomery (37.2%), Chester (36.3%), Bucks (37.8%), and Delaware (29.7%) Counties had higher rates of marijuana vaping than the state rate (26.6%).
- Youth across the four counties reported getting alcohol from friends, siblings, and parents, but the majority reported taking the alcohol without permission or giving money to someone to buy it for them. They also shared that prescription drugs are given to them by a family member or friend (32%-41%) or taken from a family member living in their home (41%- 44.6%). Seven to 13 percent of youth indicated that they purchased drugs on the internet.

# IMPACTS OF SOCIAL DETERMINANTS OF HEALTH ON BEHAVIORAL HEALTH

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**Social determinants of health impact the risk of developing behavioral health disorders, access to care for these conditions, and, ultimately, health outcomes.**

Given the importance of these determinants, focus group participants agreed that basic human needs should be addressed as part of care.

**“A lot of these families are focused on just their basic needs, and if we can help with the basic needs ... so paying rent bill. Those are probably the biggest ones; it’s the financial, employment, and shelter.”**

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**The effects of trauma on behavioral health, particularly since the pandemic, were highlighted across most groups.**

According to a provider:

**“100% of our patients experience some type of trauma.”**

Another participant said:

**“More people that have experienced trauma, more people who have experienced isolation ... we do see that there’s been an increase in the number of people who are seeking medical assistance.”**

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**Violence affects behavioral health and access to care.**

**“In addition to the shutdown which isolated families, there has been an uptick in gun violence across the city causing more trauma.”**

Another participant noted that face-to-face counseling in some communities has been limited by violence

**“Clinicians are afraid to come into the community because of gun violence ... because [they] heard on the news that there was this shooting down the street.”**

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**Racism impacts behavioral health services and resources.**

**“Racial disparities, and the racial upheaval that went on was not just stressful, it was traumatic, and it still is, it has always been for Black people. And on top of the pandemic, on top of every layer of racism, systemically that we have to deal with. is [that] mental health is not accessible. ... I can’t stress enough that there is a high need for more mental health professionals who have cultural competency, and who look like the people they serve.”**

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# SUBSTANCE USE: TOP ISSUES

## Across counties, participants highlighted opioid and alcohol use as priority concerns.

Participants also shared concerns about rising use of methamphetamines, fentanyl, marijuana, vaping, and other substances. (Note: marijuana and vaping are discussed in the Children and Youth section of this summary). In addition, participants stressed the need to expand medication disposal and overdose prevention programs, as well as increase funding for non-opioid related addiction.

### Prescription drug misuse.

"Most people don't start shooting up heroin or snorting heroin," said a participant. "They start with prescription drugs. ... People become dependent upon them, and then go to the street because they can't get them anymore. And here we are. In the middle of an opioid epidemic taking lives every single day." Another participant cited the need to address prescription drug misuse as a preventive measure: "I think prescription drugs just across the board are affecting everyone at every age. Even unintentionally."

### Fentanyl use.

Concerns about increased fentanyl use, increasingly present in street drugs, were raised. A participant noted: "We don't even see heroin in Montgomery County anymore; it's all fentanyl." Another from the same group added: "Now there are so many what we classify as 'user-dealers' in Montgomery County, people who are supporting their own habit by selling fentanyl, that the people with abuse disorders don't even have to go to Philadelphia to get it anymore. Fentanyl has been around for so long now it's just in everything. We are starting to see fentanyl in cocaine and crack."

Related concerns include the use of fentanyl in "fake drugs," the corresponding increase in juvenile overdose, and the need to educate youth about drugs that are made to look like oxycodone but are really fentanyl. "The third biggest problem we have in Montgomery County is the fake fentanyl pills. We have seen an increase in juvenile overdoses with these pills, because the quality of them is so good that they can't tell. They look like the 30-milligram oxycodone pills, they're stamped with the M, and it's just a fake pill laced with fentanyl."

### Methamphetamines.

Participants highlighted increasing availability and use of methamphetamines. According to an individual in law enforcement, "We have seen an influx of methamphetamine in the last about a year. ... Everybody sells methamphetamine now, and everyone unfortunately is using it. We've seen a seismic shift of opioid users now self-medicating with methamphetamine."

### While participants agreed on the need to sustain funding for opioid use disorders, they expressed concern about insufficient funding to prevent and treat other addictions.

"There's been a huge push relating to opioid use disorders and for good reason... But because all of the funding seems to be at the opioid use level, ... a lot of the other addictions have fallen to the wayside to some extent, and it could potentially be harder to connect people to resources because the funding is tied directly to [having] an opioid use disorder."

### Alcohol use.

Across counties, participants noted more alcohol than opiate misuse. Practitioners from several counties described high levels of alcohol misuse as a major concern and discussed its impact on families and older adults. "[There are] greater numbers of people with alcohol use issues. ... And I'm not talking about alcohol poisoning, I'm talking about people with long term alcohol use issues that are dying from that. But because opioid use disorder is so much more visible and imminent than for a person who's dying from alcohol issues, that's generally more long term, alcohol doesn't get the same traction and attention," said a participant who works in the field. Another, in private practice, cited the impact on families: "I see the effects of alcohol abuse on families. It's devastating, it affects every member of the family. I think that we can't ever lose sight of the dangers of alcohol abuse."

### Kratom.

Participants from one county discussed the use of kratom, particularly among young adults. Concerns include easy access to the drug, lack of understanding about the drug and potential side effects, including addiction, and lack of knowledge about treatment. "It's something that you can buy on Amazon, get at 711. ... It's advertised online as a safe alternative to opioids... But the problem with kratom is at a low dose, it's kind of a stimulant. So, people who want it for the opioid effect don't tend to take it as a low dose because it doesn't have the opioid effect. And it's completely unregulated. So, when you're buying it on these websites, and most of them are out of China or Russia, people don't know what's in it beyond kratom."

# KEY CHALLENGES

**Access to behavioral health care in southeastern Pennsylvania is complex and difficult to navigate, multiple participants emphasized.** Factors such as stigma, lack of health system capacity, including too few culturally and linguistically competent providers, and difficulty with navigating the system are delaying care for many.

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**Stigma:** Stigma related to behavioral health can be due to personal and familial attitudes or cultural beliefs, as well as negative perceptions held by the public. Stigma can delay or prevent people from seeking treatment, resulting in worsening symptoms and poorer outcomes. In addition, participants raised the need for providers to recognize the stigma they may bring to counseling patients with addiction.

- **“Stigma is really what keeps people from reaching out and can even keep people from helping their kids to get help too. I think more awareness is needed.”**

- A person who perceives community stigma about substance use may be more reluctant to seek care or participate in support groups.

**“Having meetings in a place where you’re going to see a lot of other members of your community, is definitely a hard thing for people in that position to do.”**

- Even when practitioners and families successfully address stigma, barriers to care remain.

**“And so by the time we do all that background work regarding the stigma, and engaging the family, and convincing the family that this would benefit them, and then we send them somewhere, and they don’t get what they need. That by the time we convince them to make that move ... there’s going to be a very long waiting list or a lot of other barriers.”**

- Stigma held by providers about patients presenting with substance use is a potential barrier to treatment.

**“There’s a lot of stigma that influences providers, our provider capacity to connect well with a person, our level of motivation to push for resources, and that certainly affects the outcome and success to see a person connected to a resource.”**

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**Bed capacity for inpatient and crisis care is limited in most counties, resulting in extended stays in emergency rooms and patients not receiving the level of care needed at times.**

- **“The hospitals are suffering from not enough staff, and there weren’t enough beds to begin with. We’re running into difficulties where people are coming to the emergency room, they’re getting approved for a hospital stay, and then we can’t find any hospital who will take them.”**

- **“It’s a lack of beds even beyond the lack of staffing. It’s a lack sometimes of the specific needed bed. If you’ve got a 15-year-old female, you need something that’s for both females and adolescents. So there might be a bed somewhere but it’s not a bed you can send this one to.”**

- **“Sometimes people need to go across the state for what is the right treatment for them and then that creates other barriers because their natural supports aren’t there with them.”**

**Lack of behavioral health professionals is leading to delayed care.**

Staffing shortages were cited across all counties, particularly for professionals serving youth and immigrants. Retention of staff, even more problematic since the pandemic, also was noted, due to low pay and professional burnout.

- “Even prior to COVID, our system experienced staffing issues across the provider system that impacted access to care for individuals. During the pandemic and more currently, I would classify the system being in a staffing crisis ... to the point where it has impacted access to care much more dramatically than I’ve seen in my career.”
- “There are extraordinary waiting lists for every type of mental health treatment. A lot of private practitioners will not even accept a referral from a new client, psychiatrists are completely unavailable.”
- “It’s not just direct support workers that are leaving the field, but it’s professionally trained licensed professionals that are leaving the field as well for a whole host of reasons. ... They are looking for benefits, they’re looking for stable and full-time work, and ... in addition (since COVID) a lot of people have reassessed how they want to live their lives, and have chosen to move on to something different.”
- “In my 34-year history I never remember telling people that we didn’t have availability. It is painful to have to tell people we don’t have availability. ... We’re seeing mass exits of employees leaving...not just their position with a particular provider, but in a lot of cases leaving the field and just burned-out from the field. We have hospitals that don’t even have all their beds available open, because they don’t have the staffing to support their beds.”
- “Not being able to hire enough staff, not enough funding, low rates of pay which make it hard to retain staff. ... So, you know, not enough hospital beds, not enough outpatient capacity, not enough residential, not enough case managers, not enough.”

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**The need for culturally and linguistically prepared behavioral health providers who reflect the communities they serve was identified as a priority in all counties.**

- “In Upper Darby, there’s like 100 different dialects that are spoken. There’s a big Asian population, so that’s just a huge issue and like a barrier for those individuals to access care.”
- “I can’t echo enough the language barrier, and the lack of bilingual providers ...Behavioral health issues are not best done through a translator, you know, for psychiatry or counseling - folks who are able to speak the language are needed.”

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**Participants from all counties noted the need for cultural competence and cultural sensitivity among behavioral health providers and health systems, as well as greater diversity among behavioral health professionals.**

- “You have people coming in who are not white who feel like there’s nobody here that looks like them. ... Being able to hire a more diverse staff is an issue.”
- “There is a sense of distrust in the healthcare system...We have to take ownership of that and be able to connect with the communities we’re serving as providers.”

**Training that builds skills of providers to help patients commit to substance use treatment is needed.** Providers need to be able to adequately assess and address substance use treatment with patients at critical points in time that may be short-lived.

- “Maybe when people decide, ‘hey, this is the sweet spot of time that I want to access treatment,’ that moment, that special moment when people make that decision. It may be when they’re on a medical floor in kidney failure. The clinical staff may not be the best folks to be intervening at that point. A nephrologist may not have motivational interviewing training to be able to really get that person committed to treatment. So, I think there’s maybe a disconnect with the medical side of things, maybe not fully understanding, SUD treatment, and what’s entailed.”
- “We don’t have the training to engage that [SUD] patient. If they’re not ready, then you know we don’t have the skills to kind of talk them into what may be the best path for them.”

Providing a “whole patient approach” to the treatment of SUD, that includes medication-assisted treatment (MAT), is being promoted across counties by encouraging primary care physicians to incorporate it into their practices. As part of this process, X-Waiver Training (which allows physicians who meet certain qualifications to treat opioid use disorder with buprenorphine in clinic offices) is needed, as is increasing awareness among providers about available resources:

- “Primary care doctors can help with this and refer to resources. But they don’t necessarily know what all those resources are.”

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**Trauma-informed care training for health professionals, school personnel, and other community organizations was noted as an essential need in most counties.** Other trainings, such as Mental Health First Aid and integrated health care, also are needed.

- “Providers need to be able to fully understand what trauma is, and how trauma presents in the populations that we’re providing services to. ... They need to receive ... training for trauma, and fully immerse themselves to understand ... the symptoms of trauma, how the symptoms of trauma present and come out in the forms of behavior.”

**FOCUS:**  
**SYSTEM NAVIGATION**  
**CHALLENGES**

**Across all counties, participants cited multiple challenges with navigating the complexity of behavioral health systems.** Obtaining a timely, appropriate level of care depends on many factors: insurance regulations, transportation, care coordination, awareness of available resources and services, and technology. Equity issues in accessing SUD treatment based on income also were noted: *“People with unlimited funds to fund this themselves have lots more options.”*

One participant summed up many of these issues:

*“The drug and alcohol system actually has a lot of potential resources, but there’s a particular path to accessing most of them and if you don’t know the path or where the entry points are, or in many cases, what your insurance allows, then it feels like there’s nowhere to turn. So, the biggest issue, aside from getting people to the point where they truly want to engage with this kind of treatment, is breaking down the barriers. So, when they are ready, they can engage. There’s a very short window in this field, like 48 hours, when a person decides they want treatment and needs to be engaged before that passes, and an opportunity is missed. ... A lot of people just think that they call up and say I’m ready for drug and alcohol treatment and then they go there, and that’s not exactly how it works.”*

**Participants from all counties cited insurance barriers to accessing behavioral health care.**

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**Providers may limit which patients they treat based on whether the patient is uninsured or has an insurance type, such as Medicaid, that pays less for SUD treatment.**

- **“Many of these patients have Medicaid insurance, which doesn’t really reimburse for services very well. And so most providers either have a limited number of Medicaid patients that they’ll accept or they won’t accept Medicaid at all. So, a lot of times patients don’t have commercial insurance that will reimburse for services adequately. ... I think that’s one of the big limitations as to why providers don’t take this on.”**

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**Insurance issues may arise for those with SUD and possible co-occurring mental health issues.**

- **“What do we do with an individual when we can’t identify whether their primary issue is a drug and alcohol addiction related issue, or a mental health issue? And then we think we’re going one path in terms of treatment, and they don’t have insurance [that covers it]. ... I think most of us would agree that in a lot of cases, it’s usually both.”**

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**Information about services for those who are uninsured or underinsured needs to be more widely known in the community.**

- A participant from an organization that provides coverage for underinsured or insured individuals seeking care for SUD said:  
**“A priority specifically for our office is making our services more known to everyone in the county, residents, school districts. The main function of our office is to help people fund treatments for drug and alcohol. That’s for uninsured or underinsured, including adolescents who have to pay co-pays for their treatment multiple times a week.”**

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**Negotiating service limitations can be frustrating.**

- “If the moment that the individual is looking for help is outside of business hours, it [creates] an added layer of challenge to accessing those services.” Another participant shared: “Finding outpatient services after a rehab or detox is absolutely a challenge as well. ... Everybody’s got their own procedures, everybody’s got different requirements. If it’s a dual diagnosis -if they have multiple co-occurring disorders -then we won’t take a patient that has this, but we might take a patient sometimes that might have this, but we don’t really do amphetamines ... we’ll do opioids, but not that. So, it’s frustrating.”

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**Across counties, challenges related to transportation were raised**

- Inadequate provider networks result in long wait times, requiring some to travel great distances to see in-network providers. A participant noted about Bucks County: “In some areas people don’t have transportation. There’s not public transportation in the upper part of the county for sure, very little in the middle, some in the lower, but people can’t even get to services.”

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**The need for a holistic, coordinated, and collaborative community-driven approach to care was seen as a priority in most counties.**

- **A culture shift that sees physical and behavioral health as components of a person’s overall health is needed:**  
“If a hospital is to serve the health and wellness needs of the community ... I think some sort of cultural or perspective shift is needed everywhere. Mental health is a thread through everything that you do. Integrated health is really, really important. ... When health organizations start to separate physical and mental health it adds to the stigma. ... It’s this is your physical health, and then your mental health is something that you need to worry about somewhere else ... and not here. It needs to all happen in the same place, and people need to understand it, and need to be educated across board not just in primary care, but everywhere.”
- **A collaborative, coordinated system of care that includes integration with community services and resources is also needed:**  
“The idea of integrating behavioral health within the communities, either a community setting, a hospital setting, whatever team you’re working with - stigma is significantly reduced, and folks have more access. It’s about breaking down the silos that our systems have created, for us to work together towards our common goals. ... I wish more institutions, especially healthcare institutions would go to community-based organizations and reach out and initiate collaboration with support. Very often our voices or voices from particular communities ... are not taken into consideration in terms of the design and the programming [from the very beginning].”

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**The need to reduce system fragmentation through greater awareness of available resources, and improved communication throughout the treatment process, was described as vital to improving care, especially for those with SUD.**

Successfully coordinating and navigating post-discharge treatment can be challenging.

- **Some providers may be reluctant to start treatment if patients are not able to get needed post-discharge services:**

“One of the biggest challenges we face is connecting patients when they leave the hospital to an outpatient provider. We’ve done a lot of work to address ... how to treat their withdrawal and potentially start them on medication for opioid use disorder, but they are only with us for a very short period of time. So, then what? We want to make sure we’re handing them off to someone that can help them.”

- **Better communication between community-based services and primary care providers is needed:**

A participant who works in behavioral health said:

“Our patients come in through primary care, and so we’re often the first line for patients and they trust us. Shopping for services is really difficult. There is no Amazon that sells all of the services at once. There’s a lot of work involved. Once we do find a place for a person to go, we don’t know what happens next, and they [community service providers] don’t have a reciprocal kind of a communication with us. ... We’re only be able to rely on what that patient tells us about how it went. A collaborative situation would be so much better.”

- **Greater awareness is needed to help people and organizations navigate services and resources for behavioral health conditions.**

“I think the systems are so complex with all the different insurers and levels of care, it’s really hard for people to figure out where to start, and it can become overwhelming. Once you get into the navigation, from my perspective, there’s a complete lack of available resources, which has just become even more apparent. Before it used to be a struggle for folks who were uninsured or had Medicaid products, now we’re even seeing it for folks that have commercial insurance or private pay.”

A participant from a community organization shared:

“We could use some help as an organization to really understand where to direct people, whether that’s numbers to call or resources or partners we could have.”

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**Warm handoffs to promote treatment goals and facilitate access to other needed services should be included in integrated care,** said participants in most counties.

- “More can be done with discharge planning, and facilitating a more successful warm handoff, getting other organizations inside, you know, before discharge to make that connection, so that there’s more likelihood to follow through in the community.”
- “We offer services such as helping people fill out government assistance, people getting evicted, people losing their income, people filing for unemployment, and we observed so much distress. So, we started bringing in MSW interns to just talk to them while they’re waiting for their services. There are a lot of opportunities about how we can deliver mental health services in very creative ways in nontraditional settings, and in community settings,” said a participant from a community organization that provides behavioral health services.

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**Trained individuals with lived experience, such as Certified Peer Specialists (CPS) and Certified Recovery Specialists (CRS), are needed to provide culturally competent community outreach and support for post-discharge patients.**

Having access to peers who have gone through the recovery process is essential, especially given the shortage of providers.

- **CRSs should be able to follow clients for extended periods to provide post-discharge support**, a behavioral health professional said:  
“What seems to be lacking is being able to continue to follow that individual from beginning to whatever is considered the end point. So, it seems like once we get them into the initial phase of treatment, the CRS is backed off because they’re established with a provider. But ... the road to recovery is not an easy one and there’s frequently relapses and other issues ... during the treatment process. So, I would love to see the CRS ... have the capacity to follow (a client) for an extended period of time.”
- **Helping people connect to services and engage with their health care providers are important CRS and CPS roles:**  
“We’re relying on CPSs to use their lived experience to help someone engage in the services that they already have or connect them to services that they’re eligible for. Knowing the resources is definitely a huge benefit for all of the providers. But especially for the person who is saying ‘I need help, but ... I don’t know what to do’ ... Having somebody who can say, ‘you don’t have to be the expert in this, let’s walk through it together,’ has been really helpful.”
- A participant who works in behavioral health commented:  
“Our biggest issue has been staffing peer supports. It’s low pay, and it’s Medicaid rates, the government pretty much pays what it pays. So, we’re competing with jobs that pay higher in the private sector.”

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**Overall, use of technology to provide behavioral services was mostly seen as positive across counties.** Participants generally agreed that telehealth has improved some access issues, such as reducing transportation barriers, increasing flexibility in appointment scheduling, and enabling those fearing exposure to COVID-19 to receive services in their homes.

- “Telehealth is the one thing that is helping the most, it helps with the transportation problem, it helps with the access problem, because we’re finding ... that the no show rate is so much lower. When you don’t have to get a ride, you don’t have to get childcare, it doesn’t matter if you have a stomachache, you know, you can still keep your appointment. The vast majority of our clients are saying we like this better; it works better.”
- “Using behavioral health services and telehealth has been a lifesaver for many of our patients during the pandemic, because they face transportation challenges and missing work, so we’re much more flexible about getting them appointment times and they keep them.”
- “There are still a lot of people that are afraid to come out into the community...a lot of people for whom transportation is an issue, or for whom their anxiety doesn’t allow them to be able to leave their home to access those services.”
- “On a positive note for telehealth, at least for drug and alcohol, we’ve seen an uptick in compliance in regards to individuals following their treatment plans. Just being able to go to IOP [intensive outpatient programs] or OP [outpatient programs] every single time you’re scheduled and go for the entire time.”

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**Challenges cited for the use of telehealth include lack of access to technology (noted across counties), telehealth fatigue, privacy concerns, and perceived differences in the quality of therapy online.**

- “There is push in the county [Bucks County] to determine where the internet deserts are in this county, where there isn’t access to internet. And hopefully that will help some, but even so, people don’t ... all have the devices.”
- “I think a barrier is that there’s so much of the virtual and online connection, right, that people are tired of it.”
- “There’s less privacy when we’re talking about communicating with people in their home; we have to be aware of their surroundings and ours ... that could be difficult at times.”
- “Telehealth, just by design of what telehealth can and can’t do, reduced the overall intensity [of therapy]. We have some family therapy programs that are provided in the home. Sometimes we do this under telehealth and hear responses like ‘I’m not comfortable my mom, kids, grandma lives upstairs and she’s compromised physically’ and so we really are being more careful around the home ... that’s one of the limitations.”

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## CHILDREN AND YOUTH

Participants across all counties spoke of the pandemic’s impact on youth. Pandemic-related stress also has affected the behavioral health of parents and, often as a result, their children.

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**With virtual schooling, school counselors, teachers, and others have had fewer opportunities to monitor youth for warning signs of behavioral health concerns.**

- “When you think about kids it’s been almost three years since they’ve had a normal school year. They have experienced so much disconnection, lack of accessibility to resources ... families and children haven’t had the supports in place that they had had before.”
- A mental health provider who works with school-aged youth said:  
“Over the course of the last couple years ... [we have] had a lot more parents suffering with addictions, we’ve had a lot more parents suffering through COVID, loss of job, depression, all those things. We’ve had a lot more parents dying, to be honest, whether it be suicide, drug overdoses, COVID itself. All the things related to the pandemic have really impacted adult mental health, and the trickle down of that with the children in schools is astronomical. And school aged children’s’ mental health is also directly impacted by their parent’s mental health.”

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**Pandemic-related social isolation, as well as grief and loss, have worsened behavioral health for children and youth.**

- A behavioral health professional who works with schools stated:  
“There is an increased number of youth that have lost caregivers, whether it’s a parent or a grandparent through this pandemic. We are really trying to keep a close eye on them, because grief may have traumatic effects. A needs assessment done in the greater Philadelphia area ... [is] projecting that 73,000 plus youth will have lost a parent or sibling by the time they’re 18 years old, and in Montgomery County, specifically, [that’s] about 11,000, and that’s pre-pandemic predictions.”

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**Increased rates of depression, anxiety, self-harm, and suicide were reported across counties:**

- “In the emergency department, we are definitely seeing increased volumes in general of pediatrics and adolescents, and I think that’s across the county, probably the country.”
- “Our young folks are struggling, and more of them are struggling now with mental health issues. I have a private practice, and I see a lot of adolescents. And the rate of anxiety, goes hand in hand with depression, is just soaring, and again, there was not enough services to serve that need. And then the youngsters, the little ones can’t even verbalize their anxiety, so they act out. And then we don’t know what to do with them. Sometimes they end up in inpatient, and it’s not really the most advantageous place for their treatment sometimes, but there’s no other options.”
- “We have a psychologist in our district specifically just to do crisis assessments for kids with suicidal ideation and more and more are younger and younger ... as young as first grade.”
- A participant who provides group therapy to youth offered:  
“Our goal is to transition our kiddos back to school, and I think because of the pandemic, I’m having more school avoidance than ever before of getting back into that building. Instead of going, they refuse, and then they’ll either engage in self harm or have a suicide attempt and that’s definitely increased.”
- “We’re seeing a lot of the trauma related to more generalized fear and anxiety probably related to COVID. I think the return to school, I think overall is positive for kids, but I think it’s also brought with it a lot of challenges and a lot of increased transitional challenges.”

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**Aggressive behavior among youth was also noted across all counties:**

- “Children with behavioral needs act out. What we see are outbursts of behavior. Our crisis services are way overworked, they can’t be there in two minutes, and that’s what schools think they need with kids throwing desks across the room.”
- “I can say in schools, across the board, we’re seeing a big uptick in aggressive behaviors with kids... just overwhelmed children trying to run from the building or come at teachers or go at other kids in a much bigger way than we’ve ever seen before. Usually, in some of our emotional support classrooms we’d see a lot of those behaviors, but now it’s ... in regular education settings as well.”
- “We are seeing an increase in violence in Montgomery County especially amongst, kids like 15, 16-year-old, 17-year-olds. The violence is increasing, and it seems to be younger kids.”
- “We’re really concerned about gun violence. Safety and personal safety is an issue and it’s a constant stressor. ... [Also] general ambient violence, but also gang involvement.”

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**While alcohol was identified across the board as the substance used most by adolescents, marijuana and vaping were also recognized as priorities to address in all five counties.**

Youth self-medication as a means to deal with unaddressed behavioral health issues also is an ongoing concern.

- “I would say that the biggest youth issues are unaddressed mental health issues. We have a lot a lot a lot of self-medicating youth.”
- “We’re definitely seeing more of the vaping, and drinking, and those sorts of things among middle and high school kids, but the young elementary kids that I deal with, it’s just acting out and shutting down behaviors.”
- “What the Single County Authority in Montgomery County is focusing on at the county level with our partnering school districts is youth using alcohol, marijuana, vaping, vaping marijuana, and just mental health and how that leads to their decisions to use substances.”

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**Changes in the legal status of marijuana in the past few years are increasing its use among youth. Perceptions of harm have decreased, increasing acceptability of its use.**

- “There’s been a dramatic increase in the use of marijuana with vaping. Kids are vaping THC all the time now. For many years, the perception of harm of marijuana had been fairly high. We were educating kids about the potential dangers of using marijuana. And then medical marijuana came, legalized recreational marijuana came, and kids being kids with a not fully developed cortex, said, ‘Oh, it’s medicine, so it’s safe.’”
- “There’s just no conception or understanding of the fact that marijuana can be addictive and high rates of usage can be problematic and long-term usage can create situations that mimic depression. We’re also seeing parents that have a medical marijuana card that are passing that knowledge and permission on to kids.”

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**While vaping of marijuana is a key concern, youth vaping of any kind was noted as an “enormous issue, regardless of what’s actually in their vape,”** said a participant who works in behavioral health.

- “We’re even seeing it as young as elementary school, but middle school definitely. ... Some students were reporting at one of the high schools that at lunchtime kids would actually bring it into the bathroom and sit on the floor and vape. ... So the problem is kids really become addicted to this. ... There are certain stores that sell to minors and kids know that. But they’ll also get things from peers ... or they’ll get people to buy it for them. A lot of them get it online, including the marijuana.”

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**Access to needed services and resources has not kept up with rising demand, resulting in long wait lists and, in some instances, a level of care that may not be appropriate for the child and family.**

- “There is a huge need for children’s inpatient mental health beds,” said one participant. For some children, such as youth who are housing insecure but do not meet criteria for homelessness or youth in transition, this can be even more problematic.

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**Schools and afterschool programs provide opportunities to monitor youth for signs of behavioral health issues and provide counseling. However, remote schooling and closure of many afterschool programs has limited earlier detection and intervention.**

- “I think that’s why we’re seeing the increase in behaviors, too, because we’re not able to be proactive, we’re not able to get to these kids, when, you know, the behaviors just start happening.”
  - “In the schools I see tremendous needs of young people that are just being met with a Band-Aid. We do what we can, but it never seems like it’s enough.”
  - “There are not sufficient supports out there for family members. Children that are living with someone with alcoholism, or drug addiction - those kids struggle, they act out, and often the reason isn’t even identified. And those kids don’t get the support that would help them cope with that situation.”
  - “We work across five different school districts in the southern Chester County [and] there’s not always consistent programming for counseling across the different districts, so there’s some disparities within the different districts as to what the schools are able to offer.”
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## FOCUS: ACCESS TO BEHAVIORAL HEALTH CARE FOR CHILDREN AND YOUTH

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**Access to services is often delayed due to lack of behavioral health providers with pediatric or specialty expertise, creating difficulty in obtaining appropriate care.**

- “We’ve had kids stuck in the emergency room for over a week. They’re living in the crisis center or they’re living in the emergency room, and they often will need staffing one-to-one with them the entire time that they’re there. ... And then ... a week has gone by and maybe the person’s doing a little bit better, maybe we’ve been able to stabilize them a little with the doctor who’s covering crisis, and then they’re stepping down to a lower level of care than they really should have had.”
- “We have seen an incredible uptick in the needs of kids who have significant behavioral issues, and a lack of providers that can support those kids effectively and safely. It also has to do with kids who have multiple diagnoses, and multiple needs, and across multiple systems. Those kids have always fallen through the cracks, but they’re falling through the cracks more now, because there just seems to be more of those kids in need right now. We are constantly having multiple system case reviews for some of these kids to try to figure out what the best supports and services are for them.”

**Behavioral health professionals from several counties noted that treatment services for youth have decreased and finding resources is challenging everywhere.**

- “The county [Chester County] itself has limited resources for youth. But I think that goes beyond the county. I think that’s the state [and] probably the country. If I have a youth that needs a detox level of care, it would be almost impossible for me to find it, unless they have private pay and go to someplace like California or Florida. Which is obviously not possible for the majority of them.” Another shared: “So, if kids are really in trouble with substances, their families are looking to go to Pittsburgh or New Jersey, or places like that to get their child care. And people aren’t willing to do it quite honestly. So that is a huge, huge problem.”
- “One of the biggest voids that I am seeing, especially for elementary aged kids, is partial hospitalization programs and inpatient programs for younger kids.”
- “It is really, really difficult to find psychiatrists. We’ll have instances of students coming back from inpatient treatment and not being able to get psychiatry services to monitor their medication going forward, much less get therapy.”

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**Better post-discharge support services**

**also are needed.** For example, a warm hand-off would help schools follow through with personal and treatment goals of students after discharge from behavioral health treatment facilities. Another issue: youth returning home from treatment facilities may face challenges related to returning to a home environment where there is ongoing substance use.

- “The warm handoff — as far as schools go — kids coming out of hospitalizations ... or even a more intensive outpatient or a partial program and back into schools - How can we help support them? What are their goals? What are their discharge goals? How can we help families make the connections they need to make upon discharge?”
- “Even if we do successfully get them through some kind of treatment path, we are often returning them to environments that are not remotely supportive in maintaining a clean and sober lifestyle. If you have parents that are using, whether medically allowed or not, it’s really hard should you manage to get yourself clean and sober to return to that environment and remain so.”

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**Finding correct information about in-network providers for health insurance plans can be difficult and delay care or disengage patients.**

- “They may only have one therapist in an organization that works with kids, but they’re not taking that insurance right now. So, there’s a lot of movement right now, especially in commercial insurances, about who’s taking what insurances. And, providers are always dropping in and out of accepting certain insurances and participating in certain plans. We have to find out what agencies are taking what insurance, and then find out which ones that take that insurance are also taking children. It could take, you know, a month to whittle down a list of providers to someone who’s taking children of that age with that insurance, and how long the waiting list is, and then by then, a lot of times we’ve lost the family’s engagement.”

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**Using telehealth for mental and behavioral health services with children and youth was seen as having both positives and negatives.**

On the positive side, according to one provider, telehealth allows youth to access services without having their friends know and the quality of the online therapy is better.

- “With the telehealth, the kids don’t have to come to the lobby and run into the kid who sits behind them in math class. And it’s just a totally different atmosphere. The kids are more open, they’re going deeper, it’s just a much better quality of therapy.”
- On the other hand,  
“Telehealth has been challenging for the kiddos. If they’re elementary school age it’s kind of hard to keep their attention or keep them engaged over a telehealth platform. So, as soon as we could our children’s advocate was seeing the kids in person again, just because she was having a much better impact that way, and it was safer for families who were still in an abusive situation.”
- Telehealth also limits providers’ ability to monitor youth who may be engaging in self harm.  
“If they’re engaging in self harm or substance use, we weren’t really able to track that because they were at home.”

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**Youth with multiple diagnoses, such as autism, can have difficulty obtaining appropriate care, including behavioral health providers, inpatient care for a behavioral health diagnosis, and psychiatry services.**

- “If there’s a diagnosis of autism, getting services or resources for those individuals, whether an inpatient level or outpatient wraparound services, has huge waitlists. And it’s a similar situation in terms of inpatient, where we frequently are unable to locate a bed, because there are very few facilities that are working with autism.”

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**Transitional-age youth experiencing homelessness may face particular challenges in accessing behavioral health services.**

Policy definitions of “homelessness” that enable access to mental health services often do not apply to transitional-aged youth, who may technically have shelter.

- “Kids that are couch surfing or living in their cars, kids that are kind of bouncing from house to house or have been kicked out of their home ... those transitional-age youth are sometimes not eligible for services through the homeless system, because they’re not technically homeless. ... Those kids fall through the cracks.”
- “There’s a segment of our young folks 18 to 24 that we’ve been focusing on a lot across the board...This transition age group are kind of left in between having the services from birth to 18, and then the adult services that don’t always fit their needs. So, that segment of our young population I think is a particularly needy one right now.”

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## OLDER ADULTS

**Across all five counties, participants highlighted that older adults were particularly hard hit by the pandemic.**

- “Our seniors have been so isolated. ... They haven’t been able to visit with family, haven’t been able to go to the grocery store and it’s just been so isolating for them. And then to compound on top of that, that access to care for them, they might not be able to access technology as savvy as other people, and even the lack of providers in the outpatient setting is very typical to or limited, for seniors. In some respects, I feel like they’ve suffered more than our kids and adolescents.”

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**The pandemic has had an impact on physical health as well as behavioral health,**

noted a participant from the faith-based community. Lack of mobility, transportation, and awareness of programs during the pandemic were cited as barriers to maintaining physical activity and health.

- “It was lack of them being able to exercise, a lot of them gained a lot of weight, and it caused a different attitude in their behavior. And the seniors are used to going out and walking together in the park and now not being able to do those walks with any freedom. They’re not physically mobile, it’s lack of transportation or they haven’t gotten the information [about program services] that they need. A lot of people were depressed and locked in, but the seniors really had it harder.”

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**Several participants noted increased substance use for self-medication and overdoses among older adults during the pandemic, linked to social isolation and depression.**

- “Hearing from partners that, because of the isolation during the pandemic and the limitation on gathering or seeing friends or going to a senior center ... it led to depression, and to self-medication. There are people in the older population not only abusing illegal substances, but abusing all sorts of substances, drinking way too much in the house.”
- “We’ve seen, since the pandemic began, an increase in the age of fatal overdose victims in Montgomery County. Prior to the COVID, most overdoses were in the 20 to 30 age group. Now we’re seeing higher overdose deaths in people ages 50 to 60 which we have never seen before. My thought would be that people are depressed, lonely, and turning to drugs that they probably haven’t used in years. And they’re not used to the purity and strength of those drugs, and they’re dying.”

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**Grief and loss among older adults have increased during the pandemic, due to loss of loved ones and limited connections with family and friends.**

- A participant noted that older adults experienced:  
“increased grief and loss due to higher COVID fatalities in older populations and were more likely to have lost friends and family members.” Another shared: “There’s also the loss of connection to family not seeing grandkids, not having the holidays, not having the same kind of experiences and just the layers of that degree.”

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**Fear and trauma have increased isolation particularly for older adults in Asian communities.** Isolation has impacted family dynamics as well. Fear of getting COVID-19 by being in public is common for older adults, but the increase of anti-Asian hate incidents during the pandemic has been an added stressor.

- A participant from an organization serving Asian older adults said:  
“The pandemic comes in a time with anti-Asian hate incidents being increased. ... We hear a lot of stories of senior citizens afraid to go out to even buy groceries, to even take a walk. So for the last year, a lot of Asian senior citizens were just stuck at home. They didn’t want to go out, they were so scared. So, then they depend on their adult children, to buy things for them to do the most basic things for them, and now we’re hearing more abuse against senior citizens by their adult children, because of this imbalance in power dynamics.”

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**Senior centers and other community venues for physical activity and socialization play a key role in preventing isolation and monitoring the mental and physical health of members.**

- “Senior centers in [Montgomery] County [that] had been serving low-income seniors on a daily basis have seen a severe drop-off in attendance since the pandemic. These were essential connection points for seniors and provided an opportunity for observation of mental health [and physical health] conditions. The increased isolation since the pandemic has had a profound impact on seniors’ mental and physical health.”
- A participant cited the influx of older adults returning to the YMCA:  
“What we saw is a return of the active adults of the senior population more than any other population...because of the connectivity, the community that they built, and just to avoid the isolation.”

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**Another issue for some older adults: grandparents taking on the responsibility of raising grandchildren and their need for assistance, which was discussed in most counties.** Participants noted that the number of grandparents raising grandchildren, including those with behavioral health needs, increased during the pandemic.

- “There have always been grandparents raising grandchildren, but, ... now it’s just at a different proportion, and maybe more people who are already struggling with mental health, and now they’re taking on this extra stress. It’s just a different level of stress, and worry. ... There has been an influx of grandparents and great grandparents raising children with behavioral health needs especially during the pandemic.”

## FOCUS: ACCESS TO BEHAVIORAL HEALTH CARE FOR OLDER ADULTS

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### Issues related to older adults with co-morbidities were discussed in most counties.

People with serious mental illness are living longer, often with ongoing chronic diseases. During the pandemic, more older adults delayed care for medical problems and accessing services. Patient health assessments, whether for primary care or for behavioral health, need to include both physical and behavioral health assessment to ensure appropriate care is provided.

- “We’ve noticed that a lot of our older patients are not taking care of their medical needs. ... We need to be more aware of looking at medical concerns and making that a part of our assessments. We need to retrain the staff to not just look at the mental health side, but to look at the whole wellness.”
- “We’re seeing people live longer and longer. We have a mental health system that does not feel comfortable supporting a patient with high physical health needs, maybe somebody who just needs nursing home level of care or just below it. But then we have an elder physical needs system that does not feel comfortable supporting somebody who may still be very actively symptomatic (with a mental health condition). And there are rules and regulations within each system that preclude serving somebody with high needs in both areas.”
- “One of the biggest problems with elders is they don’t use the services available until it’s almost too late. They don’t use hotlines, we run into them at the point where we’re dealing with compound issues. So, whether its nursing homes, other, long-term care of people living in the community I think there has to be some focus on earlier intervention.”

### Medicare coverage for behavioral health conditions, including SUD, is complex and difficult to navigate.

Payment for services depends on many factors, such as whether a facility or provider is a participating Medicare provider, the type of the Medicare plan, and the level of treatment needed.

In addition, there are treatment limits for certain inpatient and outpatient services. Medicare does not cover or has lower reimbursement rates for certain behavioral health services, which can prevent individuals from seeking needed treatment.

- One participant described Medicare as a “*convoluted process*” and another said, “Anytime we say hold on, we’re going to need to contact Medicare ... it’s quite an ordeal.”

### Other Medicare challenges for older adults with behavioral health issues are a lack of credentialed providers and difficulty accessing care for those with co-morbid medical conditions.

- “It’s really hard to find therapists and practitioners that are qualified and credentialed under Medicare that can offer services.”
- “We have a number of assisted living [facilities] that take a lot of folks into their dementia units. And then frequently what happens, if there’s behavior problems, they end up in emergency departments, and we’re being told that they have to go to an inpatient psych facility. But based on Medicare guidelines, the psych facilities can’t treat dementia, because it’s not a psychiatric diagnosis. That is a huge disservice to the patient, but it also creates a huge burden on the families.”

### Some patients are fearful of in-person appointments during the pandemic.

- “A lot of them only have phone access, and just not getting eyeballs on folks is really challenging. We offer the ability for them to come in and have support and video access, but we’re seeing a really significant fear of them wanting to come in, so that’s definitely been a real barrier for us.”

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**Use of technology poses challenges for older adults in terms of connectivity and usability and does not replace the desire for in-person social connectedness.**

- “A lot of seniors don’t have access to computer, don’t know how to access the telemedicine sites, and all those things that are being done now through the pandemic. ... We need to make sure that our seniors are aware of how to access those technologies and use them.”
- “Telehealth is difficult for them because they struggle with technology, and so they usually need some support from family members or younger children.”
- “They might be able to manage talking on the phone, but that’s not as good as being able to see someone.”

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## OTHER GROUPS

**Expectant and perinatal families.** A behavioral health professional serving pregnant and perinatal women reported an increase in anxiety and depression in this population. During the pandemic, *“Domestic abuse has also seen a bit of an increase, moms are isolated, lack of communication with friends, not much of the outside world. I would just like to add that, depressed mom’s depression is contagious. So, a depressed mom, the likelihood of her child being depressed is very likely.”*

Challenges for expectant or new mothers with behavioral health concerns include a lack of specialized providers and insurance barriers.

- **“Having access to a psychiatrist who specializes in perinatal mental health. I’m not aware of any psychiatrist that has that specialization, and the few that might be available they don’t take Medicaid.”**

Also noted: the need for centralized information about services for pregnant women and families as well as the importance of including fathers, as well as mothers, in behavioral health services:

- **“Right now, there’s not one point of entry for a family or a mom who is pregnant where she can reach out to one number and be referred to multiple places.”**
- **“Really prioritizing parent’s behavioral health, because that’s really what affects the children, and not leaving out dad. ... We talk about mom and her mental health or substance use, but dad is there too, and dad has also mental health issues and substance use issues. There’s not a lot of services available for fathers in the community at all.”**

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**People experiencing homelessness and housing insecurity.** Access to behavioral health services for those experiencing homelessness, especially adolescents, was identified as an issue in multiple counties.

- A behavioral health professional cited the lack of mental health resources for these individuals and the need for training for street outreach teams:  
**“There’s not enough mental health support for those experiencing homelessness. If they are experiencing mental health issues on the street, what we find is there’s not enough access. They go to the hospital and the hospitals put them back out on the street. But often there’s nowhere to take them, it’s just ‘go to the hospital.’ They do a few things, and then they don’t have any place to put you, and so you leave. I’d like to see some more support for our street outreach team around mental health issues and behavioral health issues, because sometimes our hands are tied, and there’s not a lot of resources for these folks on the street.”**

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**People leaving incarceration.**

- **“Individuals coming out of incarceration tend to be pretty transient when they get out. There’s a lot of housing instability, so they may start in one catchment area for a community behavior health center, and they may very quickly transition to another.”**

As a result, behavioral health services may be initiated in one area and then, depending on an individual’s new location, the behavioral health assessment process may need to be repeated—an often-challenging process that can delay care. Older adults in the re-entry process may face other obstacles, such as needing care at a behavioral residential facility but being denied due to their criminal record.

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**Immigrant communities.** Participants in all counties raised concern about the difficulty language barriers pose to accessing behavioral health care, including SUD services.

Comments included:

- **“There’s not a lot of bilingual options”**
- **“There’s a lack of interpreter services and other language barriers in trying to access care.”**

A goal of the Single County Authority in Delaware County is

- **“to get better access to language and interpreter services within the county within the next five years.”**

Stigma and insurance issues were cited as other challenges for immigrant communities:

- **“Finding those who are bilingual, those who can serve immigrants is very, very hard to find, let alone insurance. ... There is stigma, and also, it is hard to find someone who understands the cultures.”**
- **“A lot of our clients are undocumented, and so that means the places where they can get service across the board for health, especially for behavioral health are very few, so the wait times are really long. And a lot of practitioners don’t take uninsured clients.”**
- **“That’s a really rough combo, to not be insured and not speak English so, to find resources for that is really, really difficult. We have all these struggles with commercial insurances and Medicaid, and we have a very large number of uninsured patients in Montgomery County and many don’t speak English – one of our biggest challenges is finding resources for this group.”**

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**LGBTQ+ communities.** Participants in several counties shared the need for behavioral health care providers with expertise in working with those identifying as LGBTQ+.

- **“The issue becomes finding providers that have the sensitivity and understanding of, what does it mean to be transgendered? What does it mean to be queer? What does it mean for people who identify differently? So, I think, there are some providers in Delaware County that do focus on that on that group, but again, wait lists are long.”**

# SUGGESTED ACTIONS

## CARE COORDINATION

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### What's working:

All publicly funded schools in Pennsylvania are required to provide Student Assistance Programs (SAPs), which are school-based services to address students' behavioral health, including drug and alcohol use: *"The SAP team receives referrals from anyone in that building who might have concerns about a student, including drug and alcohol. The program is in place to identify kids in the very early stages of use or experimentation."* Some school districts contract with organizations to provide ancillary counseling services in schools for individual students.

### What's needed:

Calls for an integrated behavioral health system with a population health approach are supported by national organizations such as [SAMHSA](#), [American Psychological Association](#), and [American Academy of Pediatrics-American Academy of Child and Adolescent Psychiatry-Children's Hospital Association](#). In addition, Pennsylvania commissioned the [Behavioral Health Care System Capacity in Pennsylvania and Its Impact on Hospital Emergency Departments and Patient Health](#) report, whose recommendations support these approaches.

In all counties, participants called for an **integrated care model** that assesses the whole person, addresses both physical and behavioral health, and coordinates care across hospitals and community-based service providers.

- **Improve service capacity:** Address bed capacity, emergency room (ER) boarding, and staffing shortages to reduce wait times and improve access to the appropriate level of care. Improve youth access to timely, appropriate care, including inpatient services available locally.
  - **Improve care coordination:**
    - Expand warm handoffs between hospitals, ERs, primary care practices, community behavioral health service providers and community-based organizations.
    - Improve communication and coordination between community-based service providers and patients' primary care physicians. Also, encourage use of CRSs and CPSs in warm handoffs for drug overdose and other behavioral health issues.
    - Develop coordinated Crisis Response Systems available 24/7, 365 days a year.
  - **Increase awareness of behavioral health resources and services:** Hospitals can promote internal awareness and community knowledge about behavioral health services and how to access them: *"Most hospitals put out regular distributions of what's happening in their hospital system. It's a great opportunity to focus on behavioral health. It's something they could work on with their county partners ... promoting awareness of behavioral supports available in their communities and knowing where to go if they have a challenge."*
  - **Streamline system navigation for providers and the population at large.** *"Finding outpatient services after a rehab or detox is absolutely a challenge. If it's a dual diagnosis, if they have multiple co-occurring disorders ... everybody's got their own procedures, everybody's got different requirements. It's frustrating."* Create a "linear system, like a depot of services, that can be easily accessed."
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## PREVENTION PROGRAMMING

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### What's working:

#### **Prevention programs range from school-based educational programs to community drug take-back programs and programs to reduce opioid overdose.**

Participants across counties stressed the need for more prevention programs: *"Sandy Bloom [a prominent expert on trauma] often says, we're not going to be able to treat our way out of this ... we have to start thinking more about prevention ... about how we can intervene at the community level."*

Prevention programs are seen as essential to reduce risks of substance use among youth: *"When you asked about what's working, prevention is working, prevention is a science, we utilize evidence-based programs. We offer those services in schools, to parents, and in the community."*

### School-based programs that are working well:

Most counties offer drug and alcohol prevention programs for youth and the community and deem these efforts effective. *"I think our county does a good job on topics related to prevention and education and de-stigmatization talks. I think that's one thing that we do fairly well."* The Single County Authorities in Montgomery and Delaware Counties are working with school districts to provide prevention programs focused on alcohol, marijuana and vaping. They also are looking to improve access to bilingual programs. In Delaware County, a local organization received funding received from the state to provide digital devices for schools for families to engage in an eight-week virtual drug and alcohol prevention program.

### Community-based programs that are working well:

- **Project Meds** is offered by the Bucks County Area Agency on Aging to *"educate the senior population on taking medication as prescribed, the dangers of over medication, and safely disposing of unused medication."*
- Bucks County's successful **drug take-back program** was the first of its kind in Pennsylvania. *"Someone at the state level called Bucks County the Cadillac of drug take back. We have drug take back boxes in the lobby of almost every local police station. You don't have to identify yourself or interact with anyone."*
- **Delaware County Department of Human Services gives funding to many organizations in the county for evidence-based drug and alcohol prevention programs in schools** and one-time speaking engagements for parent groups and other community organizations.
- The **Strengthening Families program run by the Child Guidance Resource Center in Delaware County** is a supportive substance use prevention program for children aged 6 to 12, parents and grandparents.
- **Narcane training and distribution: Montgomery County Mobile Crisis program** provided by **Access Services** is an effective intervention that should be expanded throughout the County, a participant said. Training more professionals, including police, to provide these services could help lower overdoses. *"Overdose deaths in Montgomery County are down this year. Access Services became more involved in Norristown and started going out when someone overdoses. I think ... we should try to expand that to the entire County."*

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**What's needed:**

- **Increase access to safe, structured afterschool activities for youth** available on weekends and in the evening.
  - **Co-locate prevention and behavioral health services in community settings (“one stop shop”) where families live, work, and socialize.** For example, in partnership with community-based organizations, provide co-located substance use and behavioral health prevention programs, treatment and other intervention services in schools. *“We’re trying to advocate for a substance abuse unit in our wellness curriculum in the schools, so kids get real information, not what they’re hearing on social media or from their peers.”*
  - **Increase access to support groups** to address mental health and substance use issues.
  - **Develop texting support services that address underlying issues of substance use,** provided by trained peers or qualified therapists to individual clients. *“It’s private, which helps with the stigma. ... People are on their phones, texting with people all the time, so, whether you’re texting with your peer support or a therapist, ... that’s not something that’s gonna stand out, the way going to a twelve step meeting might feel.”*
  - **Expand effective prevention and crisis intervention models,** as noted above.
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## WORKFORCE DEVELOPMENT AND TRAINING

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**What's needed:**

- **Increase training for healthcare providers, community-based organizations, schools, law enforcement, and others** in Mental Health First Aid, trauma-informed care, and cultural competence/sensitivity. Also provide Narcan training for health and social service professionals and law enforcement.
  - **Increase awareness among healthcare providers and community-based behavioral health service providers** about behavioral health and substance use services and resources.
  - **Increase behavioral health workforce capacity and diversity** (e.g., language, racial and ethnic diversity). Increase behavioral health professionals who represent the racially and culturally diverse populations they are serving. Also, develop and use “inclusive (culturally competent) curricula” in workforce development and training (e.g., for therapists, social workers, psychologists, etc.).
  - **Develop strategies to encourage young people to pursue careers in behavioral health.** Work with colleges and universities to recruit students interested in these careers by offering tuition reimbursement and scholarships.
  - **Increase individuals with lived experience in the behavioral health workforce,** such as CPS, CRS, and community health workers.
  - **Provide programming to prevent mental and behavioral health “burn-out” among behavioral health staff.**
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## FUNDING

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### What's needed:

- **Support efforts to increase funding** to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment to appropriately address mental health needs, school-based mental health care, and community-based systems of care that provide evidence based behavioral health intervention and support in homes, communities, and schools, as advocated by the [American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association](#).
- **Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs.** *"Unfortunately, prevention doesn't get the funding that treatment gets because it's hard to prove the effects. But I think it's definitely effective. If you look at tobacco over the last 40 years, we've been pretty successful in educating our young people about the dangers of tobacco, not that some kids don't still smoke, but they know that if they smoke, they're more likely to have heart disease and lung cancer. We need to have the same push in marijuana and THC ... to try to curb this trend."*
- **Advocate for competitive salaries for behavioral health service providers** to increase retention in the profession. To sustain *"quality service year after year and have good client continuity of care,"* pay rates need to be competitive.
- **Advocate for higher Medicaid and Medicare reimbursement for behavioral health services.** Advocate for [Parity Act](#) standards to be applied to Medicare to protect beneficiaries with SUDs from discriminatory and other treatment limitations.
- **Advocate to increase funding for services not covered by insurance.** *"Mental health- based dollars have not received a cost-of-living increase since 2007... When you think about what those dollars pay for ... things like portions of mobile crisis for people who are uninsured, it supports our student assistance programs for kids in schools, and any kind of awareness or prevention. ... So, a good place to start is to create awareness of legislators."*



# CHRONIC DISEASE

ALL FIVE COUNTIES

## OVERVIEW

**Chronic diseases are a leading cause of disability and death nationwide and statewide.**

[In Pennsylvania](#), five of the ten leading causes of death are chronic diseases, including heart disease, cancer, stroke, chronic lower respiratory disease, and diabetes. As Pennsylvania's aging population grows and longevity increases, the burden of chronic diseases and associated costs [are expected to rise](#).

Numerous chronic disease indicators show how the impact of chronic disease varies across the five counties of southeastern Pennsylvania. For example, the age-adjusted rate of diabetes hospitalizations in Philadelphia in 2019 was 331.1 per 100,000 -- more than triple the rate in Chester County and roughly double that in Montgomery, Bucks, and Delaware Counties. In that same year, age-adjusted heart disease mortality rates were lowest in Bucks and Chester Counties (135.5 and 141.2 per 100,000, respectively), followed by Montgomery County (150.7), Delaware County (168.9), and Philadelphia County (198.5).

Across the five counties and within them, striking inequities in chronic disease burden correlate with poverty, a key determinant of poor health outcomes, which disproportionately affects communities of color. In Philadelphia, for example, Hispanic/Latino communities have some of the highest rates of chronic conditions, such as [asthma and obesity](#), and the city's non-Hispanic Black population has disproportionately high rates of chronic conditions such as [hypertension and diabetes](#).

To understand the impacts of chronic disease on health needs in the five-county southeastern Pennsylvania region, focus groups were convened for each county with representatives of local organizations who address chronic disease prevention and management and related risk factors. Chronic disease was also discussed in focus groups conducted with community residents in all five counties; where relevant, comments from those discussions are included below.

# KEY CHALLENGES FOR CHRONIC DISEASE PREVENTION AND MANAGEMENT

Participants discussed multiple challenges to reducing rates of chronic disease, including issues related to healthcare cost and access, as well as lack of public awareness and education:

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**Difficulty affording health insurance and out-of-pocket expenses are common challenges.**

- “We see people that no longer go and get certain services because there’s high co-pays with their insurances.”

Several mentioned that fear of incurring healthcare expenses can itself be a barrier to seeking care. A participant from a health clinic serving patients with low incomes commented:

- “All of the population that we serve, they don’t want to be in debt or have bills that they owe to hospitals. They’re very worried about that. They don’t want to be in that position, so they forego [care].”

Another added:

- “for people with insurance, fear of co-payments, and thinking it’s going to be too much [and] they can’t afford it, so not even making appointments.”

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**Lack of information and stigma surrounding chronic diseases can lead to fear and avoidance of getting screened or seeking treatment.**

A participant who managed a cancer screening program said:

- “One of the things that I saw was fear, fear of getting that diagnosis, and kind of putting your head in the sand. There seems to be a ‘Don’t ask, don’t tell, don’t know, and I’ll be okay’ kind of mentality.”
- “We have overwhelming diabetes in this city, and we have overwhelming high blood pressure in the city, and a lot of heart disease. Those things are fearful for a number of people, which makes them afraid to find out the information.”
- “I will add a lack of ... knowledge of family medical history. Oh, and stigmas and, avoidance of any kind of stigma. Like I work in colorectal cancer, and there’s a ton of stigma, male breast cancer, prostate cancer, all of it.”

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**Mental health conditions, such as depression or anxiety, can complicate or worsen chronic disease care, if not addressed.**

- “I think that comorbid mental health issues, and the broken mental health system definitely compound and accentuate all the problems faced by people with chronic diseases.”
- “People with chronic disease are at higher risk for depression and anxiety, but also those difficulties can also precipitate more physical health problems. I don’t think that there is enough integrative programming ... I think any family that’s dealing with a family member with chronic disease, there is a need for additional support beyond just addressing the physical illness.”

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**Stress management and social support are important to optimize care.**

A participant who works with people in cancer recovery said:

- “General stress management is a huge barrier, not only through it, but even after treatment. One of the things we also hear is sort of once everything stops, so treatment is done, surgery’s done, okay, your doctor’s like ‘You’re good, I’ll see you in three months,’ or whatever. It’s like ‘Holy moly, what just happened?’ It’s like post-traumatic, ‘Now what do I do?’”

Some patients also experience “scanxiety” after treatment for cancer—that is, fear and anxiety before follow-up visits to check for cancer recurrence. After a diagnosis of cancer,

- “Number one is just feeling they have the support in their life, whether it comes from friends or family, or just support of others that understand what they’re going through.”

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## IMPACT OF THE PANDEMIC ON CHRONIC DISEASE PREVENTION AND MANAGEMENT

**Participants discussed additional challenges to chronic disease care resulting from the pandemic, especially delays in seeking care due to patients’ fear of contracting COVID and a lack of provider capacity, causing long waits for many appointments.**

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With care delayed for some patients, several participants said **cancer and other conditions are more often diagnosed in later, more advanced stages.**

- “During COVID, ... people are experiencing increased isolation, and everything that goes along with that, and may not feel comfortable going to see the doctor, going in for screenings, or even going to the grocery store.”
- “Because of the pandemic, many [people] have been diagnosed later in their cancer stages. So, that’s really been an obstacle, too, because everything was kind of pushed back because of the pandemic with everybody, with everything basically. But, you know, for our cancer patients it’s been really tough in that respect.”
- “The fear of going for those screenings during COVID. A lot of people that typically got yearly colonoscopies or blood work or whatever they’re like, ‘No, we’re going to wait.’ And then things exacerbated in that time, so a lot of people are being diagnosed later, in more advanced stages.”
- “[People are] having difficulty getting medical appointments ... [For example,] diabetics who were struggling with control and not being able to see an endocrinologist for several months.”
- “We constantly have people telling us that they’re having problems with access to health care. For example, if they have to go to the ER, they have to wait, oh, like, seven, eight, nine or more hours just to be seen, where pre-COVID, that was not the case.”

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**Staffing shortages at hospitals, coupled with staff redeployment to pandemic-related care, are further challenges.**

- “Finding some of the supportive services, the social workers, the nurse navigators, if they [patients] need financial assistance– those have been a lot harder to come by.”

Another participant who works at a health clinic added:

- “We are currently in major catch-up mode when it comes to the cancer screenings, and then availability of getting folks in ... can be months waiting.”

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**With many people working remotely during the pandemic, fewer workplace wellness programs that offer screening and education are being offered.**

- “With the emphasis on the pandemic, there may be a lack of awareness even in workplaces about doing screening as part of work and offering it as part of work. Think about that: a lot of people are working remotely, and that’s where these things used to be in the office, or that people could gather to a bus [providing mobile health services] that is on office property, the access to that is reduced because of people working remotely.”

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One participant raised concern about the amount of **misinformation being disseminated about COVID treatments and vaccines**, with broader implications for following recommended prevention and health screening recommendations.

- “Because of all the media hype about the vaccines ... and the lying, and false lies and false news and stuff, I think it’s become more acceptable to say doctors and science don’t know what they’re doing. And people feel justified to reject services as a civil liberty right. Which they do, but I don’t think it’s an educated choice; I think they’re starting to just rebel against being told what they should do.”

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Participants said **the growing transition of many health services to virtual platforms was a mixed blessing—convenient for some people but depriving others of needed care due to the digital divide.**

- “It’s not for everyone. Certain appointments lend themselves much better to a telehealth or a digital appointment, but not everyone has the same connectivity and technology. We find many of our patients are able to use their cell phone to connect, but not necessarily through a computer. Some have concerns about use of minutes and things on their phones. So, it’s just not available equally across the board.”
  - “There are a lot of people who don’t know how to use the technology, so [that is] a main barrier. And ... the language of the technology is in English, so it is a problem also.”
  - “There’s also an almost paranoia fear, definitely, about technology, and who will see my records, and where will it go, and how are people using it. ... And it’s like, you know, just not understanding how all that happens and not trusting it even slightly.”
  - “I think today the digital divide is real and created almost two different worlds, in some ways, when we’re talking about chronic disease.”
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# SOCIAL DETERMINANTS OF HEALTH

**Participants in all groups emphasized the need to address social determinants of health to improve prevention and management of chronic diseases. With poverty cited as the single most important social determinant of health, participants discussed a range of closely related determinants that contribute to chronic disease:**

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**Food and nutrition.** Because of the importance of a healthy diet for preventing and managing many chronic diseases, multiple participants cited the need to improve food security as well as access to healthy, affordable food and nutrition education.

- “We know that diet plays such a huge role in managing and preventing chronic disease, so that is top of mind for me.”
- “I work in diabetes education, and I see it over and over, where people think that their diabetes is being managed, yet they’re on so many different medications. If they just tweak their diet a little bit, they’re able to manage without a plethora of medications.”
- “We are seeing that parents and grandparents that are helping to raise children [will] often, when there’s food insecurity in the family, have the children eat before them. ... So, I think food insecurity is a major issue. Anybody who’s dealing with chronic disease or maybe trying to prevent it ... would not be eating healthy if they’re dealing with food insecurity. So, that’s a major, major issue, I think.”

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**Transportation.** Participants in rural, urban, and suburban areas cited lack of affordable and convenient transportation options as a barrier to accessing health care and other resources needed to prevent or manage chronic disease.

- “Geographically, Chester County is enormous, and public transportation doesn’t get you everywhere. So, even if you have access or have insurance, being able to get around [to] make appointments is a huge challenge.”
  - “I would definitely second the [need for] transportation. Our organization is not only inside Philadelphia County, but also up into Bucks, Montgomery [Counties] ... and transportation gets even harder.”
  - “When it comes to access to health care, transportation is a huge issue ... whether it’s the cost of affording an Uber or not feeling well enough to be able to do the travel and to drive yourself. It’s always been a struggle to find transportation for treatment, but COVID really escalated that because people who were willing to, were able to pay for Uber or take public transportation were no longer comfortable or [it] was no longer available. So, I think that’s definitely been a barrier for healthcare access.”
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**Violence.** Fear of violence and other threats to personal safety were mentioned as barriers to physical activity or access to care by several Philadelphia participants.

- **“You know, there’s not as many places to walk or walk safely, so that’s definitely kind of at risk.”**

Another participant said:

- **“We have a lot of gun violence in our city. And it could be treated as a public health issue, but it isn’t. ... That has impact on transportation, whether people are really not fearful coming out of their houses to go to a screening, and how far do they have to go to get screened.”**

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**Lack of awareness and knowledge.**

Participants in all counties cited a common lack of awareness about chronic disease risk factors, prevention, and management.

Greater awareness also is needed about available resources to help prevent or manage chronic disease, such as community-based programs to access health insurance, nutritious food, or physical activity programs, as well as websites that provide education and help for those in need. As one participant put it, the issue is

- **“where are we finding those pieces of information to help make decisions on our own health?”**

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**Environmental exposures.** Indoor and outdoor pollutants were mentioned as risk factors for asthma, cancer, and other chronic diseases by several participants in Philadelphia and Delaware Counties.

A Delaware County participant said:

- **“In the southern part of the county, where we’ve got a huge industrial corridor, we have a lot of anecdotal evidence of high rates of cancer, asthma, lung conditions, and we’re even seeing things like children with chronic nosebleeds, and that shouldn’t be happening. ... So people are facing chronic illness, but physicians are not necessarily aware of the environmental hazards in the community.”**

Another Delaware County participant added:

- **“We do have the cancer corridor down 95, which has been there for a million years, all the things that [were] mentioned with regards to asthma and cancer. ... I’m old, and it’s just some of the same things are still persisting.”**

A Philadelphia participant commented on indoor exposures:

- **“I think 90% of Philly homes are very old, and that could lead to [exposure to] lead levels and asbestos, which could lead to a lot of respiratory problems for a lot of citizens in Philly.”**
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## CHILDREN AND YOUTH

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**Childhood obesity, which has increased during the pandemic, was cited as a key concern across the region,** contributing to type 2 diabetes and other chronic conditions, participants said. They focused on barriers to healthy eating and physical activity as root causes of the obesity epidemic.

- “Childhood obesity is still there, it’s still present. It’s not discussed and brought to the forefront really as much as it was ... but I think that need is still there.”
- “I’ve noticed that when kids came back [to school], they gained a lot of weight, a lot of weight. ... I mean, childhood obesity has always been a concern in this country, but even more so now – you know, some people use food to cope with the pandemic, and all the stress.”
- “It’s not just in communities experiencing food insecurity--we’re seeing that in all communities, that children just don’t have that awareness, even their families, about what healthy eating actually is.”
- “The amount of screen time children and youth are getting every single day. You know, it’s taking from physical activity, which is resulting in bad behaviors.”
- “The obesity is starting at a very young age, and that’s part of the chronic disease and if we can get our children more active, and get them involved in more activities that are available to them to join that can help.”

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**Opportunities for physical activity have been reduced during the pandemic,** due to virtual schooling, closure of many afterschool and extracurricular programs, and increased use of social media and other forms of screen time.

Several participants also cited high costs to join local sports leagues as barriers to physical activity for children and youth. As one parent (a participant in a community focus group) shared:

- “I’m a single parent, and I can’t afford to pay for my son to be doing sports, like that’s not something that’s going to happen in my household.”

In several counties, an “**epidemic of vaping**” among youth was cited as another top concern, one that increases the risk of a host of serious chronic conditions over the long term, such as heart and lung disease.

- “As we get closer to high school, not necessarily the young kids, vaping is definitely one that it is extremely concerning to us, and flavored tobacco in general.”
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**Childhood asthma and lead poisoning, stemming from environmental exposures,** were raised as additional concerns by participants in Delaware and Philadelphia Counties. Specific concerns are lead dust from paint in older homes, causing lead poisoning, and indoor pollutants such as mold and dust that can worsen asthma and allergies.

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With children and youth spending more time indoors during the pandemic, their risk of exposure to indoor pollutants has increased, one participant noted. This participant stated:

- **“Delaware County is the fifth highest– in Pennsylvania – in terms of the number of kids who are poisoned each year by lead, primarily because of peeling lead paint in older homes.”**

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Participants in every county brought up an **increase in mental health issues among children and youth during the pandemic**, along with insufficient behavioral health services to meet the demand for care. Mental health issues among youth can adversely affect their physical health, participants noted, as well as increase unhealthy behaviors, such as vaping or overeating, that contribute to chronic disease or interfere with a young person’s ability to manage conditions like asthma or diabetes.

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## OLDER ADULTS

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**Increased social isolation during the pandemic has had a range of adverse effects on older adults’ ability to prevent or manage chronic diseases,** such as delays in accessing care, barriers to good nutrition and physical activity, and an uptick in mental health issues, such as depression and anxiety, that can interfere with self-care and disease management.

Participants who work with older adults across the region commented:

- **“We’ve done everything we can to make it safe for our members but there is still some hesitation, especially amongst a lot of the seniors who we used to see coming in.”**
- **“Something what the people we serve have been facing long before the pandemic is isolation, and ... that has such a profound effect on chronic disease, and also the mitigation of it.”**
- **“We’ve seen a decrease in their function level. There’s been an increase in falls and, you know, it is notable that during the pandemic when they were less active, they did lose some ground as far as their balance, and flexibility, and strength.”**
- **“We’re seeing a lot of need to break depression and just a lot of mental angst and anxiety from COVID and as these new variants pop-up, the anxiety rises again.”**

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Several participants said they have observed a **decline in the overall health and well-being of older adults during the pandemic**, especially among those who have not resumed visiting senior centers or reengaging in other healthy activities.

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- **“When they come in for their COVID boosters or things like that, their COVID shots, flu shots, we definitely are seeing the health effects of that isolation and that is major for those that are not coming back. For those that are coming back, we’re offering as much as we can but ... they can’t just jump right in and do everything that they did before. So, it has been a progression.”**
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**In addition to longer wait times for many medical appointments during the pandemic, the growing shift to telehealth has been challenging for many older adults.**

- “Some who are even tech savvy who just don’t wanna spend a ton of time or feel a little awkward doing the Zoom calls.”
- “For seniors, it’s been for some of them challenging with the computer technology. I think a lot of seniors have had help through the senior centers and other organizations to learn technology. But it has taken them a while. Many seniors that I’ve spoken to have continued to keep in touch with their healthcare providers through the phone, probably more than the computer themselves.”
- “Some seniors can’t afford to have the internet services, things like that, so that’s been challenging for the senior population. Or just feeling comfortable enough. ... I’m amazed at how we get them on programming virtually, and the success that they have. But it’s just being familiar with that use.”

On a positive note, as older adults learn new technology skills, some are sharing their knowledge to help their peers learn to navigate virtual services.

- “You do see a lot of support from the seniors to the seniors, so I think that’s really been great. I think sometimes that peer guidance and acceptance is really huge for them, to know they’re not alone out there.”

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Participants discussed **other barriers to healthcare access** for older adults, including

- **Lack of care coordination, especially for those with multiple health issues.**  
“Many people with dementia are not getting diagnosed, and then once there is that diagnosis, once again, that care coordination is so important, because many of them have more than one chronic condition, and the dementia impacts their ability to manage that chronic condition such as diabetes.”
- **Reluctance to travel more than a short distance from home for medical appointments, even if care is available.**  
“We have found that seniors who are still driving tend to want to stay in their immediate kind of neighborhood. They’re not, as you know, not as willing to go further ... they kind of follow their routines.”
- **Lack of awareness and knowledge about their health conditions and resources,** especially among those who are homebound with little or no digital capability.  
“A lot of times older adults, they’re not going to hop on Google and see what resources are available to them. So, you know, just the unknown of not knowing what questions to ask, because you don’t know what’s out there.”

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For older adults living on fixed or limited incomes, **affording prescription medications, co-pays, and other healthcare expenses can be further barriers to managing chronic diseases.**

- “Not everyone [with Medicare] qualifies to have a Medicaid managed care program. You know, trying to get enough to eat because of limited incomes. Being able to afford medications, which could cost them thousands – I mean, just ask a diabetic what their medications cost, for example, or a cancer patient, or anyone else. Medications are extremely high cost, and there’s a [point] where they are out of luck.”

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Several participants remarked that self-care for chronic disease is hard work, requiring individuals to use motivation, planning, and organizational skills for disease self-management. **Many older adults need—but often lack—support people in their lives,** such as family members or home health aides to help them manage these tasks.

- **“A real difficulty is staying on task and dealing with the skillsets and the behaviors that you have to do in order to maintain your chronic illness, and to keep that going for the long haul. It’s very difficult to stay on track, and people slip, and they need to find [and] have supports to get back on track.”**

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One bright spot, mentioned by several participants, is **the pleasure that many older adults experience when they are able to reconnect socially with others and reengage in activities,** such as at senior centers, YMCAs, and other social venues.

One participant commented on

- **“the support that the seniors are giving each other, and how they can really help each other. And they don’t have to actually have the exact same chronic disease, but they kind of use the same tools, and they share them with each other, and I think sometimes that peer guidance and acceptance is really huge for them to know they’re not alone out there.”**

Another added

- **“I think that’s why our senior centers are so crucial, because of the interactions that they have with one another. ... We just see that when they came back, they’re just so alive again.”**

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## OTHER GROUPS

### Participants briefly discussed other populations who are at risk of poor outcomes associated with chronic disease:

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#### Immigrant and refugee communities.

Language barriers are key issues among those who lack proficiency in English.

A participant who works with immigrant communities said:

- **“Most of them, they go to these health centers, and they don’t find a lot of help, because of the language barrier. And they also don’t understand a lot of things also, just because of the language barrier.”**

Several participants mentioned that members of these communities often are afraid to seek care, especially if they are undocumented.

- **“In the population that we deal with, many have a lot of false information about applying for assistance and being deported or their status as an impairment, even if it’s not necessarily true, it impedes their desire to access care.”**

The need for healthcare providers to understand different cultural customs and traditions also was discussed. For example, in some cultures, *“they value obesity as something good,”* said one participant, who explained that in some cultures, *“people see it as prosperity,”* and they may therefore encourage their children to gain weight. In Hispanic/Latino communities, lack of access to affordable fresh food in many neighborhoods, including culturally preferred healthy foods, can increase the risk of obesity, type 2 diabetes, and heart disease.

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**Caregivers.** Participants in several counties commented on **the need to provide support for family members and others who provide care for individuals with chronic diseases.**

- **“Caregiving responsibilities can keep older adults from taking care of themselves. Caregivers often have chronic conditions themselves they’re dealing with, and providing, and connecting them with support resources is going to help them better support the patient with their chronic condition as well as help them manage their own chronic condition as a caregiver.”**

During the pandemic, some families took their older adult parents out of nursing homes to avoid COVID exposure and restrictions on visiting residents during the pandemic.

- **“That’s impacting the family now the adult daughter or son is [now] taking a long leave of absence from work to stay home and take care of that person--you know, changing family dynamics, that’s for sure a COVID-specific impact.”**

One participant mentioned the **challenges for caregivers in the “sandwich generation,”** that is, those who are raising children while caring for elderly parents or grandparents.

- **“There’s an expectation sometimes that family members will rally and that they will participate, but there’s also a reality that sometimes that doesn’t happen. So, a person who is doing the caregiving may be stuck and not only caring for a person who has a chronic disease or has cancer, but also dealing with children, or re-parenting.”**

On a related note, the closure of many adult daycare centers during the pandemic has placed new burdens on some caregivers.

- **“People who used to be able to work and ... have their people [elderly family members] cared for at adult day service now have to reconfigure their lives ... to think about what to do with older adults who need a lot more structure.”**

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**People with disabilities.** People living with disabilities who have comorbid chronic diseases often experience fragmented health care.

These individuals need *“help with coordination of care,”* said one participant.

- **“Once you get multiple different medical care teams involved ... it gets really overwhelming for people.”**

Also important are accommodations to address the needs of people with disabilities, such as hearing aids, use of a wheelchair, and Braille resources.

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**LGBTQ+ community.** Several participants cited the need for more outreach to individuals who identify as LGBTQ+.

- **“Service providers at large [do not have] a great understanding of the LGBTQ+ community.”**

Another participant, a physician, emphasized the need for more education for health professionals and screening of patients to increase use of pre-exposure prophylaxis (PrEP), a medicine prescribed to prevent HIV among people at risk due to sex or injection drug use.

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## SUGGESTED ACTIONS

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**For many community organizations, the pandemic has spurred a range of successful innovations to existing services that could be further expanded,** such as virtual wellness programs.

For example, regional YMCAs now offer online exercise classes, taught by YMCA instructors. A participant from a regional YMCA said:

- **“It’s something that we were actually looking to develop right before the pandemic started, so it happened at a very good time for us, and it’s grown a lot.”**

Depending on the branch, members can now choose to participate in person or online in a variety of disease management programs, such as group sessions to prevent type 2 diabetes, support cancer recovery, and promote heart health.

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Participants suggested a range of other strategies to improve chronic disease prevention and management, such as by starting new initiatives or scaling up model programs that are working well elsewhere. Their recommendations:

**Before patients leave a hospital or clinic, provide screening, referrals, and “warm hand-offs” to community-based health and social services.** Multiple participants in all five counties emphasized the need for hospitals and other clinical care settings to provide *“better referral to both social service resources and health resources to support people to live independently, to manage their chronic diseases.”*

Others added:

- **“I think it would be important for hospital systems to ensure that they are integrating some kind of social determinants of health screening tool, and then providing referrals. So, that could include food access, transportation needs, mental health services, and then partnering with local organizations who are focusing on those specific areas, and then referring out.”**
- **“That warm hand-off from being in a clinical environment going back to your home is a really critical time for people. ... Community-based resources, like Meals on Wheels, like senior centers, they reduce recidivism, they keep people out of the hospital, and they save healthcare dollars.”**
- **“One of the important things the hospitals could help us with the chronic conditions, especially with seniors, is letting them know that there’s tools [in the community] they can use to manage their conditions.”**
- **“If we can get those referrals from physicians in the healthcare system, when people present with chronic disease, like how they can get some help to manage it. ... I think that would be a great system.”**

Several participants pointed out that achieving this strategy likely *“will involve educating the hospital staff about what’s available in the community. .... I think sometimes it’s just that they’re not aware that those services are there for [their patients].”*

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**Bring more health and social services directly to underserved communities to increase access to care and address social determinants of health.**

Suggestions, which came from participants in all five counties, included opening health clinics in schools (*"a great place to connect to the whole family"*), offering mobile medical clinics (*"you got to meet people where they are"*), and starting pop-up produce markets or community gardens in urban areas with fewer healthy food access options. More affordable and convenient transportation options also are needed to bring people who cannot drive or take public transit to needed health and social services.

Others suggested bringing health and social services to faith-based institutions or where people shop, recreate, or work. In Philadelphia, for example, a participant cited an existing program that offers *"blood pressure screenings at [grocery] stores, and then the providers are referring the individuals if they don't have a primary care doctor already to clinical care to make that linkage."* Another participant mentioned an innovative program that bundles several preventive services conveniently together, such as [FluFIT](#), which provides a take home stool-based screening test for colorectal cancer when people receive their annual flu shot.

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**Increase networking and collaboration among community organizations and health system partners to improve resource sharing and coordination of services.** The need for greater collaboration and information sharing was raised by participants from every county.

One participant envisioned *"a vast network of organizations, nonprofits, healthcare providers, social service agencies all sharing and educating the community on the services available and how to access."* Another noted that collaboration *"helps to not only kind of maximize services, but it also lessens the duplication of efforts, as there are some folks that are [already] doing things really, really well."* Another participant, a health professional, suggested creating *"an app where you could put in food insecurity and a zip code, and get some options to give to the patient immediately, and you could text it to them."*

Coalition building was cited as a strategy that has been working well, especially during the pandemic, to meet the growing need for emergency food and other essential services. To cite a few of many examples, the [Montco Anti-Hunger Network](#) worked to equip food pantries and soup kitchens in Montgomery County with funding and food donations, while helping them to reconfigure their operations for safe social distancing amid supply chain disruptions, shortages of personal protective equipment, and loss of volunteers.

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**Broaden and intensify efforts to reduce vaping among youth.**

Participants pointed to the need for better data to understand vaping trends among youth and for school districts to shift toward policies that provide *"more supportive and restorative disciplinary actions"* for students who are disciplined for vaping, such as referral to cessation programs and other support.

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**Better inform, educate, and engage the public regarding chronic disease prevention and management.**

Limited knowledge about chronic diseases, ranging from not knowing one's family medical history to being unaware of screening guidelines and resources, was a frequently mentioned problem. More virtual health promotion programs are needed as well. A participant said:

- **“We have to try to figure out how to share information with our community in a way that is not using our jargon in our field, that’s just general language. ... Sending out the reports is not going to do it. You have to go to the communities, you have to find people [in the] places they go to share that information.”**

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**Integrate mental health services into overall care management for people with chronic diseases.**

- **“Mental health is an aspect of everything. If somebody is diagnosed with cancer, they’re going to have some depression, some anger, so mental health comes into everything. So, [we need] to have like an umbrella of mental health that goes across the board.”**

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**Strengthen efforts to close the digital divide.**

Several model programs are working well to improve digital access, but more needs to be done. The Bucks County Area Agency on Aging has created a pilot program to provide new computer tablets to older adults, along with internet connection if needed and training on how to use technology:

- **“We’ve been providing tablets to seniors to help them connect. It’s not an easy process because many seniors have not had the technology, but everything now has moved [online]. You cannot do in-person anymore. It’s almost, you know, almost impossible to do many things in-person.”**

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**Improve access to quality language services, along with culturally competent care for the region’s immigrant and refugee communities.**

- **“A proper interpretation is very important,” including “an interpreter that has some understanding of medical language so that they can provide good information for the patient.”**

Another spoke to the need for

- **“having providers or medical professionals that can communicate in the same [language]– just to better educate.”**

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**Mobilize people and organizations to work toward system-level changes on pressing public health issues.**

- **“I don’t think behavior changes are necessarily what the focus should be on. It should be focused on making the healthy choice the easy choice.”**

The same individual noted that hospitals can be a powerful voice in partnered advocacy campaigns.

- **“Healthcare provider voices can really play a big role. Patient stories can help tell that to a legislator in a very important way, and help to really – kind of a swipe of a pen, if you will, to really see what we can do to influence behaviors in a better way.”**
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# FOOD INSECURITY

DELAWARE, CHESTER & MONTGOMERY COUNTIES

To better understand needs and opportunities to improve regional food security and access to healthy food, focus groups with representatives from local organizations addressing these issues were held in Delaware, Chester, and Montgomery Counties. Information was also gathered from geographic community discussions in these counties; where relevant, comments from those discussions are included below.

## OVERVIEW

**Due to the COVID-19 pandemic, rates of food insecurity have been rising nationally and regionally.**

In 2019, before the pandemic, food insecurity nationally was the lowest in more than two decades, according to [Feeding America](#), and 35.2 million people were food insecure. The pandemic is likely to have reversed this improvement, with more than 42 million people who likely experienced food insecurity in 2021. [Considerable racial and ethnic disparities exist in food insecurity](#), with Black and Hispanic/Latino communities facing hunger at higher rates than whites.

In southeastern Pennsylvania, food insecurity remains highest in Philadelphia County, where the rate is projected to reach 17 percent in 2021, up from 14.4 percent in 2019 before the pandemic, according to [Feeding America](#). Surrounding counties also have seen sharply rising demand for emergency food assistance during the pandemic, along with increased food insecurity. In Chester County, Pennsylvania's wealthiest county, [Feeding America](#) projects food insecurity will rise to 7.4 percent in 2021, up from 6.3 percent in 2019. In Delaware County, about one in 10 residents are projected to be food insecure in 2021, up from 8.5 percent in 2019. In Montgomery County, the rate is expected to rise from 6.9 percent to 8.3 percent over the same period, and in Bucks County, from 7.2 percent to 8.6 percent

As is true nationally, emergency food providers in southeastern Pennsylvania have substantially stepped up their efforts to meet the growing need for food assistance. For example, Philabundance, which partners with 350 emergency food agencies, [distributed 55 million pounds of food in 2020](#), a record for the organization and a 60% increase from 2019. The [Share Food Program](#), the largest hunger-relief agency in the area, has been distributing 4 million pounds of food every month since the start of the pandemic.

# REGIONAL EMERGENCY FOOD PROVIDERS: PANDEMIC RESPONSE

**During the pandemic, food banks, food pantries, schools, and other food providers had to gear up quickly and creatively to meet the rising need for food.**

Many clients were first-time users of a food pantry or other emergency food provider. Participants from organizations that distributed food during the pandemic commented on the dramatic uptick in need. A participant who works for a school district shared:

- **“My opinion is it [the pandemic] pretty much just exacerbated the needs that were already there. ... I mean, I was out daily, giving meals out every day when we were shut in. I just, I saw the lines and [it was] just really tough, really tough.”**
- **“I can definitely comment on the increased incidence of food insecurity in Montgomery County as a result of the pandemic. We have served close to 25,000 additional individuals in the last year than we had previously. And that equates to about 9,494 additional households that had been impacted by the pandemic, that are in need of food assistance. And many of those folks are using our food pantry network for the very first time, and they’ve never needed food support before. So, the impact has been really quite substantial.”**
- **“Since the pandemic started, I myself as a community outreach person can testify to the fact that there are more food pantries that have opened since March of 2020, because of the pandemic. And that’s throughout Delaware County, but definitely in the City of Chester itself.”**
- **“[Our organization is] distributing about 300% more meals in our soup kitchen than we had previously, pre-COVID. We had to go from our warm meal that’s served in our dining room to to-go meals for safety, but we were distributing a lot of meals. People were coming in and getting meals for their family and they were allowed to take as many meals as they needed. We were distributing about 200% more groceries; ... And so, we went from twice a month to once a week, that people could come and get groceries.”**

While the introduction of emergency Supplemental Nutrition Assistance Program (SNAP) benefits (Pandemic Electronic Benefit Transfer program: P-EBT) and increased services of other food assistance programs have had a positive impact on food security, overall demand for emergency food has remained substantial, participants said.

- **“We have seen a dip in the numbers since public assistance benefits had become available, but our numbers are still higher than they were before the pandemic in 2019”**

Emergency food providers, schools, and other organizations that distribute emergency food had to quickly and creatively devise new COVID-safe ways of operating. For example, senior centers that had offered on-site congregate meals before the pandemic developed new processes to safely pack and distribute to-go food. A participant whose organization serves meals to older adults said:

- **“We went to a completely no-contact [process, with] everybody wearing gloves, everything’s wrapped in a brand new bag and [it’s a] basically drop and run type of situation.”**

# SOCIAL DETERMINANTS OF HEALTH AND REGIONAL FOOD SECURITY

**Job losses and other financial hardship stemming from the pandemic are key drivers of hunger in the region, along with lack of transportation, affordable housing, and language or cultural barriers, participants said. Social determinants of health that contribute to regional food insecurity include:**

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## **Poverty, exacerbated by job loss.**

- “To me, it’s all about poverty. [People are] having to make these difficult choices about how to spend the limited resources that they do have,” said a participant. Another added: “I think it’s the choice of ‘am I gonna feed my children or myself or am I gonna pay my utility bill or my food?’ I think it’s all very interrelated.”
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In focus groups with community members, concerns also were expressed about **rising food prices due to recent inflation**, which has made it even harder to afford food.

- “The price of gas, the price of food, the price of everything has increased so much that it has put a strain on families, and it definitely has impacted the aging population.”
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**Housing costs.** The escalating costs of housing across the region have further tightened food budgets for many. Some households also lack working kitchen equipment or a home altogether.

- “One of the things that we see is the relation [of food insecurity] to the high cost of housing that exists within the southern Chester County area. ... Higher living expenses really impact the ability of people to get those foods.”

In Montgomery County, a participant spoke of the “Main Line bubble,” where

- “there are folks who are house poor ... but aren’t willing to ask for help.”
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## **Transportation.**

In rural areas, such as southern Chester County or northwestern Bucks County, “*just being able to get to where that food’s available*” is a challenge, noted a participant. Some residents do not have easy access to a grocery store or a food pantry, especially if they lack a car or other affordable transportation. Transportation barriers also affect low-income urban communities, such as in areas of Coatesville, Norristown, and Chester, where many residents lack walkable access to a grocery store, which is especially challenging for those with mobility limitations, such as many older adults.

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## **Language and cultural barriers.**

For people who do not speak English as their primary language, accessing the emergency food system can be difficult, participants said, especially for those who do not have a family member or someone else to help with navigating services and interpretation. Moreover, food provided by local pantries may not reflect the cultural food preferences of immigrant households. One participant cited the need for healthy food “*that’s culturally relevant*” for local populations.

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## **Lack of knowledge and awareness.**

- “There are folks out there who aren’t connected to any organizations. And so, they may be eligible for programs, but they don’t know about them and they’re not connected with anybody that can tell them about those programs.”
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# ACCESS TO HEALTHY FOOD

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**Participants commented on the need, especially, for affordable healthy food, such as fresh fruits and vegetables, both in the emergency food system and in accessible food markets in communities.**

As one participant put it:

- **“It’s not just about having food, but it’s about having the right foods that people need.”**

In many of the region’s cities, some urban neighborhoods—often, where communities of color live—lack supermarkets and instead have many corner stores or bodegas selling mostly low-nutrition snacks and processed food, with little or no fresh produce. A Chester County participant said:

- **“There is no grocery store in Coatesville. It’s all the small convenience stores that have a tendency not to sell nutritious food [and] that often sell expired food. I [am also] concerned about the number of dollar stores that are popping up, specifically, in neighborhoods [with] low-income people of color. Of course, no nutritious foods, you know, sold at those dollar stores.”**

Participants emphasized that access to healthy food is vital for maintaining health and preventing common chronic diseases. Affordable healthy food also is crucial for those who are trying to manage chronic conditions such as type 2 diabetes or heart disease, or in treatment or recovery from illnesses such as cancer. *“A lot of people that we see, particularly within the Latino community, have [type 2 diabetes] which has some basis in food choices and food availability,”* said one participant.

The minister of a Black congregation, whose church has a community garden that gives away fresh produce and works with a local hospital to provide nutrition and health education, observed:

- **“What works really well is to bring the healthy food to the people, because access is a challenge. But if you can find innovative ways so that it’s easy for people to get [healthy food], that’s when you can really help to solve the problem.”**

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# USE OF FOOD ASSISTANCE PROGRAMS

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**Stigma remains a major barrier to using food assistance programs, both for enrolling in SNAP or other government programs, and for using food pantries and other emergency food services.**

- **“Some of the families I’ve worked with, there is almost like a stigma attached, where there’s that, ‘I don’t wanna go stand in line and have people know that I’m there to get food.’ I don’t know what the solution is to fix that. But that’s what I’ve come across with some families when I say: ‘You know, you can go here and get meals and they’re free.’ There is almost that like embarrassment to go or ‘who might see me there’ kind of thing. ... Even when there are resources available, [for] things like SNAP, sometimes it’s the need to demystify it. It’s the need to destigmatize it.”**

Another participant similarly commented that, because of stigma, *“certain folks won’t ask for help or [won’t] get their support from here—they will travel to other places.”*

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Participants discussed the need to address other **barriers to enrolling eligible people in SNAP, WIC, and other food assistance programs.**

These challenges include lack of awareness, difficulty understanding and navigating the application process, and, among immigrants, fear of exposing their legal status to others or being ineligible for some forms of government assistance.

A participant from a regional food bank commented on barriers to WIC participation during the pandemic. To have their WIC benefits reloaded every three months, mothers had to travel to WIC offices, because their benefit cards cannot be reloaded virtually.

- **“WIC participation is way down and that was [due to] the barriers of having to go to the actual office [and] the barriers that go with the cards that Pennsylvania is currently using for WIC administration. So, that’s certainly another program that could be a really vital resource to folks that’s being underutilized here in Pennsylvania.”**

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Participants discussed the need to improve access to food assistance programs for other groups, including:

**People who are undocumented and may be fearful of using the emergency food system or applying for food assistance programs.**

A participant whose organization provides health and social services to immigrants and other clients said:

- **“People who are working toward becoming citizens, wherever they are in that process, one of the things that they get concerned about [is] signing up for any sort of public benefit, just becoming a public charge and having that impact their ability to become citizens later on. ... Even with school feeding programs or things like that, oftentimes families are nervous to sign up for those programs, because they get concerned that it may impact their ability to become citizens later on.”**

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**People with limited or fixed incomes, including the “near poor.”**

Concern was cited for people whose incomes are too high to qualify for government food assistance programs, but not enough to adequately feed themselves and their families.

- **“For some, if they make \$1 too much, you know, they make \$40,000, [but] you need \$72,000 to live sustainably in Chester County.”**

Lack of understanding about income eligibility for SNAP and other programs can further worsen this barrier.

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# CHILDREN AND YOUTH

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During the pandemic, **school districts across the region geared up to distribute healthy meals to students and their families during remote learning.**

Several participants praised the efforts by many local school districts to address the nutritional needs of students and families during the pandemic.

- “I hope that all the school districts continue the really great work that they did during COVID to get out there with the families, it was really heroic what they did,” said a participant.

Another participant commented:

- “Some of the schools stepped up in a magnificent way to the point that they ended up doing seven-day-a-week feeding programs because there were some waivers in place.”

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As the pandemic continues, however, **schools are facing new challenges to their food service operations, including staffing shortages and supply chain issues,** similar to problems that other businesses and organizations have encountered.

A representative from a public school district stated:

- “Our biggest challenges are sort of the global challenges of staffing, transportation, and supply chain issues. The meals that we’re providing, although nutritionally sound, are not really up to the quality levels that our nutritional services team would like to provide, because the supply chain has been unreliable. ... [for example,] we don’t get apple slices, and the next week we don’t get carrot sticks. And then we’re having a lot of trouble staffing our school cafeterias, it’s one of several areas where we’re experiencing real staffing issues.”

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Schools also face **new challenges feeding students whose family situations have changed due to pandemic hardships.**

For example, more high school students are working during the regular school day to supplement their family’s income and therefore may not be on site for school breakfast and lunch. To accommodate these students, a participant commented on how the public school district where she works had implemented an after-hours lunch program.

- “We’re just trying to be creative with how we can still educate our kids while they’re having to work. For example, some students work during the day and attend school from 3 pm to 7 pm. We’re trying to figure out how to still provide them a lunch when it’s off-hours. So, it has caused another stressor onto our cafeteria staff, because they [students] are entitled to that.”

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During the pandemic, several participants mentioned that **more young people are under the care of their grandparents,** because their parents are unable to provide care for various reasons.

When grandparents assume caregiving duties, new barriers to family food security may arise. For example, grandparents who do not have formal legal custody of their grandchildren may have difficulty accessing some types of emergency food assistance. And those with limited incomes or age-related health impairments may not be able to procure or prepare food for other family members. A participant who works with students and families shared:

- “A lot of grandparents are raising their [grand] kids, second time generation. Parents either are in facilities, institutions, or MIA [missing in action] and grandparents don’t either have the transportation or the custodial paperwork ... to get eligible to go to food banks.”

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Participants also raised **concern about the nutritional needs of children and youth during out-of-school time periods, such as weekends, holidays, and summer break.**

Concern was expressed about young children, such as infants and preschoolers, who do not receive school meals, as well as young adults (17-24 years), who may fall through the cracks of available feeding programs. The need to address hunger among college students with low incomes was highlighted. Already an issue for these young people before the pandemic, one participant said:

- “COVID made it worse, because they [college students] were at home trying to access courses, not really accessing good nutrition as well, and not knowing where resources were.”

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## OLDER ADULTS

**Older adults, already at higher risk of food insecurity pre-pandemic, have faced new challenges during the pandemic.**

- “During the pandemic, seniors were in the highest risk group [for COVID-19], and food pantry shopping was not an ideal scenario for them.”
- “So, they really had a double whammy as a group that was at higher risk to begin with, and then they were unable to access their food supports.”

Fear of COVID-19 exposure also was a barrier to food shopping.

- “People were fearful to go to the grocery stores.”

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**Senior centers that provided congregate meal programs before the pandemic transitioned to contactless methods of providing food, such as grab-and-go meals.**

Some also used volunteers or staff to deliver meals to homes, which provided a brief opportunity to check in and socialize with isolated older adults. “*Meals-on-Wheels does do a lot more than just provide food. It provides that social connection,*” noted a participant. Others commented:

- “The senior centers actually delivered meals as well to folks who weren’t capable of carrying five frozen meals from the senior center to their homes. Partnering with the food banks, all of our senior centers received senior food boxes through the food bank. ... So, our seniors were very, very resourceful during the pandemic, just figuring out how to navigate.”
- “We had to really be resourceful in getting those seniors connected to groceries. Manna on Main Street has had a program where they deliver groceries directly to senior living facilities, and that’s just really an outside-of-the-box, innovative way to be connecting people who are eligible for food support.”

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For older adults in poor health and those living in or near poverty, **lack of working kitchen equipment and health impairments, such as loss of manual dexterity or cognitive decline, can make it difficult to prepare food.**

- “It’s one thing to give somebody a 35-pound box of produce, but if they go home and don’t have a refrigerator, what have you really accomplished? You can say, ‘Yes, we gave them healthy food.’ But [if] they have no way to store it, if they have no way to safely prepare it. If they have no way, you know, no place to eat it. You know, [with] COVID, it was grab and go, but the question for those without housing, grab and go where?”

With more home deliveries to people in need during the pandemic, these issues are frequently coming to light, the participant said.

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## SUGGESTED ACTIONS

Several participants emphasized that the emergency food system is a temporary solution to addressing hunger, and more long-term, sustainable solutions are needed to lift people out of poverty and food insecurity. Their suggestions include:

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**Work to ensure more equitable access to food assistance programs and resources throughout the region.**

- **“What we’re really concerned about is, where are those high-need communities with low resources and how [can we serve them] better?” Are there communities and ... individuals who have no access at all?”**

Hospitals could partner with local organizations to collect and share data to assess and address food access disparities in different communities. Data collection tools also are needed to measure progress toward food security goals. To ensure equitable access to resources, people from under-resourced communities also need a voice at the table.

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**Before patients are discharged from the hospital, provide “warm handoffs” to connect them with community health and social service organizations that address hunger and other needs.**

Hospitals need to “make sure that folks are connected to benefits,” and “get signed up [for] those resources that they’re eligible for, to make sure that they’re getting appropriate nutrition and other kinds of assistance they might need,” one participant said. Another said: “I would like to see the hospitals actually enroll people in benefit programs rather than doing referrals,” including enrolling eligible individuals in SNAP and public health insurance programs, such as Medicaid and Medicare.

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**Increase collaboration and resource-sharing between hospitals and community groups that are working to increase healthy food access.**

“Food is important to our operation as a church,” said the pastor of a Black congregation, which already collaborates with a local health system that provides free nutrition education workshops and other health programs at the church. More such efforts are needed, the participant advised:

- **“How can hospitals with their collective power and resources be able to make it [so that healthy foods] drop very, very easily into people’s hands?”**

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**Build the evidence base to document the clinical benefits and cost savings of a nutritionally sound diet to prevent or manage common diseases.**

- One participant noted the groundbreaking work of MANNA in Philadelphia, whose [research](#) has shown the positive impacts of a medically tailored meal program for people with serious illnesses: “As health systems are thinking about how to improve health and prevention efforts, ... being able to tap into some of that research might be helpful in the long run.” Such research also could encourage more insurers to help cover the cost of healthy food for at-risk individuals.
- Another model partnership that was cited: [Geisinger health system’s partnership with the Central Pennsylvania Food Bank](#), which distributes fresh food to patients with diabetes and their households.
- Another participant called for hospitals to share relevant data with community groups to better inform local efforts to increase healthy food resources; for example, demographic data and information on local trends related to food insecurity and diet-related conditions, such as childhood obesity.

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**Increase outreach to raise awareness and utilization of food assistance programs.**

Many participants noted that while the region has a tremendous number of emergency food agencies and other food system resources, helping people find and connect to what they need is often a challenge. Also, because many people lack online access or digital skills, several recommended developing communications that do not rely exclusively on technology. As one participant put it: the *“good old fashion way, going back to the basics of communicating with people rather than relying on them accessing technology.”* She suggested, for example, printed cards listing food pantries and other resources that churches could distribute to members. Of note, the MontCo Anti-Hunger Network recently completed its [“Build Back Better”](#) strategic planning process, with an important goal being the creation of a communications platform to better connect consumers and service providers with available resources, a representative said.

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**Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food.**

- **“Food trucks are the biggest new thing now. Why can’t we have food trucks that go around the neighborhoods to give out fruits and vegetables and give out ... all the canned goods that are sitting in food banks that people aren’t able to access? ... We have Uber Eats. Why can’t we have, like, Uber Helps? You know ... just call your local food pantry and ask what you need, what you like and they’ll bring it to you.”**

Donating healthy food in community settings that already bring people together, such as churches, can help remove the stigma of seeking food assistance. *“When there are non-stigmatized ways of being able to get the help, folks respond,”* said a participant. Speaking about her church’s community garden, which gives away fresh produce, she added:

- **“With the gardening program we have, it’s removed the stigma, because everybody grows—poor, rich, middle—it’s for everybody.”**

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**Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources.**

Participants pointed to the need for better transportation options for people in both rural and urban areas of southeastern Pennsylvania.



# OLDER ADULTS AND CARE

BUCKS COUNTY

## OVERVIEW

According to the [2019 American Community Survey](#), older adults make up 19 percent of Bucks County residents (120,628 older adults). This population, which is predominantly white (93%), is growing as baby boomers age and people live longer. Nearly 40% of older adults in the county live alone and 27 percent have a disability. Almost a quarter (22%) are employed and 42 percent have an educational attainment of high school or less. About one in ten has an income below 150 percent of the poverty line. Among older adult renters, nearly two thirds (61.2%) pay more than 30 percent of household income on rent.

To assess needs and opportunities to improve the health of older adults (age 65 and older) in Bucks County, a focus group was conducted with representatives of area organizations serving older adults. The needs of older adults were also discussed in geographic community discussions with Bucks County residents; where relevant, comments from these discussions are included below. [Please see the summary of Bucks County geographic community discussions for further details.]

# SOCIAL DETERMINANTS OF HEALTH

**For older adults with fixed or limited incomes, meeting basic needs for housing, transportation, and food is difficult, increasing their risk of mental and physical health problems.** *“Anything extra that comes up, they have to start making choices between food and other necessities. ... We see a lot more seniors needing assistance with anything extra that may come up in their lives.”* Challenges meeting basic needs, cited by multiple participants, are detailed below.

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## **Lack of affordable housing and support for aging in place.**

- While many older adults want to age in place, obtaining home health care and other home services is often difficult. Many older adults cannot afford to make home repairs and programs to assist with repairs are insufficient. Many also cannot afford senior living communities, while for others, rising rents threaten housing security.

**“All these fancy developments that ... are popping up. Most of our population and [our] clients cannot afford them.”**

- **To enter subsidized housing in the county, wait lists are long.**

**“Hundreds and hundreds of people,” often wait a year or longer. “It’s definitely a burden for anybody looking into subsidized housing.”**

- A participant from a social services organization commented on a **growing number of referrals for older adults who are experiencing homelessness**, with some living in their cars or outside.

**“We have definitely seen an increase in seniors in referrals that are coming in. ... I think seniors are particularly vulnerable if they’re living in their cars or outside. More services [need to] be available specifically for seniors who are homeless.”**

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## **Transportation barriers.**

For those who don’t drive, getting to healthcare providers or other services is a major barrier, particularly in rural areas.

- **“If someone’s living in Upper Bucks, there’s not a lot of opportunity to get to different places unless you have your own vehicle or a friend or somebody that can drive for you.”**

While some local organizations have volunteers who drive older adults to services, *“there’s not really the bandwidth here in the county that we need.”* Ride services (e.g., Lyft, Uber) are available, but the cost of these services is a barrier for some, as is access to and ability to use technology to schedule rides. Several participants noted that some older adults also have difficulty using Bucks County Transport (a nonprofit organization that provides shared rides for residents) for needed services, such as getting to medical appointments.

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## **Food insecurity.**

Local organizations have stepped up food donations during the pandemic, but more efforts are needed to provide nutritious food for older adults, especially those who are homebound.

- **“We do luckily have some programs available to provide healthy food to seniors [on a] limited basis. ... More widespread opportunity to provide healthy food to seniors that don’t have the ability to leave their homes [is needed].”**
-

# HEALTH CARE ACCESS

Participants discussed a range of barriers that limit access to health care for older adults, including:

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## **Lack of understanding about Medicare and other insurance barriers.**

- **“Seniors are overwhelmed with Medicare information, scam calls, internet scams and they are fearful and paralyzed and do not know who to trust.”**

Older adults may not realize that hearing aids, vision, and dental care may not be covered by their Medicare plan. Delays in reimbursement or lack of coverage for home health services may prevent some older adults from aging in place.

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## **Need for care coordination and support.**

Older adults often need help from an advocate or companion to make medical appointments or navigate other health care.

- **“Many of them just don’t have anybody to help them through this process, so if they can’t do it on their own, it’s gonna be a struggle. Many of the seniors that we see live in their apartments by themselves. Unless somebody can come in and help them with that, they’re not gonna be able to figure it out themselves.”**
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## **Lack of trained and affordable providers.**

Participants mentioned a shortage of home health workers; a lack of medical providers trained in geriatrics (including geriatric psychiatrists); and the need for more providers to focus on the whole person, not each separate diagnosis. A participant also commented:

- **“It’s been hard for agencies to keep a full staff of CNAs [certified nursing assistants].”**
- 

## **Lack of power of attorney or legal guardianship documents.**

For older adults who become incapacitated and refuse care for a behavioral or physical health issue, the ability of family members and healthcare providers to help is limited if power of attorney or legal guardianship is not established.

- **“Sometimes, we will get referrals from physicians’ offices or hospitals [to provide care], but if there’s not any natural supports in place [e.g., a family member or trusted friend] or guardian or power of attorney, they still ... have free will. We can’t force anybody [to receive care] unless it’s a mental health crisis, where it would be an involuntary [commitment].”**
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# IMPACT OF THE COVID-19 PANDEMIC

The pandemic has worsened many existing barriers to care and created new challenges for older adults, including:

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## **Increased social isolation and loneliness, exacerbating mental and behavioral health issues, were a top concern for all participants.**

- **“Some seniors in our county, and some seniors everywhere, just do not have enough social connections. And the pandemic has certainly made that worse for a lot of folks.”**

For older adults who have long been coping on their own with mental health challenges, the added stress of prolonged isolation may be overwhelming, prompting some to finally seek help.

- **“We’ve had some say to us, ‘you know, I thought it was okay dealing with this and then I was stuck in my apartment house.’”**

On a positive note: As COVID restrictions have eased, YMCAs in Bucks County are seeing older adults returning “*in droves*” to stay active and socialize.

- **“Coming out of the pandemic as an organization, we [were] expecting seniors to be very hesitant to come back and be around others, because of the health risks. And they ended up being like the first group and the largest group of people coming back to our facilities, and still are. So, the value of socialization for them is huge.”**
- 

## **Delays in or avoidance of care.**

Many older adults who put off medical care earlier in the pandemic are again seeking care as restrictions have eased. As a result, “*appointments piled up,*” overwhelming system capacity in many cases and further delaying care. Others are continuing to delay care because they “*still have a lot of fear and trepidation about going out.*” Stigma associated with mental illness leads some to avoid care. Others are hesitant to let service providers visit their homes, due to fear of exposing an unsafe home environment or other conditions that might threaten their ability to age in place. Especially for older adults with dementia or hoarding issues, “*they’re fearful if somebody comes in and it [their home] is really in poor condition that they will be removed, or somebody will take their home away.*”

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## **Use of telehealth.**

The shift to telehealth during the pandemic has been an obstacle for the many who lack computer technology, digital knowledge, or both.

- **“We’ve seen a shift to telehealth, and yet we know that all of our seniors aren’t equipped either with the hardware or [having] the understanding or learning how to navigate. So, I think that shift has left some of them behind.”**

Using online portals to sign up for COVID-19 vaccines also has been challenge for many.

- **“Signing up for their vaccine and such, and other appointments — their capability was just not there.”**
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## SUGGESTED ACTIONS

Participants noted several initiatives that are working well to support older adults and should be sustained or expanded. For example: *“Some of the local senior centers are super coordinated with reaching out and checking on some of their members [such as] during the lockdown, as well as the vaccine rollout -- keeping their members and members of the health community informed of what they were able to offer.”*

Several participants also cited the benefit of increased collaboration among community organizations working to address food security and other services for people in need, including older adults. *“I think some organizations working together ... have really, over the last several years, improved access to healthy foods. We still have certainly a way to go, but I’ve seen a lot of movement in a positive direction in the last several years.”*

Participants offered additional suggestions to improve the health and well-being of older adults in the county:

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### **Increase services to help older adults age in place.**

These needs include affordable home health care and programs to assist older adults with critical home repairs and other basic needs, such as food delivery for homebound older adults and utility payment assistance.

- **“Particularly for the seniors that can’t leave their homes, more opportunities for healthy foods [are needed].”**

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### **Expand access to safe, affordable housing, including subsidized housing.**

- **“I would underscore the lack of available low-income housing. It just has so many impacts across the board. I don’t know that’s a problem that a healthcare system can solve, but it is one that I think is just cross-cutting for many residents and seniors who are on fixed incomes in particular.”**

Resources to prevent and address homelessness among older adults also are needed.

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### **Train community health workers to check on and support vulnerable residents, such as older adults who want to age in place.**

These providers could

- **“work along with social workers ... to be the eyes and ears in the community and feet on the ground ... and connect with people who are vulnerable.”**

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### **Create more opportunities for older adults to have social interaction in homes, community sites, and through technology.**

- **“Just any kind of interaction -- it’s being craved right now by everyone, specifically the seniors that have been so isolated. ... Even ones who have family, they didn’t get to see them for so long. Anyone living alone is, you know, extremely isolated and missing ... one-on-one interaction.”**

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### **Create intergenerational opportunities to address community needs, such as through mentoring, intergenerational service provision, and education.**

- **“Seniors need more IT training and youth can benefit from life experiences. Seniors are also lonely and would welcome the company.”**

# FOCUS AREAS AND COMMUNITIES

This section features primary and secondary data focused on health needs associated with particular conditions requiring specialized care (cancer and disability), as well as communities whose needs have historically been less understood or adequately addressed (immigrant, refugee, and heritage communities; youth; and LGBTQ+ communities).

## CANCER

Cancer is one of the leading causes of death in southeastern Pennsylvania (SEPA).

County-level data for several cancer-related quantitative indicators previously presented in the geographic community profile tables are shown below for ease of reference:

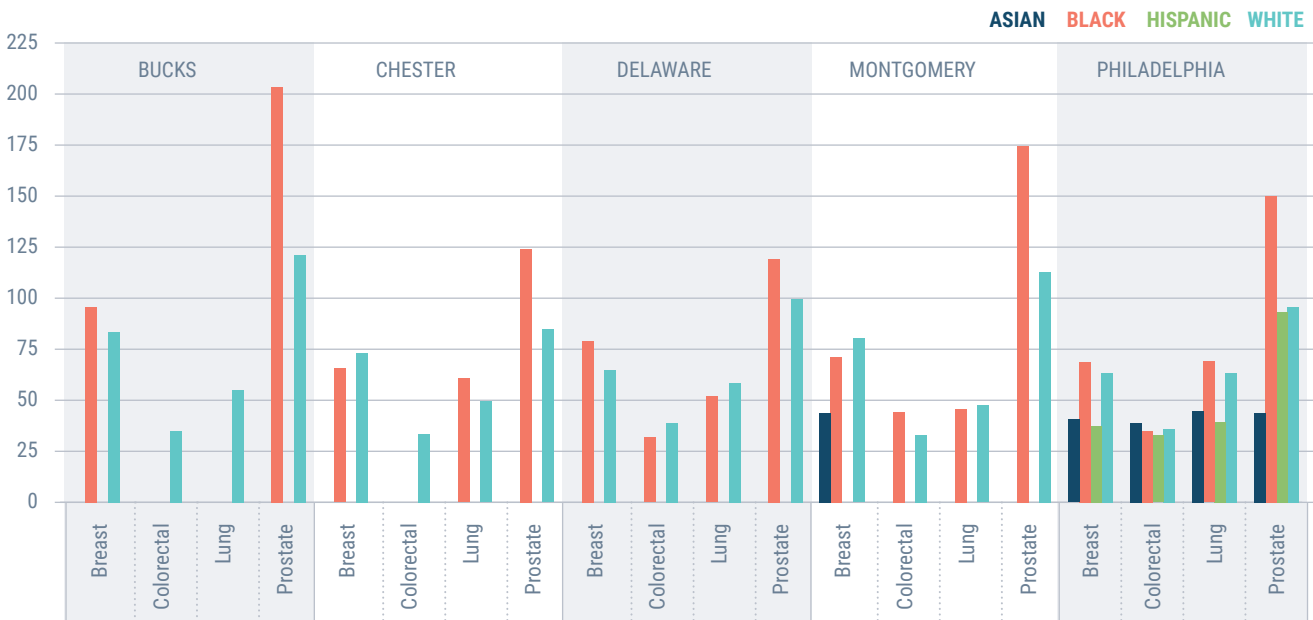
	<b>Bucks</b>	<b>Chester</b>	<b>Delaware</b>	<b>Montgomery</b>	<b>Philadelphia</b>
Major cancer incidence rate (per 100,000)*	308.7	242.9	262.9	286.1	242.5
Major cancer mortality rate (per 100,000)*	91.4	72.8	88.9	85.2	80.3
Colorectal cancer screening**	68.6%	69.5%	65.1%	71.3%	63.5%
Mammography screening**	76.6%	77.6%	77.4%	77.4%	78.3%

\* Prostate, breast, lung, colorectal cancers; crude rate per 100,000; 2019 Vital Statistics (PA Department of Health)

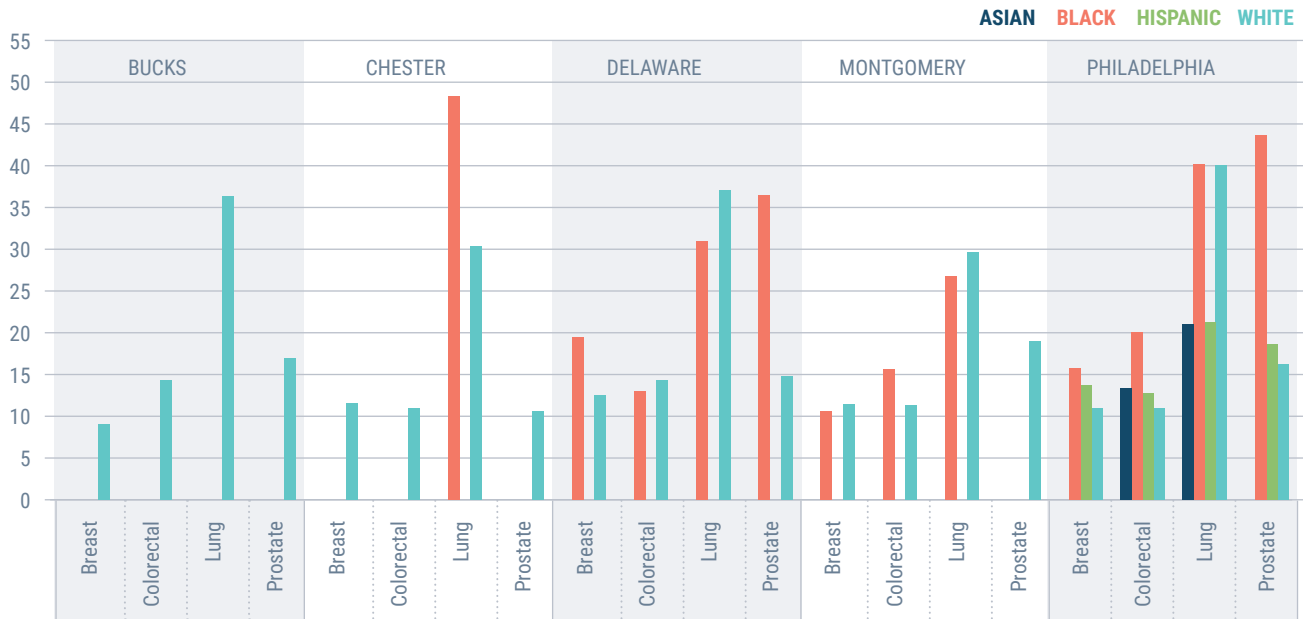
\*\* 2018 Behavioral Risk Factor Surveillance System

Age-adjusted incidence and mortality rates by race for the four most common cancers in each of the five counties, according to 2018 data from the Pennsylvania Cancer Registry on the [Cancer Statistics Dashboard](#), are presented below:

### Age-Adjusted Major Cancer Incidence by Race, 2018



### Age-Adjusted Major Cancer Mortality by Race, 2018



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.

In addition to quantitative data, qualitative data about community needs related to cancer were collected through focus group discussions on spotlight topics, including chronic disease, with representatives of community organizations and government agencies serving each of the counties (see Spotlight Topics section for more details). Key insights related to cancer from those discussions include:

- **Lack of information and stigma surrounding chronic diseases can lead to fear and avoidance of getting screened or seeking treatment.** *“One of the things that I saw was fear, fear of getting that diagnosis, and kind of putting your head in the sand,”* said a participant who managed a cancer screening program. *“There seems to be a ‘Don’t ask, don’t tell, don’t know, and I’ll be okay’ kind of mentality.”*
- **Stress management and social support are important to optimize care.** *“General stress management is a huge barrier, not only through it, but even after treatment,”* said a participant who works with people in cancer recovery. *“One of the things we also hear is sort of once everything stops, so treatment is done, surgery’s done, okay, your doctor’s like ‘You’re good, I’ll see you in three months,’ or whatever. It’s like ‘Holy moly, what just happened?’ It’s like post-traumatic, ‘Now what do I do?’”* Some patients also experience “scanxiety” after treatment for cancer—that is, fear and anxiety before follow-up visits to check for cancer recurrence. After a diagnosis of cancer, *“Number one is just feeling they have the support in their life, whether it comes from friends or family, or just support of others that understand what they’re going through.”*
- With care delayed for some patients due to the COVID-19 pandemic, several participants said **cancer and other conditions are more often diagnosed in later, more advanced stages.** *“The fear of going for those screenings during COVID. A lot of people that typically got yearly colonoscopies or blood work or whatever they’re like, ‘No, we’re going to wait.’ And then things exacerbated in that time, so a lot of people are being diagnosed later, in more advanced stages.”*
- **Staffing shortages at hospitals, coupled with staff redeployment to pandemic-related care, are further challenges.** Another participant who works at a health clinic added: *“We are currently in major catch-up mode when it comes to the cancer screenings, and then availability of getting folks in ... can be months waiting.”*

- **With many people working remotely during the pandemic, fewer workplace wellness programs that offer screening and education are being offered.** *“With the emphasis on the pandemic, there may be a lack of awareness even in workplaces about doing screening as part of work and offering it as part of work. Think about that: a lot of people are working remotely, and that’s where these things used to be in the office, or that people could gather to a bus [providing mobile health services] that is on office property, the access to that is reduced because of people working remotely.”*
- **Environmental exposures.** Indoor and outdoor pollutants were mentioned as risk factors for asthma, cancer, and other chronic diseases by several participants in Philadelphia and Delaware Counties. A Delaware County participant said: *“In the southern part of the county, where we’ve got a huge industrial corridor, we have a lot of anecdotal evidence of high rates of cancer, asthma, lung conditions, and we’re even seeing things like children with chronic nosebleeds, and that shouldn’t be happening. ... So people are facing chronic illness, but physicians are not necessarily aware of the environmental hazards in the community.”*
- **The need to integrate mental health services into overall care management for people with chronic diseases.** *“Mental health is an aspect of everything. If somebody is diagnosed with cancer, they’re going to have some depression, some anger, so mental health comes into everything. So, [we need] to have like an umbrella of mental health that goes across the board.”*

A final important source of qualitative data to inform the rCHNA process were collected by three cancer centers affiliated with participating health systems:

- Abramson Cancer Center (ACC) at University of Pennsylvania (Penn Medicine)
- Fox Chase Cancer Center (FCCC) (Temple Health)
- Sidney Kimmel Cancer Center (SKMC) (Jefferson Health)

Representatives from each of these cancer centers conducted focus group discussions with community advisory board (CAB) members January – February 2022, based on a standardized discussion guide developed jointly. There was a great deal of agreement across all discussions, with common points that resonate with items raised by the spotlight topic discussion groups above. Full summaries of each of the discussions developed by each team are presented below.

## ABRAMSON CANCER CENTER AT UNIVERSITY OF PENNSYLVANIA

To solicit feedback about cancer awareness, concerns, and ideas for addressing cancer control, the Community Outreach and Engagement (COE) program of the Abramson Cancer Center (ACC) convened two meetings of its Community Advisory Board (CAB). There were 19 attendees at the two meetings at ACC. The meetings were held on Zoom, audio recorded, and the recordings were transcribed. The COE lead team created summaries of the meeting along with selected verbatim quotations, and combined both summaries from both meetings into this summary.

### ***In your community (or in the community you serve): Is cancer seen as a health concern?***

- It is seen as a concern because it is so **prevalent**. It comes up even in general community discussions about health. *“So many people have family members, if not themselves, who have cancer or have died of cancer or are being treated for cancer. So it’s definitely seen as a health concern in the community.”*
- There are a lot of **misunderstandings about cancer**, especially related to family history, the different types, the role of the environment, treatment options, and the variety of prognoses/outcomes (i.e., people think there is nothing that can be done if someone is diagnosed with cancer).
  - *“Our people in the community don’t think there’s any connection between the environment and cancer... that’s an area which we really have to start educating a lotta communities about the connection.”*
  - *“There’s... sometimes a fear about what happens if I do end up with a diagnosis, what will happen then?”*

### ***Do people in your community talk about cancer? If so, what do you typically hear about? If not, why not?***

- People often **do not know their family history** or if they know someone in their family had cancer, they often do not know what kind of cancer their family member had. This can sometimes be because medical professionals do not share with patients where the cancer started after it has metastasized.
  - *“I use my cousin as an example. She died before 50 from colon cancer but did not know that there was a family history because nobody in the family shared it. And so she kept being misdiagnosed for something like bronchitis. By the time it was staged, it was end stage.”*
  - *“The health system does not do a good job, especially for brown and black people, to explain what was the original point of origin. It’s kinda like they have – it’s all over... Where did it start? And oftentimes family members never even get that information in order to share with family if they so choose to do so.”*
- **Diverging opinions regarding cancer’s stigma:** on the one hand, some saw cancer as having less stigma than other diseases/illnesses (COVID/AIDS), but for others, it is harder to talk about cancer than sex/sexuality.
- People are most likely to talk about cancer if it **affects someone close to them**, but it is not top of mind otherwise. *“The people in the community talk about cancer. Not, till they get it and/or somebody close has it because for many people, it’s associated – without the education about cancer, it’s associated with fatality, and who wants to talk about that?”*
- **Groups where there is general conversation about health** are usually more comfortable talking about cancer. It also might **be easier to talk about cancer when it’s discussed alongside other health concerns** rather than on its own. *“Where there is strong advocacy, strong support groups, where you have a lotta survivors, there is a lot of conversation. ... Until it hits home, it may not come up as a general conversation.”*
- When there is discussion about cancer, the **mental health aspect is often neglected**, which it shouldn’t be. *“It was tougher for me to learn how to be a cancer survivor than when I was actually in treatment. I would notice these cycles of anxiety around my appointments, and the weeks leading up, I was just – I would experience things that I never experienced in my entire life with respect to anxiety and just irritability and fear.”*

**Are there cultural nuances about cancer in your community that should be noted? Are there cultural beliefs or behaviors among your community that make cancer prevention and access to cancer care more challenging?**

- Sometimes **religion** plays a role (e.g., “Can’t do anything about it. This is His will”).
- There are potentially **cultural factors** that affect misinformation about cancer and screening and other preventive measures, which could have many long-term negative consequences. For example, cultural ideas about sex prevent people from getting their children the HPV vaccine.
- Other **perceptions in different cultural groups** related to treatment include:
  - There is a myth in the Black community that when someone with cancer has surgery, the cancer spreads throughout the body.
  - When someone must go to the hospital, it is seen as a death sentence—there is not much knowledge around treatment and how people could get better. People do not understand the difference between a comprehensive cancer center and a community hospital.
- **Trusted messengers (especially survivors)** are an important factor to consider when addressing cultural factors.
  - Speakers’ bureaus would be a great asset to Philadelphia, as only one cancer center currently has one. The speaker could be a physician, health educator, or nurse, depending on the audience.
  - Highlighting survivors’ stories and good outcomes of treatment could help: *“Highlight survivor stories, highlight good outcomes in there, and I mean, I think a lotta this is educational, and a lot of it is you’re dealing with folks, they don’t wanna talk about – they got enough stuff going on, they don’t wanna talk about more bad news.”*
  - Messages need to be tailored to the group/community, and trusted messengers are key. Organizations can come in and fill this role, too, in some cases. It is especially effective when they have a health and wellness committee/group within the organization.

- Having **resources in both Spanish and English** is important, as well as making sure the materials are written at a level most people can access/understand: *“...we have bilingual staff that can have those conversations, but I think about people walking into other establishments that may not get that in their native language, in a way that they can relate to.”*

**Do you think there is good/adequate awareness or knowledge of cancer? Do people seem aware of particular cancers, and if so, which ones? Which cancers do you believe there should be better awareness of?**

- Many people do not know about the different kinds of cancer and just see it as one thing. There are varying **degrees of knowledge** related to different types of cancer. For example, there is not enough awareness of blood cancers, lung cancer, or connection between HPV and head/neck cancer. While there is agreement that there is strong awareness of breast cancer, opinions differ about prostate cancer wherein some think there is a lot of awareness and others do not. There is also a lack of knowledge about the **different degrees of cancer** (precision medicine can help with this).
- It takes a **great deal of effort to have sustained interest** in the topic. It can also feel overwhelming to think about and look out for the signs of all possible cancers.
- The **patient-provider relationship** is key, and providers need to not dismiss the concerns that patients bring to them: *“you’ll have people going in really trying to advocate for themselves, and you have a healthcare provider that isn’t listening...A savvy person may walk out that door and into another healthcare provider door, and sometimes they won’t walk into any healthcare provider, period.”*
- Communities that need special attention include the **LGBTQ community and people who are pregnant**.
- **Advertising for specific cancer treatments can be confusing** for people. *“The pharmaceuticals have new commercials on TV about various different medications for cancer. If you’ve seen that come out, there’s a slew of ‘em out there now, and folks are confused.”*

**Do you think people in your community know about cancer screening? Do you think some cancer screenings are more well-known than others?**

- There is more awareness of breast cancer screening and colorectal cancer screening, less awareness of lung cancer screening. *"There are certainly some others like lung cancer screenings still a lotta people are not aware of. We need to do a better job with that one."*
- Many people don't become proactive about being screened until they know someone personally with cancer.
- It would be great to piggyback off of COVID testing/screening to get more people screened for cancer.
- There has been some success in a drive-by Flu-FIT campaign at Abramson.

**If someone wanted to know more about cancer, where do you think they would go? What health information (cancer information) do you think they would trust the most?**

- **People in their circles** (family nurse, friends and family, someone close to them, people from their church)
- **Someone who looks like them** is more trusted than someone of another race: *"I've heard directly from survivors and the ambassadors that they want to talk to people that look like them."*
- **People generally trust their doctors and team**, including navigators or social workers at cancer centers: *"...we've done surveys of our community members, and they all say they wanna hear about trials from their doctors."*
- At the same time, people do not always trust that the healthcare system is supporting them, in part because of the huge costs: *"...I know we still have high copays for a lotta different things, but a lotta people don't necessarily feel like the health system is there for them."*
- People may seek out information from the **internet or organizations like the American Cancer Society**.
- For older adults, **partnering with a group like the Philadelphia Corporation for Aging** would be a good idea.
- It is important to **consider the whole person** when educating them about cancer. **Funding** is necessary to take ideas and put them into action.

**What could we do better to get the word out to your community about the importance of cancer screening? Where would we place/put them? Who should our collaborators be? What would those messages sound like?**

- **Neighborhood, local, ethnic newspapers/magazines.** These are the magazines in their neighborhoods, stores, businesses, and they read them regularly. *"They read the Philadelphia Tribune. They read the Philadelphia Sun. They read the Westside Weekly. They read the Leader."*
- Young people get cancer too, so **social media** is an important outlet for that age group (Instagram, Facebook, Twitter, TikTok), especially with greater use due to the pandemic and not being able to get outside.
- Other important sources include the sometimes overlooked outlet of the **radio, leaders at trusted community organizations, and documents** like infographics with QR codes to websites for further information. A specific resource suggested was a **one-pager** that lists the cancers you can screen for, the age at which you are supposed to be screened, and a phone number for someone within Penn who can help a patient schedule the screening.
- **Variety in messaging** is important—things are not one-size-fits-all. People need to hear that cancer can be treated and you can be a survivor—people do not hear that message often.
- Having **health care in unexpected places** was suggested. Bringing it to where people are, like libraries, churches, mosques, synagogues, supermarkets, parking lots, buses, laundromats, donut shops, and food pantry lines. This ensures that they do not have to worry about transportation or babysitting.

**How could we make it easier or more likely that people in your community would be screened for cancer? What are the biggest barriers they face in getting cancer screenings?**

- It is important to remember the **social determinants of health**. Some people are just trying to survive, so cancer screening is not top of mind. There are barriers, like the cost of prep for colorectal cancer screening and getting to/from the screening, even when people get signed up/scheduled to be screened.
  - *"Well, if you have a car or you have someone that can drop you off and pick you back up who has the luxury to take off work, who can pay for the parking, all of those things, that they didn't have to come on a bus, there are so many things that we don't consider when we're talking about communities who every day are trying to just figure out how to survive."*

– “We don’t think about the fact that I could go to the CVS and purchase the stuff for the prep, but everybody doesn’t have the resources to go and plop down \$20 to \$25 to buy the Miralax, the Dulcolax, the – what is that, the Gatorade and those kinda things.”

- **Self-advocacy** is important, too, including empowering people to get a second opinion if they want.

## FOX CHASE CANCER CENTER

Fox Chase Cancer Center (FCCC) conducted a focus group with five members of their Community Advisory Board (CAB). For all questions, participants were asked to answer as a voice for the community they serve. The participants are representatives of the following community organizations with whom FCCC closely partners:

- A Hug Saved My Life
- Bethel Deliverance International Church
- FCCC Patient and Family Advisory
- Sista’s Daughters Inc.
- Delaware Valley Community Health (FQHC)

### *Awareness and Knowledge of Cancer*

Cancer is seen as a health concern in all the communities represented in the group. Specific concerns include: **access to treatment and screenings, high rates of diagnosis and death, and fear of screenings and cancer itself**. There is also a concern about **late-stage diagnosis of cancer** which is occurring more as cancer screenings and doctor’s visits have decreased since the start of the pandemic.

Several members stated that many community members **do not talk about cancer and find it taboo** to even discuss their own experiences with cancer. This crosses generations, where many in older and younger generations have been taught not to talk about cancer. Several participants said this was mainly among the African American community. As one participant explained: “*Even my generation, because they were raised by that generation of quietness and so we are trying to break that cycle, but still no one’s talking about it, and if they talk about it it’s in a whisper.*”

Another participant explained that while **breast cancer and others such as thyroid cancer are typically discussed, there are others that are more taboo, such as gynecological cancer**. This is a topic that no one talks about. There are also **superstitions among many cultures**, including the Russian population she works with, that if you talk about cancer you will bring it in to your life. There are also beliefs among many in the community that they will not get cancer and therefore do not need to get screened. As one participant stated: “*Why do I want to do these things to my body, you know I’m not going to get cancer, it’s not going to happen to me.*” This participant also mentioned that from a male perspective, many men think they are invincible and do not need screening.

Participants stated that there is a lot of knowledge about breast cancer, but there are other cancer types that people are not as familiar, such as kidney cancer. Consistent with the point above, gynecological cancers are often not discussed, and many women feel they may be too old to have these types of cancers.

### *Cancer Screening*

There is both a **lack of knowledge about cancer screening and a fear of the screening** and possible resultant cancer diagnosis among the community. Individuals may also be more likely to receive common cancer screenings, such as breast and prostate cancer, but may be more reluctant to obtain colon cancer screening. Skin cancer screening also seems to be underperformed.

The group felt that there needs to be **more information among general practitioners about the importance of screening**. There are some who do not prescribe it among adults they consider to be too old for screening.

One barrier for screening is **distrust of the medical community**. This is also a large barrier for research as well. **Wait times** in medical offices are another barrier. Additionally, a barrier for members of the **LGBTQ+ community is worry about if the healthcare facility will be an affirming healthcare location** (will they be gendered correctly, is there access to appropriate restrooms, etc.?)

**Methods for decreasing screening barriers** include any screening tests that can be **conducted at home**, such as the at home colorectal cancer tests. Similarly, a **mobile screening** unit to bring screening to the community can reduce barriers for some populations. However, others, such as those that live in senior housing communities, may not like this option because they don’t want everyone that lives in their building to know when they obtain a screening.

Several suggestions were made for **how to increase awareness of screening**:

- **Working with providers to make sure they recommend screening** to all adults of an appropriate age.
- Outreach can also be conducted at **social clubs**.
- Providing reading material is also a useful tool. *"Provide information to take home that is presented in a certain way and would engage them from the standpoint of saying yes here is the stage of life this pertains to you, and you know, things are not over, in that sense, meaning you're not past the risk of cancer."*

**Personal testimonials are also important:** *"The best message also is testimonial and word of mouth in the faith based community, because they are going to believe testimony of those that have partaken of your services."* It is also important that the people that go into the community to tell them about their screening options are relatable and *"look like the community I'm talking to."*

It was also suggested that when conducting community outreach events, **focus should be on wellness, not sickness or medical issues**. For example, perhaps instead of calling events health fairs, calling them a wellness fair or community day, in order to bring in more people. Using educational tools, such as the inflatable colon, are also great learning options.

### *Health Information Resources*

Participants were asked where they thought members of their community would go for cancer information. Several participants stated that people in the community talk to their **friends and family** for information. This includes individuals such as **adult children that are physicians or cancer survivors that might be a friend or acquaintance** who are willing to have a conversation about their experience.

Common websites that community members utilize are the American Cancer Society and National Cancer Institute's websites. Additionally, NCI-Designated Cancer Centers are useful resources.

### **SIDNEY KIMMEL CANCER CENTER**

Representatives from the following organizations participated in the discussion: African Family Health Organization (AFAHO), American Cancer Society, Bucks County Health Improvement Partnership, Chamber of Commerce for Greater Montgomery County, Chinatown Clinic, For Pete's Sake Foundation, Hepatitis B Foundation, Philadelphia Chamber of Commerce, Philadelphia Corporation for Aging, Philadelphia Department of Public Health, and SEAMAAC.

**Cancer is a concern in the community but not always discussed or acted on:**

- *"I believe there is a concern as there is awareness about it, however, too often people are not doing the wellness preventative steps."*
- *"It is a concern, but I don't hear people talk about it until they or someone they know is diagnosed with cancer."*

**Discussions about cancer include a focus on:**

- **Diagnosis.** *"A lot of what I hear is around people being diagnosed with cancer. From a prevention standpoint, it is common to hear people talk about what habits to avoid that may cause cancer such as smoking." "There is no general discussion about the importance or availability of screenings. Most discussion is around positive diagnoses."*
- **Role of traditional medicine.** *"I hear people say that if you take this medicine, you know, this certain traditional medicine, you will be cured of cancer. So sometimes there are these rumors that go around. Eat this certain food and it'll take your cancer away or keep you from getting cancer."*

**The community does NOT talk about cancer openly, because:**

- **Fear. Cancer is like the death penalty.** *"I think one of the challenges is that people still see cancer as being fatal. It's not seen as a chronic disease where prevention, early screening really can make a difference." "...a lot of fear around a diagnosis, and that cancer means death is kind of how it's simply thought about in the community."*
- **Cultural beliefs such as if it is not talked about, it will not happen:** *"...because in many cultures it's like foretelling, right? You don't want to talk about it because you may make it happen. This was something that came up in the African immigrant communities, and also the Pacific Islander communities, that some things that are too scary, that are related to death particularly, they just don't want to hear."*
- **Stigma also plays a role:** *"I also think that is where some of the misperceptions are. That cancer is hereditary, and that often stigmatizes the families who have cancer diagnoses, which further limits discussion - people often don't want their community to know if they have cancer. I think it can be overwhelming, too - so many different cancers, so many different messages!"*
- **Gender differences** around willingness to talk about cancer, with men seen as being less willing to engage.

### Cultural nuances about cancer include:

- **Fatalism.** *"...because they don't think of screening traditionally as something that they do, and because you know, there's a lot of other cultural issues. Like fatalism, and like other things that fate, why would I bother?"*
- **Taboo.** *"To some Chinese or Asians, there's a taboo, you know? Something's wrong with you when you have cancer. Something you have done. Not necessarily it's a natural cause or something happened."*
- Undocumented immigrants without **health insurance** are concerned about a positive diagnosis and cost of care: *"A lot of our clients are undocumented, and a cancer diagnosis and screenings are often avoided, because if I test positive or if I have a positive screening, it's overwhelming too, like how am I supposed to pay for this? And can I get care? I'm not sure if I'm allowed to get care because I'm undocumented."*
- **Other barriers to screenings:**
  - *"People are resistant to getting screened, because ignorance is bliss, and it's not a problem if I don't know."*
  - *"Many of our clients live in the moment and so they don't think much about prevention. Some are afraid of getting screenings or just don't want to take off work."* (representative of immigrant serving organization)
  - Cervical cancer is an issue for women in some communities (for example, African immigrant communities) because clients are not comfortable with pelvic exams.

### Many are aware of cancer, but there are varying degrees of knowledge, especially related to different types of cancer, and the knowledge is not always accurate:

- **Greater awareness of breast cancer, especially among women, and some awareness of lung, cervical, colon, and liver cancer.** But not much knowledge of other forms of cancer. *"In the African immigrant community, people are mainly aware of breast, cervical, and liver cancer. But some steps are being taken to raise awareness around other kind of cancers as well through our health programs."*
- **Greater awareness of breast cancer screening**, but less information on lung cancer screening or prostate cancer screening. *"Lung cancer screening and eligibility needs to be made more clear, especially with the high death rates seen nationally (not sure what it looks like locally)."*

- **Prevention:** *"I think is greater awareness that cancer kind of runs in the family. ...There's really very little information around prevention, what you can do to minimize your risk."*
- **Accuracy:**
  - *"I also think there is a difference between awareness and knowledge. Many are aware, but the knowledge is not always accurate - there are many misperceptions."*
  - *"In the local focus groups we have done in the AA and AI communities, they mention breast, lung, colon cancer. In the Chinese communities, they also are aware of liver cancer (many know someone who has had liver cancer), but there are many misperceptions about it. In the AI communities locally, we have heard that people confuse liver cancer with cirrhosis and hepatitis."*

### When it comes to cancer, the messenger matters:

- **Trusted messengers** include:
  - Community-based organizations: *"So we have found that we are the trusted party, also because we can accommodate languages and people who are not literate and just from a practical standpoint. We're able to communicate and reach people. And so it feels like a lot of the burden has fallen on community organizations for this kind of general public health messaging. Which, to a point, makes sense. And if we have a relationship with people, then that's fine."* *"With regard to our clients, they come first to their cultural health navigator because of their trust, then we send them to health centers."*
  - American Cancer Society website: *"When my family members were diagnosed we utilized ACS resources"*
  - *"Community and religious leaders. A lot of the time, the messenger is more important than the message."*
- **Places where people are thinking about their health** would be a good promotion site, such as health clinics. *"But so many of my clients that go to the health center, and you know, I don't, I'm not familiar really what kind of care they would get at a health center. Are they getting information in their own languages about screenings? ...just places where they're thinking about their health would be a good place."* *"Our patients at the clinic would most likely come to our physicians at the clinic to get the information."*

## Messages about Cancer

- Make sure information is offered in **languages that communities speak**.
- **Change the narrative of cancer as a chronic disease.** *"It's not seen as a chronic disease where prevention, early screening really can make a difference. So I think once we do a better job changing that narrative, you'll have more people being proactive..."*
- **Focus on preventative care** including healthy lifestyles to minimize the risk of cancer: *"Another area of messaging that gets neglected is like preventative care. ...the conversation around cancer is really restricted to like what happens when you have a diagnosis, and when you're already sick. ...connecting diet, nutrition, exercise, regular screenings, dental care. You know, these little day-to-day choices, there's not really a clear line drawn between those decisions and avoiding a cancer diagnosis."*
- **Marketing that explains how to prevent or live with cancer:** *"...there's so much messaging from pharmaceutical companies about the medications that treat all these different forms of cancer, which then plays into this society factor of fear, where there isn't the PSA's explaining about how do you prevent it or how do you live with cancer... So if we could flip the communication or marketing trend to be more educational, PSA format...why can't we do that for cancers, you know? Make it trendy and make it stick with people. That lasts a long time."*
- **Imagining the impact of cancer:** *"In the past whenever I did some workshops on screenings, I noticed that I had a better effect when I focused on people imagining what would happen to their lives if they did get cancer."*
- **Engage men around screening:** *"...agree that men's engagement around managing personal health seems to lag behind women's engagement. More dialogue and comfort discussing prostate cancer would be welcome."*
- **Consider the context** of people's lives: *"It is also important to consider how the messaging of prevention in ways that are reaching the audience if they are too busy working and making ends meet day to day."*
- It is also important to include information on the **availability of treatment and resources**.

## Suggestions for Cancer Screening

- Addressing lack of time and transportation as barriers through **flexible hours and increased accessibility**:
  - *"(Senior) caregivers who are caring for someone who may be homebound or have some difficulties at home oftentimes don't have the time to get these screenings. So, maybe find flexible timing and outreach efforts that these caregivers can take some time to get these screenings that would be helpful."*
  - *"People's time is a barrier. Making it easier to get screened. Offering screening where people frequently visit, such as community organizations and at work."*
  - *"Continue to partner with specific communities, bring the screening to where the people are presently: businesses/companies, churches, schools, etc."*
- An example of a successful intervention is the **screening bus:** "
  - *We loved the screening bus. We loved it. It was a huge hit. It was great, because it was coming to where the community was. People know where our office is, they feel comfortable here. Our case managers were able to vouch for the bus, and we were there in person to explain everything. It was convenient and really efficient and effective. We loved, loved, loved the bus. More busses, please."*
  - *"We have the bus come to the Wyss Wellness Center and that is great!"*
- **Providing support at every step:**
  - *"...if you look at the whole picture, there are challenges at every step, right? Individual, personal, systemic. I think bringing the screenings to where people are is really important, and knowing that your community may have access issues, transportation issues, issues with, you know, flexible work hours. I also think linkage to care is something that I think people are concerned that they're going to be diagnosed with something that they won't be able to follow up on."*
  - *"Most of our people are undocumented...they would need assurance to get the appropriate and free cost treatment after diagnosis."*

# DISABILITY

According to the [Centers for Disease Control and Prevention](#), “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.”

One in four adults (61 million) in the U.S. live with some type of disability. In 2019, approximately 13 percent of residents of the five-county southeastern Pennsylvania (SEPA) region were living with a disability. People with disabilities have a wide range of diverse needs that may require particular forms of health and social support, but understanding of their population-level needs is limited due to underrepresentation in population-based surveys or qualitative studies and a lack of targeted data collection efforts.

## Survey Development & Administration

A survey was developed to assess the health needs of people living with disabilities in the SEPA region (see online Appendix). The questions were adapted from a survey developed by Magee Rehabilitation Hospital for their 2019 community health needs assessment. The questions addressed respondents’ disability, general health status, health care access, health behaviors, non-medical needs, employment status, use of technology and assistive devices, community participation and resource needs, and demographic characteristics. A committee composed of representatives from Bryn Mawr Rehab Hospital, Good Shepherd Penn Partners, Magee Rehabilitation Hospital, MossRehab, and St. Mary Rehabilitation Hospital reviewed and approved the final survey.

The survey was fielded as an online survey October – November 2021. The link to the survey was distributed to a list of contacts generated by committee members, which included partner organizations, community programs, and support groups across the region. Committee members also sent links to their own networks of current and former patients. All who completed the survey and provided an email address were entered in a gift card drawing.

Frequency analysis was conducted on 341 unique submissions. Where appropriate, free response items were coded for key themes by the project team. Frequencies for multiple choice and coded free response items are reported below. For items that were “check all that apply,” percentages may add up to greater than 100 percent.

## Survey Results

### Respondent Characteristics

The table below 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.

		N	%
<b>Gender</b>	Female	163	47.8
	Male	173	50.7
	Other	3	0.9
	Blank	2	0.6
<b>Age</b>	<18	1	0.3
	18-39	33	9.7
	40-59	111	32.6
	60-70	102	29.9
	>70	92	27.0
	Blank	2	0.6
<b>Race</b>	American-Indian/Alaskan Native	3	0.9
	Asian	8	2.3
	Black/African-American	66	19.4
	Native Hawaiian/Pacific Islander	0	0
	White	256	75.1
	Some other race	4	1.2
	Blank	8	2.3
<b>Ethnicity</b>	Hispanic, Latinx, or of Spanish origin	9	2.6
	Not of Hispanic, Latinx, or of Spanish origin	324	95.0
	Blank	8	2.3
<b>Education</b>	Less than high school degree	7	2.1
	High school degree or equivalent	56	16.4
	Some college	57	16.7
	Associate degree	31	9.1
	Bachelor degree	77	22.6
	Graduate degree	111	32.6
	Blank	2	0.6

### *Additionally:*

- Over half of respondents reported being **married or living with a partner**.
- Almost half of the sample are **retired (48%), 29 percent are not currently working, and 11 percent are working full-time**. For those not currently working, the most frequently cited barriers included physical or functional limitations, potential loss of benefits, and needing support on the job.
- **About 77 percent are residents of the five-county SEPA region (Bucks: 11%, Chester: 5%, Delaware: 7%, Montgomery: 12%, Philadelphia: 41%)**, with an additional 2 percent from other parts of Pennsylvania. The remainder are largely from New Jersey, New York, Delaware, and Maryland.

### *Disabilities and Limitations*

- Most respondents **(79%) reported their disability as permanent**.
- While **78 percent described their disability or limitation as physical**, 30 percent described it as cognitive and 27 percent as characterized by chronic pain.
- Approximately half of respondents **(49%) reported having their disability or condition for over five years**.
- A large majority **(78%) indicated that their mobility is impacted** by their condition. **Forty-one percent reported impacts on self-care** and 32 percent on remembering and/or concentrating.
- Of those respondents who indicated that they **require personal assistance for life activities (57% of the total sample)**, 67 percent indicated that unpaid family and friends provide this care.
- **22 percent 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:
  - **46 percent of respondents reported falling** within the past 12 months.
  - **42 percent had been diagnosed with high blood pressure or hypertension**.
  - **25 percent reported being diagnosed with a mental health condition**. Of these respondents, 70 percent indicated that they are currently receiving treatment for it.
- **A majority of the sample reported good (41%) or very good health (22%)**. An additional 26 percent 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 (82%) and dental care (43%)**. Roughly one-third of respondents reported using emergency care (36%) and nearly a quarter used psychological and/or counseling services (21%).
- Of the 30 percent 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: **concern about COVID-19 exposure at the health care setting, inability to get an appointment, and inability to find a provider who understood their condition**.
- A large majority **(81%) reported that they have used telehealth services** in the past 12 months, and a majority of these respondents found **services beneficial (74%)**.
  - 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**.

## Disability-Related Resources

- **24 percent of respondents reported needing special equipment or assistive device(s)**, 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 (11%)
  - Ramp for their home (11%)
  - Railings, bars, or other non-mechanized assists (9%)
  - Motorized wheelchair, cart, or scooter (8%).
- About a third (**29%**) reported that they currently participate in **support groups**, with an additional 21 percent 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:
  - Complementary therapy (33%)
  - Adaptive sports programs (22%)
  - Support for caregivers (relief support or respite) (22%)
  - Transportation support (21%)
  - Peer mentors (19%).

## Non-Medical Needs

- With respect to housing, the biggest challenges were related to home access and safety:
  - **About a quarter of respondents (26%) with a physical disability indicated that they cannot enter or leave their home without assistance from someone else.**
  - **One in five 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.
- **Fourteen 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.

- **A small, but consistent, subset of the sample expressed significant financial needs:**
  - Eleven percent reported that there was a time in the last 12 months when they were **not able to pay mortgage, rent, or utility bills.**
  - Approximately 12 percent **experienced food insecurity.**
  - Eleven percent needed the **services of an attorney but were not being able to afford one.** Most common legal needs pertained to planning documents (e.g., will, power of attorney), public benefits (e.g., SSI/SSDI), and domestic relations (e.g., divorce, custody).

## Lifestyle

- While 36 percent of respondents shared that they exercise at least 30 minutes three or more days per week, **27 percent indicated that they never participate in such activity.** Most frequent barriers to physical activity were: lack of knowledge of exercises appropriate for their condition, lack of interest, and not having the physical capability to participate in exercise.
- **A majority of respondents (71%) reported eating at least one serving of fruits and vegetables in a typical day.**
- **Substance use was not prevalent in the sample:** 93 percent indicated that they do not currently use tobacco, and 87 percent stated that they do not feel that drug or 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.**

# IMMIGRANT, REFUGEE, AND HERITAGE COMMUNITIES

The five-county southeastern Pennsylvania (SEPA) region is home to a diverse mix of communities representing a wide range of racial and ethnic backgrounds. These communities consist of foreign-born immigrants and refugees, as well as those native-born to the U.S. with cultural and heritage ties to diasporic communities.

A critical point to underscore about such communities is their heterogeneity in terms of demographic makeup, experiences, and needs. Not only is this section premised on the understanding that no community is a monolith, there is recognition that, under the scope of the current assessment, the ability to fully represent the breadth of the diversity in the region is limited. Insights from primary and secondary data presented in this section therefore seek to illuminate experiences of a subset of communities in the region. Inclusion is based on availability of recent local data for these communities. In addition to using publicly available secondary information on specific communities, support and funding were provided to organizations across the region with both the interest and capacity to collect primary data about health needs from the communities they serve or share relevant secondary data. Data collected from surveys, focus groups, and case management intake records are presented below.

## Background

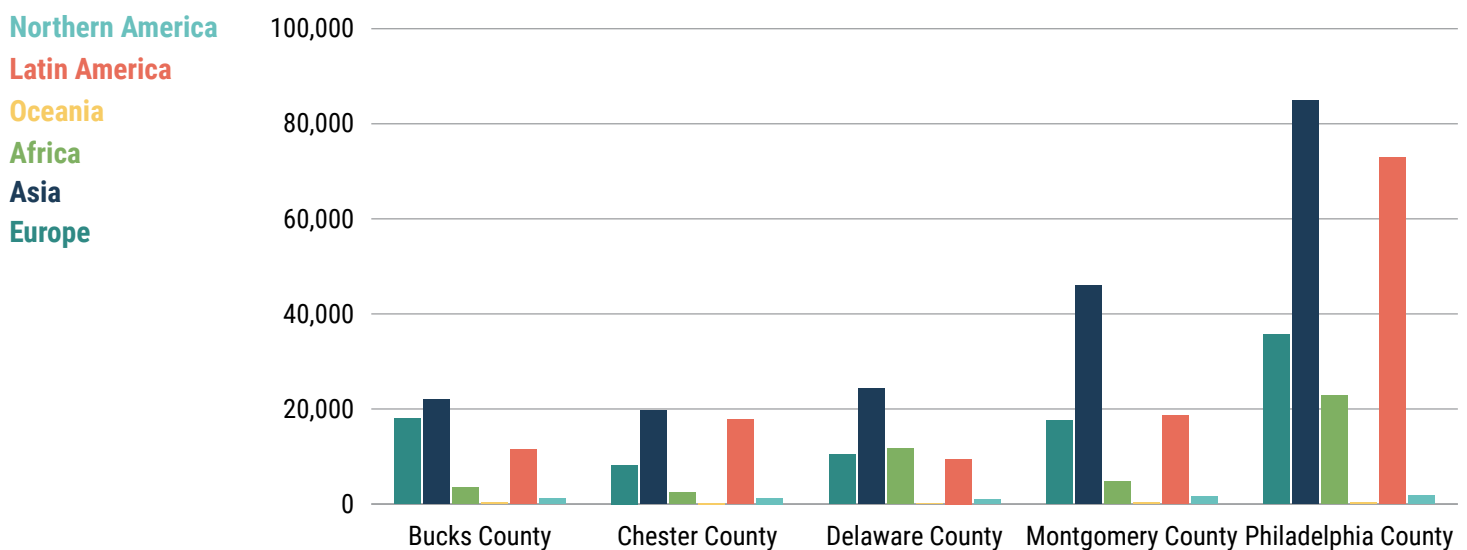
According to 2019 data, approximately 12 percent of residents in the region are foreign-born, with county-level estimates as below:

### Foreign-Born Residents

Bucks	Chester	Delaware	Montgomery	Philadelphia
<b>9.7%</b>	<b>9.8%</b>	<b>10.3%</b>	<b>10.7%</b>	<b>14.1%</b>

As shown in the graph below, based on 2018 5-year estimates, places of birth for foreign-born residents varied across SEPA five counties. Those born in Asian or Latin American countries made up a significant share of the foreign-born population in each of the five counties. Also of note is the large share of foreign-born residents in Bucks County hailing from European countries, as well as those born in African countries in Delaware County.

## Foreign-Born Population Place of Birth by Country, 2018

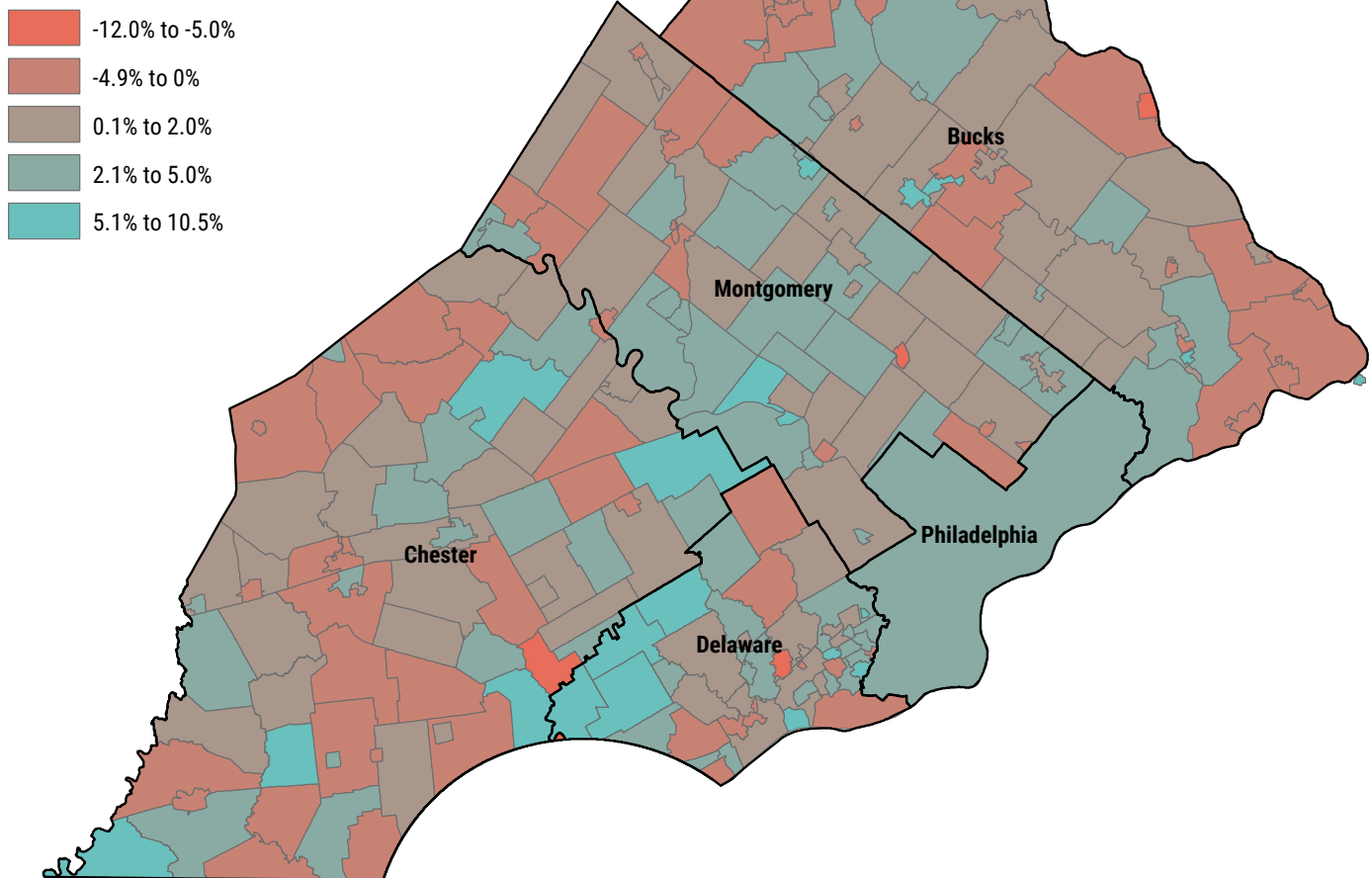


Source: ACS 5-Year Estimates (2014-2018)

During that same period, municipalities with the greatest number of foreign-born residents were Philadelphia (218,489 or 13.9% of the population), Upper Darby Township in Delaware County (16,988 or 20.5% of the population), and Bensalem Township in Bucks County (11,454 or 19.0% of the population). The map below, adapted from [this report](#) developed by the Delaware Valley Regional Planning Commission, illustrates the changes in foreign-born share of the population by municipality between 2010 and 2018.

Relative to the native population in SEPA counties, foreign-born residents were more likely to have a higher median age, lower rates of homeownership, and bifurcation in educational attainment (i.e., higher rates of those with less than a high school education, as well as those with graduate degrees). Foreign-born residents were more likely to be self-employed and overrepresented in industries such as Services, Natural Resources/Construction/Maintenance, and Production/Transportation/Material Moving.

### Change in Foreign-Born Share of Population, 2010-2018



Source: U.S. Census ACS 5-year Estimates (2006–2010, 2014–2018)

## General Health Needs

The rCHNA qualitative data collection (see summaries of community conversations, spotlight discussions, and data collected for focus areas and communities) revealed consistent themes of barriers to health faced by local immigrant and refugee communities. These include:

### Language and cultural barriers.

Many foreign-born residents are English language learners (ELL) with varying levels of English proficiency. Discussion participants raised the need for language services encompassing qualified interpreters and widely available translated materials to ensure equitable access to health care and other services for ELL. This need is particularly acute for certain types of health care (for example, treatment for mental health conditions), where having high quality interpretation or a language concordant provider is critical for optimal effectiveness. The need for providers and health care systems to provide culturally responsive care that takes into account cultural norms and is grounded in cultural humility was underscored, as was the value of community members seeing and working with providers who “look like them.”

### Anxiety and safety concerns

- The political and societal climate of the past several years have contributed to an atmosphere of anxiety and fear among some communities, particularly among those who fear deportation and family separation, that adversely affects health. For example, the recent discourse on public charge deterred many, including those who were eligible, from applying for public benefits or programs that provide necessities, such as health care and food, due to fears that the application process will divulge information to federal immigration officials about who they are and where they are living. (A recent [survey](#) conducted by the Pennsylvania Immigrant and Citizenship Coalition found that these fears were shared by youth, with two-thirds of respondents expressing that they do not feel safe in school and a third sharing specific concerns related to U.S. Immigration and Customs Enforcement presence in schools.)
- Anti-Asian violence during the pandemic has led to fear among Asian elders that prevent them from leaving their homes, resulting in social isolation and delayed access to care and other services or resources that support health. This exacerbates issues arising from the need to manage multiple chronic conditions, low health literacy, and difficulties navigating complex health care systems.

### Impacts of the COVID-19 pandemic on economic stability.

Diverse immigrant communities were disproportionately affected by stay-at-home orders that shut down businesses and resulted in widespread job losses for the large proportion of immigrants working in retail, service, and hospitality industries. The financial hardships and economic instability have hit these communities hard, leading to increased rates of food insecurity, housing instability, anxiety, and depression.

## Refugee Communities

Though not specifically discussed during the qualitative data collection, it is important to note the specific needs of refugees, especially in light of recent world events that have led to the arrival of Afghan and Ukrainian refugees to the region. While data specific to these communities have yet to be fully available, those seeking asylum often arrive with significant medical conditions including injuries from war, infectious diseases, and unmanaged chronic health conditions. Refugees also experience emotional trauma resulting from war, displacement, and loss of loved ones, and are frequently diagnosed with posttraumatic stress disorder (PTSD) and other mental health conditions.

Data from January 2020 to December 2021 collected by [Nationalities Service Center](#) (NSC) provide a snapshot of recent arrivals to the region. As one of three refugee resettlement agencies in the area, NSC case managers conduct an intake needs assessment for any client enrolling in programs such as medical case management; legal support; services for survivors of human trafficking, torture, domestic violence and other crimes; and employment readiness assistance.

Among the 446 clients interviewed for intake, 51.1 percent were male, 48.0 percent female, and 0.9 percent endorsed other gender identities. The median age was 35 years, with the largest share of the group (64.1%) ages 25 to 44 years. Clients' countries of origin were diverse, with particularly significant representation of African and South Asian countries.

### Countries, Nations and Territories

(most frequent in **bold**)

Count Percent

Methodology Note: Data capture of clients' country, nation, and/or territory of origin was retrieved from client immigration documentation, or via client self report.

<b>Africa</b>	116	26.0%
29 Countries, Nations and Territories: <i>Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo (Democratic Republic of), <b>Congo (Republic of the), Cote d'Ivoire, Egypt, Equatorial Guinea, Eritrea, Ghana, Guinea, Kenya, Liberia, Mali, Mauritania, Morocco, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, <b>Sudan</b>, Togo, Uganda, Zimbabwe</b></i>		
<b>South Asia</b>	78	17.5%
3 Countries, Nations and Territories: <i>Bangladesh, India, <b>Pakistan</b></i>		
<b>Central America</b>	57	12.8%
5 Countries, Nations and Territories: <i>Costa Rica, El Salvador, <b>Guatemala, Honduras, Nicaragua</b></i>		
<b>Middle East</b>	51	11.4%
8 Countries, Nations and Territories: <i><b>Afghanistan, Iran, Iraq, Jordan, Palestine, Syria, Turkey, Yemen</b></i>		
<b>North America</b>	39	8.7%
2 Countries, Nations and Territories: <i><b>Mexico, U.S.</b></i>		
<b>Europe</b>	32	7.2%
4 Countries, Nations and Territories: <i>Czech Republic, Poland, Russia, <b>Ukraine</b></i>		
<b>Caribbean</b>	30	6.7%
6 Countries, Nations and Territories: <i>The Bahamas, Cuba, Dominican Republic, <b>Haiti, Jamaica, Trinidad &amp; Tobago</b></i>		
<b>South America</b>	23	5.2%
9 Countries, Nations and Territories: <i>Argentina, Belize, Brazil, Chile, Colombia, Ecuador, Guyana, Peru, Venezuela</i>		
<b>Southeast Asia</b>	10	2.2%
3 Countries, Nations and Territories: <i>Myanmar (Burma), Malaysia, Thailand</i>		
<b>Asia</b>	7	1.6%
3 Countries, Nations and Territories: <i>China, Kazakhstan, Philippines</i>		
<b>Other or Unknown</b>	3	0.7%
1 Countries, Nations and Territories: <i>Papua New Guinea</i>		

Clients' health-related needs were assessed in the following domains:

- **Food access.** 23.5 percent expressed either not having enough food for the week or being unsure. Regardless of this response, a large majority (72.0%) indicated using multiple sources to obtain the food they ate, including some form of assistance. This assistance was most frequently in the form of SNAP/ food stamps, friends or family members, or food banks or other resources.
- **Health conditions.** Slightly over a third (34.8%) of clients had an urgent medical condition.
- **Health care access.** Half of clients did not have health insurance (with half of those due to not being currently eligible), and 43.7 percent did not have a regular doctor or clinic they visited. A third expressed needing help with accessing dental care and 21.5 percent help with accessing vision care.

Based on feedback gathered on health education materials, NSC also identified needs for information about how to access language interpretation services, dental care, and Medicaid among their client population.

### African and Caribbean Communities

As indicated by data in the overview and refugee discussions in this section, African and Caribbean communities are a large and growing segment of the immigrant population in the region. This is consistent with a larger [national trend](#) of immigrants from African and Caribbean nations comprising a larger share of the Black population in the U.S., as the current population of 4.6 million Black immigrants is projected to double to 9.5 million by 2060. One in five Black people in the U.S. are either immigrants or children of immigrants. Between 2010 and 2019, Philadelphia saw a 121 percent increase in the Black immigrant population.

Despite this growth, there is a relative dearth of targeted data collection efforts about these communities in the region. Examining the NSC dataset with a focus only on those clients from African or Caribbean countries of origin (N = 146), there are some indications of higher need relative to other populations served by NSC:

- Nearly 38 percent of clients were either not sure or did not have enough food for the week.
- Approximately 40 percent had an urgent medical condition.

Health care access needs for this group were comparable to the full dataset with all clients.

A [recent survey](#) of COVID-19-related needs among African and Caribbean communities conducted by the [Coalition of African and Caribbean Communities](#) (AFRICOM) identified top needs among respondents as employment, housing, food, and access to the internet. Suggestions for resources to help with these needs included cash assistance, as well as assistance with employment, community resource navigation, supports for youth learning, immigration and legal needs, housing and utility needs, health care and insurance, and food and clothing.

In addition to AFRICOM, nonprofit organizations like [African Cultural Alliance of North America](#) (ACANA), [African Family Health Organization](#) (AFAHO), and [Multicultural Community Family Services](#), play a critical role in supporting these communities. Recognizing this role, the Office of Immigrant Affairs and the Mayor’s Commission on African and Caribbean Immigrant Affairs in Philadelphia conducted an [assessment](#) of these nonprofits to better understand their capabilities and needs, as well as identify potential areas of support. Of the 24 organizations who participated in the survey, over half have operating budgets of \$20,000 or less. Consistent with that, high priority areas for support involved assisting with fundraising/development and revenue generation and access to systems of support and capacity-building. This suggests opportunities for local government and health care organizations to ensure the continued growth and financial health of largely grassroots organizations providing essential services to underserved communities.

## Asian Communities

Asians represented 6.5 percent of the population in the five-county SEPA region in 2019, with highest concentrations in Philadelphia and Montgomery Counties. As shown above, Asian immigrants account for a large proportion of the foreign-born population in both of these counties. Similar to African and Caribbean immigrant communities, there is limited up-to-date information about the health needs of Asian communities in the region owing to a lack of recent, specific, and systematic data collection efforts. The information presented below draw upon data collected and provided by organizations serving Asian communities in Montgomery and Philadelphia Counties.

The Asian American Coalition for Health and Human Services (AAC) in Montgomery County reflects the diversity of Asian communities in Montgomery and Bucks Counties, with representation from Bangladeshi American, Chinese American, Filipino American, Indian American, Korean American, Nepalese American, Taiwanese American, and Vietnamese American communities. With leadership from the [Philip Jaisohn Memorial Foundation](#) (Jaisohn Center), much of the recent efforts of the AAC have been focused on COVID-19 response, significantly increasing COVID-19 vaccination rates among the communities served by member organizations.

In December 2021, HCIF conducted a 90-minute focus group discussion with 12 members of the AAC to learn about community assets and needs related to health. Questions were adapted from discussion guides developed for other rCHNA qualitative data collection. Key insights from this discussion are described below.

### • Community assets

- Across all communities, **social connections** between community members was cited as a source of strength, enabling support for members who may not know each other. For elders in these communities, connections through communities like apartment complexes facilitate sharing of information about resources and events by **word of mouth**. Large church networks providing social service support, availability of daycare for elders, and communication tools like KakaoTalk and WeChat were also raised. **Support within families**, particularly intergenerational family support, was noted as a particularly important form of social connection. One participant raised the downsides of reliance on family support for things like health care access, as waiting for the availability of adult children to accompany elders to healthcare appointments can delay care.
- The value placed on **preventive care and health awareness**—with a focus on harmony between healthy eating, exercise, and medicine—was shared as a particular source of strength for some communities.
- Past successful community engagement efforts around health for Asian American communities across the Delaware Valley (for example, with the American Cancer Society) underscore the importance of **engaging health leaders from Asian communities** (e.g., doctors, priests) who can provide health information in different languages.

## • Challenges and barriers to health

- **Mental health and substance use issues** were a prevailing concern among AAC members. Stigma associated with mental health conditions, drug use, and suicide prevents communities from talking about it. The lack of culturally sensitive resources and facilities, as well as mental health care providers who speak community members' languages, pose barriers for seeking treatment for these issues. One participant noted that a belief that prayer can solve mental health issues in strong Christian communities can also be a challenge to seeking care, suggesting a need for particular outreach to spiritual leaders in communities.
- **Language barriers** were top of mind for all communities, with several citing limitations around interpretation due to a lack of face-to-face interpreters. These barriers were noted as being particularly problematic for elders.
- Several members raised the impact of **attitudes towards health and health care** on seeking care. Some communities may perceive no need to seek preventive care if they do not feel ill, especially if they distrust the health care system or feel shame for seeking help. Some may avoid talking about health conditions within the family, leading to family members not having a complete understanding of their family history. Other communities shared the “tunnel vision” that exist among members that prevent them from paying much attention to health, telling themselves to work “work through it.”
- Challenges **accessing specialists**, especially those who are language concordant and not an hour's drive away, were also shared.
- For smaller communities, it can be difficult to get attention and health resources directed at them, leading to a **lack of awareness** of what is available for help.

## • Issues specific to youth

- Concerns about the **mental health** of teens were prevalent, especially in light of the COVID-19 pandemic impacts on being able to interact with others and build friendships with peers. The need for therapy in schools, as well as therapy provided by bilingual or Asian therapists who understand teens' cultural contexts and barriers, was noted.
- Several AAC members discussed the **generation gap** between youth and parents. The lack of communication between parents and children, especially around issues like relationships, drugs, alcohol, and sex, may lead to parents not being aware of issues their children may be experiencing until they become serious or reach a stage of crisis.
- **Identity issues** for Asian American youth were also raised, which were connected to academic pressure and high parental expectations, as well as racism and threat of anti-Asian hate crimes.

## • Issues specific to elders

- Challenges with **technology and internet access** were noted among elders, posing barriers to telehealth. To address this, some noted successful models of intergenerational teaching to increase digital literacy among older adults.
- Issues with **depression and anxiety** among elders arising from lack of social connection and communication with family members were raised. Most “just accept and not deal with it.”
- Navigating **aging in place and family dynamics** is complex. Elders prefer to live with family, but adult children may find it difficult to care for parents as they age and have more serious needs. These children need respite, but it may be difficult to get an adult sitter to provide support. Elders, for their part, are afraid to be a burden on family members, leading them to try to be as independent as possible and therefore not asking for help when they need it.
- Other issues discussed were **lack of transportation and worsened physical conditions** due to delayed care.

## • Ideas for potential solutions

- Seminars with psychologists to talk to parents and kids about mental health
- Youth center to give youth an outlet where they can feel they belong and build their self-confidence
- Directory of health care providers by ethnic community
- Engaging ambassadors within communities to share their stories of resources and benefits—as one member put it, “we trust our own people.”
- Immigrant groups with longer histories in the community sharing information with and supporting newer immigrant communities

Themes related to mental health noted in by AAC member are corroborated by a recent survey conducted by the [Philadelphia Chinatown Development Corporation](#) (PCDC), as part of the [Chinese Immigrant Families Wellness Initiative](#) (CIFWI). The [2020 Wellness Leadership Program Impact Report](#) summarizes survey findings (N = 78), reporting that 46 percent of youth respondents (aged 15 to 23) and 100 percent of parent respondents indicated COVID-19 had an impact on their mental health. The most common adverse experiences among youth were family pressure, racism, poverty, and sexual abuse, while parents identified family pressure, death, unemployment, and illness. The Wellness Leadership Program, one component of CIFWI’s strategies to promote mental health wellness, seeks to “raise mental health awareness, develop leadership skills, and promote healthy communication with family” among high school and college students. The 3-month program led to positive effects among the 2020 cohort of youth participants, including lowered anxiety and increased self-compassion and functional health.

One major source of stress and anxiety for Asian communities are increased incidents of anti-Asian hate during the pandemic. PCDC collected data from 315 respondents in March 2021 to explore this further. According to PCDC’s [Anti-Asian Racism Incident Survey Report](#), one in seven had personally experienced an anti-Asian racism incident, with 39 percent of the incidents taking place in public settings. The most common form of incident was racial slurs/name calling (63%), followed by physical intimidation (34%). Over three quarters of respondents did not report the incident to police or any agency due to language barriers and distrust. Such findings bear further widespread and systematic examination to better understand and respond to the ongoing implications of such racial trauma on mental health for local Asian communities.

The health needs of Southeast Asian immigrant and refugee communities in Philadelphia, as revealed by data provided by [SEAMAAC](#), share commonalities with findings already discussed. SEAMAAC has served South Philadelphia communities for nearly 40 years, supporting as many as 18 distinct linguistic communities with a wide array of programming, including education programs for youth, health and social services, and community development initiatives. During the COVID-19 pandemic, SEAMAAC expanded its programming to encompass robust hunger relief efforts.

The following sources of data collected by SEAMAAC were reviewed and analyzed for this report:

- 1. Focus groups** conducted with Cambodian, Chinese, Burmese, Bhutanese, Laotian, and Vietnamese client groups in 2019 to discuss community health needs to inform the development of services for a new health center.
  - 2. Philadelphia Immigrant and Refugee Experiences (PIRE) survey** of clients (N = 78), many of whom were completing their initial intake for case management services from September – November 2021.
  - 3. Interviews** with SEAMAAC staff about physical health and social determinants of health conducted in December 2021.
- 1. Across all client focus groups**, the following were expressed as common needs related to health and therefore important features for the new health center:
    - Providing language services, particularly on-site interpreters
    - Ensuring health care is affordable
    - Minimizing wait times
    - Addressing transportation barriers
    - Providing easily understood health education material in diverse languages
    - Ensuring that staff are welcoming and respectful
    - Providing a wide array of services (including specialties) at one site
    - Offering mental health treatment and education
    - Facilitating the passing down of cultural norms such as respect for elders to youth

## 2. Survey results include:

- A majority of respondents are female (65.4%) and residents of South Philadelphia (84.6%), with a median age of 47 years. Those identifying as Indonesian, Chinese, or Burmese made up over 65 percent of the respondents.
- A large majority express difficulties with speaking, reading, and writing in English.
- Nearly 60 percent are renters, with about half able to pay rent each month (20.5 percent indicated that they do not pay, perhaps reflecting older adults living with family members). Similar patterns were seen with paying for utilities.
- When paying for required expenses, 19.2 percent express needing help from a government agency or other agency/organization, with an additional 9.0 percent indicating that they do not have enough money and do not have anyone who can help and a further 3.8 percent receiving help from family or friends.
- Approximately 30 percent report feeling unsafe sometimes or all or most of the time in their neighborhoods.
- Nearly half are in poor (15.4%) or fair (26.9%) health.
- A majority are able to do the following themselves or with the help of an adult family member:
  - Make a medical appointment
  - Seek emergency care
  - Use transportation to complete everyday tasks
  - Attend regular and new appointments
- Of the 55 respondents who shared what they were most worried about (responses were coded into categories; since respondents provided multiple answers, percentages add up to more than 100%), most common concerns were related to:
  - Their health (45.5%)
  - Finances (41.8%)
  - COVID-19 pandemic (20.0%)
  - Their family (18.2%)
  - Lack of employment (18.2%)
  - Immigration status (10.9%)
  - Housing (9.1%)

- Of the 47 respondents who shared what they are proud of accomplishing in the U.S., the most frequently cited were:
  - Raising their children, providing them an education, and feeling pride in their accomplishments (36.2%)
  - Being employed (14.9%)
  - Making a life for themselves in the U.S. (10.6%)

## 3. Staff interviews revealed themes common to other data collection efforts described above:

### • Behavioral health

- Across the Southeast Asian communities that SEAMAAC staff support, behavioral/mental health is not considered to be a part of health; health is considered to be purely physical. Many clients express that their intake conversation is the first time anyone has asked about their mental health.
- Mentioning behavioral/mental health is extremely taboo, and stigma can make it offensive to ask about mental health. The closest thing that clients will acknowledge is stress, which is seen as normal, not a big deal, and something that can be overcome.
- The connection between behavioral health issues like addiction and physical health is not often understood. Addiction is sometimes understood related to drugs, not gambling or drinking.

### • Priority health needs

- Chronic diseases such as diabetes, hypertension, high cholesterol, heart disease
- Health care access and affordability, medication management, health literacy
- Addiction (gambling and/or drinking)
- Elder care

### • Priority social needs

- Poverty and its cascading effects such as food and housing insecurity, which contribute to health problems
- Lack of transportation contributes to loneliness, especially for elders who may be unable to socialize with others other than their family members
- Depression and loneliness resulting from lack of social contact (e.g., when factory workers whose main source of socializing is through the workplace are unable to work due to illness)

- **Prioritizing of work before health due to lack of safety nets like savings and concerns about job loss**
- **Barriers to addressing health concerns**
  - Lack of language access in healthcare settings, as well as in interactions with landlords and schools
  - Immigration status
  - Lack of transportation and accompaniment
  - Long wait times at health clinics
  - Complexities around accepting public benefits, immigration status, and employment
  - Trauma, which affects ability to plan and prioritize needs
  - Internalized feelings of being undeserving of assistance
  - Discrimination based on language, race, or ethnicity
  - Lack of education for clients about navigating systems AND lack of education for providers around barriers that client face
- **Attitudes and beliefs about preventive care**
  - There is a prevailing lack of urgency around it for many communities, as it is regarded as not necessary or a luxury most are unable to afford.
  - Strategies to increase willingness to seek preventive care include framing in terms of potential negative future financial impacts and impacts on loved ones.
- **Impacts of COVID-19**
  - Widespread loss of family and friends, especially in the first 6 months of the pandemic. Cambodian and Indonesian communities were particularly hard hit.
  - Job loss, ranging from factory jobs to closing down of small businesses; women lost jobs due to daycare and childcare centers closures.
  - Digital divide, compounded with language barriers, made it difficult for parents to help their children with online learning.
  - Disparities in access to federal financial assistance like stimulus checks, resulting in financial hardship that put people's housing at risk.
  - Early reluctance to seek health care has led to even more delays in health care currently, as clients face long waits for appointments (especially for specialists).
- **Needed resources**
  - Safe, affordable, quality housing
  - Decent paying jobs
  - More access to culturally appropriate foods (e.g., halal food markets)
  - Benefits that can be accessed by undocumented clients (including transportation assistance)
  - Employment/work readiness programs (high school and adult)
  - Workshops addressing topics such as nutrition/healthy diet, tenants' rights and responsibilities, and bills (medical, utility)
  - Time! Healthcare providers do not have or give enough time with clients. Sustained changes require investment in every case and a holistic approach that takes into account social determinants of health, education about resources, and a person-in-environment (PIE) approach.

### Hispanic/Latino Communities

Hispanic/Latino communities made up 8.9 percent of the population across all five SEPA counties according to 2019 estimates. Chester and Philadelphia counties are home to large Hispanic/Latino communities. An analysis [provides a snapshot](#) of Philadelphia's Hispanic/Latino population, which nearly doubled between 2000 and 2018. A large majority hail from Puerto Rico, followed by residents originally from the Dominican Republic, Mexico, and Central America. One in five are foreign-born. Local Hispanic/Latino populations have contended with significant systemic barriers to employment and housing that have contributed to the highest proportion of residents living in poverty (37.3%) than any other racial/ethnic group in the city. This has driven poorer health outcomes, such as higher rates of chronic disease and mental health conditions than other racial demographic groups. Compounding these issues is an array of barriers to health care access, including language barriers, greater likelihood of lacking health insurance coverage than other groups, and higher unemployment rates that contribute to lower incomes and inability to afford health care. Fears related to immigration status and immigration law enforcement have been exacerbated in recent years, posing further barriers to seeking out health care.

These vulnerabilities have translated to communities that have been disproportionately impacted by the COVID-19 pandemic. A recent [data brief](#) catalogues the toll on Philadelphia Hispanic/Latino communities and the factors contributing to the highest age-adjusted rates of COVID-19 incidence, hospitalization, and mortality, and lowest testing rates of racial/ethnic groups in the city. These factors include greater likelihood of being employed in essential occupations, living in overcrowded conditions that are often multigenerational, and lacking a private vehicle (and consequent reliance on public transit or other means that increase the risk of transmission and reduced access to testing and health care services. The digital divide is particularly acute for this group.

The 2019 rCHNA incorporated insights about health needs for Hispanic/Latino communities collected for the assessment, as well as an assessment focused on the [health needs of communities in North Philadelphia](#) conducted in 2018. The current report provides summaries of primary data collection conducted in partnership with organizations serving Hispanic/Latino communities in Montgomery County.

[ACLAMO](#) is an organization based in Montgomery County that “provides educational programs, social services, and access to health and wellness programs to Latinos and other community members to empower them to fully achieve their life potential.” ACLAMO developed a survey to assess the health and well-being of Spanish-speaking communities in Montgomery County, with some focus on the impacts of the COVID-19 pandemic on these communities. HCIF provided assistance with questions and administered funding to support staff time on this project and provide gift cards to respondents. ACLAMO translated the survey into Spanish and conducted the survey with program participants in Lansdale, Norristown, and Pottstown from January – February 2022. The survey was administered as a structured interview with ACLAMO staff asking questions and recording responses. Frequencies for multiple choice and coded free response items are reported below. For items that were “check all that apply,” percentages may add up to greater than 100 percent.

The 126 responses collected were distributed across the three sites as follows:

County	Count	%
Lansdale	26	21%
Norristown	47	37%
Pottstown	53	42%
TOTAL	126	

### Respondent Characteristics

Respondents were primarily female, between the ages of 30 and 49, and Hispanic/Latino/a. A large majority were Central American or Mexican American/Chicano. Most of the sample were married or living with a partner.

		N	%
<b>Gender</b>	Female	115	91%
	Male	8	6%
	Blank	2	2%
<b>Age</b>	20-29	15	12%
	30-39	52	41%
	40-49	42	33%
	≥ 50	17	14%
<b>Race</b>	Hispanic/Latino/a	124	98%
	Indian	1	1%
	White	1	1%
<b>Ethnicity</b>	Central American*	41	33%
	Dominican	5	4%
	Indian	1	1%
	Mexican American/Chicano	58	46%
	Puerto Rican	9	7%
	South American*	9	7%
	Blank	3	2%
<b>Marital Status</b>	Single	24	19%
	Legally married	65	52%
	Living together with a partner	26	21%
	Divorced	5	5%
	Widowed	4	3%
	Blank	2	2%

\* If respondents indicated that they were Central or South American, they were asked to name their home country. Most common responses were Honduras, El Salvador, Guatemala, and Ecuador. Other countries represented with only one or two responses included Colombia, Costa Rica, Nicaragua, Peru, and Venezuela.

### *Household Characteristics*

- Ninety-four percent of respondents indicated that they lived with others. Of those, over half (57%) said they lived with two other adults, while 16 percent lived with one other adult and 15 percent with three other adults.
- A majority of the sample had at least three children under the age of 18 at home: one (12%), two (32%), or three (26%).
- In the household, 98 percent of respondents reported being either a parent or grandparent.
- The language most spoken in households was Spanish (90%).

### *Health Status*

- A majority of the sample reported fair (21%) or good (52%) health.
- In terms of diagnosed physical health conditions, responses were as follows:
  - Diabetes: 17% (with an additional 10% not sure)
  - Asthma: 13% (with an additional 7% not sure)
  - Hypertension: 16% (with an additional 6% not sure)
- Eight percent of respondents shared that they had been diagnosed with a mental health condition. Of those 10 respondents, 60 percent were receiving treatment for that condition.

### *Health Service Use*

- Seventy-seven percent of the sample had used health services in the past 12 months. Those respondents indicated using the following health services (in order of frequency):
  - Primary care: 68%
  - Dental care: 58%
  - Emergency or urgent care: 29%
  - Sexual or reproductive health care: 23%
  - Hospital inpatient care: 12%
  - Psychological counseling: 12%
  - Home health care: 7%

- Thirteen percent of respondents shared that there was a time when they needed medical care in the past 12 months but did not get it. The reasons for not receiving this care by these respondents (n=16) were given as follows:
  - Difficulty scheduling an appointment: 81%
  - Difficulty affording medical care: 75%
  - Difficulty communicating with a provider: 69%
  - Not knowing where to go: 44%

### *Health Status*

- Respondents indicated significant impacts of the COVID-19 pandemic on their lives, including childcare center/school closure (84%), work hour reduction (84%), income reduction (81%), and job loss (51%). Twenty-seven percent reported that a family member had to continue working outside the home as an essential worker, and 13 percent shared that they had to move out of their home.
- When asked about other impacts on their lives and health, respondents provided free responses, which were coded for themes. Of the 54 responses given, the most frequently reported negative impacts were related to:
  - General emotional and mental health: 46%
  - Finances and anxiety related to finances: 37%
  - Physical health: 9%
  - Family and friends: 7%

## Health Barriers

- Survey participants were asked about potential barriers to health they may experience.
  - The biggest barriers to health expressed were related to finances: 46 percent reported being stressed about employment or money, and 41 percent said they could not afford what they needed to be healthy (with an additional 10 percent indicating that they were not sure). Twenty-nine percent shared that they experience racism and/or discrimination.
  - The sample reported having healthy food available near their homes (93%), feeling safe in their neighborhoods (90%), having the transportation needed to get to the doctor (82%), having reliable internet service (80%), and being able to access health care when they need it (79%).
  - When asked about problems not mentioned, 20 responses were gathered. Most frequently mentioned were lack of resources and help (30%), emotional or mental health issues (25%), physical health issues (20%), challenges with family (20%), and changes to life and routines (5%).
- Of the barriers to health presented, the top priorities for respondents (who selected up to four) were related to (in order of frequency of selection):
  - Availability of healthy food near their homes
  - Employment and money concerns
  - Having transportation to go to the doctor
  - Feeling safe in their neighborhoods
  - Having access to health care when they need it
  - Being able to afford what they need to be healthy

## Food Security

- Three questions were asked to assess food security in the last 12 months:
  - Over a quarter of respondents (27%) reported skipping a meal because there was not enough money or resources to get food.
  - Seventeen percent shared that their household had run out of food because of a lack of money or other resources.
  - Five percent indicated that they had gone without eating for a whole day due to lack of money or other resources to get food.
- Sixty-five percent of the sample reported that they had received food from a food pantry or other organization in the past 12 months.

## Family Priorities

Respondents selected up to four community services that were the most important for helping to keep them and their families healthy. In order of frequency, the most important services were:

- Housing or housing case management (e.g., tenant/landlord disputes, eviction)
- Immigration services
- Rental or utilities assistance
- Youth programs (afterschool) or childcare

## Communication

When asked how they get information about health services and issues in their community, respondents selected up to four options. The most commonly selected option by far was one-on-one peer discussion/word of mouth. Other sources (in order of frequency) were:

- Facebook Live
- School or church
- Video or TV programs or commercials
- Pamphlets/brochures
- Billboards/public transportation advertisements

[Centro Cultural Latinos Unidos](#) (CCLU) supports Latino children, youth, and parents in Pottstown with educational, recreational, legal, and health services. CCLU convened a focus group composed of 13 clients and their children in November 2021. CCLU conducted the focus group in Spanish; the discussion was recorded, transcribed, and translated into English for coding and analysis. Key themes from the discussion include:

- **Lack of information or communication** about health resources, including where to go or what to do to stay healthy.
- **Lack of health insurance** prevents people from going to see a doctor or going to a clinic *“without being rejected because we don’t have it.”* This lack of insurance also leads to high medical bills: *“I got sick and I had to pay tons of bills, and now they are sending me more. All because I don’t have health insurance. They said, ‘But, you don’t have insurance?’, and they said, ‘Unfortunately, you have to pay. You can pay cash, or you can use your credit card.’ It was harder because I was scared, because I didn’t have that amount...”*
- Other barriers to health care access include **difficulty getting access to a physician, transportation barriers, and long waits for care** (*“over an hour, even if the pain is killing you”*), which can be due to a variety of causes: *“Well, you need to get a translator, they need to check you have health insurance, what’s covered by the insurance... it’s a long wait. And one is ill.”*
- Others elaborated on issues with **language access**, including lack of interpreters. In some cases, children are asked to interpret: *“For example, when my son took ill, it was 1 a.m. I explained his symptoms to his doctors, and they said, ‘I didn’t understand you; we are going to refer you to X, it’s the only place with Spanish speakers. I can’t understand what you say.’ They were upset at me.... They would tell my son, who was in pain, ‘You need to translate what your mother said.’ I was angry. How could he translate when the pain was killing him?”*
- **Inequitable treatment:** *“When we go to the hospital, they don’t treat us as they should.” “They make you wait. If you don’t speak English, they don’t treat you, or they treat you in the hall, while standing.”*

- **Impacts of the COVID-19 pandemic** were felt by adults and youth alike.
  - A participant shared that illness prevented her from working and consequently she didn’t have the money to pay rent, while a youth participant expressed her fear that missing so much school due to illness would mean that she would not be able to pass the eighth grade.
  - Others shared challenges with **access to vaccines:** *“Yes, for the vaccines, you had to wait a while, and they didn’t have many Spanish-speakers for the appointments. They made you phone a line, there, they referred you to another line, and no one could really tell you the time and day of your appointment. So, that took a long time. Then, when you had to go back for a check-up, there was no one there to provide the proper assistance. They didn’t do their job.”*
  - Referencing a clinic that was set up to facilitate vaccine access, one participant shared, *“It helped, but there’s more information needed on the status of the vaccination process, where they need to go, if it’s appropriate or not.”* The need for more accessible, reliable sources of information was widely endorsed: *“Something that would make us feel safer would be having more information. Maybe a fixed hotline we could call to get reliable information.”*
- Potential solutions include **offering affordable transportation to care, “pro bono” doctors** (those who can treat people without asking for their medical insurance, their social security information: *“They shouldn’t ask where you come from, if you have insurance or not. They just should accept you.”*), and doctors (including specialists) and doctors who are Hispanic or speak Spanish.

# YOUTH VOICE

Children and youth represent a population with diverse health needs and unique vulnerabilities that require urgent attention in order to prevent lifelong negative repercussions and maximize the potential for growth and thriving.

Unfortunately, the barriers to well-being for all children and youth in the region are significant, as many families across the five counties [struggle with economic stability to support their children](#), and racial and ethnic inequities related to [education](#) and [health outcomes](#) persist. The negative impacts of the COVID-19 pandemic and response on youth learning and development and a [wide array of issues like housing and health](#) are increasingly being documented

Against this backdrop, to facilitate understanding of health issues specific to children and youth, several types of inputs are represented in the report, including:

- Quantitative data on youth (middle and high school student) behavior related to mental health and substance use presented in the county profiles
- Qualitative information about the needs of children and youth from birth to age 18 gathered in each geographic community conversation and spotlight discussion (see individual summaries throughout the report).

In addition, the Steering Committee sought to hear directly from youth (ages 11-25) to ensure robust inclusion of youth voice in the rCHNA. A subset of participating health systems (Children's Hospital of Philadelphia, Einstein Healthcare Network, Main Line Health, Penn Medicine, and Trinity Health Mid-Atlantic) formed a committee to guide the development of this data collection process, which centered on the engagement of youth-serving organizations and programs based in the five-county region. Specifically, program leads were presented with an opportunity to facilitate discussions with youth participants about youths' perceptions of community assets and barriers to health, health needs specific to youth, and ideas for potential solutions. All organizations received funding to hold these discussions, and youth participants received gift cards for their time.

From an initial list generated by subcommittee members, additional outreach was conducted through existing networks (e.g., Greater Philadelphia Extracurricular Collaborative, Philadelphia Youth Sports Collaborative). Twenty-five organizations were engaged to participate in this data collection, representing youth in Bucks, Chester, Delaware, Montgomery, and Philadelphia counties:

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## Falcons 215

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[After School Activities Partnerships \(ASAP\)](#)

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[Black Women in Sport Foundation](#)

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[Born With Purpose](#)

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[Caring People Alliance](#)

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[Children's Hospital of Philadelphia Adolescent Initiative](#)

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[Focused Athletics](#)

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[Ivy Hill Youth Association](#)

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[La Liga del Barrio](#)

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[Liberty Youth Athletic Association](#)

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[Lutheran Settlement House](#)

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[Mercy Neighborhood Ministries](#)

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[National Network for Youth / Valley Youth House \(Montgomery County\)](#)

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[Open Door Abuse Awareness Prevention](#)

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[Parent Power](#)

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[Philadelphia Chinatown Development Corporation](#)

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[Philadelphia City Rowing](#)

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[Philadelphia Robotics Coalition](#)

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[Philly Teen VAXX Ambassadors](#)

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[Starfinder Foundation](#)

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[Sunrise of Philadelphia](#)

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[The Common Place](#)

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About a third of organizations offer sports programming to youth, in addition to other educational and enrichment support, including mentoring and coaching. Others provide out-of-school-time programs, offering a variety of arts-based, educational/tutoring, and youth leadership development programming.

A total of 354 youth participated in 34 discussions held in November 2021 – February 2022. These discussions were conducted both virtually and in-person, at the discretion of the organization, and facilitated by trusted program leaders and staff. Discussions ranged from 30 to 129 minutes, with an average length of approximately 60 minutes. The age distribution of participants is as shown below:

Age	Count	%
<13	33	9.3%
13-15	170	48.0%
16-18	117	33.1%
19-22	24	6.8%
>22	6	1.7%
Missing	4	1.1%
Total	354	

Geographic representation was as follows:

County	# of groups
Bucks	1
Chester	3
Delaware	2
Montgomery	2
Philadelphia	29

NOTE: The number of groups does not add up to 34, as some groups included representatives from multiple counties.

Within Philadelphia, most groups represented either North or West Philadelphia. Residents of Southwest Philadelphia, Center City (including Chinatown), South Philadelphia, Northeast Philadelphia, and Northwest Philadelphia were also represented across the groups. One group included representatives from South New Jersey as well.

Facilitators were given a discussion guide with six questions and suggested prompts (see online Appendix) and provided additional guidance as requested. Facilitators were supported by note takers and, in some instances, opted to record the discussion to capture specific quotes from participants. Organizations summarized the discussion using a report-back form that was provided to them and, where appropriate, submitted additional materials such as notes or sign-in sheets. Based on the report-back form submissions and additional materials, responses were coded for key themes. Frequency of mention across discussions was calculated as a percentage based on 30 submitted reports (some organizations opted to combine multiple discussions into a single report). Since multiple themes were discussed in each group, percentages total over 100%. The themes, percentages, and, where appropriate, illustrative quotes from the discussions are presented on the following pages.

## Community Assets

Youth identified the following as key resources and assets that make their communities healthier:

Theme	%	Description and Examples
<b>Connections/mutual support</b>	47%	Participants cited the importance of <b>cohesive, community bonds/relationships and support networks</b> for health. These connections enable community members to be <b>accountable</b> to one another, as several groups valued being able to “watch out” for and check in on one another. Those <b>“willing to take the journey with you”</b> and who <b>“you can count on”</b> are sources of <b>motivation, inspiration, and “cheerleading.”</b> By confiding in one other and acknowledging shared struggles, these strong networks provide <b>mutual care</b> , and foster a sense of <b>belonging and inclusion</b> .
<b>Community spaces/ organizations</b>	33%	Youth frequently noted the importance of spaces like <b>recreation centers and outdoor greenspace</b> (e.g., parks, running trails) in promoting health. These represent not only a space for physical activity and sports, but as important, <b>safe places for community gathering</b> . Participants also noted the need for <b>spaces for creative exploration and expression</b> , as well as the critical role played by local non-profit organizations, faith-based organizations, and businesses in creating a thriving community.
<b>Shared values/mindset</b>	30%	Youth participants underscored the value of shared values and positive mindset for community health. They repeatedly mentioned values related to <b>diversity, unity, freedom, voice, acceptance, inclusion, respect, and collaboration</b> as essential.
<b>Supports for healthy eating</b>	30%	Quite a few group discussions had a strong emphasis on the need for supports for healthy eating. Though youth noted a few existing supports (e.g., school lunches, grocery stores), they also noted the need for support through the growth of resources like <b>farmers markets and produce trucks</b> .
<b>Health resources</b>	27%	Youth recognized the contributions of facilities like <b>pharmacies</b> (especially in light of the COVID-19 pandemic) and <b>health care professionals</b> (including mental health care providers and dentists) in fostering health. <b>Mental health supports</b> were of particularly interest for participants.
<b>Leaders and role models</b>	27%	Participants cited the crucial role of trusted community leaders and adults in their lives who can serve as positive role models and <b>mentors</b> . These include <b>teachers, coaches, counselors, and community police officers</b> who demonstrate that “they care.”
<b>Community activities</b>	27%	Opportunities to connect as a community through <b>community clean ups, donation drives, and cookouts</b> were mentioned by youth participants as positive influences on community health.
<b>School and extracurricular programs</b>	23%	Participants strongly endorsed the role of school-based and extracurricular programs in supporting health. These programs included <b>sports and other afterschool programs</b> that provide opportunities for <b>building connections</b> between youth, fostering <b>social emotional learning</b> , and enabling <b>creative expression</b> .
<b>Supports for physical activity</b>	17%	Participants discussed the importance of fostering opportunities for physical activity more generally, beyond the mention of specific facilities like recreation centers, gyms, or outdoor spaces.
<b>Clean, safe environments</b>	13%	Several groups noted the need to ensure neighborhood and school environments are <b>clean and safe</b> . Safety encompassed protection from air <b>pollution or mold/asbestos in schools</b> , as well as more generally from <b>physical, emotional, or psychological harm</b> .

## Community Needs

Participants were asked to share the biggest challenges and barriers to health in their communities:

Theme	%	Description and Examples	Illustrative Quotes
<b>Violence and safety</b>	<b>67%</b>	A predominant concern for youth was the rampant violence in their communities. This is largely in the form of <b>gun violence</b> , but participants also cited instances of <b>interpersonal violence</b> . Youth mentioned <b>fight in schools, police brutality, and gangs</b> in association with violence. For youth of Asian descent, fear of <b>anti-Asian hate crimes</b> was significant. This threat of violence had cascading impacts on youth, both direct and indirect, resulting in <b>not feeling safe enough to go to parks or work out outside</b> . This fear also has a strong negative impact on mental health through experience of <b>toxic stress</b> .	<p><i>"Gun violence...We all know that we were on track to break the record for the most homicides in a year, and I know that it was a lot of killing going on and I know a lot of people affected by it. And I just wanted to say that's a big problem because...we're losing people and people are losing their lives all over dumb stuff like a simple argument or even things that people shouldn't be doing like drug deals, stuff like that."</i></p> <p><i>"There needs to be better gun control. Like everyone – anybody can handle a gun at this point. There's some crazy people out there that just go straight to the killing and not really any solutions."</i></p> <p><i>"And it makes me even more feel some type of way because I cannot wait to move out of Philly and I grew up here. And things, when I was growing up, wasn't like this at all. They do have violence here and there but nothing like this."</i></p>
<b>Food</b>	<b>50%</b>	Participants were concerned about the <b>lack of access to healthy foods</b> in their communities and <b>food insecurity</b> . Many noted the easy access to cheaper fast food and unhealthy foods in corner stores, with supermarkets being further away and less accessible without a car. Youth were interested in increasing access to fresh produce and <i>"good-tasting, nutritious food that will fuel kids for the day."</i>	<p><i>"A lot of people don't have access to healthy food. And so a change I think should be made is one that promotes access to healthy food. Because food insecurity is not only access to food at all but access to food that is healthy and benefits you rather than harms you."</i></p> <p><i>"I think changes, like really big changes such as Pennsylvania has a P-EBT, like all of those benefits have helped my family at least, because during the pandemic one of my parents actually lost their job. And my other parent was affected significantly, because her job involves like, a more person-to-person thing. And she was unable to do that obviously because the COVID-19, which caused us to be in a weird financial situation, so benefits such as P-EBT and Pennsylvania's support has been really helpful. Those changes, I think, were like some of the biggest ones in my family."</i></p>

<p><b>Mental health</b></p>	<p><b>50%</b></p>	<p>Mental health is a pressing issue for youth. Participants shared the multiple factors influencing mental health in their communities, including concerns about <b>violence and safety</b> as mentioned above and the impact of <b>COVID-19 pandemic</b> stay-at-home orders. Youth frequently mentioned their experience of stress. For example, some cited <b>generational trauma and toxic stress</b> associated with directly experiencing AND living in communities contending with <b>racism, poverty, violence, or substance use</b>. Others cited the challenges of <b>balancing competing demands</b> of schoolwork and parental expectations. Compounding these factors are issues related to <b>stigma</b> associated with mental health concerns in some communities of color and <b>challenges with accessing mental health supports</b> and treatment (lack of awareness of available resources, not being able to get timely appointments, affordability). There is a sense that youth mental health concerns are <b>not taken seriously</b> by adults in their lives, with some telling themselves that <i>"it's not that bad"</i> and getting the message that they should <i>"keep going, you will be alright, get over it."</i></p>	<p><i>"For physical health, people are a lot more willing to go to doctors and learn about their challenges but with their mental health there is a certain stigma, and they don't want to talk about their issues."</i></p> <p><i>"In the community, trauma builds up. That's why they reflect also the trauma..."</i></p> <p><i>"Even though resources are available for mental health support, there is a stigma, especially in the Asian community where one can go for help and not feel judged. People may not get help because of the stigma."</i></p> <p><i>"The Black community does not think that mental health is a thing."</i></p>
<p><b>Substance use</b></p>	<p><b>33%</b></p>	<p>Participants shared the impact of substance use in their communities, including <b>drug addiction and overdose</b> and <b>peer pressure</b> related to smoking and alcohol use. For several groups, drugs were mentioned in association with violence in their communities.</p>	<p><i>"I wanna throw in instead of like the strengths, I would say the weakness like drugs especially in Philly like in Kensington areas are horrible."</i></p>
<p><b>Environment</b></p>	<p><b>30%</b></p>	<p>Youth noted the negative impacts of <b>pollution and lack of trees and greenspace</b> in their communities. Several groups were particularly concerned about the presence of <b>trash in public areas and illegal dumping</b> in their communities.</p>	<p><i>"A challenge that we face is people taking advantage of the community and littering and putting trash everywhere basically."</i></p>

<b>Racism and inequity</b>	<b>27%</b>	<p>Racism and resulting inequities in health, as well as inequity arising from discrimination based on <b>other identities</b> (e.g., gender, sexual orientation, ability, intersectional), were of great concern to youth participants. <b>Disparities in COVID-19 outcomes, differing levels of investment in certain communities, associated socioeconomic disparities, and hate crimes</b> were raised in these discussions.</p>	<p><i>"Within health care, there's a lot of discrimination based on color and sexual orientation, which is crazy, because that affects a person's health. Also one thing for individuals who are part of LGBTQ, doesn't really trust...doesn't receive the right medical care. And within the Black community, 37 percent of Black women don't really trust the health community. So I think that ties into being a part of the Black community and being part of the LGBTQ+ community."</i></p> <p><i>"Looking back to the past few years, as a young person going through taken out of school, no vaccine to begin with, seeing Black people that look like you getting murdered, seeing an uprising on TV and try to focus on academics, trying to work, go to college - going through these things and not enough time to process and trying to push through saying 'it's not that bad.' Then thinking about 'Even with access to vaccines and mental health resources it's still very hard to keep going and go get the vaccine and mental health."</i></p>
<b>Housing/ neighborhoods</b>	<b>23%</b>	<p>Several groups discussed <b>lack of affordable housing</b> in communities, <b>housing insecurity, homelessness</b>, the impact of gentrification, and the <b>lack of sustained investment</b> in neighborhoods. One group discussed the interrelationship between lack of housing and mental health concerns.</p>	<p><i>"Homeless people being out on the street 24/7."</i></p> <p><i>"I'd like to change the gentrification of the neighborhoods."</i></p>
<b>Resource information and navigation</b>	<b>23%</b>	<p>Youth shared challenges related to getting information about available health resources and navigating systems to obtain these resources. They expressed a desire for <b>clear communication and education</b> about these resources. They advised potentially using <b>social media</b> and adopting <b>positive, youth-focused approaches</b> to reach youth with health information and messages.</p>	<p><i>"Maybe more of like advertising things that aren't bad. Like, for example, everywhere I go...we see a lot of posters everywhere but it's all advertising parties and nothing is really advertising like yoga classes or meetings like this that we can actually put our input in. I feel like it's very limited to...this information to who we can extend it to. I'm pretty sure there are parents who would love to join and give their input...Being more vocal about the good things and the little things."</i></p>

<p><b>COVID-related concerns</b></p>	<p><b>17%</b></p>	<p>The COVID-19 pandemic had and continues to have a significant impact on youth and their communities. The stay-at-home orders associated with the pandemic negatively impacted youth mental and physical health. In addition, the challenges associated with <b>vaccines and masking in schools</b> persist, leading to a great deal of confusion with <b>changing rules and eroding trust in adults</b>.</p>	<p><i>"...the thing is that with the pandemic, especially during like the more harsh periods of the pandemic, I don't think anyone can learn during virtual learning at all. Like the majority of students who are more hands on or like who are definitely more used to in-person learning definitely had a hard time, and now they're having an even harder time adapting to school that's going back in person and it just feels like we're all behind. And it's very easy to feel overwhelmed, especially for those with a lot of responsibilities at home as well."</i></p> <p><i>"My mental health and emotional health were affected because of fear of getting sick and being angry that people would not get vaccinated and might inconvenience them but do good for the community's health."</i></p> <p><i>"I used to not talk to people and now I do because I needed to because of being lonely and I got more comfortable with new people. But now I get highly anxious by the lack of people but also having people around, because I am concerned for my family's health and I am concerned about people's view on the vaccine. I am afraid of saying something if I say I support the vaccine. Will that turn people against me?"</i></p>
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<p><b>Interpersonal dynamics and communication</b></p>	<p><b>23%</b></p>	<p>Several groups were concerned with negative interpersonal dynamics and communication in their communities. Some cited the detrimental effects of <b>“toxic” attitudes, disrespect, comments that impact body image, and making assumptions</b>. Some of these negative dynamics can play out on <b>social media</b>. Other youth shared that sometimes they experienced language barriers and that there were <b>no spaces to express themselves and foster meaningful, deep connections</b> among community members.</p>	<p><i>“...Most of the issues is basically people not communicating with each other as much as they should be or like not understanding where the other person is coming from in order for them to help...”</i></p> <p><i>“People not being able to understand someone else’s opinion...it’s like when you don’t understand it creates conflicts. It will not be a healthy community.”</i></p> <p><i>“...people don’t want to change what they’ve been doing for periods of time, it’s what they’re used to. So if you have like something new or you want to change what’s going on, it’s like an issue and then it becomes like a big problem. And they tend to go on... people aren’t getting heard, no one’s understanding what others are saying...down to it is people who undermine others and don’t try to listen on other people’s issues.”</i></p>
<p><b>Transportation</b></p>	<p><b>17%</b></p>	<p>Some participants shared barriers to accessing transportation, even with critical needs like attending school and going to medical appointments. The main issues include <b>lack of available, affordable options</b>.</p>	<p><i>“I would use Transnet [a program by Medicaid] but you need to schedule in advance. If you have something urgent it’s hard to get there. For example, when I was pregnant and going into labor, I called and couldn’t get a ride.”</i></p>
<p><b>Health care access</b></p>	<p><b>17%</b></p>	<p>Youth brought up challenges with <b>accessibility and affordability of health care</b>. The lack of free clinics, the significant distance needed to be traveled for some facilities (or, put differently, few options close by), low appointment availability, long wait times, lack of insurance, and high costs of deductibles were particularly noted. Related to other needs raised, <b>lack of knowledge of available resources where they can go without parents and are free</b> was shared.</p>	<p><i>“Yeah, like, my dad, he works for himself. He has his own business and he doesn’t have insurance and he got hurt working ‘cause he’s a construction worker and like, he’s been – his back is like really bad and I’m like, ‘Are you going to the doctor?’ ‘No, it’s too much. I’m gonna have to tough it out.’ And I think that’s kind of messed up ‘cause he’s doing all this work and he can’t even – he can’t afford insurance ‘cause he has three daughters, so, it’s just a lot.”</i></p> <p><i>“...so, with difficulty accessing mental health, I think that mental health resources, like I think it’s hard to find providers, and like to pay for it too. I have personal experience with this, like I was trying to find with my mom, but a lot of places are either just like - there wasn’t like enough staff. And some of them just didn’t pick up - they had like a waitlist. So, it was just very hard to find like - to get access to help. So, I think that should be improved.”</i></p> <p><i>“I have been to the emergency a few times and each time it was more than a 2-hour wait.”</i></p>

## Youth Needs

The main issues for health for youth (with particular prompts related to health care) were shared as follows:

Theme	%	Description and Examples	Illustrative Quotes
<b>Mental health</b>	<b>60%</b>	<p>Similar to what was expressed related to mental health needs in their communities, youth shared with greater intensity their own experiences with <b>stress, pressure, and burnout. Depression, anxiety, and trauma</b> due to the COVID-19 pandemic and community violence were widely shared across groups. A theme of <b>balancing</b> between school, parental expectations, other responsibilities, and social life was consistent across several groups. Other sources of stress and toxicity include <b>expectations around physical appearance and beauty</b>, often exacerbated by social media. Challenges of not talking about mental health issues due to <b>stigma and accessing mental health resources</b> like therapy (long wait times for appointments, limited number of therapists within insurance networks, difficulty finding information, need for parental consent, lack of affordable options) were also raised by participants.</p>	<p><i>"I said the most important issues when it comes to youth nowadays, was mental health. Although COVID-19 does affect our physical health quite a bit I feel like mental issues right now are more prevalent, because as we're starting to like go back and forth between the COVID restrictions. I feel like...it's a lot easier for everyone, especially the youth, to feel overwhelmed. Especially how like earlier, she talked about how her friend was getting overwhelmed with schoolwork. I feel like the pandemic and the two years of completely virtual school has like really made it hard for us to get used to our pace when it comes to schoolwork, and academics, and extracurriculars now that we're like starting to uplift those restrictions. It's really hard to keep up with everything when you haven't done it at all for like two years, and it's like quite abrupt as well."</i></p> <p><i>"On the subject of mental health, a lot of the times people my age will joke about it... it's become such a...maybe convenient or casual topic that you can't ever really tell when someone's serious about something. Like it's just hard to determine who actually needs help."</i></p> <p><i>"I have heard people call our generation the generation of mental health. Some people in the older generation don't take it as seriously as it's supposed to be. They think that it's just 'oh, you're sad...go to church, go pray, go read the Bible'—it's always the same answer. So I think our biggest issue is mental health as the younger generation."</i></p> <p><i>"How things are portrayed toward youth. I feel like we see a lot of things, pick up on a lot of things that we shouldn't, like body health or people trying to be things that they're not and it'll turn out bad for them...like anorexia or especially with the oversized community. Because I feel like people equal health as in you're not bigger but in all actuality, you can be healthy in any size, and I feel like that targets children more than it should."</i></p> <p><i>"It's not always easy to talk to people, like actually have a conversation about your mental health with everybody because not everybody's gonna care...it's been times where I've actually tried to talk to somebody about my mental health and they just like 'I don't care.' So with that, you shut down and you don't wanna talk to anybody because you feel like you can't talk to anybody."</i></p> <p><i>"Doctors prescribing [psychiatric] medication to kids rather than looking deeper into a situation. In school, teachers suspending kids rather than talking to them."</i></p>

Violence and safety	40%	<p>Like the discussion of violence and safety in their communities, youth brought up the impact of widespread gun violence/ easy access to guns on their feelings of safety. They shared that they want to have <b>safer options for being outside and active. Trauma and concerns that “they will die either by the virus or gun violence”</b> were expressed. Some youth expressed a desire to find out how to respond to racist violence without resorting to violence themselves. <b>Cyberbullying</b> was also raised as another form of violence experienced by youth.</p>	<p><i>“There’s something traumatizing about exiting a train station and seeing someone being carjacked at knifepoint does something to you and having to walk past things like that on your way to school is super problematic.”</i></p> <p><i>“And it’s like, when I was younger, back in like middle school and elementary school days, it was not like that. Like, I could go to a park and it’s a lot of people there. I don’t have to worry about running into a gang or seeing a group of kids with black hoodies on, walking around, messing with people or starting stuff. It’s like, I don’t have to worry about that. I went to the park, played and went home safely. And now, it’s like, ‘cause I walk home, you know, from school but I change my route every single time going home. Like I can take three different routes in walking home to get to my house just so I make sure that I’m not being followed or no one’s coming from behind me. Like, I’m very aware, especially now that I’m further away, like, walking from West Philly to Southwest, I’m just more aware of my surroundings.”</i></p> <p><i>“A while back when I was sitting with some people that I called friends, people started driving up slowly in black cars with tinted windows. I told them we should leave. They were like no its fine. I left. They rolled down the windows and started shooting. Two to three people died at that party. Everyone started running but I had a head start. You can’t even sit at a park anymore.”</i></p>
Health care access	30%	<p>The major points across discussions related to health care access emphasized challenges with getting the right information about available health care resources and how to access them, <b>understanding and navigating confusing systems</b>, and managing insurance (and related cost issues, to be discussed below). Participants raised challenges with not getting navigational support from providers, as well as quality issues stemming potentially from <b>bias/ stereotyping and lack of staffing</b>. The issue of a local hospital closing was also mentioned.</p>	<p><i>“I think that for the Black community, it’s very hard to see a doctor, especially given the...current and past racial discrimination within the medical field. It’s very hard for Black people to say, ‘oh I’m gonna go to the doctor to get a checkup’ or ‘oh I’m gonna go to the doctor because I have X, Y, and Z medical condition.’ ‘I’ll figure it out on my own, I’ll be fine, I’ll use these natural resources’...I’m going to go to a hospital that’s not gonna give me the same care because of my skin color?—absolutely not! Just not being able to see doctors in that position that look like us, it discourages you from going.”</i></p> <p><i>“It’s hard to get myself to get meds.”</i></p>
Social needs	30%	<p>The most commonly cited social needs raised were related to <b>food (access to healthy foods), housing, financial instability, and transportation</b>.</p>	<p><i>“I know a lot of people who...had to hurt other people to make sure their family was ok. So when I think about health in my community, I think like financially, making sure everyone is cool so they don’t have to hurt other people so that their family can eat and can have food for the household...”</i></p>

<b>Substance use</b>	<b>27%</b>	<b>Ready access</b> to drugs, alcohol, cigarettes, and vapes was raised by several groups, leading to problems with addiction. One group raised that use of such substances was a <b>coping mechanism</b> for stress and pressure.	<i>"And I feel like anybody could get vape. It's like so easy. It's not like they need to make the like age limit to where you can smoke or a little bit higher so that people can – no kids can buy it and have more education in schools about that type of stuff. Like nobody knows that vaping is way worse than cigarettes and it's like killing your lungs faster than cigarettes did to the organs, that we all see people dying from lung cancer and having like cold and then burns."</i>
<b>Need: Supportive adults</b>	<b>23%</b>	The need for supportive adults in youths' lives was mentioned several times across groups. The important role of these adults as <b>volunteer mentors, positive and responsible role models, and "trusted people that they can go to in order to discuss things"</b> was emphasized by youth, especially to provide support and a sense of safety for difficult or uncomfortable issues they may be experiencing. Youth shared a sense of feeling <b>"let down"</b> by adults at school due to lack of nurses and medical staff; lack of timely and supportive response from security personnel, teachers, and police to violence and bullying; and a lack of mentorship.	<i>"I would say that something we're missing in our community is responsible role models or good role models for the youth, you know. Because it's easy to go out there and just be out and doing whatever you want to do, but when you go out and all you see, you know, is people doing the wrong thing, you know, it's hard to see people doing the wrong thing and not do it yourself 'cause it's even more difficult to know what you're supposed to be doing..."</i>  <i>"Probably like more encouragement for youth to stand up for themselves, and just like encouragement from their parents, encouragement from teachers, because a lot of times when they don't say anything or like they just let it slide by, it's like you're kind of like giving up on a child..."</i>  <i>"Counselors mainly just help you get into college, but don't wanna talk about your feelings."</i>
<b>Physical health</b>	<b>20%</b>	In contrast to their responses to questions about community needs, youth did raise a few points about physical health issues experienced by youth. Several pointed out <b>obesity and lack of sleep</b> being prevalent across youth. One group shared the importance of greater awareness of <b>chronic conditions</b> affecting youth and increasing support for such conditions.	<i>"I think physical health is also important. Many of my peers don't sleep much because of too much school work."</i>
<b>Need: Communication/connection</b>	<b>20%</b>	Several groups noted the importance of efforts related to increased and improved communication between peers and with adults. Youth across groups shared challenges with <b>socializing (including experiencing anxiety), communicating with new friends, and feeling lonely and disconnected</b> as a result. The negative impact of communicating through <b>social media</b> was also mentioned.	<i>"And then like just a lot of face-to-face interaction, and also like text each other, I guess, but not as much as right now. But then right now, because of how advanced technology is, there's so many social media apps that you can use to communicate with each other. And also, because of COVID, you kind of like - I see some youth be kind of like lost the way of...just like being able to communicate with others."</i>

<p><b>Need: Wellness supports for youth</b></p>	<p><b>13%</b></p>	<p>A number of discussions mentioned the need for more general resources for youth mental and physical wellness. These could include <b>informational resources, social or emotional wellness resources, or creation of spaces or activities</b> where they can be free, safe, and have fun.</p>	<p><i>"I think it's habits, like we - like young people...are like learning about stuff they need to do - they can do better to help themselves keep themselves healthy. But...like once you have bad habits over time, and it's really hard to change those."</i></p> <p><i>"I think I'd say especially rec centers. 'cause one thing I know that makes me stressed is my work so I want tutoring but I want affordable tutoring or even free, 'cause in my area everything is so expensive and I don't get that because a majority of minorities can't afford that."</i></p>
<p><b>Cost of health care</b></p>	<p><b>13%</b></p>	<p>In addition to issues with health care access noted above, several groups discussed the impact of <b>insurance coverage limitations and high costs associated with specialty care and therapy.</b></p>	<p><i>"I was at the doctors and somebody was just talking about like trying to get on birth control and I overheard the doctor say, 'Well, your insurance doesn't cover this, so, you can't get on it.' And they was like just telling her, like, 'Just keep using condoms.' And stuff like that. And I just feel like, and for females, like, that's just like us having to pay for - pay for pads. Why should we have to pay for something that we can't control our period? So, I just feel like pads should be free and if somebody wants to get on birth control, they need birth control, they should just get it for free."</i></p>
<p><b>Youth autonomy, decision-making, and voice</b></p>	<p><b>10%</b></p>	<p>The importance of youth voice and autonomy for health-related decision-making was emphasized by a few groups. Instead of telling them what to do, <b>providing relevant information so that they can make informed decisions</b> was preferred by youth.</p>	<p><i>"When you bring to them [elder people] your problems, they're gonna try to tell you things that the way they see it. I'm telling you that I see it this way and you're trying to tell me to see it that way, so we're not going to get like the solution. When I bring to you the problem, you should sit down with me and we should discuss it, like what can we do to solve it. The elder people sometime they think that they know everything and they don't want to listen to us and our own opinion."</i></p>
<p><b>Sexual health</b></p>	<p><b>10%</b></p>	<p>A few groups raised that issues of sexual health were specific to youth, especially as they are experiencing puberty.</p>	<p><i>"In terms of the female community, with like both mental health and physical health, I think that like better sex education in schools is something that's really important. And sex education that is updated to like our modern perceptions of gender and sexuality. I think that's something that's really important for improving both the mental and physical sexual health of especially teenagers, and especially women and people in the LGBTQ community. Because good education can sort of combat stereotypes which can be very harmful like both mentally and physically to people in those communities."</i></p>

## Potential Solutions

Participants contributed ideas for potential solutions for improving health for youth and their communities:

Theme	%	Description and Examples	Illustrative Quotes
<b>Social needs</b>	<b>53%</b>	Youth shared ideas for improving <b>food access</b> (e.g., food delivery/car services to increase accessibility for those particularly in need), <b>building affordable housing</b> and providing more resources to those experiencing homelessness, making <b>transportation options more accessible</b> , and <b>providing workforce development</b> and employment opportunities.	<i>"Housing... definitely housing because there's many buildings that could be rebuilt that's in Philly that aren't used and that could be used for housing. But also equity within housing. Equity in jobs. And education."</i>
<b>Mental health supports</b>	<b>50%</b>	Participants offered many creative ideas for providing mental health supports in the community and in schools. Increased <b>access to mental health professionals</b> (counselors, therapists) in community settings, as well as in schools was raised. <b>Peer advocates and teen mentors</b> supporting mental health were also suggested. Youth had ideas for <b>creating spaces for openly talking about mental health</b> (including as a student-led club), as well as <b>measures schools could adopt</b> (periodic anonymous mental health check ins, mental health periods, mini-breaks, or wellness days, mental health days off, de-stressing equipment like weighted blankets in a room focused on wellness). Other ideas included providing <b>workshops on self-care</b> that offer tools such as meditation, as well as <b>campaigns</b> with messages to raise awareness of the body neutrality movement. Youth viewed these efforts as all serving to <b>normalize and destigmatize</b> mental health issues, with some noting the importance of educating parents. It was also emphasized that mental health supports should be <b>free or low cost</b> to increase accessibility.	<p><i>"I said this before, but just like getting more access to mental health resources. I guess, maybe, like giving schools - having schools have more counselors so that students can talk to them."</i></p> <p><i>"A lot of our youth and even the young adults and adults period have gone through a traumatic experience so just having that trauma-informed care..."</i></p> <p><i>"Certain groups where you can just sit and listen to someone talk. Because a lot of the times people treat their disorders so casually that if you just let them speak they'll go to rambling on and start revealing things that they would have never said if they were actually paying attention. So you should sit and listen to people sometimes...and you never know what they're gonna say, as long as you're just quiet you listen they can talk on and on and you'll actually find something out that you can see if you could help them with."</i></p> <p><i>"I would try to like "casualize" therapy because it seems like therapy is such a taboo. Like everybody's like, oh, if you go to therapy you're crazy or therapy is not for you, you don't need it...I would try to normalize therapy, casualize it, casualize talking about mental health in a positive way... And to make group therapy sessions and things like that and have communication, instead of having like someone says something and it doesn't get heard by someone else, things like that."</i></p>

<p><b>Safety</b></p>	<p>43%</p>	<p>Youth noted several strategies to potentially <b>increase safety in play areas and neighborhoods</b> (e.g., cameras, officials and other monitoring of playgrounds). To stop gun violence, participants mentioned <b>gun control</b> to get guns off streets. Others suggested building capacity for <b>healthy conflict resolution</b> and creating <b>positive outlets for arguments or anger</b>. Youth discussed the <b>role of police</b> (increasing numbers, having more officers who “look like me”) and strengthening <b>community policing</b>.</p>	<p><i>“Better gun protection laws...who’s accessing this type of stuff? How they’re getting their hands on it and how can we make it safer for those communities so that people who may not be in the right state having access to this type of stuff, or children getting access to it. What we can do to protect ourselves and others, along with the children in the neighborhood getting access to this type of stuff. Better safety measures.”</i></p> <p><i>“I think definitely fixing up Germantown but not pushing out people that lived in Germantown. But fixing it up to a point that it feels like a stable environment. I don’t want to say more police around Germantown because that wouldn’t help but doing something that would help prevent violence.”</i></p> <p><i>“Our police are a major part of this community and they have a lot to do with the interactions between the community and them and so trying to strengthen those community relations and realize that every single cop that you see is not necessarily a bad cop....Just strengthening community policing would be major for communities in general.”</i></p>
<p><b>Community activities/facilities</b></p>	<p>43%</p>	<p>Participants felt that increasing community activities like <b>clean ups and social events</b>, as well as facilities like <b>recreation centers or skating rinks</b>, would improve health in their communities. In particular, they emphasized creating <b>safe spaces for youth</b>, such as community gardens, or events like sports tournaments. Such gathering places could offer health-related programming. One group discussed a <b>one-stop-shop for youth</b> to get services and assistance with navigating complex systems, as well as connect with other youth.</p>	<p><i>“I will like kind of say what you said, like community service. And I feel like our biggest issue may be ...the many homeless people that you see out there, there’s probably like, as I came here today I probably seen like 10 homeless there, I always see every day. And I feel like we as community could do... what is it like donation to give out food and stuff and clothes since there’s also COVID so it’s like obviously, they’re affected by all this COVID and stuff. And like me and my friends during COVID we actually planned out and made food, and then we surprised homeless people, we drove around South Philly or North Philly and stuff, we just gave out food. So, I feel like if our community do that, I feel like we could get more people, more homeless out the streets and stuff.”</i></p> <p><i>“I would say like more recreation centers around the community to like keep kids off the street, stuff like that.”</i></p> <p><i>“I want somewhere where I can feel safe....I want somewhere where everybody’s gonna accept me for who I am and not just look at me for, she has an accent, she’s from that place. I want them to see me for who I am and not from where I’m from or how I’m different. I just want them to see me for me.”</i></p>

<p><b>School and extracurricular programs</b></p>	<p><b>43%</b></p>	<p>The potential to create and offer <b>more clubs to cultivate hobbies</b>, programs to encourage self-development, <b>classes to build life skills</b>, and <b>sports activities to foster social emotional learning</b> was very appealing to youth participants. They emphasized that it was important that the programs be <b>fun and foster connection</b> with others.</p>	<p><i>"I feel like afterschool programs, like, [name] said, she said, not all kids like school but at least, if they know that they could go to basketball practice once the school day is out, they'll give them a motivation or a reason to come to school and to do their schoolwork and do good so that they can stay on their basketball team."</i></p> <p><i>"A lot more programs and stuff but more specifically free programs because the poverty in Philadelphia is like really high and so a lot of people can't afford a lot of things. And so I would say a lot more free programs that people can join because I've noticed that when youth aren't a part of a program or a job or just like not doing anything with themselves, they more so get in a lot more violence and more drama, gun violence and all that type stuff that they could avoid. But since they're not a part of anything they're more so to be in it. And so if there's more free programs for them to join they have more opportunities to find something that they like to do or something that like interests them or something like makes them happy to do."</i></p> <p><i>"Youth in developmental workshops, getting your own sense of identity, just to know that there are things out there, putting youth on different podcasts, different things like that... to just see what out's there in the world."</i></p>
<p><b>Supportive adults</b></p>	<p><b>33%</b></p>	<p>As raised in responses to an earlier question, the importance of supportive adults in youths' lives cannot be overstated. Again, participants expressed a strong desire for <b>strong community leaders, community volunteers, positive role models, and mentors to help keep them "safe and off the streets."</b> In addition to "teachers who care" (ideally hired from the community), youth offered an idea for building connections with police in schools, as well as thoughts around providing training to adults working with youth on social emotional learning. In addition, one group discussed educating parents on conversations about race and gender.</p>	<p><i>"I guess like in my school community, like once I talked to one of my counselors, it took me a long time. It was like after I went through a really hard time, I didn't talk to her during that hard time. But then it was like after with college applications, which I'm doing right now. And then I started talking to her about problems that I had in the past, and then she was - it was like really helpful and she really made me feel a lot better. And so, I guess, just like counselors in schools, like in school communities work really well."</i></p> <p><i>"Definitely partnering up with schools and being more vocal about females...about our body parts, menstrual cycles, what can we take including herbal things, that could be brought into health. Having the nurses not be in the nurse office and to come check. 'Cause I'm pretty sure there's a lot of students that I knew I grew up would not just really care about themselves because they were suffering from depression from home and their parents didn't check up on them.... So I feel like...the way that you take care of yourself root from childhood."</i></p>

<p><b>Health care access and affordability</b></p>	<p><b>30%</b></p>	<p>Consistent with responses to earlier questions, youth shared the need for <b>financial and navigational supports</b> when seeking to access health care. The need for <b>more affordable and accessible health care facilities</b>, such as neighborhood clinics, was emphasized. The <b>qualities of health care providers</b> are also important – increasing representation of people of color and diverse gender identities, as well as hiring/training providers who are committed to providing equitable care, was suggested by participants.</p>	<p><i>“Uniformly having providers accessible especially those who are people of color, and/or Queer.”</i></p>
<p><b>Support systems and resources</b></p>	<p><b>23%</b></p>	<p>From a general perspective, youth are in need of support systems that are <b>integrated and help them connect to needed resources</b>. Similar to health care, youth need help finding out about available resources for other needs and ultimately connecting with them. This was particularly noted for immigrant communities who may be contending with language barriers and fear/anxiety related to asking for help. Some suggested <b>school-based support systems</b>, while others discussed <b>community-based systems that seek to ensure services provided are widely known, accessible, and effective</b>. Some youth suggested culturally relevant <b>public education and awareness campaigns</b> to spread the word about these systems and resources.</p>	<p><i>“For me, I guess like if I could design my own community, I would put in like a lot of support systems, and just build like a friendly environment where everyone can depend on each other, and just help each other out.”</i></p> <p><i>“The youth don’t want the resources that are provided...the youth need more help. They need people to actually go to them with the resources.”</i></p> <p><i>“Resources on different types of topics. So like family issues, on an individual basis as well relationships, how to form integral, intimate, intentional relationships.... You want to have a joyful road in life. You don’t want to just do anything just for the sake of doing it. I think resources, education, self-development are things that our communities could use.”</i></p>
<p><b>Environment</b></p>	<p><b>20%</b></p>	<p>Suggestions for improving local environments included community <b>clean ups</b>, planting <b>more trees and more plant life</b>, putting up more <b>murals</b>, providing more <b>garbage cans</b>, and preventing <b>illegal dumping</b>.</p>	<p><i>“I would say... getting together and cleaning yards around the neighborhood because seeing trash every day because it doesn’t bring a good image in your mind.”</i></p> <p><i>“Why do you have to clean up a neighborhood just to kick people out? Why can’t all people be allowed to live in their neighborhood? A clean equitable neighborhood, so that they don’t have to go to a white neighborhood to get good produce.”</i></p>

<p><b>Community connections and collaboration</b></p>	<p>17%</p>	<p>Participants discussed the importance of building connections and <b>trust with communities</b>, especially for the medical community. This could be achieved by working with <b>trusted messengers</b> and <b>sustaining initiatives</b> in communities (participants noted programs that end when funding ends). Youth also emphasized the need to build connections and collaboration within communities, <b>being supportive of one another and fostering diversity and equality</b>. By building stronger connections and collaborations, these youth feel that advocacy efforts would be that much more effective.</p>	<p><i>"The problems within our community are here by design. Since they are man-made, man/woman can fix them."</i></p> <p><i>"Have more activities and programs for people of different ages and different ethnicity to join. This can bring people out of their house and educate each other so there's less misunderstanding or miscommunication."</i></p> <p><i>"I would have people from different backgrounds, ethnically, race, etc. People of different ages... basically people who are different from each other... so they can all share their ideas and their beliefs and they can also like come to understandings for each other. Which is something that could help people in the real world, like meeting new people from different places, from different backgrounds, with different histories...it could help people understand those people better. I honestly feel that would make the world a little bit better so there's not so much fighting and disagreement."</i></p> <p><i>"Having that somebody that cares about you, that really want to see you grow, it helps....In the Philadelphia community, we have a lot of violence and you know, and having somebody that constantly asks you 'are you ok? Are you having a good day? If you really like the equipment, how it feels and whatnot?' It really makes me feel like somebody values my opinion and for them to value my opinion says a lot."</i></p>
<p><b>Physical activity</b></p>	<p>13%</p>	<p>Youth shared the importance of increasing access to opportunities for physical activity that are <b>safe and ideally outdoors</b>.</p>	<p><i>"I would like to see a recess in the schools. I know high schools may not do that but I really miss recess. Since I graduated from 8th grade I had recess, but 9th, 10th, I did virtual in 11th but that don't count, and now I'm in 12th and still no recess. I really miss recess. I like to go outside, get fresh air, run around. I feel like kids, even older kids like us teenagers, we still need it."</i></p>
<p><b>Youth voice</b></p>	<p>13%</p>	<p>Several groups prioritized the need for youth leadership and voice related to health improvement in their communities. They expressed wanting to be <b>taken seriously, taking a "seat at the table," "speaking out," and crossing generational divides</b> by sharing their ideas and working alongside adults to improve health.</p>	<p><i>"Our generation is very defensive...and we also feel like we know it all. But we forget that these people have lived through hard times. And they might actually have some insight in a way to help us better. In the moment you may not see it as it's gonna help me... but as a younger generation I feel like we don't know how to take things with a grain of salt...Open-minded. And this can also go for our older generation, too, to be open-minded to us. But I feel like it's a two-way street. Because I've talked to like a bunch of older people, and I have to say that it's one of the best things that I've done. When you want to get somewhere in life, when you want to do something, you look at those people who are doing what you want to do because at the end of the day, they've done it, they've done it."</i></p> <p><i>"Solutions in the community is giving your youth a voice, not only in their towns but bigger!"</i></p>

<b>Substance use</b>	<b>13%</b>	A number of groups noted the importance of programs to address <b>addiction, including increasing services provided in communities, and reducing access to substances</b> by preventing them from being sold to youth.	<i>"...all those people that are on the streets, there should be facilities like rehabs specifically for them to get back on their feet because they always go to locking them up. But in reality, it's not that you control, it's a mental illness – so we shouldn't be putting people in jail for something that they can't control like addiction."</i>
<b>Social media</b>	<b>13%</b>	Youth acknowledged the power of social media as a major form of communication in their lives. Some suggested <b>harnessing the power to spread</b> important health messages, while others suggested the need to <b>ensure that it isn't being used to spread misinformation</b> . Participants offered the idea of <b>education campaigns</b> to share the impacts of cyberbullying and trolling.	<i>"Social media is like a cup—you know, it depends on what you fill it with. You can fill it with poison, or you can fill it with water, you can fill it with juice. What are you consuming on social media? When you go on Youtube, what are you watching? What are you putting your mind, what are you using your brain for?"</i>

# LGBTQ+ COMMUNITIES

One of the goals of [Healthy People 2030](#) is to improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender people.

In recognition of the challenges posed by limited and inconsistent collection of sexual orientation or gender identity information, several Healthy People 2030 objectives are focused on increasing the collection of such information in national surveys, including the Behavioral Risk Factor Surveillance System. Such information is critical for identifying and gaining a more comprehensive understanding of the unique health needs of lesbian, gay, bisexual, transgender, queer/questioning, and other identity (LGBTQ+) communities.

Available data underscore the need for urgency not only in understanding, but action. Targeted data collection efforts amply demonstrate the increased risk of poor physical and mental health outcomes among those identifying as LGBTQ+. These stem from intersecting challenges related to societal stigma, interpersonal and institutional discrimination, heightened threat of violence, and lack of access to culturally-affirming and informed health care. The greater likelihood of risky health behaviors, such as higher rates of substance use, found among members of LGBTQ+ communities must be examined in light of these significant stressors. Inclusive, responsive systems of care are necessary to mitigate these increased risks and establish the conditions for sustained well-being for LGBTQ+ communities.

Since 2015, the Pennsylvania Department of Health (PA DOH) has sought to systematically assess the health needs of LGBTQ communities throughout the Commonwealth with what is now the biannual [Pennsylvania LGBTQ Health Needs Assessment](#). For the 2020 assessment, PA DOH partnered with Bradbury-Sullivan LGBT Community Center and the Research & Evaluation Group at Public Health Management Corporation to administer an online survey to LGBTQ-identified Pennsylvania residents. A total of 6,582 respondents participated in the survey, which was available in English and Spanish. Most respondents identified as gay (34.7%), bisexual or pansexual (29.8%), lesbian (18.3%), or queer (10.4%). One in six identified as non-binary (9.2%), genderqueer (2.7%), genderfluid (2.6%) or another gender (2.0%). Nearly half the sample was between the ages of 25 and 49 years and nearly a third under 25. A large majority (83.8%) identified as white, with the remaining identifying as Black or African American (4.6%), another race (4.5%), multi-racial (4.5%) or Asian (2.0%); seven percent identified as Hispanic or Latinx. The sample was highly educated, with 86 percent having greater than high school levels of educational attainment.

Across the entire sample, key findings demonstrate:

- Interest in incorporating healthy living strategies into their lives among nearly all respondents.
- Widespread experience of respect for their LGBTQ identity by their friends and household members.
- Lack of trust of health care providers, as a quarter of respondents have not disclosed their LGBTQ identity with any of their health care providers and over a third fear seeking health care services because of past or potential negative reactions.
- Significant barriers to health care, with over 40 percent experiencing at least one barrier to health care, such as inaccessibility of LGBTQ-affirming providers (too far away, not covered by their health insurance) or inability to afford costs.
- High prevalence of mental health concerns, as nearly three quarters of the sample experienced a mental health challenge in the past year; of those, less than half received counseling or mental health treatment. In their lifetimes, over half have had thoughts of suicide or self-harm.
- Widespread lifetime experience of discrimination based on LGBTQ status.
- Nearly 40 percent have experienced violence from a family member, partner, or spouse. Nearly a quarter report experiencing violence based on their LGBTQ status, with greater likelihood among respondents of color or those who identify as transgender, non-binary, or genderqueer.
- Financial challenges, with nearly a third experiencing food insecurity and more than one in four reporting that they do not have any money left over at the end of the month.
- About a fifth of the sample reporting experiencing homelessness in their lifetime. Nearly a third of respondents of color, as well as nearly a third of transgender, non-binary, or genderqueer respondents, report experiencing homelessness.

Philadelphia residents comprised 13.6 percent of the sample, while residents of Berks, Bucks, Chester, Delaware, Lancaster, Montgomery, and Schuylkill Counties made up the 21.8 percent of respondents designated as a separate Southeastern Pennsylvania (SEPA) region.

Results specific to these areas include:

	<b>Philadelphia</b>	<b>Southeastern PA</b>	<b>PA BRFSS Comparison</b>
Smoking	25%	26%	17%
Binge drinking	38%	31%	17%
Having at least one primary risk factor for HIV	42%	34%	7%

Highest priorities to address in each area include:

- **Philadelphia:** Depression, alcohol/drug addiction, and loneliness/isolation
- **SEPA:** Depression, suicide, and bullying

From a health care perspective, findings from Philadelphia respondents shed light on gaps in care, as:

- Nearly 22 percent do not have a personal doctor or healthcare provider
- Nearly a quarter have not visited a doctor for a routine checkup in the past 12 months
- Almost a third have experienced a negative reaction from a healthcare provider upon learning their LGBTQ status
- A third do not believe most of their healthcare providers have the medical expertise related to their health needs as an LGBTQ person.

To address the needs revealed by this assessment, the following actions are recommended:

- Support connections to LGBTQ-competent providers;
- Support initiatives that address social determinants of health;
- Identify community-wide mental health supports;
- Support chronic disease prevention;
- Promote tobacco cessation opportunities;
- Encourage health screening discussions and health education;
- Bolster community supports for black, indigenous, and people of color;
- Prioritize the health needs of transgender, non-binary, genderqueer, and individuals born intersex;
- Continue and enhance data collection; and
- Partner with LGBT community-based organizations.

Respondents were asked, **“What is one thing you would like to tell healthcare providers to be more welcoming?”** Here are some of their messages:

If you claim competence, I should not be put in a position of educating you on basic care. If you do not claim competence, at least be prepared for an LGBTQ person to walk through your door.

Don't assume everyone is cisgender.

Accept and understand that identity often doesn't change how you need to do your job.

Be honest with us.

Train staff on transgender interactions and appropriate usage of pronouns and communication skills. We are a population highly vulnerable to mistreatment by medical staff, and most likely do not trust that we will be treated fairly from person to person, as many assumptions are made by our appearance. It is exhausting.

Just because we don't 'look gay' doesn't mean we are not gay.

Ask if I'm lonely or depressed.

Take 'first, do no harm' seriously. That's not just physical, but also intellectual and emotional.

Ask everyone their pronouns.

Educate yourself.

I know that 'sex' on the intake form is needed for medical reasons, but it would be great if you could also include 'gender' and 'pronouns' on the forms.

A rainbow flag goes a long way.

Please be mindful of body language and facial expressions when someone confides that they are LGBTQ+.

Be more welcoming to the trans community.

Source: 2020 Pennsylvania LGBTQ Health Needs Assessment

Findings from the 2019 Youth Risk Behavior Surveillance System provide information about the experiences of youth in Philadelphia (a comparable dataset is not available for other counties in the five-county region). More than 1,200 9th to 12th grade high school students from 25 randomly selected Philadelphia public high schools completed the anonymous, self-administered survey in spring 2019. Nearly a quarter of respondents identified as lesbian, gay, bisexual, or unsure.

Among those students:

- Nearly half seriously considered suicide in the prior 12 months (almost three times the rate of heterosexual students) and were over three times more likely to be treated for a suicide attempt than their heterosexual peers.
- Relative to their heterosexual counterparts, LGB students were more likely to report that their mental health was not good (80.3% vs. 55.6% of heterosexual students) and that they felt sad or hopeless for 2 or more weeks in the past year (64.9% vs. 35.3%).
- Compared to 14.3 percent of heterosexual youth, 33.7 percent of LGB youth report drinking in the past 30 days. Binge drinking is also more prevalent among LGB youth relative to heterosexual peers (13.7% vs. 3.8%).
- LGB youth also experienced being physically forced to have sex, sexual dating or physical dating violence, and electronic bullying at much higher rates than their heterosexual peers.
- Thirty percent of LGB youth report experiencing homelessness.

# COMMUNITY HEALTH NEEDS

All quantitative and qualitative inputs were organized into 12 community health needs that were categorized across three domains:

<b>Health Issues</b> <i>Physical and behavioral health issues significantly impacting the overall health and well-being of the region</i>	<b>Access and Quality of Healthcare and Health Resources</b> <i>Availability, accessibility, and quality of healthcare systems and other resources to address issues that impact health in communities across the region</i>	<b>Community Factors</b> <i>Social and economic drivers of health as well as environmental and structural factors that influence opportunity and daily life</i>
<ul style="list-style-type: none"> <li>• Chronic Disease Prevention and Management</li> <li>• Mental Health Conditions</li> <li>• Substance Use and Related Disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Access to Care (Primary and Specialty)</li> <li>• Food Access</li> <li>• Healthcare and Health Resources Navigation (Including Transportation)</li> <li>• Culturally and Linguistically Appropriate Services</li> <li>• Racism and Discrimination in Health Care</li> </ul>	<ul style="list-style-type: none"> <li>• Community Violence</li> <li>• Housing</li> <li>• Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.)</li> <li>• Socioeconomic Disadvantage (e.g., Poverty, Unemployment)</li> </ul>

Participating institutions' ratings of the community health needs were aggregated and are listed below in order of priority (please see "Our Collaborative Approach" for details on the prioritization process):

- |   |  |                                       |
|---|--|---------------------------------------|
| <b>1.</b> Mental Health Conditions                  | <b>5.</b> Healthcare and Health Resources Navigation         | <b>9.</b> Community Violence          |
| <b>2.</b> Access To Care (Primary and Specialty)    | <b>6.</b> Racism and Discrimination in Health Care           | <b>10.</b> Housing                    |
| <b>3.</b> Chronic Disease Prevention and Management | <b>7.</b> Food Access  | <b>11.</b> Socioeconomic Disadvantage |
| <b>4.</b> Substance Use and Related Disorders       | <b>8.</b> Culturally and Linguistically Appropriate Services | <b>12.</b> Neighborhood Conditions    |

Potential solutions for each of the community health needs, based on all qualitative data collection efforts, are also included.

# Mental Health Conditions

- Youth and adult community members and community partners prioritize mental health as their top health need.
- Significant mental health needs across the region are indicated by:
  - High rates of depression among youth and adults (1 in 5 adults report diagnosed depressive disorders, and many more are undiagnosed)
  - Across the 5 counties, 15 percent of residents report frequent mental distress.
  - Suicide mortality and suicide attempts/ideation rates among youth (particularly among those who identify as LGBTQ+) that persist and are likely to show increases when more recent data is made available.
- These concerning trends were exacerbated by the social isolation, stress, and fear experienced due to the COVID-19 pandemic.
- Pandemic-related trauma is particularly compounded for those communities also contending with trauma associated with high levels of poverty, community violence, and racism.
- If left undiagnosed or untreated, there is increased likelihood of serious issues that result in increased health care (especially emergency department) utilization and co-occurring substance use disorders.
- Populations particularly affected include youth, older adults, immigrant communities, LGBTQ+ communities, those experiencing homelessness and housing insecurity.
- There continues to be a significant lack of community-based, integrated mental health treatment options and a particular dearth of resources for youth with mental health needs and their families.

## Potential Solutions

- **Improve care coordination as part of an integrated care model** that assesses the whole person, addresses both physical and behavioral health, and coordinates care across hospitals and community-based service providers:
  - Expand warm handoffs between hospitals, emergency departments, primary care practices, community behavioral health service providers and community-based organizations.
  - Develop coordinated Crisis Response Systems available 24/7, 365 days a year.

- **Increase awareness of behavioral health resources and services.** Hospitals can promote internal awareness and community knowledge about behavioral health services and how to access them.
- **Increase access to safe, structured afterschool activities for youth** available on weekends and in the evening.
- **Create spaces for openly discussing mental health for youth** to normalize/destigmatize mental health issues.
- **Co-locate prevention and behavioral health services in community settings (“one stop shop”) where families live, work, learn, and socialize.** For example, in partnership with community-based organizations, provide co-located behavioral health prevention programs, treatment, and other intervention services in schools.
- **Increase access to support groups** to address mental health and substance use.
- **Increase training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence/sensitivity.**
- **Increase behavioral health workforce capacity and diversity** (e.g., language, racial, and ethnic). Increase number of professionals who represent the racially and culturally diverse populations they serve.
- **Increase individuals with lived experience in the behavioral health workforce.** Peer advocates and teen mentors may be particularly effective sources of support for youth.
- **Provide programming to prevent “burn-out” among behavioral health staff.**
- **Support efforts to increase funding** to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment, as advocated by the [American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children’s Hospital Association.](#)

## Access to Care (Primary and Specialty)

- The supply of primary care providers across the region compares favorably to national data and trends with uninsured rates are improving regionally, but challenges remain with increasing provider acceptance of new patients with Medicaid coverage.
- Barriers to access to primary care for communities are due to:
  - Lack of providers in neighborhoods (especially in NE/SW Philadelphia, rural areas in suburban counties)
  - Affordability (particularly among those who are uninsured, those with lower incomes unable to afford co-payments/deductibles)
  - Language/cultural barriers (notably among immigrant communities and English language learners)
- The above issues are exacerbated with specialty care, with added challenges posed by even more limited availability of appointments, high cost, and lack of care coordination/linkage with primary care.
- Impacts of the COVID-19 pandemic include:
  - Increased enrollment in Medicaid (increases ranging from 11% to 20% in 5 counties, 2020-2021)
  - Longer wait times for appointments, especially for specialty care
  - Gaps in access to preventive services, including immunizations for children/youth, health screenings/diagnostic testing for adults (e.g., chronic diseases, breast/colon/prostate cancer)

### Potential Solutions

- **Provide education and information about Medicaid (e.g., eligibility, coverage) and assist with enrollment.**
- **Create high quality free or low-cost health care options** to serve those who may be uninsured or underinsured.
- **Establish comprehensive health centers** that would address not only physical health, but also mental health and dental care. (It is worth noting that though not the highest priority, there was consistent mention of the need for improved access to dental care across different communities, suggesting a potential opportunity to explore improved linkage to dental care providers.)
- **Bring more health and social services directly to underserved communities through health clinics in schools or mobile medical clinics.**
- **Embed social workers in primary care practices, such as family medicine, pediatrics, and OB/GYN offices.** These professionals could help to assess, refer, and enroll individuals and families in other needed health and social services.
- **Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”** Community members expressed the need to ensure that all staff are welcoming and respectful.
- **Provide on-site language interpreters and health education materials in diverse languages.**
- **Increase the racial, ethnic, and language diversity of staff and providers** to better reflect the communities they serve.
- **Increase transportation assistance**, including adding options for those not eligible for certain benefits.
- **Expand appointment availability and hours in low access areas.**
- **Address barriers to telehealth (e.g., related to internet or device access or digital literacy)** and provide necessary support to ensure high quality telehealth experiences.

# Chronic Disease Prevention and Management

- Conditions like heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute the majority of the top 5 leading causes of death for all counties.
- Notable differences between counties in southeastern Pennsylvania:
  - Rate of premature cardiovascular deaths significantly higher in Philadelphia County
  - Cancer mortality rates highest in Delaware and Philadelphia Counties
  - Hypertension-related hospitalization rates highest in Bucks, Delaware, and Philadelphia Counties
- Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, which disproportionately affects communities of color. In Philadelphia, for example, Hispanic/Latino communities have some of the highest rates of chronic conditions, such as asthma and obesity, and the city's non-Hispanic Black population has disproportionately high rates of chronic conditions such as hypertension and diabetes.
- The COVID-19 pandemic has negatively impacted chronic disease prevention and management. Notably, there have been delays in seeking care, as found in qualitative reports and indicated by lower health care utilization in 2020 as compared to previous years. The full impacts will be clearer with data from 2021 and beyond.

## Potential Solutions

- **Better inform, educate, and engage the public regarding chronic disease prevention and management.** Address limited knowledge about chronic disease screening guidelines and resources through engaging campaigns on varied platforms, including virtual health promotion programming.
- **Engage trusted community leaders to help spread important messages** (for example, promoting cancer screening). Men sharing their stories around personal health and screening may serve as particularly effective examples for other men.
- **Expand successful innovations from the pandemic, such as virtual wellness programs.**
- **Bring screenings and health education to faith-based institutions or where people shop, recreate, or work.** Provide flexible times.
- **Integrate mental health services into overall care management for people with chronic diseases.**
- **Before patients leave a hospital or clinic, provide screening, referrals, and “warm hand-offs”** to community-based health and social services, as well as resources that assist with lifestyle changes for people managing chronic conditions.
- **Increase networking and collaboration among community organizations and health system partners** to improve resource sharing and coordination of services.

# Substance Use and Related Disorders

- Substance use disorders often co-occur with mental health conditions.
- Substance use is associated with community violence and homelessness.
- Drug overdose rates continue to be high due to the opioid epidemic. The drug overdose rates in Bucks, Delaware, and Philadelphia Counties exceed the overall Pennsylvania rate. It is the leading cause of death for young adults.
- The opioid epidemic is associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS).
- Use of other substances, especially during the COVID-19 pandemic, was of pressing concern to community members and partners. Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth, were raised as increasingly prevalent. High rates of marijuana vaping among youth in the four suburban counties.

## Potential Solutions

- **Sustain and expand prevention programs**, ranging from school-based educational programs to community drug take-back programs.
- **Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs.**
- **Expand school-based services** that address students' behavioral health, including drug and alcohol use.
- **Broaden and intensify efforts to reduce vaping among youth.** Collect better data to understand vaping trends among youth and encourage school districts to shift toward policies that provide *"more supportive and restorative disciplinary actions"* for students who are disciplined for vaping, such as referral to cessation programs and other support.
- **Reduce youth access to substances** by preventing their purchase by youth (e.g., drugs purchased on the internet).
- **Expand Narcan training and distribution.** Training more professionals, including police, to provide these services could help lower overdoses.
- **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.
- **Develop texting support services that address underlying issues of substance use**, provided by trained peers or qualified therapists to individual clients.
- **Streamline system navigation for providers and the population at large** to facilitate access to outpatient services after discharge from inpatient facilities.

# Healthcare and Health Resources Navigation

- Community members and partners widely viewed navigating healthcare services and other health resources, like enrollment in public benefits and programs, as a challenge due to general lack of awareness, fragmented systems, and resource constraints.
- Healthcare providers, particularly in the primary and acute care setting, can play an integral role in linking patients directly to health resources or to community health workers or care coordinators.
- Navigation includes information as well as transportation. Many individuals, especially older adults, face significant challenges securing transportation to healthcare and health resources. Lack of accessible, affordable transportation options was raised in a large majority (70%) of qualitative meetings, with the need spanning urban and suburban counties. Financial and logistical issues associated with travel can be a barrier to accessing healthcare and health resources.

## Potential Solutions

- **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** available for those in most need (e.g., older adults, some immigrant communities).

# Racism and Discrimination in Health Care

- Racism is recognized as an ongoing public health crisis in need of urgent, collective attention.
- The COVID-19 pandemic has unmasked and amplified longstanding health and economic disparities experienced by communities of color. Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are further examples of inequities stemming from structural racism.
- Representatives of communities of color shared their mistrust of healthcare providers and institutions arising from seeing such disparities and personally experiencing discriminatory treatment in health care settings.
- Such experiences can lead to forgoing of needed care, resulting in increased morbidity and mortality.
- Anti-Asian hate crimes have increased during the COVID-19 pandemic. Fear of violence among Asian older adults has led to reluctance in leaving their homes, resulting in increased social isolation and adversely affecting mental and physical health.

## Potential Solutions

- **Train and hire people with lived experience, such as community health workers and community peer specialists, to work in communities that have been historically marginalized.**  
These workers, who could be embedded in local community organizations, would be paid a fair wage to connect people to care, help them navigate services, and assist as their advocates within the health system.
- **Increase hospital investment in grassroots community organizations that are working to address social determinants of health and related needs.**
- **Expand and improve the training of healthcare providers around anti-racism, structural racism, implicit bias, diversity awareness, cultural competence, and trauma-informed care.**
- **Increase the number of people of color in healthcare leadership positions.**
- **Ensure diversity, equity, and inclusion efforts and plans within healthcare institutions include an explicit focus on racism and discrimination, with focus on policies, care practices, and ongoing measurement.**
- **Create and fund ongoing forums for community leaders to work with health system partners to address issues of racism and discrimination in health care.**

# Food Access

- Issues of food access focus primarily on food security, defined as having reliable access to a sufficient quantity of affordable, nutritious food. Many community members experience challenges with obtaining sufficient food of any kind, as well as report issues with accessing healthy food more specifically.
- The financial challenges brought on by the COVID-19 pandemic has led to an increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits.
- Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities.

## Potential Solutions

- **Ensure more equitable access to food assistance programs and resources throughout the region.** Hospitals could partner with local organizations to collect and share data to assess and address food access disparities in different communities. Data collection tools also are needed to measure progress toward food security goals. To ensure equitable access to resources, people from under-resourced communities also need a voice at the table.
- **Before patients are discharged from the hospital, provide “warm handoffs” to connect them with community health and social service organizations that address hunger and other needs.** Ensure that patients are connected to public benefits for which they are eligible.
- **Increase collaboration and resource-sharing between hospitals and community groups that are working to increase healthy food access.**
- **Build the evidence base to document the clinical benefits and cost savings of a nutritionally sound diet to prevent or manage common diseases.**
- **Increase outreach to raise awareness and utilization of food assistance programs.** The sheer number of food resources and agencies in the region requires consistent outreach efforts to help people find and connect to what they need. Such assistance should use a wide range of formats and media to reach diverse audiences.
- **Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food.** Possible ideas for exploration include food trucks or produce distribution from local community gardens.
- **Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources** for people in rural and urban areas of southeastern Pennsylvania.

# Culturally and Linguistically Appropriate Services

- About 12 percent of the population across the 5 counties were not born in the U.S. As much as 45 percent of residents of some geographic communities report speaking English less than very well.
- The need for culturally concordant providers and resources to address language barriers was raised in over 50 percent of qualitative meetings.
- Provision of high quality language services (oral interpretation and written translation) is critical for providing equitable care to these communities.
- Beyond language access, cultural and religious norms influence individual beliefs about health. Providers and systems equipped to engage patients about these beliefs and integrate them into care is needed.

## Potential Solutions

- **Increase the racial, ethnic, and language diversity of staff and providers** to better reflect the communities they serve.
- **Develop organizational language access plans that outline protocols for identifying and responding to language needs.**
- **Explore the 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.** This could mean sharing funding with community organizations for providing consultative support based on their linguistic or cultural expertise or healthcare navigation support to patients.
- **Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”**

# Community Violence

- Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties.
- In 2020, Philadelphia lost 447 people to gun violence, the most gun-related homicides in 30 years. It is the leading cause of death for Black men ages 15-43 and Hispanic/Latino men ages 15-31.
- Community violence driven by community disadvantage disproportionately impacts N, NW, and SW communities in Philadelphia.
- The trauma associated with exposure to gun violence is widely felt in communities, especially among youth. However, they report experiencing significant challenges in accessing the necessary mental health supports to address the negative impacts of such exposure.
- Women, youth from immigrant communities, and LGBTQ+ communities are at higher risk of interpersonal violence, including intimate partner violence (IPV), sexual assault, and sex trafficking. Reports of increased risk of IPV associated with COVID-19 stay-at-home orders have been shared by local advocates.
- Negative social media engagement, including cyberbullying, among youth can be a source of community violence.

## Potential Solutions

- **Increase awareness and availability of youth programs to prevent violence, including educational programs, sports, and other recreational activities.** Communication strategies that encompass youth culture and include youth input are needed, as is more funding.
- **Integrate social and mental health services into existing youth activities.** Also provide training for individuals who are trusted by and work with youth (e.g., teaching artists, coaches, teachers, parents) in addressing trauma and other violence-related issues. Help parents advocate for needed mental health services.
- **Build youth capacity for healthy conflict resolution and create positive outlets for arguments or anger.**
- **Create more safe spaces for people to talk about the violence they experience.**
- **Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”**
- **Increase accountability and coordinated action in addressing community violence from the city, schools, health systems, higher education, neighborhood civic association groups, and community-based organizations.** As an integral part of these efforts, hospitals can:
  - **Increase advocacy for policies to prevent or reduce violence,** including initiatives to address poverty and other social determinants that contribute to violence.
  - **Partner with community-based organizations to build on each other’s strengths and increase funding opportunities.**

# #10 Housing

- Safe, stable housing is critical for physical and mental health and well-being. Lack of stable housing is associated with 27.3 fewer years of life expectancy.
- Health issues associated with housing instability include behavioral health issues (mental distress, depression, developmental delays in children, falls among older adults) and medical conditions such as asthma and lead poisoning. Households may forgo needed health care due to financial strain.
- In 2018, 40 percent of Philadelphia households were cost-burdened (when a household spends 30 percent or more of its income on housing costs, including rent, mortgage payments, utilities, insurance, and property taxes). This figure is expected to be higher as a result of the COVID-19 pandemic.
- Poor housing conditions like old lead paint, asbestos, infestations, lack of running water or HVAC, and damaged infrastructure disproportionately impact communities with low incomes.
- Lack of affordable housing is a major driver of homelessness.
- Although point-in-time counts of individuals experiencing homelessness indicate decreases in overall numbers in all five counties over the past several years, continued focus on addressing homelessness is critical, especially when the moratorium on evictions ends.
- People experiencing homelessness are at increased risk of mental health and substance use disorders and experiencing discrimination and bias in healthcare settings.
- Homelessness experienced by youth and older adults are of particular concern for local advocates.

## Potential Solutions

- **Drive solutions that prevent homelessness**, including advocating for livable wages, more affordable housing, and services that support aging in place.
- **Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.**
- **Increase investments by hospitals, managed care organizations, and others in supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness.** These programs, which have been shown to reduce healthcare costs, provide housing and rent subsidies along with wrap-around services to prevent homelessness and re-incarceration.
- **Explore strategies that aggregate funds to support rental assistance.** Encourage health systems and health insurance providers to invest in rental assistance.
- **Explore development of an equitable acquisition fund** to preserve and create affordable housing.
- **Expand programs that support habitability and raise awareness of available resources for housing repair assistance.** Such programs can help older adults age in place.
- **Evaluate existing hospital housing programs for potential expansion**, including those that provide home repairs and remediation for high risk youth (e.g., with asthma) and older adults.
- **Train and encourage health care providers, including primary care physicians, to conduct regular housing insecurity assessments for patients, particularly families, and make referrals as appropriate.** Also train health professionals and social service providers to use a trauma-informed approach when caring for individuals experiencing homelessness or housing insecurity.
- **Increase Rapid Re-housing Programs.** These programs help individuals and families to quickly return to permanent housing, while also building community and landlord relationships to increase affordable housing.
- **Invest in respite housing for individuals in urgent need of transitional housing.**

# Socioeconomic Disadvantage

(e.g., poverty, unemployment)

- Individuals living at or near poverty levels have higher rates of adverse health behaviors and outcomes; poverty resulting from structural racism is the underlying determinant for many racial/ethnic health disparities.
- Inadequate education, limited opportunities, and unemployment are key drivers of poverty.
- Poverty among children and adults tends to cluster in communities; these communities collectively experience trauma and toxic stress, lower life expectancy, limited access to healthcare and health resources, and greater exposure to unhealthy living environments.
- Poverty rates are nearly 4 times higher in Philadelphia compared to suburban counties overall, but pockets of high poverty clusters are seen in suburban counties.

## Potential Solutions

- **Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs.**
- **Partner with local community-based organizations who provide public benefits enrollment assistance** to ensure that residents receive all the benefits (e.g., SNAP, Earned Income Tax Credit) for which they are eligible.
- **Collaborate with community colleges and universities to develop and expand programs** focused on skills training and development to increase access to family-sustaining careers.
- **Train and employ returning citizens.**
- **Advocate for improvements to the disability system** to ensure that people with disabilities are able to work without losing attendant care services.
- **Provide workforce development/pipeline programs with schools.**
- **Increase access to Science, Technology, Engineering, Arts, and Mathematics (STEAM) education for youth.**

## Neighborhood Conditions (e.g., blight, greenspace, air/water quality, etc.)

- Greater neighborhood blight (e.g., abandoned homes, vacant lots, trash) is more likely in high poverty areas and is associated with increased community violence. This has a negative impact on physical activity, as youth expressed avoiding going outside to exercise due to fears of violence.
- Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards. Communities often brought up community clean ups as important community-building activities.
- Access to outdoor greenspaces and recreation areas like parks and trails are lower in these neighborhoods. The negative impact of such lack of spaces on mental and physical health was shared by community members.
- Communities expressed concerns about air pollution and climate change, particularly in S Philadelphia, Delaware County, and flood-prone SW Philadelphia.
- Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity, and further racial segregation.

### Potential Solutions

- **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.**

# 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	Resource
Bucks County Housing Link	<ul style="list-style-type: none"> <li>Point-in-Time Count Data</li> </ul>
Centers for Disease Control and Prevention	<ul style="list-style-type: none"> <li>Behavioral Risk Factor Surveillance System Data (PLACES)</li> <li>CDC/ATSDR Social Vulnerability Index</li> <li>Youth Risk Behavior Surveillance System Data</li> </ul>
Chester County Department of Community Development	<ul style="list-style-type: none"> <li>Point-in-Time Count Data</li> </ul>
Children First (formerly Public Citizens for Children and Youth)	<ul style="list-style-type: none"> <li>No More Dreams Deferred: Building an Education System that Works for Black and Hispanic Students in the Philadelphia Suburbs (Mar 2021)</li> <li>Underwater: 2019 Regional Reports on Child Well-Being (Mar 2019 – Feb 2020)</li> </ul>
City of Philadelphia	<ul style="list-style-type: none"> <li>A Digital Equity Plan for the City of Philadelphia (Jan 2022)</li> <li>Connecting Philadelphia: 2021 Household Internet Assessment Survey (Oct 2021)</li> <li>Language Access Plans</li> <li>Nonprofit Assessment Survey Report for African and Caribbean Immigrant/Refugee-led Organizations (Spring 2021)</li> </ul>
Coalition of African & Caribbean Communities (AFRICOM)	<ul style="list-style-type: none"> <li>COVID-19: Needs and Recommendations Among African and Caribbean Immigrants (Mar 2021)</li> </ul>

Community Legal Services of Philadelphia (Youth Action Board)	<ul style="list-style-type: none"> <li>How the Pandemic Response Has Failed Young People &amp; What We Need to Thrive (Aug 2021)</li> </ul>
Delaware County Council	<ul style="list-style-type: none"> <li>Examination of Health and Public Health Service Delivery in Delaware County, Pennsylvania (Jul 2020)</li> </ul>
Delaware Valley Regional Planning Commission	<ul style="list-style-type: none"> <li>Broadband: Understanding the Digital Divide (Oct 2020)</li> <li>Immigration in Greater Philadelphia: FY 2021 Update (Jul 2021)</li> </ul>
Drexel University Urban Health Collaborative	<ul style="list-style-type: none"> <li>COVID-19 in Context: Racism, Segregation and Racial Inequities in Philadelphia (Jun 2020)</li> <li>The Impact of COVID-19 in Latino Communities in Philadelphia (Jun 2021)</li> </ul>
Feeding America	<ul style="list-style-type: none"> <li>Map the Meal Gap Data</li> </ul>
HealthShare Exchange	<ul style="list-style-type: none"> <li>COVID-19-related Emergency Department Utilization</li> <li>Emergency Department Utilization</li> <li>Emergency Department High-Utilizers</li> <li>Gun-related Emergency Department Utilization</li> </ul>
HUD Exchange	<ul style="list-style-type: none"> <li>Point-in-Time Count Data (Continuum of Care Programs in Delaware County and Montgomery County)</li> </ul>
Pennsylvania Department of Health	<ul style="list-style-type: none"> <li>Pennsylvania 2020 LGBTQ Health Needs Assessment (Jan 2021)</li> <li>Vital Statistics (Birth and Death Records)</li> </ul>
Pennsylvania Office of the Attorney General	<ul style="list-style-type: none"> <li>Pennsylvania Uniform Crime Reporting System</li> </ul>
Pennsylvania Health Care Cost Containment Council	<ul style="list-style-type: none"> <li>Hospital Inpatient Discharge Data</li> </ul>
Philadelphia Chinatown Development Corporation	<ul style="list-style-type: none"> <li>PCDC's Anti-Asian Racism Incident Survey Report (Mar 2021)</li> <li>Wellness Leadership Program 2020 Impact Report (Chinese Immigrant Families Wellness Initiative) (Sep 2021)</li> </ul>
Philadelphia Department of Public Health	<ul style="list-style-type: none"> <li>2020 Health of the City Report (Dec 2020)</li> <li>Growing Up Philly: The Health and Well-being of Philadelphia's Children (Mar 2020)</li> </ul>
Philadelphia Office of Homeless Services	<ul style="list-style-type: none"> <li>Point-in-Time Count Data</li> </ul>
Pennsylvania Commission on Crime and Delinquency, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Education	<ul style="list-style-type: none"> <li>Pennsylvania Youth Survey Data</li> </ul>
U.S. Census Bureau	<ul style="list-style-type: none"> <li>American Community Survey Data</li> </ul>

#### Notes

- Vital statistics data were supplied by the Bureau of Health Statistics and Registries, Pennsylvania Department of Health, Harrisburg, PA. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions.
- 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 this entity 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, payor and physician specific information—provided to this entity, are error free, or that the use of data will avoid difference of opinion or interpretation. This analysis was not prepared by PHC4. This analysis was done by PDPH. 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:

<https://www.phila.gov/documents/regional-community-health-needs-assessment/>