IMPLEMENTATION **STRATEGY**

2025

ADVANCING HEALTH. TRANSFORMING LIVES.

Phoenixville Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

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LETTER FROM THE **CEO**

OUR MESSAGE TO THE COMMUNITY

Phoenixville Hospital is committed to meeting the health needs of our region and growing with our communities to provide access to high quality care, close to home. To achieve this goal, we must understand the community's evolving unmet health needs. To that end, Phoenixville Hospital — in collaboration with our local community partners — completed the 2025 Community Health Needs Assessment (CHNA) and Implementation Strategy, which identifies the region's health priorities and our collective path forward.

As a healthcare leader, Phoenixville Hospital is committed to advancing health and wellness in all the communities we serve. Our work extends far beyond the walls of our hospitals and health system. Together with our community partners focused on the health needs in our communities, we are implementing life-changing programs and services.

My sincere thanks to the nearly 2,000 citizens and stakeholder participants throughout all of the Phoenixville Hospital communities who generously offered their time and valuable insights during the comprehensive CHNA process. I'd also like to recognize the time and talent of our hospital's advisory group, comprised of hospital staff and representatives from community organizations.

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

I am very grateful for your continued feedback, involvement and support. Together, we are Advancing Health and Transforming Lives across our region.

Sincerely,

Rich McLaughlin, MD
President & CEO, Phoenixville Hospital

ABOUT
THE REPORT

IMPLEMENTATION STRATEGY (IS)

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

Phoenixville Hospital's Implementation Strategy (IS) includes goals and strategies on how to address and how to solve key findings from the CHNA.

IRS MANDATE

The CHNA report is a complete review of primary and secondary data analyzing demographic, health, and socioeconomic data at the local, state, and national levels. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA), requiring that nonprofit hospitals conduct CHNAs every three years. Phoenixville Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements. Phoenixville Hospital is proud to present its 2025 IS report to the community.

ABOUT
PHOENIXVILLE HOSPITAL

Located in Phoenixville, PA, and a member of Tower Health, Phoenixville Hospital is a 144-bed facility that provides comprehensive medical services through emergency room visits, inpatient admissions, outpatient procedures and community outreach programs. Phoenixville Hospital's services include an award-winning cardiovascular program, a fully accredited cancer center, NAPBC-accredited breast health center, an acute inpatient rehabilitation center, and a large robotic surgery program. Phoenixville Hospital is accredited by The Joint Commission and has been recognized for its quality outcomes and clinical expertise across services lines that include advanced joint replacement surgery, advanced heart failure care, and the designation as a Primary Stroke Center.

MISSION STATEMENT

Phoenixville Hospital is an organization that serves our patients and engages with our communities to provide health and healing to all of those in need. We are committed to clinical excellence and innovation; education; equitable access to care; creating a sense of belonging; and improving the health and wellness in the communities we serve.

VISION STATEMENT

Proactively Advance Healthier Communities

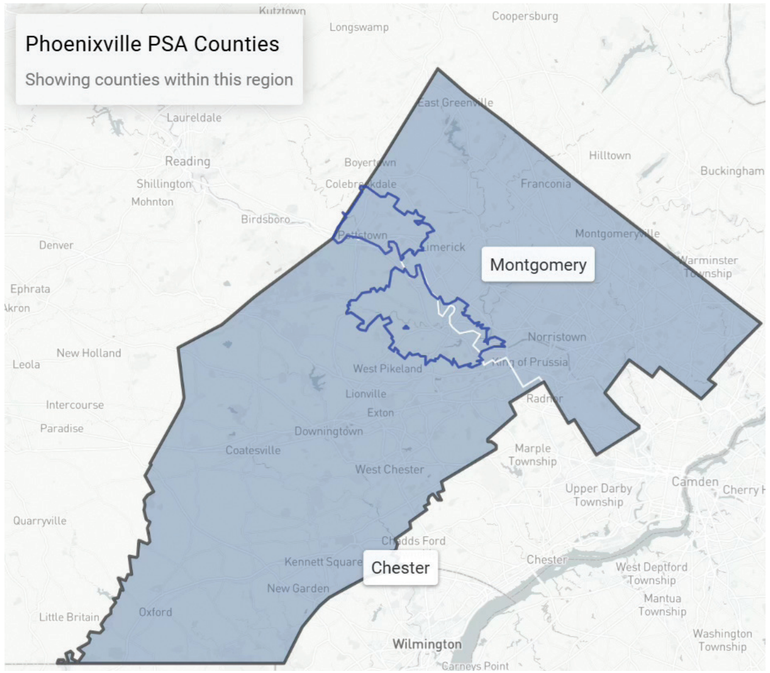
REPORT
SERVICE AREA

Phoenixville Hospital's primary service area (PSA) includes the zip codes listed below within Chester and Montgomery Counties. (table and map from pages 10 and 11 of Phoenixville CHNA – different description)

Figure 1: Phoenixville Hospital Primary Service Area Zip Codes

ZIP CODE	NAME
19403	Audubon
19407	Audubon
19408	Eagleville
19409	Fairview Village
19415	Eagleville
19426	Collegeville
19442	Kimberton
19453	Mont Clare
19456	Oaks
19457	Parker Ford
19460	Phoenixville
19464	Pottstown Borough
19465	Pottstown Coventry
19468	Royersford
19470	Saint Peters
19474	Skippack
19475	Spring City
19481	Valley Forge
19482	Valley Forge
19490	Worcester
19493	Valley Forge
19494	Valley Forge
19495	Valley Forge
19496	Valley Forge

Figure 2: Phoenixville Hospital's Service Area



OUR FOCUS

Phoenixville Hospital's 2025 Implementation Strategy (IS) is a key component of the community health needs assessment process as it delineates the strategies and goals designed to meet prioritized needs and sets the stage for action and execution of initiatives that effectively impact health outcomes and sustain improvements in health status across our communities.

Much of today's delivery of health care should acknowledge the social and economic factors that influence health. These factors, called social determinants of health (SDOH), include our race, income, education level, and livable home and community environments. Understanding the strong impact of SDOH requires us to step aside from our traditional health care approaches and to pursue innovative best practices to improve health. The 2025 IS was built on accomplishments and lessons learned, as well as the challenges and complexities, of 2022 CHNA and IS efforts.

A DEEPER PERSPECTIVE:
CHNA PRIORITIES

The 2025 IS outlines Phoenixville Hospital's continued focus on the whole person, is patient- and community-centered, and supports the optimal use of a plethora of health care and human service resources to improve health. Community participants emphasized the need to improve access to equitable care and behavioral health and to expand health education and prevention. Inequities such as demographical differences highlight the importance of weaving an equity focus within all areas of health.

The effectiveness of the 2025 IS is strengthened as we translate our understanding and knowledge of what the community told us into dynamic policies and best practices. Community input guides our efforts to diligently understand past successes and pitfalls in continuously improving the health of our communities through the following areas of focus:

A) ACCESS TO EQUITABLE CARE

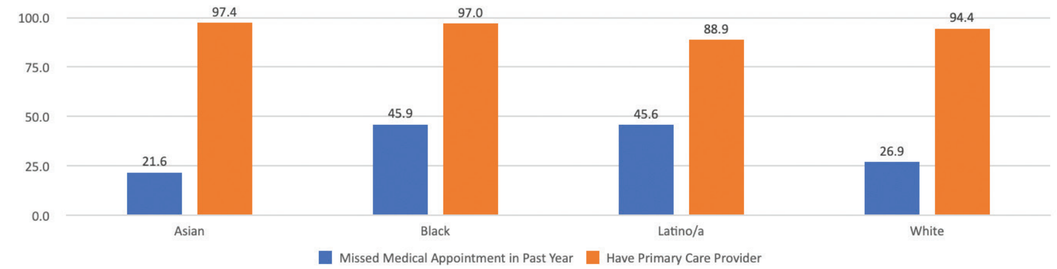
Access to equitable care was strongly emphasized throughout all steps of data collection. When assessing diverse and disparate populations, many social factors and barriers to health care access and services (e.g., inadequate healthcare coverage, high costs, insufficient availability of providers, transportation, and language barriers) were uncovered. These barriers have a very dramatic impact on community members' ability to access quality health care and achieve a higher quality of life.

Focus group participants and key informants highlighted several key issues affecting access to healthcare. These include the difficulty of navigating healthcare systems described as maze-like, the challenge of health literacy among populations with limited education, and the systemic barriers faced by non-English speakers and immigrants. There are also concerns about the lack of follow-through in healthcare provision, such as obtaining medications or continuing therapy, and the reliance on emergency rooms for primary care due to lack of access to regular medical services.

Source: Access to Care LA, 2020

The chart below shows community survey respondents who missed a medical appointment in the last year, and who have a primary care provider. Respondents who identify as Hispanic or Latino were less likely to report having a primary care provider, while respondents who identified as Non-Hispanic Black and Hispanic or Latino were more likely to report having missed or delayed a medical appointment in the past year.

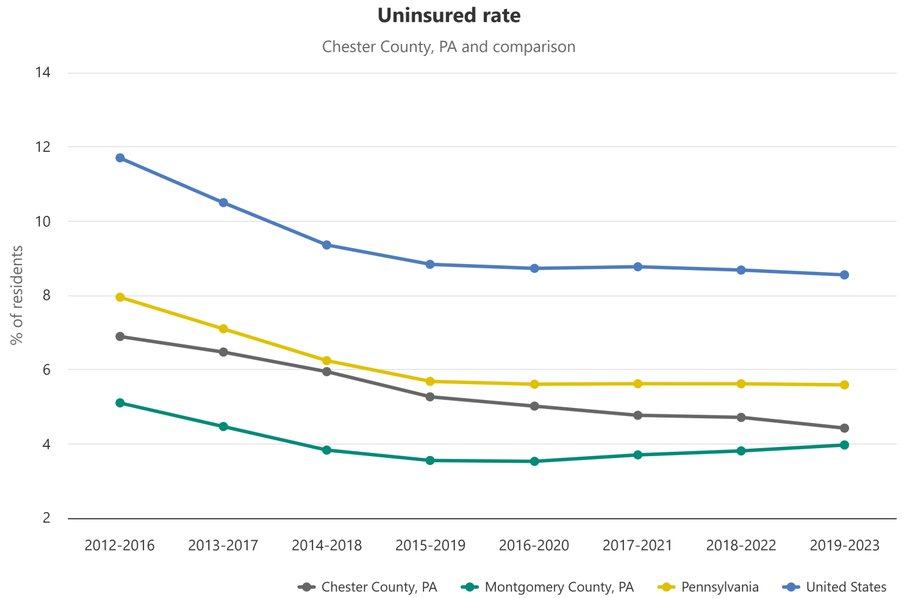
Figure 3: Access to Care – Survey Respondents



Source: Tower Health Community Survey, 2024

The uninsured rate in Chester County, PA, and Montgomery County, PA, has consistently been lower than the state and national averages from 2012 to 2023. Both counties have seen a steady decline in their uninsured rates over this period, reflecting broader trends in Pennsylvania and the United States. The data indicates significant improvements in insurance coverage across all regions, with Chester County showing the most notable decrease.

Figure 4: Uninsured rate



Created on Metopio | metop.io/i/dqcjuya4 | **Data source:** U.S. Census Bureau: American Community Survey (ACS) (Tables B27001/C27001)

Uninsured rate: Percent of residents without health insurance (at the time of the survey).

GOAL:

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

Strategy	Action Items	2025	2026	2027	Metrics (per year)	Partners
Utilize community health professionals to improve access to care for vulnerable community members.	Connect patients to primary and specialty care	X	X	X	100 patients referred	Community health professionals Primary and Specialty care practices
	Identify and address SDOH	X	X	X	30% of patients have SDOH needs addressed	
	Conduct health literacy assessments	X	X	X	75% of patients/community members complete the health literacy assessment	
Provide Nurse Outreach to vulnerable populations	Community health nurses will provide health information and referrals to community resources to address unmet health needs	X	X	X	50 nurse outreach visits conducted	King Terrace (low income housing) Whitehall VA Housing Phoenixville Area Community Services Project Outreach First United Church
Improve access to transportation	Utilize Ride Health platform to coordinate free transportation to and from appointments for eligible patients	X	X	X	5% increase in number of rides annually	Ride Health Community transportation services Phoenixville Hospital Case Management Nursing Admin

GOAL:

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

Strategy	Action Items	2025	2026	2027	Metrics (per year)	Partners
Improve access to screening mammograms	Partner with Reading Hospital Mobile Mammography Coach for screening mammograms in vulnerable population	X	X	X	1 Mobile Mammography event coordinated	Reading Hospital's Mobile Mammography Coach
	Partner with community organizations to obtain mammography screening vouchers for uninsured women	X	X	X	50 screening mammograms performed	Healthcare Access Penn Radiology Phoenixville Free Clinic
Create ways to listen to the community	Implement a patient and family advisory committee (PFAC)	X			Committee implemented	Patients and family members
	Host quarterly PFAC meetings	X	X	X	4 meetings held	

B) BEHAVIORAL HEALTH

Behavioral Health includes the prevalence of mental health disorders and access to mental health services, addressing issues like depression and anxiety, and other disorders, as well as substance use disorders such as addiction to drugs and alcohol. Community members and leaders expressed the following unmet needs in the community:

- Mental health resources
- Increased service accessibility and adequacy
- Increased support for marginalized groups
- Transportation support
- Respect in medical settings

The table below shows the counts of Behavioral Health hospitalizations for Phoenixville Hospital by health condition. The most common Behavioral Health hospitalizations were related to mental health and opioids:

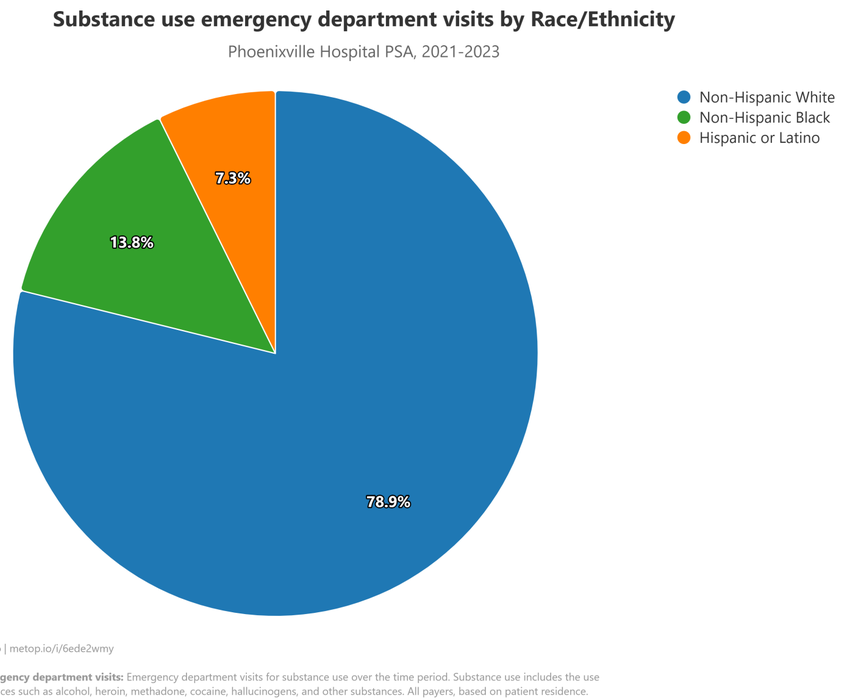
Figure 5: Count of hospitalizations

Health Condition	Number of Hospital Admissions, 2021-2023
Mental Health	1,431
Opioid-Related	997
Substance Use	658
Suicide and Self-Injury	160
Alcohol Use	491

Source: Phoenixville Hospitalization Data, 2021-2023

The chart below shows from 2021–2023, the majority of Phoenixville Hospital Emergency Department visits related to substance use were among the Non-Hispanic White population.

Figure 6: Substance use Emergency Department visit by Race/Ethnicity



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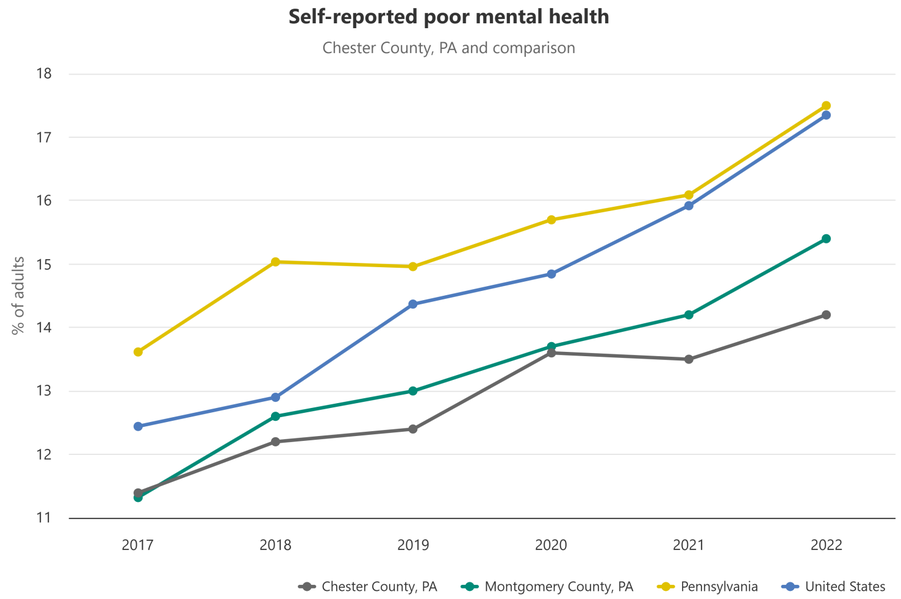
Substance use emergency department visits: Emergency department visits for substance use over the time period. Substance use includes the use of controlled substances such as alcohol, heroin, methadone, cocaine, hallucinogens, and other substances. All payers, based on patient residence.

Self-reported poor mental health in Chester County, PA and Montgomery County, PA has increased over the years, with Chester County showing a higher rate in recent years. Pennsylvania and the United States have also seen a rise in self-reported poor mental health, with the national rate surpassing that of both counties in 2022. The data indicates a growing mental health crisis across all levels.

Figure 7: Poor self-reported mental health



Created on Metopio | metop.io/i/6rb8qh4e | **Data source:** Centers for Disease Control and Prevention (CDC): PLACES

Self-reported poor mental health: Percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

GOAL:

Improve access to behavioral health and behavioral health support services.

Strategy	Action Items	2025	2026	2027	Metrics (per year)	Partners
Increase mental health awareness and reduct stigma	Provide programs on behavioral health issues to community	X	X	X	2 programs on Behavioral Health topics conducted	
	Host Mental Health Fun Day	X	X	X	200 community members attend	Phoenixville Recreation Center
	Collaborate/assist community organizations with behavioral health referrals	X	X	X	2 organizations identified as collaborative partners	Community-based organizations
	Utilize social media to provide mental health education	X	X	X	12 social media posts 10% increase in engagement	
Increase access to mental health support	Collaborate/Provide support groups addressing mental health	X	X	X	50 participants referred/attend support group	Chester County Health Department
Employee Health and Wellness	Marvin Telemedicine	X	X	X	95% use of service satisfaction reported	TH Wellness Committee
	Tower RISE	X	X	X	95% use of service satisfaction reported	TH Wellness Committee
	Offer pet therapy monthly for staff	X	X	X	12 visits from therapy dog	Patient Experience Council Volunteer Services

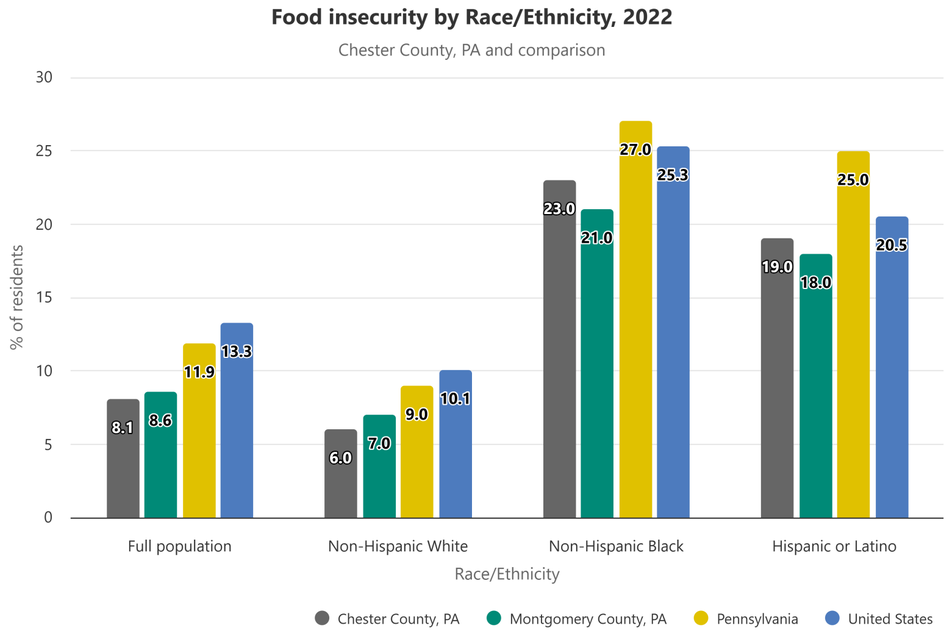
C) HEALTH EDUCATION AND PREVENTION

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

Community members expressed various challenges related to health behaviors, including difficulties in managing weight, controlling blood sugar levels, and accessing credible health information and resources. The importance of support groups and community resources like healthcare providers, telehealth, and online information portals is emphasized as instrumental in helping individuals manage their health effectively. Additionally, the coverage of health insurance and the availability of healthcare providers who accept Medicare and Medicaid are significant concerns, especially for those managing chronic diseases and mental health conditions.

Food insecurity rates vary significantly across different racial and ethnic groups in Chester County, Montgomery County, Pennsylvania, and the United States. Non-Hispanic Black and Hispanic or Latino populations experience higher rates of food insecurity compared to the full population and Non-Hispanic White populations. This disparity is evident at both the county and state levels, as well as nationally.

Figure 8: Food insecurity by Race/Ethnicity

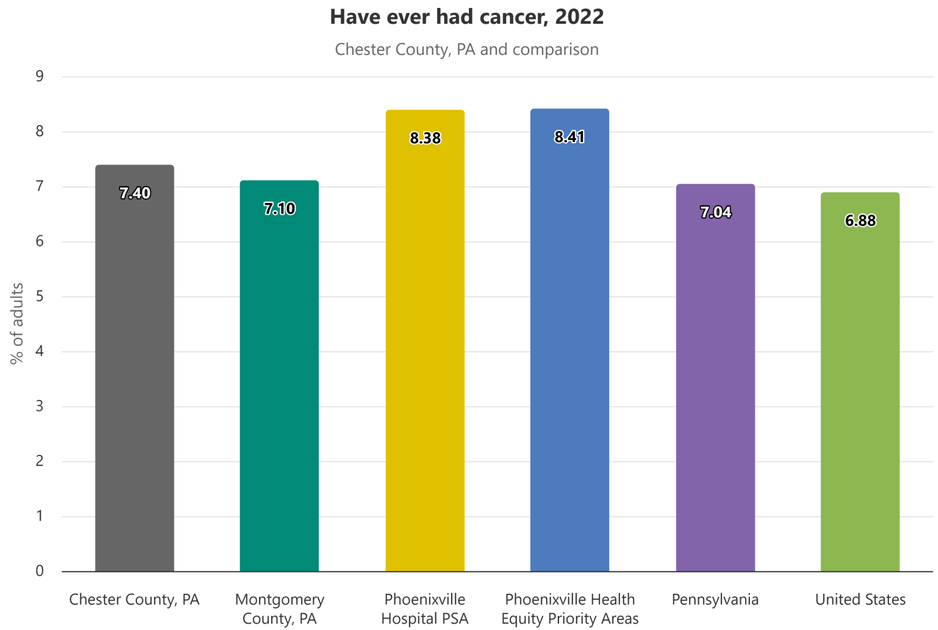


Created on Metopio | metop.io/i/u5zzv47k | **Data source:** Feeding America: Map the Meal Gap

Food insecurity: Percentage of the population experiencing food insecurity at some point. Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food, as represented in USDA food-security reports. 2020 data is a projection based on 11.5% national unemployment and 16.5% national poverty rate.

Have ever had cancer rates vary across different areas, with Chester County, PA, having the highest rate at 7.4%. Pennsylvania's overall rate is slightly lower at 7.0%, while the United States has a rate of 6.9%. Notably, the Phoenixville Health Equity Priority Areas have the highest rate at 8.4%.

Figure 9: Have ever had cancer



Created on Metopio | metop.io/i/x3r2h377 | **Data sources:** Behavioral Risk Factor Surveillance System (BRFSS) (County and state level data), Centers for Disease Control and Prevention (CDC): PLACES (Sub-county data (zip codes, tracts))
Have ever had cancer: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have cancer (other than skin cancer). Data for counties and states are age-adjusted. Data for zips, tracts and smaller layers are raw.

GOAL:

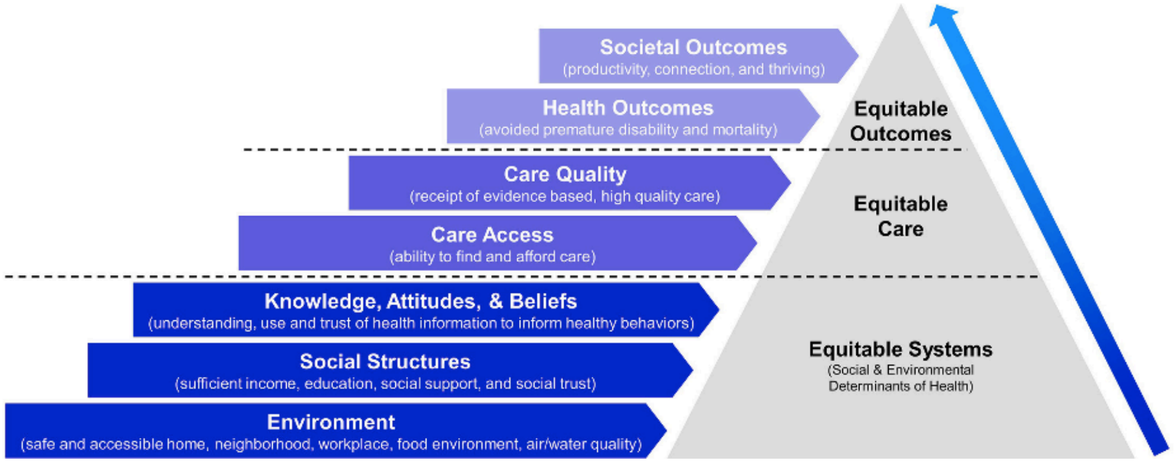
Provide disease education and prevention opportunities in the community, specifically targeting disparate and vulnerable populations.

Strategy	Action Items	2025	2026	2027	Metrics (per year)	Partners
Provide chronic disease education	Provide health education programs focused on older adult/senior population	X	X	X	10 programs held	Phoenixville Senior Center Phoenixville YMCA Phoenixville Recreation Department
	Provide chronic disease education to other vulnerable populations including low income, Veterans, etc.	X	X	X	10 programs held	Community-based organizations
Increase awareness of food resources in community	Partner with organizations to ensure community has access to healthy food to promote health living	X	X	X	100 referrals to food resources	Chester County Food Bank Community Gardens Phoenixville Area Community Services (PACS) Project Outreach
	Partner with community organizations to provide nutrition education	X	X	X	5 nutrition education programs conducted	Chester County Food Bank
Offer community-based outreach in Spanish/Portuguese to address language barriers	Collaborate with organizations to provide health information to Spanish- and Portuguese-speaking community members	X	X	X	200 participants	Alianzas De Phoenixville Kate's Casa St. Ann's Roman Catholic Church Phoenixville Free Clinic
Engage with local school districts to further wellness education and programs	Provide school-based wellness education for staff and students	X	X	X	5 school-based programs condcuted	Local school districts
Provide cancer prevention and screening activities	Provide tobacco wellness programs	X	X	X	500 participants	Local school districts Community-based organizations
	Provide information on cancer prevention and screening at hospital and community events	X	X	X	2 events conducted	Community-based organizations

D) HEALTH EQUITY

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

Figure 13: Health Equity Pyramid



Source: Prentice et al, Advancing health equity in the aftermath of COVID-19: Confronting intensifying racial disparities

As shown in the image below, about one in five black adults and one in ten Hispanic, Asian, and American Indian or Alaska Native (AIAN) adults reported unfair treatment by a health care provider due to race or ethnicity.

Figure 14: Unfair Treatment by a Health Care Provider Due to Race or Ethnicity

Percent who say that a doctor or other health care provider treated them unfairly or with disrespect in the past three years because…					
	Hispanic	Black	Asian	AIAN	White
…their race or ethnic background	11%	18%	10%	12%	3%
…some other factor, such as their gender, health insurance status, or ability to pay for care	14%	18%	11%	26%	13%
...were treated unfairly or with disrespect for any reason	17%	24%	15%	29%	14%

Source: KFF Survey on Racism, Discrimination, and Health (June 6-August 14, 2023)

GOAL:
Creating Health Equity

Strategy	Action Items	2025	2026	2027	Metrics (per year)	Partners
Implement a Health Equity Council	Convene a multidisciplinary Health Equity Council	X	X	X	Quarterly meetings held	
	Develop and Implement a Health Equity Plan targeting a specific health disparity in the community	X	X	X	Health Equity Plan established and approved by Board of Trustees Metrics reported to Board of Trustees	
Address Language Access and Barriers	Increase the number of healthcare providers who are medically certified interpreters		X	X	Train approximately 3 health care providers annually	
Improve health literacy in the community	Provide Adolescent Health Literacy to high school students	X	X	X	100 students reached	Local school districts
	Educate health care professionals on best practices for communicating with patients and teachback method	X	X	X	100 health care professionals educated	

GOAL:
Creating Health Equity

Strategy	Action Items	2025	2026	2027	Metrics (per year)	Partners
Collaborate with community organizations serving diverse communitites to provide cultutally appropriate health education	Participate in culturally diverse community events addressing health and wellness	X	X	X	2 community cultural/diversity events attended	Alianzas De Phoenixville LGBTQ Equality Alliance
Improve digital health literacy in the community	Promote Telehealth to community	X	X	X	100 older adults educated	Community organizations
	Collaborate with local health care professionals to offer educational sessions and workshops	X	X	X	2 educational sessions facilitated	
Develop a Diverse Workforce	Provide Job Shadowing Opportunitites to the Community	X	X	X	Provide job shadowing opportunities for 50 students	Local high schools, colleges, and universities

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