COMMUNITY HEALTH NEEDS

2022 ASSESSMENT

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Pottstown Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

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LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Rich Newell

Chief Executive Officer,
Pottstown Hospital

Pottstown Hospital is committed to meeting the changing health needs of our communities while working to develop programs and services that provide our region with high-quality care close to home.

To achieve this goal, we must first identify the community's evolving health needs. Pottstown Hospital – in collaboration with all Tower Health facilities and our community partners – completed the 2022 Community Health Needs Assessment (CHNA), which identifies our region's health priorities and determines our collective path forward.

Hospitals are required to conduct a CHNA every three years to retain their nonprofit status. The data for this CHNA was collected regionally and reported for our hospital service area. Working with our strategic and community partners, Pottstown Hospital will use the results of this assessment as a foundation to develop tactics to address each of the identified regional health priorities: Access to Equitable Care, Behavioral Health, Health Education and Prevention, and Health Equity.

Pottstown Hospital is committed to advancing health and transforming lives throughout Berks, Chester, and Montgomery counties. As a leading health care provider, we strive to positively impact the health and well-being of our patients, as well as the broader communities we serve. Many of our programs and services have been developed to address specific regional health needs or overcome barriers to care. These efforts continue to make a difference in the lives of individuals and families. We are grateful for our community partners who worked to help make these programs possible.

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

I would like to offer my sincere thanks to the citizens and stakeholder participants throughout all the Pottstown Hospital communities who generously volunteered their time and valuable insights during the comprehensive CHNA process.

I am beyond thankful for your ongoing support and continued involvement in the well-being of our communities. By working together, we can continue to change lives across our region.

Sincerely,

Rich Newell

Chief Executive Officer,
Pottstown Hospital

Questions or comments
regarding the CHNA can be sent via email to
PottstownCommunityHealth@towerhealth.org

ABOUT
THIS REPORT

COMMUNITY HEALTH NEEDS ASSESSMENT INTRODUCTION

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 Pottstown Hospital included input from those who represent the broad interests of the community. They specifically included representatives served by the hospital facilities, mainly those knowledgeable of public health issues, information related to the vulnerable, underserved, disenfranchised, and 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.

In the fall of 2022, Pottstown Hospital will release its Implementation Strategy Plan (ISP), which includes goals and strategies to address 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. Pottstown Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements.

Pottstown Hospital is proud to present its 2022 CHNA report and its findings to the community.

CONSULTANT INFORMATION

Tower Health contracted with Tripp Umbach, a private health care consulting firm, to complete a CHNA. Tripp Umbach has conducted more than 400 CHNAs and has worked with more than 800 hospitals. Changes introduced by the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts among providers, public health agencies, and community organizations to improve the communities' overall health and ensure access to essential services.

CHNA PROCESS — COMMUNITY ENGAGEMENT

The CHNA process began in February 2021, and the collection of quantitative and qualitative data concluded in September 2021. As part of this needs assessment, a vast number of residents, educators, government, health care professionals, and health and human services leaders in Pottstown Hospital's service area participated in the study. Information collected from leaders provided a deeper understanding of community matters, health equity factors, and community needs. See Figure 1. Pottstown Hospital collected community and key informant surveys, community leader interviews, and focus group data to engage and capture the community's perspective.

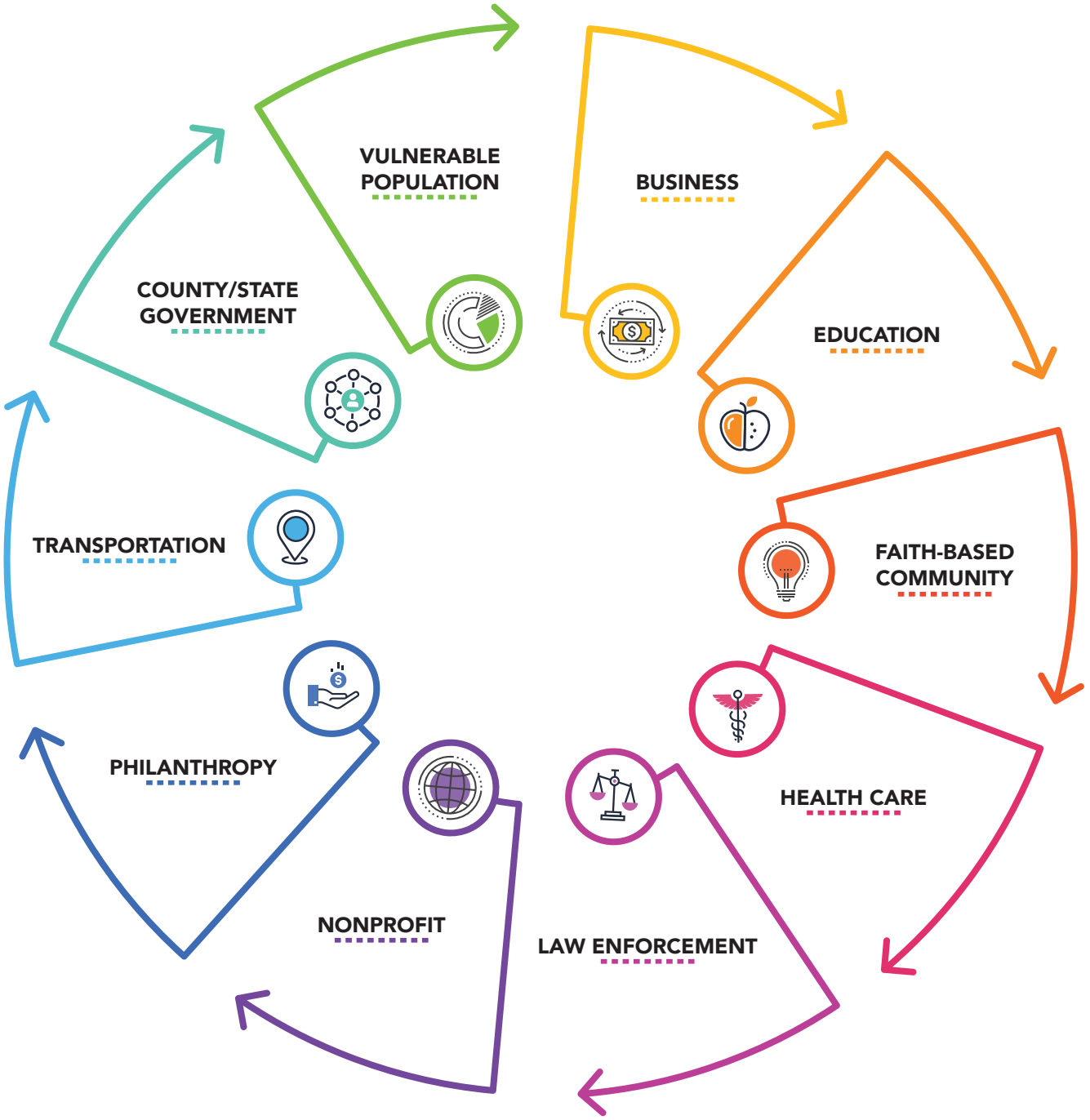
Various types of data, such as county demographics and chronic disease prevalence were gathered from local, state, and federal databases to compile secondary data.

Community surveys, key informant surveys, and community leader interviews were dispersed to garner participation from all members residing or working in the primary service area. The data collected identified the needs, high-risk behaviors, barriers, societal issues, and concerns of the underserved and vulnerable populations. Information from focus groups with hospital leadership and community partners who provide services and care to the region was also included in the collection phase.

While multiple steps made up the overall CHNA process, Tripp Umbach worked closely with members of the working group[1] to collect, analyze, and identify the results to complete the hospital's assessment.

[1] Members of the working group consisted of Casey Fenoglio, Community Wellness Program Manager, Pottstown Hospital; Ha T. Pham, Senior Principal, Tripp Umbach; Barbara Terry, Senior Advisor, Tripp Umbach; and Julia Muchow, Project Manager, Tripp Umbach.

Figure 1: Pottstown Hospital's Community Engagement



2021-2023 COMMUNITY HEALTH REGIONAL PRIORITIES

The CHNA roadmap was designed to engage all aspects of the community, from community residents to community-based organizations, health and business leaders, educators, and policymakers, to identify health care needs and recommend possible solutions to address health issues identified.

Numerous secondary and quantitative data sources were gathered from noted public health sources to establish the current health status of the population. Primary data was collected specifically from community stakeholder interviews, key informant surveys, focus groups with health care leaders and community leaders, and a broad-based community survey in English and in Spanish. The primary and secondary data created a framework of current health status as outlined in the CHNA roadmap in Figure 2.

Figure 2: Roadmap for Community Health Needs Assessment at Pottstown Hospital[2]

[2] It is important to note that data collected for the 2022 CHNA has limitations in information. Secondary data utilized for the report is not specific to the hospital's primary service area but rather provides a scope or picture to a larger geographic region. Data was also limited to the most recent publicly available data years. Primary data obtained through interviews and surveys is also limited in representation of the hospital's service area as information was collected through convenience sampling.

POTTSTOWN HOSPITAL

WHO ARE WE?

Pottstown Hospital is a 219-bed facility with a full range of health services, including inpatient and outpatient, medical and surgical, and diagnostic and emergency care. Pottstown Hospital has 1,150 health care professionals delivering compassionate, safe, quality care, working hard to be a place of healing, caring, and connection for patients and families in the community. Pottstown Hospital is home to many of top-tier services, including:

- Cancer Center
- Cardiopulmonary/Respiratory (EKG, Pulmonary Function Lab)
- Center for Orthopedics and Spine
- Emergency Department
- GI/Endoscopy Center
- Imaging
- Inpatient Dialysis
- Intensive Care Unit
- Interventional Radiology
- Inpatient Psychiatric Unit & Geri-Psych
- Laboratory/Pathology
- Neurosciences
- Nuclear Medicine
- Occupational Medicine/Travel Health Services
- Radiology Suite
- Rehabilitation Services
- Surgery
- Women's Health Services
- Wound Care

At Pottstown Hospital, advancing your health and wellness is our mission. Pottstown Hospital is accredited by The Joint Commission and has been recognized for its quality outcomes and clinical expertise across many service lines. Its cancer program is nationally recognized. The hospital also is a Primary Stroke Center, Joint Commission certified for hip and knee replacement, and Heart Failure and Chest Pain certified. Its Emergency Room, which is the second busiest in Montgomery County, sees more than 40,000 patients a year.


Pottstown Hospital
TOWER HEALTH

MISSION

The mission of Pottstown Hospital is to provide compassionate, accessible, high-quality, cost-effective health care to the community; to promote health; to educate health care professionals; and to participate in appropriate clinical research.

VISION

Pottstown Hospital will be an innovative, leading regional health system dedicated to advancing the health and transforming the lives of the people we serve through excellent clinical quality; accessible, patient-centered, caring service; and unmatched physician and employee commitment.

REPORT SERVICE AREA

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community. Pottstown Hospital's primary service area (PSA) includes 11 ZIP codes within Berks, Chester, and Montgomery counties.[3]

Pottstown Hospital PSA	
ZIP Codes	**Town/Neighborhood**
19464	Pottstown
19465	Pottstown
19468	Royersford
19512	Boyertown
19518	Douglassville
19519	Earlville
19525	Gilbertsville
19545	NS - Included in 19512
19548	NS - Included in 19512
19457	NS - Included in 19465
19472	NS - Included in 19525

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

EVALUATION OF
2019 CHNA IMPLEMENTATION STRATEGY

Pottstown Hospital has worked over the last three years to develop and implement strategies to address the health needs in the study area and evaluate the effectiveness of the strategy created in terms of meeting goals and combatting health problems in the community.

The evaluation process determines the effectiveness of the previous plan. The working group tackled the problem statements for each past priority and strategy and developed ways to address its effectiveness. The self-assessments on each of the strategies are internal markers to denote how to improve and track each of the goals and strategies within the next three years. The following tables reflect highlights and accomplishments from Pottstown Hospital. Specific metric information/measurable indicators can be obtained from the hospital's administrative department.

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

Goal 1. Increase access to health care services by community members, particularly those considered vulnerable and/or living in underserved areas.

STRATEGIES	ACTION STEPS
Increased cultural awareness, diversity, and inclusion	Participated in diversity, inclusion, and cultural competency trainings.
Streamlined access to care facilities	Implemented the Tower Access Project.
Increased access to local FQHCs	Developed a plan to provide immediate follow-up appointments and transportation to patients post discharge.

2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH (SDOH)

Goal 1. Identify and address Social Determinants of Health (SDOH).

STRATEGIES	ACTION STEPS
Implemented SDOH in Emergency Department	Planned, pilot-tested, and implemented SDOH screening project.
Identified and removed transportation barriers	Implemented Ride Health.

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

Goal 1. Implement chronic disease prevention and management programs in the primary service area, specifically targeting vulnerable populations.

STRATEGIES	ACTION STEPS
Provided disease specific education and screening programs	Provided disease specific education.
	Provided free cancer screenings.
	Established a relationship with Tower Health Medical Group for hypertension screenings and follow-up referrals.
Engaged in Tower Wellness Programs	Implemented short- and long-term wellness initiatives.
Encouraged community members and youth to engage in physical activity and healthy eating	Developed a Community Supported Agriculture (CSA) Program that provides free fruits and vegetables and nutrition education.
	Built a relationship with local school districts and participated in their wellness committees.
	Participated in school wellness activities for youth.

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

Goal 1. Improve access to screening, assessment, treatment and support for behavioral health.

STRATEGIES	ACTION STEPS
Improved access to behavioral health programs	Implemented a warm handoff program in the ED
	Partnered with Tower Behavioral Health to increase access to inpatient treatment options
Increased awareness of available resources	Participated in community-based health education and awareness events
	Updated Pottstown Hospital's website to include behavioral health information and resources

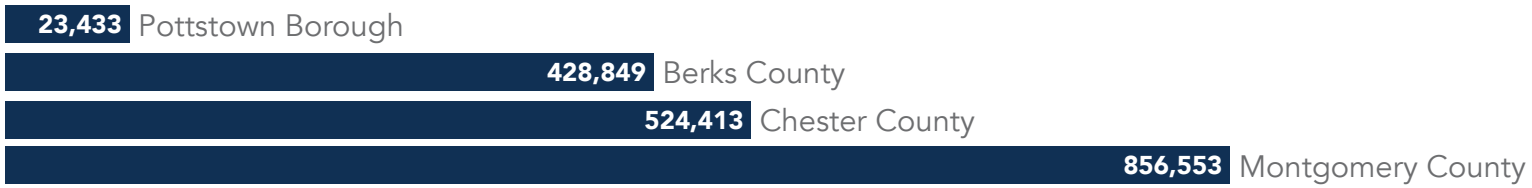
Goal 2. Decrease stigma related to behavioral health.

STRATEGIES	ACTION STEPS
Designed and implemented an anti-stigma campaign	Partnered with community organizations to design and implement a mental health campaign during COVID-19
	Disseminated the campaign to over 20,000 households
	Hosted events to build awareness of campaign

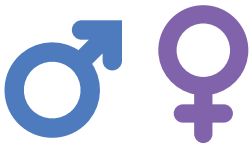
COMMUNITY AT A GLANCE

The health of an individual is largely influenced by the choices we make for ourselves and our families and the available opportunities to make those positive choices. These influences affect our ability to make healthy choices; afford care, housing, and food; and cope with stress factors.

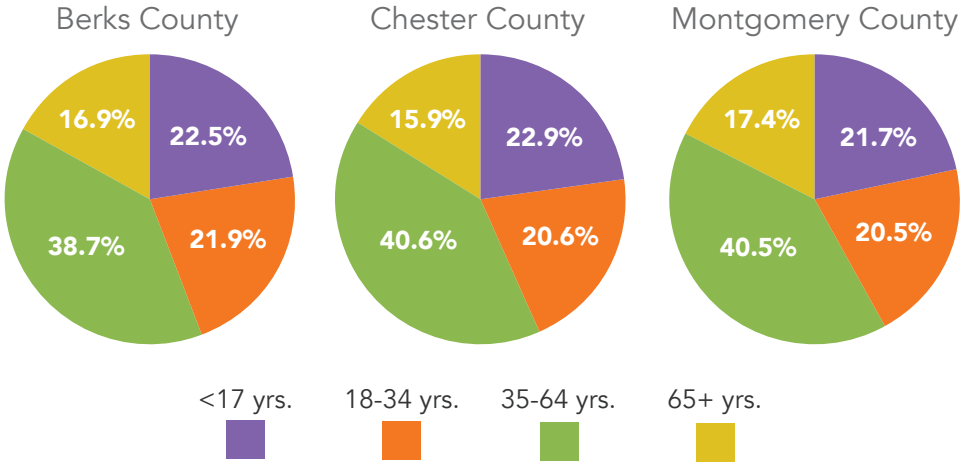
POPULATION



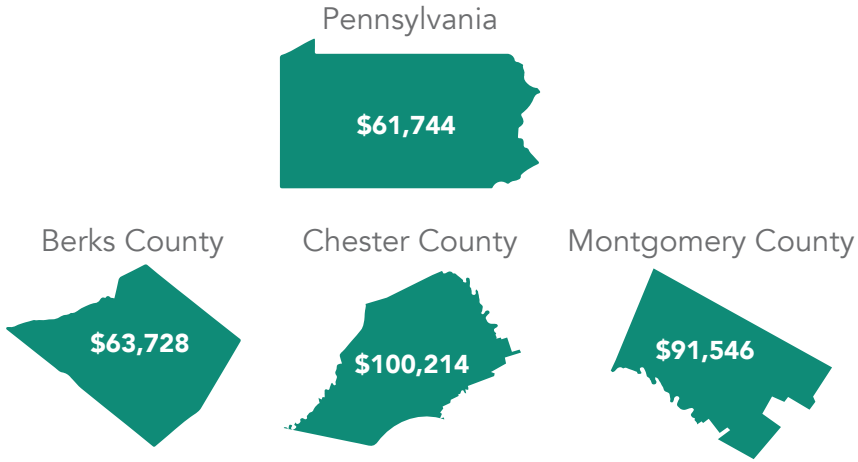
GENDER



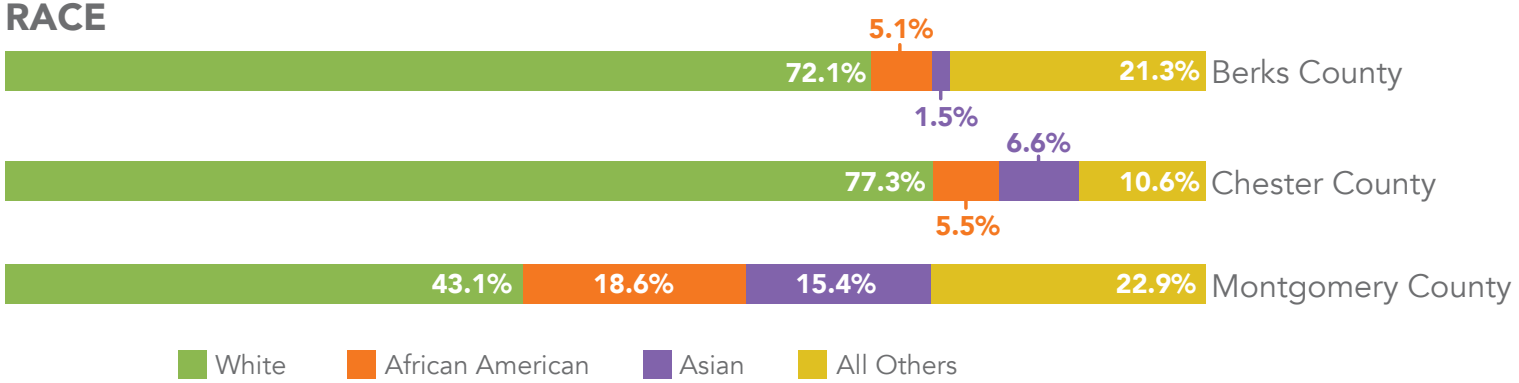
AGE DISTRIBUTION



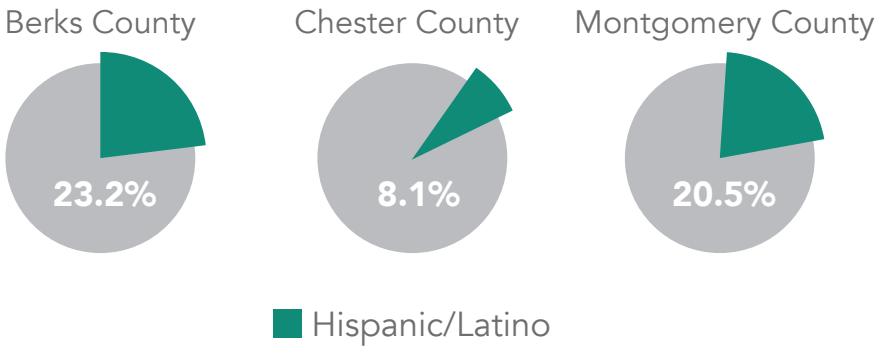
MEDIAN HOUSEHOLD INCOME



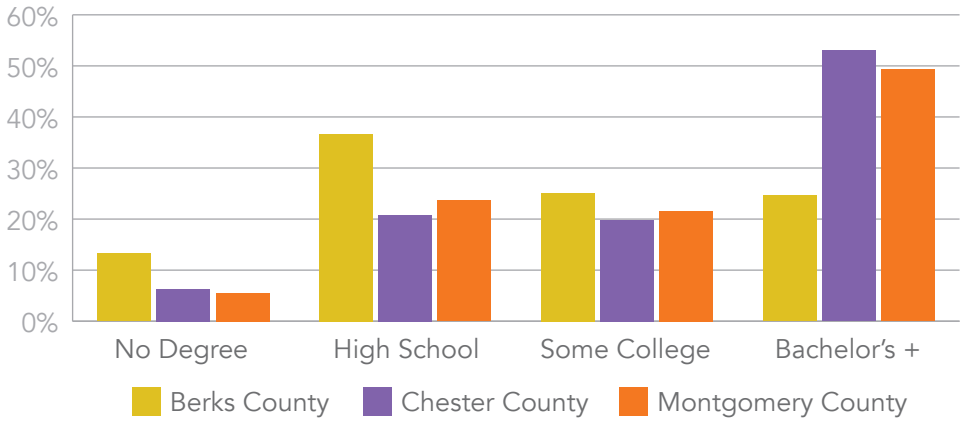
RACE



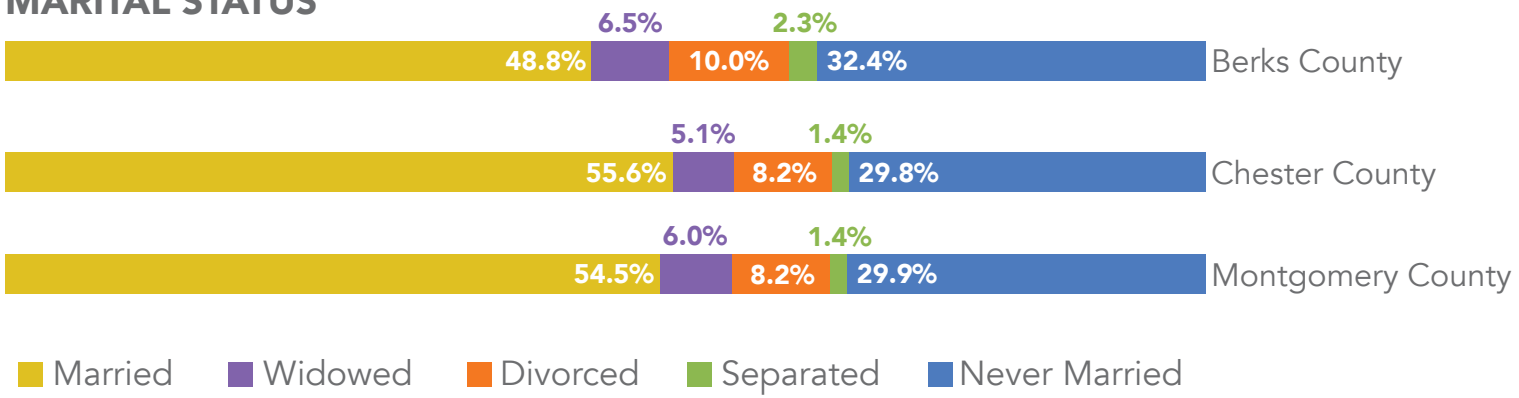
ETHNICITY



EDUCATION

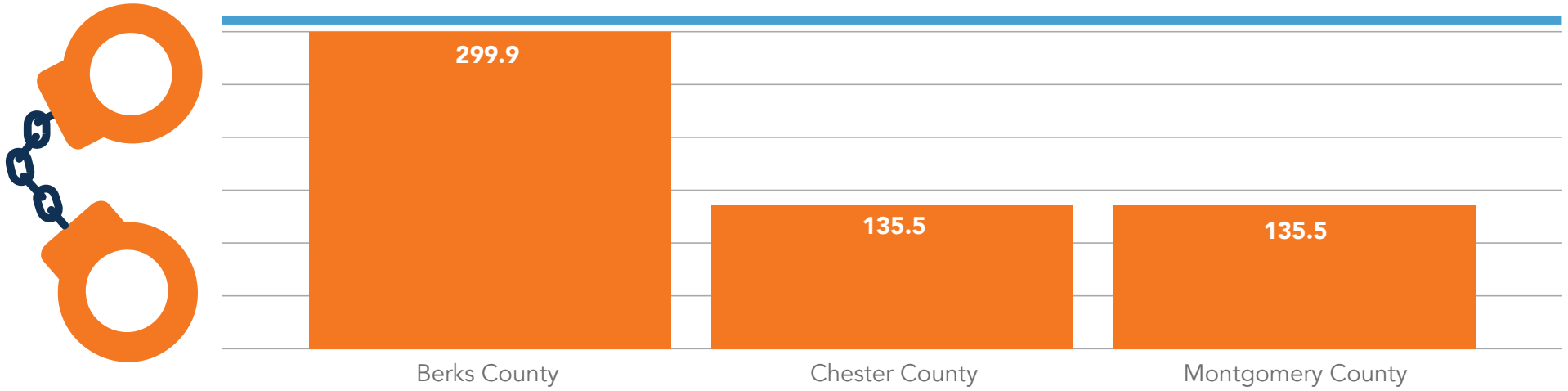


MARITAL STATUS



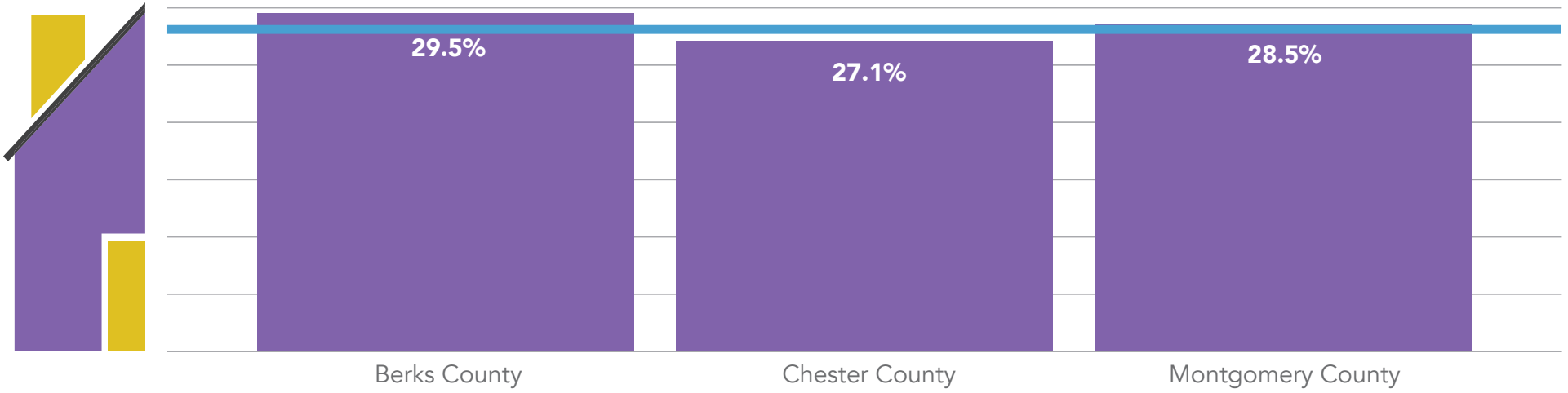
OUR ENVIRONMENT

VIOLENT CRIME
(per 100,000 population)



Note: The blue line indicates the rate in Pennsylvania of 315.6.
Source: FBI Uniform Crime Reports 2020

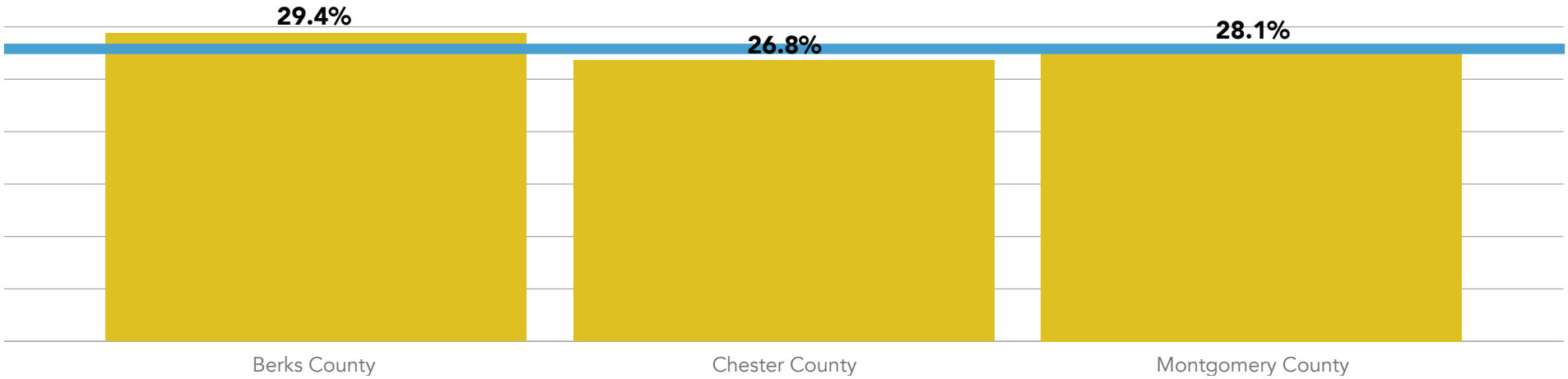
HOUSING COST BURDEN
(Households where housing costs are 30% or more of total household income)



Note: The blue line indicates the percent in Pennsylvania of 28.1%
Source: U.S. Census Bureau 2019

SUBSTANDARD HOUSING

(Units having 1) lack of complete plumbing, 2) lack of complete kitchen, 3) 1+ occupants per room, 4) the percentage of household income greater than 30%, and 5) gross rent of household income greater than 30%)



Note: The blue line indicates the percent in Pennsylvania of 28.1%
Source: U.S. Census Bureau 2019

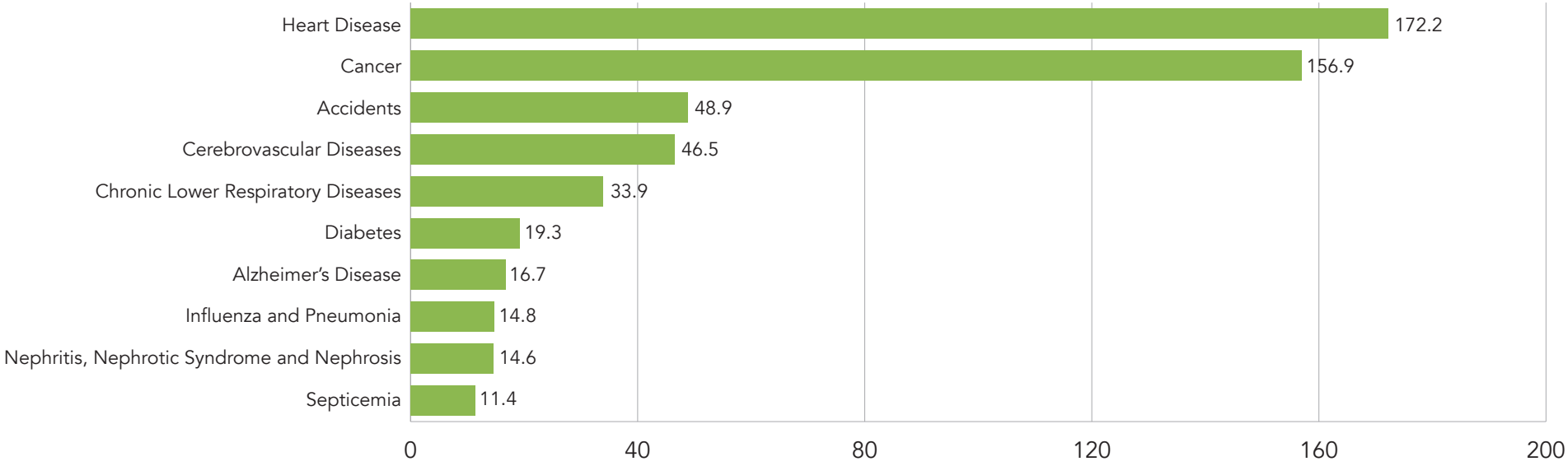
HOUSING OCCUPANCY BY RACE

	Owner-Occupied Housing (Percent)			Renter-Occupied Housing (Percent)		
	Berks County	Chester County	Montgomery County	Berks County	Chester County	Montgomery County
White	75.5	77.8	76.0	24.4	22.3	24.1
Black	41.7	48.0	46.7	58.3	52.0	53.3
Asian	71.3	67.4	62.8	28.7	32.6	37.2
Native American or Alaska Native	40.1	64.1	50.2	59.9	35.9	49.9
Some other race	43.2	25.3	29.7	56.9	74.7	70.3
Multiple race	40.8	56.6	48.8	59.2	43.4	51.2

Source: U.S. Census Bureau 2019

TOP CAUSES OF DEATH IN BERKS COUNTY

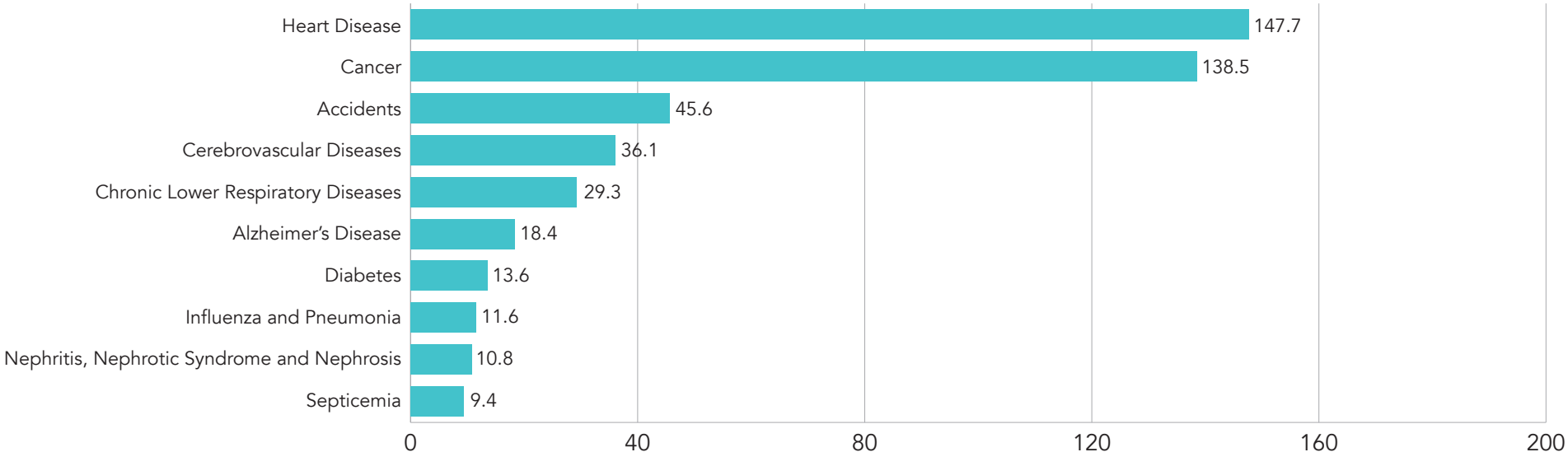
(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

TOP CAUSES OF DEATH IN CHESTER COUNTY

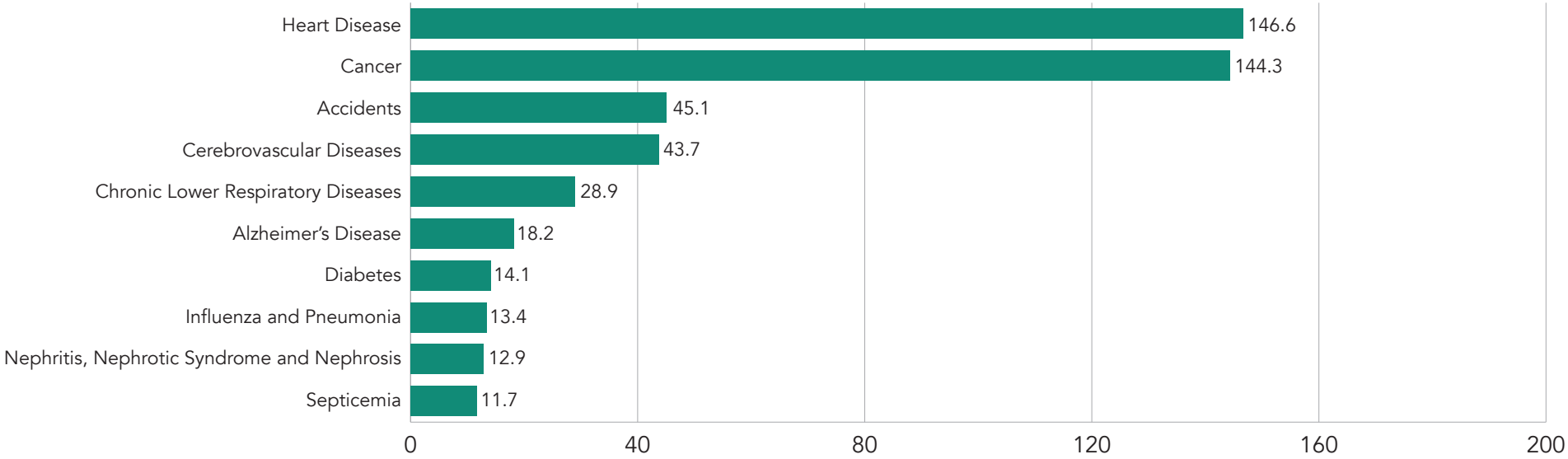
(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

TOP CAUSES OF DEATH IN MONTGOMERY COUNTY

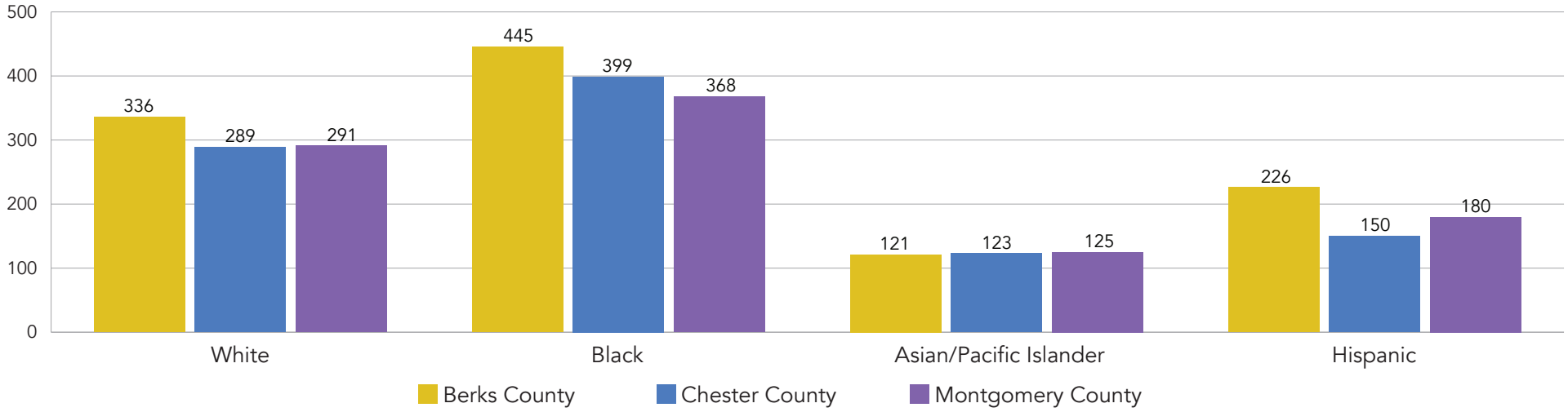
(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

HEART DISEASE DEATHS BY RACE/ETHNICITY BY COUNTY

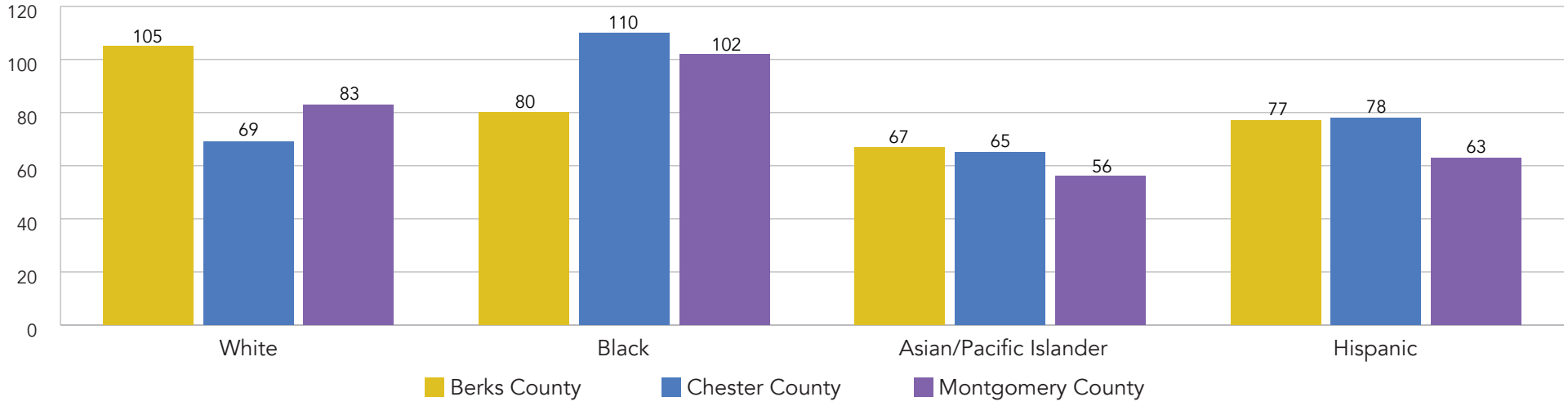
(ages 35 years+ per 100,000 population)



Source: Pennsylvania Department of Health 2019

OVERALL STROKE DEATHS BY RACE/ETHNICITY BY COUNTY

(ages 35 years+ per 100,000 population)

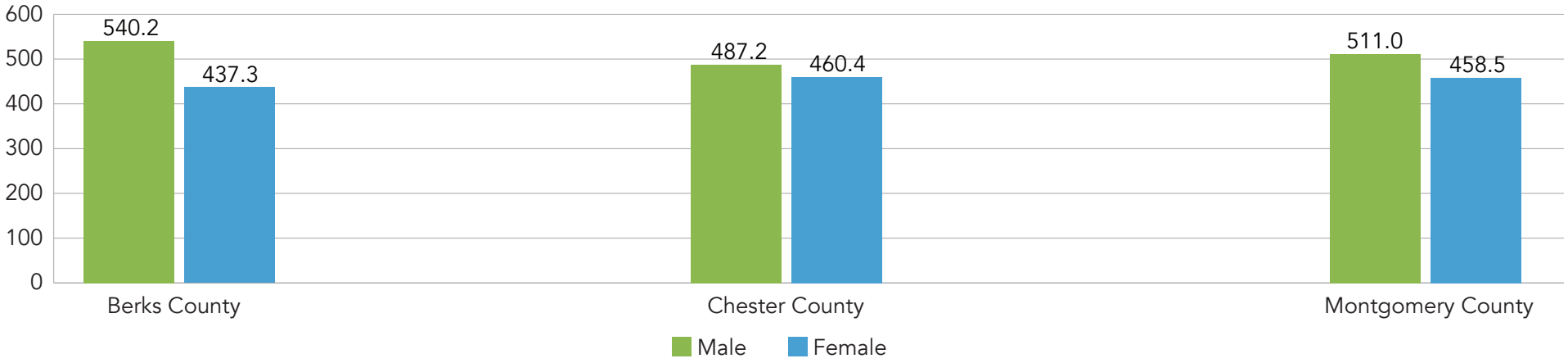


Source: Pennsylvania Department of Health 2019

OVERALL CANCER INCIDENCE

ALL CANCERS INCIDENCE RATES BY GENDER

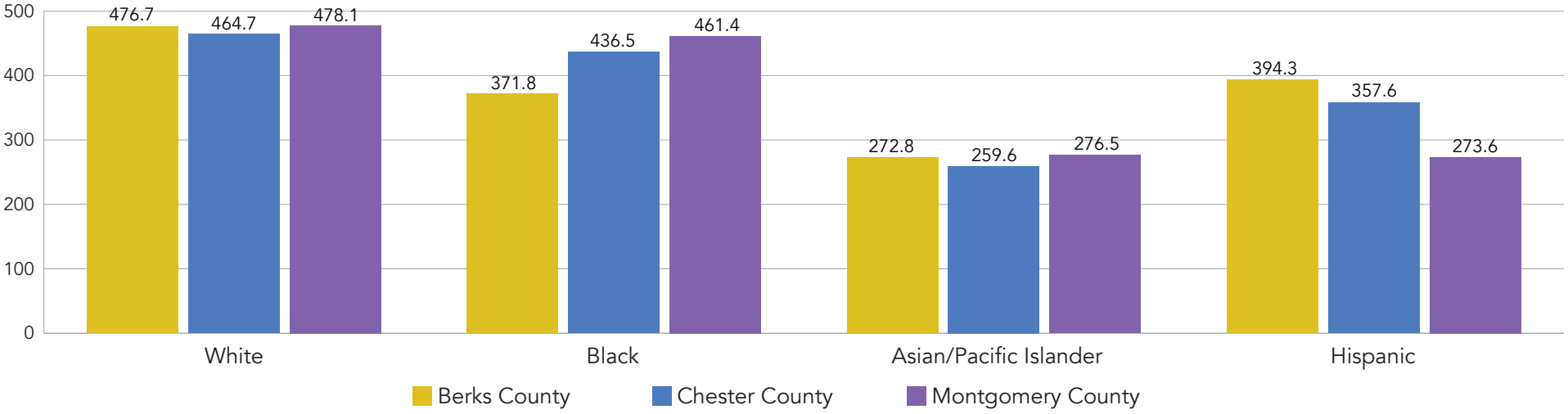
(per 100,000 population)



Source: Pennsylvania State Cancer Profiles 2014-2018

ALL CANCERS INCIDENCE RATES BY RACE

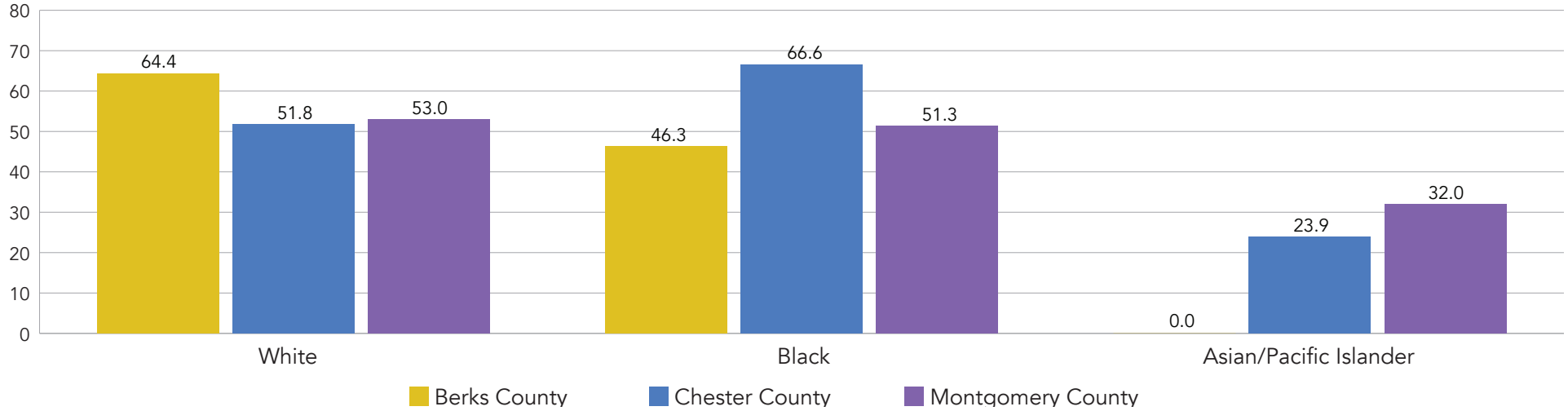
(per 100,000 population)



Source: Pennsylvania State Cancer Profiles 2014-2018

LUNG AND BRONCHUS CANCER INCIDENCE RATES BY RACE

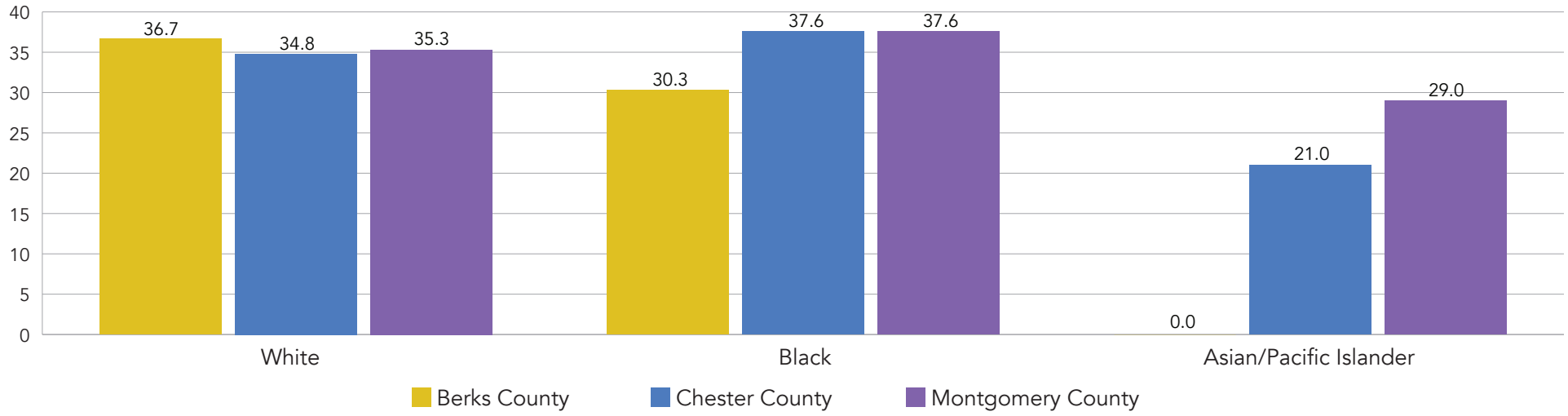
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

COLON AND RECTUM CANCER INCIDENCE RATES BY RACE

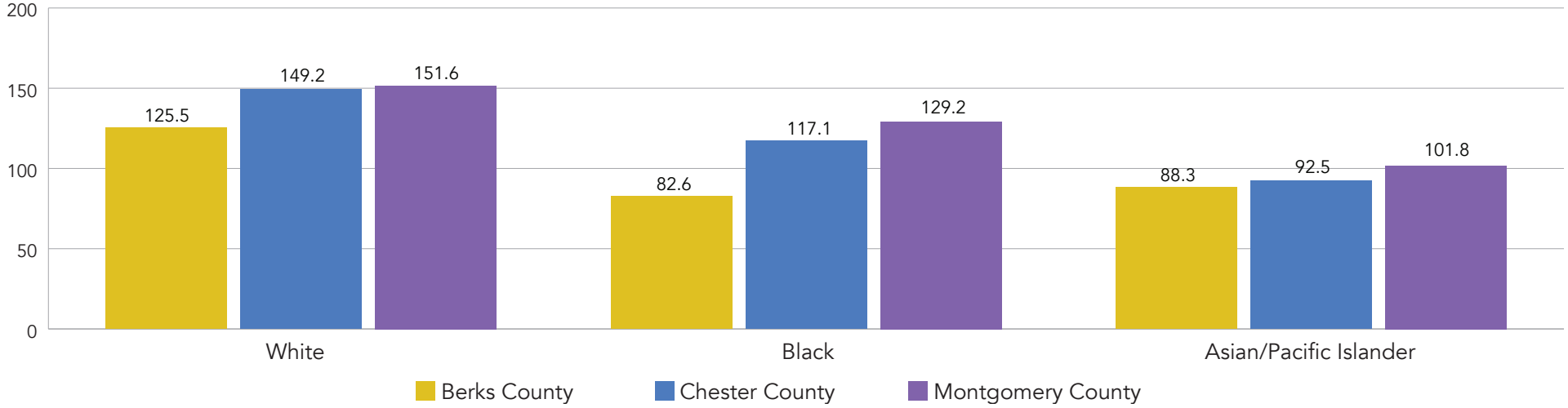
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

FEMALE BREAST CANCER INCIDENCE RATES BY RACE

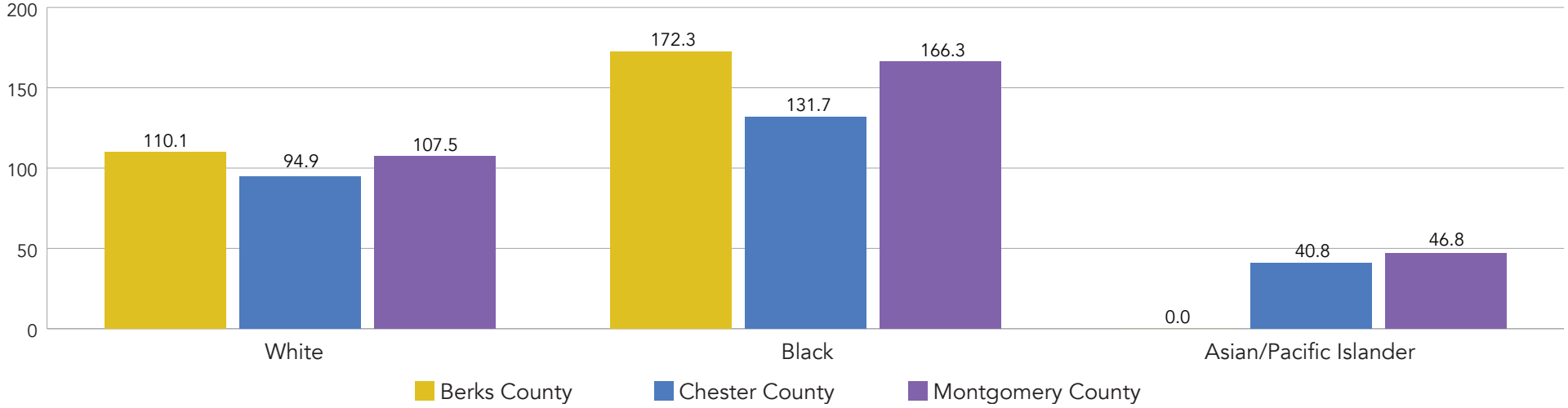
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

MALE PROSTATE CANCER INCIDENCE RATES BY RACE

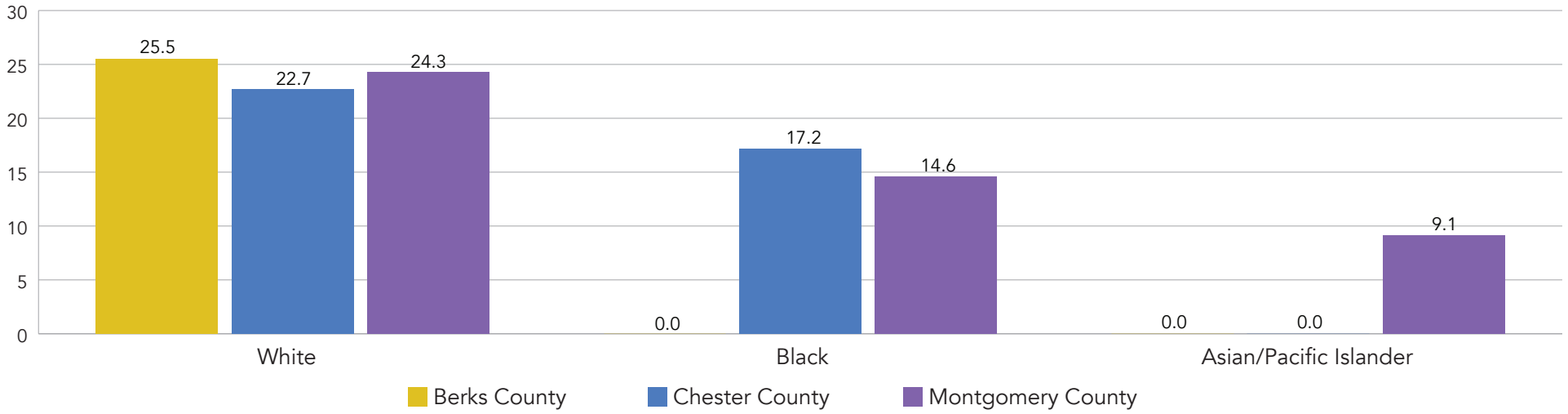
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

BLADDER CANCER INCIDENCE RATES BY RACE

(per 100,000 population)

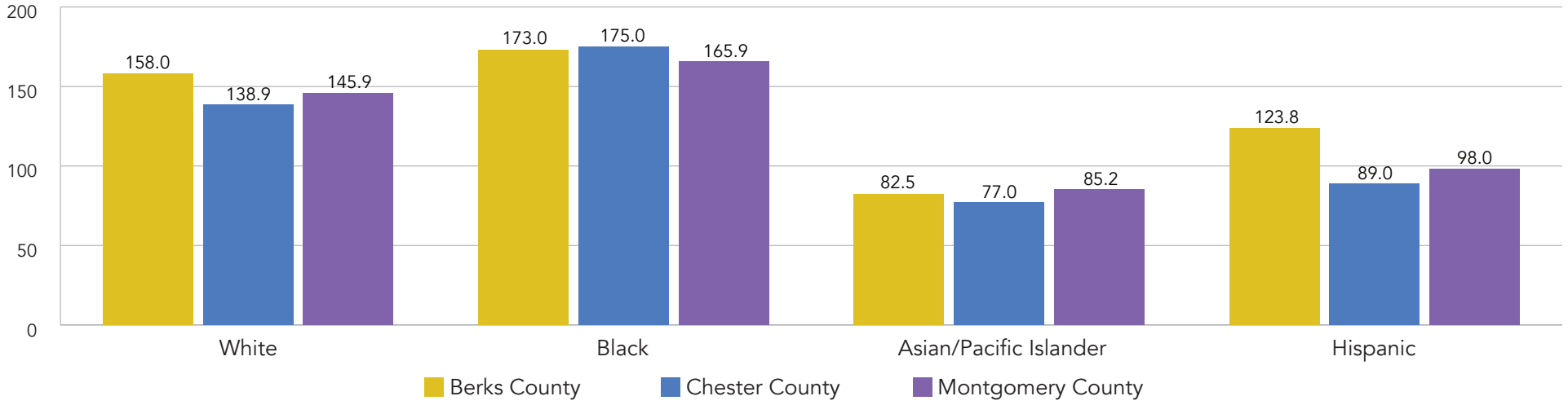


Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles 2014-2018

OVERALL CANCER INCIDENCE

ALL CANCER DEATH BY RACE AND ETHNICITY

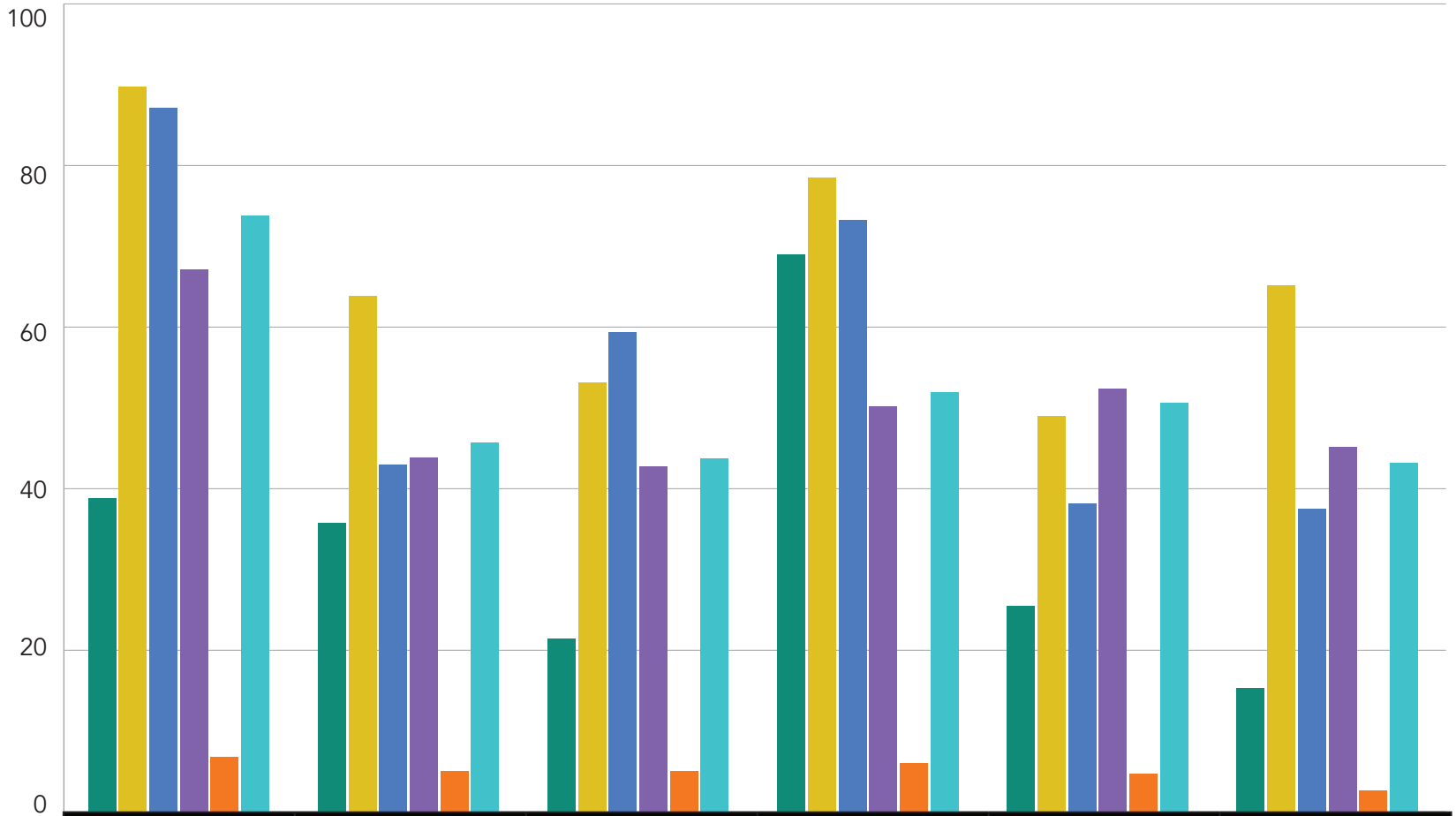
(per 100,000 population)



Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.
Source: Pennsylvania State Cancer Profiles. Death data 2015-2019; incidence data 2014-2018.

ADULT EMERGENCY ROOM VISITS PER 1,000/MONTHS ZIP CODE SUMMARY

The figure below depicts ZIP codes within Pottstown's primary service area related to adults who visit the emergency room per month broken out by race/ethnicity.

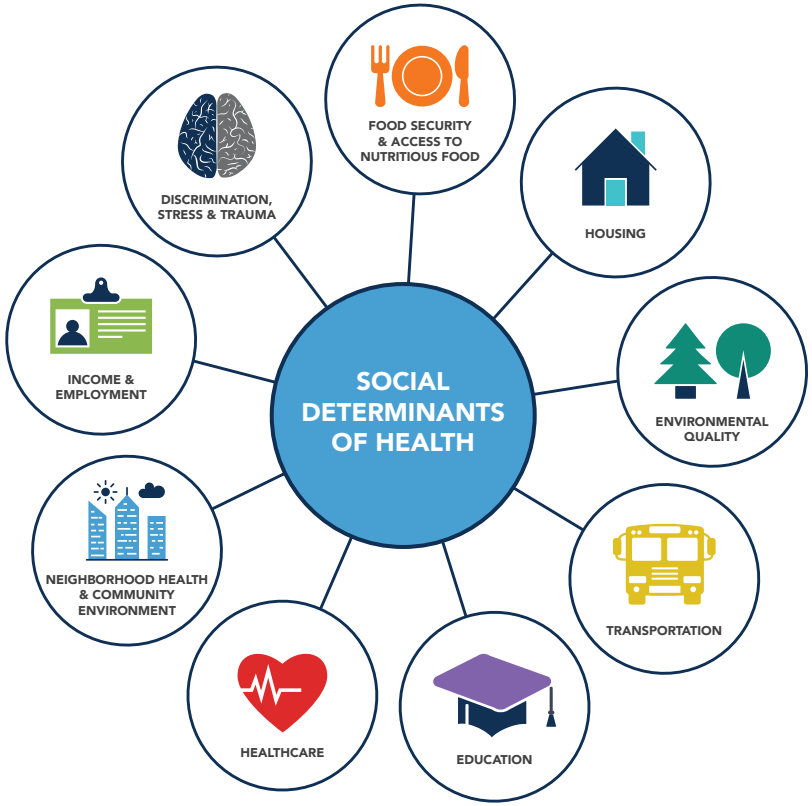


	19464	19465	19468	19512	19518	19525
Asian	38.8	35.7	21.4	**69.0**	25.5	15.3
Black	**89.8**	**63.8**	**53.1**	**78.5**	49.0	**65.2**
Hispanic	**87.1**	43.0	**59.4**	**73.2**	38.2	37.5
White	67.1	43.8	42.7	50.2	**52.4**	**45.1**
Other Race	6.8	5.0	5.0	6.0	4.7	2.6
All Adults	**73.8**	**45.7**	**43.7**	**51.9**	**50.6**	**43.2**

Note: ZIP codes 19519, 19545, 19548, 19457, and 19472 were unavailable. The red figures indicate high emergency room visits when compared to the benchmarked data of all adults within the specific ZIP code.
Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

WHERE WE LIVE, LEARN, WORK, AND PLAY
AND HOW IT AFFECTS OUR LIVES

Figure 3: Influential Factors



Where we live, learn, work, and play are important factors that shape one's overall health standing. Communities that have access to healthy foods, livable-affordable homes, quality education, and a safe/clean environment are healthier compared to their counterparts. Our social and physical environments have strong impacts on our overall health aside from our traditional health care settings. Social and environmental factors include our race, income, education level, and livable home environment (i.e., community).

According to the Robert Wood Johnson Foundation, social inequalities are linked to unhealthy behaviors; however, community investments in proven programs and policy changes can reduce disparities, allowing residents to make it easier to make better healthier choices, thus reducing illnesses.

FACTORS THAT INFLUENCE OUR HEALTH

Social determinants of health (SDOH) such as safe/clean housing, discrimination, community violence, education, employment, food access, transportation, and language comprehension play a vital role in the overall health and well-being of an individual.

Individual choices play a key role in good health and well-being; however, those choices must be made available to yield a good outcome. SDOH play a substantial role in providing residents with choices; not everyone has access to the same choices. Providing health equity provides an equal opportunity for individuals to live healthier lives.

Figure 3 Illustrates factors that influence the lives of community residents.

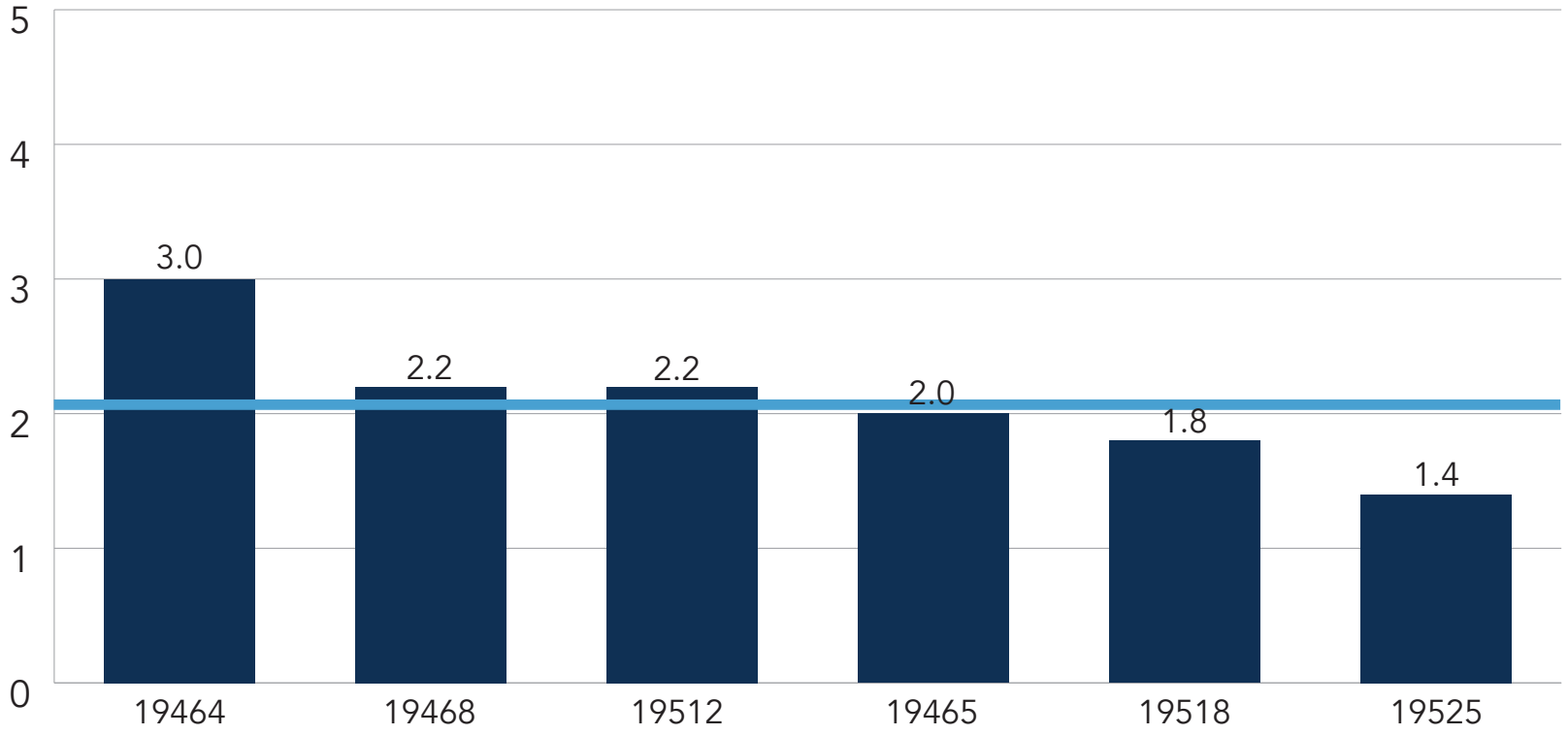
Figure 4: County Health Rankings: Berks, Chester, and Montgomery Counties
(1-67) (1=Healthiest)

Source: County Health Rankings and Roadmaps 2021

In 2004, Dignity Health and IBM Watson Health jointly developed a Community Need Index (CNI) to assist in gathering vital socioeconomic factors in the community. Every populated ZIP code in the United States is assigned a barrier score of 1,2,3,4, or 5 depending upon the ZIP code's national rank (quintile). A score of 1 represents the lowest rank, while a score of 5 indicates the highest rank. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.

The CNI score is an average of five barrier scores that measure various socioeconomic indicators of a community such as income, culture, education, insurance, and housing. The CNI scores below were found using the 2020 source data.

Figure 5: CNI Scores



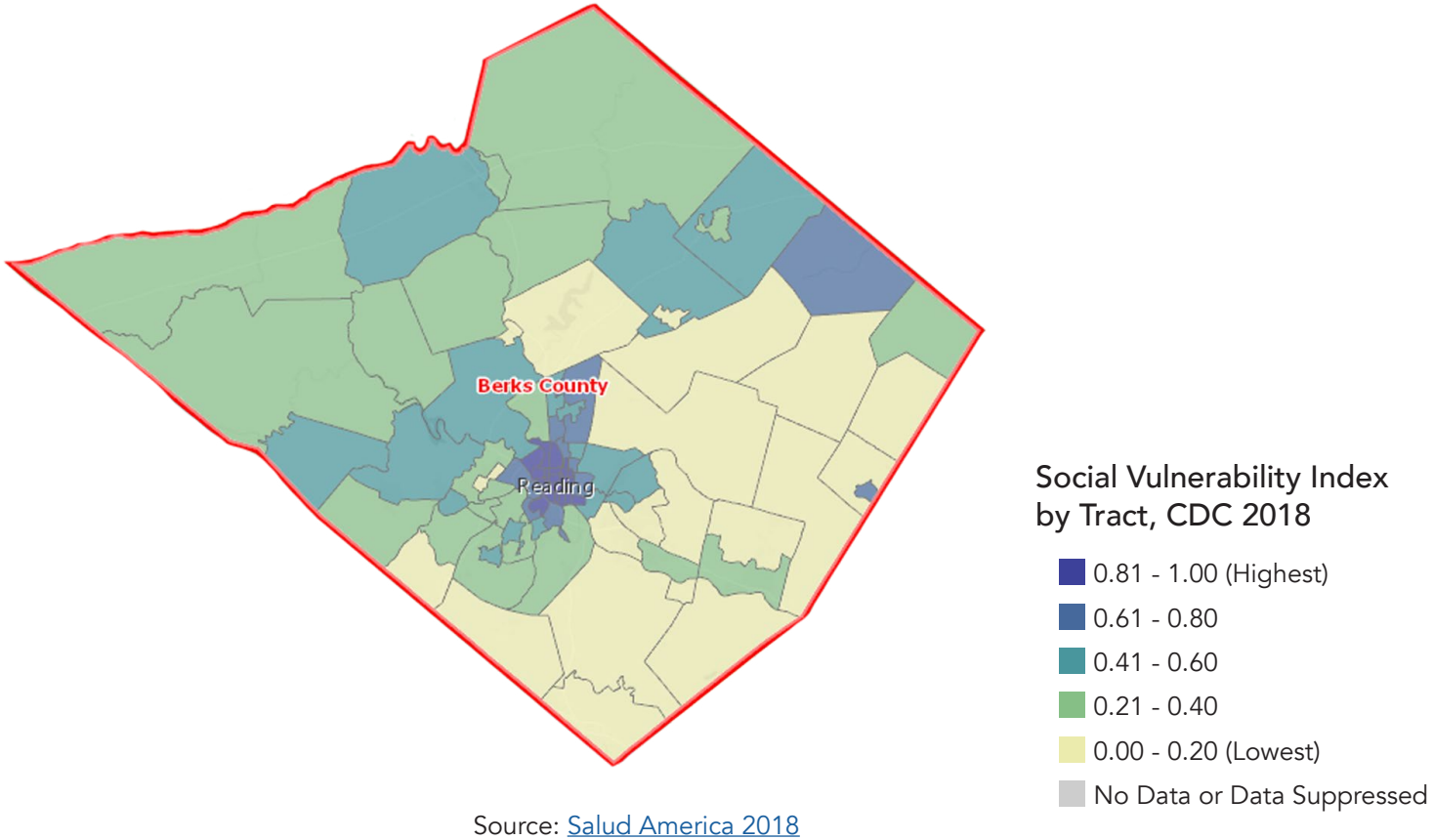
Note: The blue line indicates the CNI ZIP code mean of 2.1.
Source: Dignity Health Community Needs Index

SOCIAL VULNERABILITY

In Berks County, the Social Vulnerability Index Score is 0.62. The vulnerability score ranges from 0-1 with 0 being the least vulnerable and 1 being the most vulnerable. Berks County's score shows a high level of vulnerability. Factors such as poverty, lack of access to transportation, and crowded housing may weaken a community's ability to prepare for and respond to hazardous events, such as natural disasters or disease outbreaks. Reducing social vulnerability can decrease both distress and economic loss.

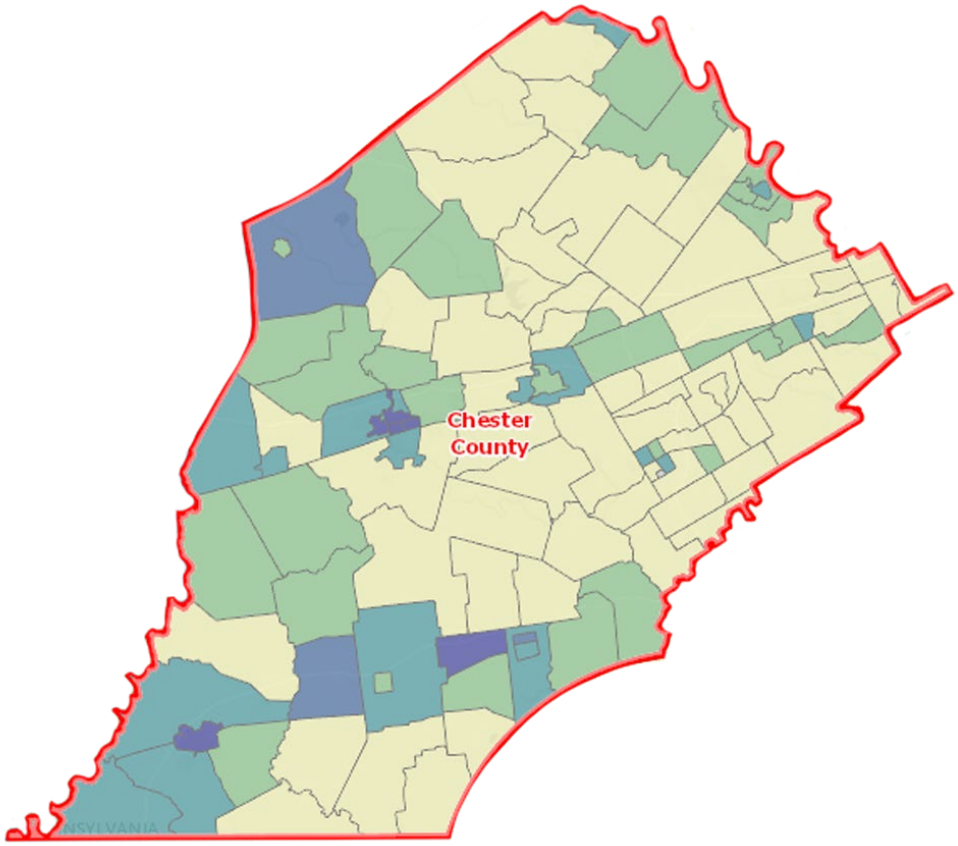
The social vulnerability maps display three-county-wide measures of the region that encompasses Pottstown Hospital. Pottstown Hospital's service area is limited to Western Montgomery County, Southern Berks County, and Northern Chester County.

Map 6: Social Vulnerability Index in Berks County



Source: Salud America 2018

Map 7: Social Vulnerability Index in Chester County

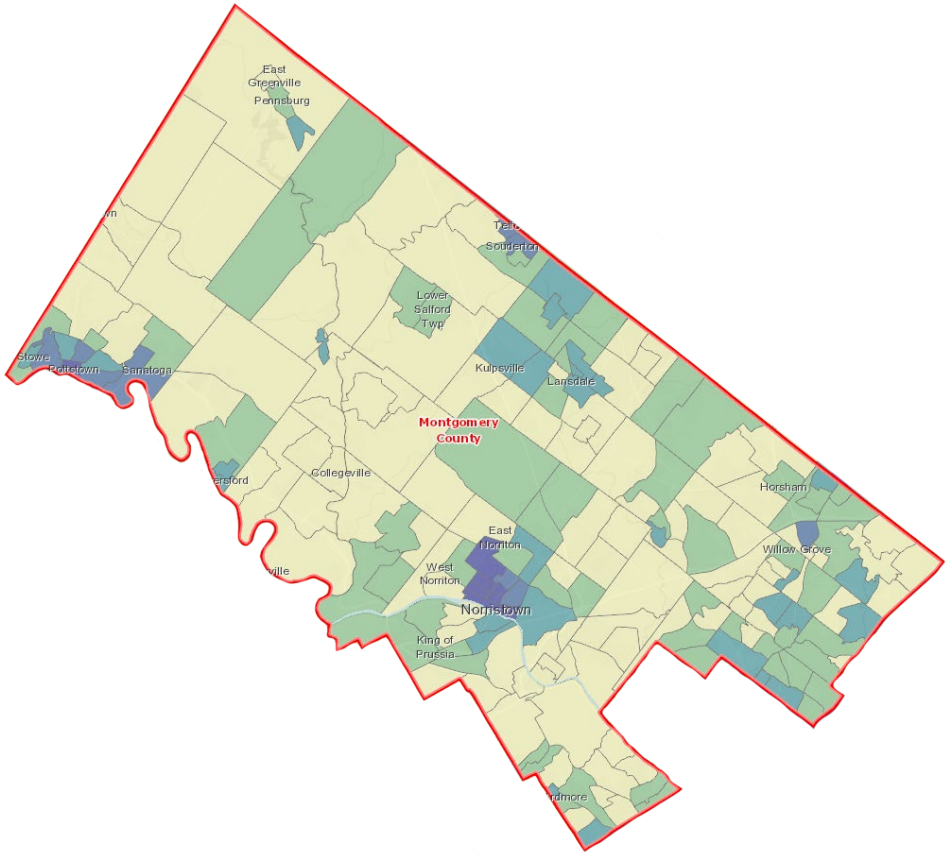


Social Vulnerability Index by Tract, CDC 2018

- 0.81 - 1.00 (Highest)
- 0.61 - 0.80
- 0.41 - 0.60
- 0.21 - 0.40
- 0.00 - 0.20 (Lowest)
- No Data or Data Suppressed

Source: Salud America 2018

Map 8: Social Vulnerability Index in Montgomery County



Source: Salud America 2018

Social Vulnerability Index by Tract, CDC 2018

- 0.81 - 1.00 (Highest)
- 0.61 - 0.80
- 0.41 - 0.60
- 0.21 - 0.40
- 0.00 - 0.20 (Lowest)
- No Data or Data Suppressed

POTTSTOWN HOSPITAL
STREET MEDICINE

In January 2021, Tower Health Medical group partnered with Access Services to launch Street Medicine, a program that works to improve access to health care for individuals experiencing homelessness. The need for this program was established from the 2019 Community Health Needs Assessment, which identified Access to Health Care, Access to Behavioral Health Care, Social Determinants of Health, and Chronic Disease Prevention and Management as the four main health priorities in the community. When thinking about the population that is most impacted by all four target priorities, those experiencing homelessness go to the top of the list.

Whether rain, snow, or shine, Emergency Medicine providers at Pottstown Hospital venture into the community every Tuesday from 10 a.m. to 2 p.m. to provide onsite medical care to the homeless community; it could be at a tent in the woods, a church, or even in a parking lot. The program works to reduce unnecessary emergency department visits and hospitalizations by providing onsite primary and urgent care services. However, Street Medicine doesn't stop at the visits on the street. Tower Health Medical Group and Access Services are invested in the continued health of the community and recognize the importance of ongoing primary and specialty care. Street Medicine works to build trust among the homeless and health care providers to bridge the gap to individual engagement with routine primary care. To ensure immediate access and tailored health care and behavioral health care, the multi-disciplinary Street Medicine team now includes essential partners, such as Community Health and Dental Care and Creative Health Services.

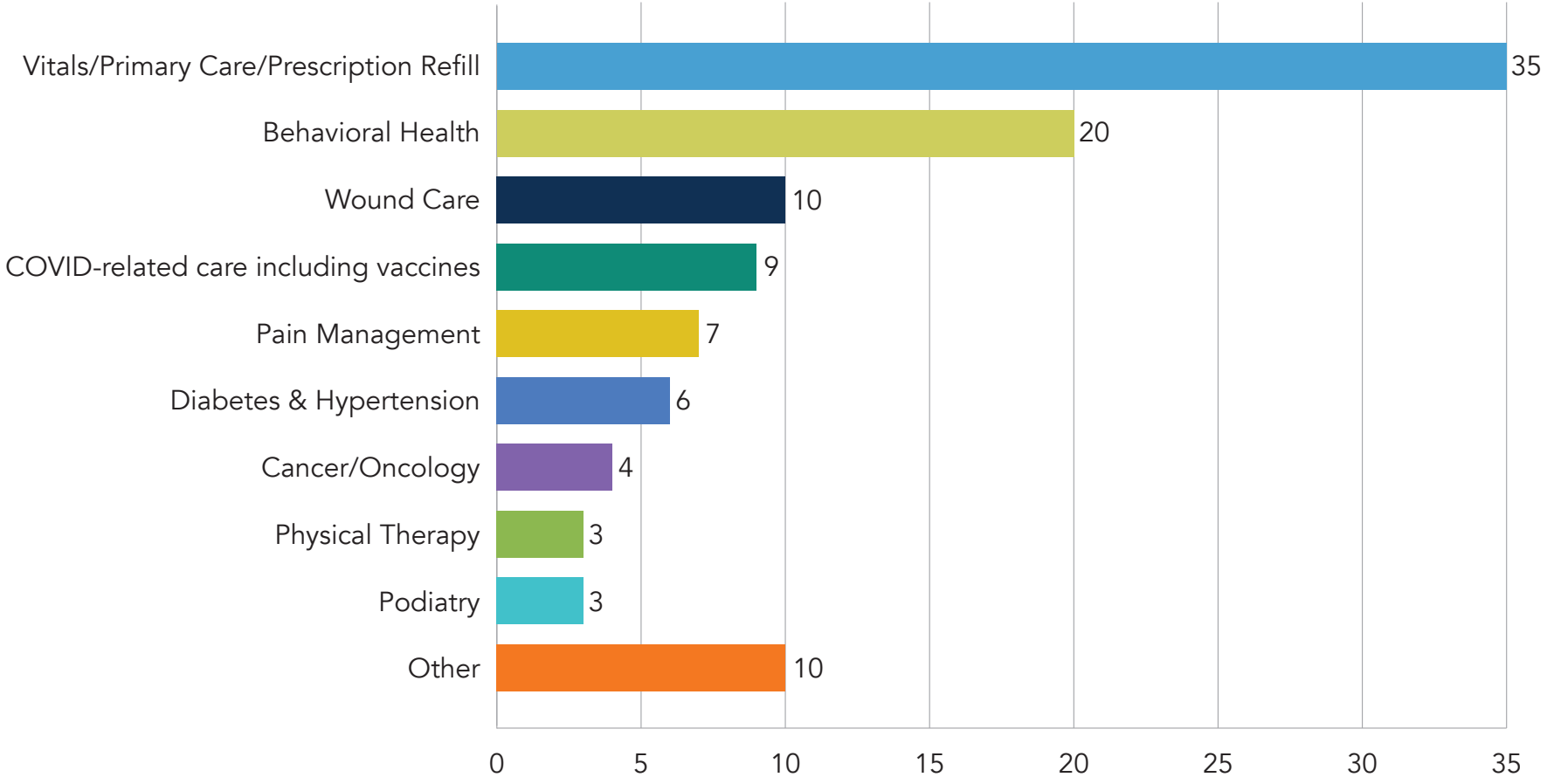
In the calendar year 2021, the Street Medicine team served 107 unique individuals experiencing homelessness in Pottstown Borough. Street Medicine patients relied on the health care services provided, and many patients accessed Street Medicine multiple times. The number of visits ranged from 24 to just one per patient, with an average of three visits per patient. The average patient age was 45, with 63% identifying as male and 37% identifying as female.

Of the patients seen at Street Medicine, 74% (79 patients) were referred to Community Health and Dental Care. Of the patients referred, 66 patients successfully scheduled a visit, with several patients scheduling more than one visit for a total of 271 appointments scheduled.

Of the patients scheduled, 55% completed at least one visit to Community Health and Dental Care (36 patients). The total number of completed appointments for the 36 patients was 146. Twenty-three patients had completed more than one visit and continued to follow up as recommended.

Figure 9 shows the primary health need and reasoning for engaging with Street Medicine for all 107 patients.

Figure 9: Street Medicine Primary Needs



PULLING IT TOGETHER

Building on the vital work that has been under way, Pottstown Hospital places an unrelenting focus on actions required to continually improve health and quality of life for its residents. Focus groups with community members and hospital leadership drew similarities in top community health needs.

Figure 10 shows the top community health needs identified by focus groups.

Participants of the CHNA across the various data collection methods 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. We can conclude that plans to improve health can be achieved through the following areas of focus:

A) Access to Equitable Care
B) Behavioral Health
C) Health Education and Prevention
D) Health Equity

A) ACCESS TO EQUITABLE CARE

Pottstown Hospital deploys continuous improvement efforts to better understand the contributing factors that impede access to equitable care and how best to address identified barriers and gaps in the provision of health care and services. Improving an organization's capacity to provide access to equitable care for vulnerable and ethnic populations is a continuous and evolving process.

The pandemic further helped the health system to realize the even wider gaps that resulted as related to accessing care such as the lack of knowledge regarding available health services and programs, the high costs of health care and insurance, the lack of trust, and the limited capacity to provide quality and appropriate care because of a lack of cultural competence among providers and limited language services.

Figure 11 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 11: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Lack of affordable insurance
- Unconscious bias and stigmas
- Economic/unemployment
- Lack of cultural competence among practitioners
- Lack of access to care and services
- Lack of transportation

"Why are People Treated Differently?"

- Race/ethnicity - 45%
- Insurance coverage - 18%
- Not speaking English - 18%

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Affordability
- Lack of trust
- Availability of services
- Lack of transportation
- Lack of insurance

"What are the Barriers to a Quality Life?"

- Economic disparities
- Navigating the health care system
- Cost of health care/medications
- Mental illness
- Lack of insurance
- Not understanding treatment plan

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care?"

- Affordability
- Lack of transportation
- No insurance
- Lack of trust
- Availability of services

"What are the Barriers to a Quality Life?"

- High costs of care/meds
- Lack of insurance
- Economic disparities
- Difficulty navigating health care system
- Difficulty getting around

COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of access to health care providers/specialists
- Lack of affordable health care
- Lack of elder care options
- Lack of higher paying jobs

"What are the Most Important Health Issues?"

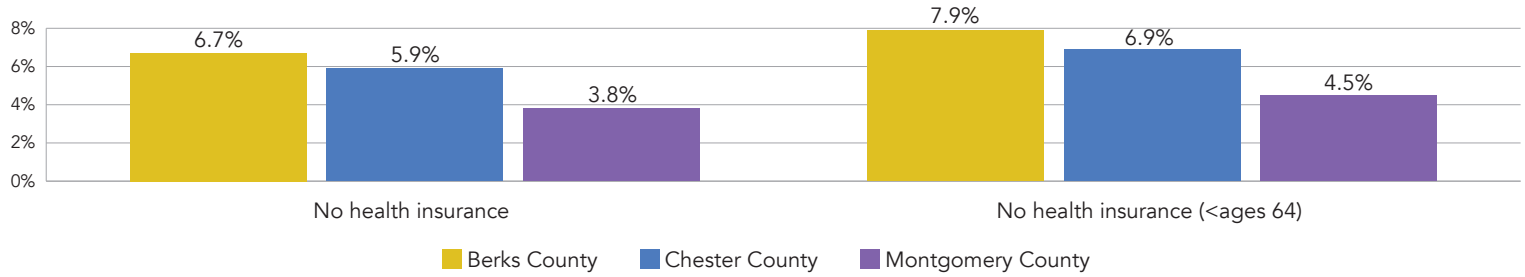
- Behavioral health/mental health
- Drug/alcohol use
- Aging issues (arthritis, hearing/vision loss)
- Lack of exercise
- Cancers

"What are the Barriers to a Quality Life?"

- Ease in accessing health care, doctors
- Low crime, safe neighborhoods
- Good jobs, healthy economy
- Good schools
- Healthy behaviors and lifestyles

Figure 12 shows the percentages of Berks, Chester, and Montgomery County residents who have no health insurance coverage or coverage via Medicare. Over the last few CHNA cycles, we have seen the percentage of insured people steadily rise; however, efforts to improve access to care must continue.

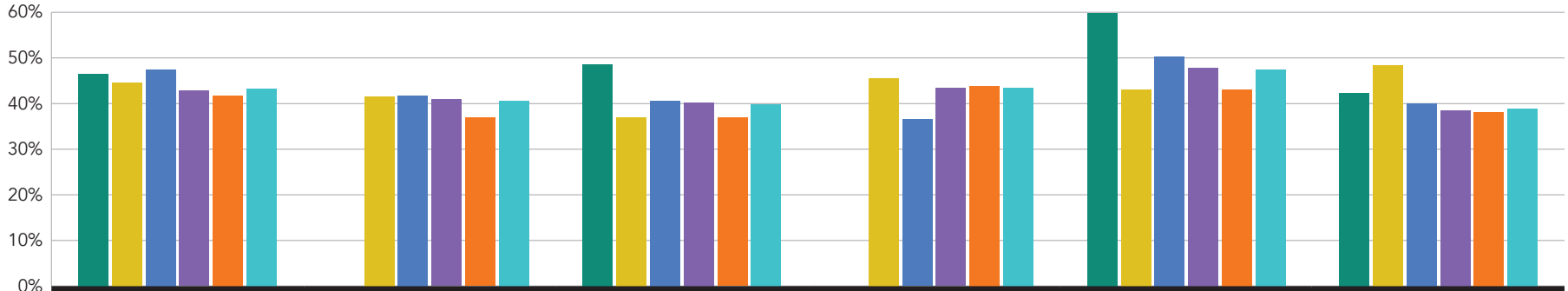
Figure 12: Percentage of Population with No Health Insurance Coverage



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

The PA Health Equity Analysis Tool (HEAT) provides a geographic perspective at the granular level to areas that have opportunities to improve equity.[5] The below figure depicts ZIP codes within Pottstown Hospital's service area related to adults who obtain primary care visits.

Figure 13: Percentage of Adults with Primary Care Physician Visits by ZIP Code Summary



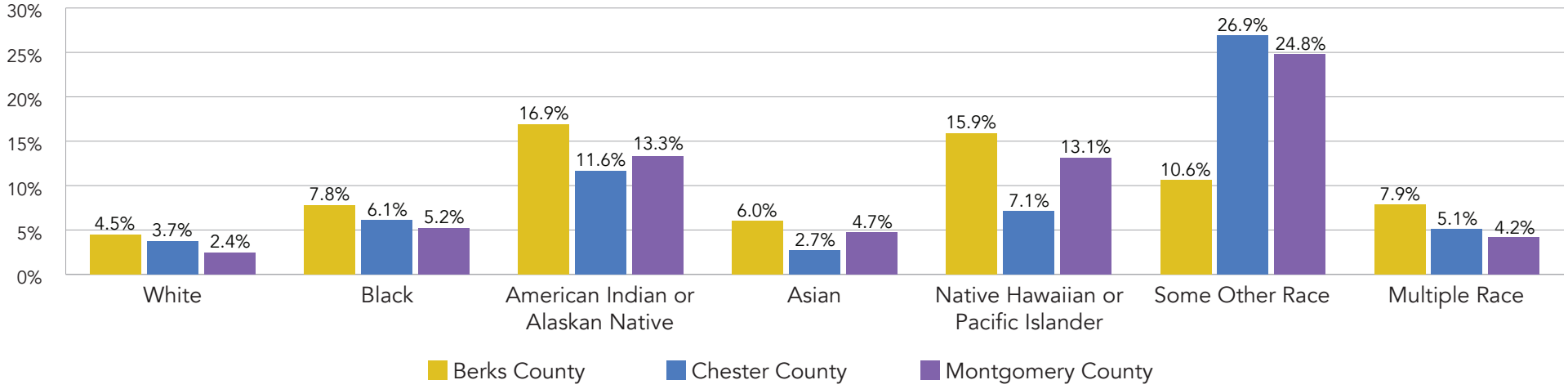
	19464	19465	19468	19512	19518	19525
Asian	46.5	**0**	48.6	**0**	59.8	42.3
Black	44.6	41.5	**37.0**	45.5	**43.1**	48.4
Hispanic	47.5	41.8	40.6	**36.5**	50.3	40.0
White	**42.8**	40.9	40.3	**43.4**	47.9	**38.5**
Other Race	**41.8**	**36.9**	**36.9**	43.9	**43.1**	**38.2**
All Adults	**43.3**	**40.6**	**39.8**	**43.5**	**47.5**	**38.9**

Note: The figures bolded in red indicate low percentages of adults with primary care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

Although the percentage of uninsured has increased over the past several years, Figure 14 shows the range of uninsured people by race in Berks, Chester, and Montgomery counties. The Healthy People 2030 target is to increase the portion of the population covered by health insurance to 92.1 % overall. As of 2018, 89.0% of the population under 65 years had medical insurance.

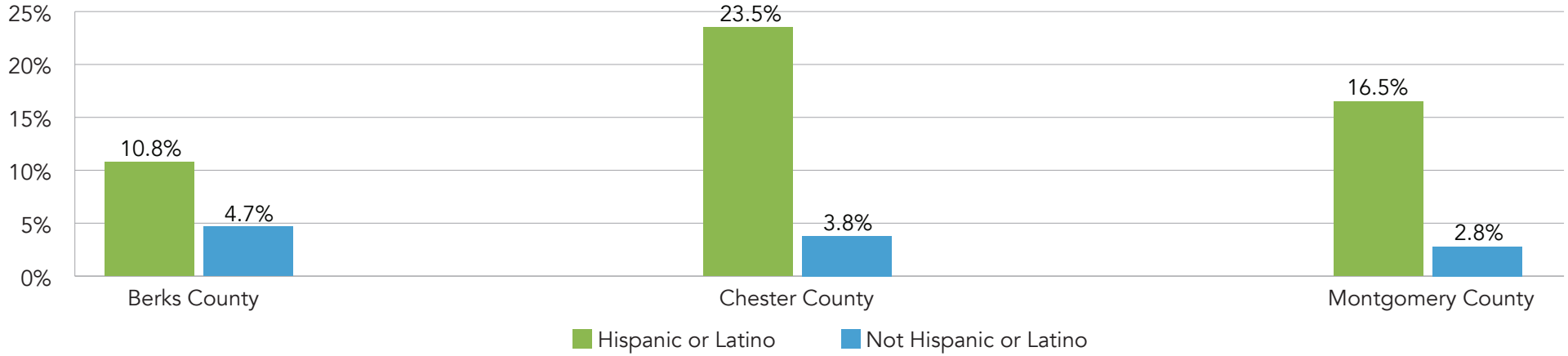
Figure 14: Percentage of Uninsured Population by Race



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

Figure 15 shows higher uninsured Hispanic or Latinos in the counties.

Figure 15: Percentage of Uninsured Population by Ethnicity



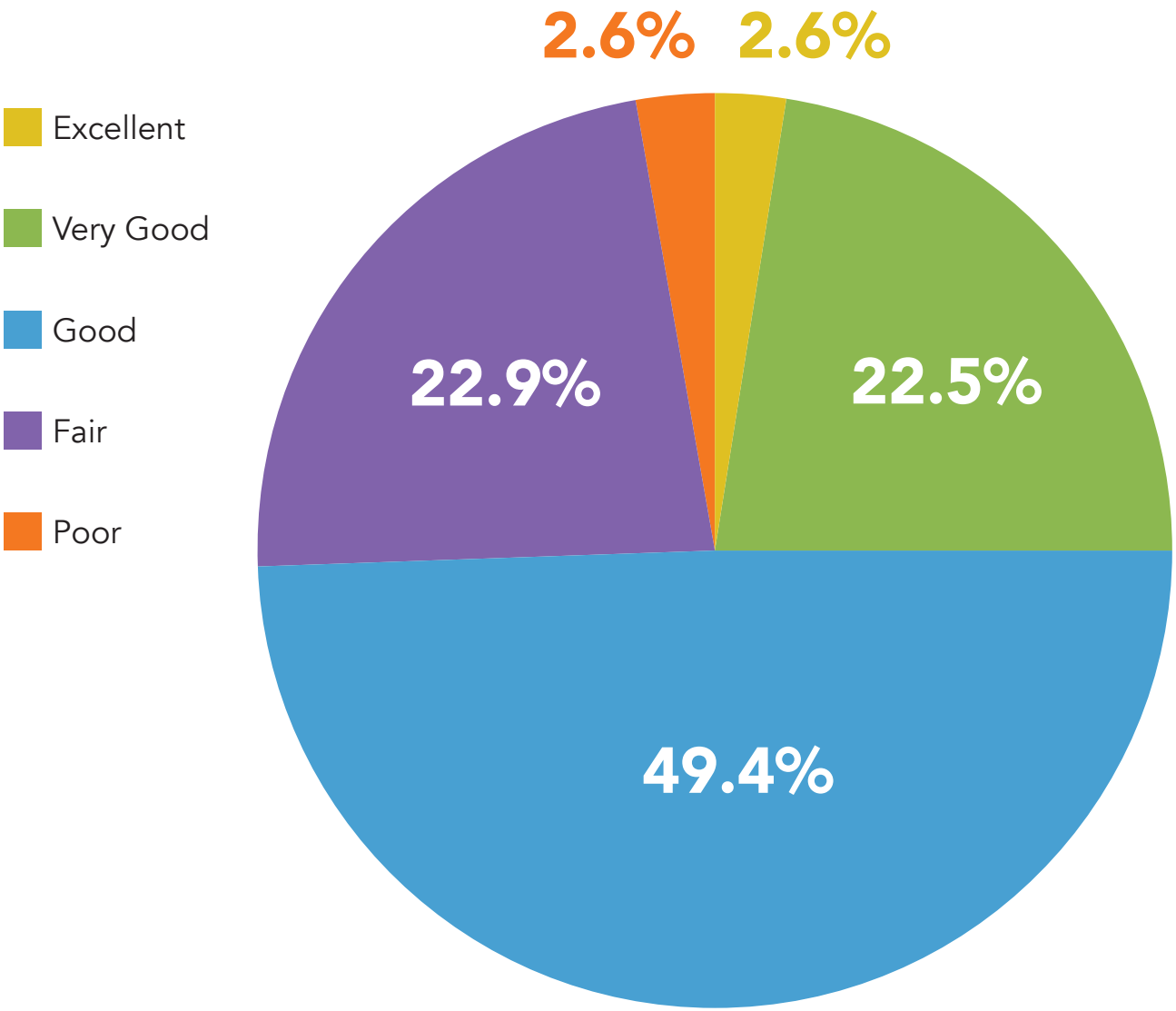
Source: U.S. Census Bureau, American Community Survey 2019

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

When asked to rate their health status, 74.5% (n=537) for this CHNA of community health survey respondents stated good, very good, or excellent health (Figure 16).

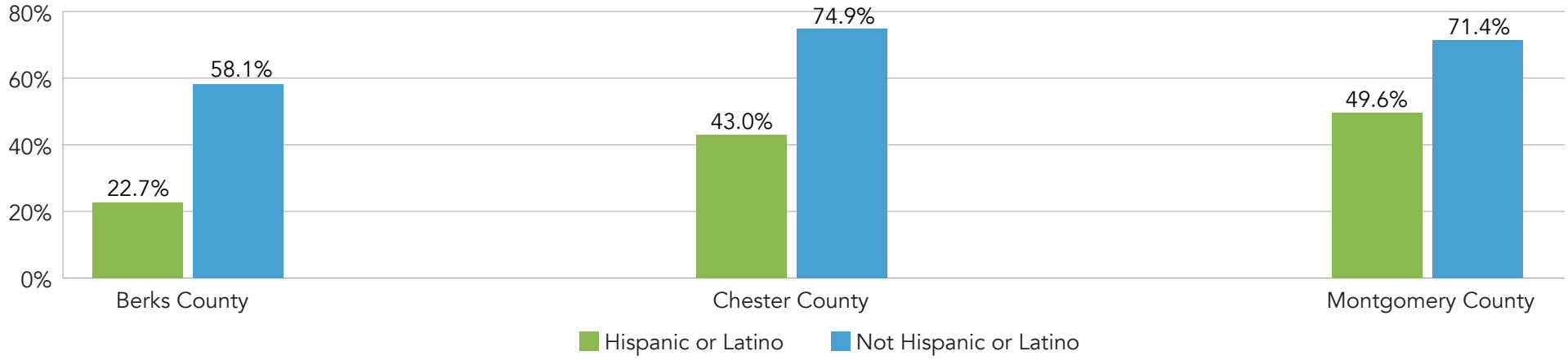
54.2% (n=363) noted the need for blood pressure screenings and 47.0% (n=315) cited the need for routine checkups to keep themselves and their families healthy.

Figure 16: Description of Overall Health



Economic status and income are strongly associated with morbidity and mortality. Income directly influences health and longevity and may perpetuate or exacerbate health disparities. Income inequality has grown substantially over recent decades.

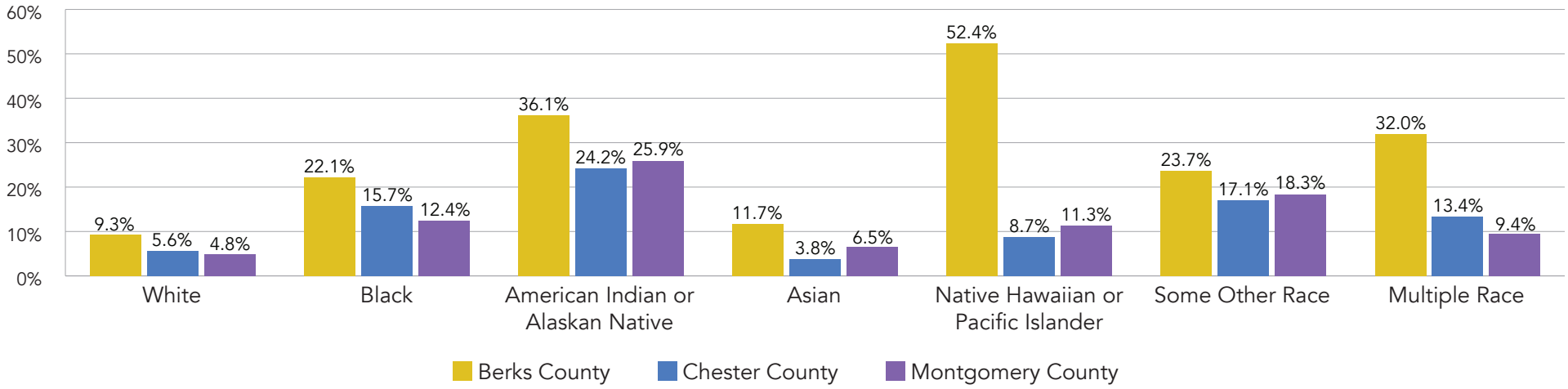
Figure 17: Families Earning More Than $75,000 by Ethnicity



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

Figure 18 reports the percentage of the population that is below 100% of the federal poverty line (FPL) by race.[6] The Healthy People 2030 target is to reduce the proportion of people living in poverty to 8.0%. In 2018, 11.8% of people lived below the poverty

Figure 18: Population Below 100% FPL by Race

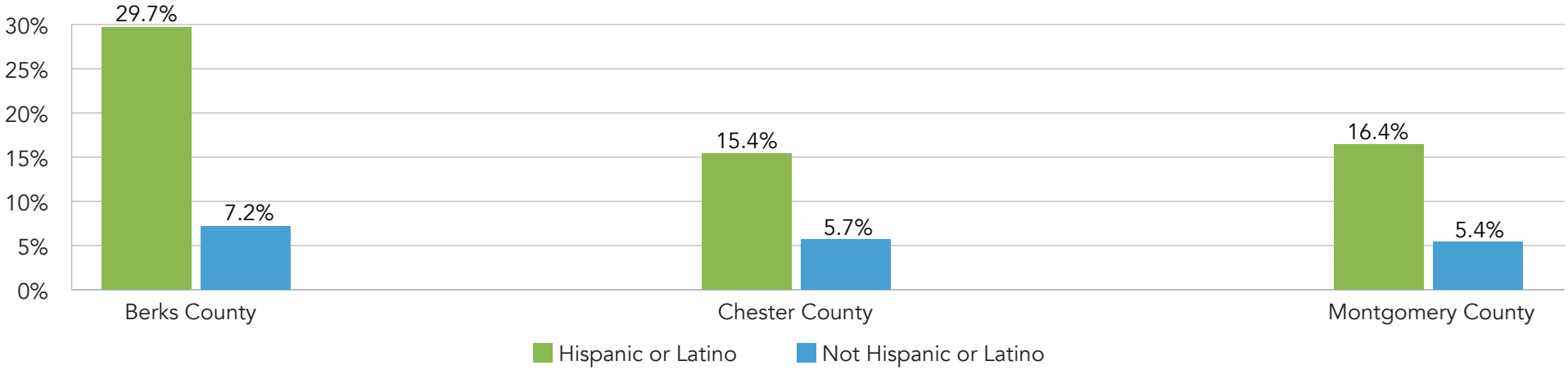


Source: U.S. Census Bureau, American Community Survey 2019

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

Figure 19 reports the percentage of the population below 100% of the federal poverty line by ethnicity.

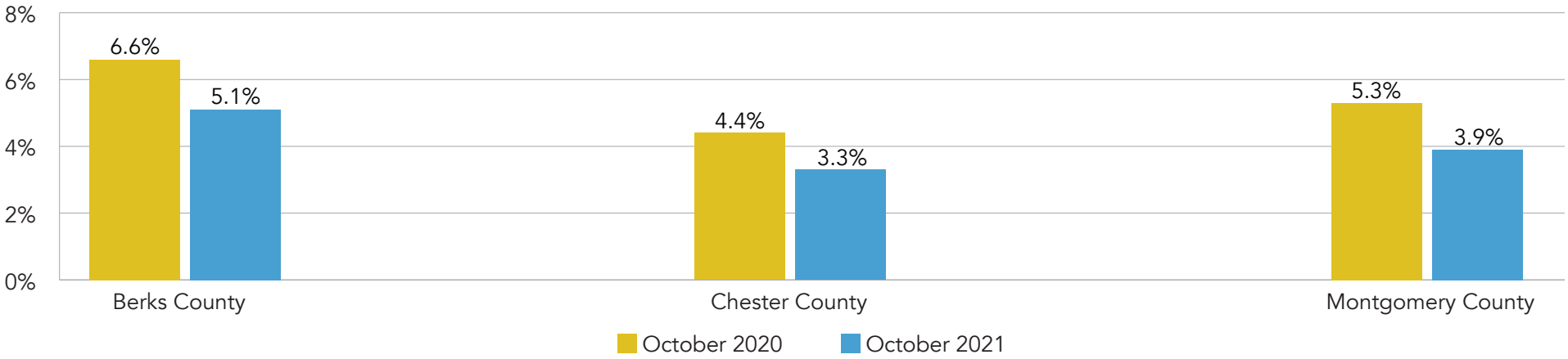
Figure 19: Population Below 100% FPL by Ethnicity



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

Figure 20 illustrates the unemployment rates in Berks, Chester, and Montgomery counties.

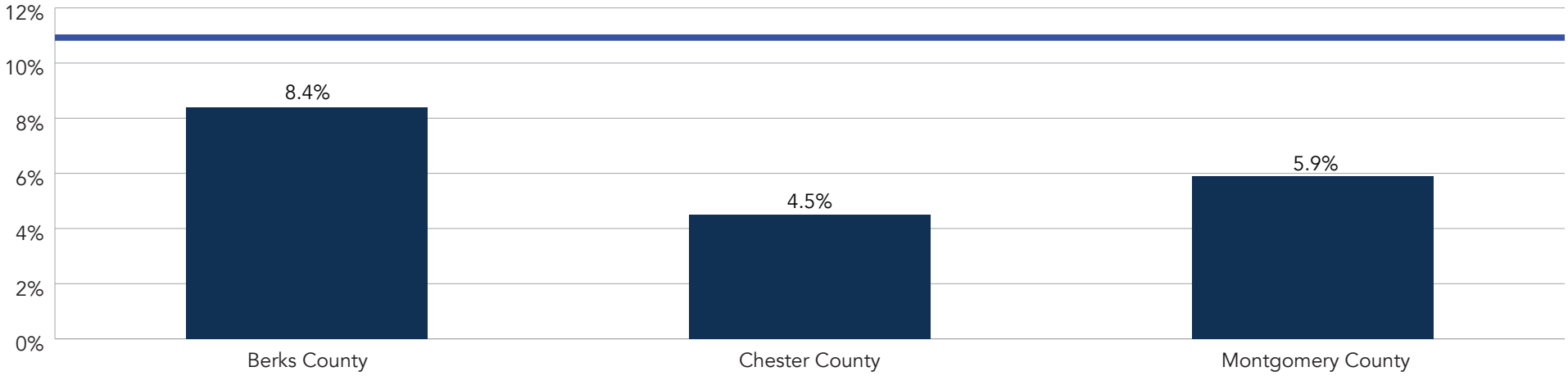
Figure 20: Unemployment Rates



Data Source: U.S. Department of Labor, Bureau of Labor Statistics 2021

Figure 21 shows a higher rate of Berks County residents not having a motor vehicle when compared to those in Chester and Montgomery for the years 2015-2019. Lack of reliable transportation can hinder one's ability to get to and from medical appointments, meetings, work, or things needed for daily living.

Figure 21: Households with No Motor Vehicle

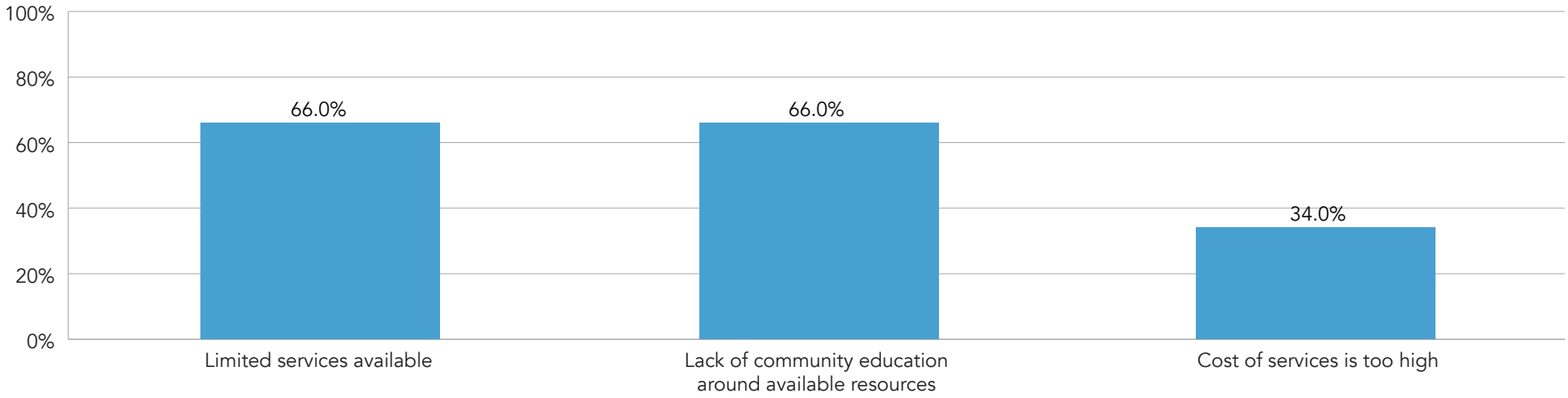


Note: The blue line indicates the rate in Pennsylvania of 10.9%

Source: U.S. Census Bureau, American Community Survey 2015-19

Primary data collected from key informants were asked what contributes to the transportation issues in their community, the top three responses were limited services 66.0% (n=33), lack of community education around available resources 66.0% (n = 33), and high cost of services 34.0% (n=17).

Figure 22: Contributors to Transportation Issues in the Community (Top Three Responses)



When community residents were asked to select statements that best applied, the top five responses included: I received or plan to receive the COVID-19 shot 81.4% (n=522), I receive the flu shot each year 72.5% (n=465), I use sunscreen or protective clothing for a planned time in the sun 63.3% (n=406), I exercise at least three times per week 37.1% (n=238), and I eat at least five servings of fruits and vegetables each day 37.1% (n=206).

Figure 23: Self-Assessment Statements (Top Five)

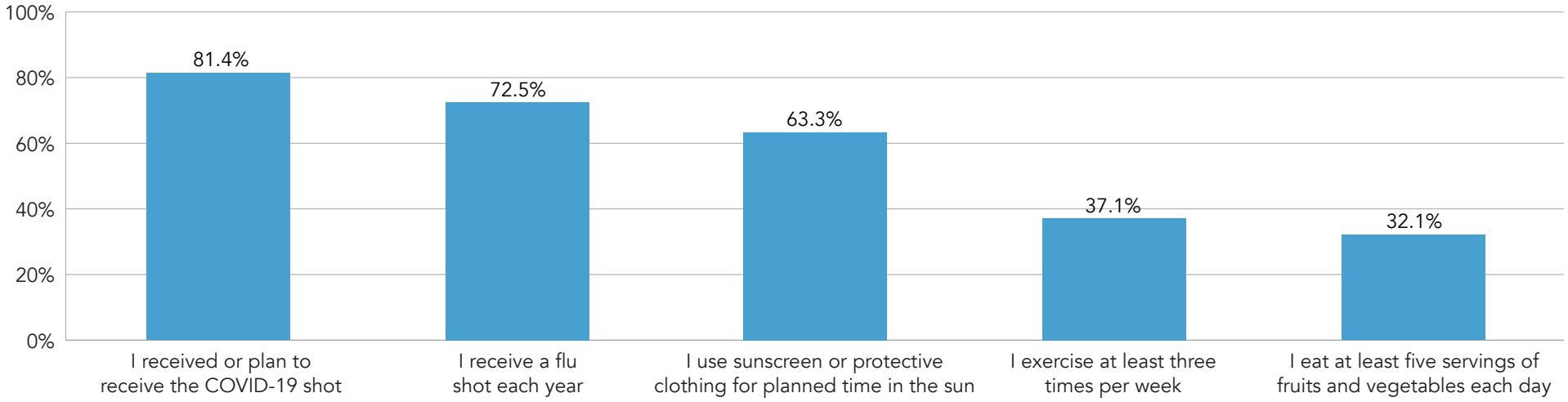
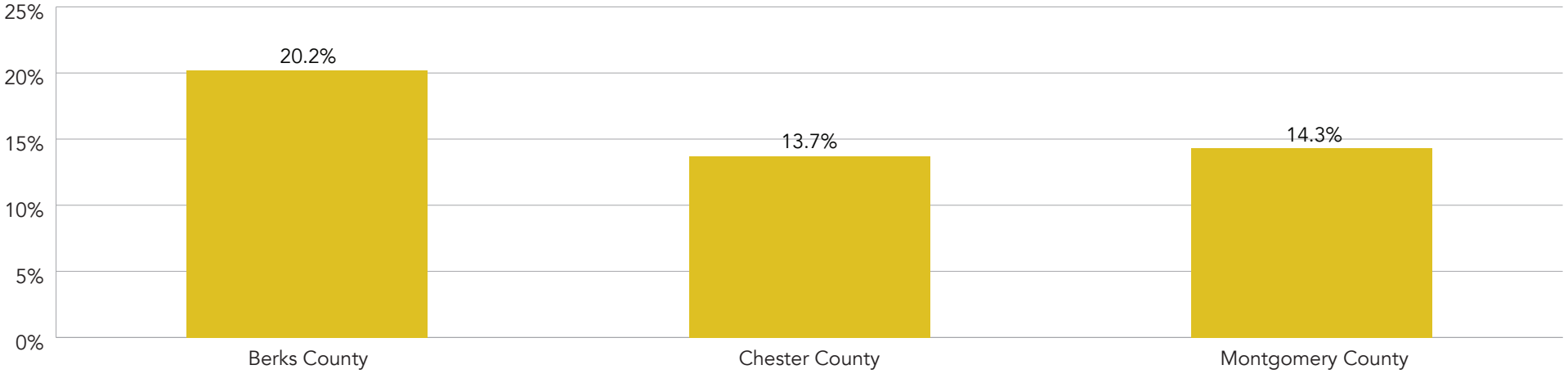


Figure 24 revealed the percentage of residents in Berks, Chester, and Montgomery counties who reported their health as fair or poor.

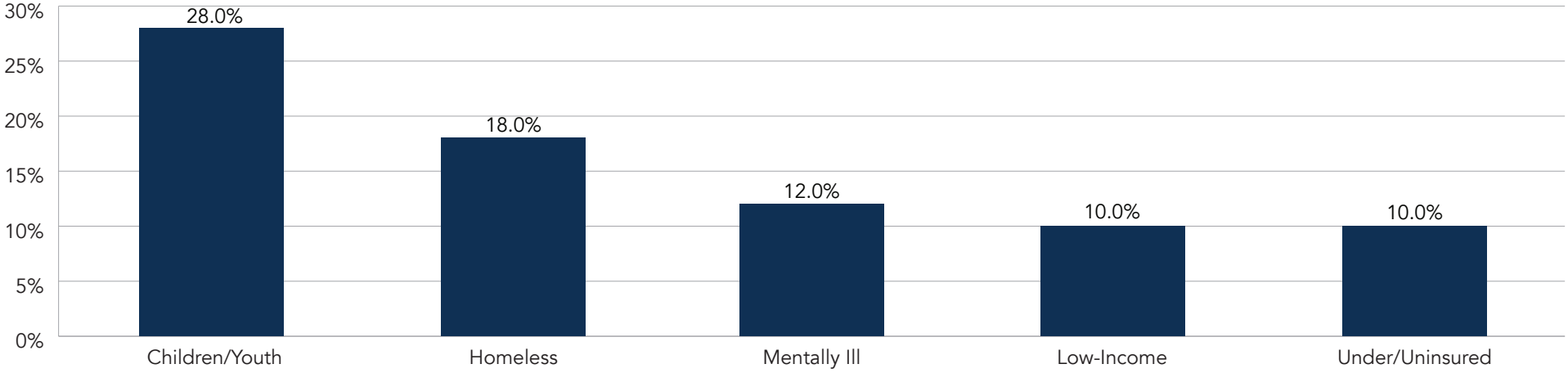
Figure 24: Fair or Poor Health – Age-adjusted



Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2019

Primary data collected from key informants were asked to list the top five populations most vulnerable in their community, children/youth 28.0% (n=14), homeless 18.0% (n=9), mentally ill 12.0% (n=6), low-income 10.0% (n=5), and under/uninsured populations 10.0% (n=5) were identified.

Figure 25: Top Five Vulnerable Populations in the Community



B) BEHAVIORAL HEALTH

During the COVID-19 pandemic, the need for access to behavioral health services became even more evident as a result of COVID mandates such as social distancing, wearing masks, mandatory lockdowns, and isolation. Mental health issues and drug and alcohol use have increased significantly as employers and employees worried about the suspension of productive activity, loss of income, and an ever-present "fear of the future" (National Institutes of Health). The impact of COVID-19 on the workplace further resulted in mental health issues such as anxiety, depression, post-traumatic stress disorder (PTSD), and sleep disorders. This impact was especially noted among health care workers, especially those on the front line, migrant workers, and workers in contact with the public.

Pottstown's CHNA focus groups, stakeholders, key informants, and survey respondents reported "improving access and availability of behavioral health and mental health services and programs" as having a great impact on the overall health of their surrounding communities and a high priority for improving health status.

Figure 26 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 26: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Stigma around mental illness
- Lack of insurance and high co-pays

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care?"

- Lack of health care coordination
- Substance abuse
- Lack of access to behavioral health/mental health services

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Limited access to behavioral health/mental health services
- Substance abuse
- Poor integration and coordination of services

COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

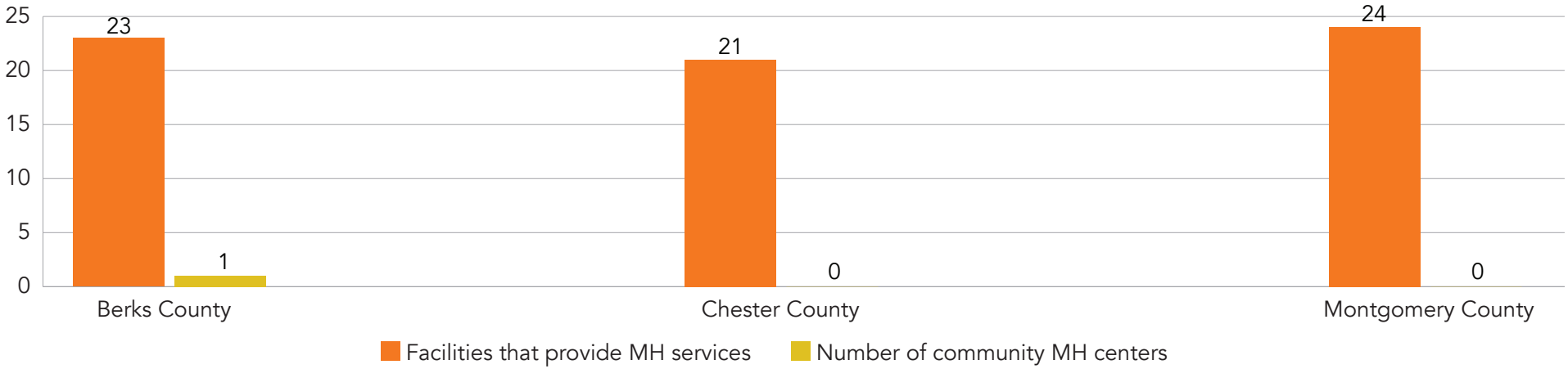
- Lack of access to behavioral health/mental health services
- Drug/alcohol use
- Lack of access to drug and alcohol services

Figure 27 illustrates the number of facilities that provide mental health services and the number of community mental health centers in Berks County, Chester County, and Montgomery County.

Community mental health centers (CMHC) fill the need for mental health treatment and services throughout the country. CMHCs are community-based organizations providing mental health services, sometimes as an alternative to the care that mental hospitals provide. CMHC represents a basic change in social acceptance and attitudes related to mental health. CMHCs were designed to move mental health care from the traditional hospital or state "custodial" care to the community where holistic programs, family-centered care, and therapeutic services enhance recovery and restoration.

Community mental health facilities are specific to mental health illnesses. Children, adults, and individuals who are chronically mentally ill or have been discharged from an inpatient mental health facility can be treated at a community mental health center.

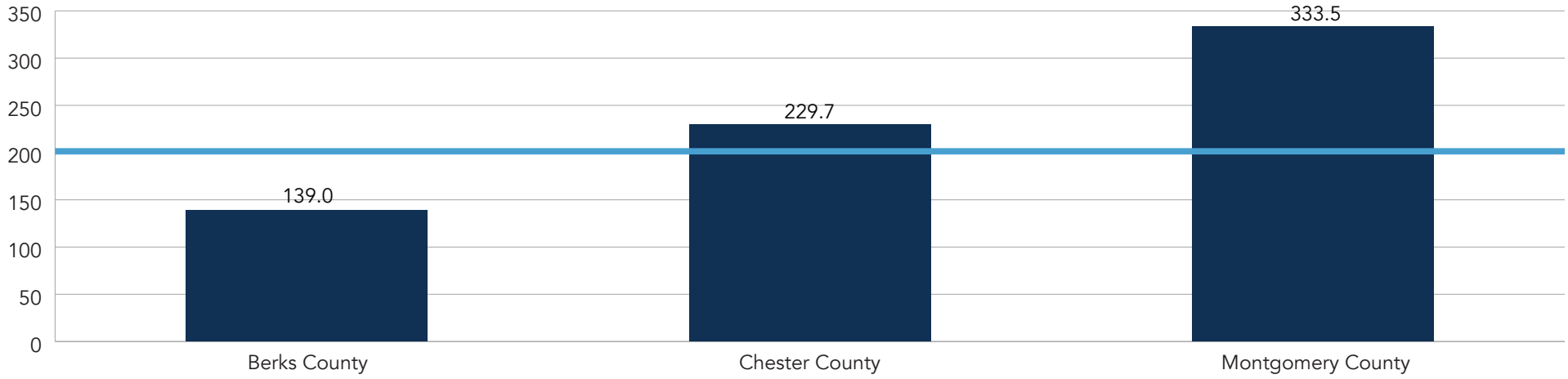
Figure 27: Mental Health Facilities and Centers



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

Figure 28 illustrates the shortage in the number of mental health providers (per 100,000 population) in Berks, Chester, and Montgomery counties.

Figure 28: Mental Health Providers

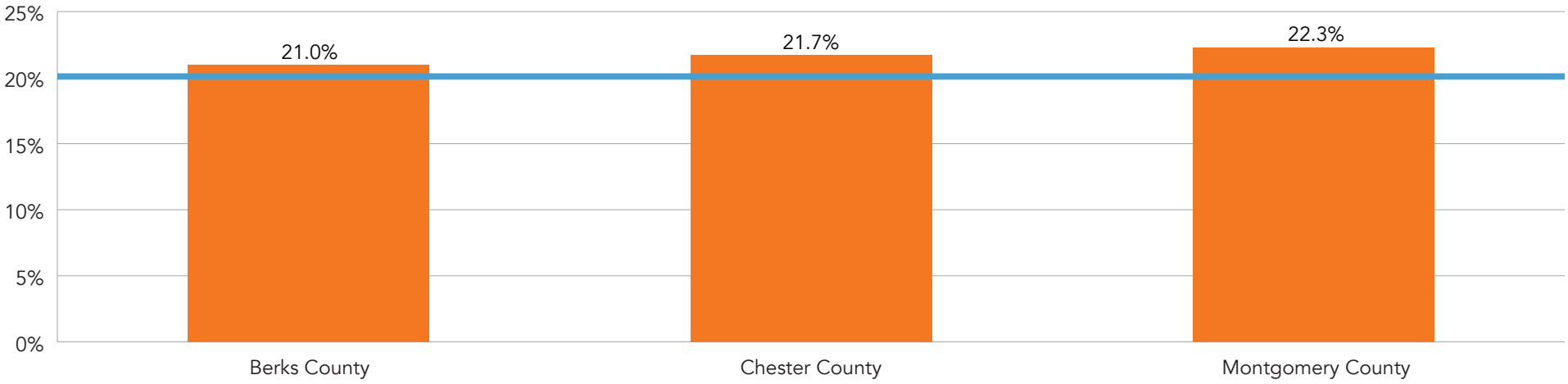


Note: The blue line indicates Pennsylvania at 206.5.
Source: County Health Rankings & Roadmaps 2019

Alcohol and tobacco use are root causes and can exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk when compared to the United States. When analyzing alcohol consumption, rates are worse or the same in Berks, Chester and Montgomery counties when compared to the state.

Figure 29 illustrates the percentage of adults who are heavy drinkers in Berks, Chester, and Montgomery counties. Heavy drinking is defined as having more than two drinks per day for men and more than one per day for women, over the past 30 days.

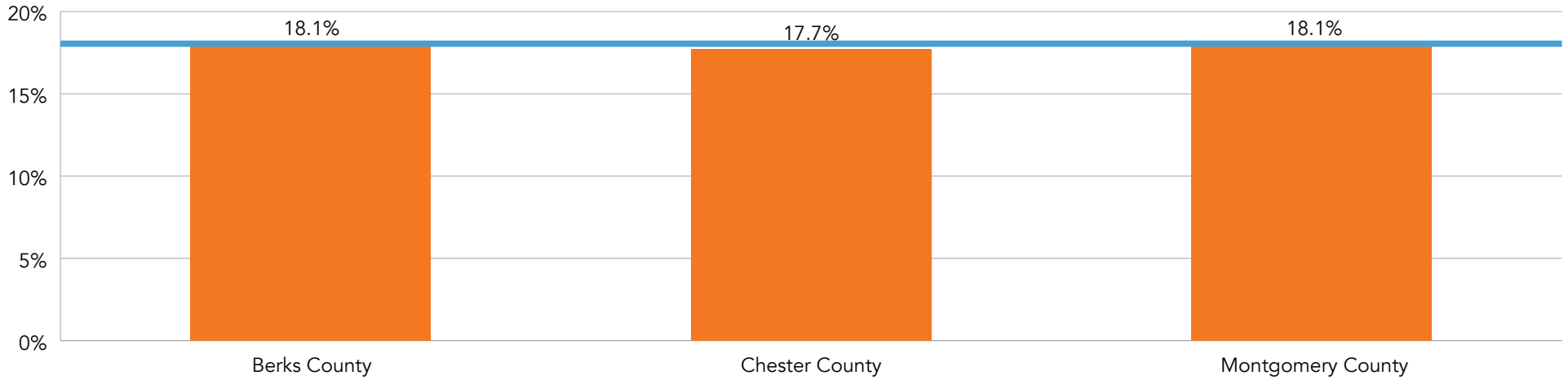
Figure 29: Alcohol Consumption (18 years and older who are heavy drinkers)



Note: The blue line indicates Pennsylvania at 20.2%.
Source: County Health Rankings & Roadmaps 2018

Figure 30 illustrates the percentage of adults who are binge drinkers in Berks, Chester, and Montgomery counties. A binge drinker is an adult age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

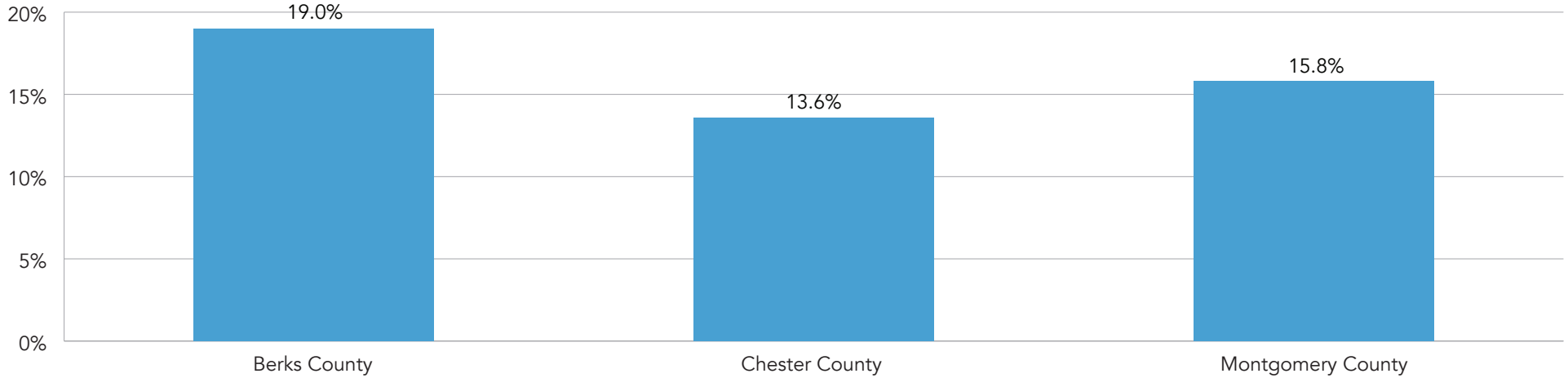
Figure 30: Alcohol Consumption (18 years and older who are binge drinkers)



Note: The blue line indicates Pennsylvania at 18.1%.
Source: County Health Rankings & Roadmaps 2018

Figure 31 shows adults 18 and older who smoke every day or some days in Berks, Chester, and Montgomery counties. Smokers are adults aged 18 and older who report having smoked at least 100 cigarettes in their lifetime and smoke every day or some days.

Figure 31: Tobacco Usage – Current Smokers



Source: CDC, Behavioral Risk Factor Surveillance System 2018

C) HEALTH EDUCATION AND PREVENTION

Health education programs help people better understand how to manage an existing health condition and how to prevent further illness, which is paramount to good health. Pottstown Hospital's community education and disease prevention programs are designed to engage and empower individuals and communities to practice healthy behaviors that reduce the risk of developing chronic diseases and to improve management for chronic diseases such as heart disease, diabetes, and high blood pressure. According to the World Health Organization, "health education enables people to increase control over their own health."

The Pottstown CHNA process revealed the need for understanding cultural and language barriers to improving health and the need to promote healthy lifestyles and practices. Health education and health literacy empower individuals to make informed health decisions and help them effectively navigate today's complex health care delivery system. Through health education, patients and families can successfully implement treatment plans, manage chronic conditions, and prevent complications and/or hospitalizations. By improving health literacy and education to the broad community, the health organization's paradigm shifts from treating disease to a focus on wellness, healthy behaviors, and positive health outcomes.

Figure 32 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 32: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Health literacy and poor education
- Lack of awareness/access to available resources/services
- Cultural and language barriers
- Transient populations, lack of continuity of services, especially among children

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care?"

- Health literacy
- Culture and language barriers
- Lack of exercise/physical activity
- Lack of access to healthy foods
- Tobacco use

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Health education and literacy
- Lack of community education on available services
- Low education
- Lack of exercise/poor eating habits

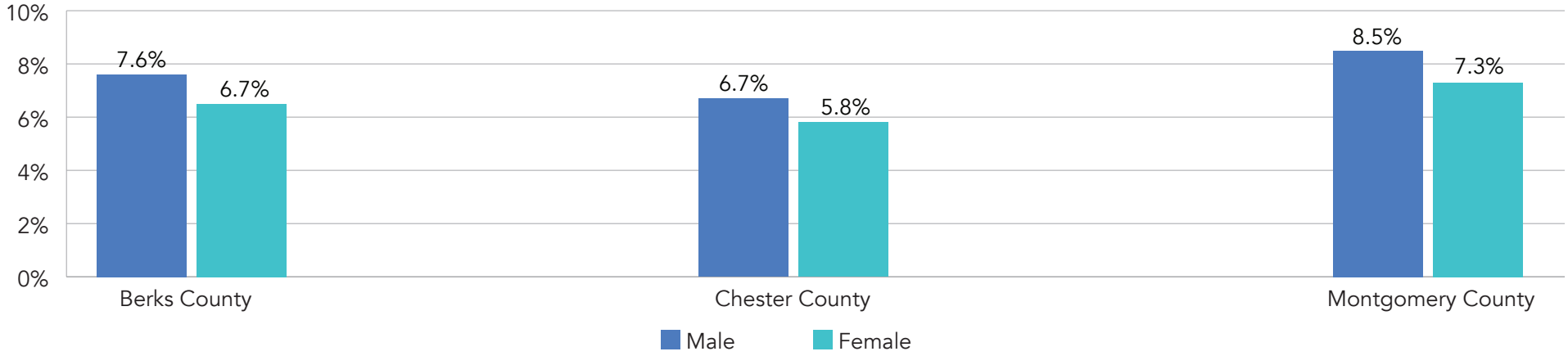
COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Unhealthy lifestyles and behaviors
- Poor nutrition and eating behaviors
- Lack of exercise
- Lack of access to healthy foods
- Need for chronic disease prevention/management education

Figure 33 shows the percentage of adults aged 20 and older, by gender, who have been told by a doctor that they have diabetes.

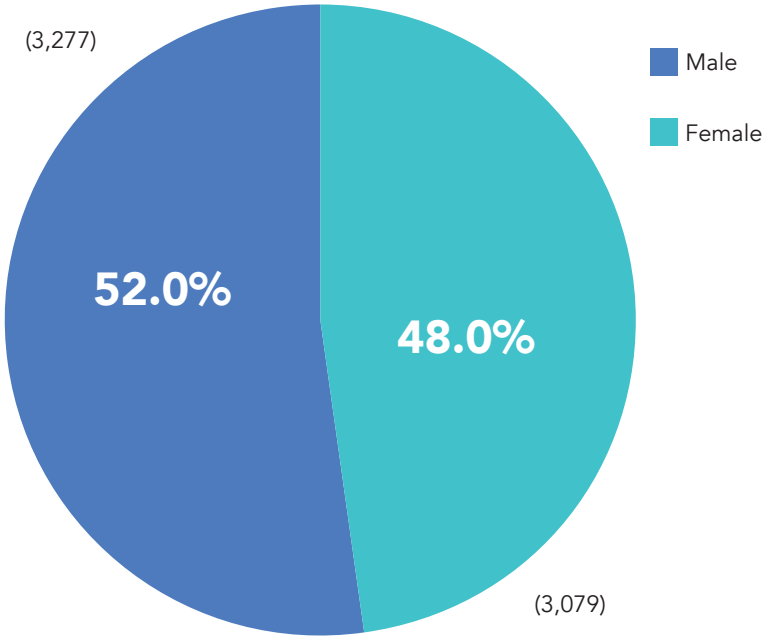
Figure 33: Diabetes by Gender



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.

Figure 34 shows the 2021 diabetes registry of patients at Pottstown Hospital by gender.

Figure 34: Diabetes Registry Patients by Gender



Source: EPIC Clarity

Table 35: Diabetes Registry Patients at Pottstown Hospital by Ethnicity

Ethnicity	Diabetes Registry Patients
Hispanic or Latino	196
Not Hispanic or Latino	6,005
Patient Refused	26
Unknown	128
Total	**6,355**

Source: Epic Clarity

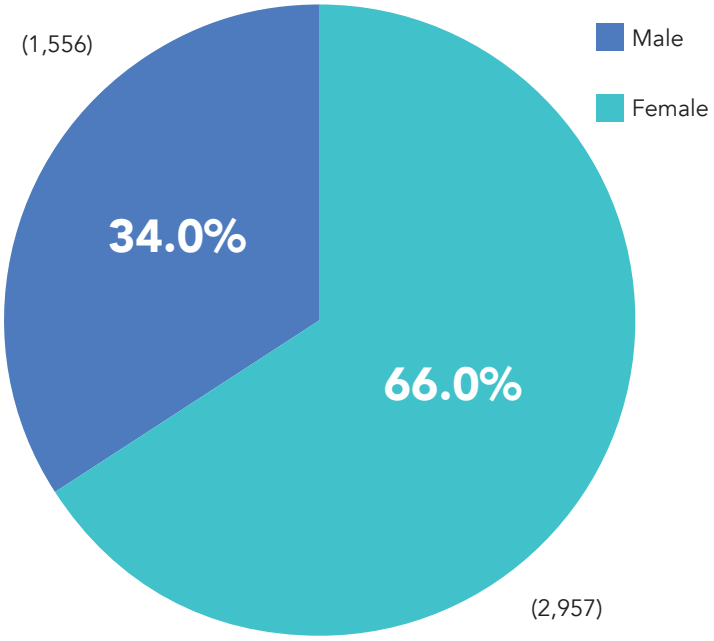
Table 36: 2021 Diabetes Registry Patients at Pottstown Hospital by Race

Race	Diabetes Registry Patients
American Indian or Alaska Native	12
Black or African American	625
Hispanic	2
Native Hawaiian or Other Pacific Islander	16
Other	124
Other Asian	53
Patient Refused	70
Unknown	46
White or Caucasian	5,408
Total	**6,356**

Source: Epic Clarity

Figure 37 shows the 2021 asthma registry of patients at Pottstown Hospital by gender.

Figure 37: Asthma Registry Patients by Gender



Source: EPIC Clarity

Table 38: 2021 Asthma Registry Data at Pottstown Hospital by Ethnicity

Ethnicity	Asthma Registry Patients
Hispanic or Latino	211
Not Hispanic or Latino	4,008
Patient Refused	37
Unknown	257
Total	**4,513**

Source: Epic Clarity

Table 39: 2021 Asthma Registry Data at Pottstown Hospital by Race

Race	Asthma Registry Patients
American Indian or Alaska Native	4
Black or African American	590
Hispanic	1
Native Hawaiian or Other Pacific Islander	9
Other	115
Other Asian	28
Patient Refused	118
Unknown	63
White or Caucasian	3,585
Total	**4,513**

The following table reveals the number of patients who completed a health screening/preventative health measure at Pottstown Hospital.

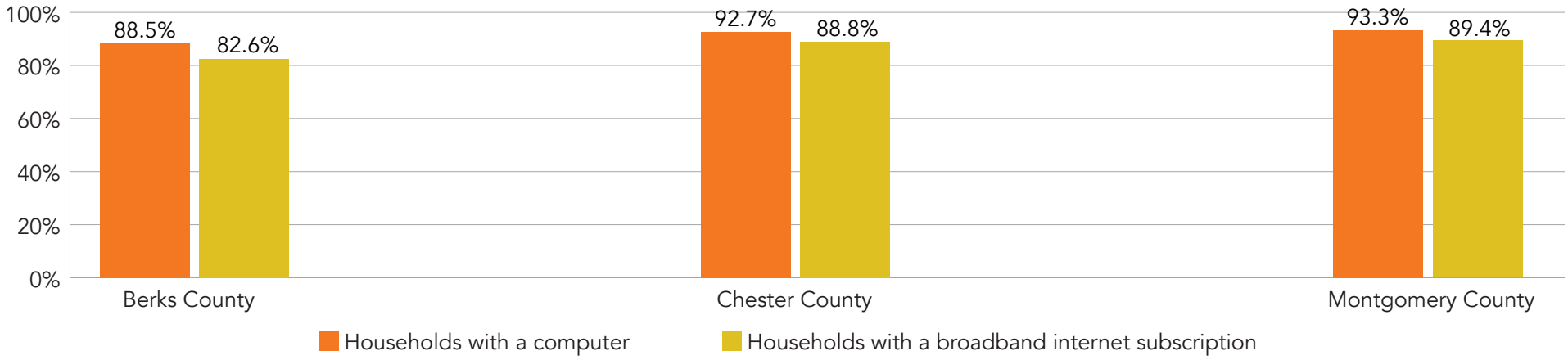
Table 40: Patients who completed Health Screenings/Preventative Health Measure

Year	Mammography	Colonoscopy	Flu Shot	PCP Visit
2018	3,835	1,430	4,109	1,507
2019	7,379	3,068	8,509	12,038
2020	9,199	4,065	10,667	17,982

Source: Epic Clarity

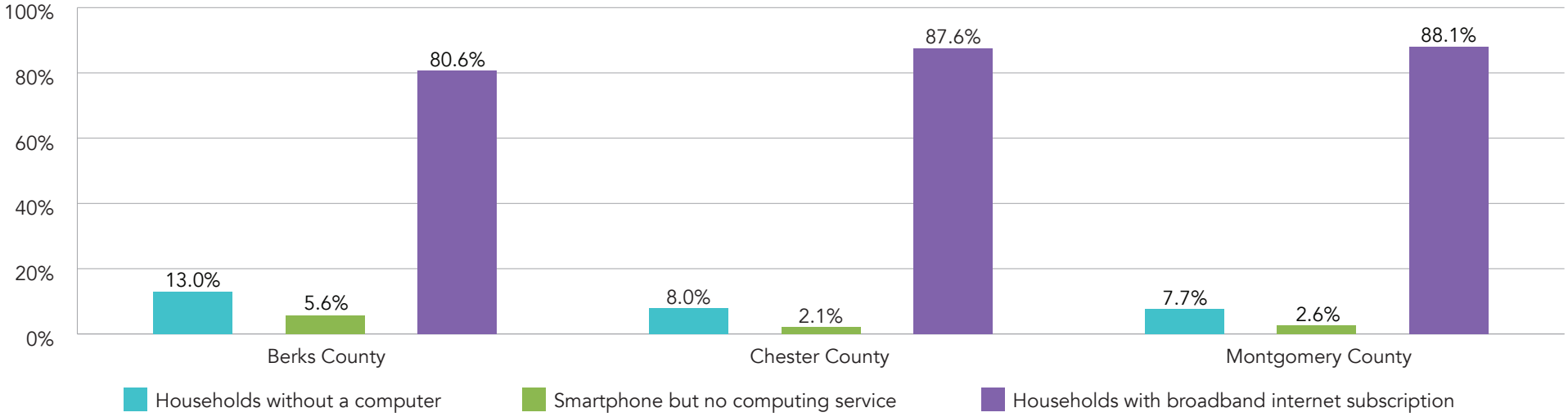
Figure 41 illustrates the percentage of residents in Berks, Chester, and Montgomery counties with a computing device or internet service. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet as a means of reaching targeted audiences. This avenue allows underserved or disenfranchised populations web access to obtain health education.

Figure 41: Percentage of Households with Computer or Internet



Source: U.S. Census Bureau 2019

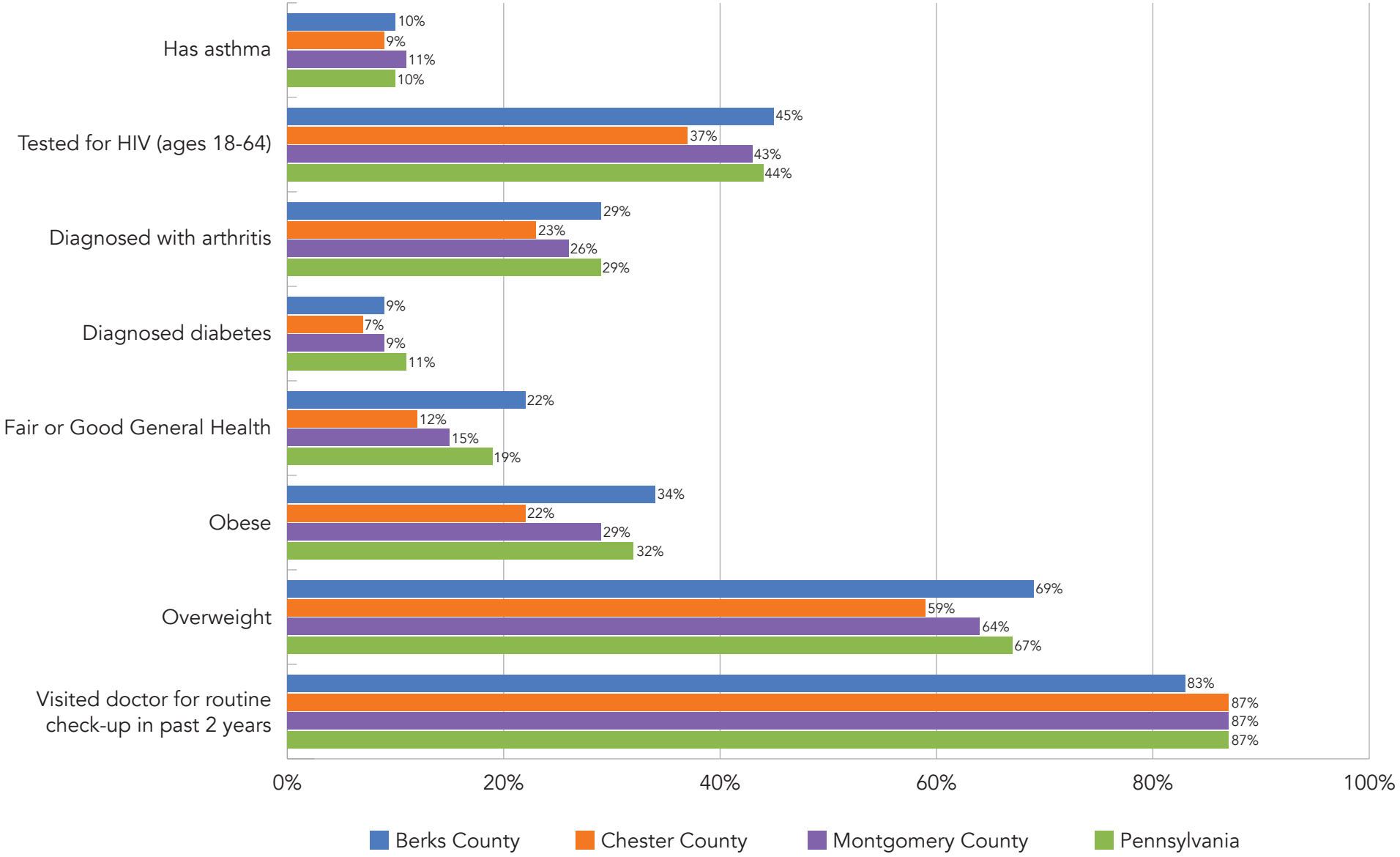
Figure 42: Percentage of Households with Limited Technology



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

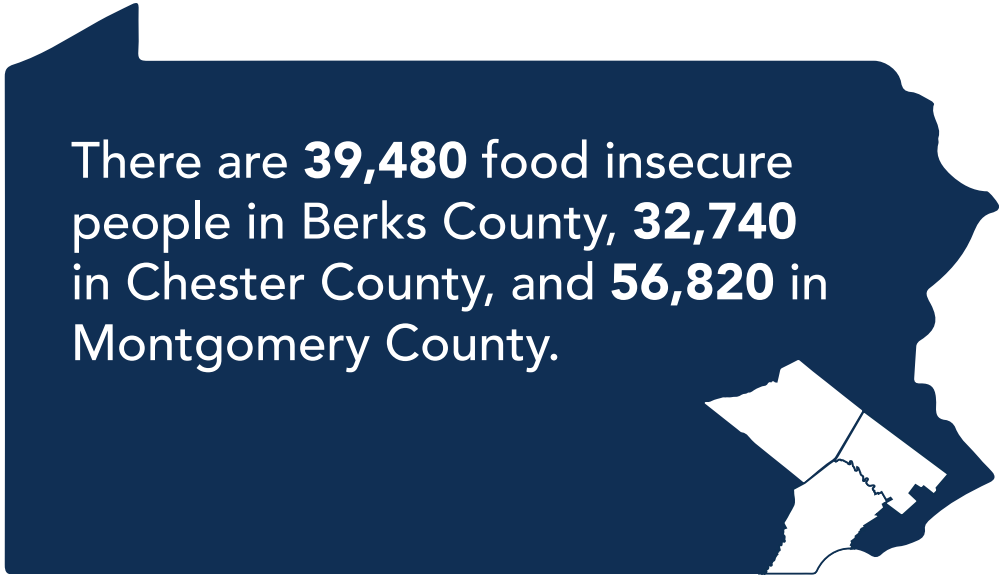
Figure 43 shows adult health risk behaviors, health outcomes, and general health in Berks, Chester, Montgomery counties, and in Pennsylvania. Specifically, the graph depicts the obesity/overweight rate of individuals in Berks County exceeding the state rate.

Figure 43: Overall Adult Health Risks



Source: Pennsylvania Department of Health 2017-2019

The USDA refers to food insecurity as the lack of access (periodically) to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecurity may reflect a household's need to make tradeoffs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. Lack of access to healthy foods impacts chronic diseases such as obesity/ overweight, diabetes, and high blood pressure.



Source: Feeding America 2019

SM SNAP Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP)[2] reported the following in Berks, Chester, and Montgomery counties:

- 59,288 Berks County residents received $7,163,720 in SNAP benefits; 24,141 Chester County residents received $2,841,501 in SNAP benefits; and 50,742 Montgomery County residents received $6,201,417 in SNAP benefits to help make ends meet in December 2018.
- Low-income SNAP participants spend $1,400, or nearly 25%, less in annual medical costs than low-income adults who don't participate in SNAP.
- SNAP boosts wages for workers who do not earn enough to afford a basic diet and helps those who are between jobs while they search for work.

Source: Coalition Against Hunger 2018

[7] SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move toward self-sufficiency.

COVID-19 AND THE IMPACT ON FOOD INSECURITY

In early 2020, COVID-19 spread across the United States, creating an economic recession. The pandemic has negatively impacted millions of people for the first time who are experiencing food insecurity along with those who experienced food insecurity before the COVID-19 crisis.

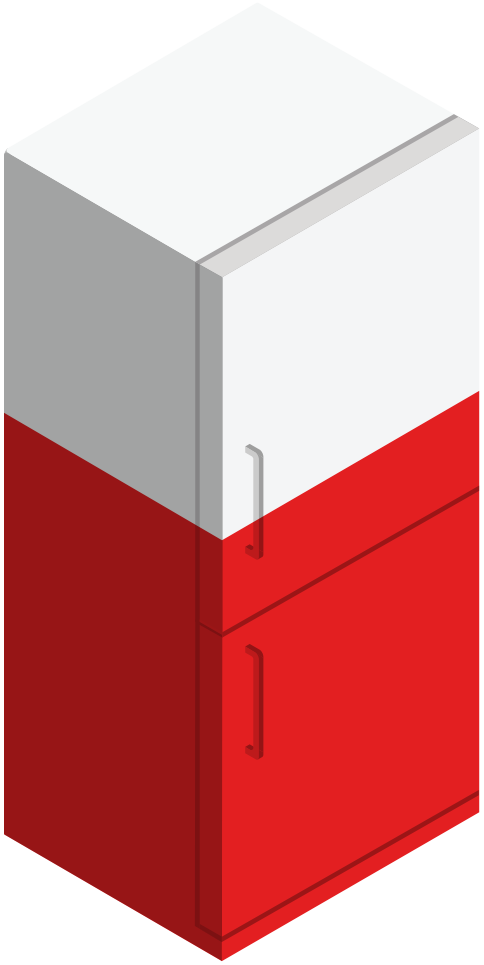
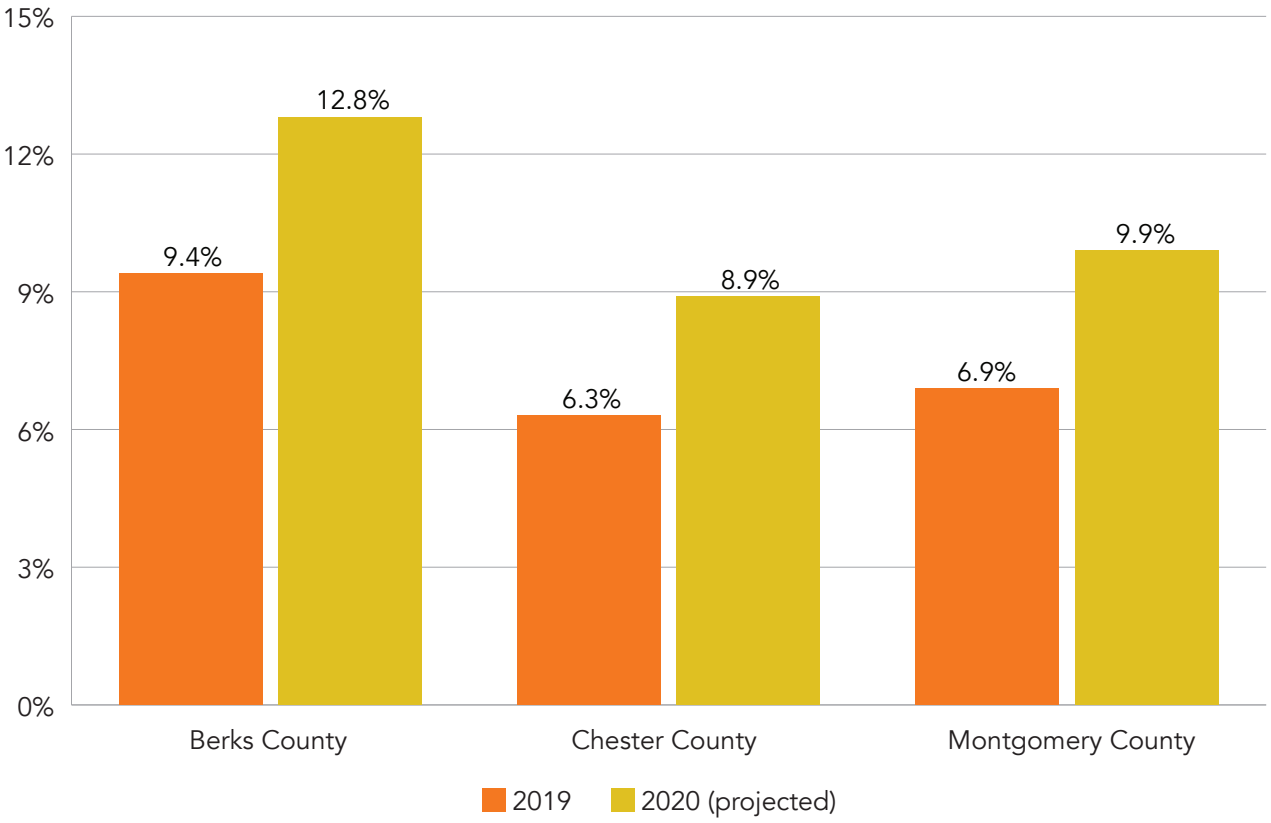
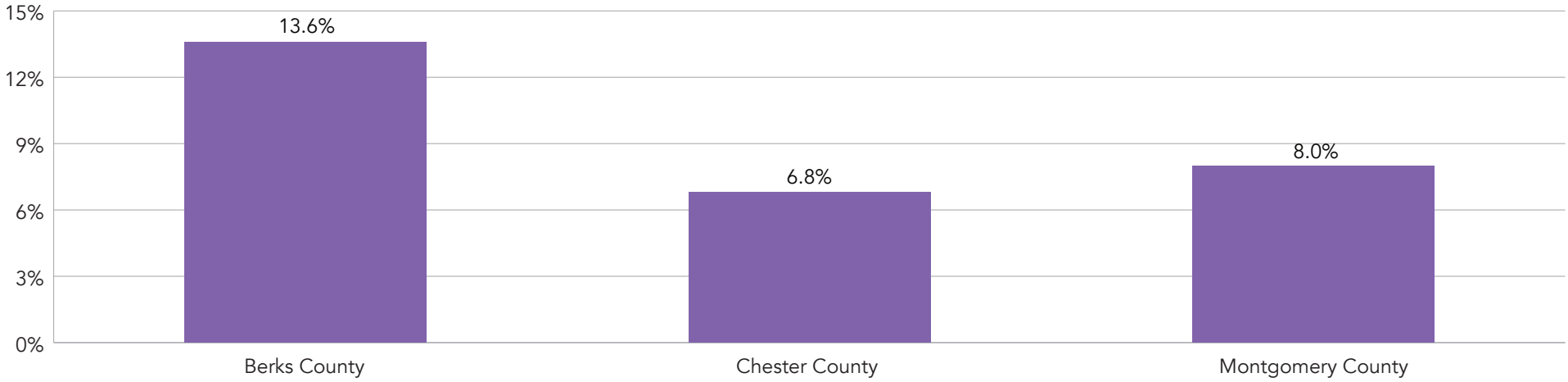


Figure 44: Food Insecurity



Source: Feeding America 2019

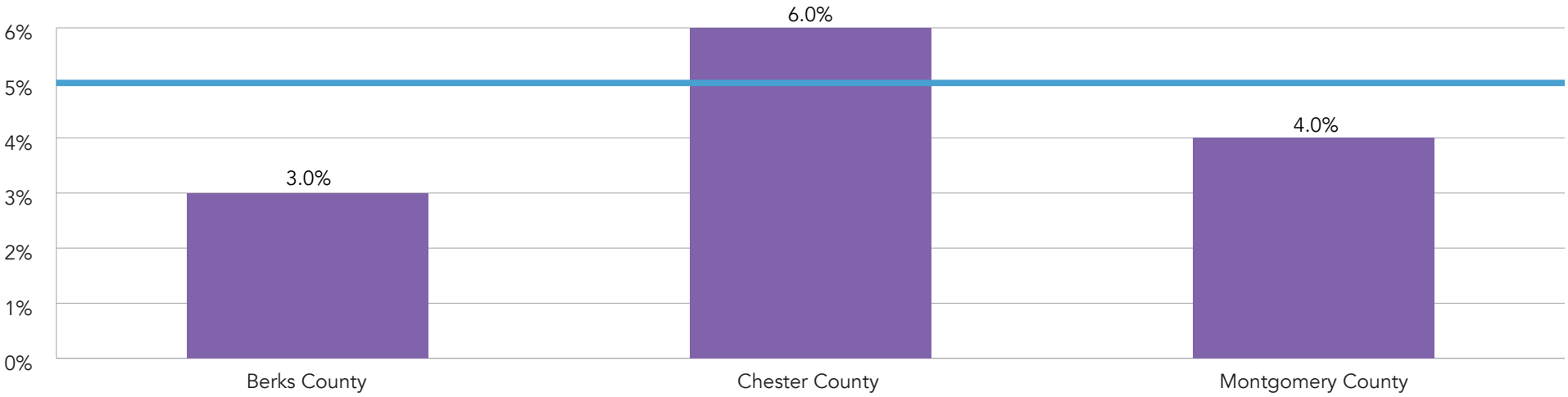
Figure 45: Child Food Insecurity



Source: Feeding America 2019

Figure 46 reports the percentage of the population who are low-income and do not live close to a grocery store.

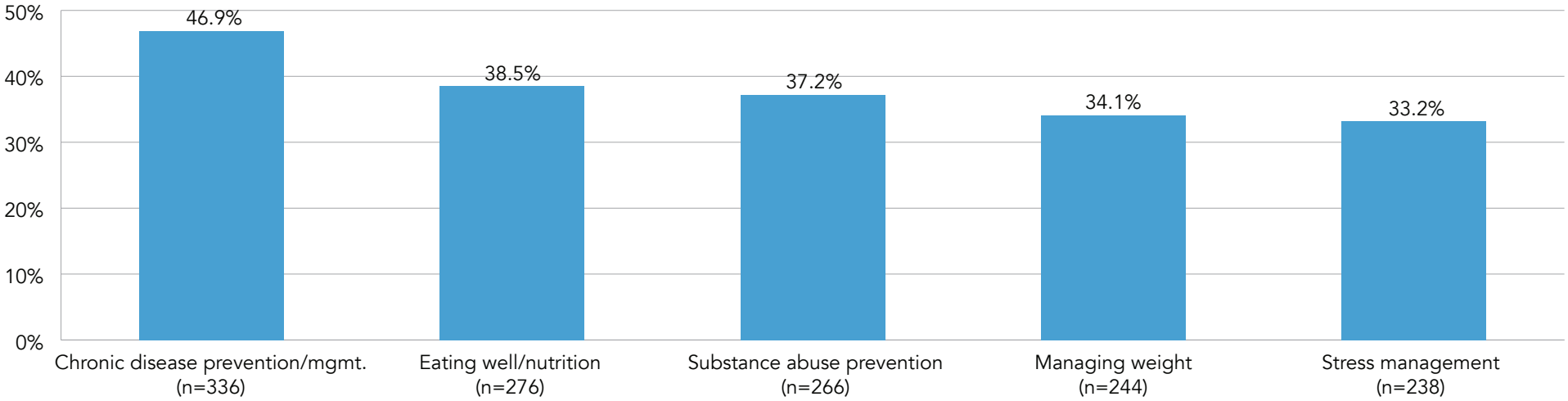
Figure 46: Limited Access to Healthy Foods



Note: The blue line indicates the overall rate in Pennsylvania of 5.0%.
Source: County Health Rankings & Roadmaps 2015

Figure 47 from the community survey shows health behaviors on the type of information people in the community need more information.

Figure 47: Top Health Behaviors for Which People Need More Information



Community health respondents in the Pottstown service area, when asked about the top challenges faced, reported overweight/obesity, joint or back pain, and arthritis.

Figure 48: Top Three Challenges Faced

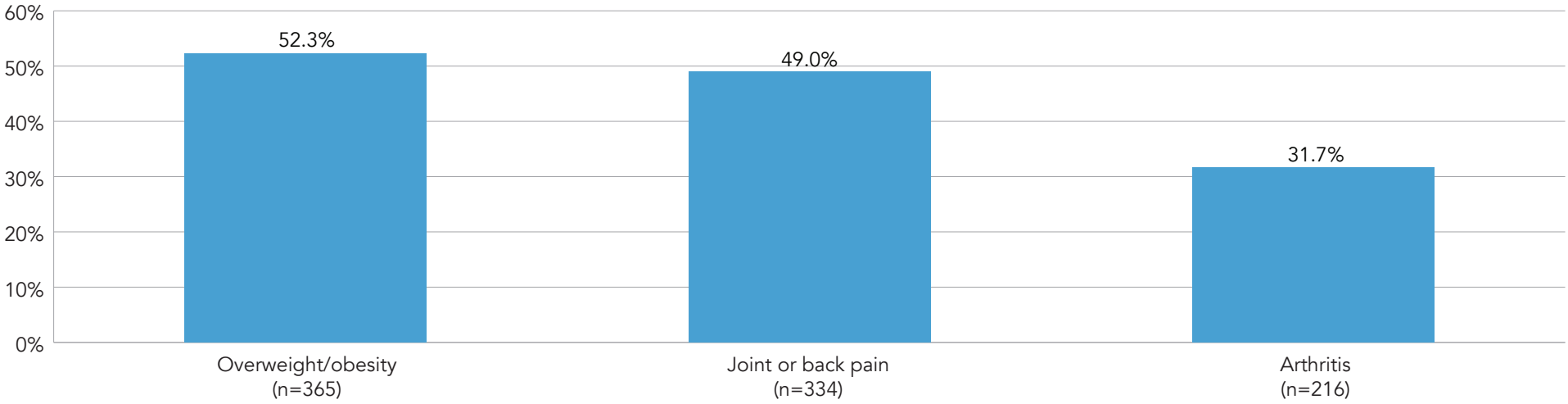
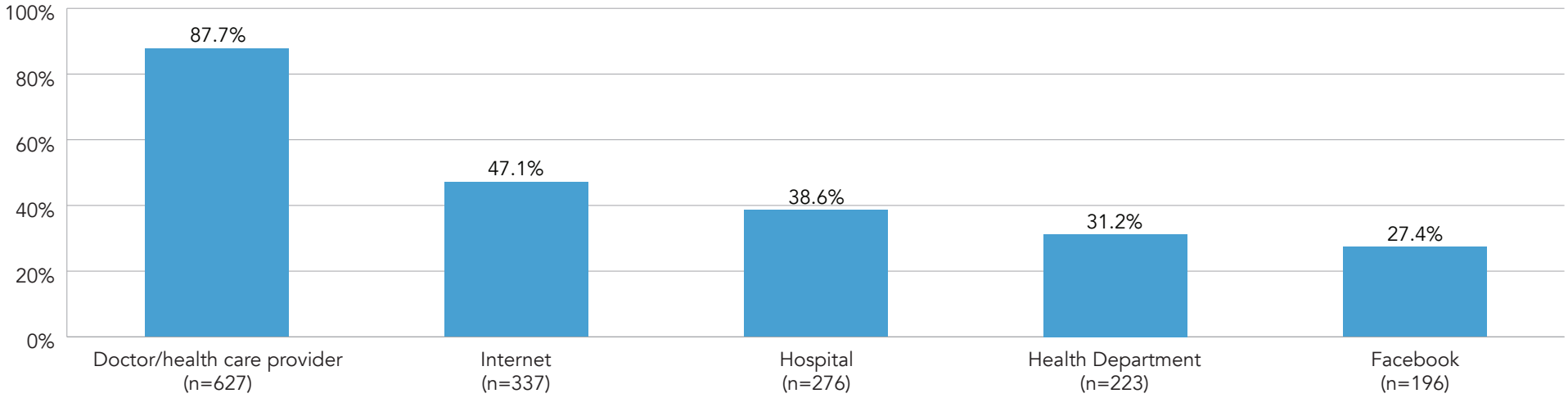


Figure 49 from the community survey reports how the community wants to receive health information.

Figure 49: Top Ways Community Wants to Receive Information



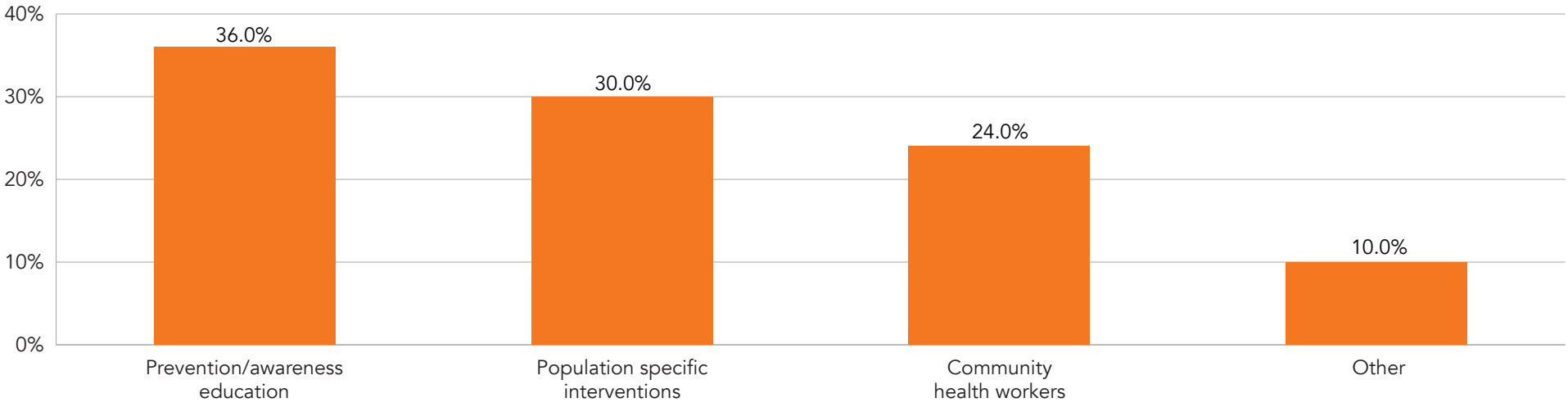
A healthy lifestyle prevents chronic diseases such as heart disease, diabetes, and some forms of cancer, to name a few. Nationally, the CDC reports that six out of 10 persons have at least one chronic disease. Furthermore, the CDC reports that the benefits of healthy eating and physical activity decreases the occurrence of chronic diseases for adults but also impacts the following aspects of human life:

- Can help you live longer
- Keeps skin, teeth, and eyes healthy
- Supports muscles
- Boosts immunity
- Lowers risk of heart disease, type 2 diabetes, and some cancers
- Supports healthy pregnancies and breastfeeding
- Helps the digestive system function
- Helps achieve and maintain a healthy weight

When asked in the community survey "important factors that contribute to a healthy community," 41.1% (n=299) of community survey respondents noted healthy behaviors and lifestyles. A total of 52.3% (n=356) of Pottstown community survey respondents indicated overweight/obesity as their main health challenge. In identifying top persistent health problems in the community, more than one-third of community residents (38.7%; n=279) reported lack of exercise and 37.3% reported cancers (n=269).

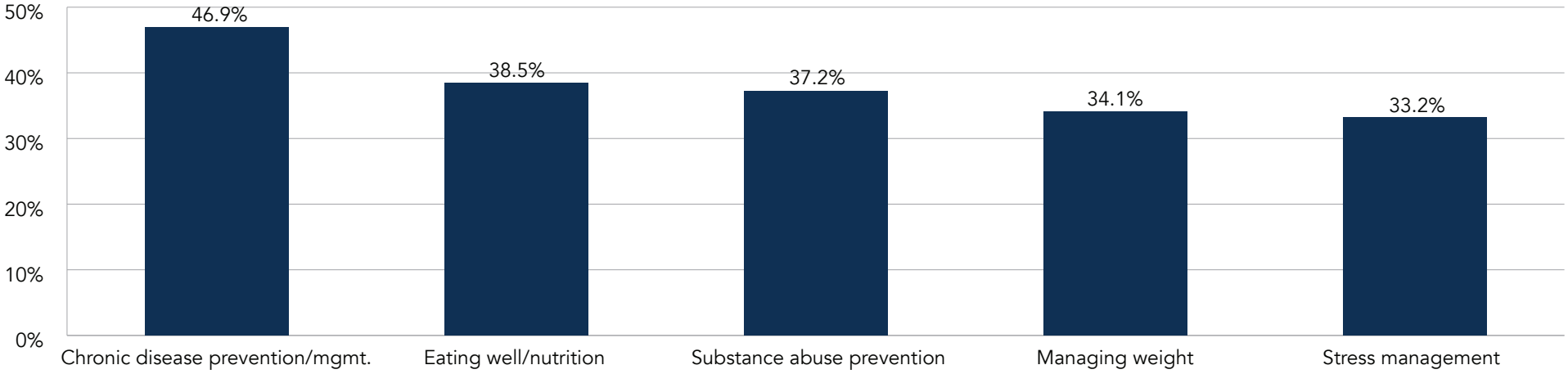
Interviewed community stakeholders and key informants reported lack of exercise/inadequate physical activity as a high-risk behavior in the community. When key informants were asked the following question, "Type II diabetes, pre-diabetes, and obesity affects many members of our community. What can we offer the community to achieve and maintain optimal health?" their responses are as follow:

Figure 50: Key Informant Results to Achieve and Maintain Health



CHNA stakeholders, key informants, and community survey respondents emphasized the impact of healthy foods, good nutrition, and physical activity on a quality lifestyle and spoke to education, health literacy, and prevention to improve community health and wellness. The following chart from the community health survey capitalizes on survey respondents' viewpoints as related to the value of health education and health literacy:

Figure 51: Top Health Behaviors People in Your Community Need More Information About



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 delivery system.

When assessing the diverse and disparate population, many SDOH and barriers to health care access and services were uncovered. Barriers such as a lack of transportation, inadequacy of language and interpretation services, lack of insurance coverage, and cultural bias and discrimination, to name a few, have a very dramatic impact on the capacity to provide quality health care and the quality of life for Pottstown Hospital's communities. Interventions that improve health equity and reduce disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently.

SYSTEM POLICIES

Health equity is impacted by policies and systems that serve as barriers to equitable care. These policies and systems may favor one group over another, negatively impacting health and quality of life.

LANGUAGE/CULTURE

Meeting the needs of diverse populations through culturally and linguistically appropriate care and patient specific services such as language, literacy, accessibility to interpretation services and targeted outreach to disenfranchised populations can provide health equity.

SOCIAL DETERMINANTS OF HEALTH

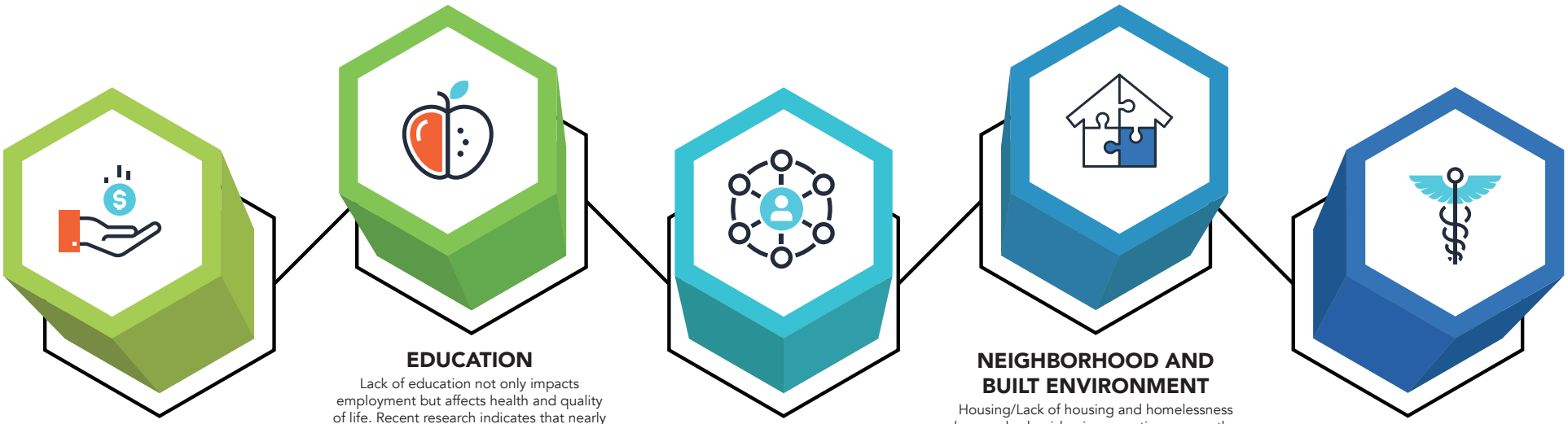
Health equity demands a multi-sectoral approach to engage and mobilize the broad community to address social, economic, educational and environmental factors that influence health, defined as SDOH.

GENERAL OVERVIEW OF SOCIAL DETERMINANTS OF HEALTH

As defined by the World Health Organization (WHO), SDOH are the economic and social conditions that influence individual and group differences in health status. These economic and social conditions under which people and groups live may increase or decrease the risk for a health condition or disease among individuals and populations. Addressing SDOH is paramount to creating a healthier community.

Various domains categorize SDOH; Figure 52 displays five domains as categorized by Healthy People 2030. SDOH domains are also contributors to health disparities and inequities across the nation. Data links determinants and domains to health status, such as the correlation of one's ZIP code resulting in drastically different health statuses for patients with the same/similar health conditions. The literature stresses the need for multi-sector organizations to collaborate in efforts to address social determinants and make positive impacts on overall patient health. In addition, targeting specific populations with specialized interventions is imperative to providing equitable health care.

Figure 52: Understanding SDOH (Healthy People 2030).



Source: Healthy People 2030

LESSONS LEARNED FROM COVID-19 AND HEALTH EQUITY

The effects of COVID-19 are far-reaching and long-lasting. The Centers for Diseases Control and Prevention (CDC) reported that essential employees (those in health care, food services, and transportation) were much more likely to die than other workers. Hispanics are nearly two times more likely to contract the disease as whites. Blacks have been hospitalized at three times the rate of whites, and American Indian/Alaska Natives have lost loved ones at more than double the rate of whites.

Race and ethnicity are markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

In Pennsylvania, non-Hispanic whites experienced 83.2% of all COVID-19 deaths. However, the impact of looking at the data by age determined multiple, age-specific disparities for Hispanics and non-Hispanic Blacks compared to non-Hispanic whites. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

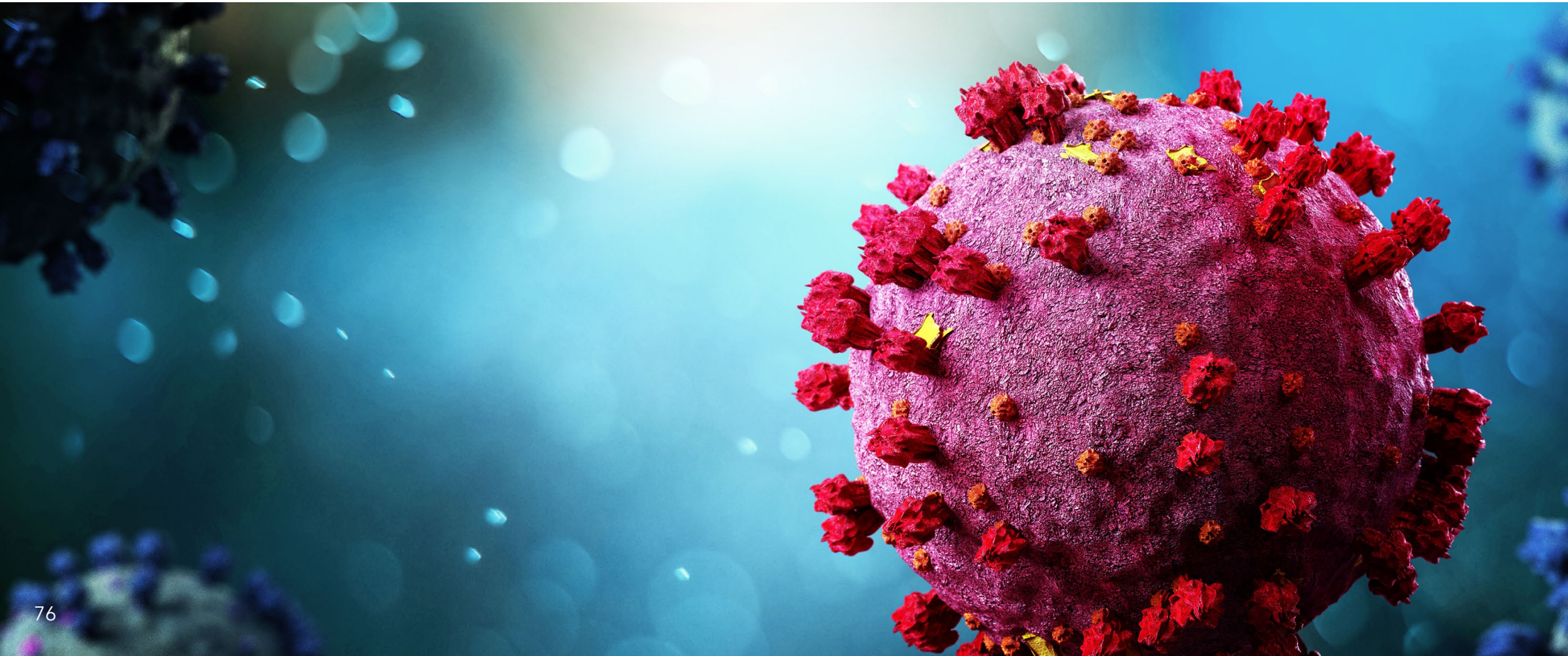
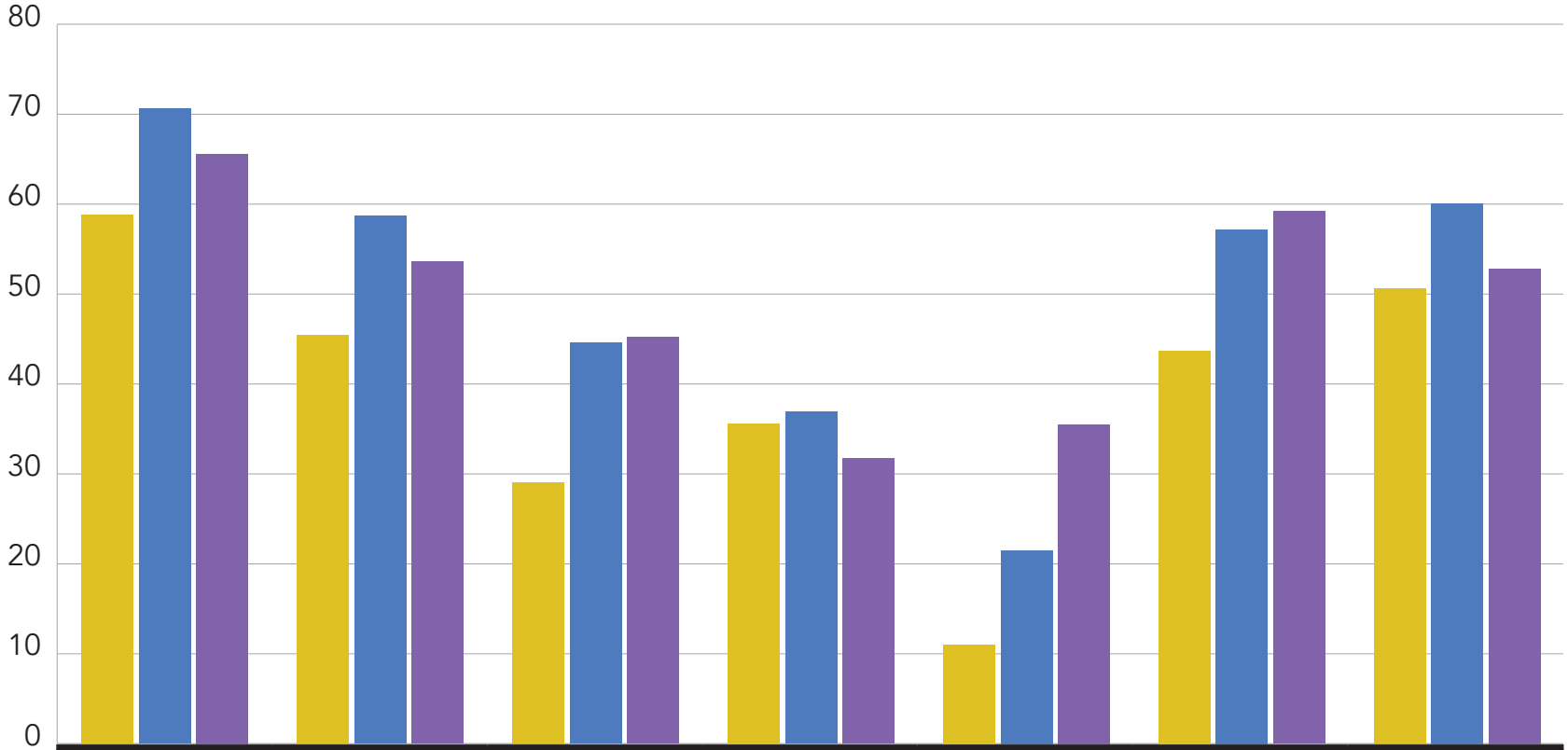


Figure 53: Full Vaccination Coverage for Race/Ethnicity



	All Races/ Ethnicity	White	African American	Asian/Pacific Islander	Native American	Hispanic	Not Hispanic
Berks County	58.8%	45.4%	29.0%	35.6%	11.0%	43.7%	50.6%
Chester County	70.6%	58.7%	44.6%	36.9%	21.5%	57.2%	60.1%
Montgomery County	65.6%	53.6%	45.2%	31.7%	35.5%	59.2%	52.8%

Note: Data presented in the above chart was collected in January 2022. Updated information can be obtained from the PA Department of Health.

Source: The PA Department of Health

Reviewing data by demographics such as age, gender, race, and ethnicity are markers for other underlying conditions that affect health. Additional factors such as socioeconomic status, access to health care, and exposure to the virus related to occupation are relevant to uncovering the challenges around vaccination access and acceptance, as well as understanding the impact and providing opportunities to develop mitigation solutions.

DRIVERS OF DISEASE INEQUITIES

Multiple factors continue to contribute to poor health outcomes social and health inequalities in marginalized communities. Unfortunately, the COVID-19 pandemic has further exacerbated existing inequalities with many people suffering from chronic illnesses and other conditions that increase their risk of severe illness. Underserved communities continue to feel the brunt and the lack of investment in addressing barriers to health and productive lives in marginalized communities leads to many other health and social consequences.

Independent drivers of disease inequalities and a multi-sectorial approach are needed to reduce the impact of COVID-19 and other health issues among marginalized, disenfranchised, vulnerable, and underserved communities. (See Figure 55).

DISCRIMINATORY POLICIES

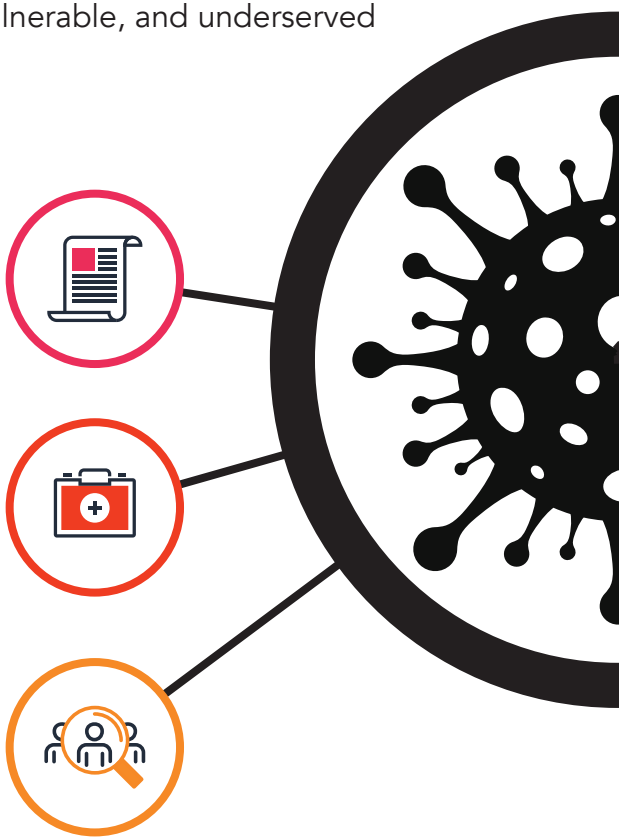
Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare.[8]

LIMITED ACCESS TO ESSENTIAL SERVICES AND RESOURCES

Barriers towards health insurance, childcare, sick leave, paid leave, or access to PPE, make some demographics more prone to COVID-19 inequities.[9]

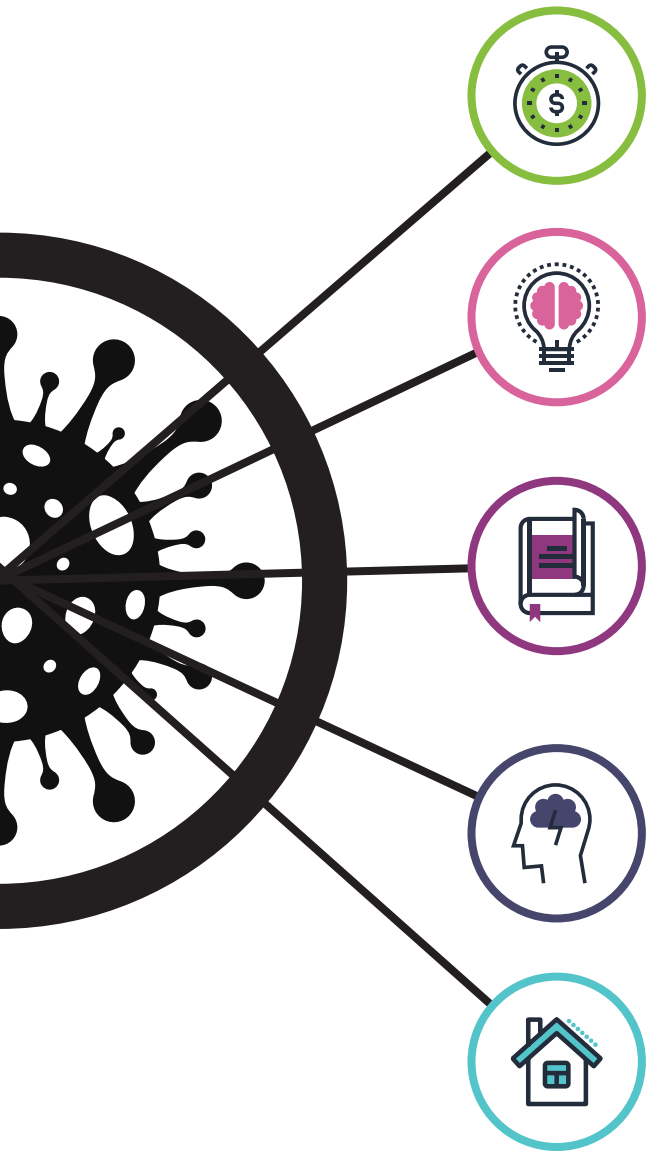
HISTORY OF RACISM & SOCIAL DISCRIMINATION

Systemic racism and other forms of social discrimination have contributed to discriminatory policies, limited investment in community well-being, lack of access to quality healthcare, and a poor sense of trust between communities and health and social systems.[8,10]



[8] CDC, 2020
[9] Pew Research Center, 2020
[10] Health Affairs, 2020
[11] NY Times, 2020
[12] NIMH, 2020
[13] Harvard, 2020
[14] L.C. Cooper and D.C. Crews, 2020
[15] J. Jaiswal, C. LoSchiavo, and D. C. Perlman, 2020
[16] CDC, 2020

Figure 54: COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities (The Health Equality Initiative)



POVERTY

Living in poverty, health is one of many priorities.[16]

MISTRUST

Insufficient community engagement, combined with misinformation or a lack of consistent information as well as a history of discrimination, causes many marginalized communities to lack trust towards health and social services.[14,15]

LOW HEALTH LITERACY & MISINFORMATION

People from ethnically and racially diverse communities didn't have the opportunity to develop skills to identify credible news sources, which has been shown to correlate with low health statuses.[13]

CHRONIC STRESS

Stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications.[12]

OVERCROWDED LIVING CONDITIONS

Many groups live in overcrowded conditions such as multi-generational homes or nursing homes, prisons, homeless shelters, or other kinds of group "homes." This can make it difficult to social distance and increase the risk for COVID-19. Factors such as unemployment can lead to homelessness, and therefore increased vulnerability to COVID-19.[8,11]

Source: The Health Equality Initiative 2020

CONTRIBUTORS TO HEALTH EQUITY

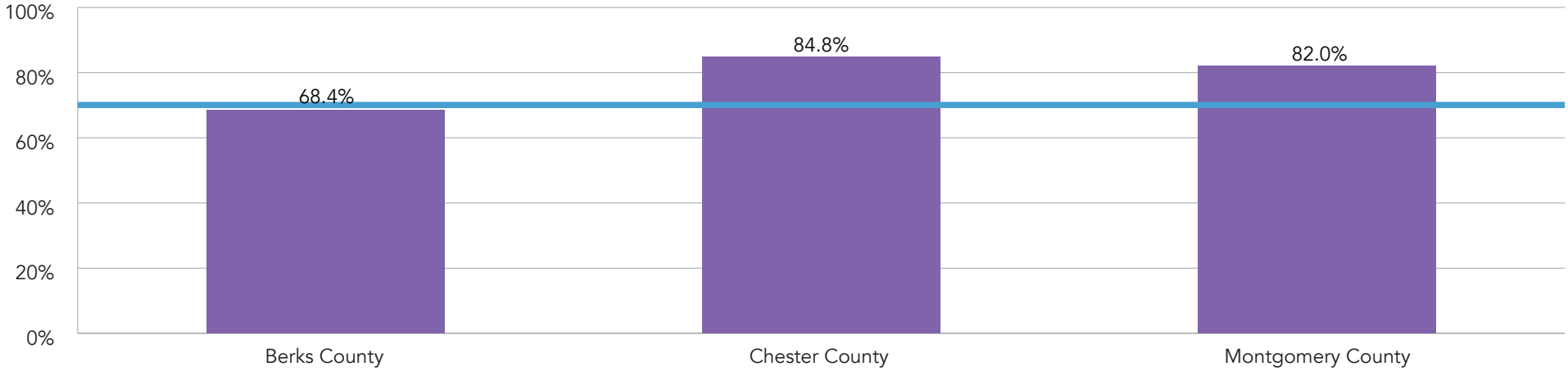
Understanding and addressing the needs of increasingly diverse and disparate populations is a major challenge for health care organizations. As a key aspect of improving health equity and decreasing health disparities, Pottstown Hospital continues efforts to enhance the provision of culturally competent 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 delivery system.

When assessing the diverse and disparate population, a multitude of SDOH and barriers to health care access and services were uncovered. Barriers such as a lack of transportation, inadequacy of language and interpretation services, lack of insurance coverage, and cultural bias and discrimination have a very dramatic impact on the capacity to provide quality health care and the quality of life for Pottstown Hospital's communities.

Interventions to improve health equity and reduce disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently.

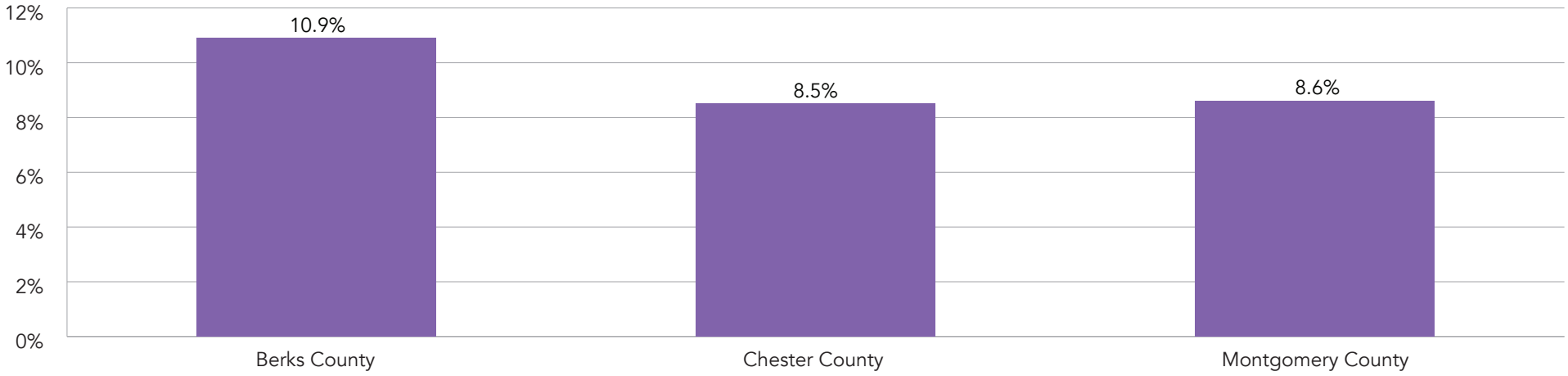
As of February 2022, 68.4% of Berks County residents are fully vaccinated against COVID-19, with 84.8% in Chester County and 82.0% in Montgomery County. In Berks County, 10.9%, 8.5% in Chester, and 8.6% in Montgomery counties are hesitant against getting the vaccine. This may be because of historical trauma, misinformation, government mistrust, and other factors. Salud America! reported that 51.9% of Latinos in Pennsylvania have received at least one dose of the COVID-19 vaccination.

Figure 55: Vaccinated Residents as of December 8, 2021



Note: The blue line indicates the overall rate in Pennsylvania of 71.8%.
Source: Salud America!

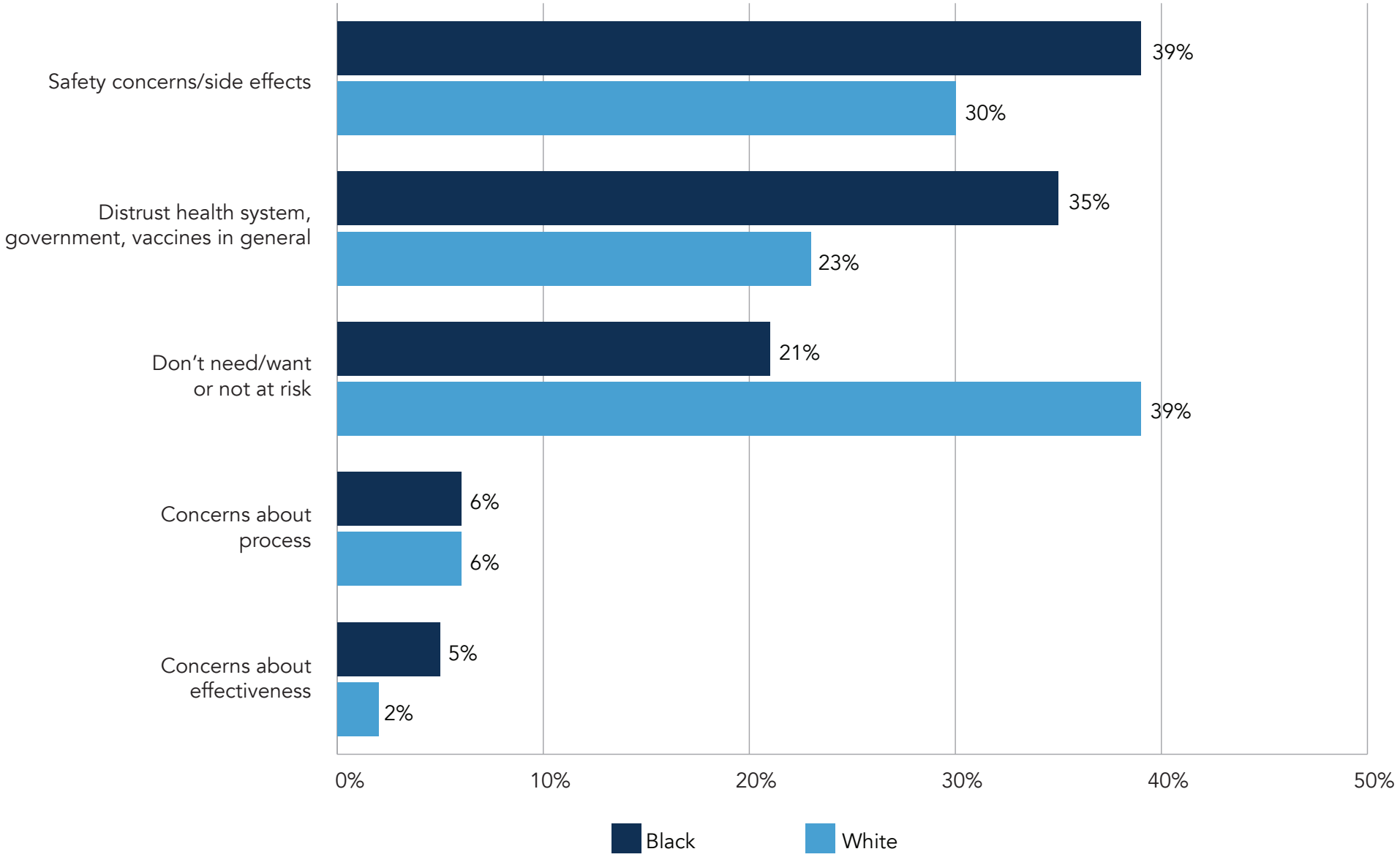
Figure 56: Unvaccinated Residents as of December 8, 2021



Source: Salud America!

Figure 57 reports national data of adults who are vaccine hesitant. Respondents cite safety concerns and distrust among the top reasons.

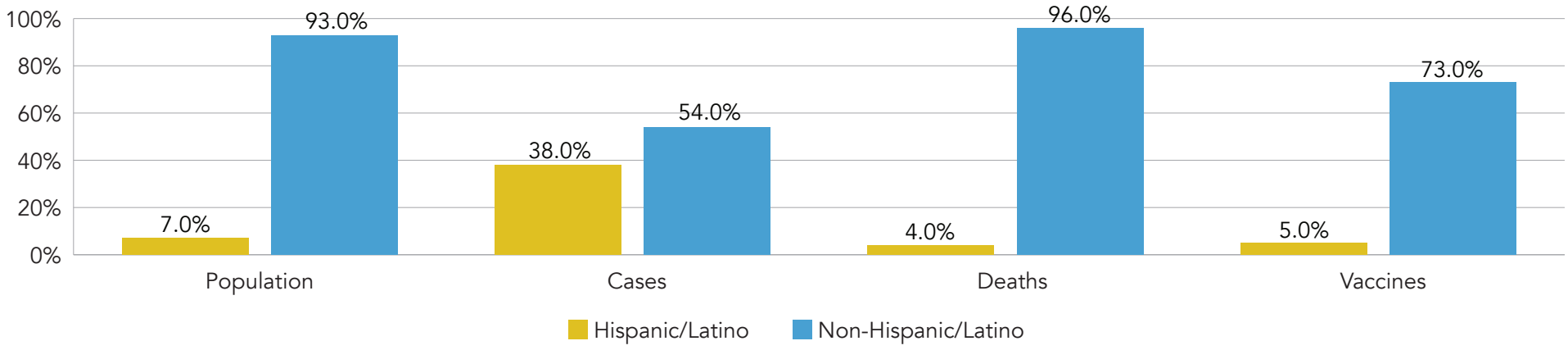
Figure 57: Those who say why they would not get a COVID-19 vaccine 2020



Source: KFF/The Undefeated Survey on Race and Health

Figure 58 reports Pennsylvania's cases, deaths, and vaccines by ethnicity.

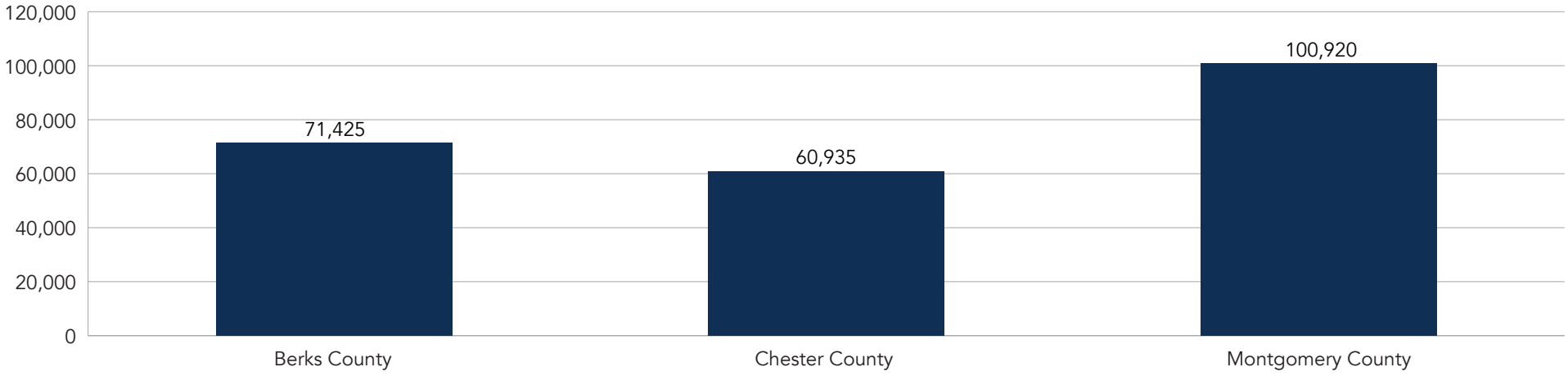
Figure 58: COVID-19 Outcome by Ethnicity



Source: Johns Hopkins University & Medicine 2021

Figure 59 reports the cumulative COVID-19 case numbers for the length of the pandemic by county.

Figure 59: COVID-19 Cases



Source: Johns Hopkins University & Medicine

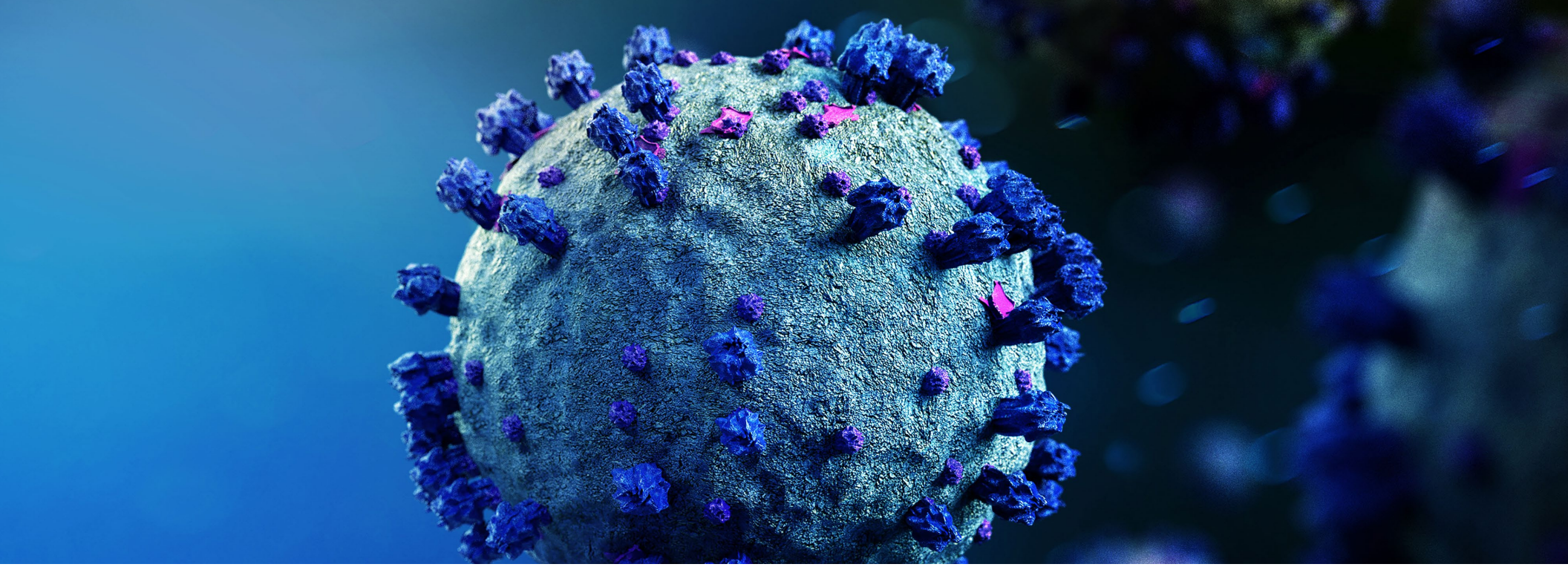
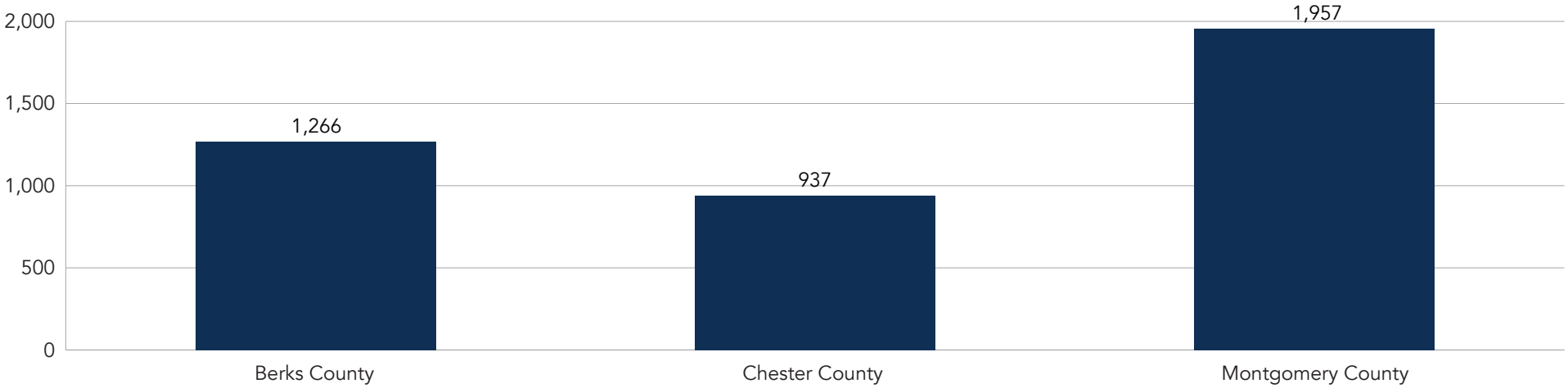


Figure 60 reports the cumulative COVID-19 death numbers for the length of the pandemic by county.

Figure 60: COVID-19 Deaths



Source: Johns Hopkins University & Medicine

Recognizing the systematic differences in the health status of different population groups, Pottstown Hospital places a key focus on health equity and improving the health of vulnerable and ethnic populations. Many of the complex issues related to health equity are often rooted at the community level; when identified and elevated, they provide opportunities for the community hospital to better understand and address social determinant issues. Pottstown Hospital works closely with its community partners and groups to identify and address social determinants of health and to drive proactive strategies that address health disparities, bridge the gaps in the provision of essential care, and improve health outcomes among targeted groups and populations.

An awareness that health equity is not a result of personal choices but more related to poverty, structural racism, and discrimination was discussed during the CHNA process.

Figure 61 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 61: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the Contributors and Barriers to People Accessing Equitable Care?"

- Unconscious bias and stigmas
- Lack of cultural competence among practitioners
- Practitioners' inability to relate to needs of binary groups
- Lack of training, awareness of religious restrictions
- Lack of transportation

KEY INFORMANT SURVEYS

"What are the Perceived Barriers to Accessing Care?"

- Lack of transportation
- No insurance
- Lack of trust
- Availability of services

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Accessing Care and Services?"

- Culture and language barriers
- Lack of trust
- Availability of services
- Lack of transportation
- Lack of insurance

COMMUNITY SURVEYS

"What are the Perceived Barriers to Accessing Care and Services?"

- Lack of access to health care providers/specialists
- Lack of affordable health care
- Lack of elder care options
- Lack of higher-paying jobs

Figure 62 from the community survey reports how respondents identified the top factors that contribute to a healthy community.

Figure 62: Top Factors that Contribute to a Healthy Community

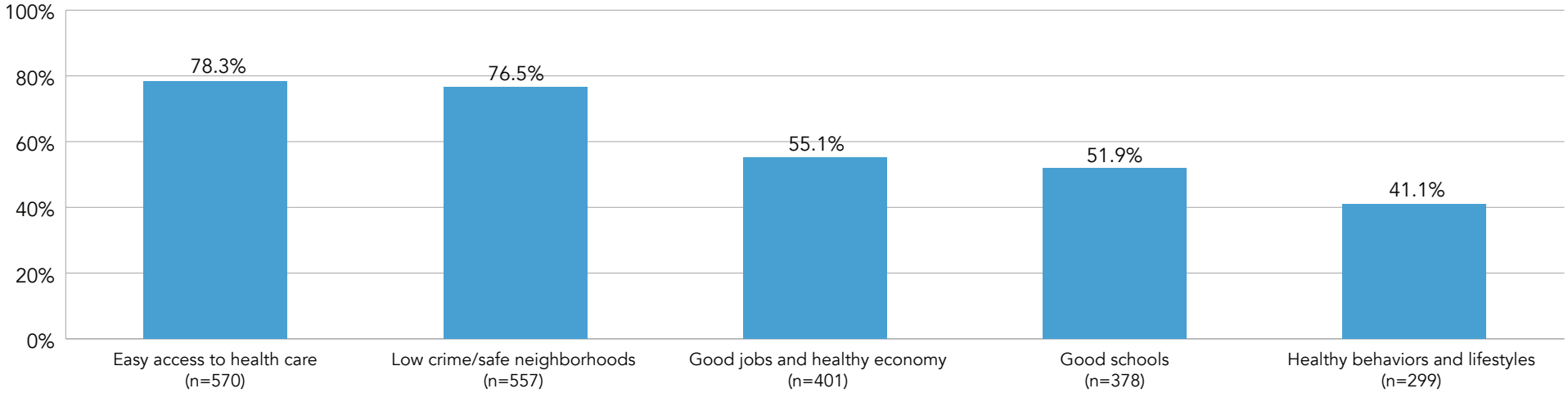


Figure 63 reports the top factors that would improve the quality of life for residents in the community.

Figure 63: Top Factors that Would Improve Quality of Life

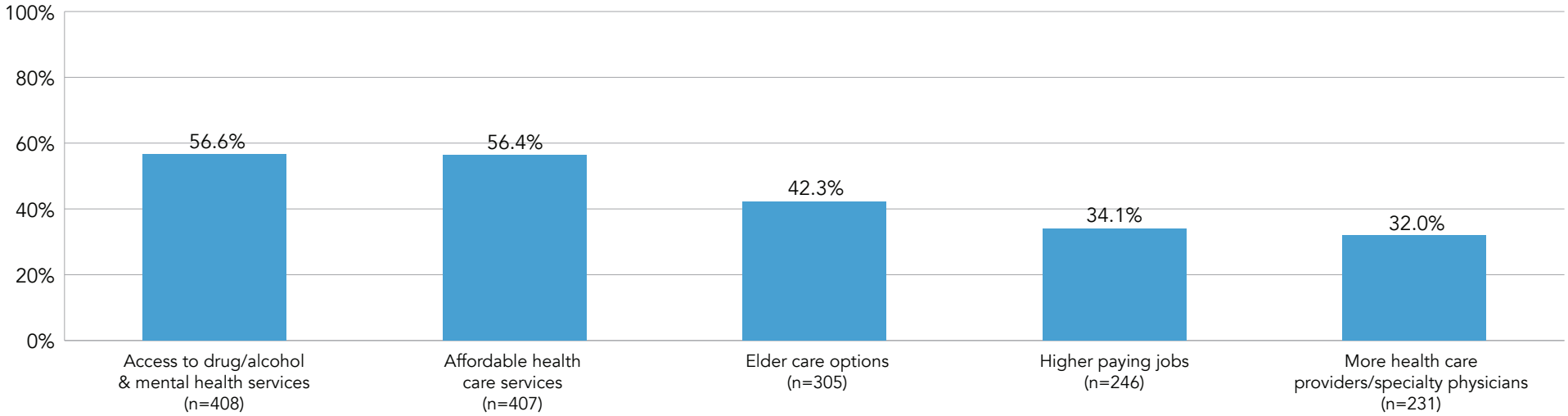


Figure 64 reports the health screenings or services that are needed to keep themselves/family healthy.

Figure 64: Health Screenings Needed to Keep Themselves/Family Healthy

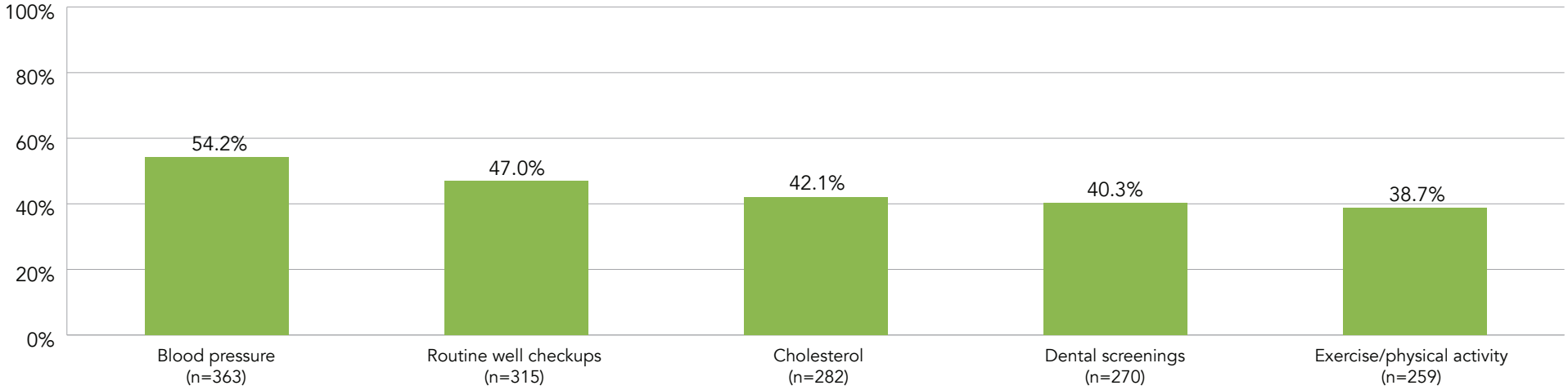


Figure 65 reports survey responses to issues that prevented access to care.

Figure 65: Issues that Prevented Access to Care

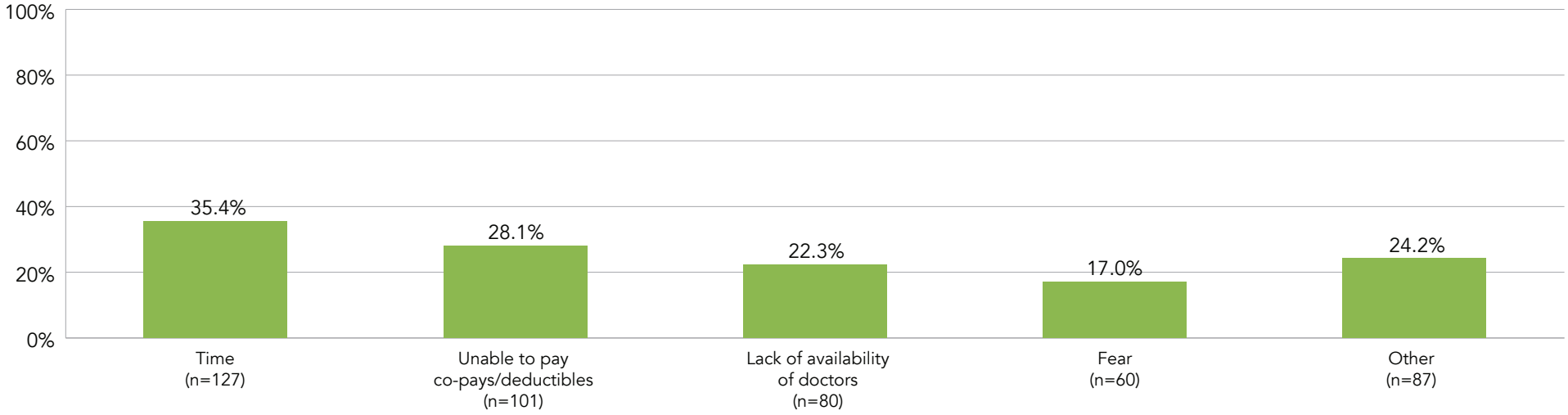
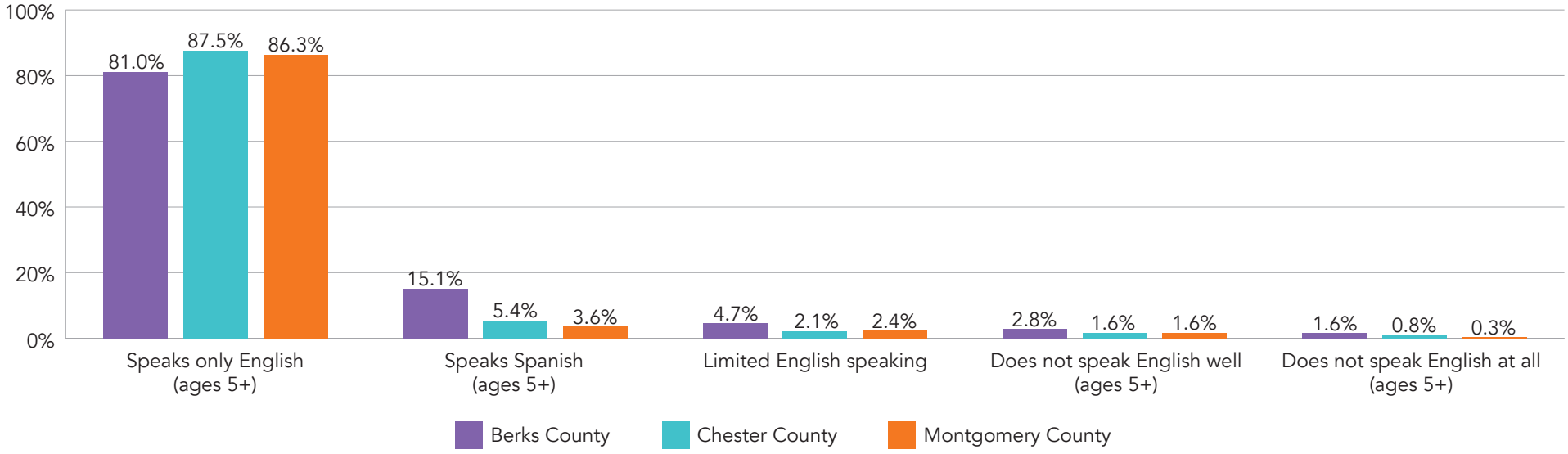


Figure 66 reveals the percentages of residents who speak only English and Spanish and residents who are limited in English speaking.

Figure 66: Households with Residents Speaking English Only, Spanish, and Limited English

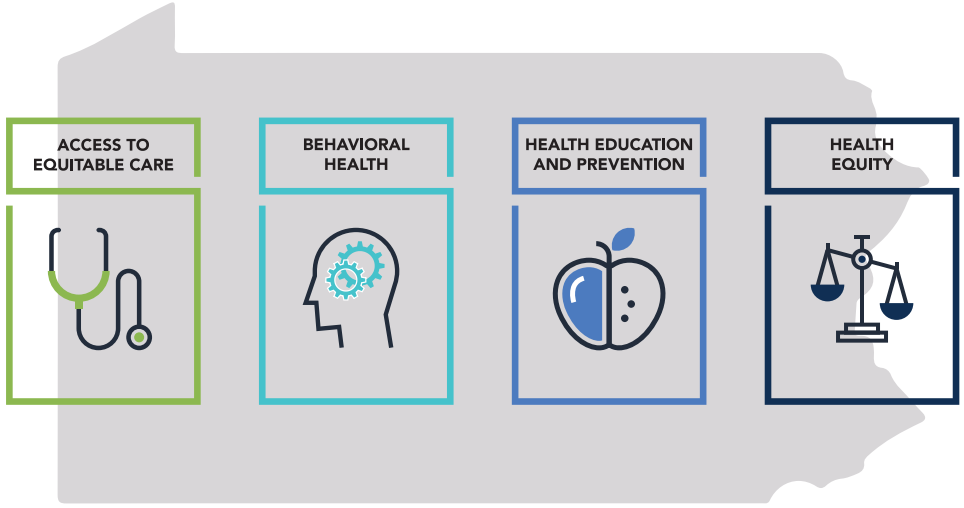


Source: U.S. Census Bureau, American Community Survey 2018

CHNA FOCUS AREA FOR
POTTSTOWN HOSPITAL 2022

Improving health equity is a daunting task as it extends well beyond the walls of the hospital, reaches deep into the community sectors, and travels toward local and state governments where health policies and protocols are developed. The American Medical Association (AMA) Center for Health Equity imagines health equity as "providing health care that values people equally and treats them equitably and a nation in which all people live in thriving communities where resources work well; systems are equitable and create no harm nor exacerbate existing harms; where everyone has the power, conditions, resources, and opportunities to achieve optimal health."

Recognition is increasing across the health care environment that improving health and achieving health equity demands a multi-sectoral approach and requires the health system to engage and mobilize the broad community to address social, economic, and environmental factors that influence health. For example, the lack of access and availability of public transportation impacts not only access to health care but affects employment, reduces access to affordable healthy food, and impacts important drivers of health and wellness.



Improving health equity engages all community sectors and partners to work together to promote health equity and sustainability of the community through job creation and economic development, transportation access and mobility, access to foods and nutrition, physically active and safe neighborhoods, and improved educational status. Most importantly, to improve access to equitable health care, health equity must be the focus, at all levels, and embedded into our practices, processes, actions, and outcomes.

CONCLUSION

WHAT'S NEXT … IT'S COMPLICATED

One of the most challenging aspects of providing quality health care is the difficulty that populations and individuals experience in navigating the health care system. Access to equitable health care becomes more complicated and complex based on geographic factors – where people were born, live, work, and play – and economic, cultural, educational, and social factors. The health system may provide a plethora of recognized physicians, best practice services, and special programs, but access is complicated if residents lack transportation and insurance. There is a direct correlation between the ease of accessing health care and the overall health of a community.

Access is complicated for vulnerable populations such as the elderly, unemployed/underemployed, and low-income. Those factors serve as barriers to care and limit their ability to seek care early, often resulting in a health crisis, emergency visit, or hospitalization for illness and conditions that could be prevented. Access is complicated for ethnic patients with language barriers, limited English-speaking skills, and low levels of education. Culturally competent and appropriate care and treatment are essential to improving health and ensuring good outcomes. Just because we built it does not mean they will come.

Improving health equity is a daunting task as it extends well beyond the walls of the health system, reaches deep into the community sectors, and travels toward local and state government where health policies and protocols are developed. There has been increased recognition across the health care environment that improving health and achieving health equity demands a multi-sectoral approach. This approach requires the health system to engage and mobilize the broad community to address social, economic, and environmental factors that influence health. For example, the lack of access and availability of public transportation impacts not only access to health care but affects employment, access to affordable healthy food, and many other important drivers of health and wellness.

As the next step, Pottstown Hospital will advance efforts to align and integrate the many voices and ideas offered from the community as received through the focus groups, a community survey, community stakeholder interviews, and provider interview processes. Pottstown Hospital will engage and collaborate with our community partners on the development of the CHNA Implementation Strategy Plan.

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Pottstown Hospital

TOWER HEALTH

Advancing Health. Transforming Lives.