Tower Health Pottstown Hospital

APPENDICES

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Appendix A - Community Stakeholder Interviews

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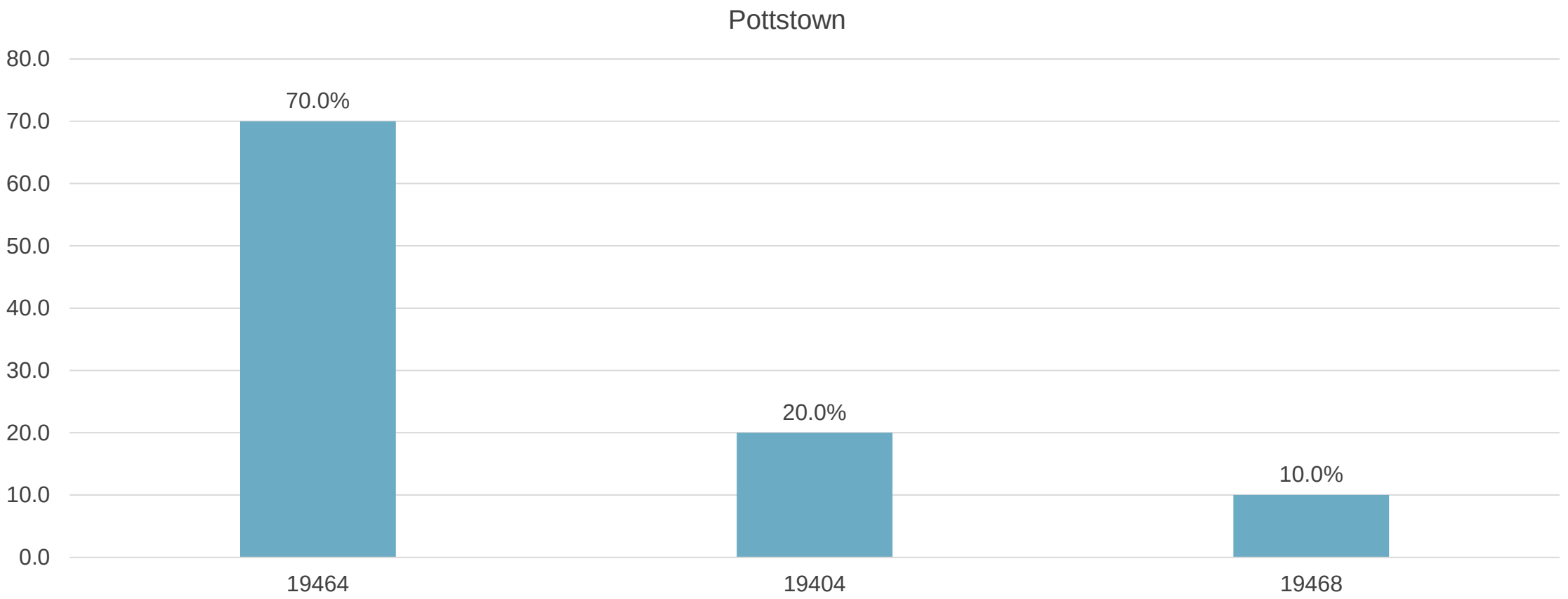
Introduction

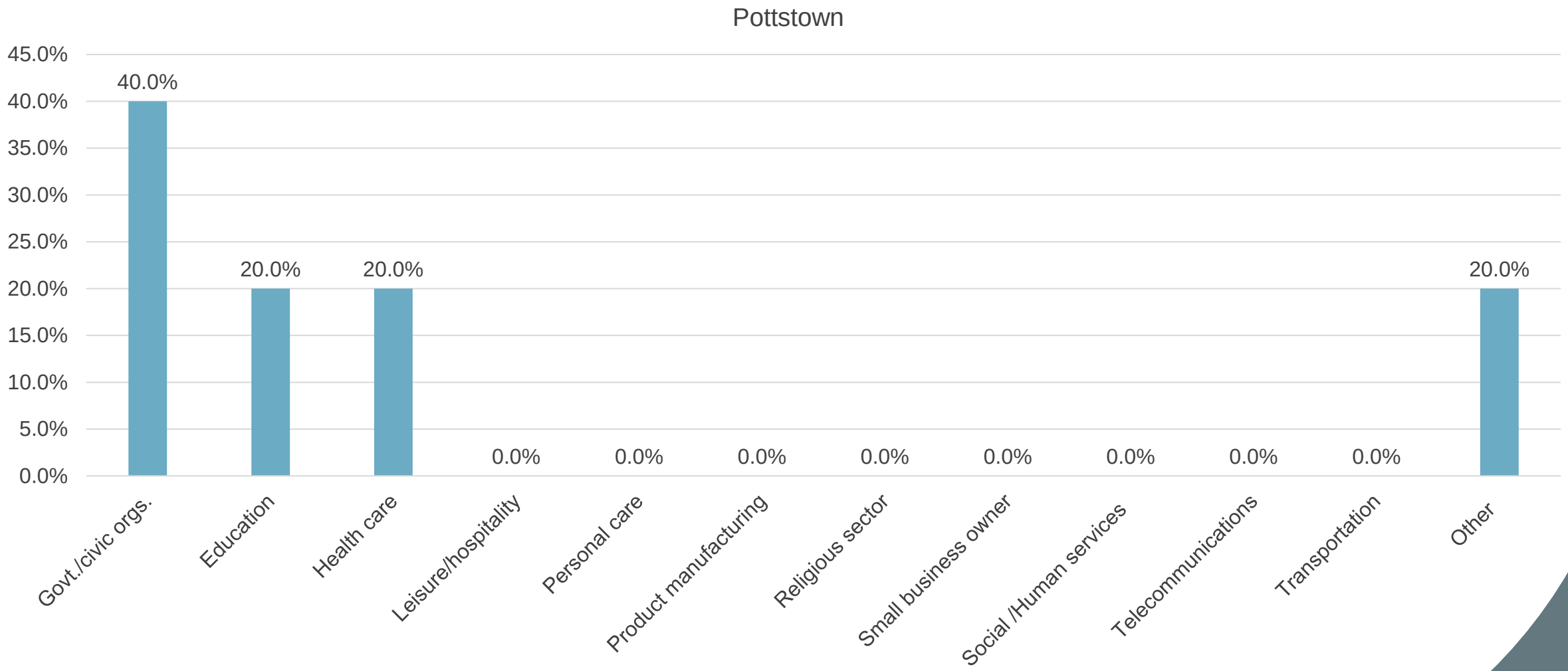
- Tripp Umbach worked closely with representatives from Tower Health to identify community stakeholders. An email was delivered to community stakeholders to introduce Tripp Umbach and define the stakeholders' role in the CHNA process. The email introduced the project and conveyed the importance of the CHNA for the community. Each interview was conducted by a Tripp Umbach consultant and lasted approximately 30 to 45 minutes in duration. Each community stakeholder was asked the same set of questions, as developed by Tripp Umbach and approved by Tower Health representatives. The interviews provided a platform for stakeholders to identify health issues and concerns affecting residents in the service area, as well as ways to address those concerns. A diverse representation of community-based organizations and agencies were among the stakeholders interviewed.
- 10 community stakeholder interviews were conducted beginning in March 2021 within the hospital region. Industry leaders interviewed represented the below businesses:
    1. Community Health and Dental Care
    2. Creative Health Services
    3. Montgomery County Board of Commissioners
    4. Montgomery County Community College
    5. PA House of Representatives
    6. Pottsgrove School District
    7. Pottstown Area Health and Wellness Foundation
    8. Pottstown Borough
    9. TriCounty Chamber of Commerce
    10. TriCounty Community Network

ZIP Code Where Work

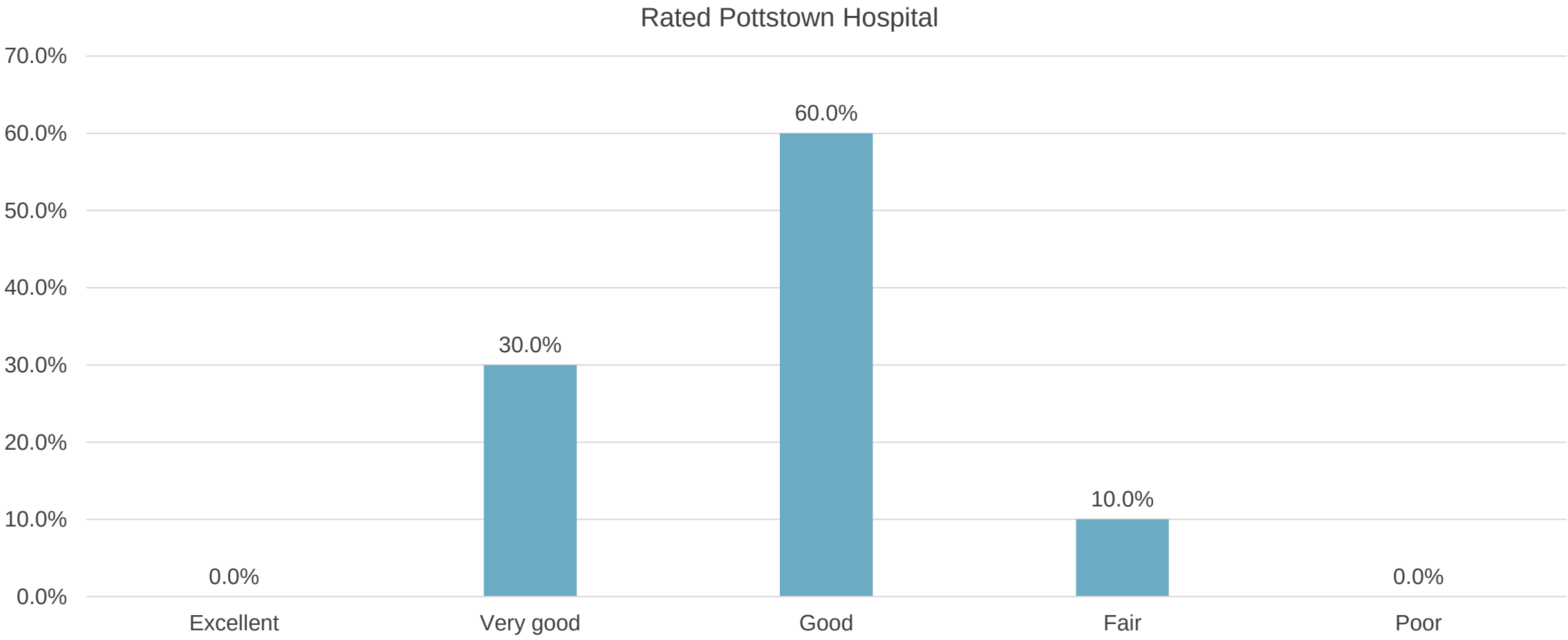


- 100% of community stakeholders worked in Montgomery County. (Not shown on graph.)

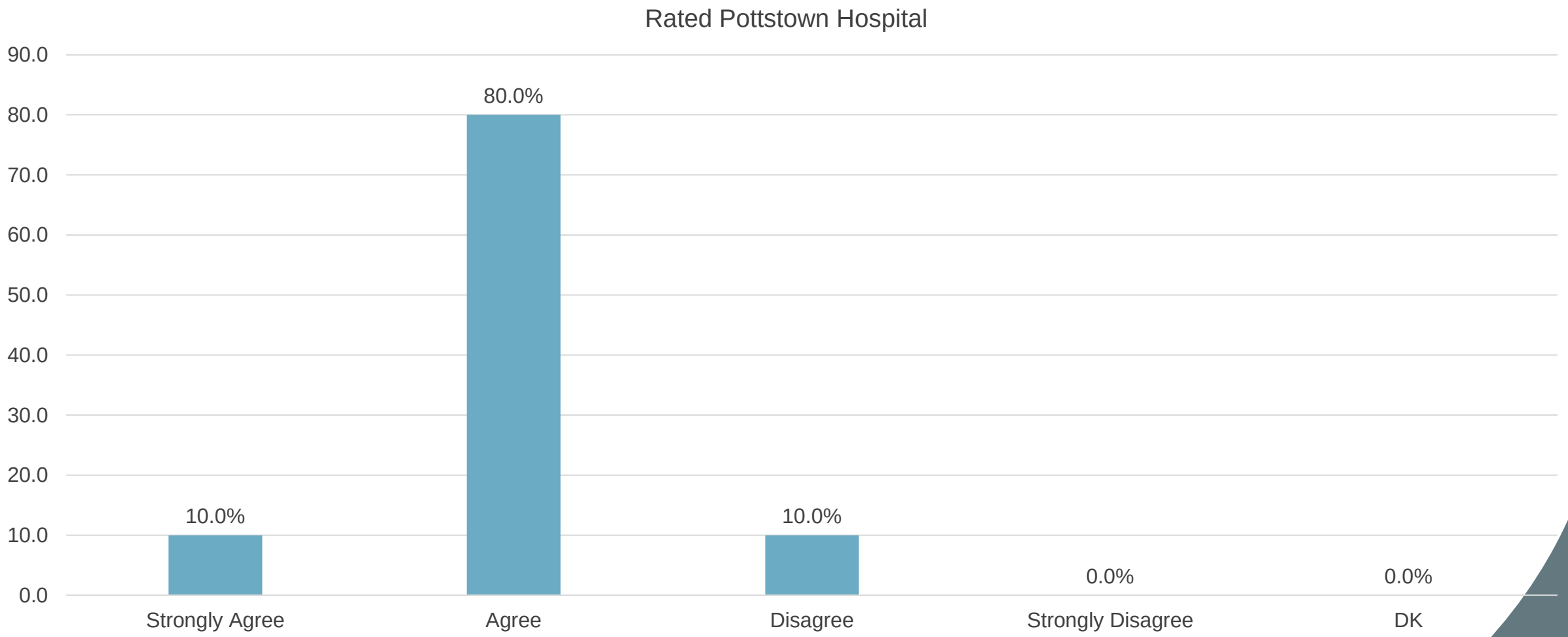
Represented Industry



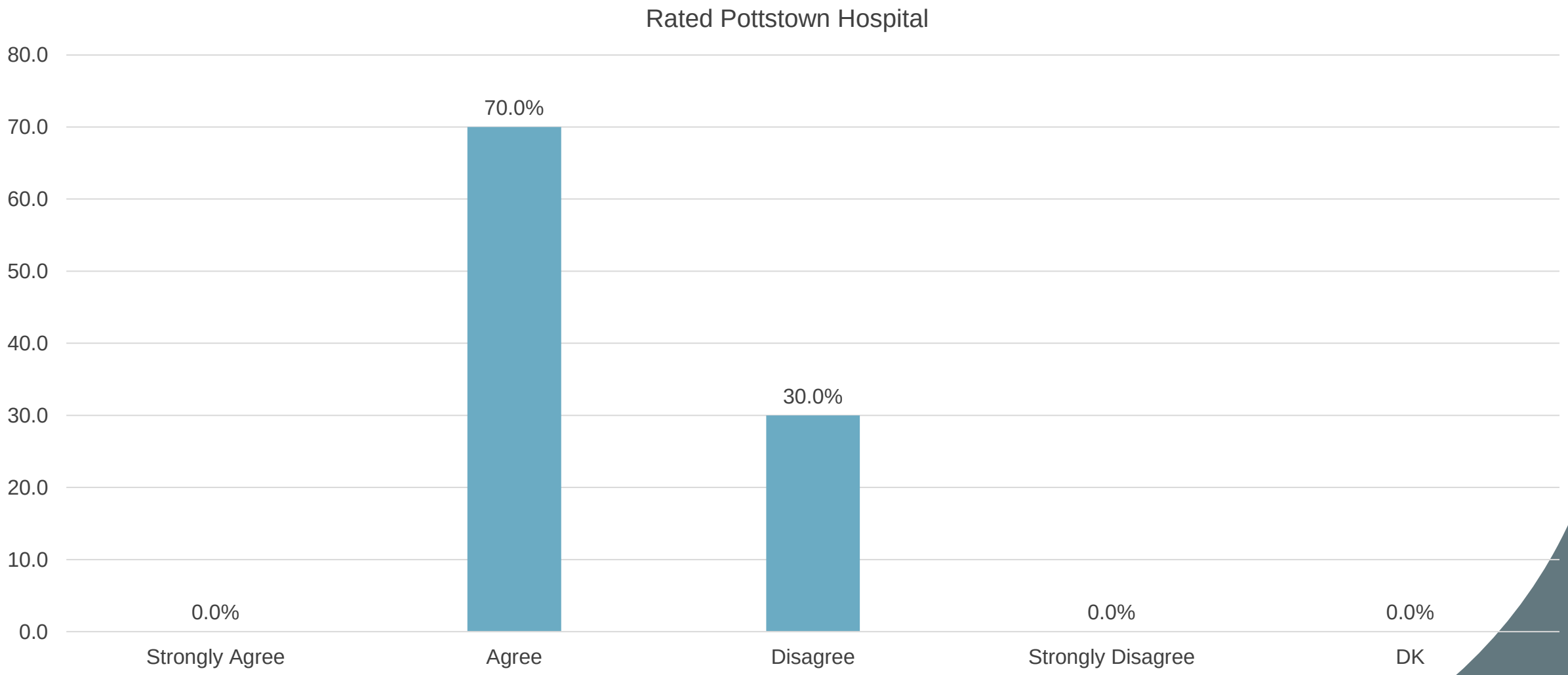
Rate Health and Human Services in Community



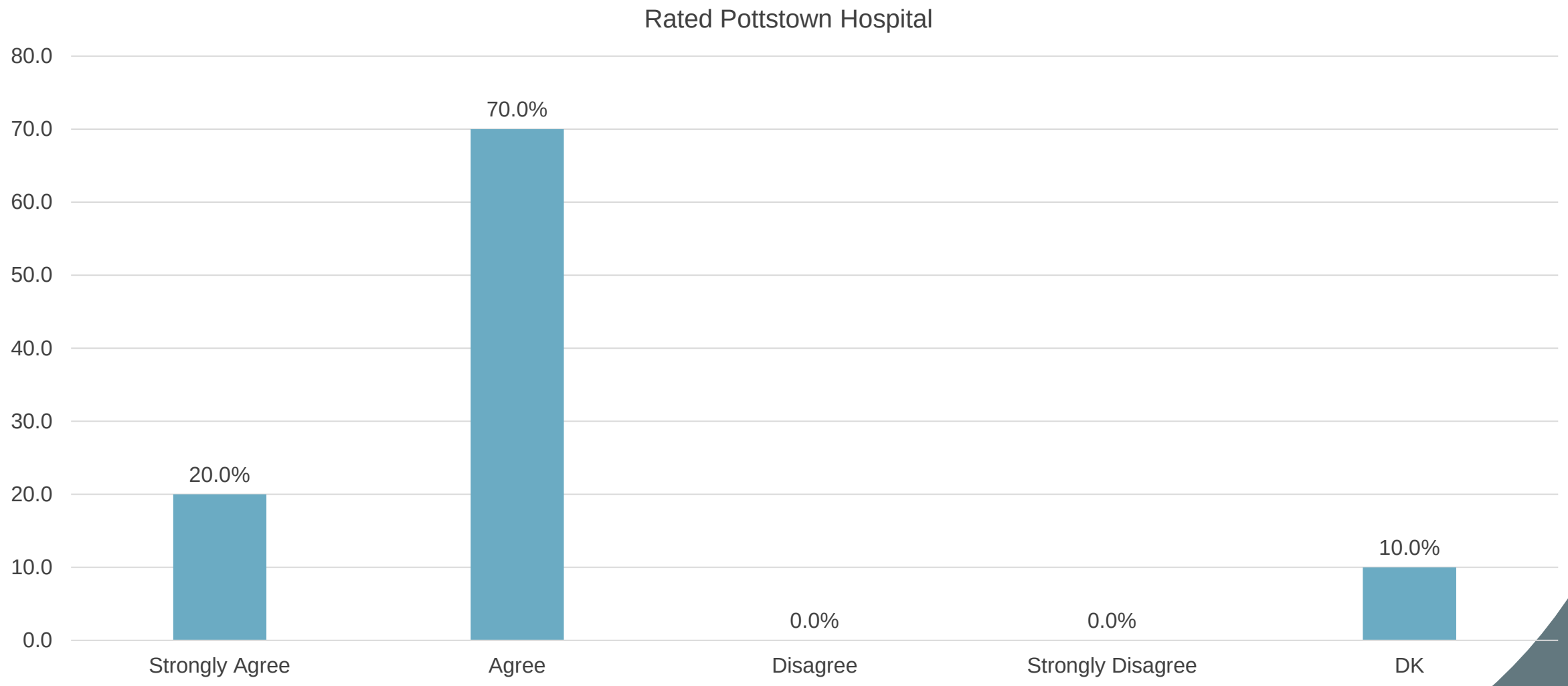
Rate How Hospital Offers High-Quality Health Care for the Community



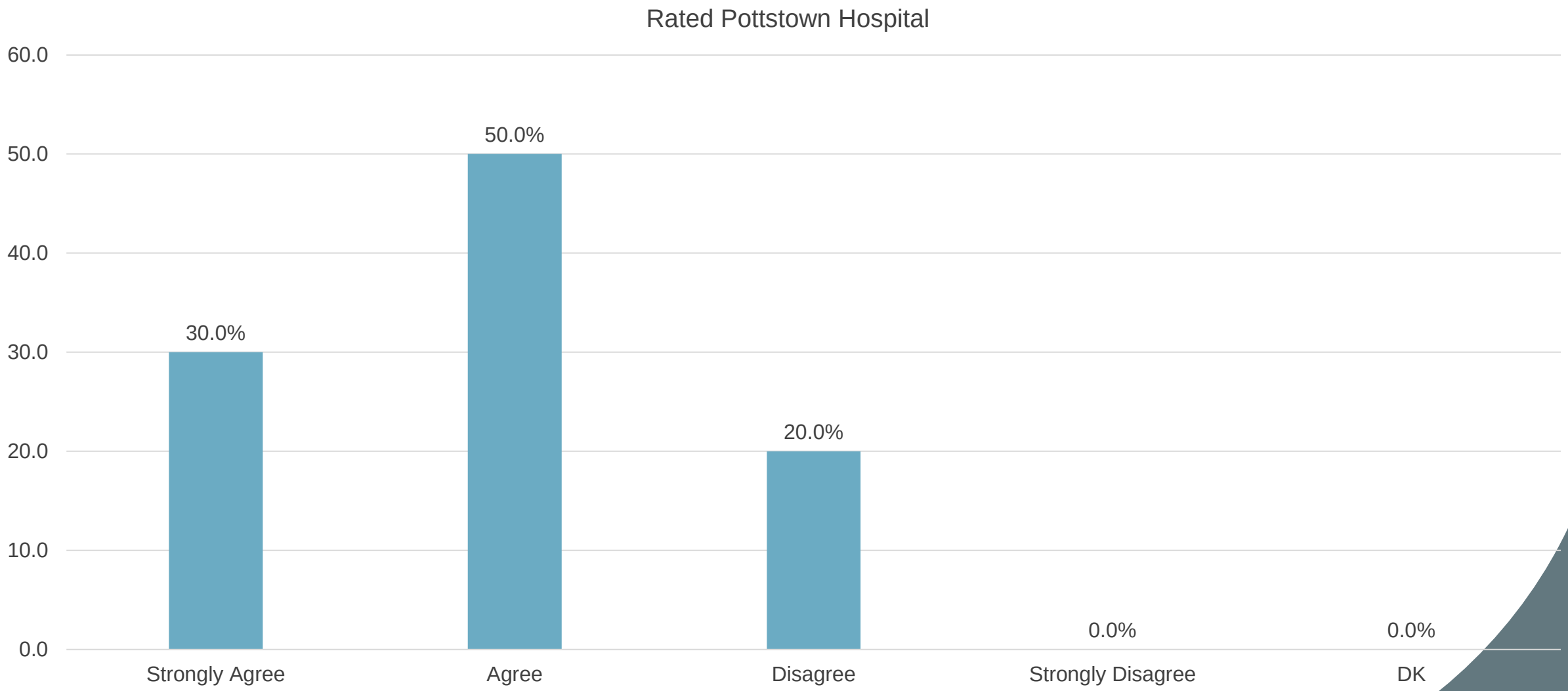
Rate How Hospital Addresses needs of Diverse and Disparate Populations



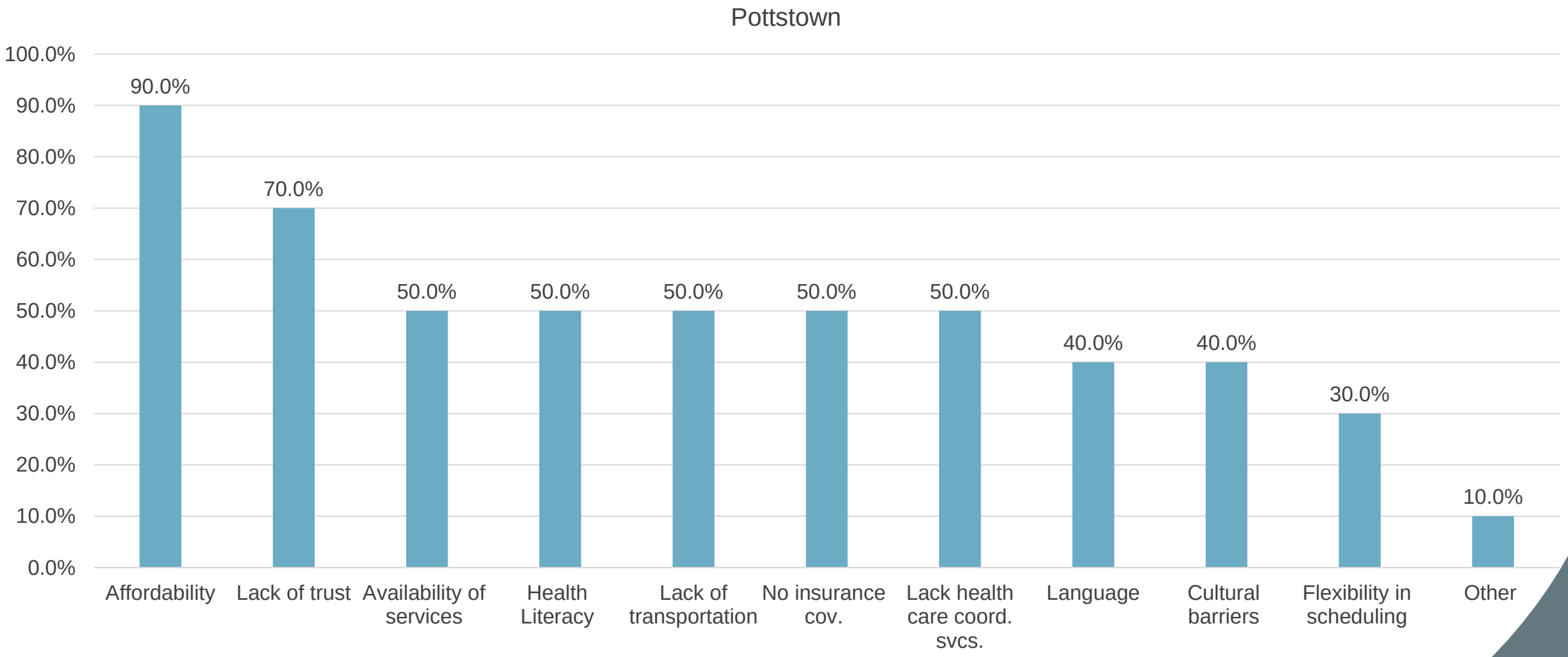
Rate How Hospital Ensures Access to Care Regardless of Race, Gender, Education, and Economic Status



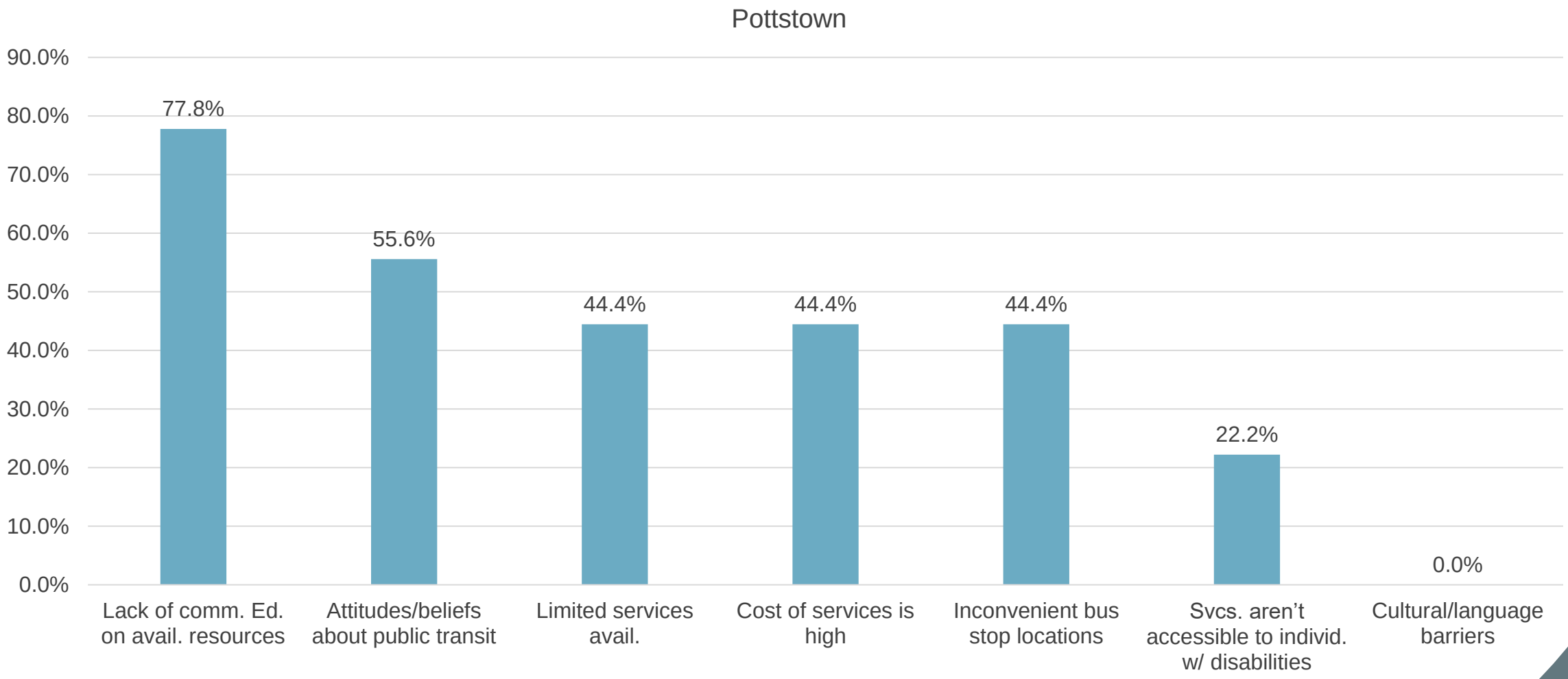
Rate How Hospital Works to Identify and Address Health Inequalities



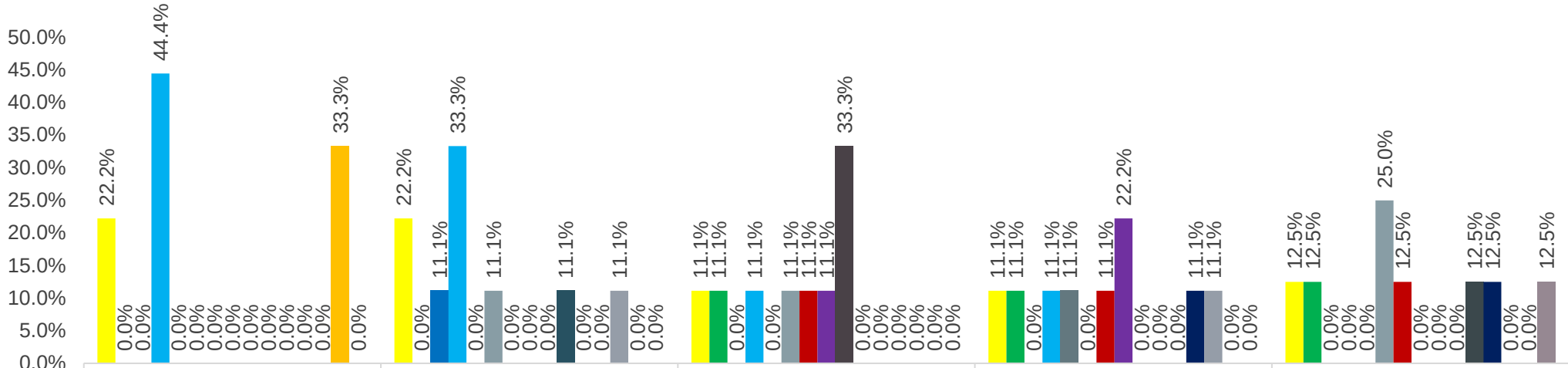
Perceived Barrier(s) for People Not Receiving Care or Services — Check all that apply



Following contributions to the transportation issues in the community — (Top three)

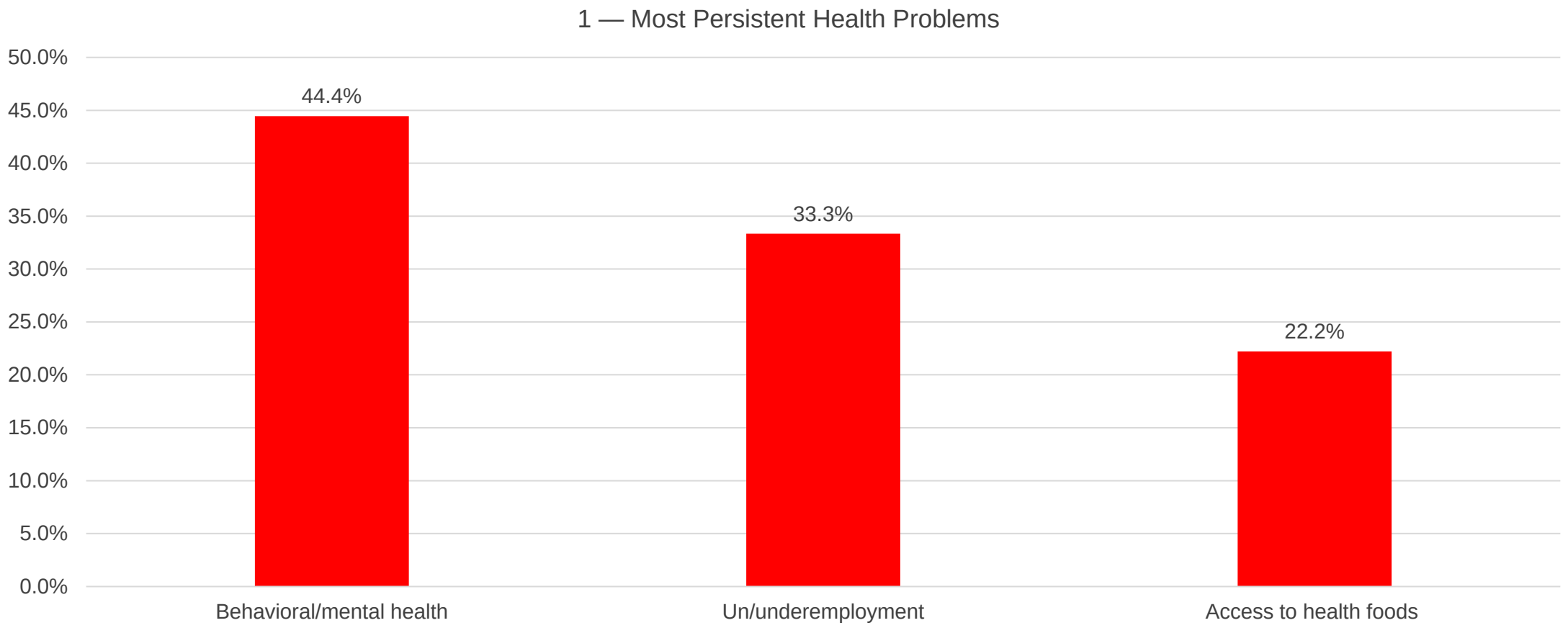


Top 5 persistent “Health Problems” in the community?



	Most Important = 1	2	3	4	5
Access to health foods	22.2%	22.2%	11.1%	11.1%	12.5%
Adolescent health	0.0%	0.0%	11.1%	11.1%	12.5%
Aging problems	0.0%	11.1%	0.0%	0.0%	0.0%
Behavioral/mental health	44.4%	33.3%	11.1%	11.1%	0.0%
Cancers	0.0%	0.0%	0.0%	11.1%	0.0%
Care for moms/babies	0.0%	11.1%	11.1%	0.0%	25.0%
Child abuse/neglect	0.0%	0.0%	11.1%	11.1%	12.5%
Domestic violence	0.0%	0.0%	11.1%	22.2%	0.0%
Drug/alcohol use	0.0%	0.0%	33.3%	0.0%	0.0%
Heart disease	0.0%	11.1%	0.0%	0.0%	0.0%
Homelessness	0.0%	0.0%	0.0%	0.0%	12.5%
Injuries or violence	0.0%	0.0%	0.0%	11.1%	12.5%
Lack of exercise	0.0%	11.1%	0.0%	11.1%	0.0%
Un/underemployment	33.3%	0.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	12.5%

Top 5 persistent “Health Problems” in the community?



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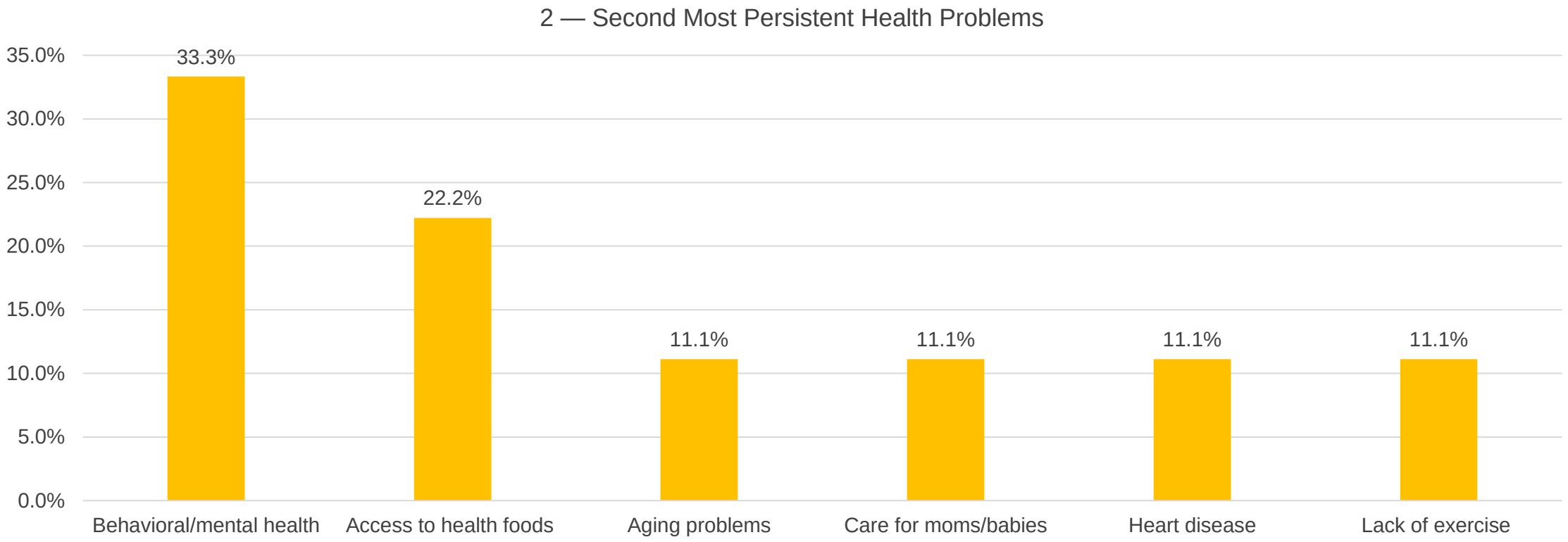

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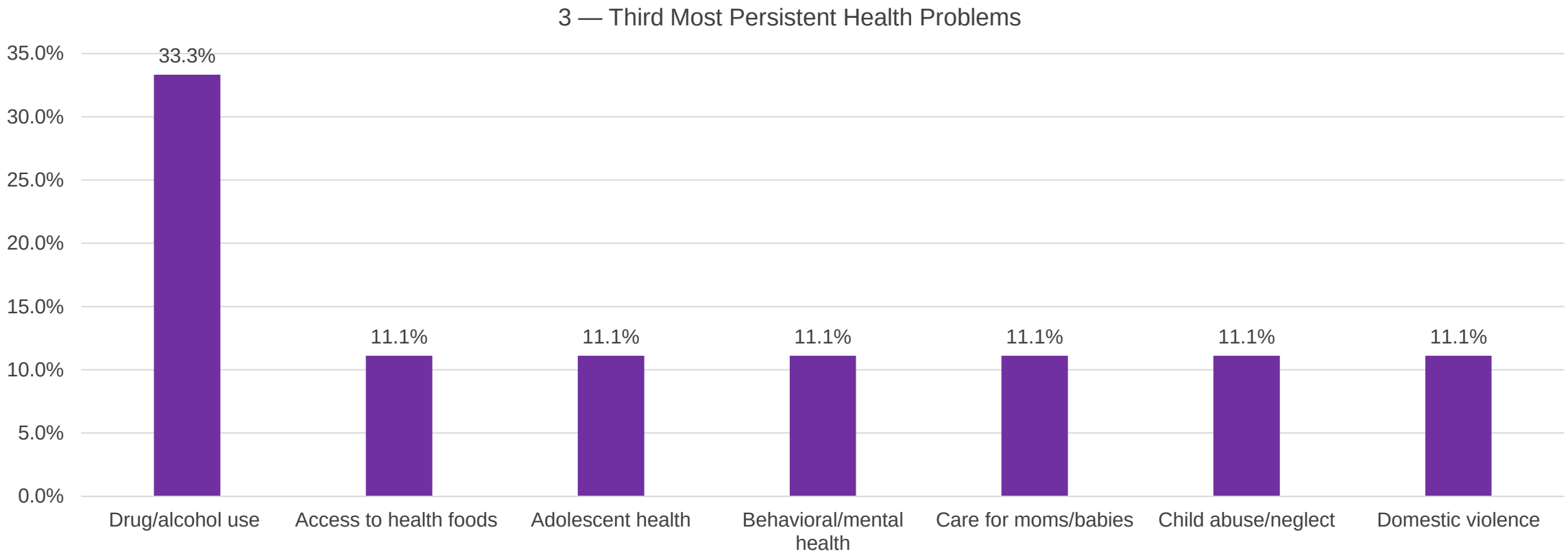
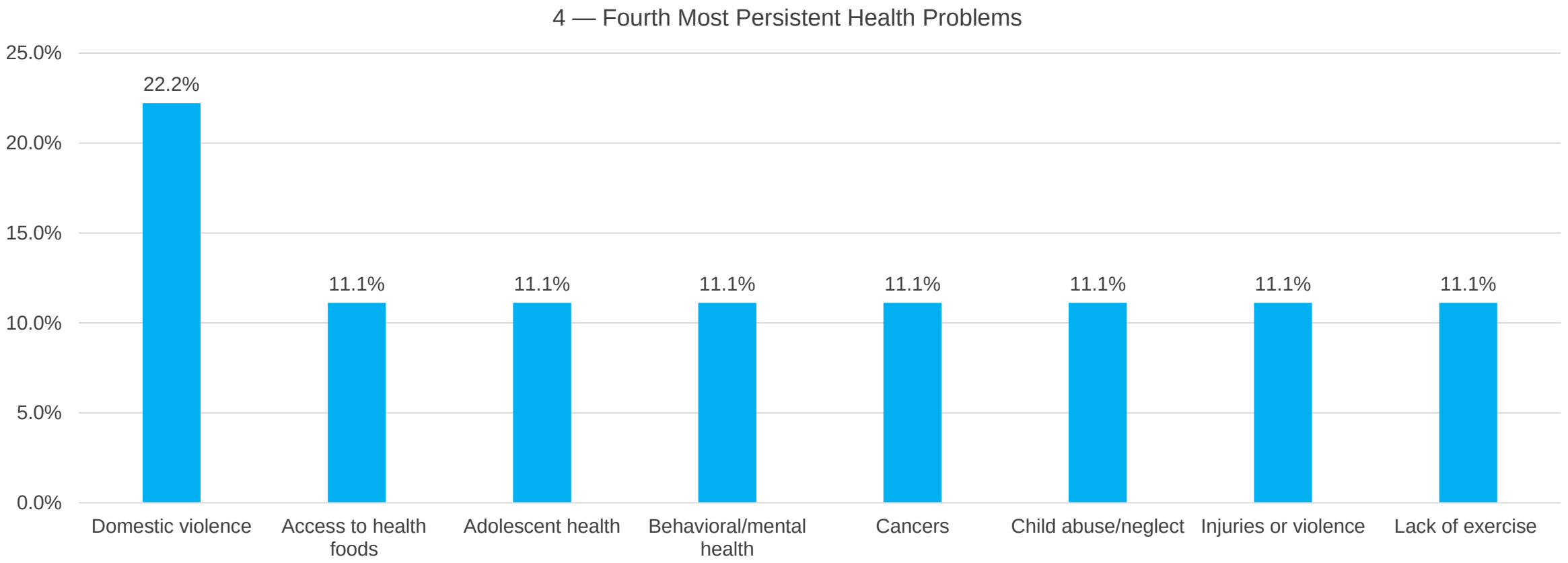
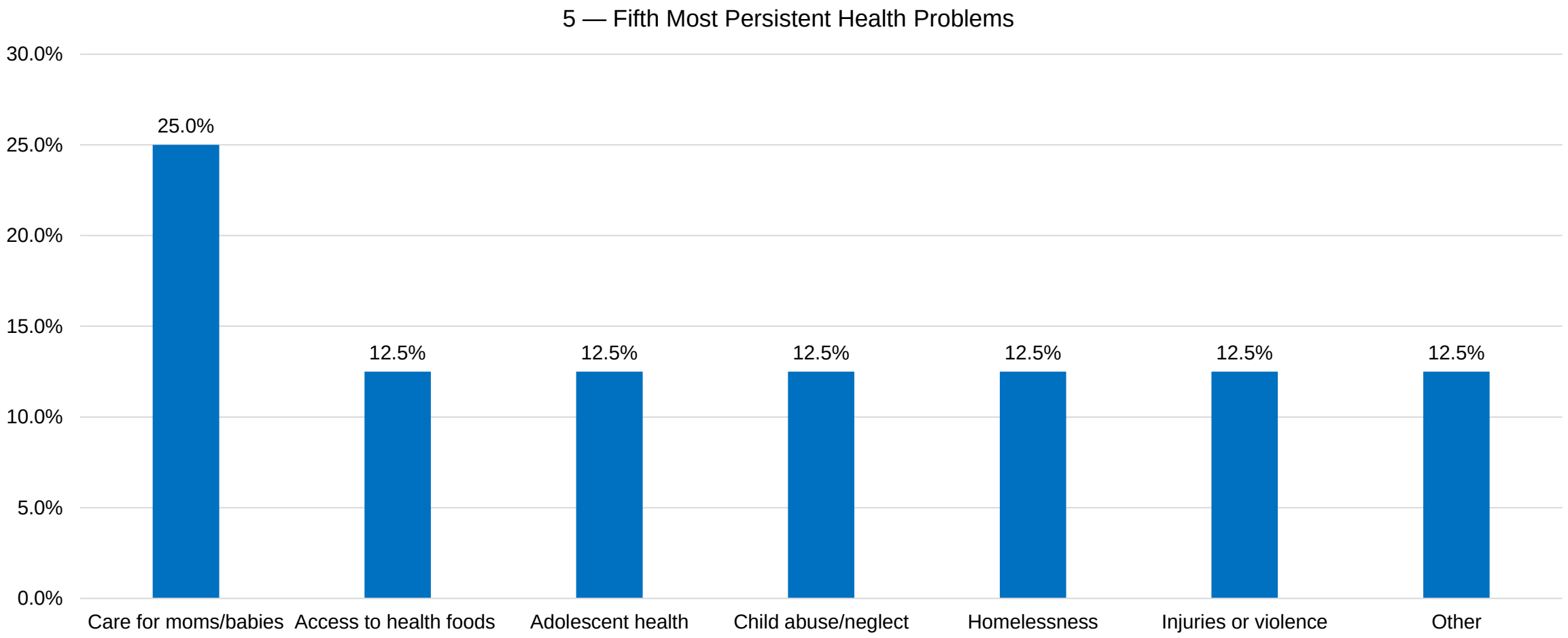


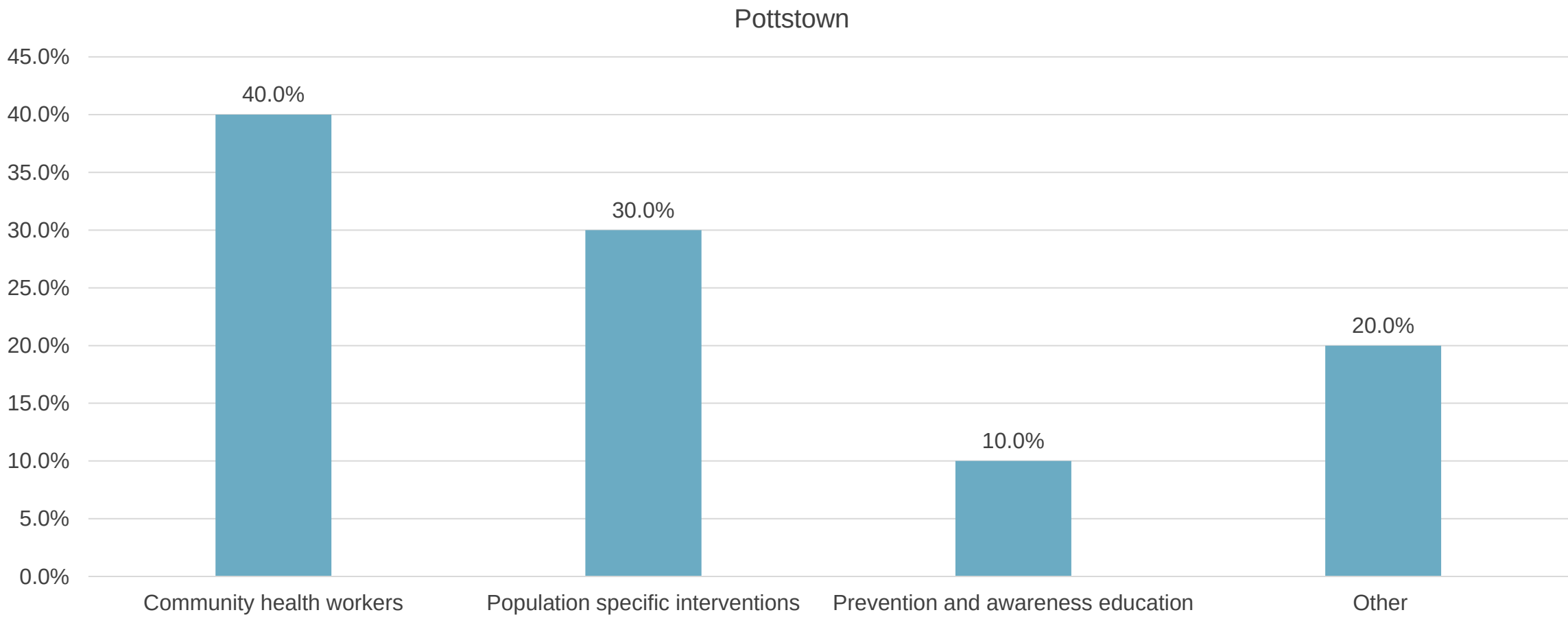
Top 5 persistent “Health Problems” in the community?



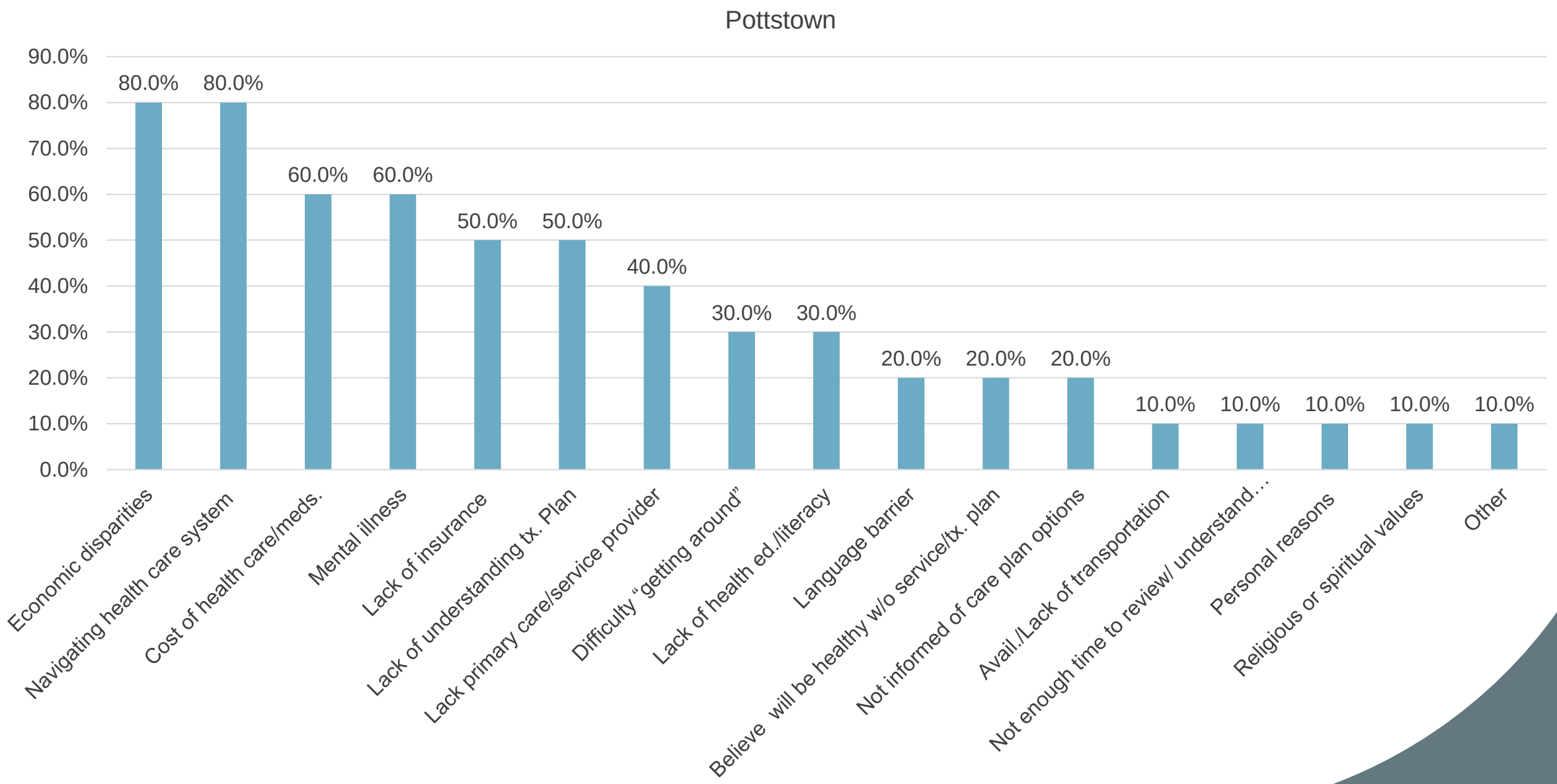
Top 5 persistent “Health Problems” in the community?



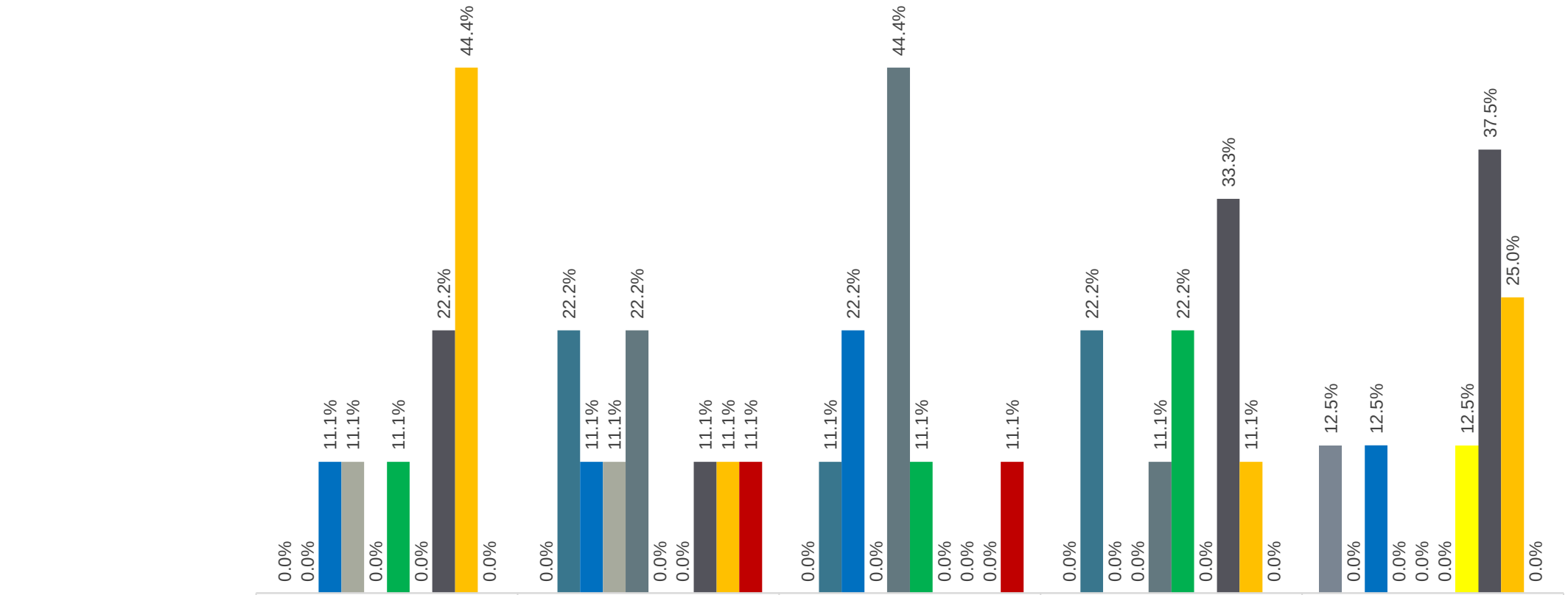
Type II diabetes, pre-diabetes and obesity affects many members of our community. What can we offer the community to achieve and maintain optimal health?



Most significant barriers to improving health and quality of life – Check all that apply

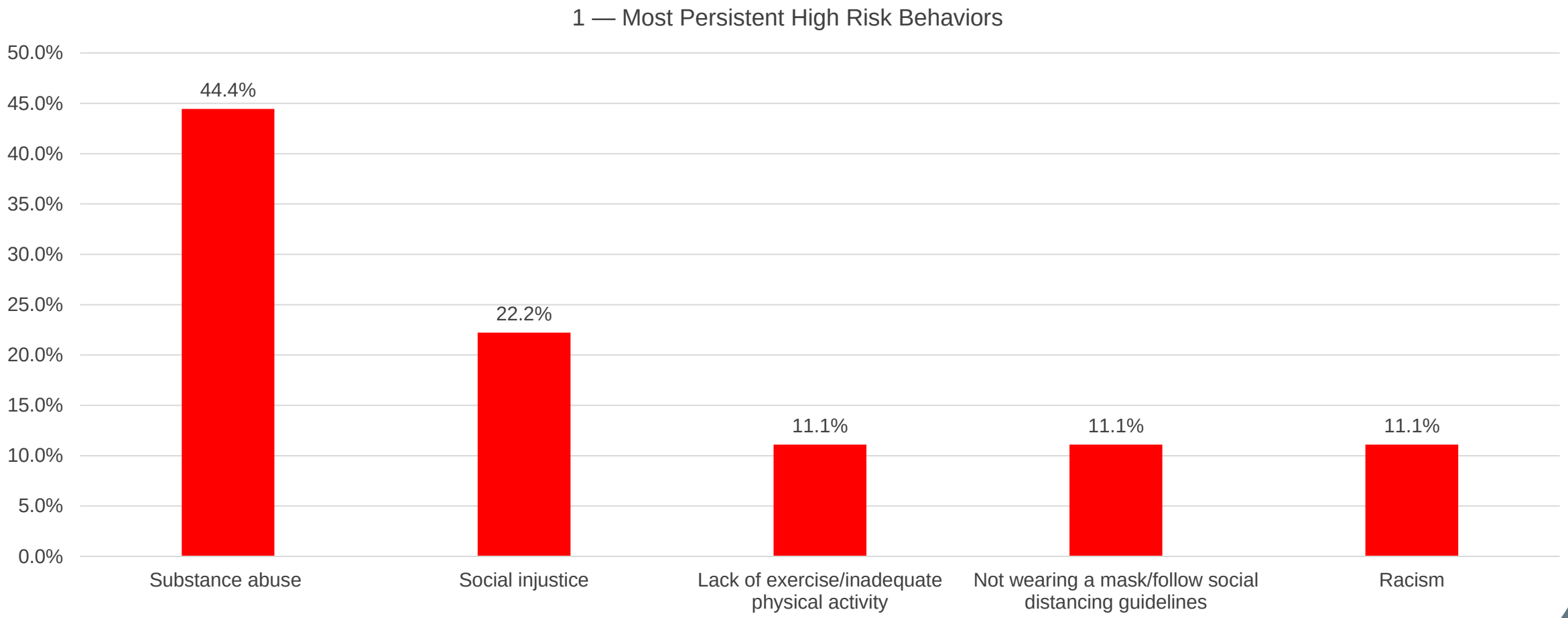


Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



	1 = Most Important	2	3	4	5
Fighting	0.0%	0.0%	0.0%	0.0%	12.5%
Lack of education	0.0%	22.2%	11.1%	22.2%	0.0%
Lack of exercise/inadequate physical activity	11.1%	11.1%	22.2%	0.0%	12.5%
Not wearing a mask/follow social distancing guidelines	11.1%	11.1%	0.0%	0.0%	0.0%
Poor eating habits/Unhealthy eating habits	0.0%	22.2%	44.4%	11.1%	0.0%
Racism	11.1%	0.0%	11.1%	22.2%	0.0%
Sexting and other risky uses of social media	0.0%	0.0%	0.0%	0.0%	12.5%
Social injustice	22.2%	11.1%	0.0%	33.3%	37.5%
Substance abuse	44.4%	11.1%	0.0%	11.1%	25.0%
Tobacco use	0.0%	11.1%	11.1%	0.0%	0.0%

Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



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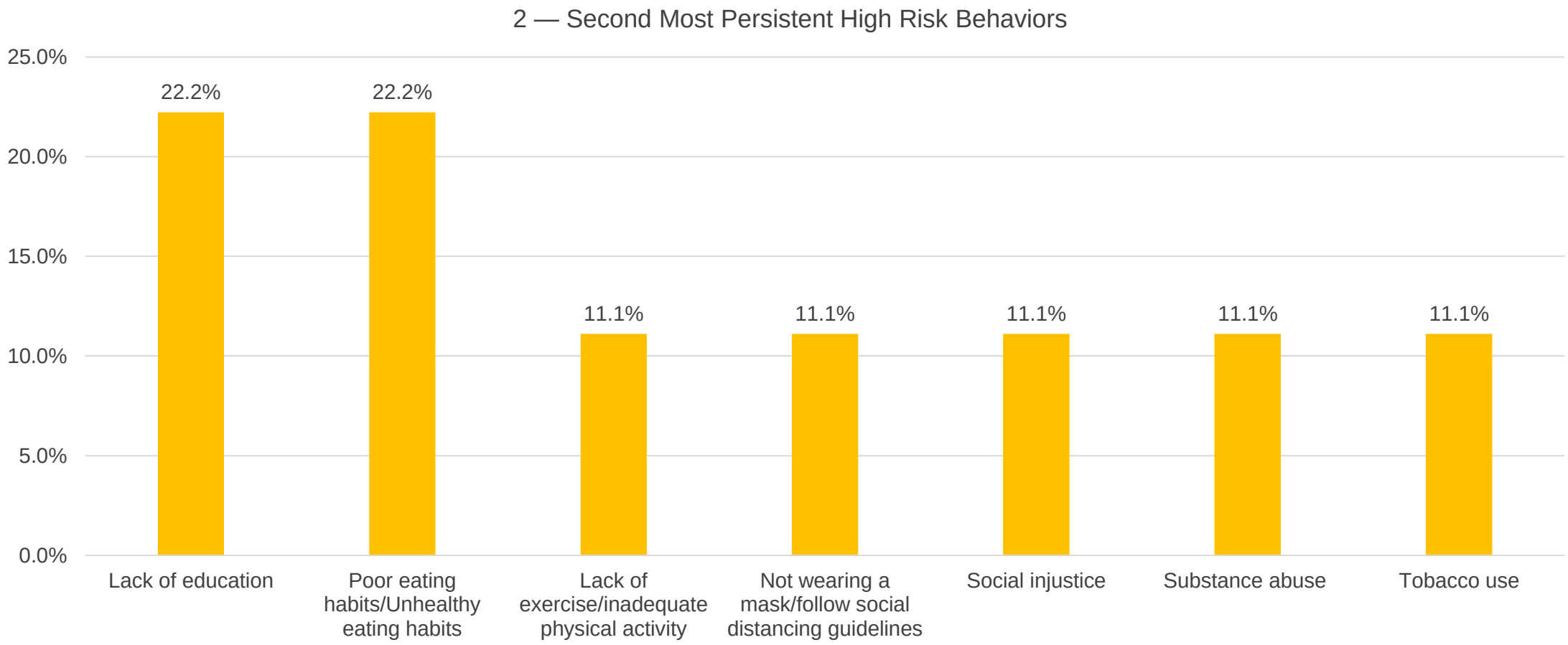

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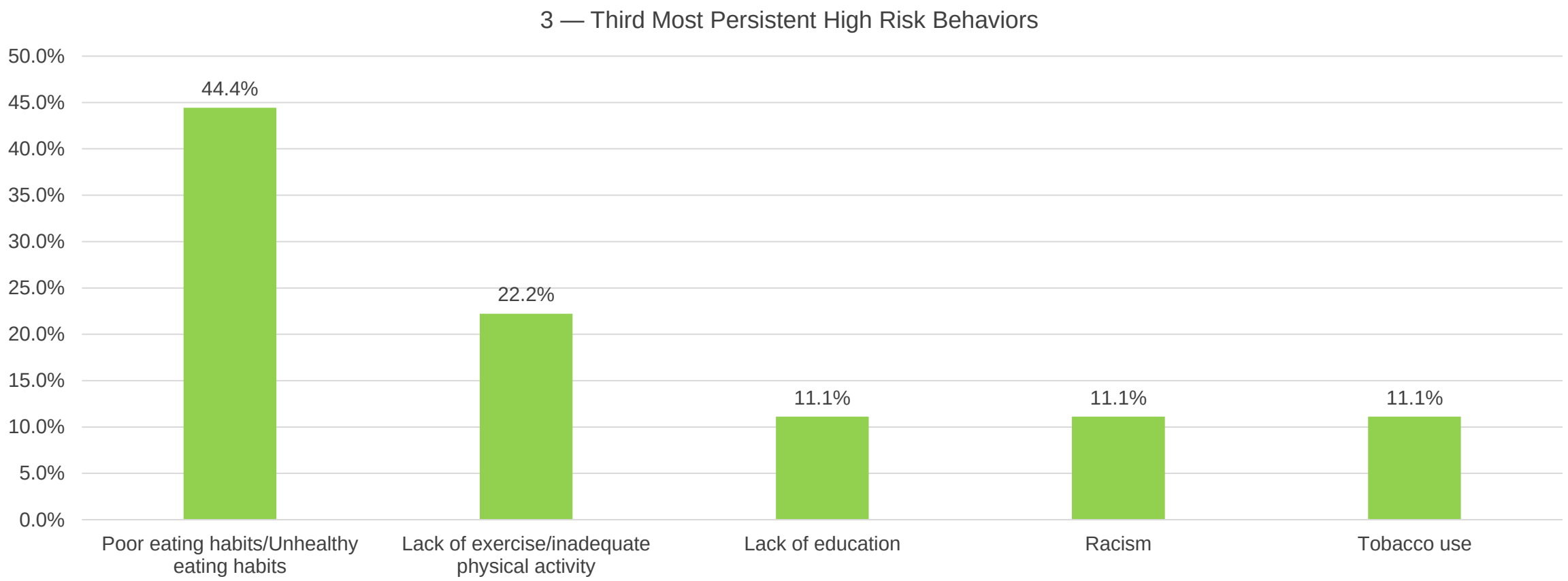

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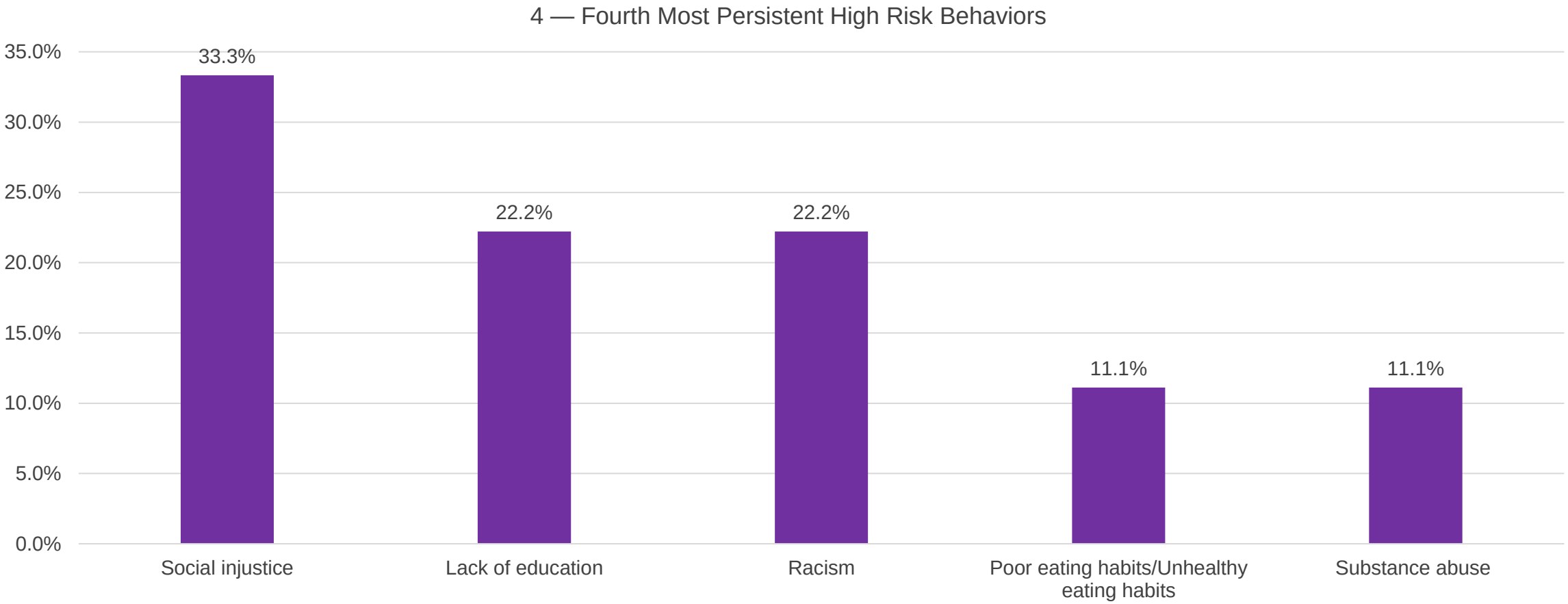

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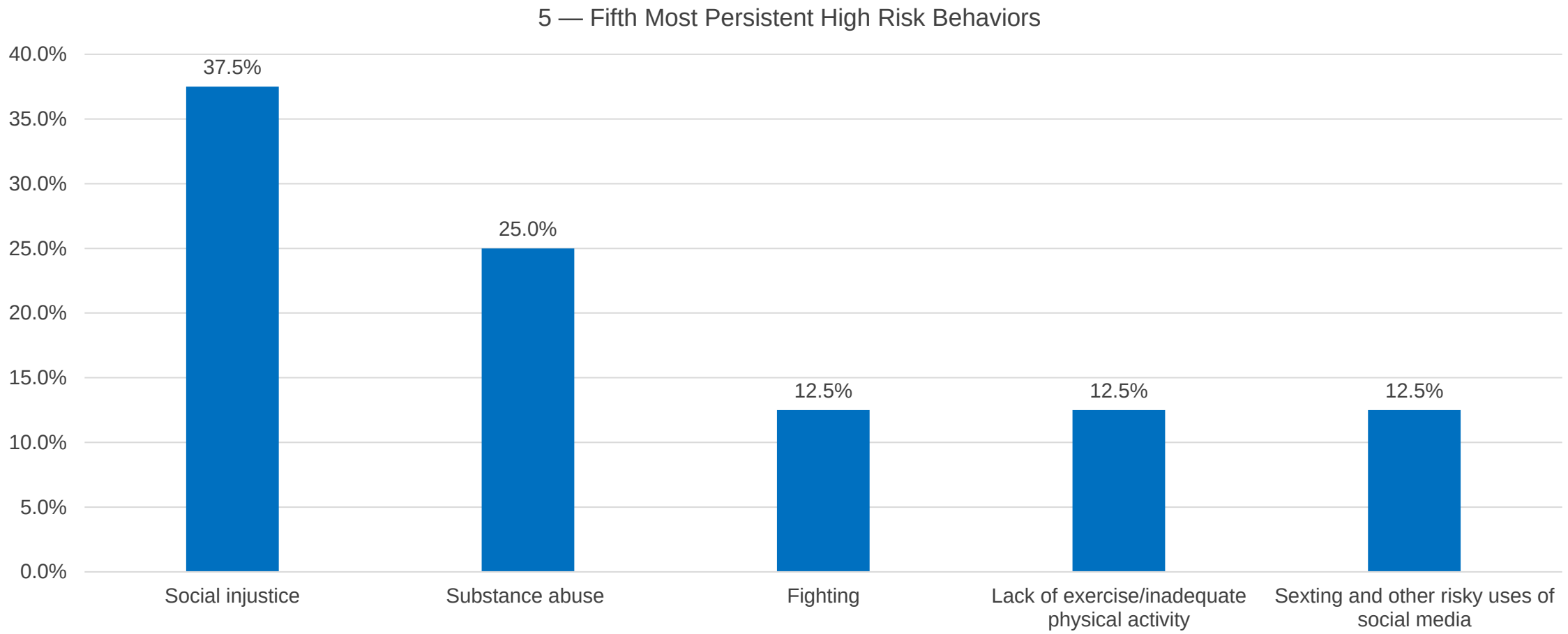
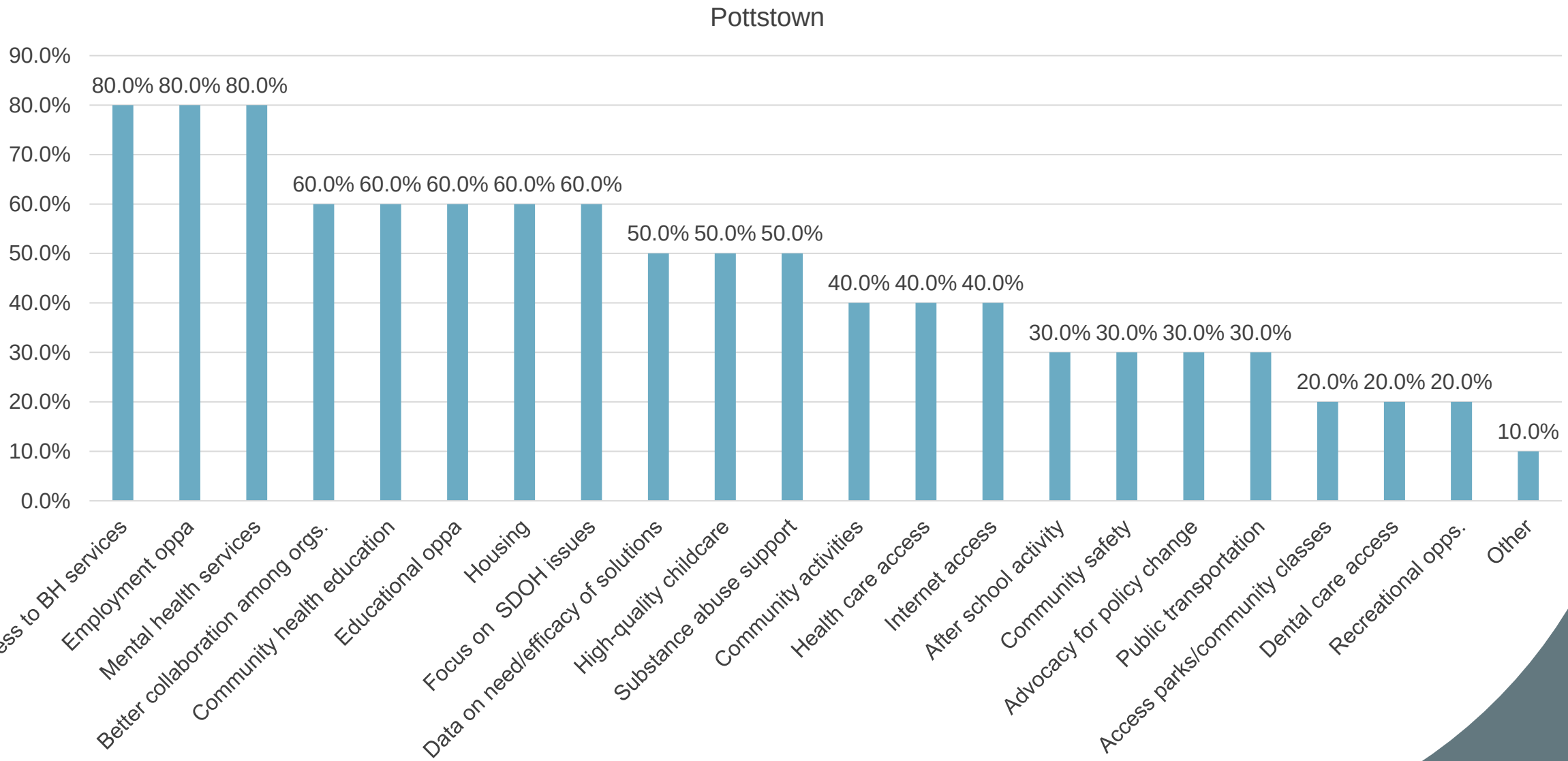
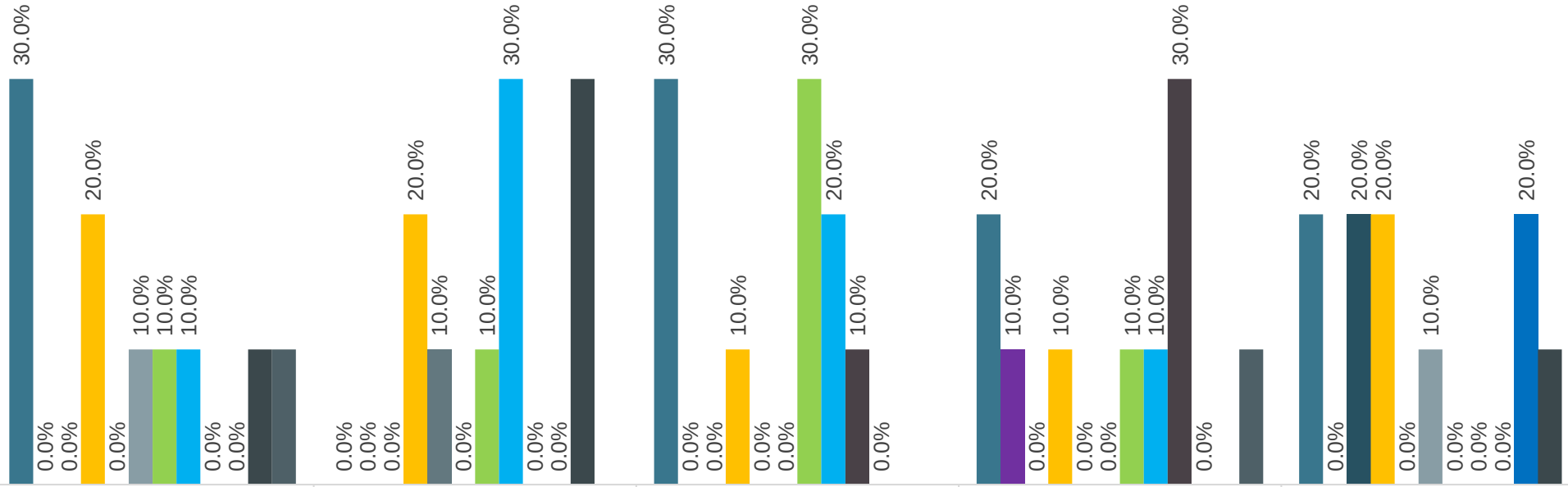


What would improve the quality of life for residents in your community? — Check all that apply

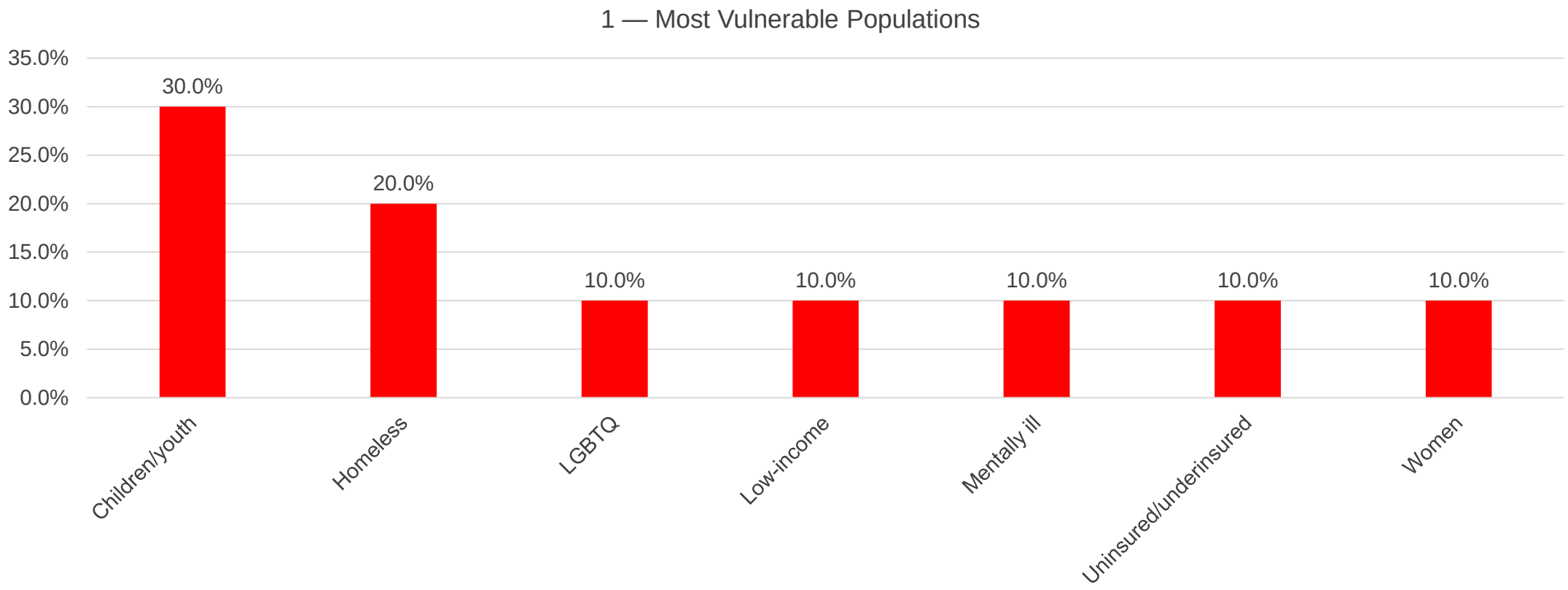


Top 5 populations that are the most vulnerable in the community?



	1 = Most Vulnerable	2	3	4	5
Children/youth	30.0%	0.0%	30.0%	20.0%	20.0%
Chronically ill	0.0%	0.0%	0.0%	10.0%	0.0%
Disabled	0.0%	0.0%	0.0%	0.0%	20.0%
Homeless	20.0%	20.0%	10.0%	10.0%	20.0%
Immigrant/Refugee	0.0%	10.0%	0.0%	0.0%	0.0%
LGBTQ	10.0%	0.0%	0.0%	0.0%	10.0%
Low-income	10.0%	10.0%	30.0%	10.0%	0.0%
Mentally ill	10.0%	30.0%	20.0%	10.0%	0.0%
Minorities	0.0%	0.0%	10.0%	30.0%	0.0%
Older adults	0.0%	0.0%	0.0%	0.0%	20.0%
Uninsured/underinsured	10.0%	30.0%	0.0%	0.0%	10.0%
Women	10.0%	0.0%	0.0%	10.0%	0.0%

Top 5 populations that are the most vulnerable in the community?



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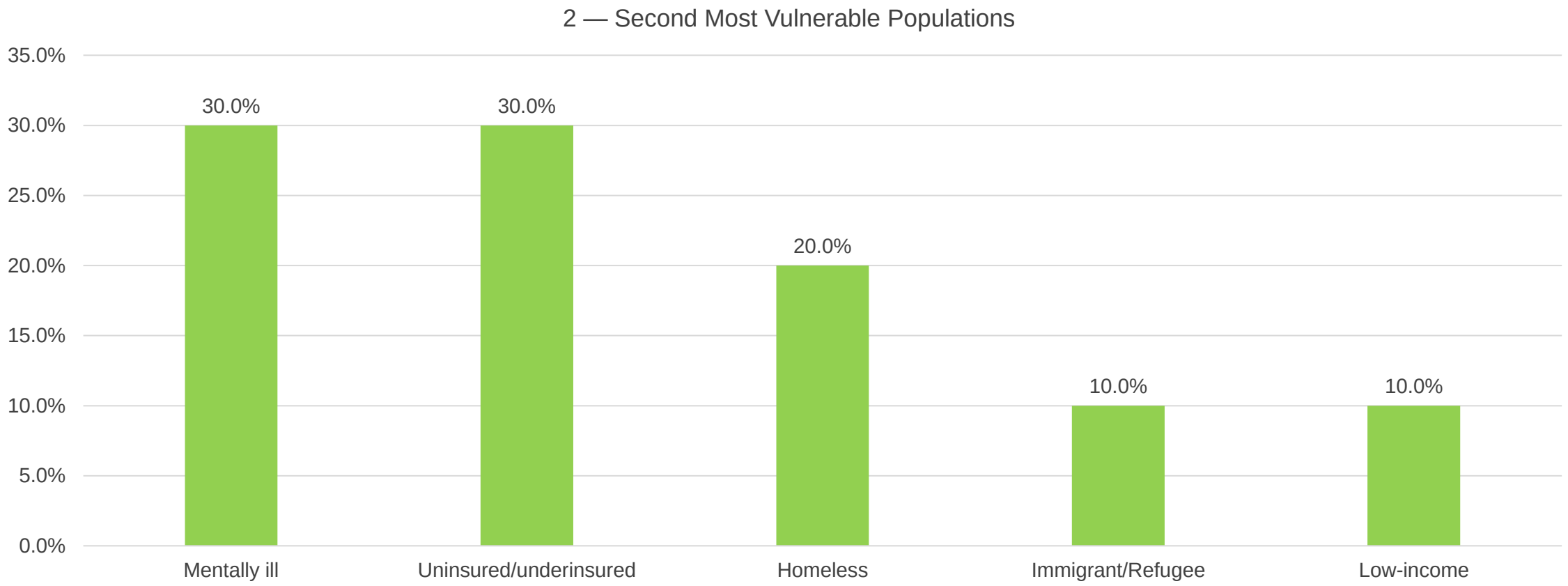

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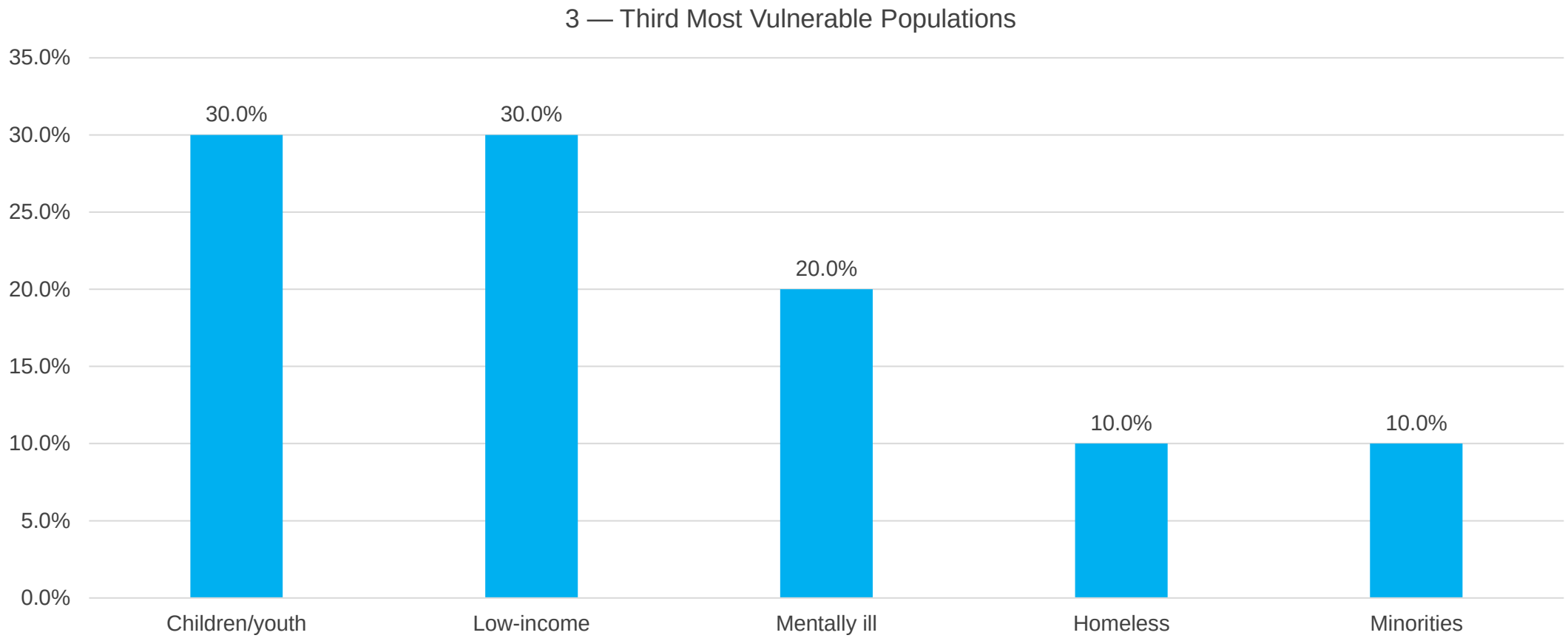

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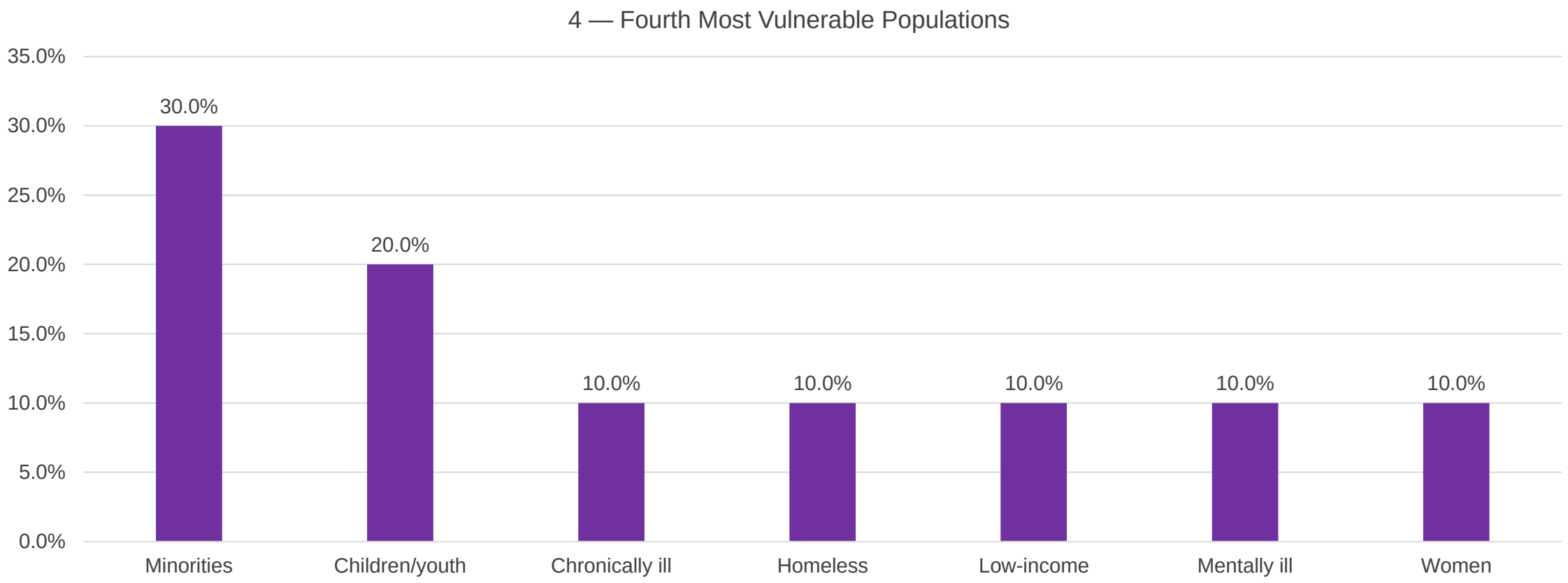

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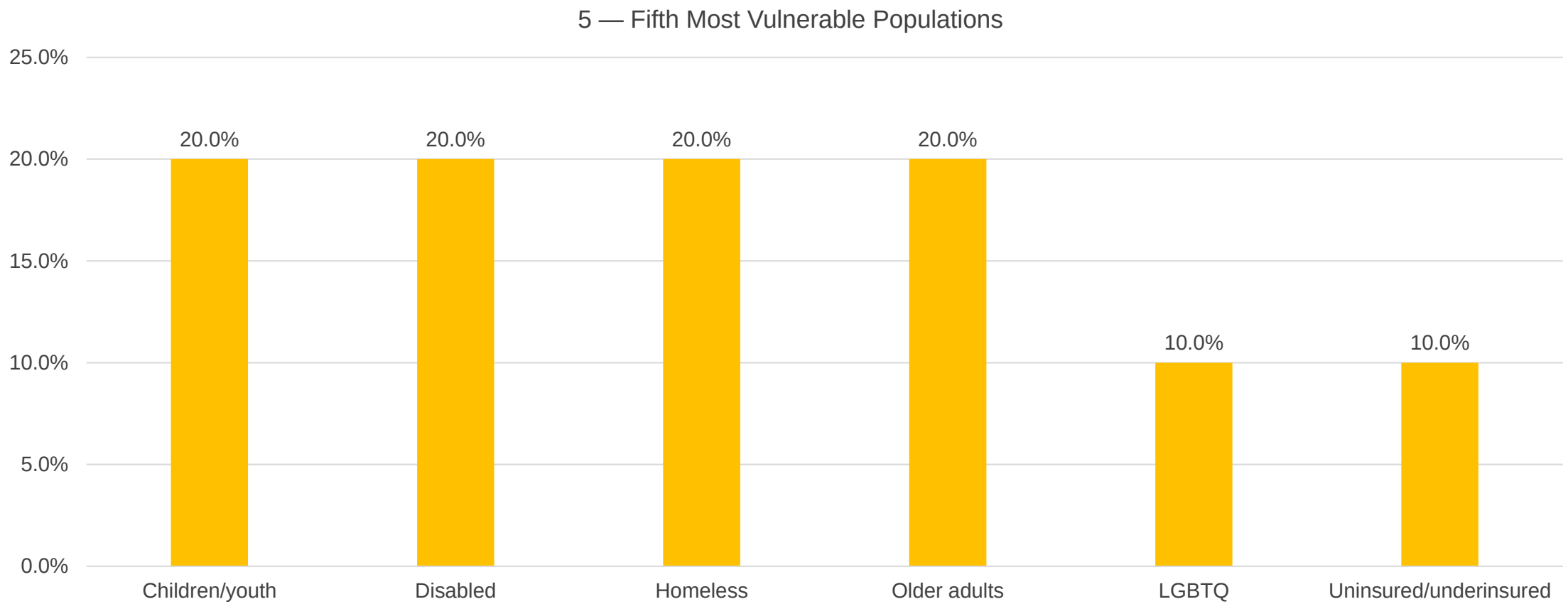
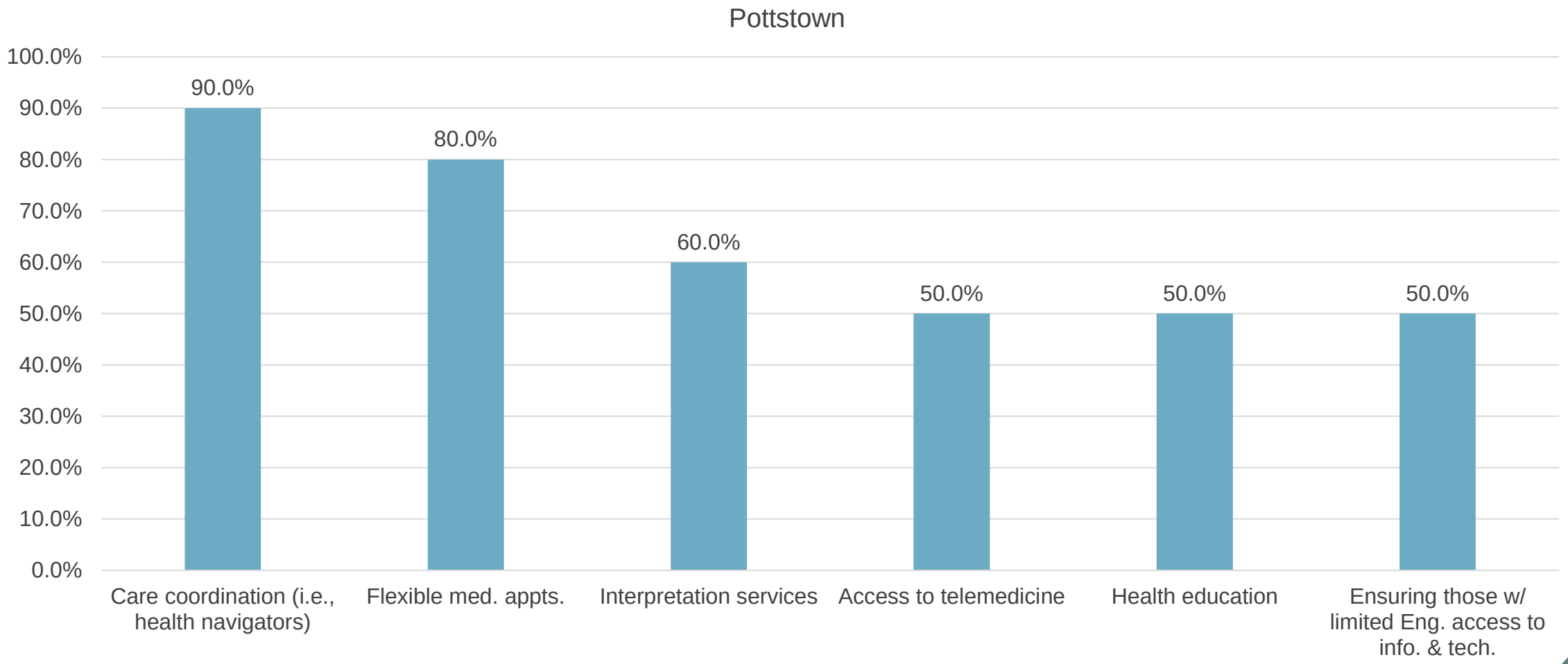
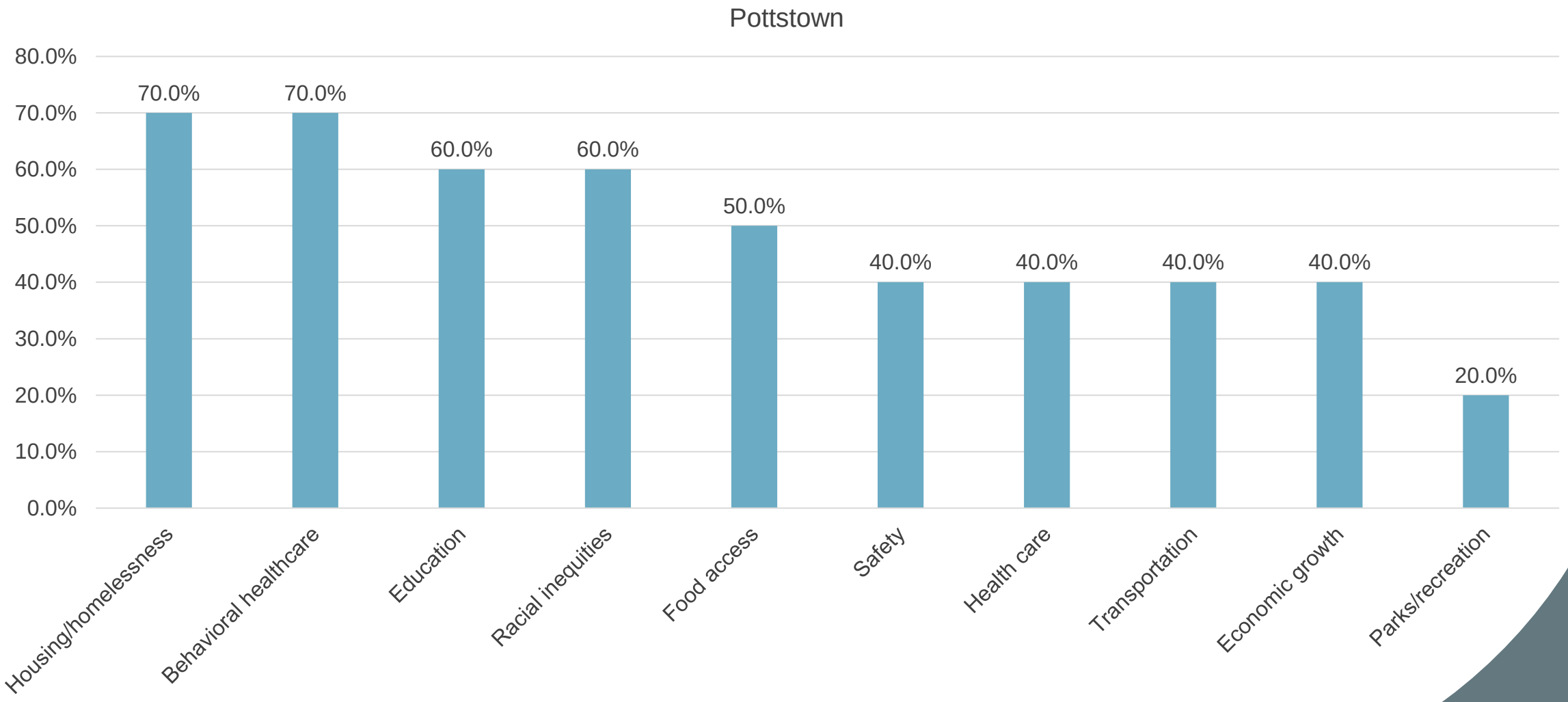


Solutions to help vulnerable populations meet their health needs — (Select all that apply)



What community needs are currently siloed and need further collaboration among non-profits, healthcare, government? (Check all that apply)



How did COVID-19 further impact care, specifically among the underserved and disenfranchised population(s)?

- COVID-19 siloed populations even more.
- It exacerbated food security, unemployment, and the loss of health insurance.
- Instilled fear and reinforced existing barriers.
- People lost jobs and had to use resources they did not use before like food and rental assistance. They were not focusing on their health so there was a shift in how people prioritized their needs.
- Dramatically less access to care and educational opportunities. People did not have the technology to access or understand how to utilize this kind of care.
- Lack of internet access and lack of paid sick days. Many of the workers in homecare do not have paid sick leave. This presented inequalities that have always existed. Created a large substance abuse problem and mental health issue.
- Population did not seek treatment and did not quarantine – they were not educated and needed additional help with the connection. Lack of information on the virus which led to more community spread. They did not understand the importance of social distancing etc.
- PA has not been good in responding to COVID - counties all had different responses. Our local mental health providers pivoted to telemedicine due to necessity. COVID fast-forwarded the health settings. They did not lose patients to cancellations and behavioral health was on top of proving services to people. Behavioral health treatment had to keep going as the services had connections to other services. The vaccines brought out inequalities, especially in the black communities.
- People got healthier if they can access care and knew how to make the system work, but for the underserved – nothing changed. This population was further disenfranchised. COVID made getting care more difficult.

Did telemedicine and virtual platforms ease access to care? In what way?

- Telemedicine allowed for continuous contact and connection. Education pieces can be wrapped into this telemedicine piece.
- The platform highlighted gaps in care.
- Yes, but only to populations that can access the services.
- It only helped populations who were comfortable to access the services.
- Improved access. We were able to provide services through this avenue. We saw improvements in continuing with our outreach efforts.
- Those that like this platform have access. Not everyone has internet or a computer to participate.
- People did not have to leave work to go to the doctor. It opened more access opportunities - made access easier. The platform also helped with scheduling and avoided community spread.
- Behavioral health created more health services. Having technology experience kept people in touch. Physicians maintained a link during a critical time.
- It gave access to those needing behavioral health services. There was a lot of panic in March, so the state used telehealth to reduce barriers to services. We have more people using telemedicine and access was much more improved in this model.

What actions could your hospital take to better address health disparities?

- Telemedicine piece is very important to continue. Needs to be stronger.
- Invest in Pottstown long-term with intervention services.
- Deeper partnerships with community organizations and strategies aimed at addressing the needs of this community.
- Work with organizations that address certain needs and populations for better, more coordinated efforts.
- Providing education and consistency about vaccination. Stick with one campaign so people do not get overloaded with information. Utilize the right message.
- Continue to grow education programs and continue access for all.
- The Pottstown community is diverse. Work to provide more health workers in the community. Integration for different types of positions. Especially for mental health and chronic conditions. Making sure access is open for workers to get care.
- Work with other health care providers and organizations and for better care coordination. Health events to be open to the public, more involvement as residents want to be involved.
- Internal documents that the hospital uses in understanding how they track their health disparities in reaching out to communities of color. We want the hospital to be able to reach out more to the community.
- Better coordination of care across different services – Behavioral health services are limited in care coordination due to policy issues.

Excluding healthcare, what organizations should collaborate to address behavioral health in our community?

- All organizations
- Churches
- Community members
- County organizations
- Educational groups
- Non-government organizations (Laurel House)
- Nonprofit service providers with vulnerable clientele
- Police Departments
- Prison system
- Schools
- Veteran organizations
- Anyone we can bring to the table. Mental health tries to work with schools with lots of school-based programs. Evidence-based programs in mental health strategies. Need to understand trauma-informed care. The community does not understand the trauma that people often experience.
- More behavioral health specialists are needed. Having more counselors and psychologists and community awareness. Some churches have a counselor in these areas which is helpful. We need an education pipeline to increase people in the behavioral health care field. Tri-County health counselors get people connected.
- Creative health services – we are a designated community health center for the region. We are the public health connection to residents. We need health centers and collaboration with organizations like wellness foundations. We need to be care coordinators. We are the HUB – connecting us back, to the community.

What do you want the hospital to know that we haven't already asked?

- Our teachers, counselors, and building administration people are at the forefront– we need support to help the community be healthier. We are willing to participate when and where we can.
- We need to recognize the hospital is under enormous pressure to be all things to all people but unfortunately, they are constrained financially.
- Financial benefits of collaborating where it makes sense. We can see more Medicare population lessening the overhead cost of care at the hospital. This might benefit the referral constraints which can lower the cost of the hospital for preventive care. Lessen the cost of services of the hospital. College wants a strong relationship with the hospital, and we are happy to help in any manner.
- Pottstown hospital is a wonderful partner. The leadership wants to involve the community. Explore different strategies. We still need to keep pushing with resources.
- More community involvement and exposure to the health services at the hospital.
- Thank their employees for their personal sacrifices. We need to be more entrepreneurial. Seek partnering dollars as the hospital will be competing with telehealth. People are moving to the area and the hospital can take advantage of these new residents.
- Looking at the mission of hospital and address its concerns. What is our purpose for the community and what is effective in the region?

Public Commentary

1. Do you feel that the assessment you reviewed included input from community members and organizations?

Yes – 90%

No – 0%

Don’t know – 10%

2. Do you feel that the assessment you reviewed excluded any community members or organizations that should have been involved in the assessment?

Yes – 0%

No – 80%

Don’t know – 20%

3. Were there needs in the community related to health that were not present in the CHNA (e.g., physical health, mental health, medical services, dental services, etc.)?

Yes – 20%

No – 70%

Don’t know – 10%

4. Were the implementation strategy directly related to the needs identified in the CHNA?

Yes – 80%

No – 10%

Don’t know – 10%

Public Commentary

How did this CHNA and resulting Implementation plan benefit you and your community? If no, in what way would the implementation plan be beneficial to you and your community?

- Anytime you can be reflective and can turn ideas into collaboration efforts is a win for the community.
- It gave residents a voice. It made them have ownership and allowed them to be heard. There needs to be more outreach. Have to change the way the people perceive the hospital - needs a better image. The staff has been great during COVID. The marketing of services of the hospital is important and we need to make it look happier. The message of the hospital needs to be reviewed and better portrayed.
- Gave a good peek at the overall needs and how they impacted our strategic plan.
- Good overall benefits going through the exercise to collect data and feedback especially from the populations in need.
- We worked and brainstormed initiatives together. We need full implementation on past initiates because they were good, but COVID stopped this, and we need to restart the initiatives again.
- Increased awareness – eye-opening.
- I think this effort made needed services more accessible to the community.
- Allowed open and honest feedback – want outcomes to be more useful.

Public Commentary

Please share any additional feedback on the CHNA /Implementation Plan that was not covered already?

- Additional positive stories should be shared. We need outreach with the impact of the hospital itself. We are losing the message regarding the hospital — there needs to be better branding of its image.
- I hope we can continue with the initiatives. We need to add on and not restart it. We need to get back on the course.
- Remind the hospital that they are serving people in the region.

Tower Health Pottstown Hospital

Appendix B – Health Equity Focus Group

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Pottstown Hospital Health Equity Focus Group

Focus groups were conducted during June 2021 to collect information and capitalize on communication among health and human service providers. The focus groups enabled its participants to explore and clarify insights and perspectives in a manner that maximizes participation and builds on synergy. Designed to collect and synthesize in-depth information on community provider's thoughts and opinions related to health and health equity, the focus group questions directed participants to look at health and health equity through the broadest lens and scope. The health equity focus groups emphasized a two-fold aim:

1. Better understand barriers faced by vulnerable populations
2. Identify action steps to remove barriers to improve health equity

Facilitated focus group interactions expanded a delicate but challenging conversation regarding health equity and enabled community participants to examine changing perceptions, beliefs, and attitudes related to acknowledging contributors to health equity, identifying health disparities, and improving health equity. Through facilitation, an open and candid environment was created, allowing health and human service providers to speak openly and to share perspectives and real stories regarding the impact of health inequities and health disparities of the diverse populations they serve. The health equity focus groups composed of community representatives, clinical, and human service providers were encouraged to uncover and discuss a plethora of complex and compelling barriers, needs of the diverse and disparate populations they serve and to anticipate what actions should be undertaken to address health equity.

Discussion Area of the (7) health equity focus groups:

1. Contributors to health inequity (SDOH contributors to health inequality (i.e., transportation, education, low-income, lack of access to health care, uninsured/underinsured, and mistrust)
2. Impact of racial and social disparities on quality of care
3. Areas having the most impact on people being treated differently (e.g., education, race/ethnicity, income, insurance, not being able to speak English)
4. The magnitude of social and racial inequalities in health in the workplace, education, housing, and government areas
5. Identifying who is accountable for equitable health care
6. Obstacles and barriers to health equity
7. Recommendations to improve health equity
8. Call to action
9. Knowledge facilities need to know related to the community

The discussions among the health equity focus groups unveiled the following "Call to Action" recommendations: health equity and cultural

1. Building a diverse workforce that is reflective of the communities they serve.
2. Continuing to advance cultural competency, language, and translation services.

3. Improve patient engagement and increase awareness/communications of available services and programs both to the community as well as across the hospital.
4. Strengthening communication, partnerships and community engagement.
5. Continue the distribution of health information and reinforce health education.

The objectives of the focus groups were achieved as community participants openly and emphatically expressed care and concern for the disparate and vulnerable populations they serve.

1. Contributors to Health Inequity
Pottstown
• Affordable insurance • Unconscious bias and stigmas among Black/Brown communities • Practitioners' inability to relate to needs of binary groups • Lack of training and awareness of religious restrictions (i.e., clothing and physically touching) • Access to care and availability of different services and treatments • Person's willingness and comfort in pursuing care for ongoing trauma

2. Impact of Racial and Social Disparities and influence on Quality of Care Received
Pottstown
• Language barriers and inadequate translation impacts quality of care • Quality language services build confidence and add more clarity • Racial disparities stem from societal issues and result in social inequality, bias, and stigma, etc. • Address root causes and SDOH through a racial justice lens • Engage community members, listen and learning cultures, life experiences, and provide opportunity to elevate their voices

3. Impact of Patients Being Treated Differently
Pottstown
• Race/ethnicity - 45% • Insurance coverage - 18% • Not speaking English - 18% • The race/ethnic makeup of a resident is the first point of reference • Education- teaching people about the world/world view so ppl can relate to one another • Ppl assume I do not speak English; treatment changes once I speak English • Change the setting and customer service treatment • Need education — lots of ways to present ourselves, you may want to cover up things, but you can't cover up race

4. How Big of a Problem are the Following Areas as Related to Social and Racial inequalities: health, workplace, education, housing, government?
Pottstown
• Health - 100 % major problem • Education - 100% major problem • Housing - 100% major problem • Govt. - 100% major problem • Diversity is not represented in leadership positions, schools, nor business • Issues of race and valuing differences challenges own sense of identity • Have multi-race providers to serve residents • Immigration laws should help, protect, and assist in obtaining jobs • Govt. reps need info from community to make policy changes • Social and human rights issues as ppl are judged on qualities and environmental factors • Education system tied to race; current system designed to support white rich kids • We focus more on differences than similarities as seen in all aspects of underlying biases • Language barriers • Housing issues for Black/Brown communities • Historically, Black/Brown tend to rent, higher risk of homelessness • Have a high transient community with limited networks and shared knowledge

5. Who Should Be Accountable?

Pottstown

- Govt. - 56%
- Health care system - 33%
- Personal/ individual -11%

- Health is a human right
- Govt. should have strong role – many do not trust gov't
- Health care is moving in the right direction, needs to fix itself
- In other counties, no one person can provide and ensure that everyone has access to quality and affordable health care
- Personal/Individual- Ppl need to commit, held accountable for behaviors
- Some ppl do not want help - they must accept their own personal role
- Employers have a responsibility to diversify the workforce

6. Barriers and Obstacles That Stand In the Way

Pottstown

- Prioritization of funding
- Distrust of health care providers
- Getting ppl to contribute and invest in the process
- Lack of accountability
- Lack of power and knowledge
- More adequate training and workshops for medical professionals
- Personal responsibility — ppl must recognize the role they play in their health
- Remove stigmas and help connect to social services and resources

7. Recommendations to Address Health Inequities

Pottstown

- Advance cultural competency services, and multilingual events
- Educate and prepare physicians to better advocate on behalf of diverse patients
- Recruit and hire diverse leaders and staff
- Expand outreach through community health workers
- Ensure community advisory board has a voice on the board
- Work with local providers and street medicine programs to provide care in a familiar, comfortable setting

8. Actions to Improve Health Equity (Call to Action)

Pottstown

- Improve health literacy and understanding of the medical-care setting
- Provide preventive health care screenings using telehealth
- Advocate for state and govt. level funding to address SDOH
- Continue CBO collaborations
- Provide patient-centered care with patients being part of care decisions and having knowledge of options

9. What the Hospital Needs to Know About the Community

Pottstown

- The community does not know Pottstown is part of Tower Health. Ppl go to Reading Hospital not knowing that it is the same health system
- Ppl do not know Pottstown is a non-profit organization
- Ppl need to know what services are available
- Pottstown Hospital needs better image and promote changes

Capturing Data / Reduce Rates Among Ethnic Groups/Information and Identifying Interventions
Pottstown
Capturing Data • More efforts towards integrated health Reduce rates among racial ethnic groups • Market educational efforts towards specific and relatable communities — use influential residents in underserved communities Identify Interventions • School-based initiatives can extend into the homes • Working with the health and education systems to advocate for prevention efforts • Food insecurity is a huge concern • Provide education so ppl can improve their own health • Verify where issues are, understand why, and make data-driven decisions • Provide outreach and care to those who face obstacles and have comorbidities • Partner to address comorbidities

Tower Health Pottstown Hospital

Appendix C – Leadership Focus Group

Pottstown Hospital
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Pottstown Hospital Leadership Focus Group

Focus groups were conducted during June 2021 to collect information and capitalize on communication with the leaders of Tower Health hospitals. The focus groups enabled its participants to explore and clarify insights and perspectives in a manner that maximizes participation and builds on synergy. Designed to collect and synthesize in-depth information on leadership's thoughts and opinions related to health and health equity, the focus group questions directed participants to look at health and health equity through the broadest lens and scope. It is often noted that (1) leadership commitment and involvement are vital to an organization's ability to address complex issues and (2) the beliefs and perspectives of leadership may have the greatest impact on how an organization achieves cultural competency and improves health equity.

The leadership focus groups emphasized a two-fold aim:

1. Better understand barriers faced by vulnerable populations
2. Identify action steps to remove barriers to improve health equity

Facilitated focus group interactions expanded a delicate but challenging conversation regarding health equity and enabled Tower Health leaders to examine changing perceptions, beliefs, and attitudes related to acknowledging contributors to health equity, identifying health disparities, and improving health equity. Through facilitation, an open and candid environment was created, allowing leaders to speak freely and honestly as essential to hear health equity perspectives and real stories regarding health equity and health disparities of the communities. Leadership focus groups composed of administrative, physicians and clinical, leaders were encouraged to uncover and discuss a plethora of complex and compelling barriers, the needs of the diverse and disparate populations they serve and to make recommendations on what actions may be undertaken to address health equity.

Key themes from the (7) leadership focus groups:

1. Contributors to Health Inequity (SDOH Contributors to Health Inequality (i.e., transportation, education, low-income, lack of access to health, uninsured/underinsured, and mistrust/trust factor)
2. Leadership Actions to Provide Equitable Care
3. Using Data to Identify Gaps
4. Use of Clinical Data
5. Staff Training
6. Consistently Providing Training to Staff towards Culturally and Linguistically Appropriate Care
7. Having Health Equity as an Organizational Priority

Key themes from the (7) leadership focus groups unveiled the following recommendations (Call to Action):

- ☐ Develop a plan to achieve health equity

Pottstown Hospital

- ☐ Importance of continuing to build a more diverse workforce at the leadership and staff levels; reflective of the community served
- ☐ Improve on the level of awareness related to available services and programs both to the community as well as across the health system
- ☐ Strengthening communication and community engagement. Solidify existing partnerships and collaborations. Creation of a community advisory board.
- ☐ Continuing to advance cultural competency, language, and translation services
- ☐ Sharing of information across the system regarding available services and programs as a few hospitals were not aware of the many programs available and active at the system level

The focus groups objectives were achieved as hospital leaders openly and emphatically expressed care and concern for the disparate and vulnerable populations they serve.

1. Contributors to Health Inequity
Pottstown
• Un/underemployed • Lack of transportation • Poverty and lack of housing • Health literacy and poor education • Access to available programs and services • Navigation difficulties • Stigma around mental illness • Lack of insurance and high co-pays • Transient populations, lack of continuity of services, esp. among kids

2. Leadership Actions to Provide Equitable Care

Pottstown

- Educate community to access resources
- ED has street medicine
  Program that removes insurance and transportation barriers for the homeless
- Social workers address and bridge people to services
- Nurse and financial navigations provide services and medications based on coverage
- Screen and link underserved with dental care
- Conduct skin cancer screenings for underserved
- Improve access in making online appts, more patient centric
- Offer facility as meeting space for community groups and help build trust

3. Using Data to Identify Gaps

Pottstown

- Has policy in place to let patient know who is treating them and along with choice on where to get care
- Medical staff teaches that racism from a patient isn't tolerated, and patients also informed that racism isn't tolerated
- Has mission statement, goals, and education on diversity and inclusion for doctors and staff members
- Addresses cultural competencies and recruit staff who represent the community

4. Use of Clinical Data

Pottstown

- Look at local BH centers, local foundations, tri-county network data
- Use readmissions data to identify repeat users, resources to non—urgent ED users who are just lonely
- Use MAT warm handoffs info to provide resources, medications, appointments and coordination of care
- Partners with Pottstown Pharmacy – meds to bed program for after hours

5. Staff Training

Pottstown

- Requires annual competency training and quiz for all employees
- Conducts cultural competency outreach and CEU credits open to all staff

6. Consistently Providing Training to Staff towards Culturally and Linguistically Appropriate Care

Pottstown

- Community connection project supports housing, food, utilities, transportation, and safety.
- Navigator works with at-risk patient for a year, connects them to needed resources:
  - 211 for housing
  - CSA program for 2,000 lbs. of organic produce shared among 35 families
- Educates providers and develop resource binder for providers to refer to patients needing assistance
- Conducts discharge planning, psycho-social screenings, and appropriate follow up care to all patients

7. Having Health Equity as an Organizational Priority

Pottstown

- Continue efforts to address inequalities such as transportation, telemedicine, outreach clinics
- Plan to address health equality and improve access to health services

Recommendations and Implementation Strategies

Pottstown

- Create a community advisory board to assist in getting the word out on available services
- Partner with CBOs to create a one-stop shop and promote 211
- Work with practice managers to update community services and inform on needs of specific populations
- Provide multilingual materials and instructions

Importance of leadership and governance team reflecting the diverse community it serves (Polling Question)

Pottstown

Very Important - 60%
Moderate Importance - 40%

- Diversity in our leadership but not enough to match community

Does your leadership team reflect its community? (Polling Question)
Pottstown
Yes - 60% No - 40% • Community has pockets, but do not represent our entire community • BOD is diverse in background, race and ethnicity • Need for more diverse employee workforce • Leadership team and many staff invested in the community, live here and involved in the community • Work with other firms to recruit diverse staff but some candidates not comfortable and choose to go elsewhere • Had implicit bias training and looking for skilled development leaders • Have ample growth opportunities and accountability at the system level

Tower Health Pottstown Hospital

Appendix D - Key Informant Survey

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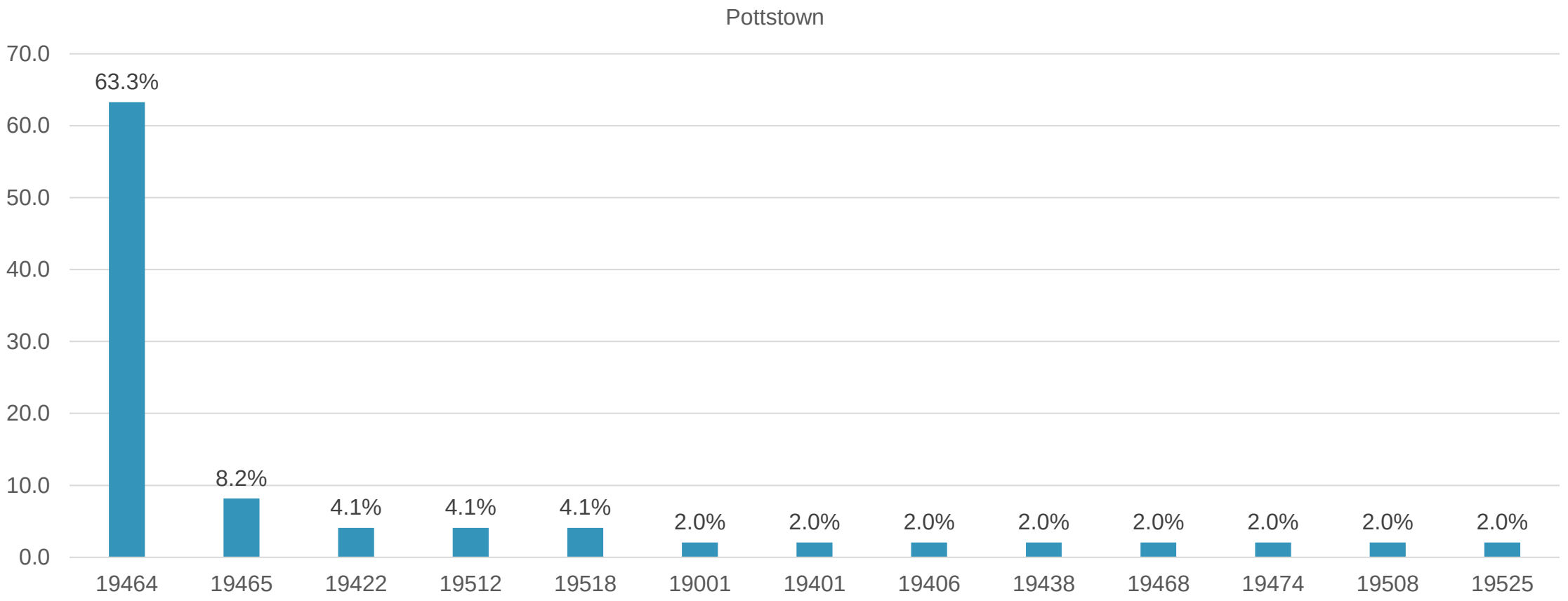
Introduction

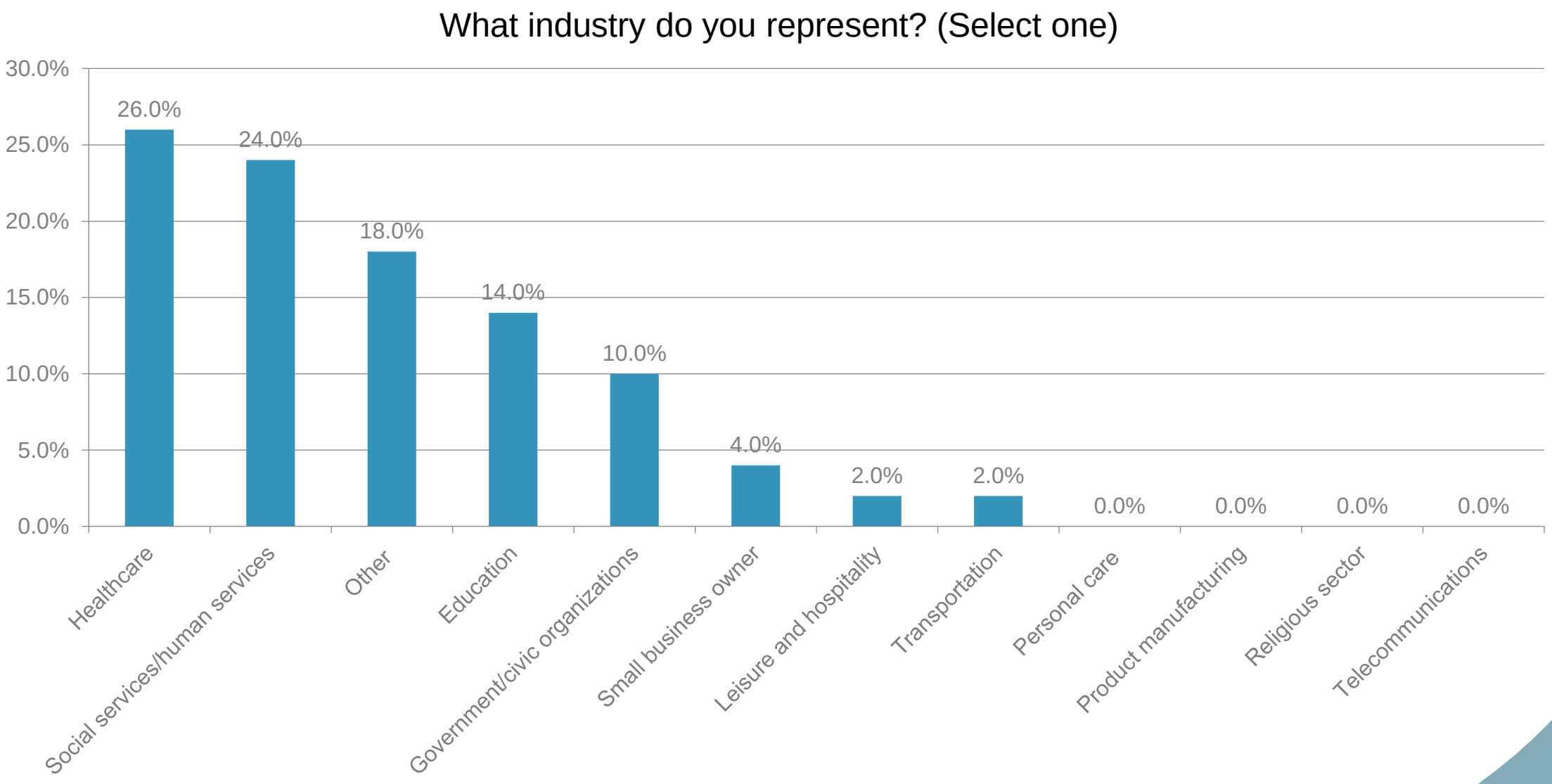
- Tripp Umbach worked closely with representatives from Tower Health to identify key informants in the region. A robust database was created to request survey participation from leaders in the region. An email was sent to key informants by representatives of Pottstown Hospital to introduce the CHNA process. The email introduced the project and conveyed the importance of the CHNA for Tower Health System and for the community.
- A key informant survey was programmed into Survey Monkey to collect feedback from respective populations.
- The data collection period ran from February 2021 – August 2021.

ZIP Code

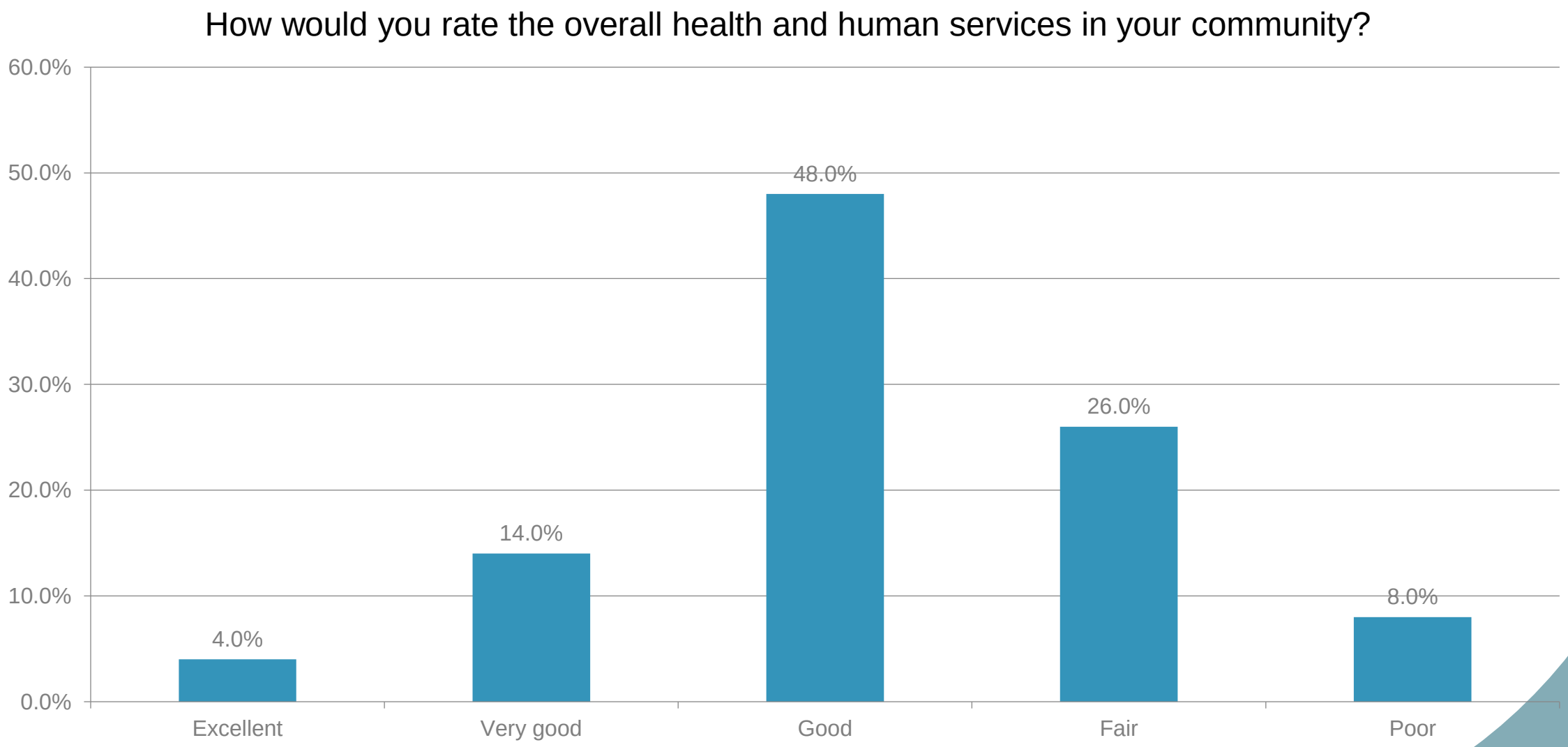


- 80.0% of key informants worked in Montgomery County, 10.0% in Berks County, 6.0% in Chester and 4.0% reported other counties.

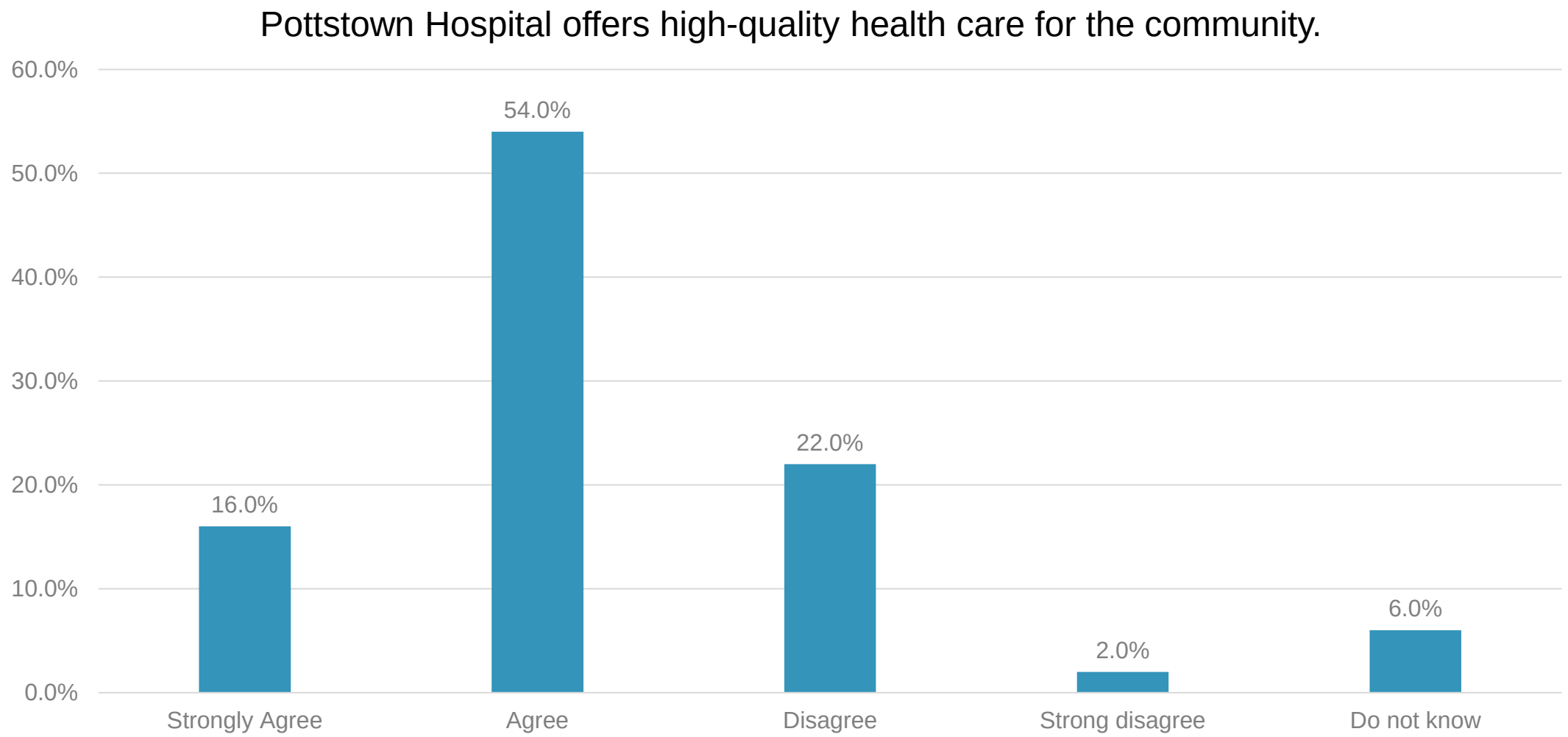
Represented Industry



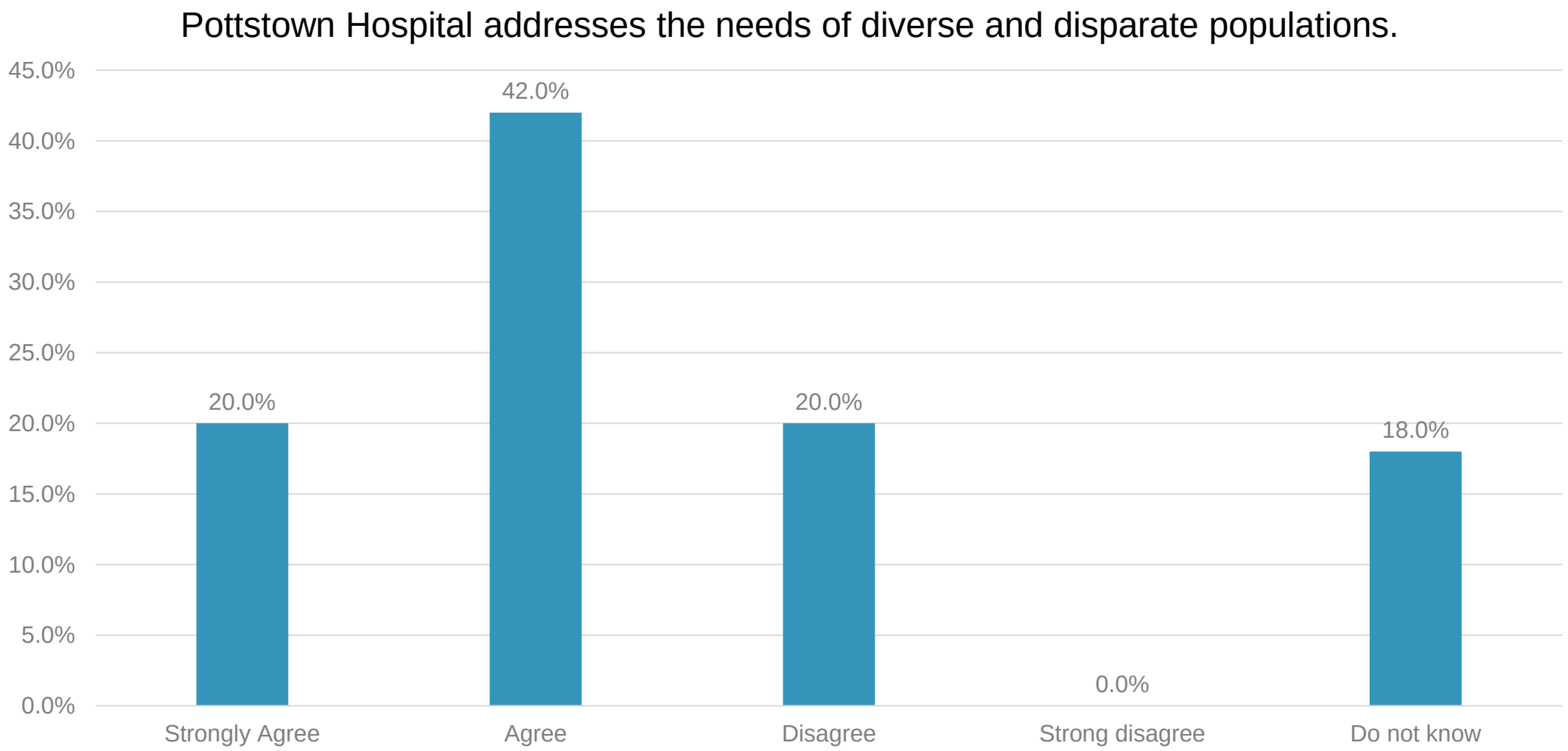
Rate Health and Human Services in Community



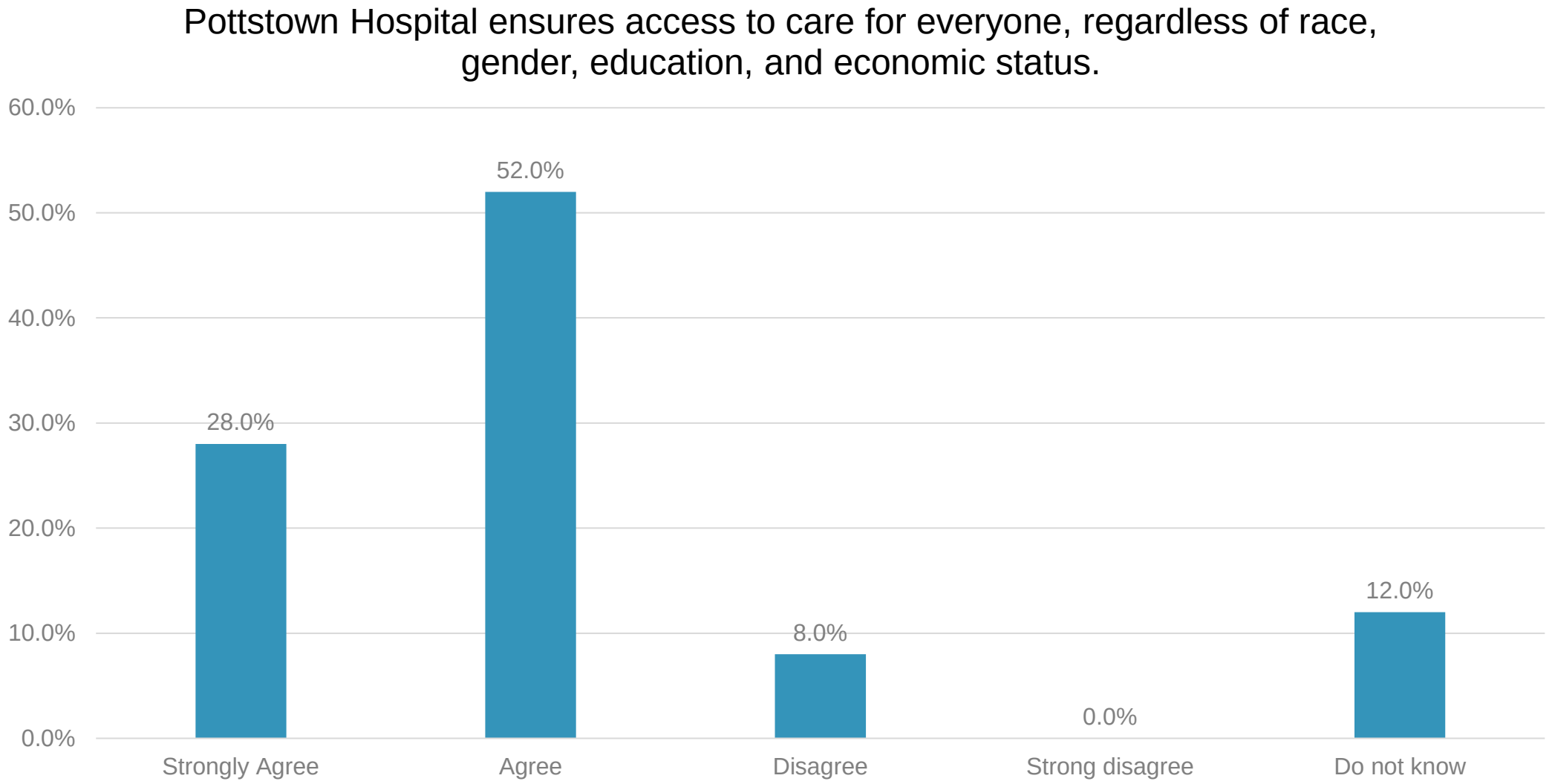
Rate How Hospital Offers High-Quality Health Care for the Community



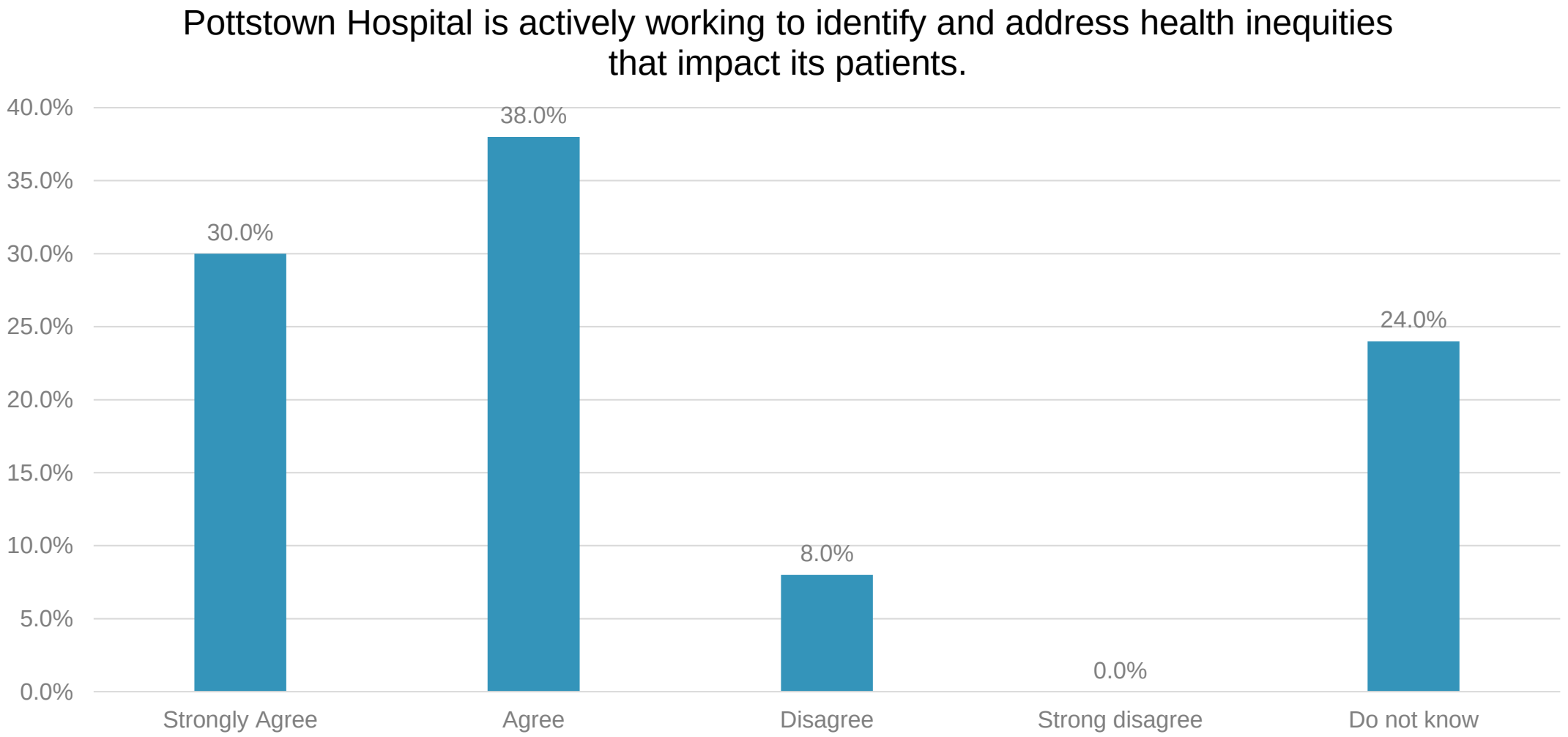
Rate How Hospital Addresses needs of Diverse and Disparate Populations



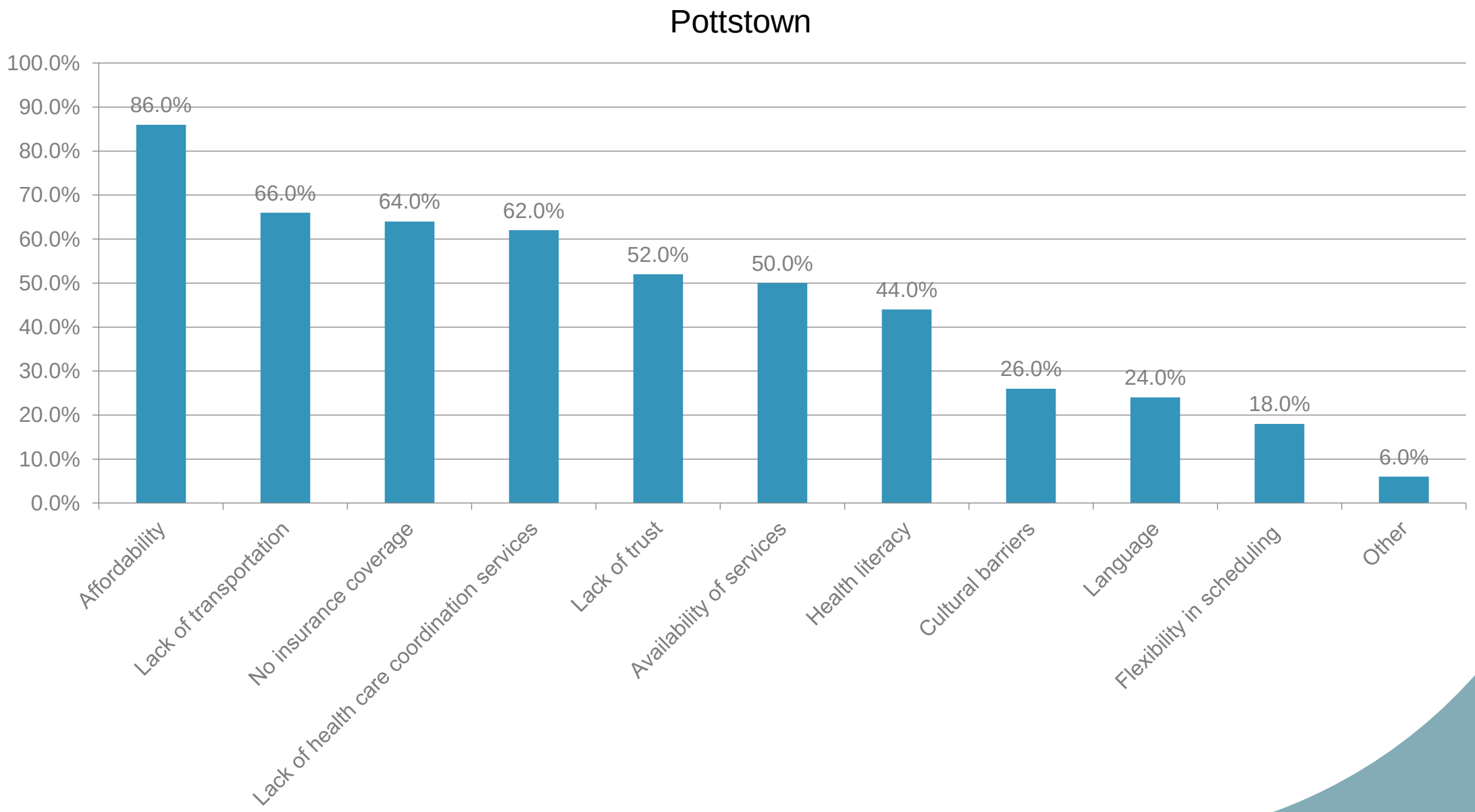
Rate How Hospital Ensures Access to Care Regardless of Race, Gender, Education, and Economic Status



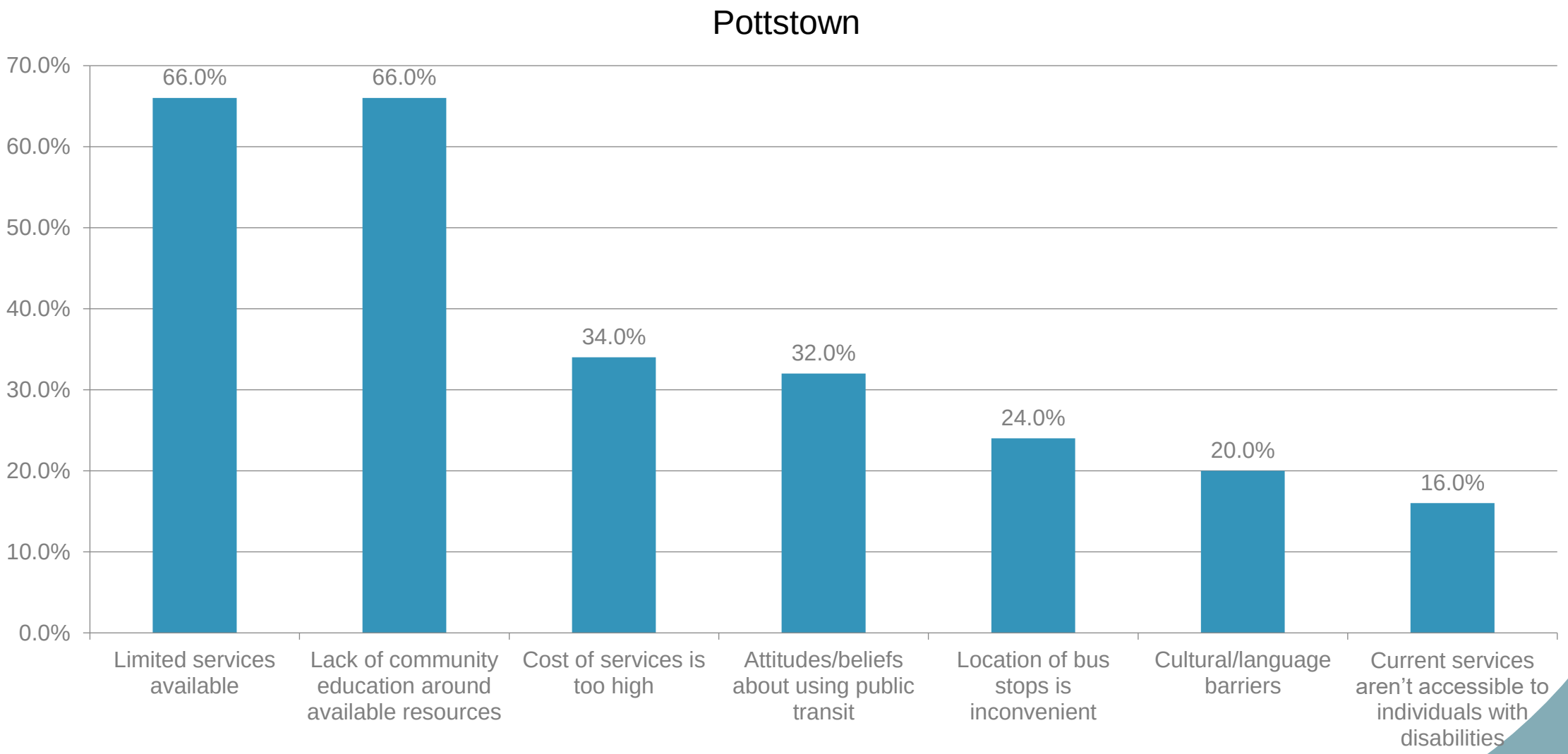
Rate How Hospital Works to Identify and Address Health Inequalities



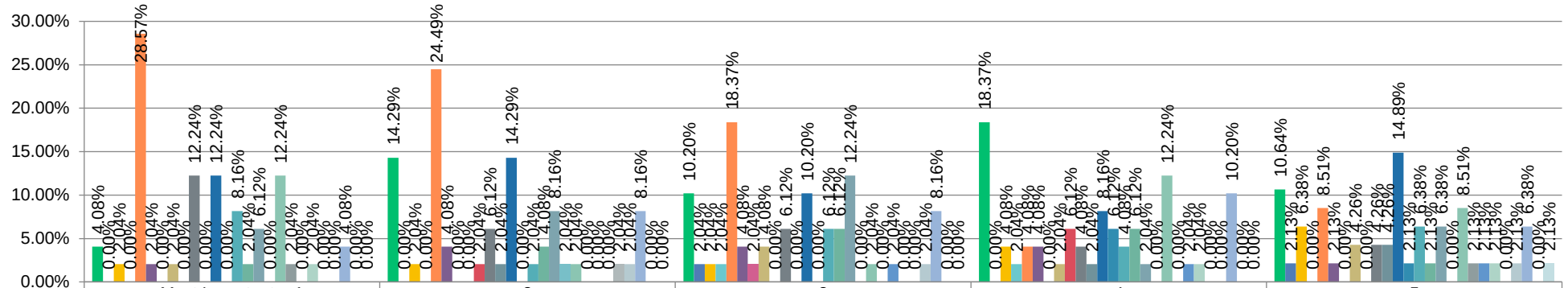
Perceived Barrier(s) for People Not Receiving Care or Services — Check all that apply



Following contributions to the transportation issues in the community — (Top three)

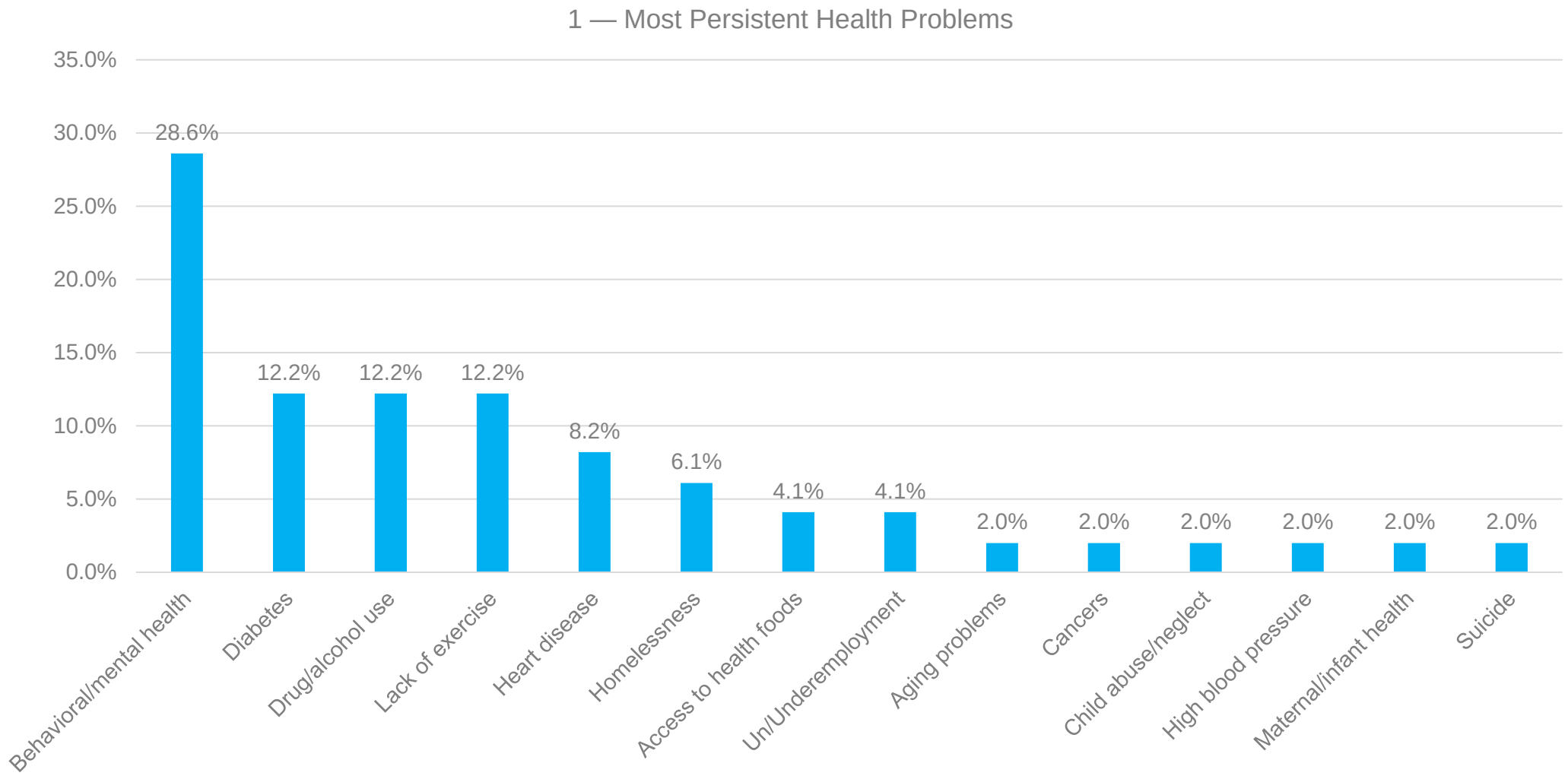


Top 5 persistent “Health Problems” in the community?

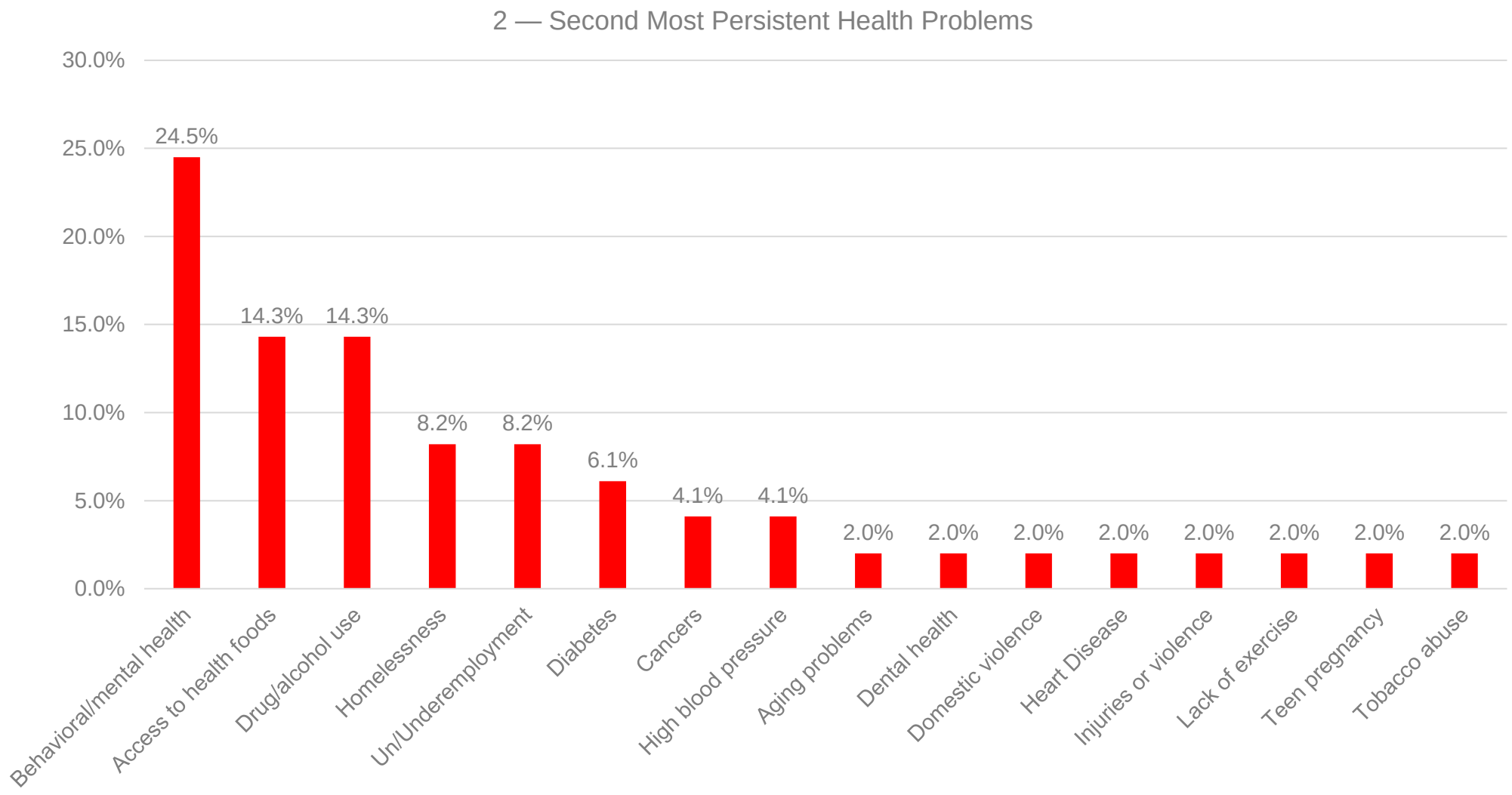


	Most Important = 1	2	3	4	5
Access to health foods (i.e., poor diet)	4.08%	14.29%	10.20%	18.37%	10.64%
Adolescent health	0.00%	0.00%	2.04%	0.00%	2.13%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	2.04%	2.04%	2.04%	4.08%	6.38%
Asthma	0.00%	0.00%	2.04%	2.04%	0.00%
Behavioral/mental health	28.57%	24.49%	18.37%	4.08%	8.51%
Cancers	2.04%	4.08%	4.08%	4.08%	2.13%
Care for moms/babies	0.00%	0.00%	2.04%	0.00%	0.00%
Child abuse/neglect	2.04%	0.00%	4.08%	2.04%	4.26%
Dental health	0.00%	2.04%	0.00%	6.12%	0.00%
Diabetes	12.24%	6.12%	6.12%	4.08%	4.26%
Domestic violence	0.00%	2.04%	0.00%	2.04%	4.26%
Drug/alcohol use (i.e., substance abuse)	12.24%	14.29%	10.20%	8.16%	14.89%
Family planning/birth control	0.00%	0.00%	0.00%	6.12%	2.13%
Heart disease	8.16%	2.04%	6.12%	4.08%	6.38%
High blood pressure	2.04%	4.08%	6.12%	6.12%	2.13%
Homelessness	6.12%	8.16%	12.24%	2.04%	6.38%
Injuries or violence	0.00%	2.04%	0.00%	0.00%	0.00%
Lack of exercise (i.e., overweight/obesity)	12.24%	2.04%	2.04%	12.24%	8.51%
Maternal/infant health	2.04%	0.00%	0.00%	0.00%	2.13%
Respiratory/lung disease	0.00%	0.00%	2.04%	2.04%	2.13%
Suicide	2.04%	0.00%	0.00%	2.04%	2.13%
Teen pregnancy	0.00%	2.04%	0.00%	0.00%	0.00%
Tobacco abuse	0.00%	2.04%	2.04%	0.00%	2.13%
Unemployment/underemployment	4.08%	8.16%	8.16%	10.20%	6.38%
Vision issues	0.00%	0.00%	0.00%	0.00%	0.00%
Other	0.00%	0.00%	0.00%	0.00%	2.13%

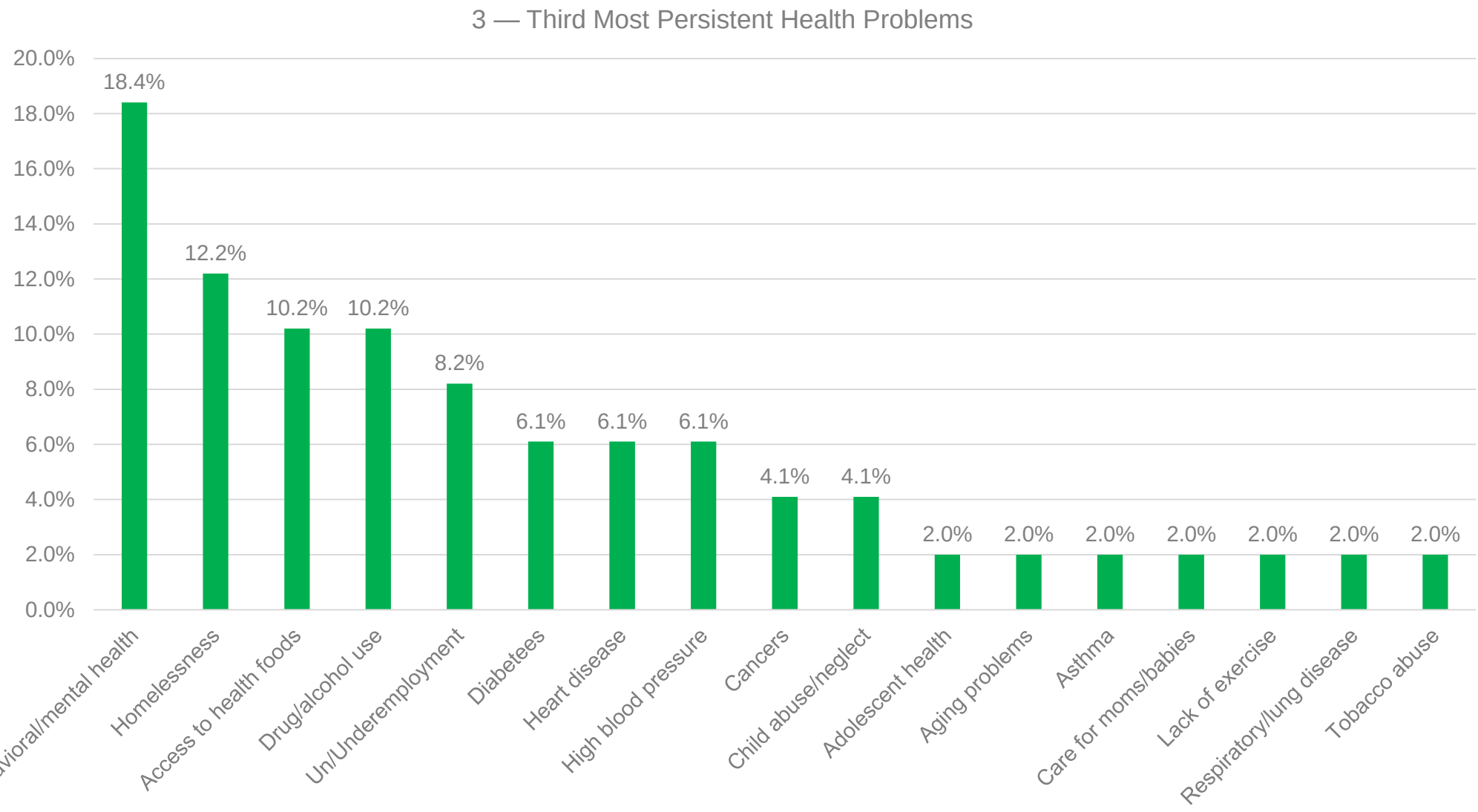
Top 5 persistent “Health Problems” in the community?



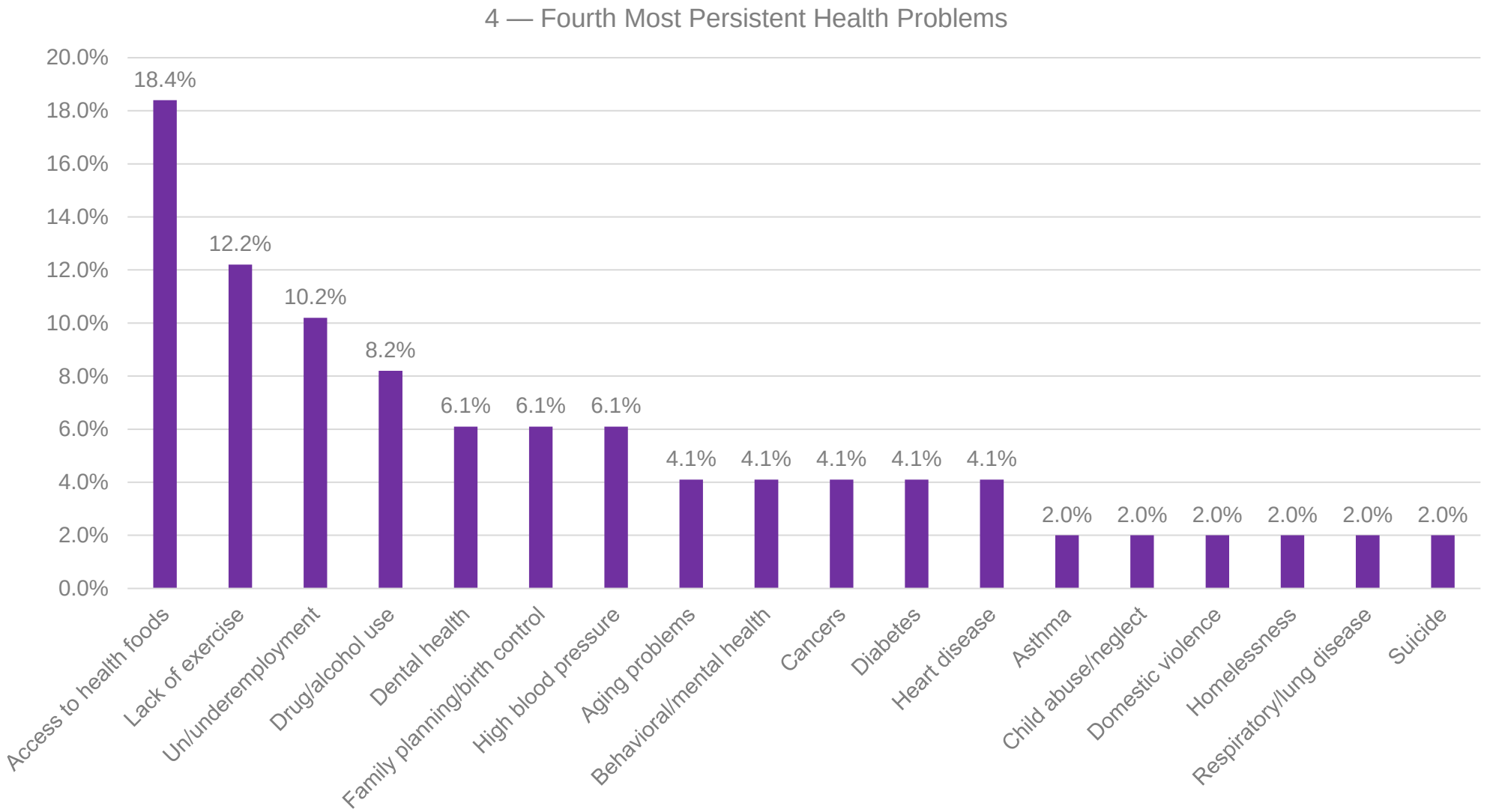
Top 5 persistent “Health Problems” in the community?



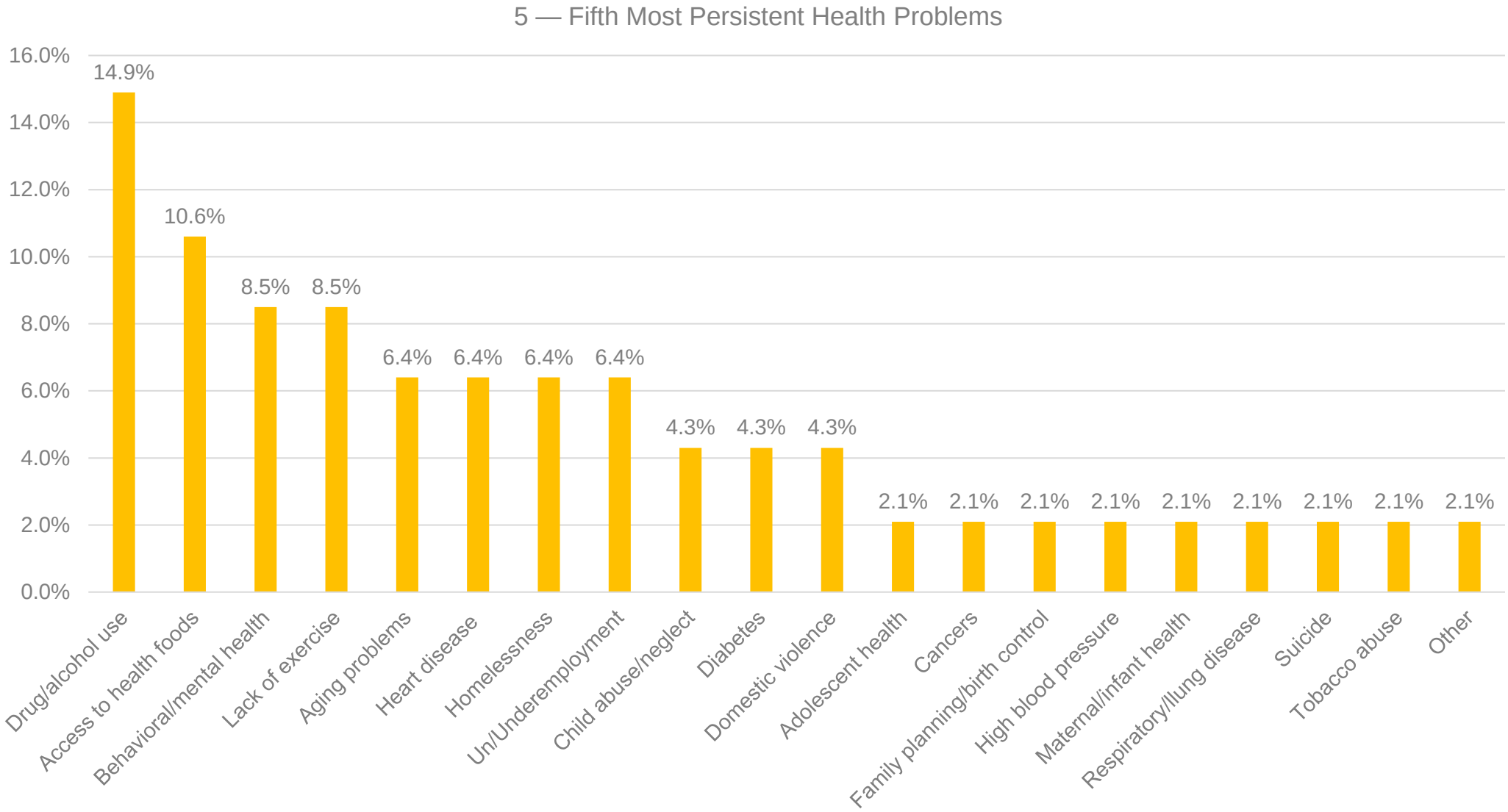
Top 5 persistent “Health Problems” in the community?



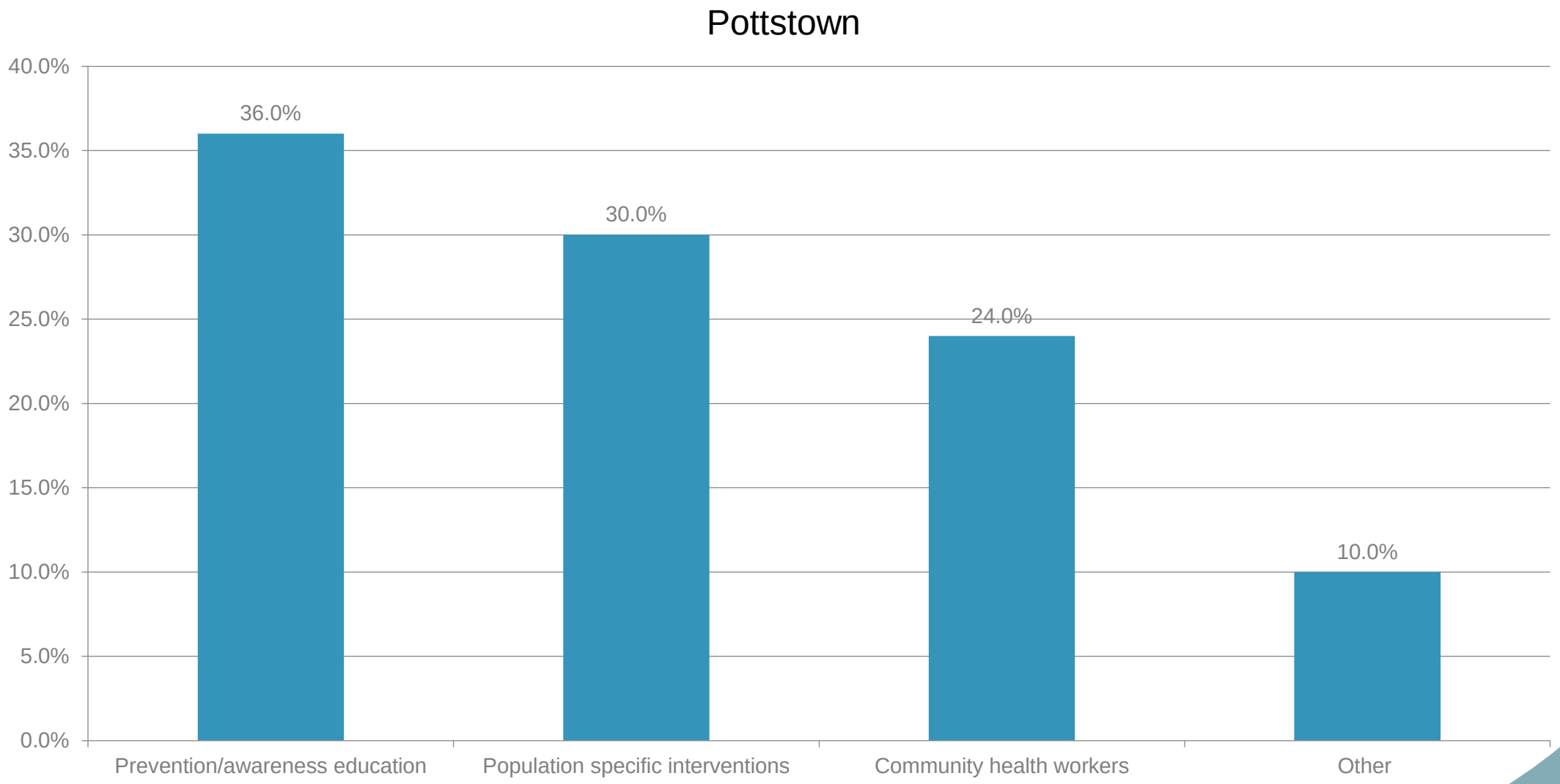
Top 5 persistent “Health Problems” in the community?



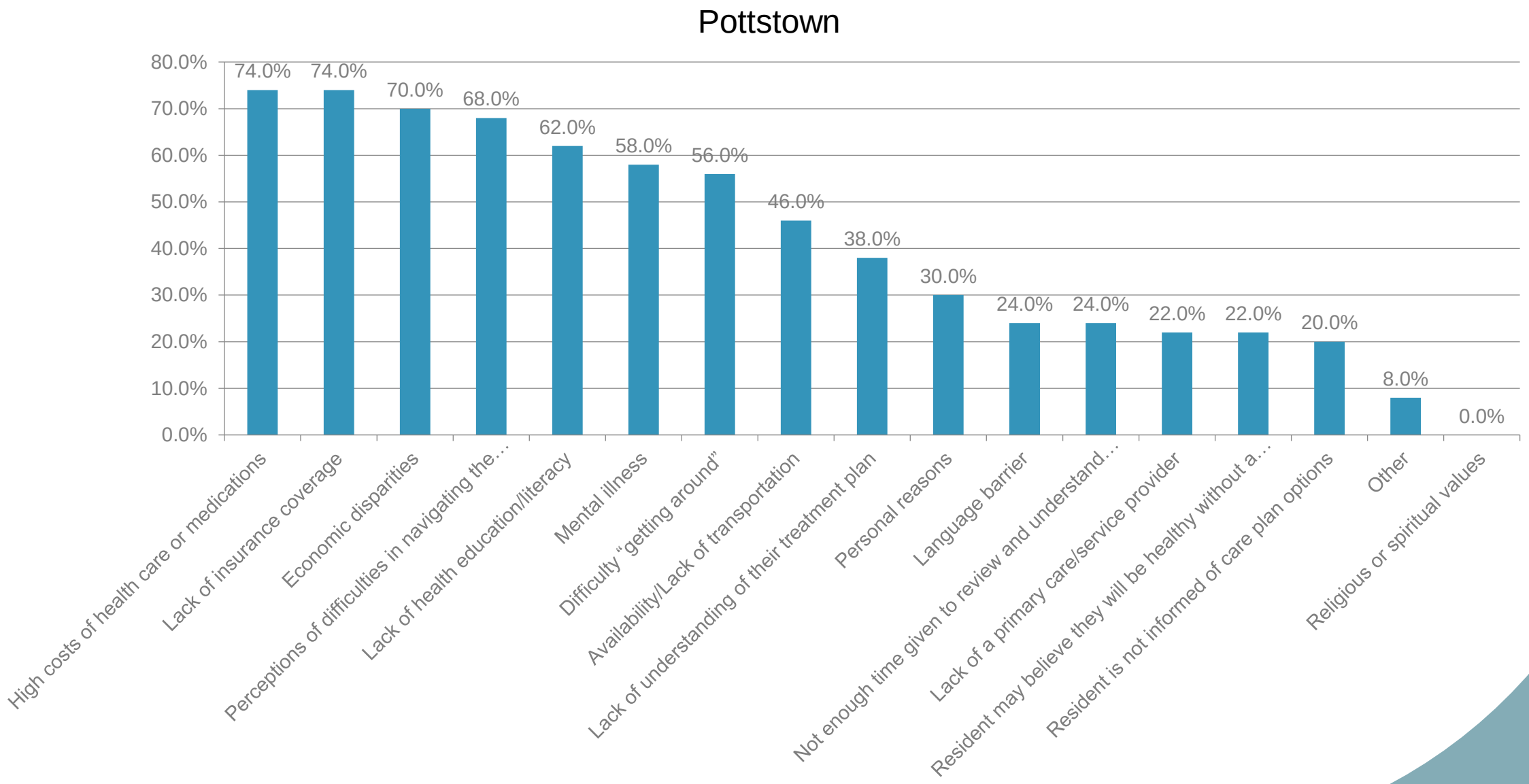
Top 5 persistent “Health Problems” in the community?



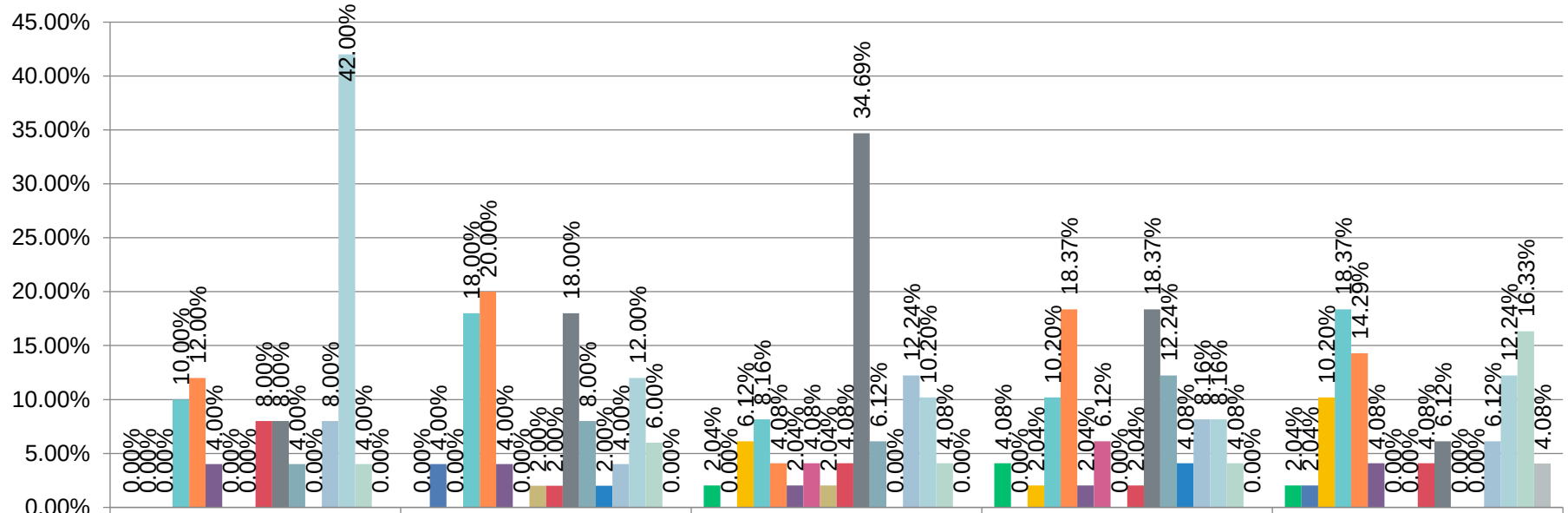
Type II diabetes, pre-diabetes and obesity affects many members of our community. What can we offer the community to achieve and maintain optimal health?



Most significant barriers to improving health and quality of life – Check all that apply

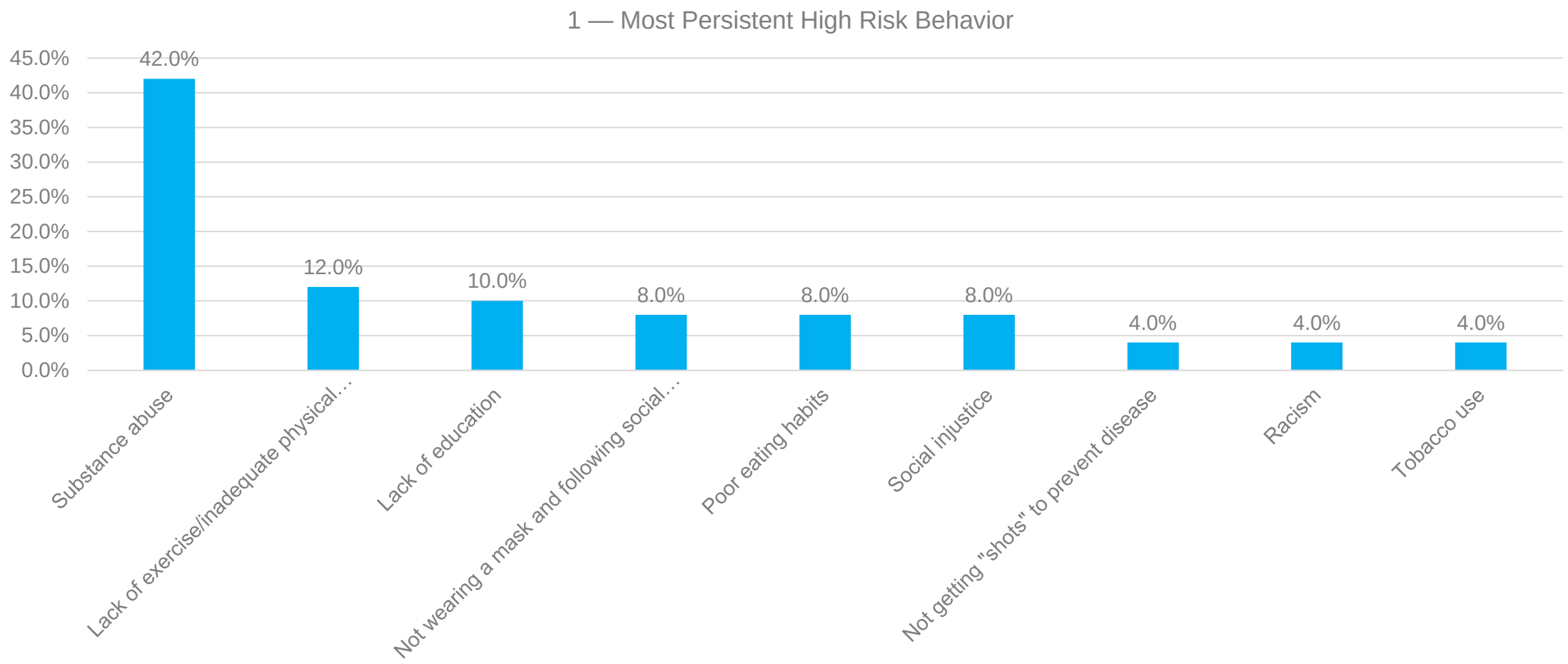


Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important

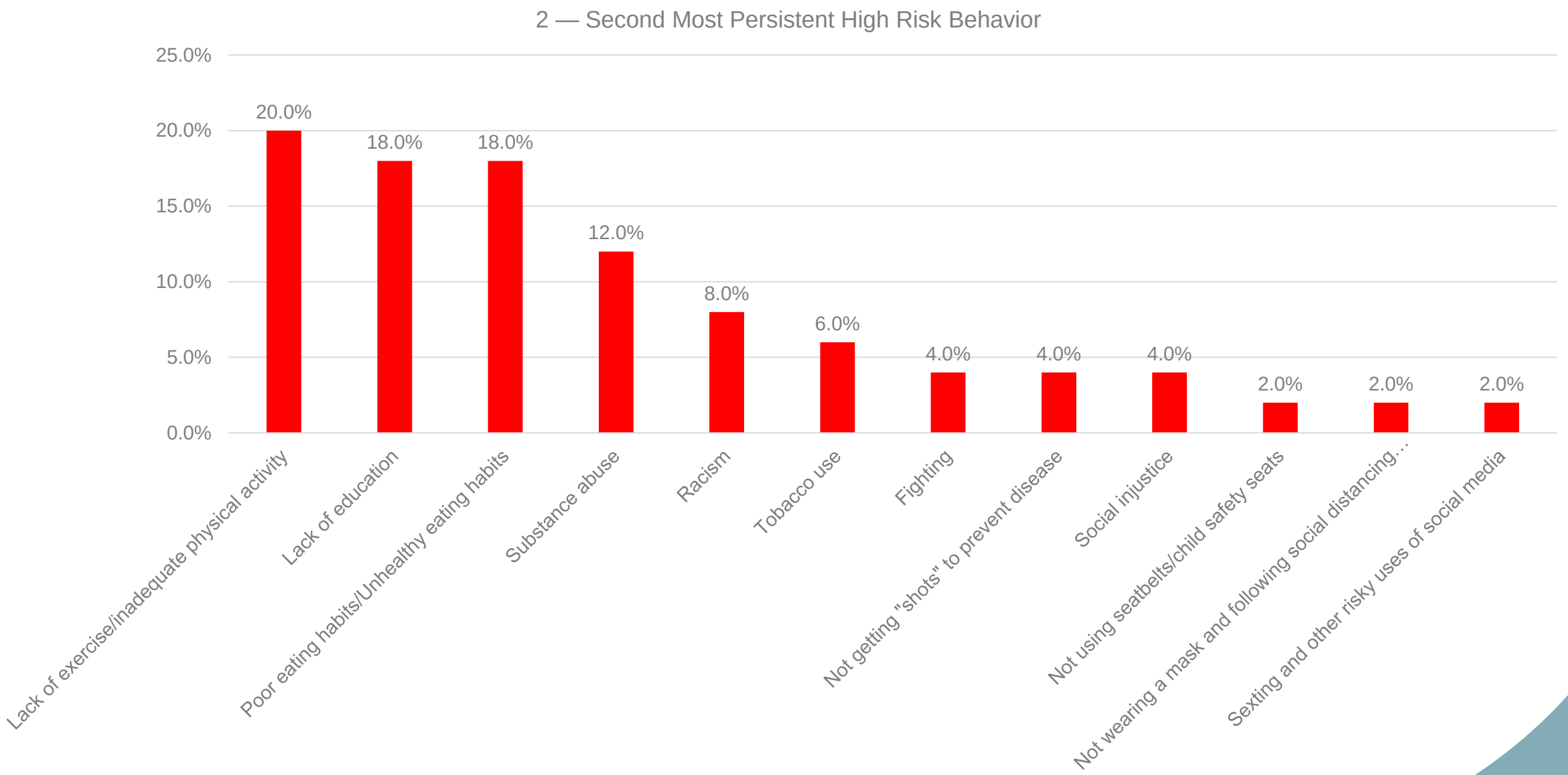


	1 = Most Important	2	3	4	5
Dangerous driving	0.00%	0.00%	2.04%	4.08%	2.04%
Fighting	0.00%	4.00%	0.00%	0.00%	2.04%
Illegal activities like trespassing or vandalism	0.00%	0.00%	6.12%	2.04%	10.20%
Lack of education	10.00%	18.00%	8.16%	10.20%	18.37%
Lack of exercise/inadequate physical activity	12.00%	20.00%	4.08%	18.37%	14.29%
Not getting “shots” to prevent disease	4.00%	4.00%	2.04%	2.04%	4.08%
Unsafe sex/Not using birth control	0.00%	0.00%	4.08%	6.12%	0.00%
Not using seat belts/child safety seats	0.00%	2.00%	2.04%	0.00%	0.00%
Not wearing a mask and following social distancing guidelines	8.00%	2.00%	4.08%	2.04%	4.08%
Poor eating habits/Unhealthy eating habits	8.00%	18.00%	34.69%	18.37%	6.12%
Racism	4.00%	8.00%	6.12%	12.24%	0.00%
Sexting and other risky uses of social media	0.00%	2.00%	0.00%	4.08%	0.00%
Social injustice	8.00%	4.00%	12.24%	8.16%	6.12%
Substance abuse (i.e., alcohol/drug abuse)	42.00%	12.00%	10.20%	8.16%	12.24%
Tobacco use	4.00%	6.00%	4.08%	4.08%	16.33%
Other	0.00%	0.00%	0.00%	0.00%	4.08%

Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



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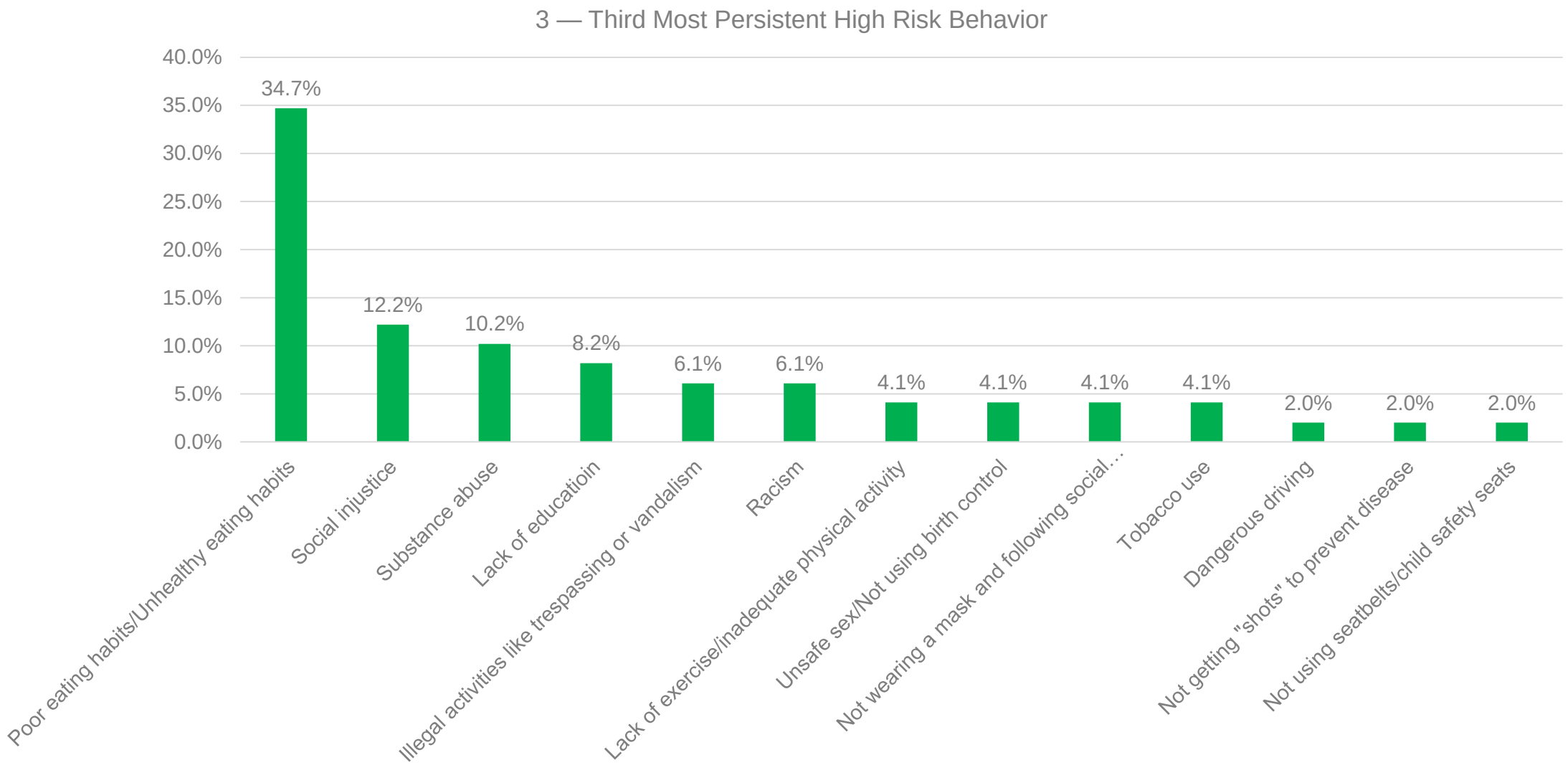
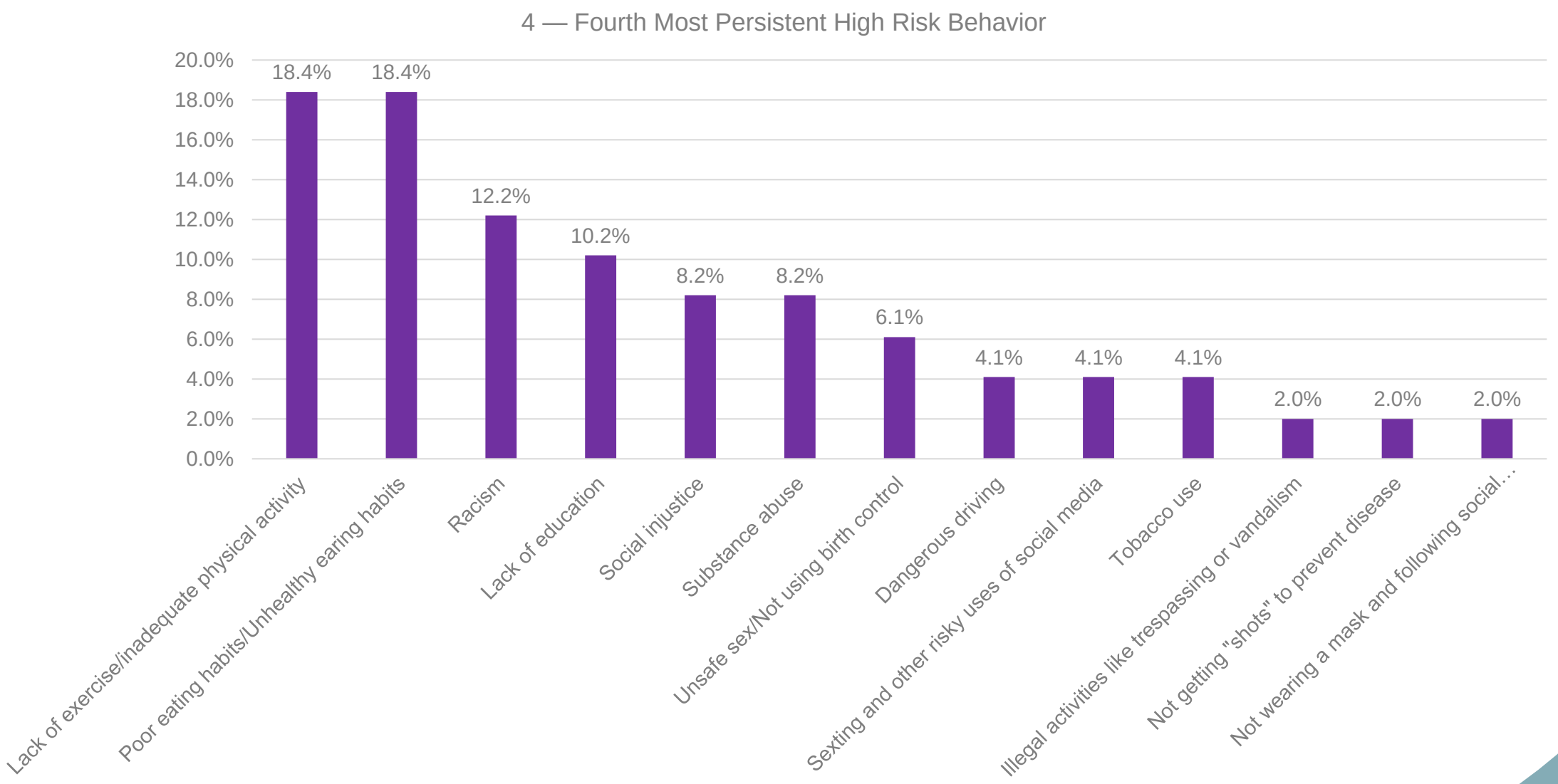


Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



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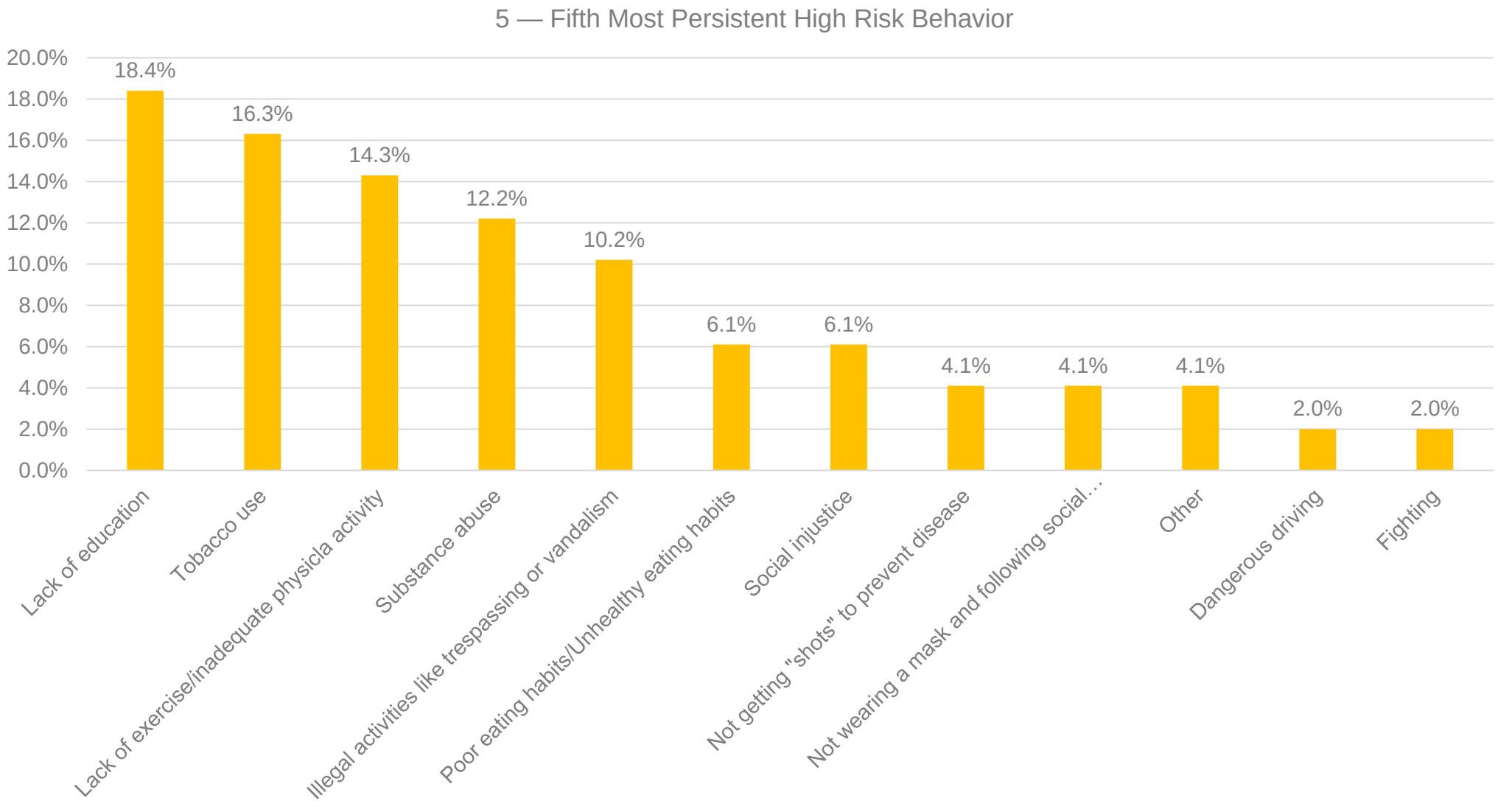
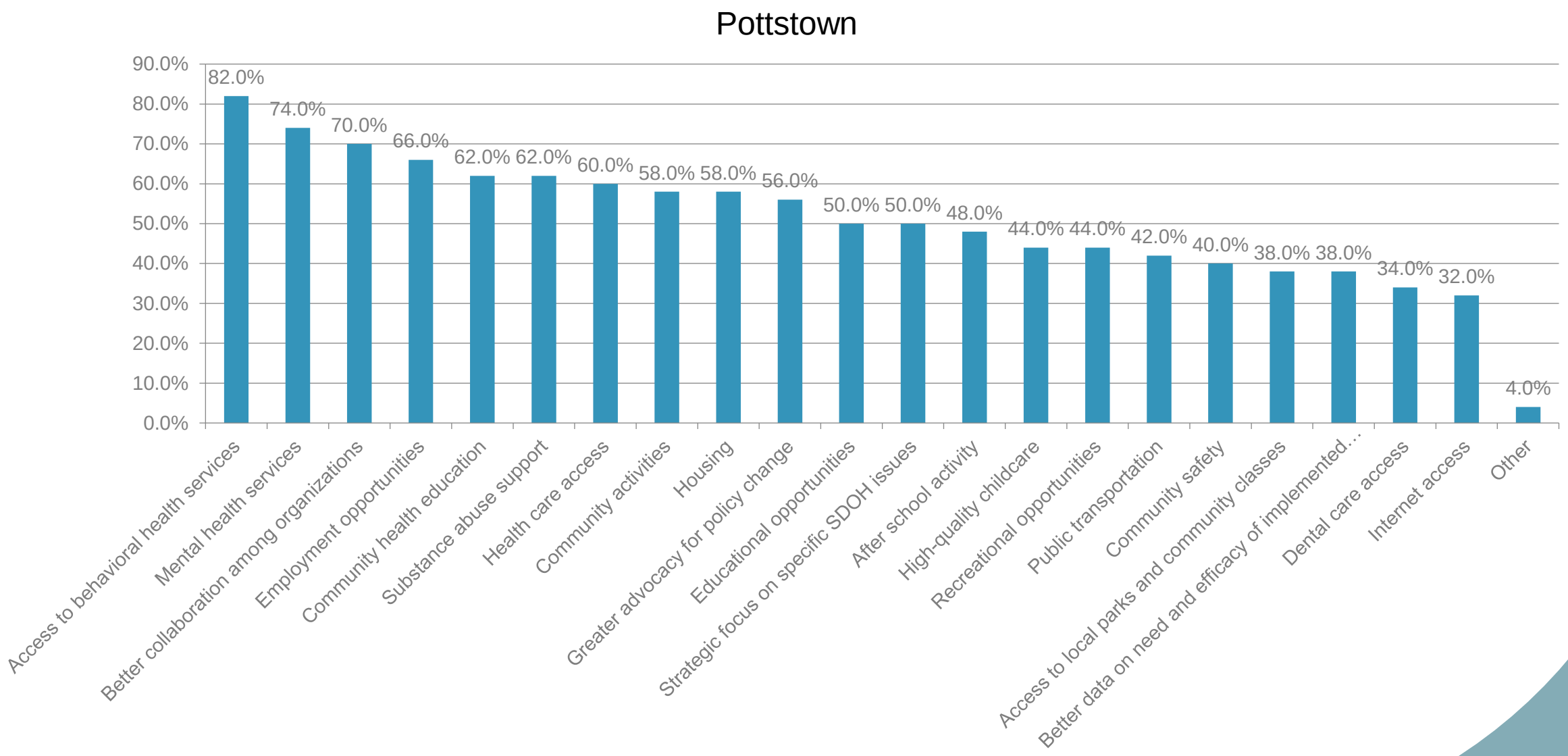
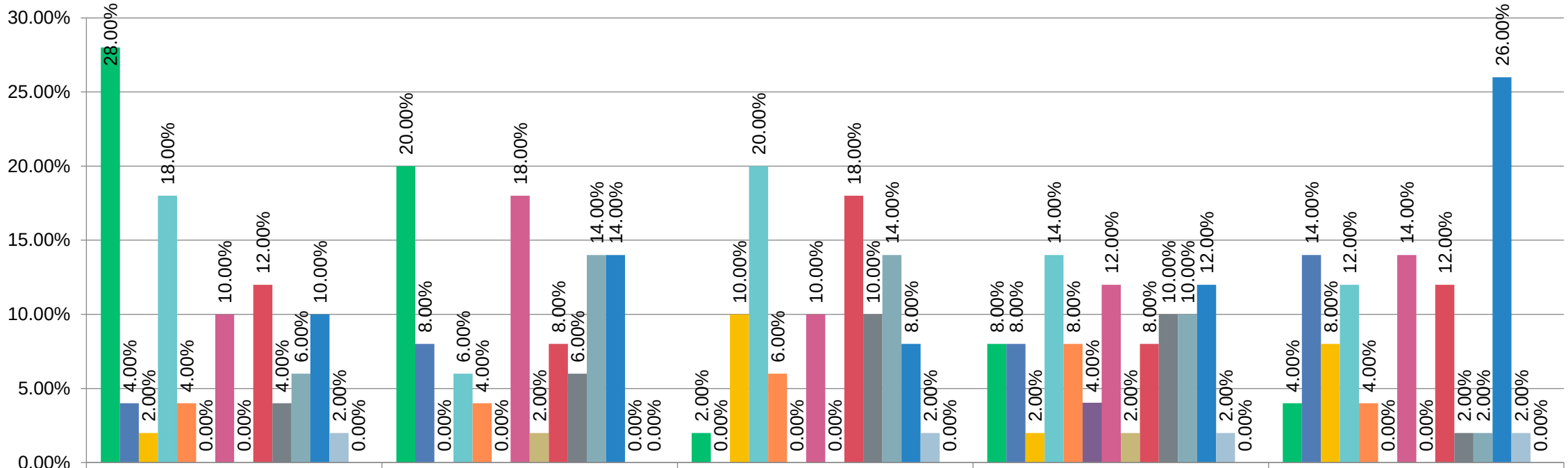


What would improve the quality of life for residents in your community? — Check all that apply

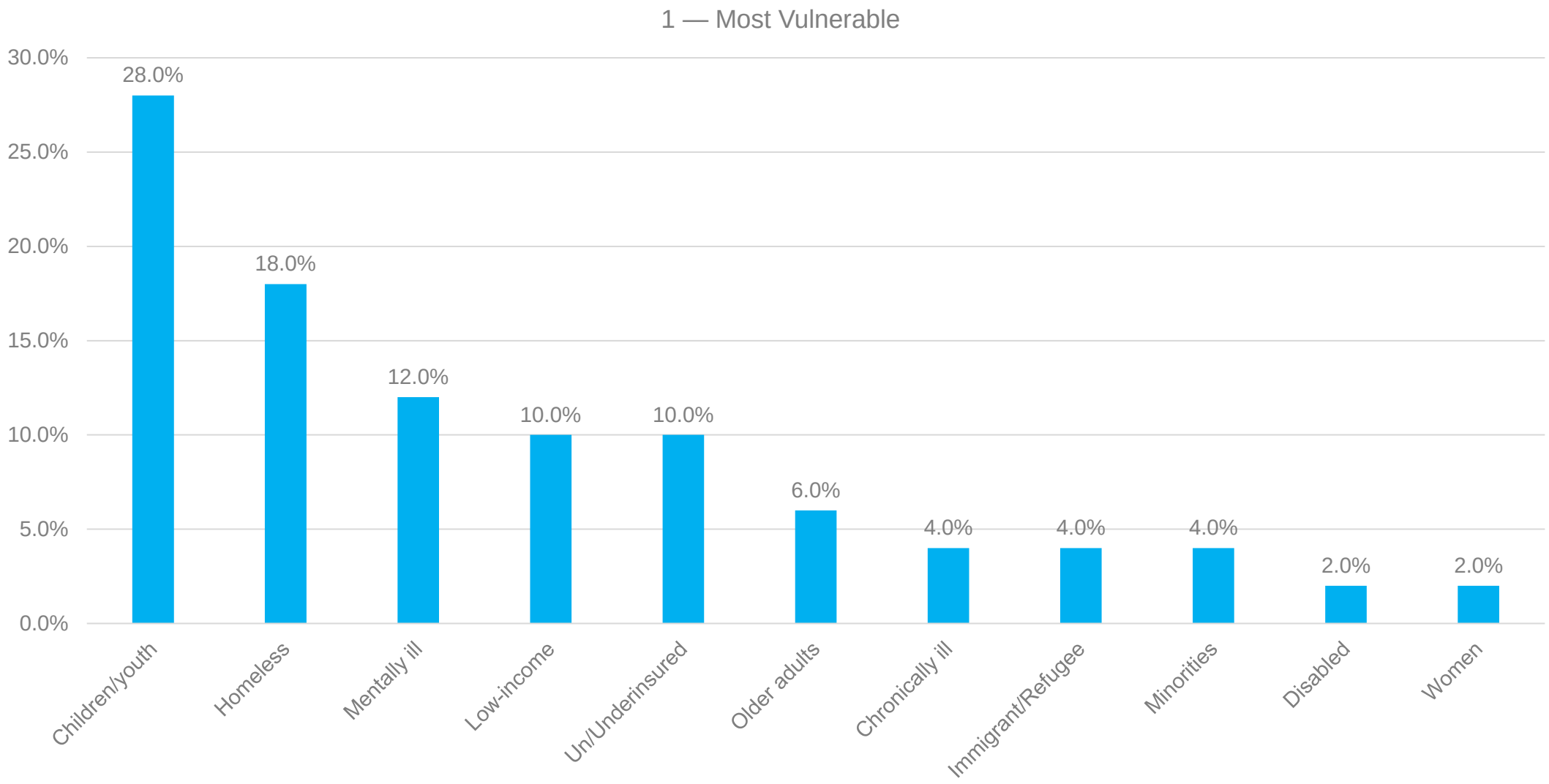


Top 5 populations that are the most vulnerable in the community?



	1 = Most Vulnerable	2	3	4	5
Children/youth	28.00%	20.00%	2.00%	8.00%	4.00%
Chronically ill	4.00%	8.00%	0.00%	8.00%	14.00%
Disabled	2.00%	0.00%	10.00%	2.00%	8.00%
Homeless	18.00%	6.00%	20.00%	14.00%	12.00%
Immigrant/Refugee	4.00%	4.00%	6.00%	8.00%	4.00%
LGBTQ	0.00%	0.00%	0.00%	4.00%	0.00%
Low-income	10.00%	18.00%	10.00%	12.00%	14.00%
Men	0.00%	2.00%	0.00%	2.00%	0.00%
Mentally ill	12.00%	8.00%	18.00%	8.00%	12.00%
Minorities	4.00%	6.00%	10.00%	10.00%	2.00%
Older adults	6.00%	14.00%	14.00%	10.00%	2.00%
Uninsured/underinsured	10.00%	14.00%	8.00%	12.00%	26.00%
Women	2.00%	0.00%	2.00%	2.00%	2.00%
Other	0.00%	0.00%	0.00%	0.00%	0.00%

Top 5 populations that are the most vulnerable in the community?



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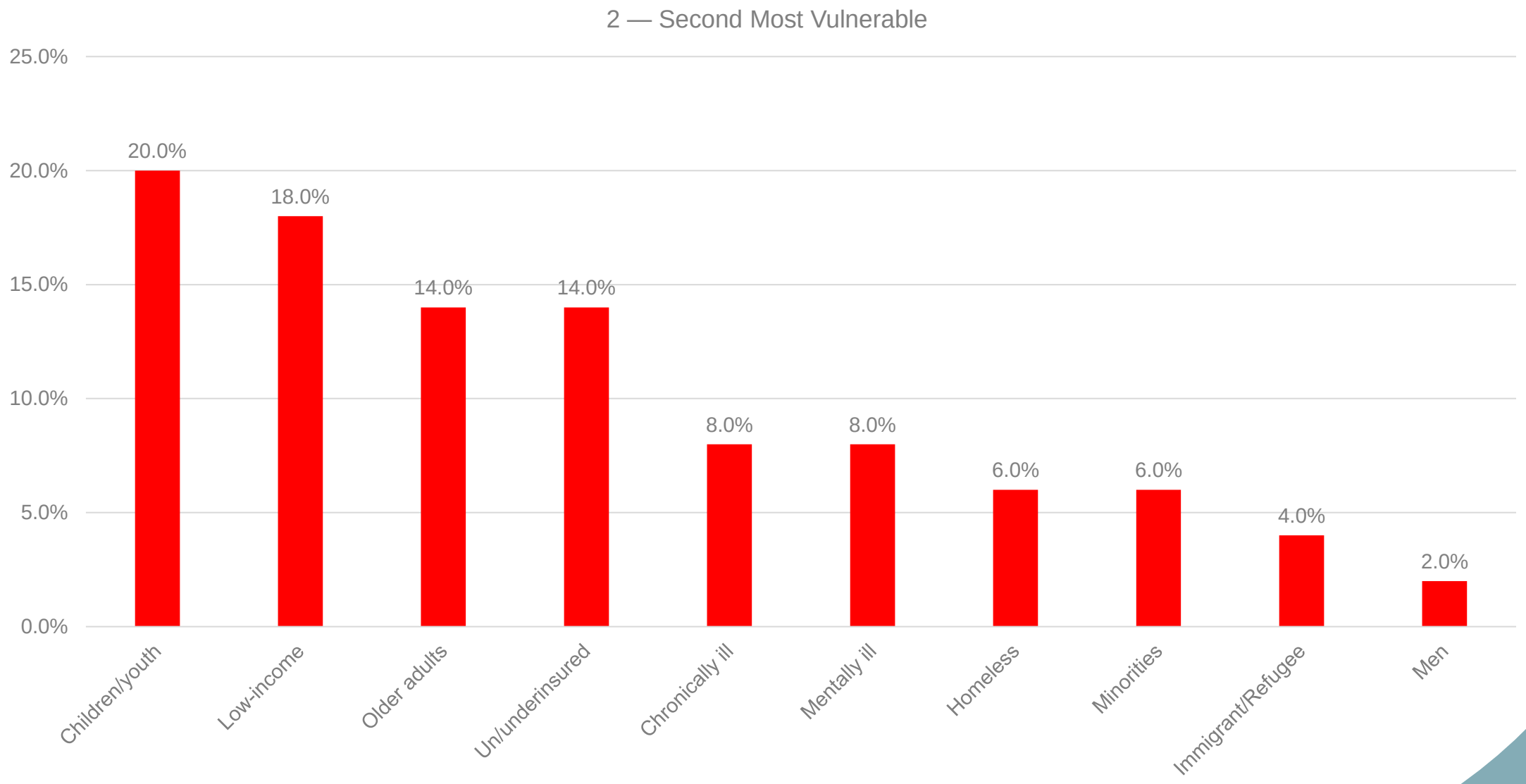

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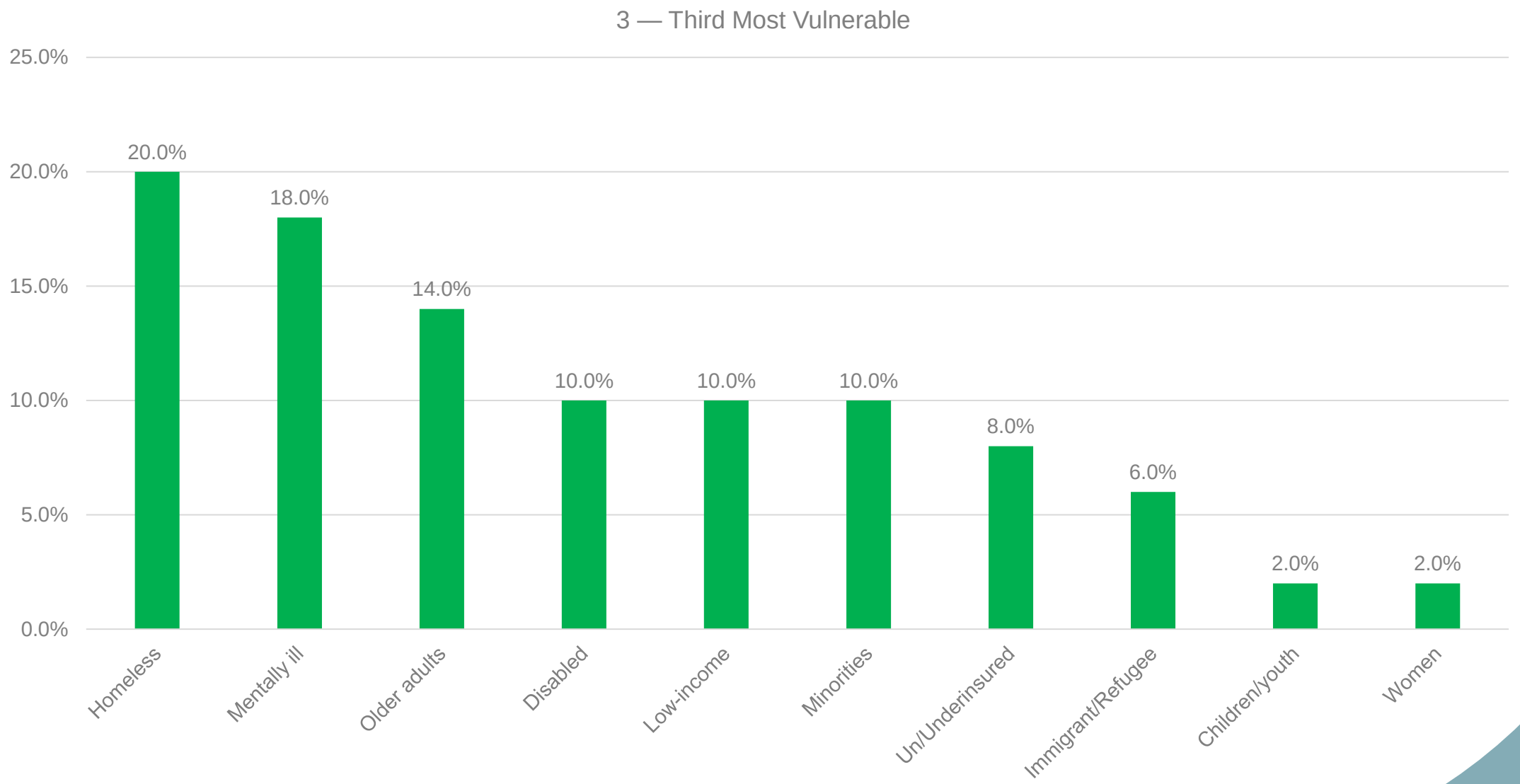

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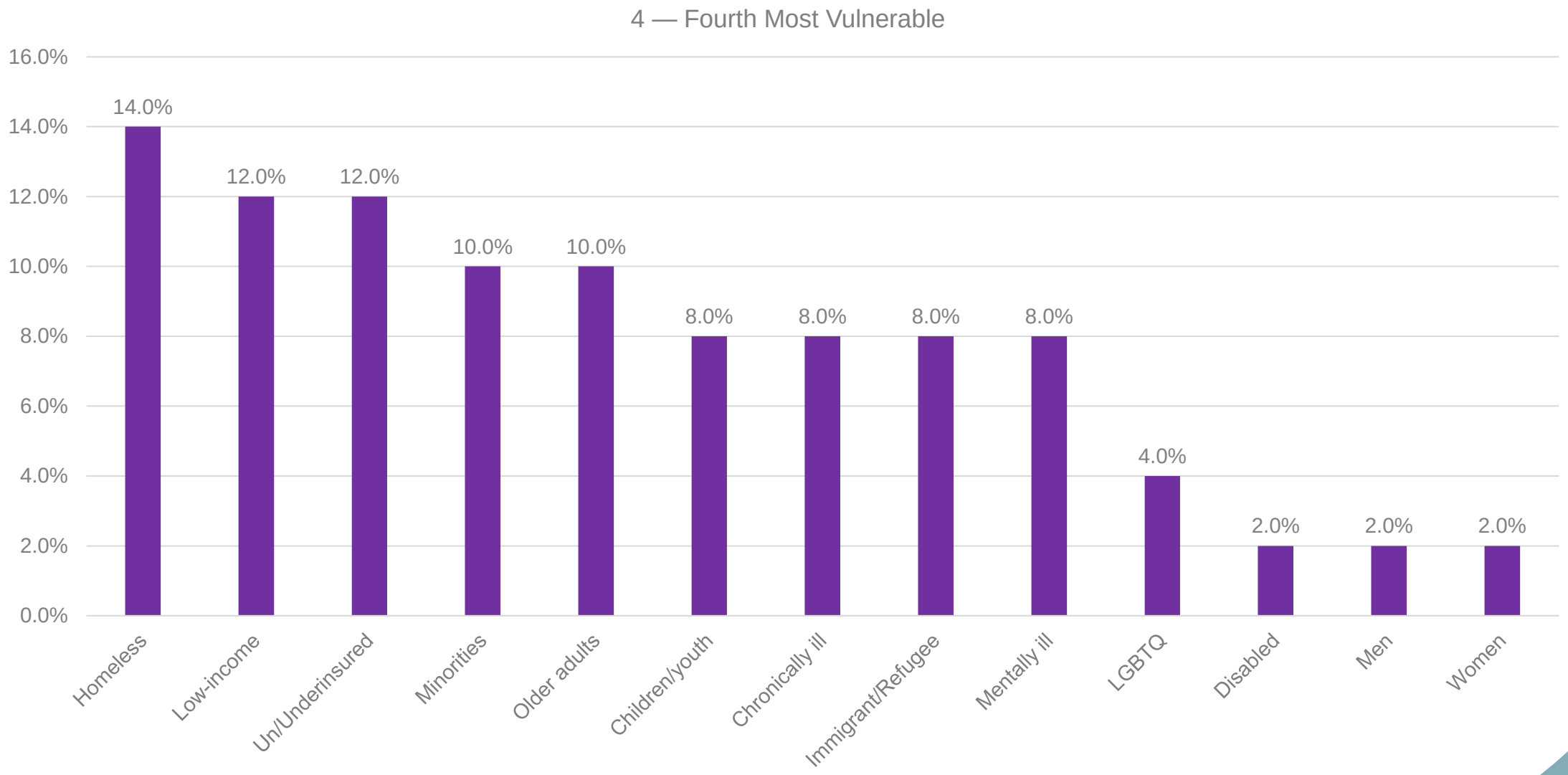

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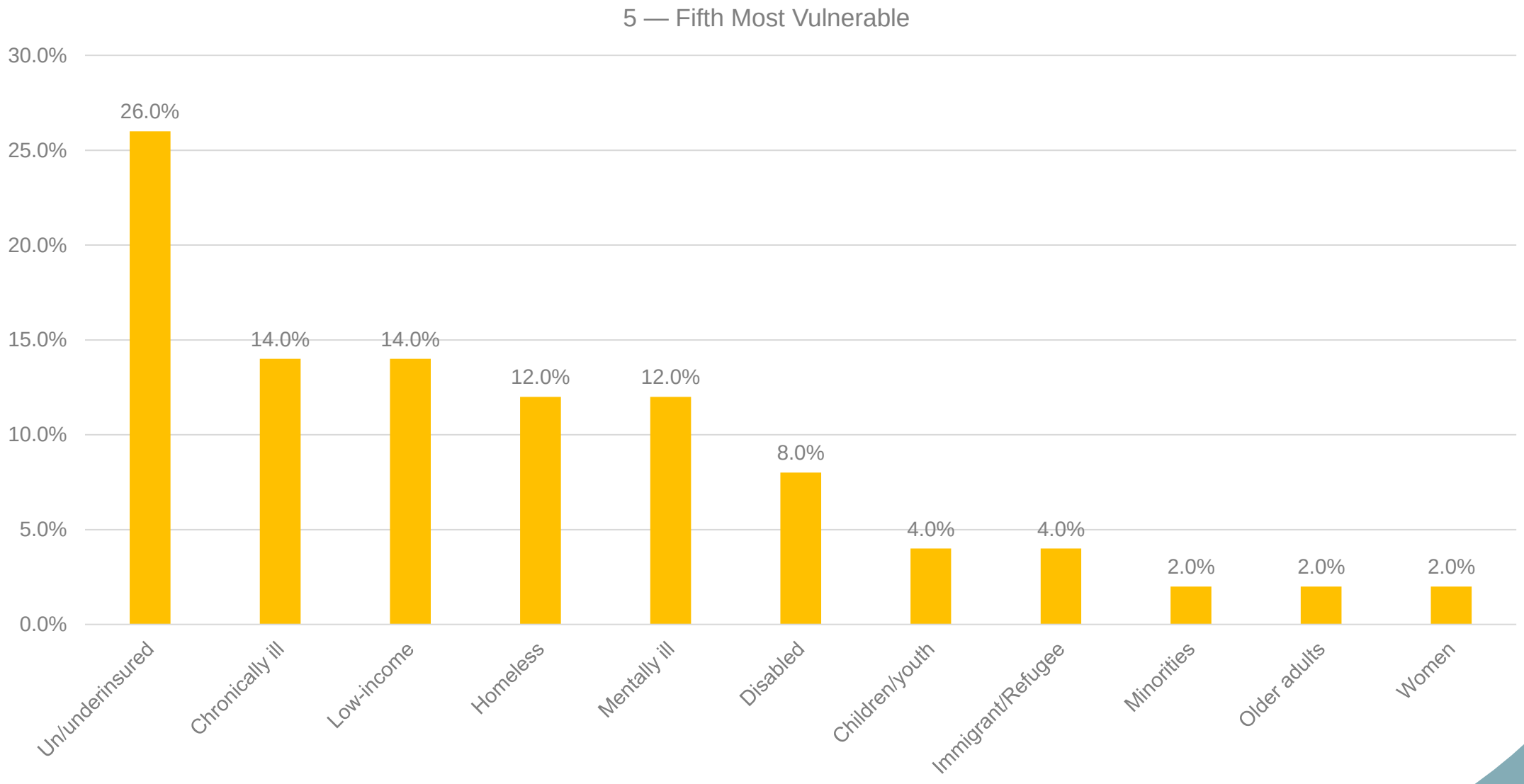
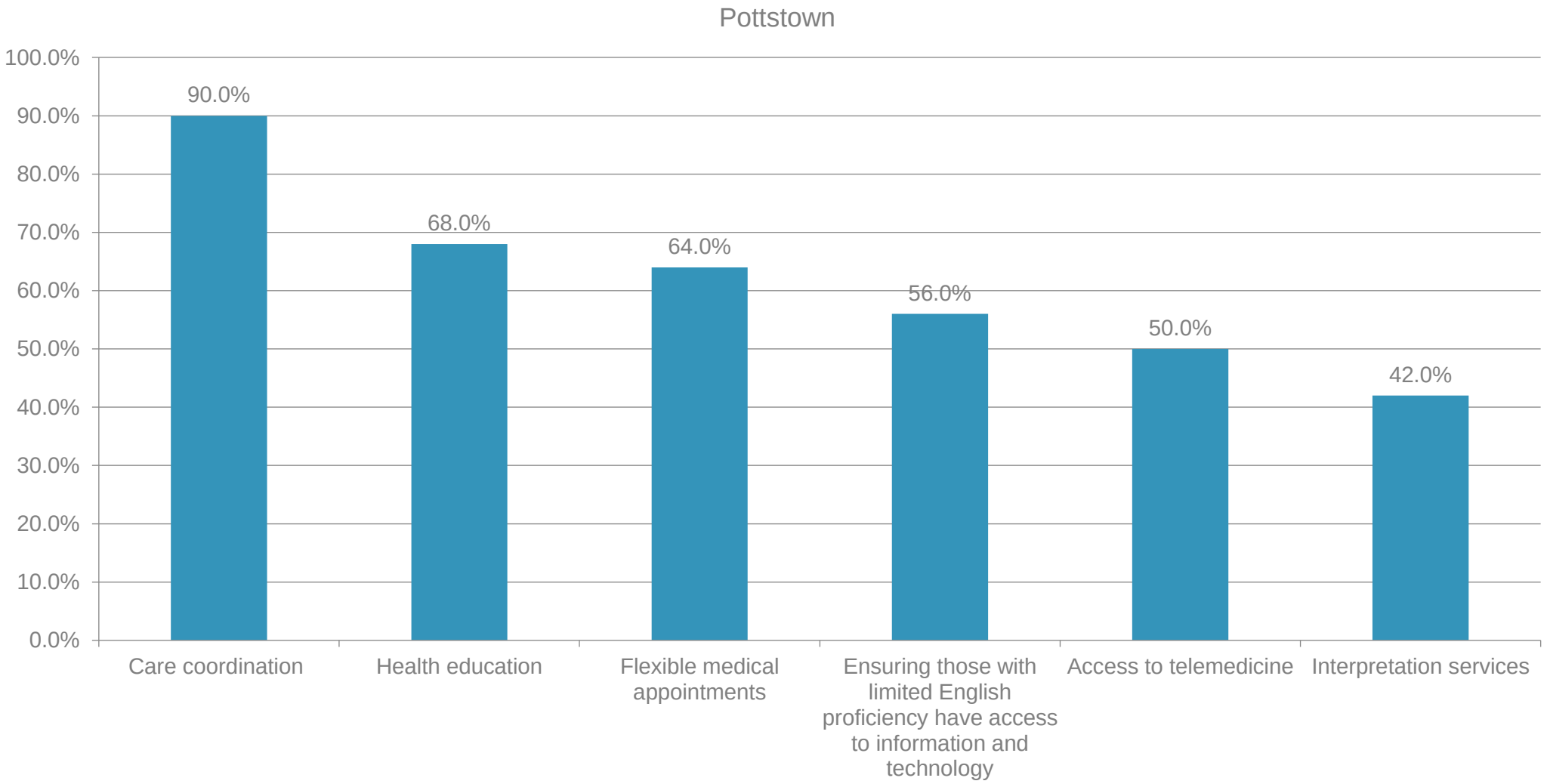
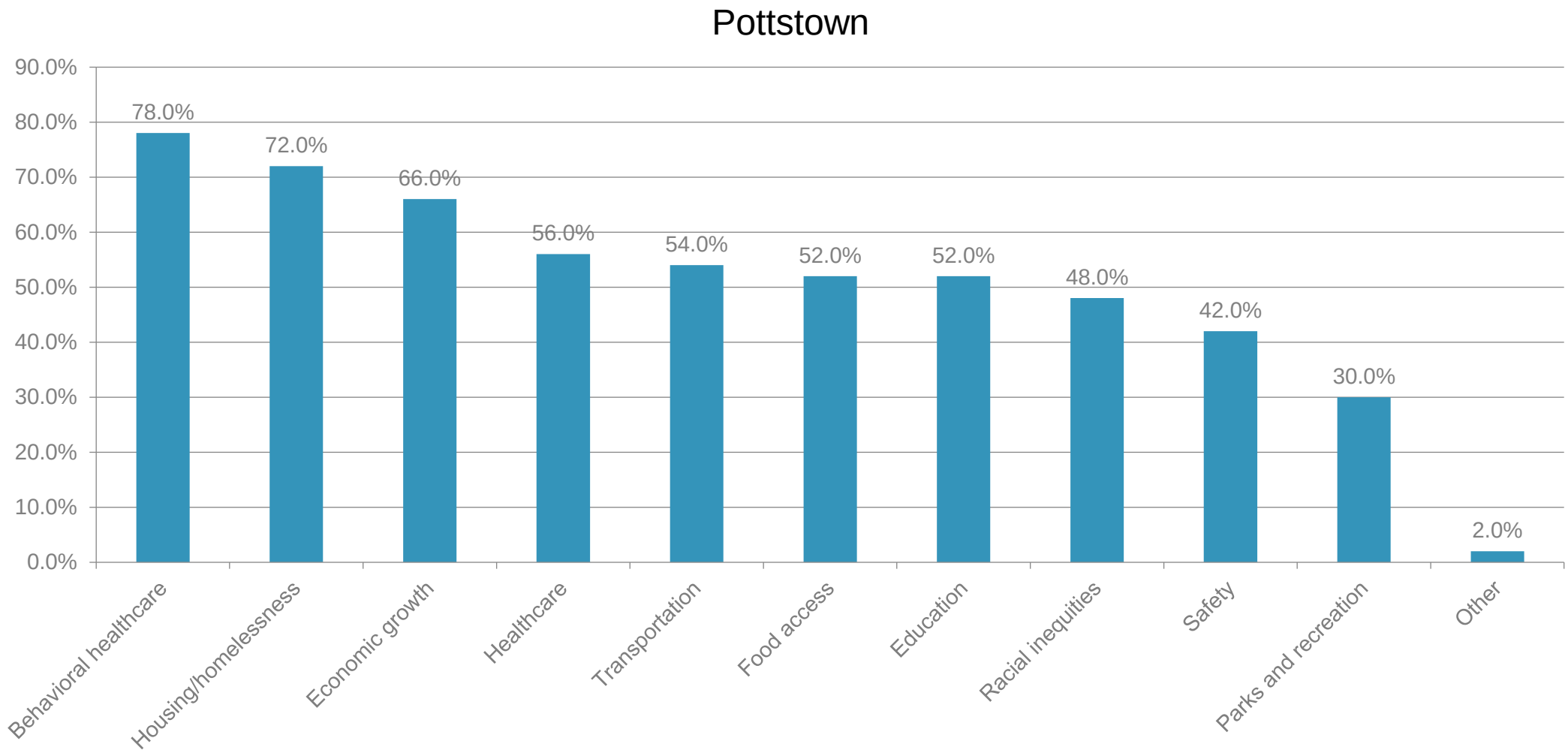


Solutions to help vulnerable populations meet their health needs — (Select all that apply)



What community needs are currently siloed and need further collaboration among non-profits, healthcare, government? (Check all that apply)



How did COVID-19 further impact care, specifically among the underserved and disenfranchised population(s)?

- Delayed care, disparities were magnified – created larger gaps, no health care maintenance due to fear, lack of trust in healthcare institutions
- Internet access impacted underserved, low-income, and other populations with no/limited technology education. Facilities that provided internet services were closed limiting connection
- Created more isolation. Saw an increase in mental illness, domestic violence, and suicide.
- Transportation issues as people did not use due to fear and limited available services
- Impacted employment and created employment loss
- Communities of color were impacted by inequitable distribution of vaccinations and other healthcare resources. Education interruptions affected these communities.
- Access to vaccine for shut-in individuals was and continues to be a major issue
- Created housing deficits with employment limitations.
- Limited services for doctors' appointments; fewer in-person visits
- Misinformation further complicated the understanding and knowledge of preventative care
- Covid spread quickly among these underserved
- Limited hospital visitations
- Underserved were at greater risk because they were front line workers
- COVID-19 exacerbated existing barriers and created new barriers for these populations.
- Community organizations that serve the underserved experienced disruption in services, and their capacity to serve was impacted
- COVID-19 eliminated many places for low-income and homeless adults to be indoors.
- The inability to accompany clients to medical appointments impacted the comprehension of the medical appointments by the clients we serve
- Lockdowns further progressed mental health, depression, suicide and drug and alcohol addictions. Seniors in facilities died, children were isolated, and suicide was evident even in elementary students
- Communities that have family members living together or socially congregating; were more high risk as this population work in high risk (front line or service orgs) jobs which presented risk in communities they live in.
- Communication with underserved communities was nearly impossible.
- Lose of job and healthcare benefits

Did telemedicine and virtual platforms ease access to care? In what way?

- Provided affordable health care access, eased care for those with internet access, knew where to go, had the knowledge and education to use platform. Effected seniors, low-income, minorities, populations that did not speak English
- Relieved travel time and created more flexibility
- Some resident so not want to use this platform
- Gave care in safety and comfort of home
- People do not trust internet conversations as there could be an improper diagnosis
- Therapy was continued as the physical office was closed
- No other outlet – gave continuity of services
- Reduced some barriers that underserved populations experience. There are some disabled individuals that benefited from this service delivery model
- Provided great access to maximize point in time care
- Allowed access to physicians; however, things were missed due to not being in-person for evaluations.
- Telemedicine helps sped up the process to get proper treatment sooner

What actions could your hospital take to better address health disparities?

- Health education and awareness to all staff and community residents.
- Enhanced Partnerships with agencies to address high priority issues.
- Continue community outreach and working with community resources. Continue with Street Medicine, access to clinics, primary healthcare providers
- Begin to coordinate with home health care providers in providing access to a wider range of medical processes, such as vaccines and other medical substances.
- Provide care coordinators for common chronic health conditions for patients to easily access.
- Work to understand why patients do not follow through with recommendations
- Bridge the gap between emergency and primary care.
- Make it easier for underserved communities to navigate the use of the hospital.
- Advocate, support, and fund community collaboration such as community gardens, time banking, free food movements, and neighborhood organizations. Ensure employees are a reflection of the community such as people who have disabilities, POC, the LGBTQ community, and other minority groups.
- Offer better quality care, more insurance coverage, support universal heath care
- Prioritize mental health and healthy living practices
- Better physicians
- Working together with social agencies that can provide and help developed trusted relationships with communities of color.
- More translators available to help people understand their health situations, as well as create a sense of trust.
- Find better solutions to help the uninsured get access to care, other than primary care they are receiving in local community clinic.
- Identifying "hotspots" in the local community and formulate a targeted response.
- Help middle class people who have insurance, but high deductibles or co-insurances.
- Better access to outside agencies; More consistent community education and wellness programming.
- Set up a community station in the community. The hospital is out of reach for many people who don’t drive.
- More community intervention.
- Focus on trauma in childhood
- Improve on coordination of care

What actions could your hospital take to better address health disparities?

Continued from previous…

- Develop infrastructure to collect and disseminate data needed to understand and address health disparities. Focus on reporting access and equity data relevant to internal and external barrier reduction benchmarks that have been/will be identified by specific vulnerable populations and their support systems. The data and implementation of this data towards treating historic inequity will serve to guide the hospital in its effort to improve the quality care delivered to the community it serves, improve community trust through intentional transformation transparency, and help community partners understand and potentially build around/support the hospital efforts.
- The provision of implicit bias training for healthcare professionals. Other trainings should focus on cultural competency and accessibility. Utilize available communication technology to better support patient care and being aware of those technologies that may increase barriers to patient care. Many individuals have this barrier. Technology is a barrier to older adults, low-income, hearing impaired and others creating internal and external benchmarks with disabilities. A direct investment in partnerships in the community with our institutions, business community, and nonprofit community in areas of high chronic disease to increase access to healthcare. Strategic placement of healthcare facilities and clinics within communities of need that lack knowledge of resources, access to transportation, and trust in the unjust systems they find themselves dependent upon. The facilities and programs should be both managed and staffed by people from the community they serve. Provide sensory friendly spaces for those that would benefit from this support, such PTSD or Autism. Peer-based systems navigators for community members, and community navigators for providers (to ease cultural competency barriers). An investment of employee time and hospital funds in the support of/development of collaborations which, through robust and ongoing stakeholder engagement (including provider clients representing vulnerable populations), will steer the development and implementation of practices which will increase healthcare access throughout areas of high chronic disease.

Excluding healthcare, what organizations should collaborate to address behavioral health in our community?

- Access Services, Creative Health, Progressions, Holcomb
- Churches, religious institutions, faith-based
- Civic organizations, service organizations and clubs
- community health and dental
- Community healthcare providers, health providers
- Creative Health Services
- Creative health
- Family Services
- Food banks
- Government/county services, city planners
- Health and human service organizations
- Homeless shelters
- Housing
- Mental health organizations
- Mission Kids
- Organizations that deal with racism as a public health crisis
- Peer support programs
- Police
- Recreation departments for mentors, jobs and internships
- Schools
- senior living/youth organizations
- Substance abuse shelters
- YMCA

What do you want the hospital to know that we haven’t already asked?

- Weave racial inequities and social justice into public health plans.
- Connect to the community and build trust as it is important for the future.
- Current negative press is deterring patients from coming to the hospital - improvements are needed.
- Getting patient to see a psychiatrist is difficult or with getting help for drugs and alcohol services.
- That just because someone which a language barrier doesn't ask, it does not mean that they do not need an interpreter.
- How does the current culture impact our most vulnerable?
- ER services need improvement.
- The hospitals has had a bad reputation for a quite some time. Smaller community hospitals tend to do better when larger health systems take over.
- More transparency and scale pricing may help people to go to the hospital before an emergency occurs
- Advertise the positive outcomes of The Cancer Center.
- Partner with education providers to prepare the local workforce for entry-level employment opportunities.
- Educate staff on more MH awareness, provide training, and recourses for where and how to discharge patients.
- Treated people like humans. People are discouraged and aren't seeking health assistance because they feel they are either ignored and not heard.
- We are very grateful for the partnership and for the community.
- The hospital should be a staple in the community for wellness, not sick care.
- More public awareness of programs.

Tower Health Pottstown Hospital

Appendix E - Community Surveys

Pottstown Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Introduction

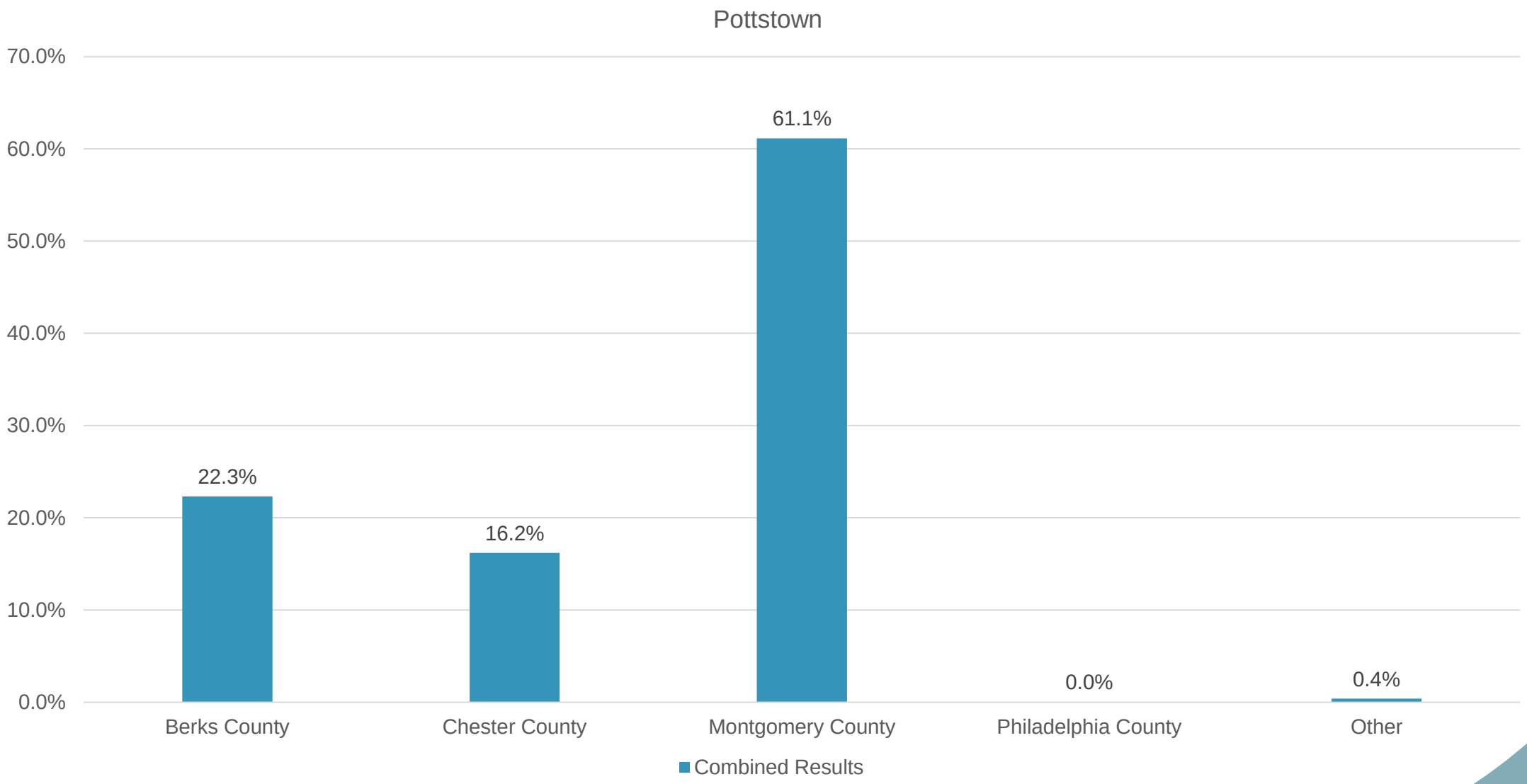
- A community survey was employed to collect input from populations within Tower Health Pottstown Hospital's service area in order to identify health risk factors and health needs in the community.
- Working with the Tower Health working group the community survey was promoted on social media platforms, newspapers, hospital websites, relationships with community-based organizations, community associations, and clinics. Hundreds of surveys were collected from community residents.

➢ The survey was accessible on Survey Monkey and available in both English and Spanish. In total, 1,063 surveys were used for analysis. 1,050 surveys were collected in English and 13 surveys were collected in Spanish.

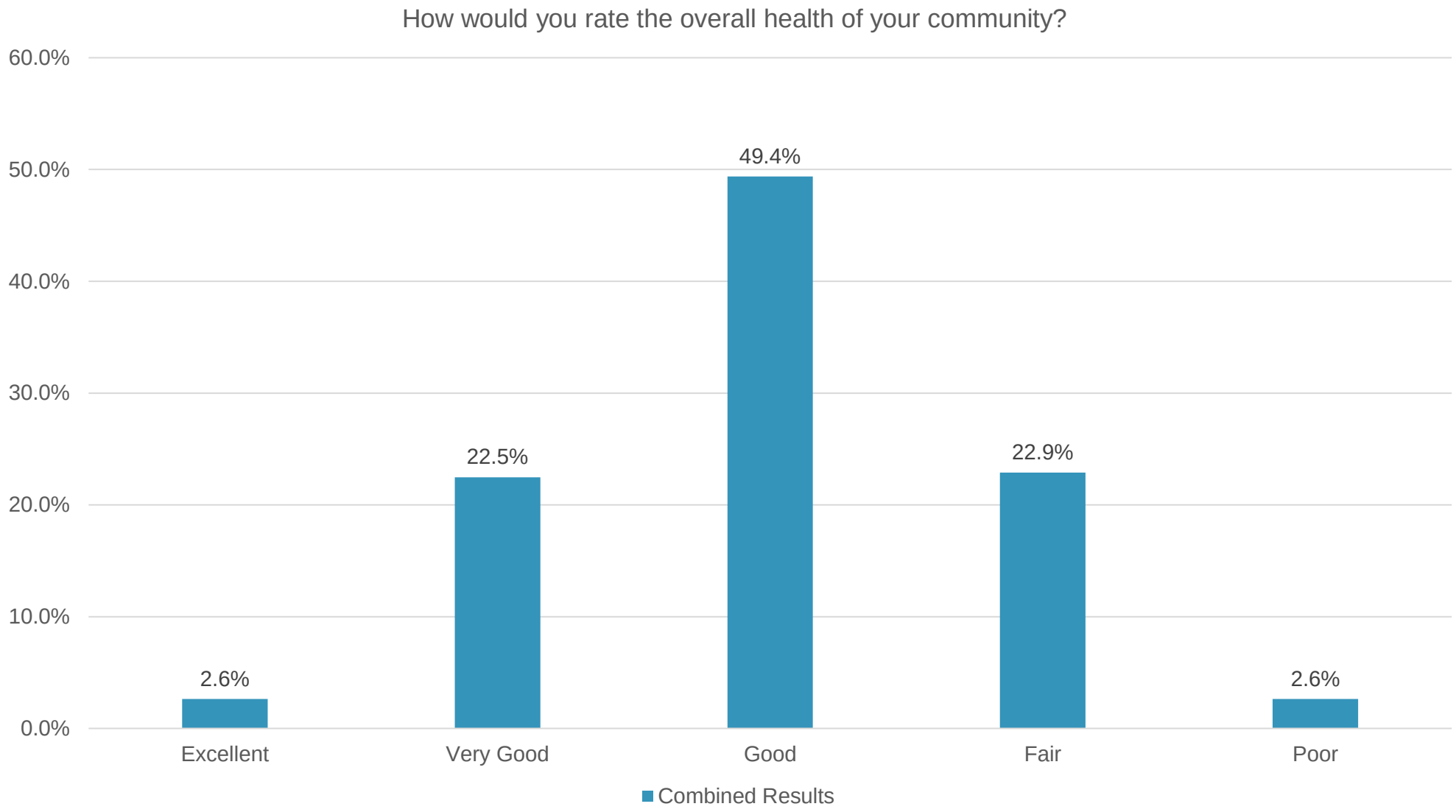
➢ The data collection period ran from July 2021 – September 2021.

Note: "Check all that apply" referenced within the PowerPoint refers to questions where the survey respondents have the ability to select more than one option/choice to the question.

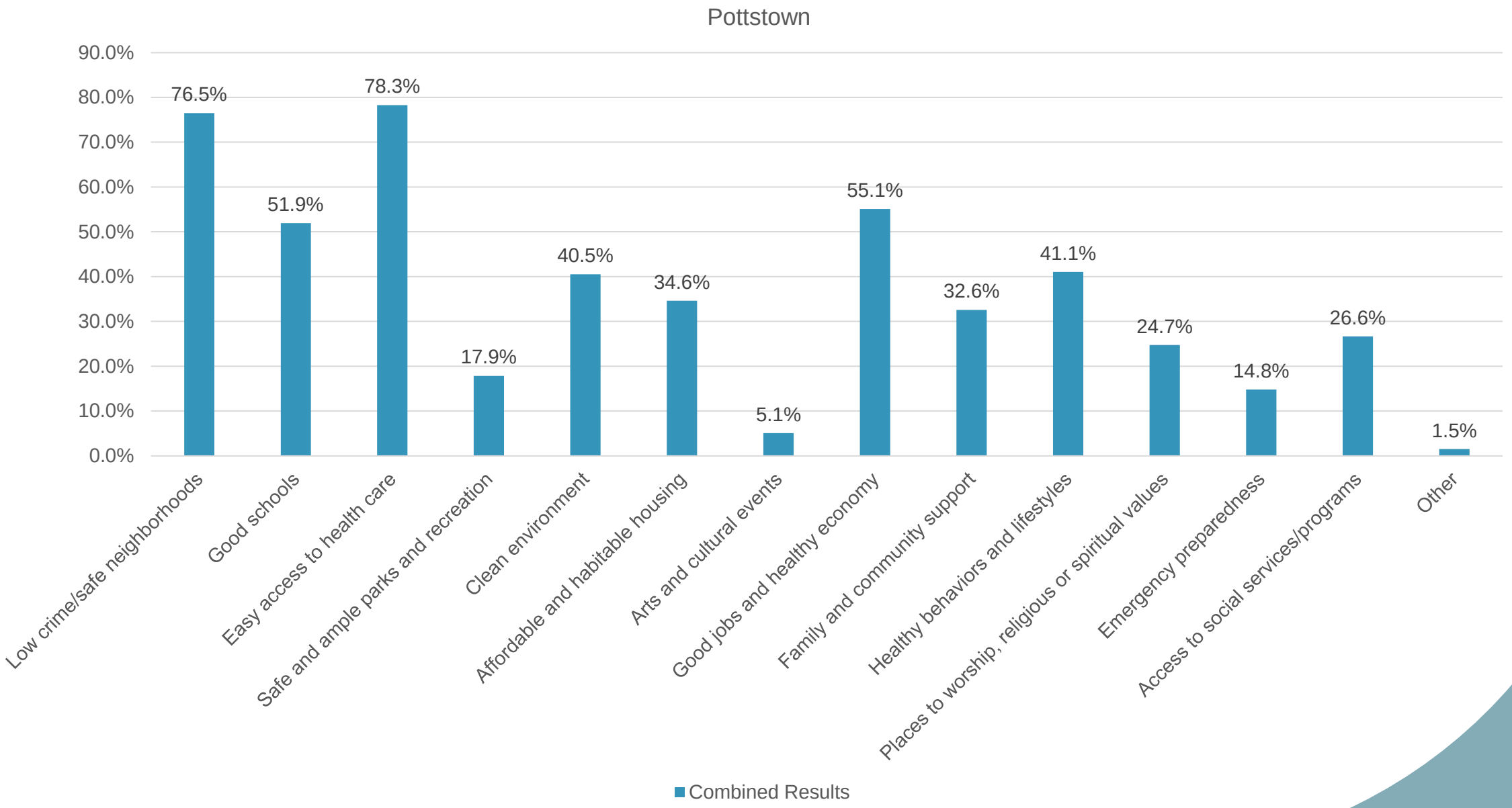
County Where Live



Rate Health and Human Services in Community



What Are the 5 Most Important Factors That Contribute to a “Healthy Community”?



Common Themes

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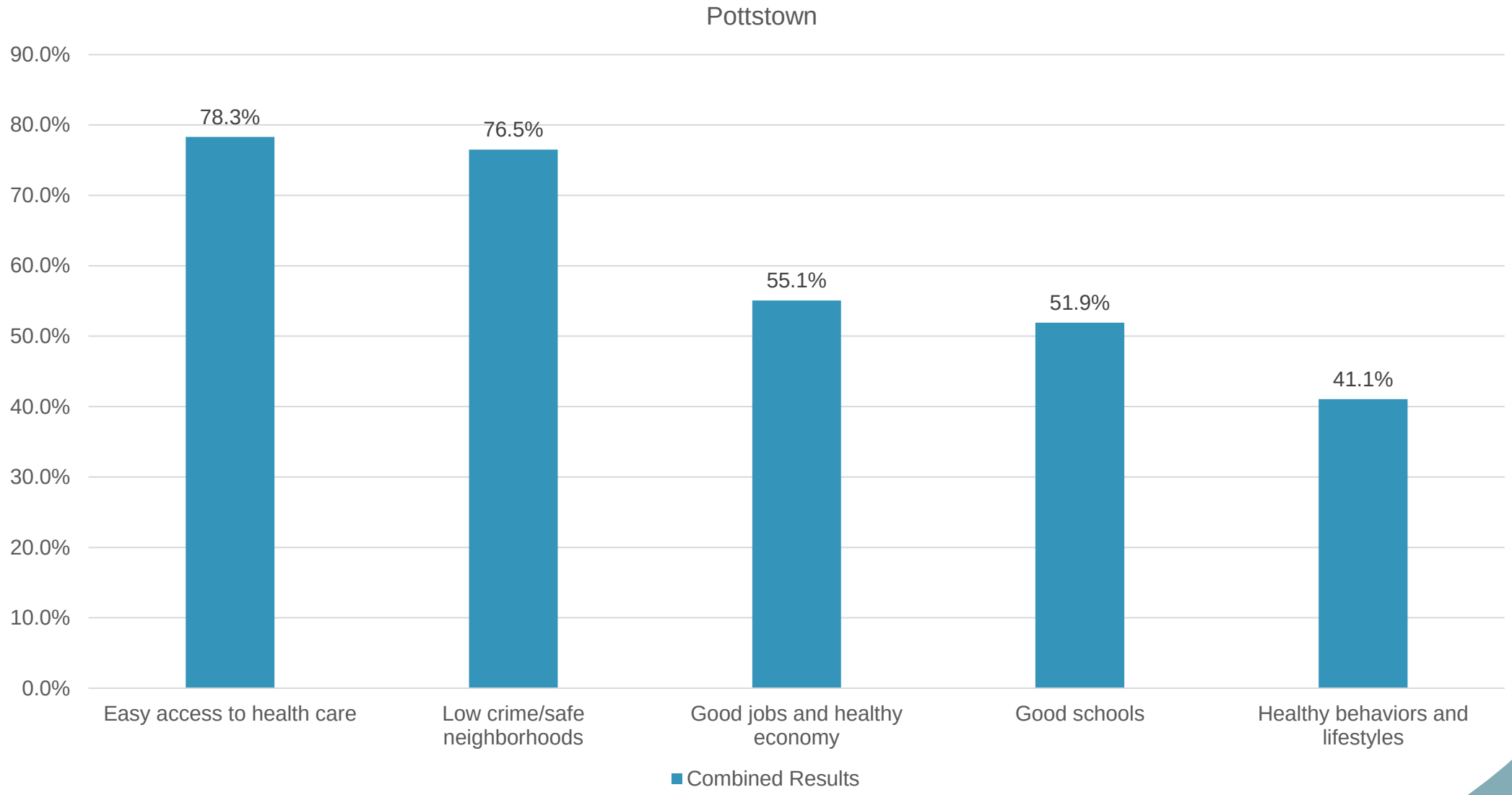
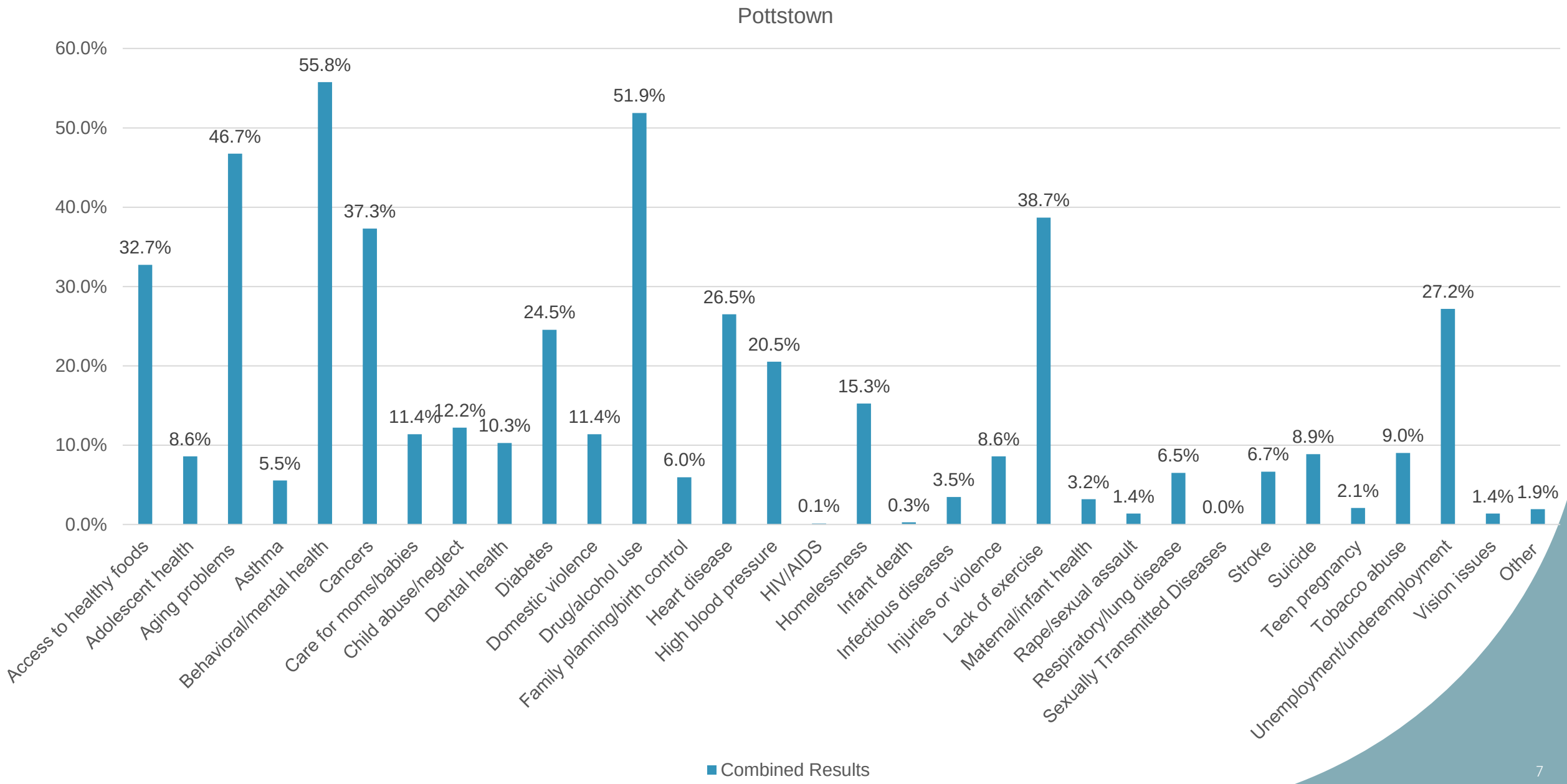


The above chart depicts the top 5 most important factors.

Top 5 persistent “Health Problems” in the community?



Common Themes
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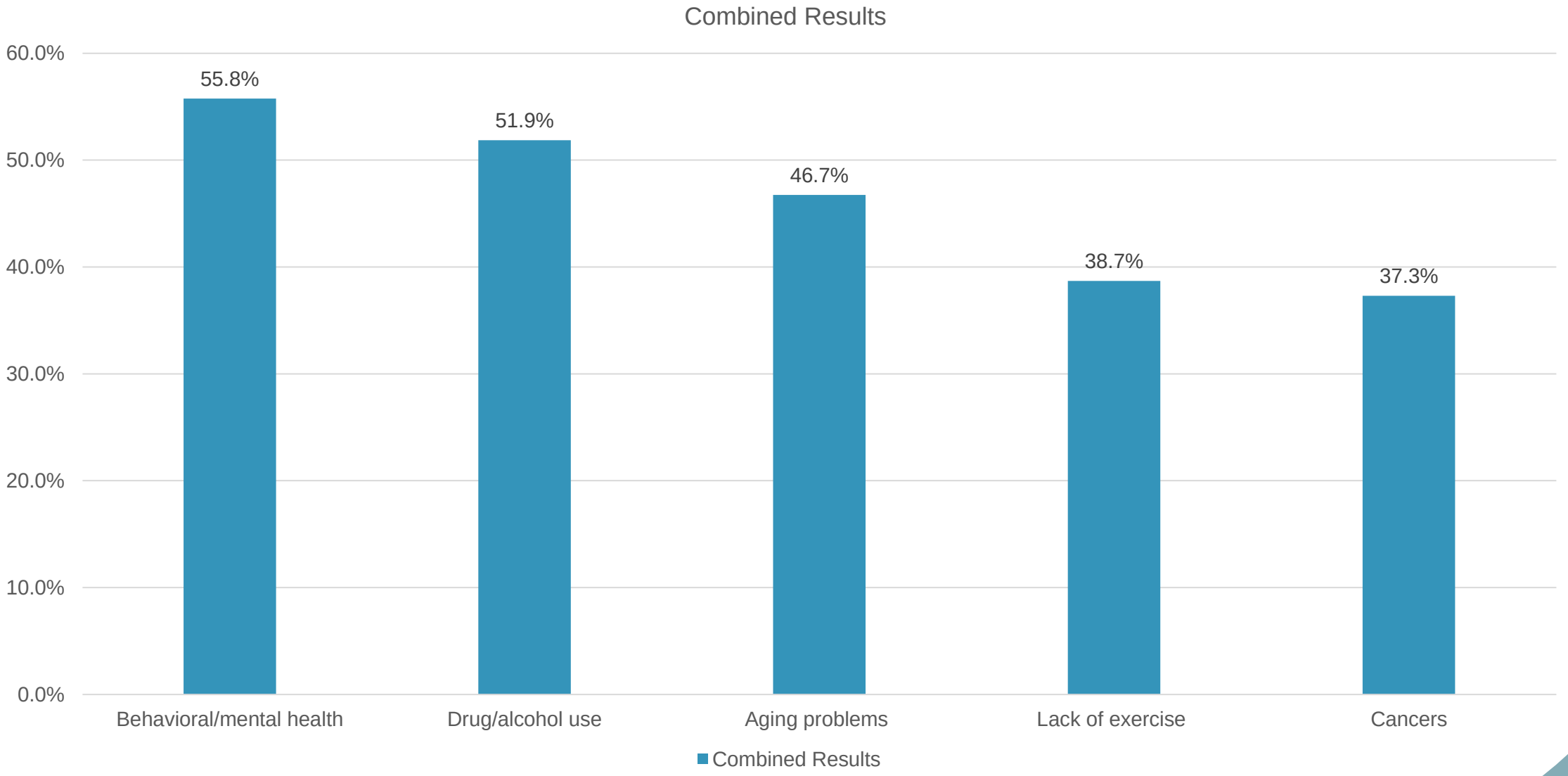
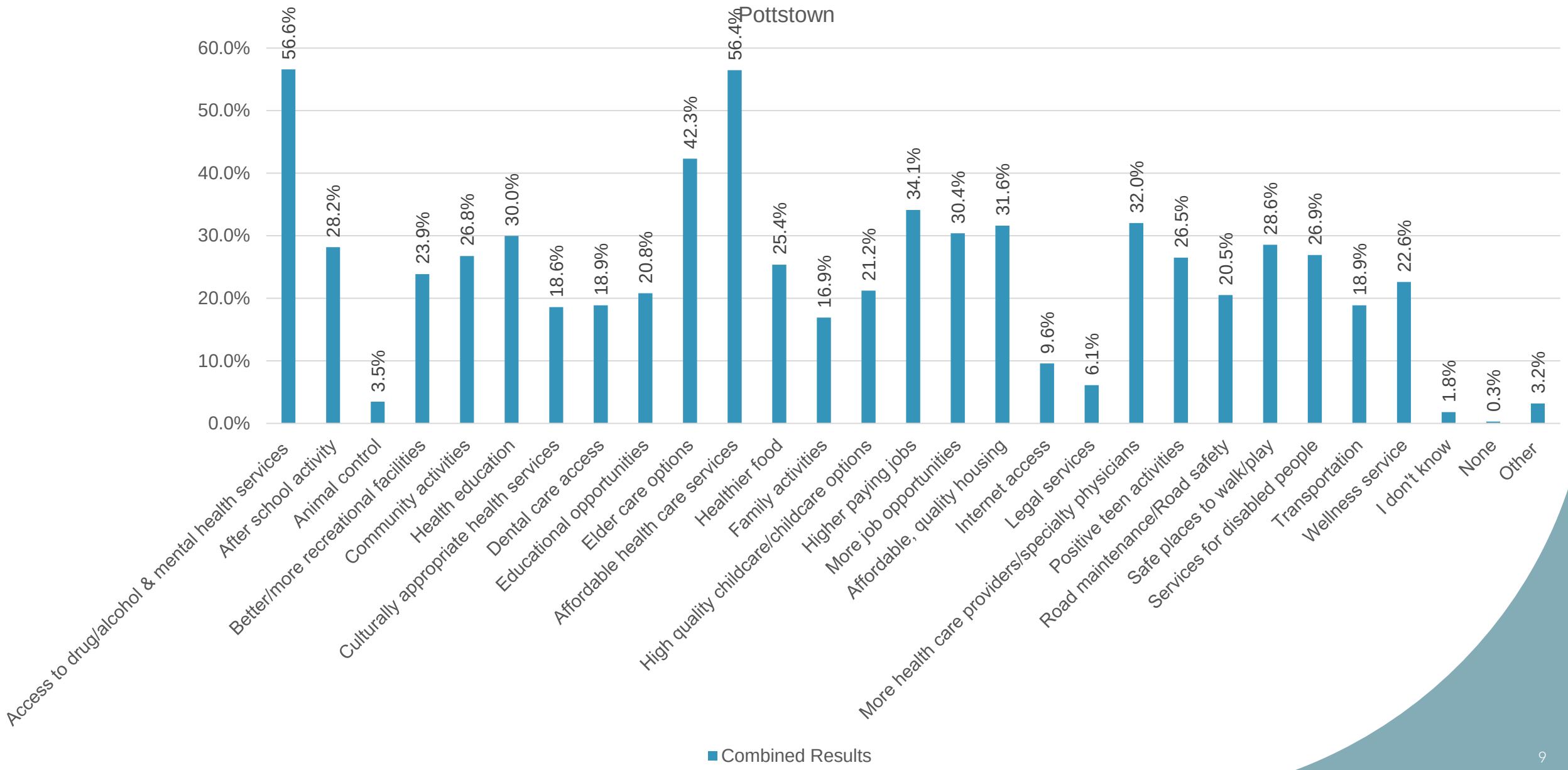


The above chart depicts the top 5 health factors.

What would improve the quality of life for residents in your community? — Check all that apply



Common Themes

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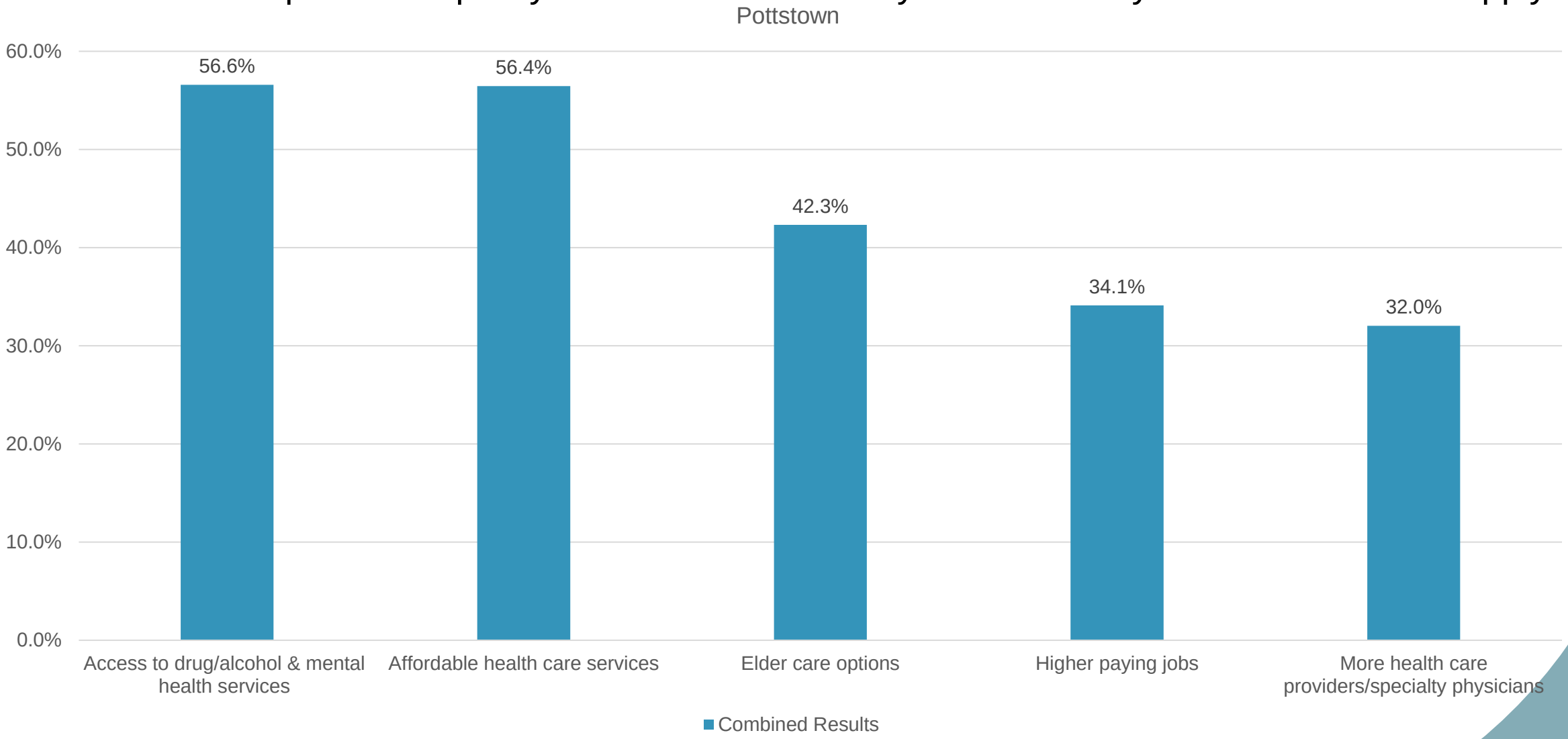
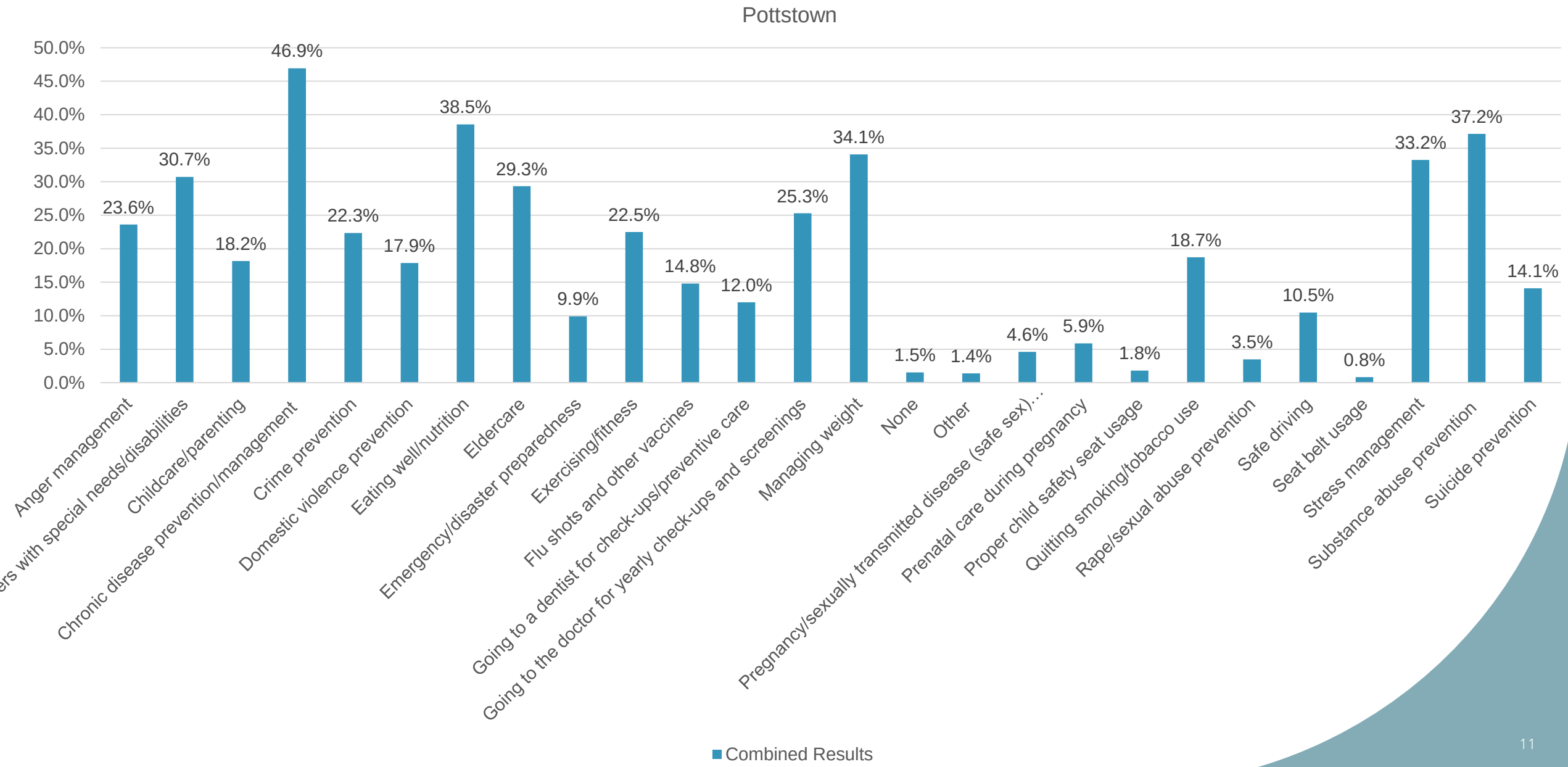


The above chart depicts the top 5 factors that would improve the quality of life for residents.

Select the Top 5 “Health Behaviors” People In Your Community Need More Information About



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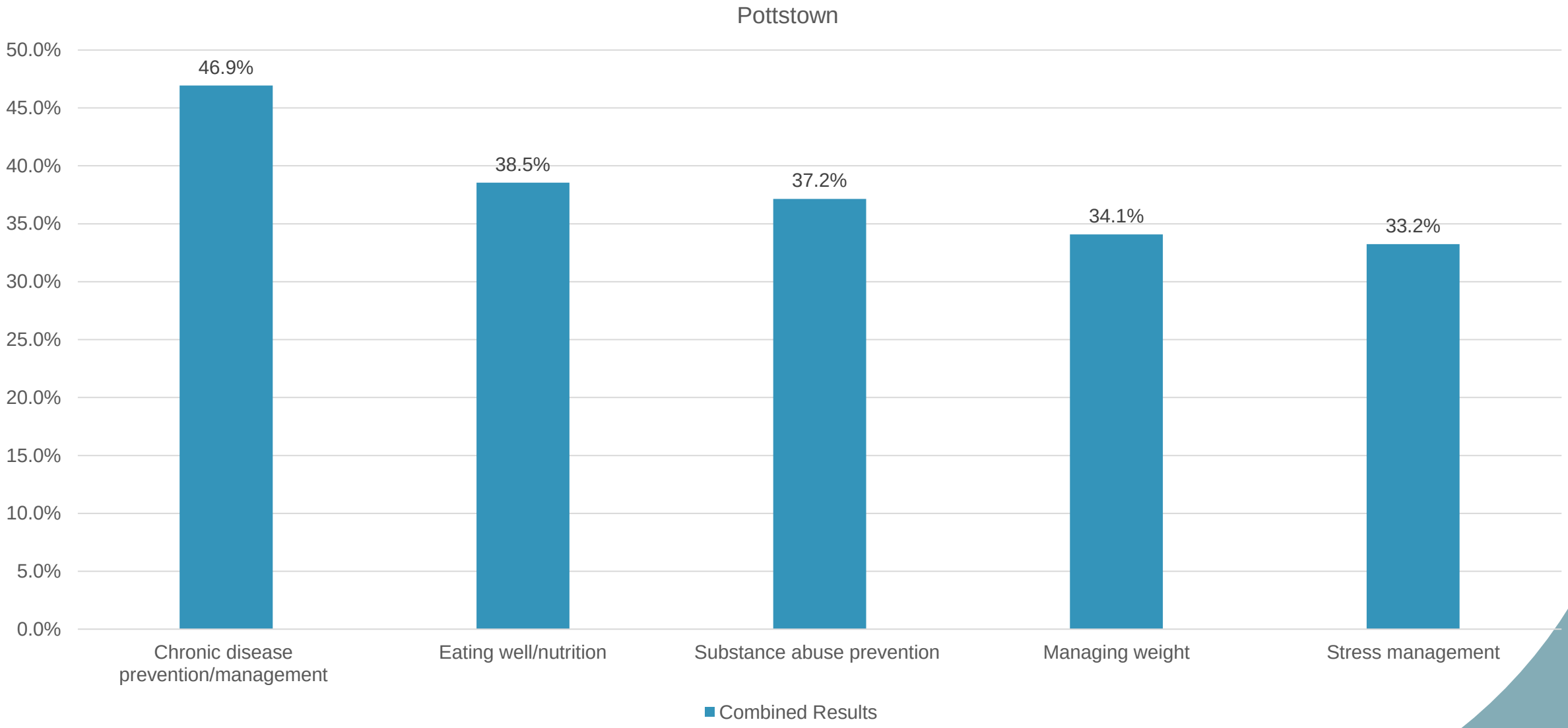
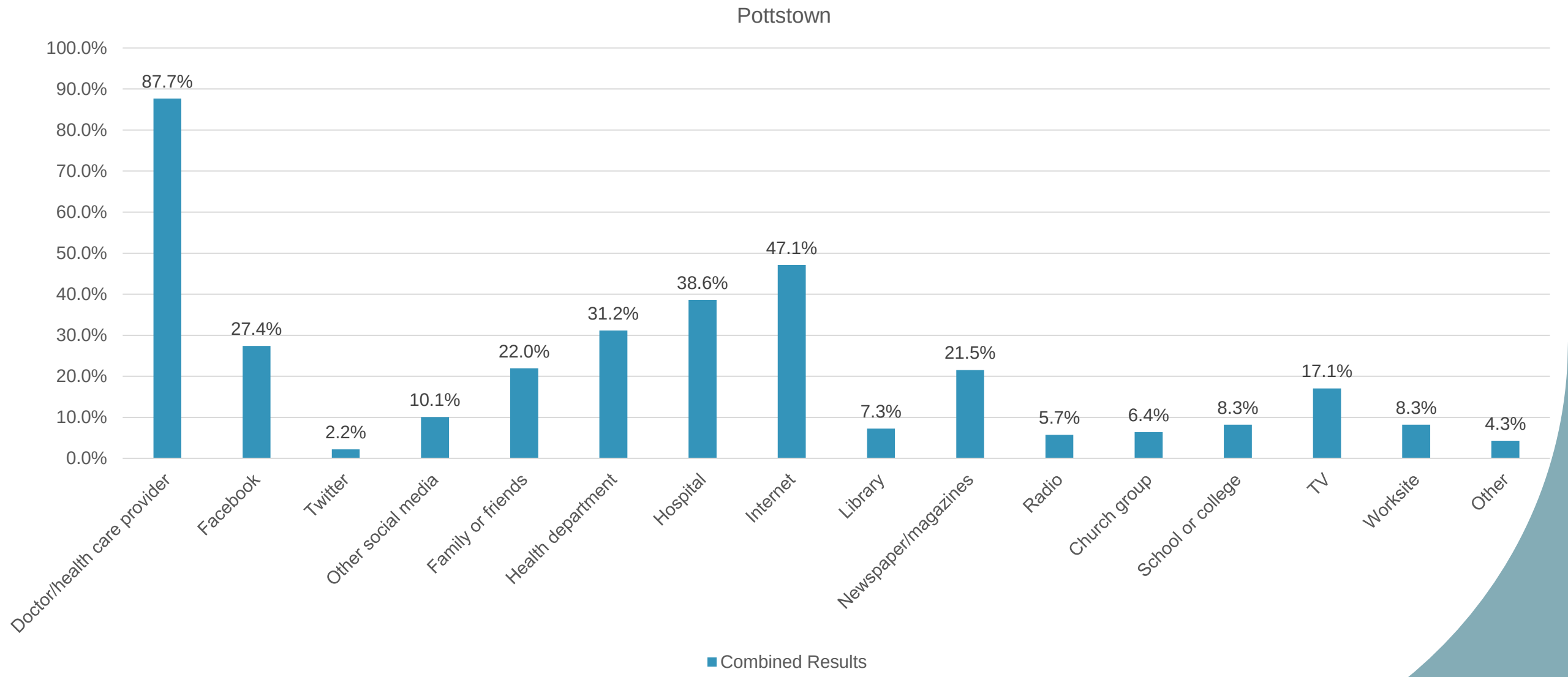
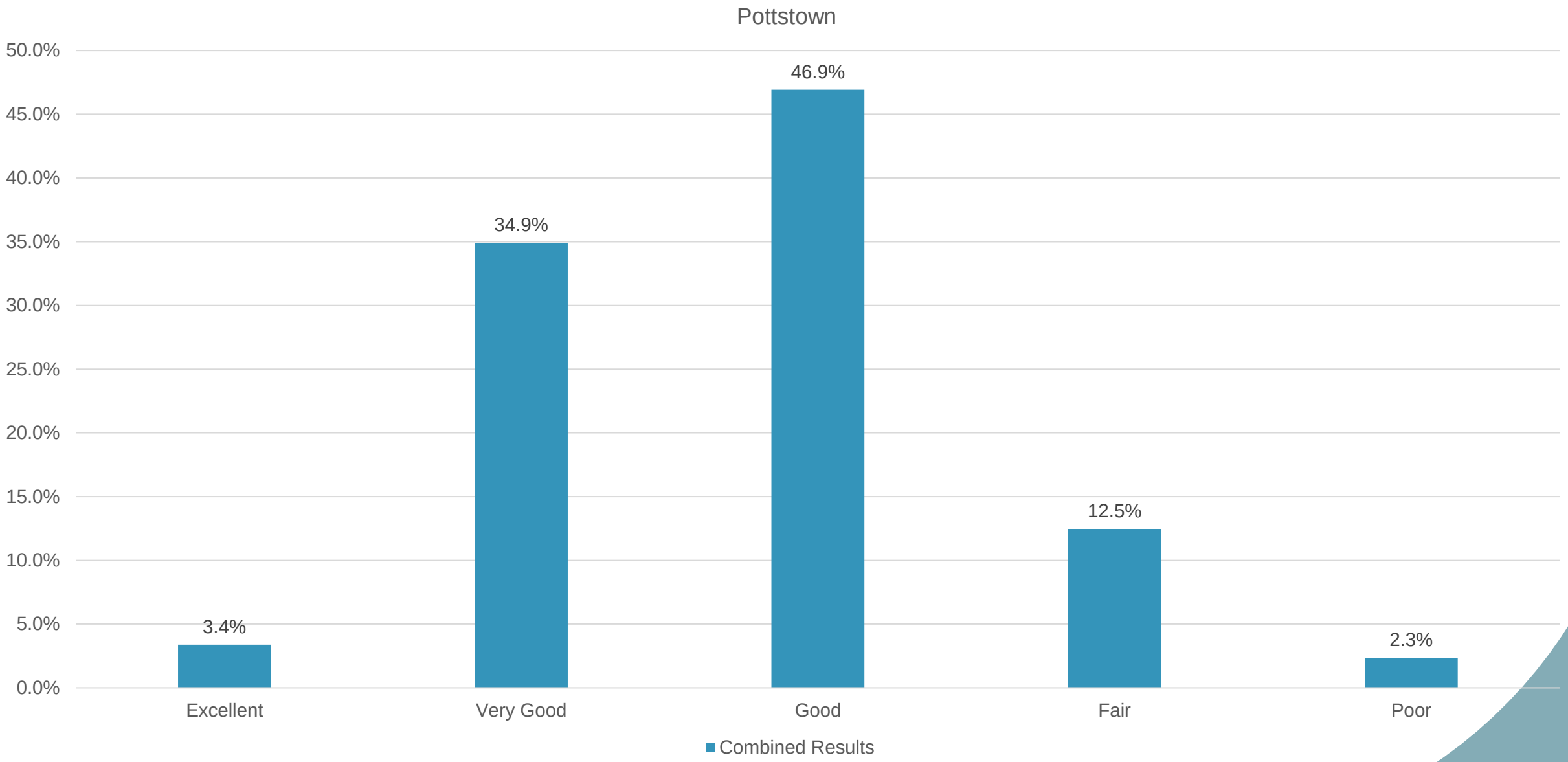


The above chart depicts the top 5 health behaviors people in the community need more information about.

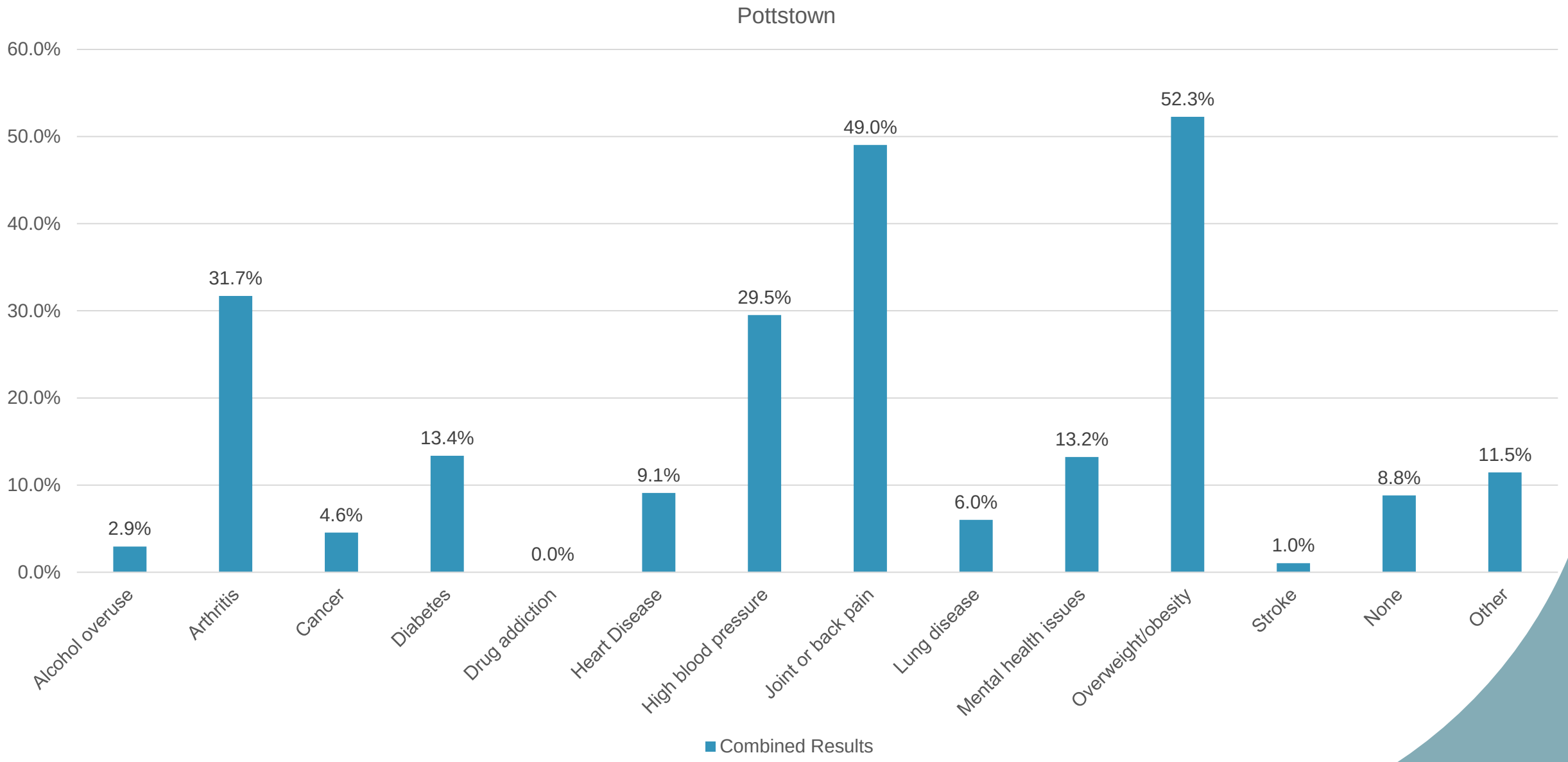
How Would You Like to Receive General Health Education Information (Check all that apply)



How Would You Describe Your Overall Health



Top 3 Health Challenges Currently Faced



Common Themes
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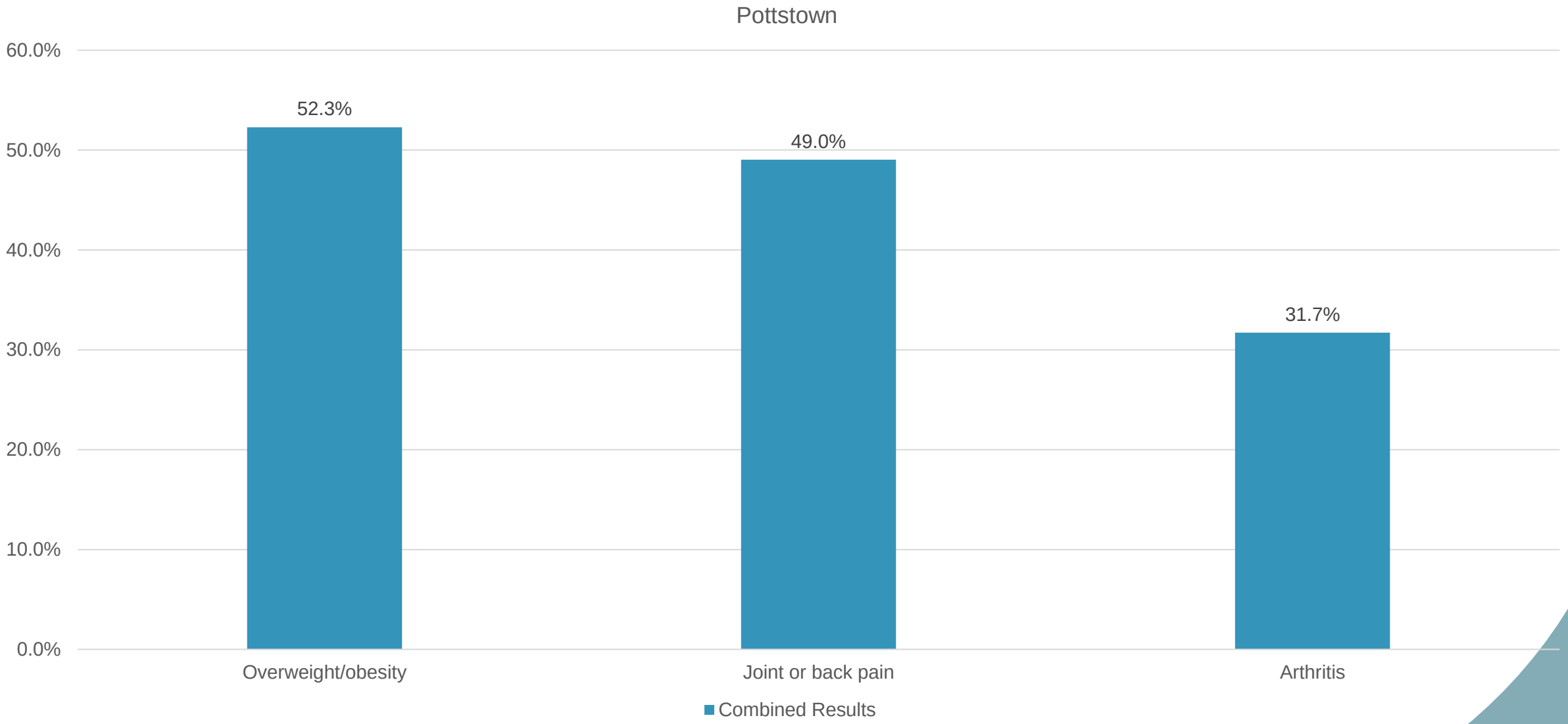
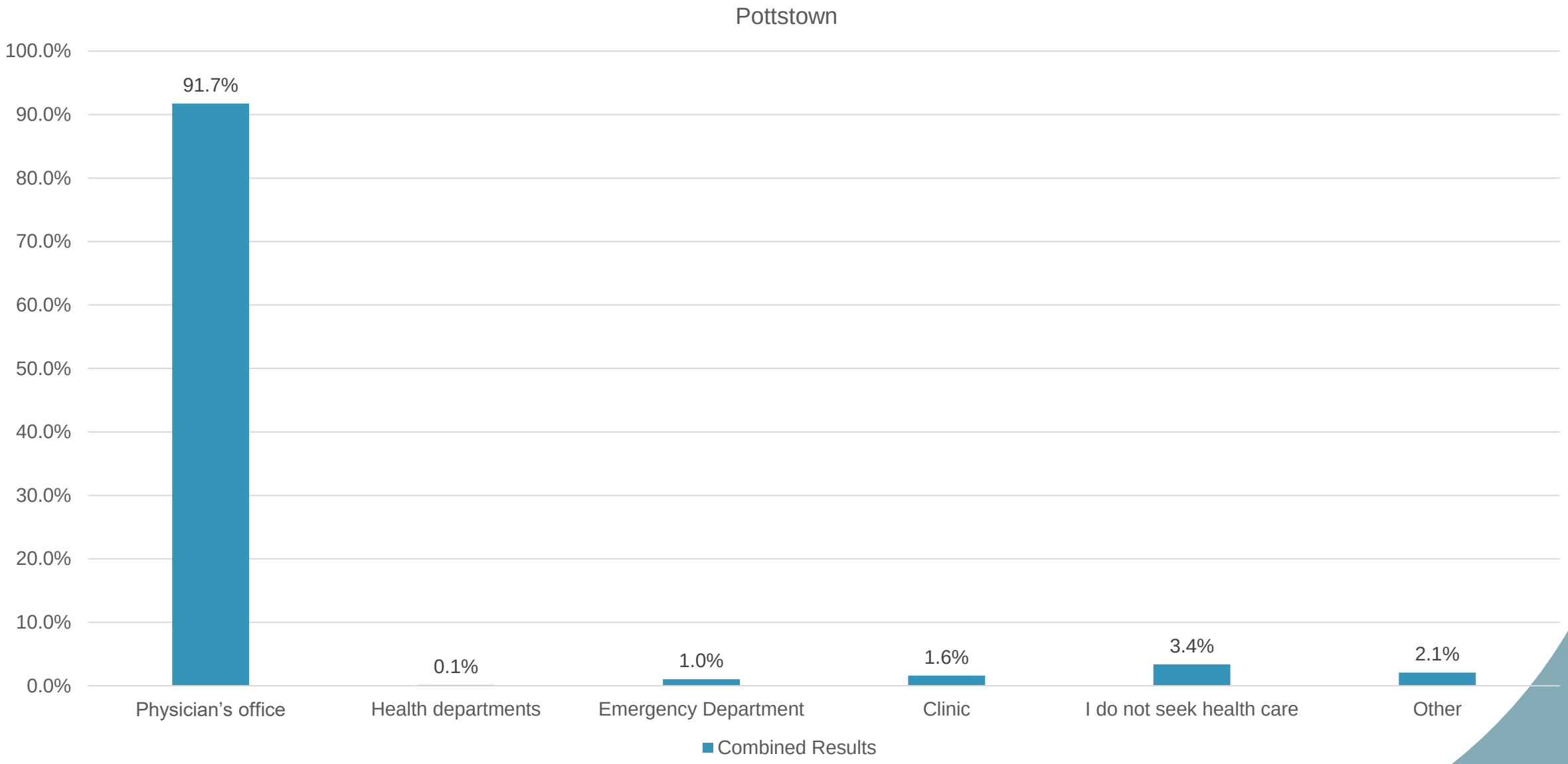
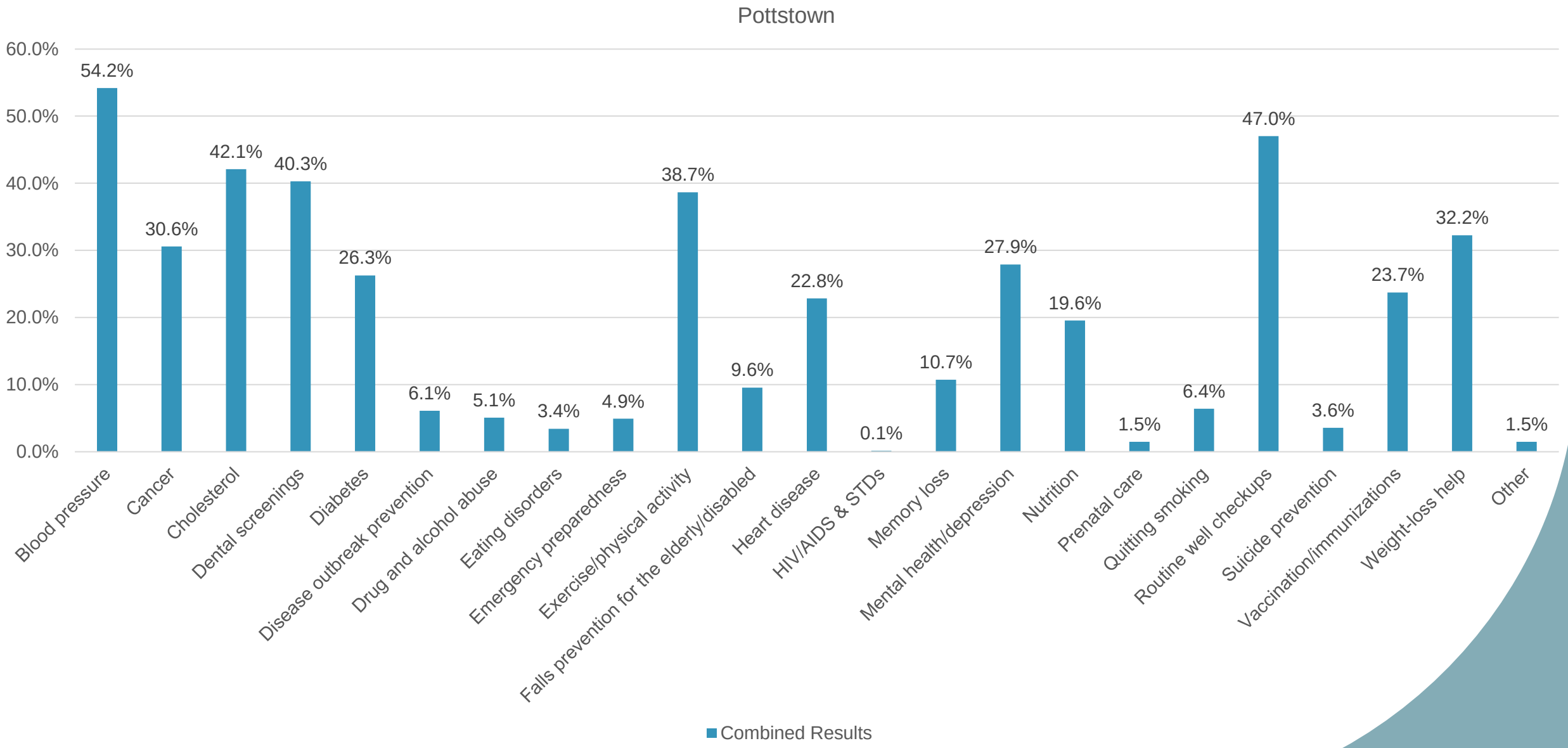


The above chart depicts the top 3 health challenges respondents currently face.

Where Do You Usually Go For Health Care?



What Types of Health Screenings and/or Services are Needed to Keep You and Your Family Healthy?



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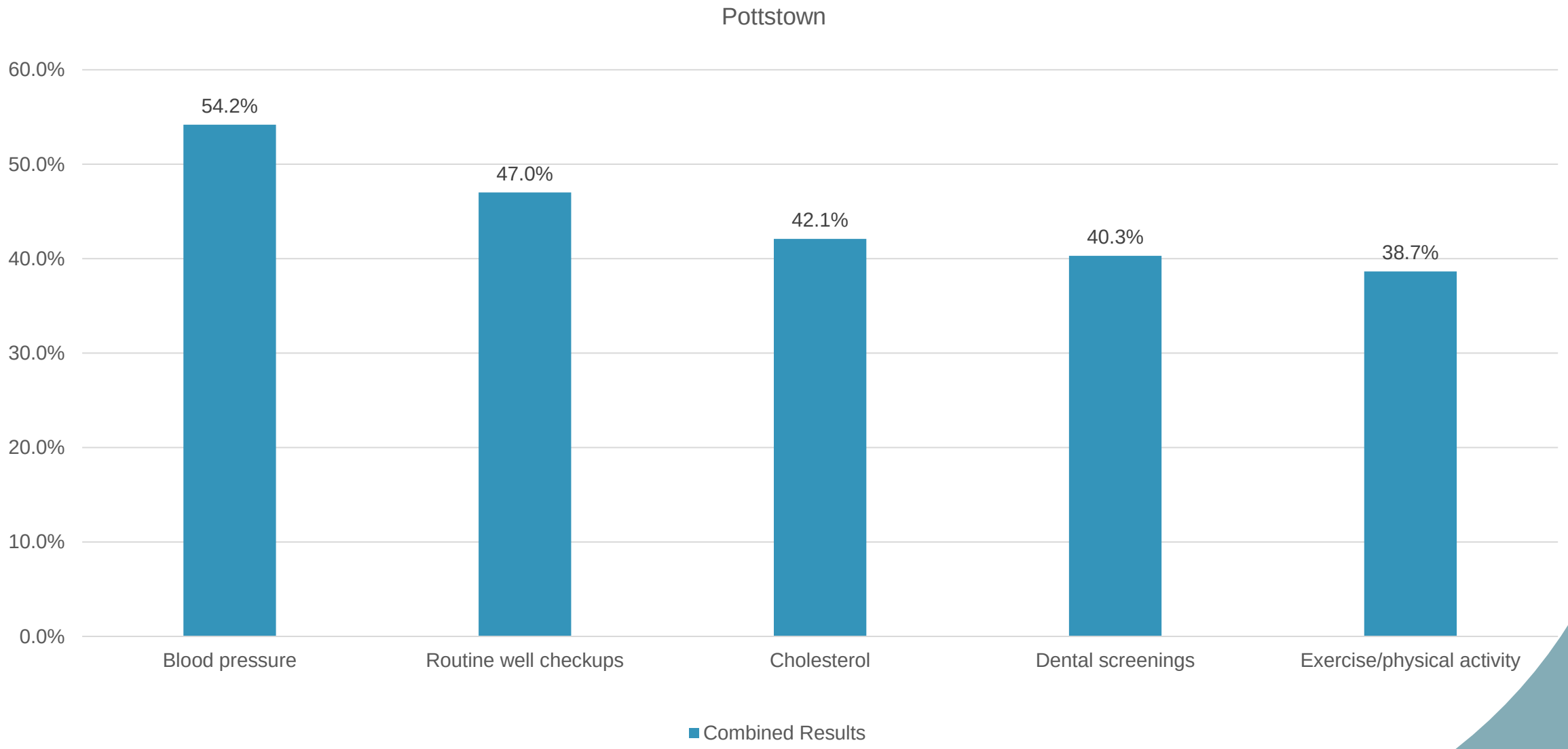
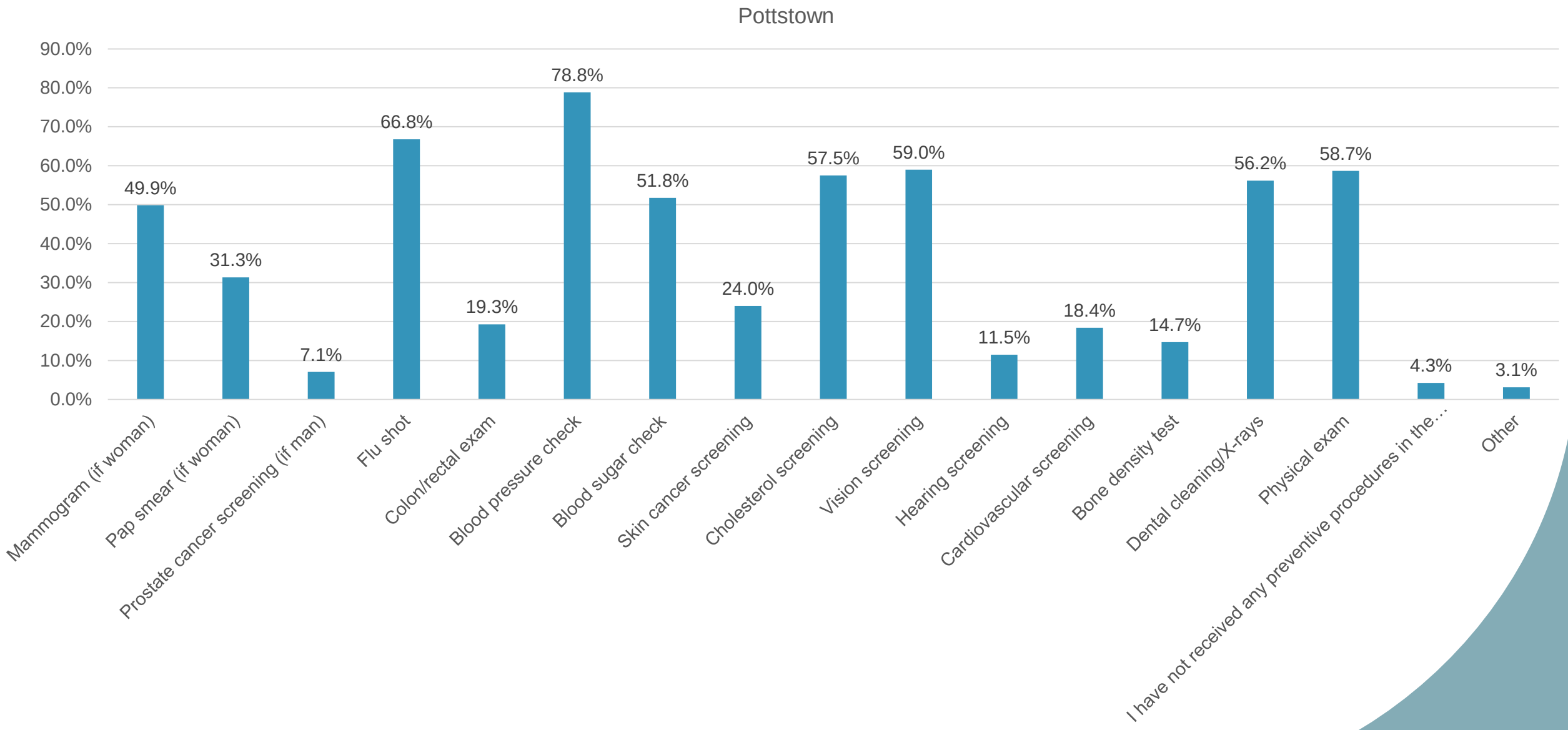


The above chart depicts the top 3 health challenges respondents currently face.

Which of the Following Preventive Procedures Have You Had in the Past 12 Months? (Check all that apply)



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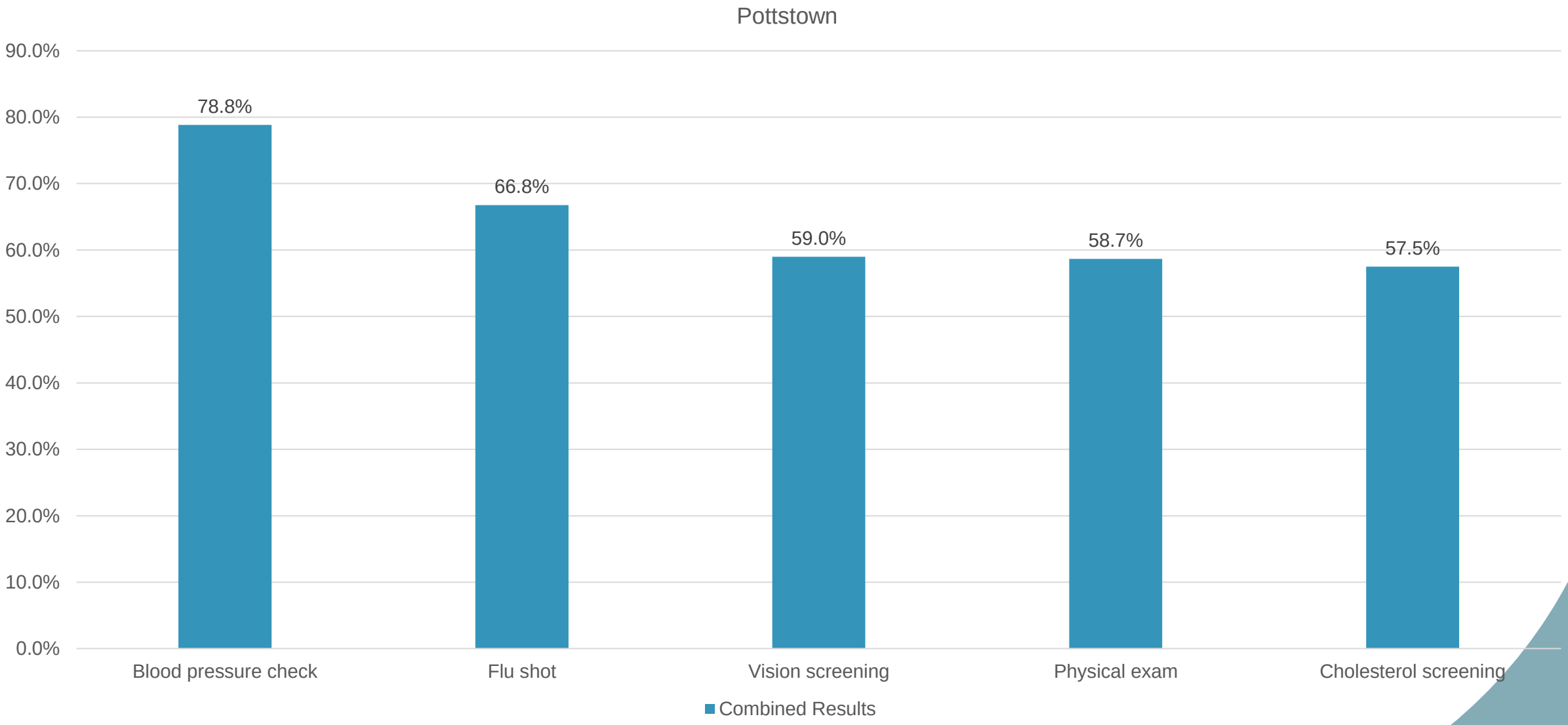
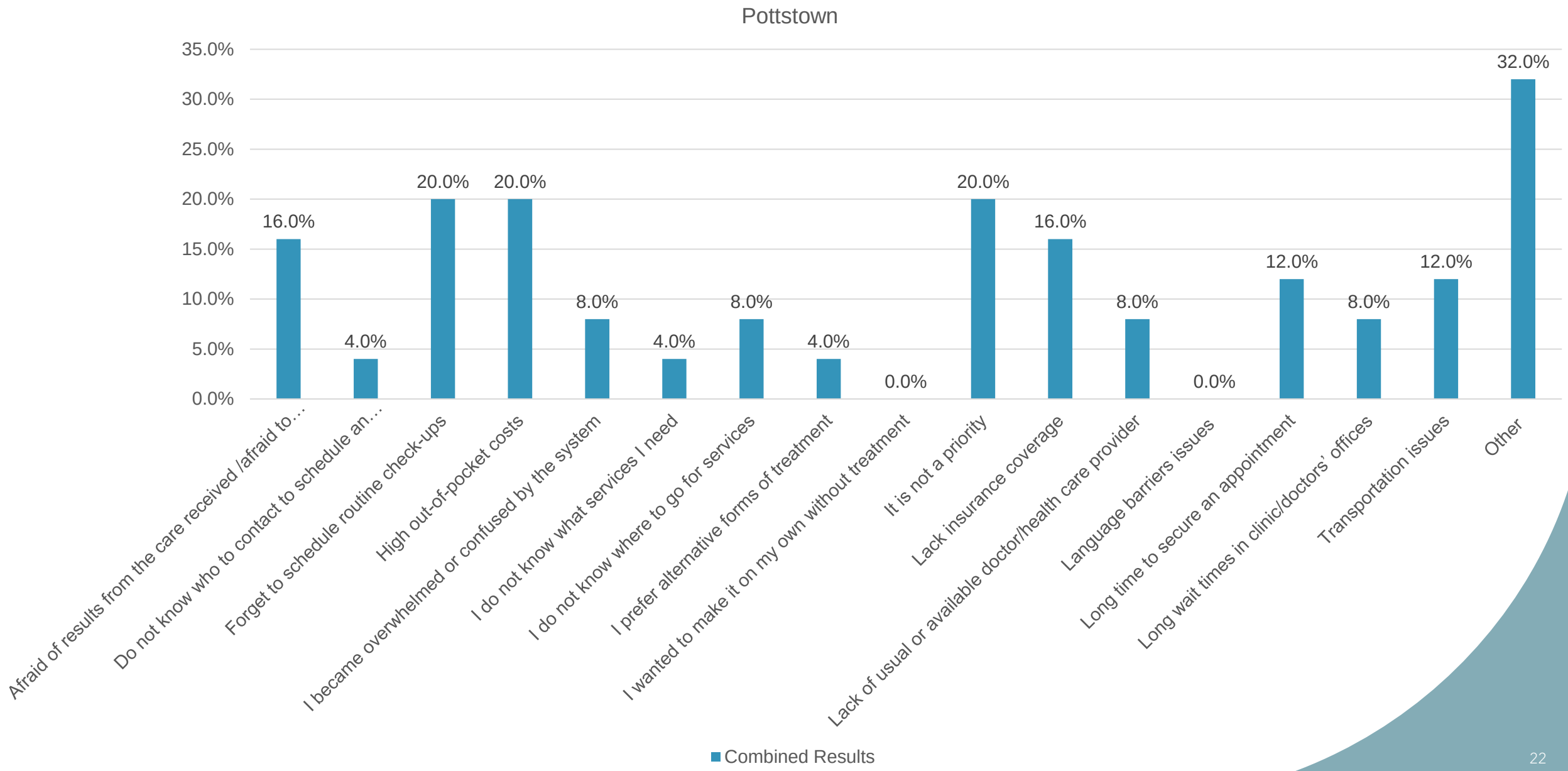
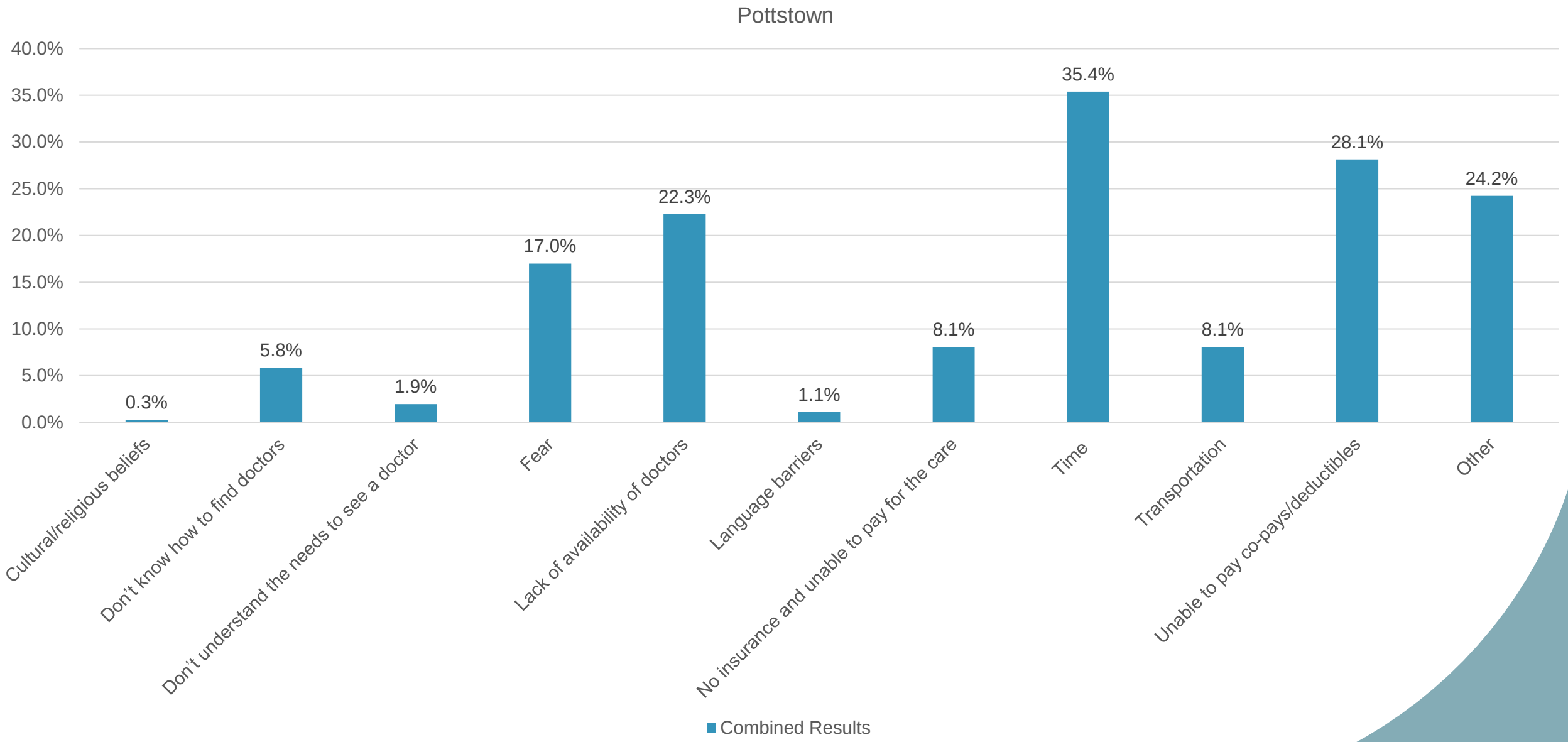


The above chart depicts the top 5 preventive procedures respondents had in the past 12 months.

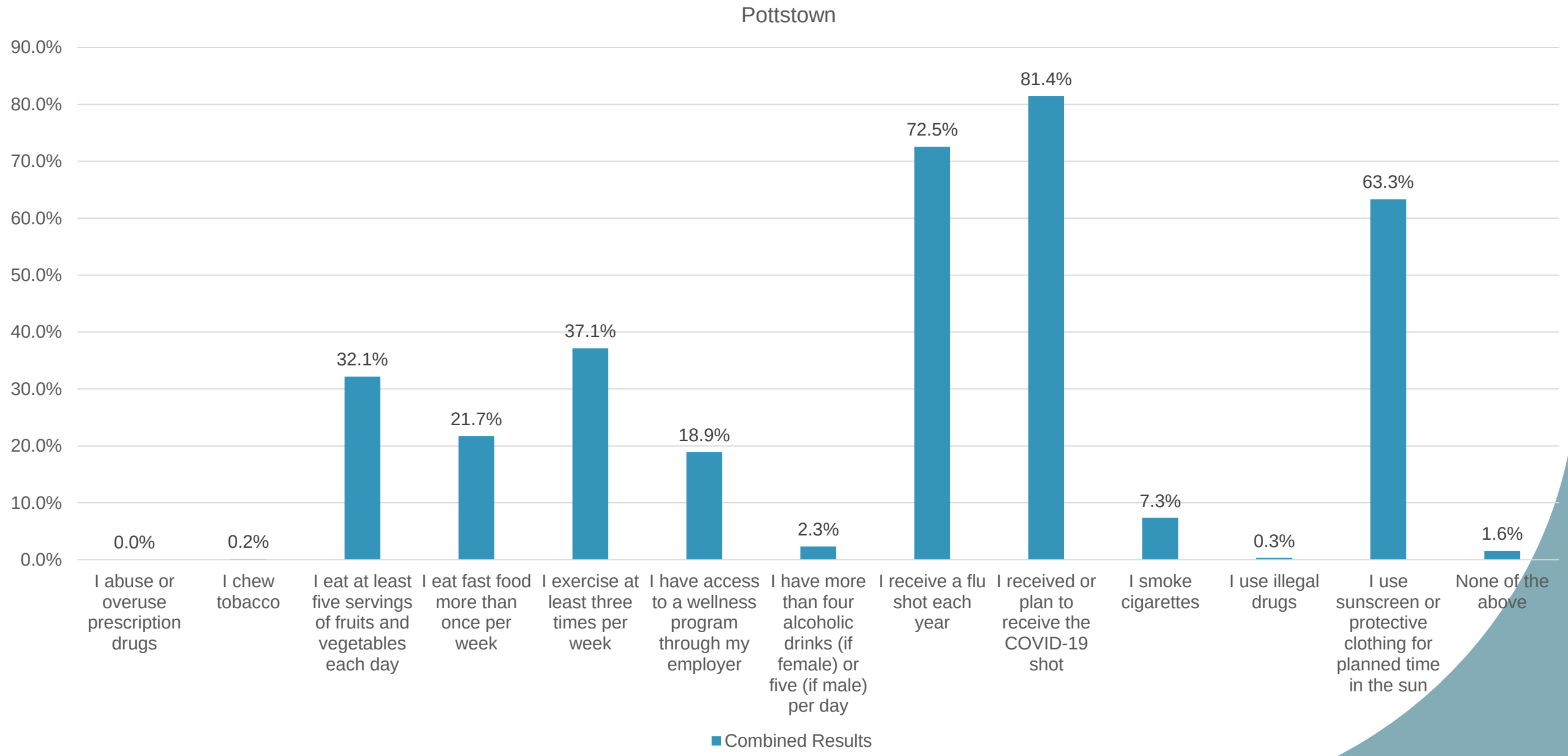
If You Have Not Received Preventive Care Services, Why Not?



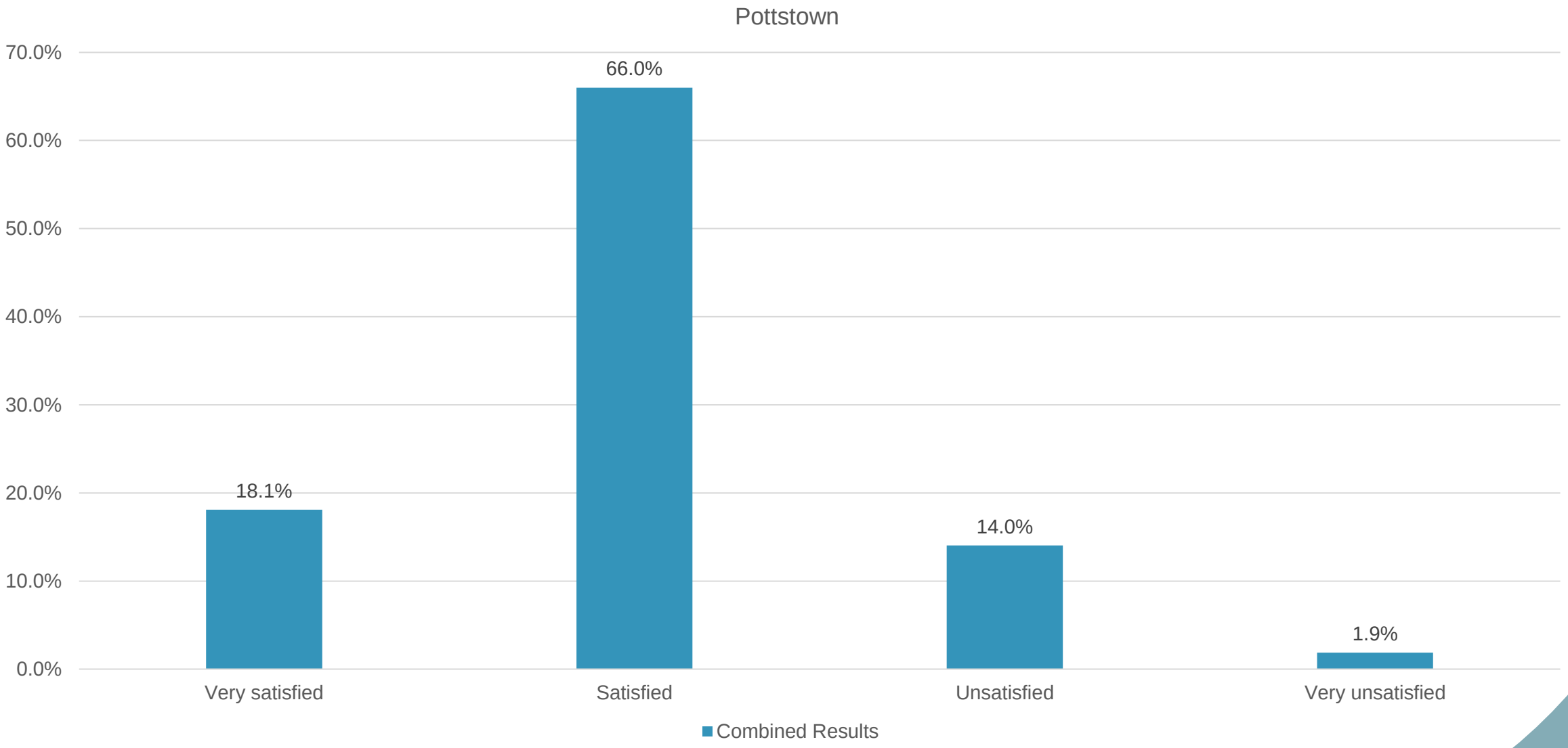
Are There Any Issues That Prevent You From Accessing Care? (Check all that apply)



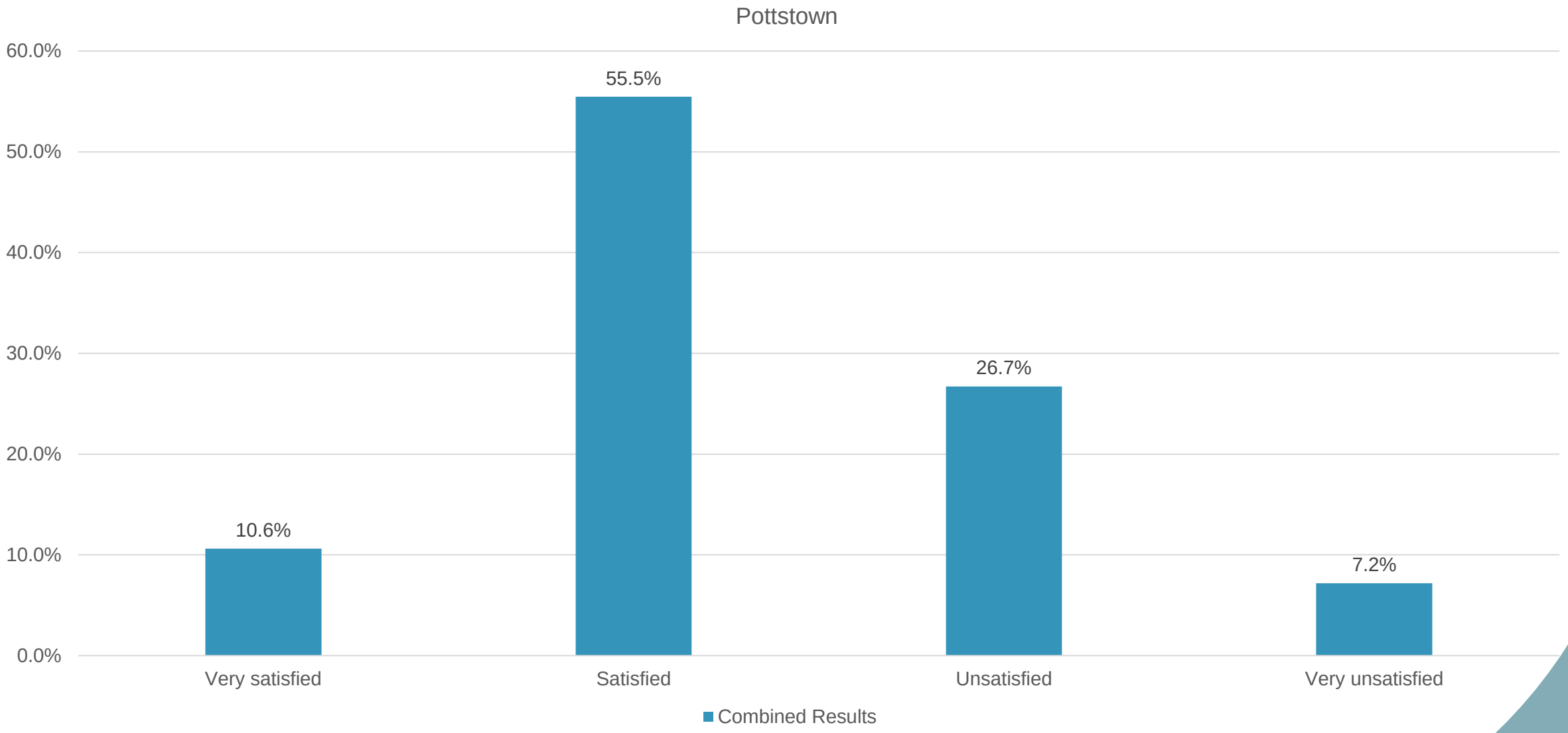
Please Choose All Statements That Apply To You (Check all that apply)



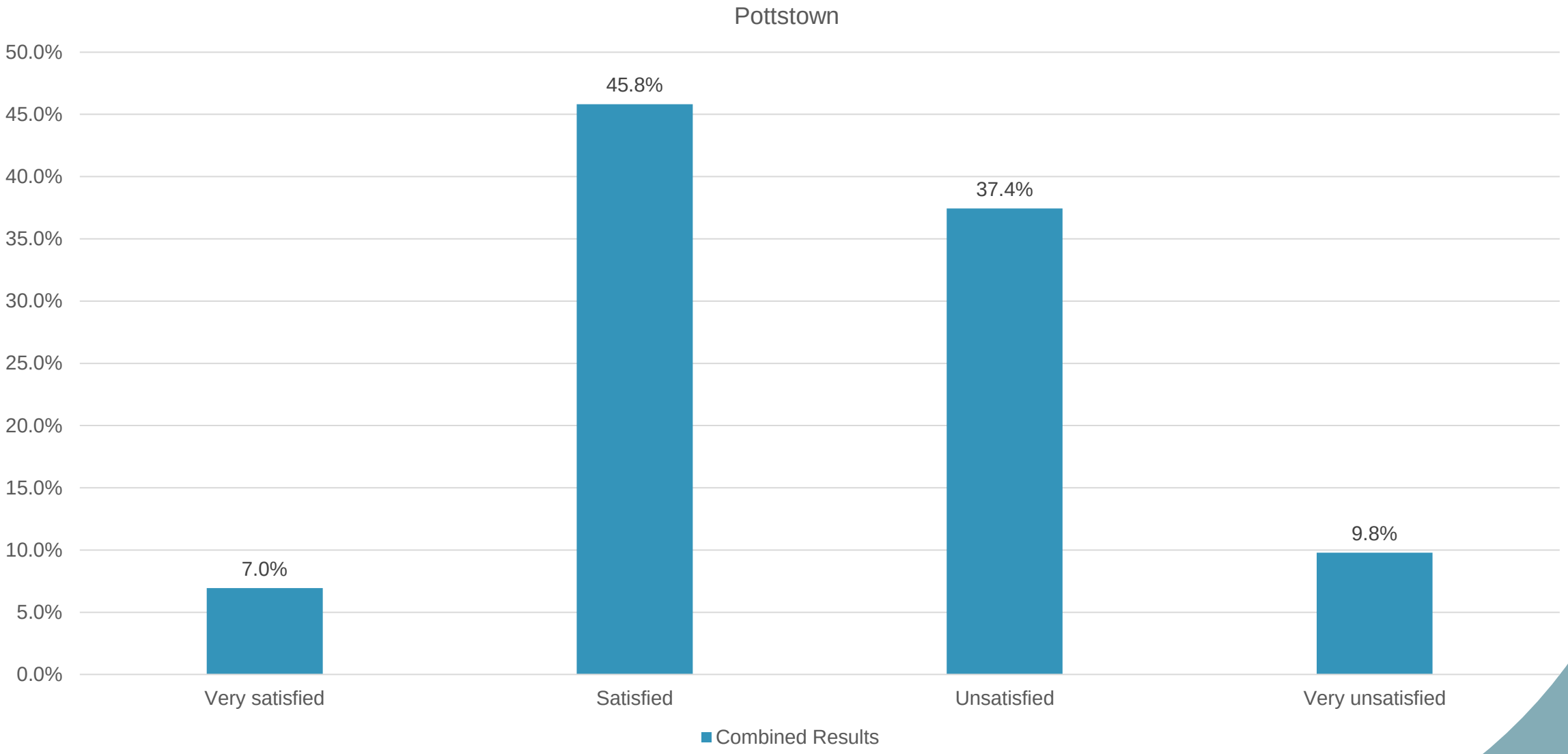
I Am Satisfied With The Quality Of Life In My Community



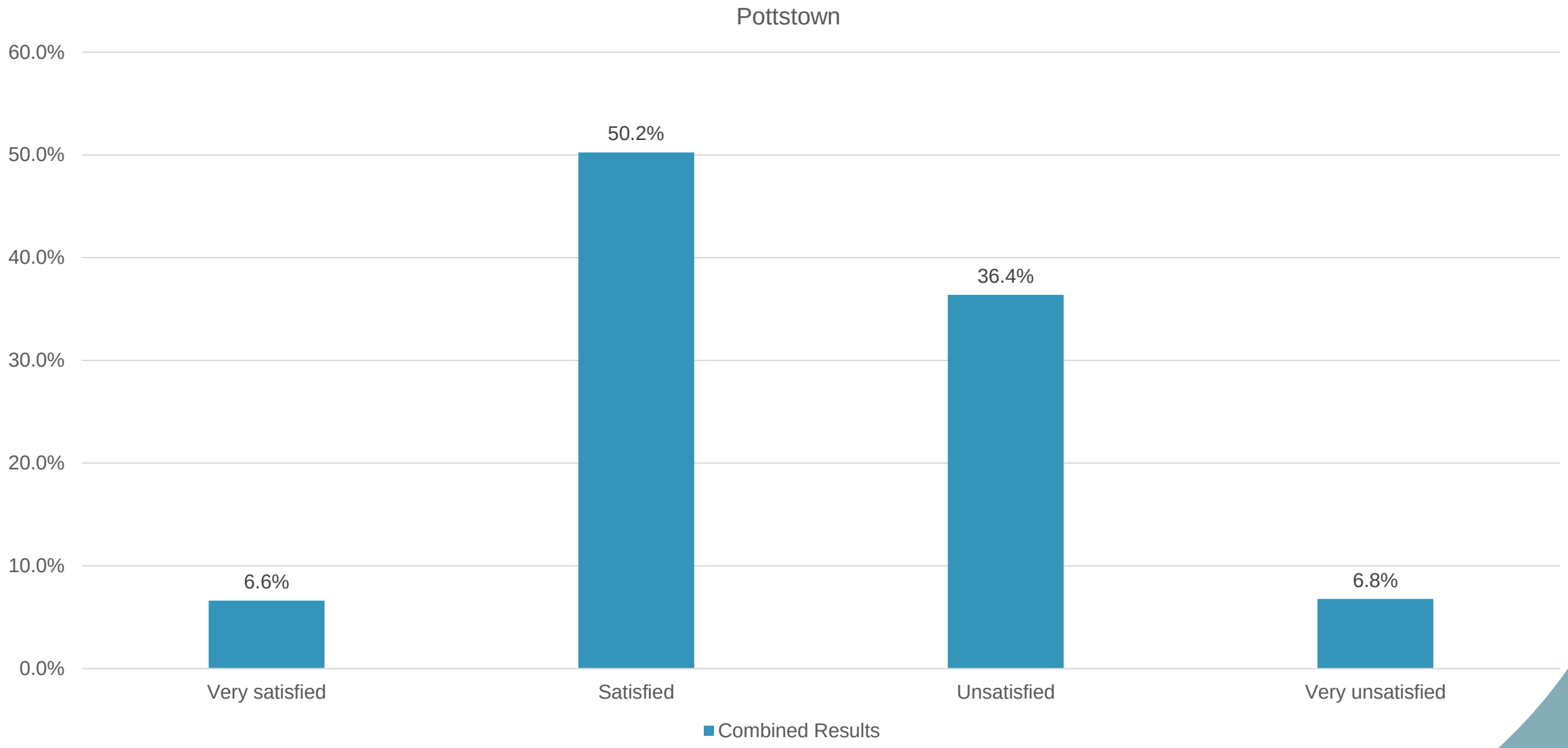
I Am Satisfied With The Health Care System in my Community



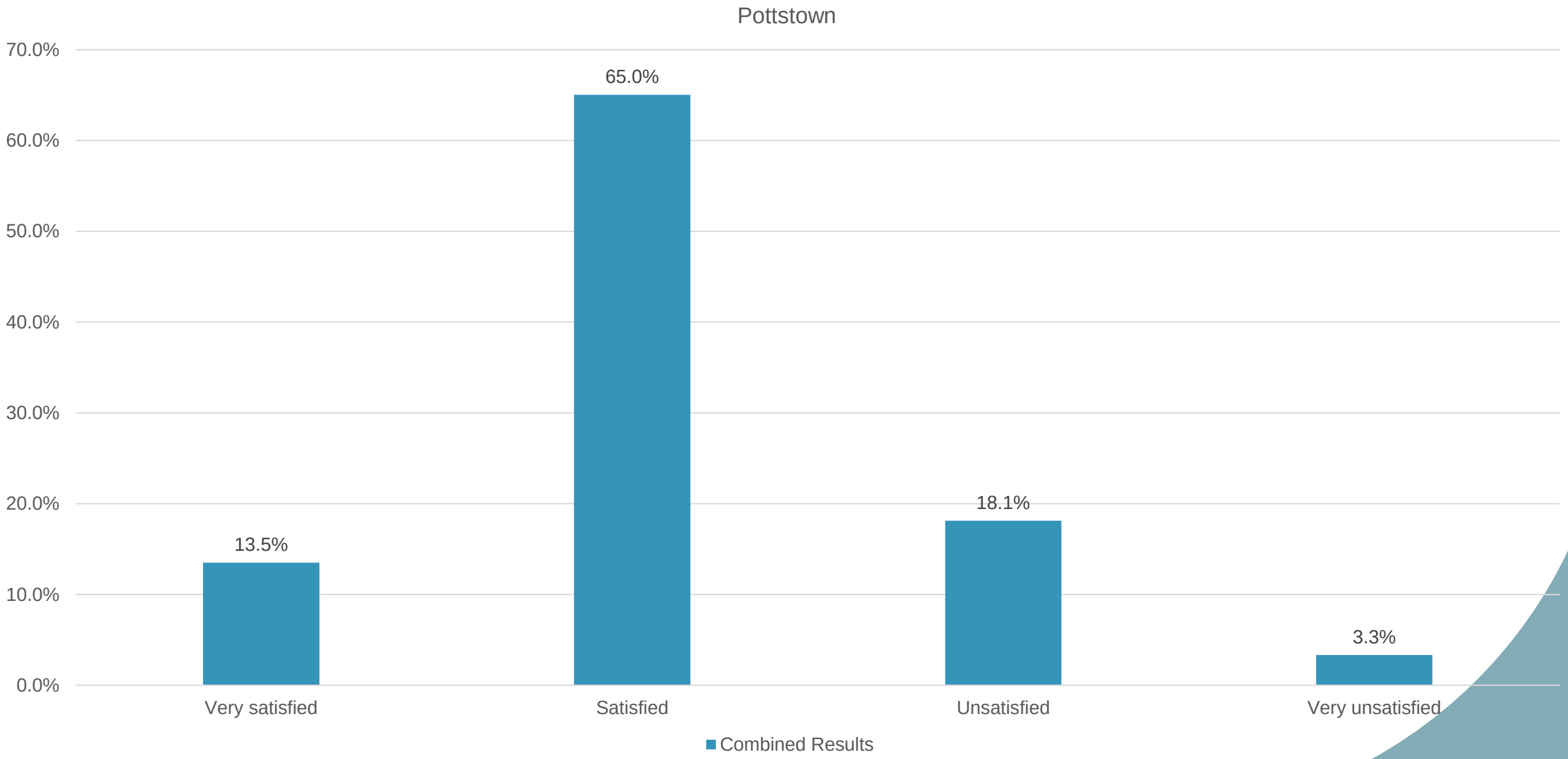
All individuals and groups in my community have the same and equal access to contributing and participating in the community's quality of life.



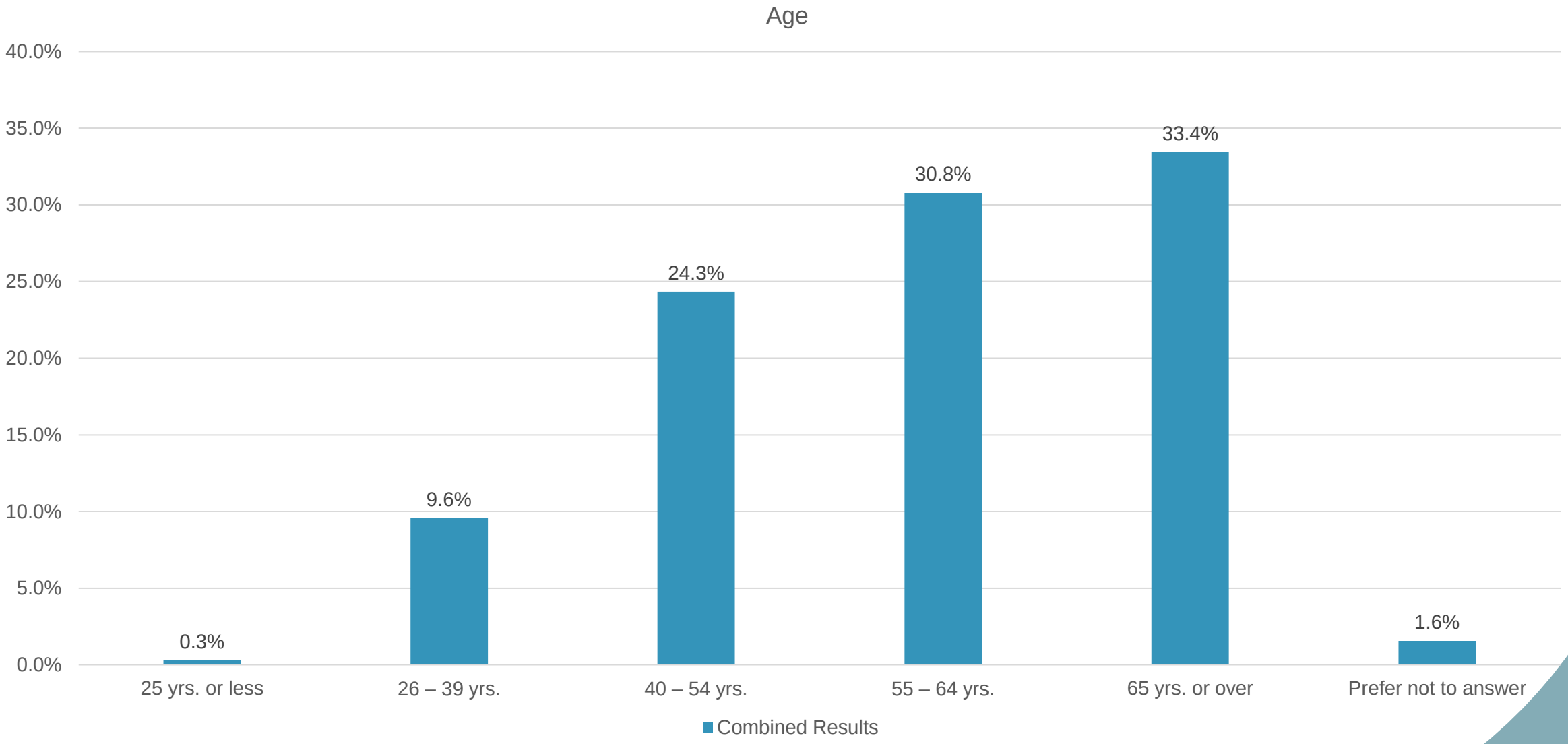
I Am Satisfied with the Amount of Health and Social Services in my Community



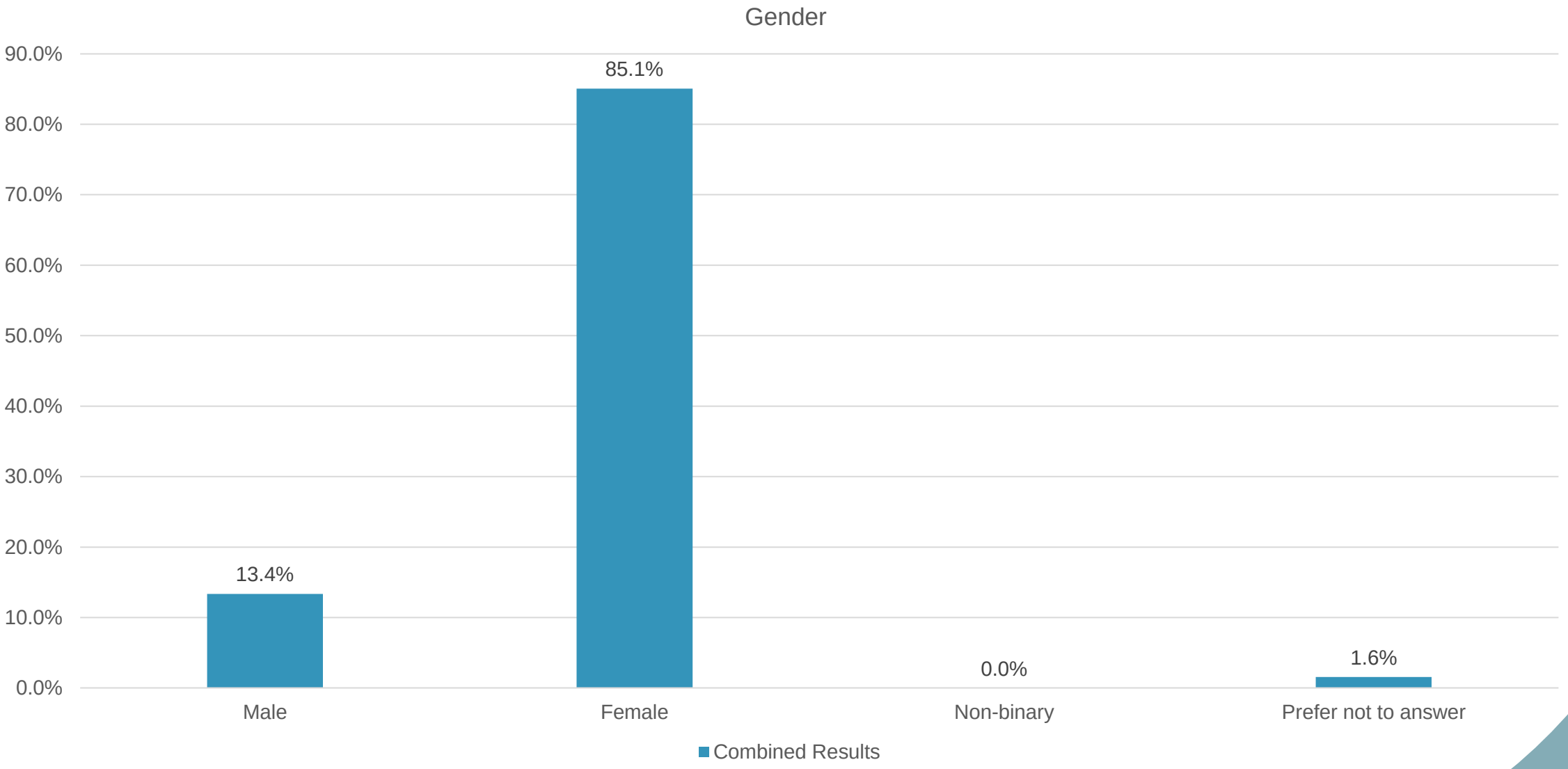
I Am Satisfied with the Diversity of my Health Care Providers



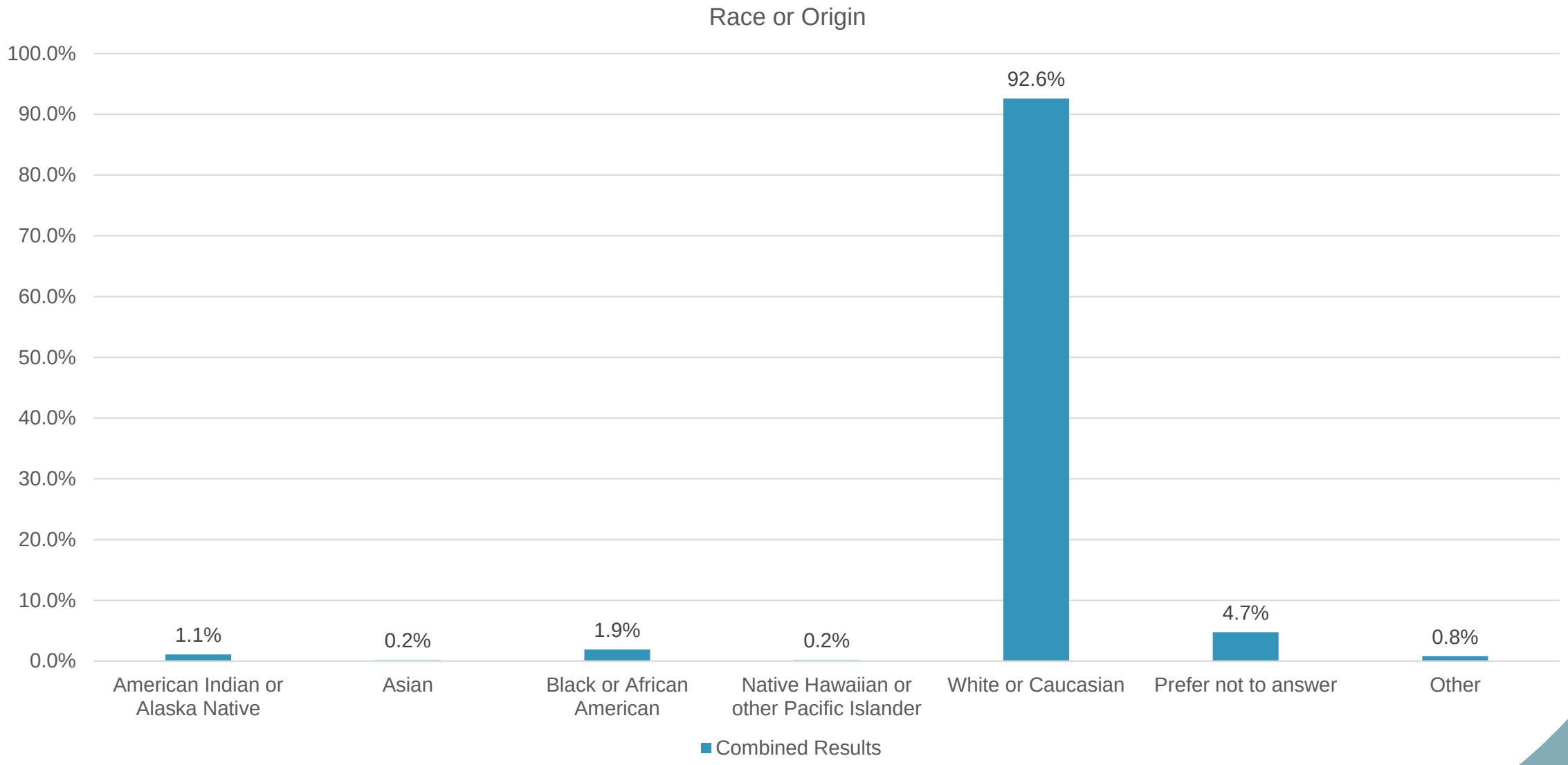
What is Your Age?



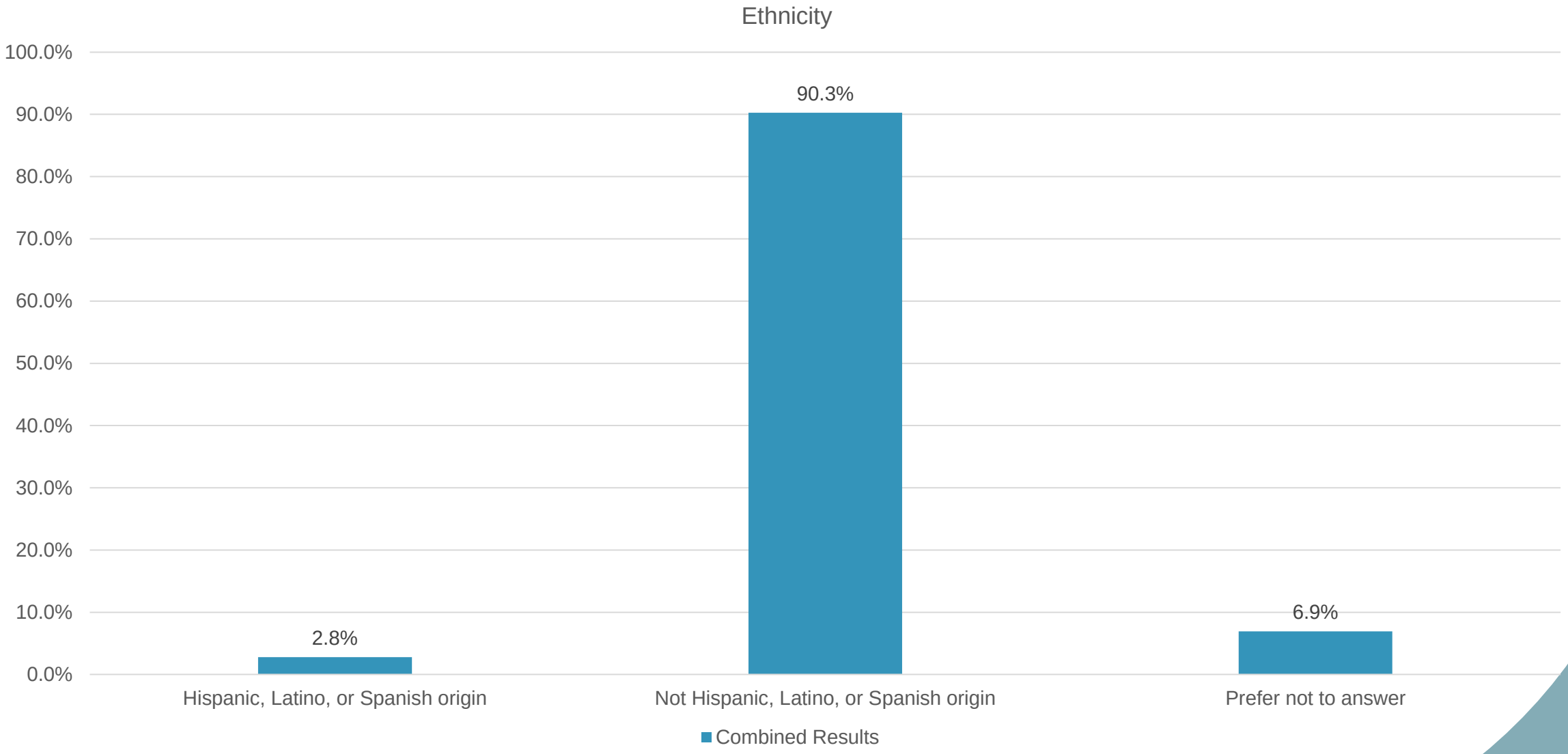
What is Your Gender?



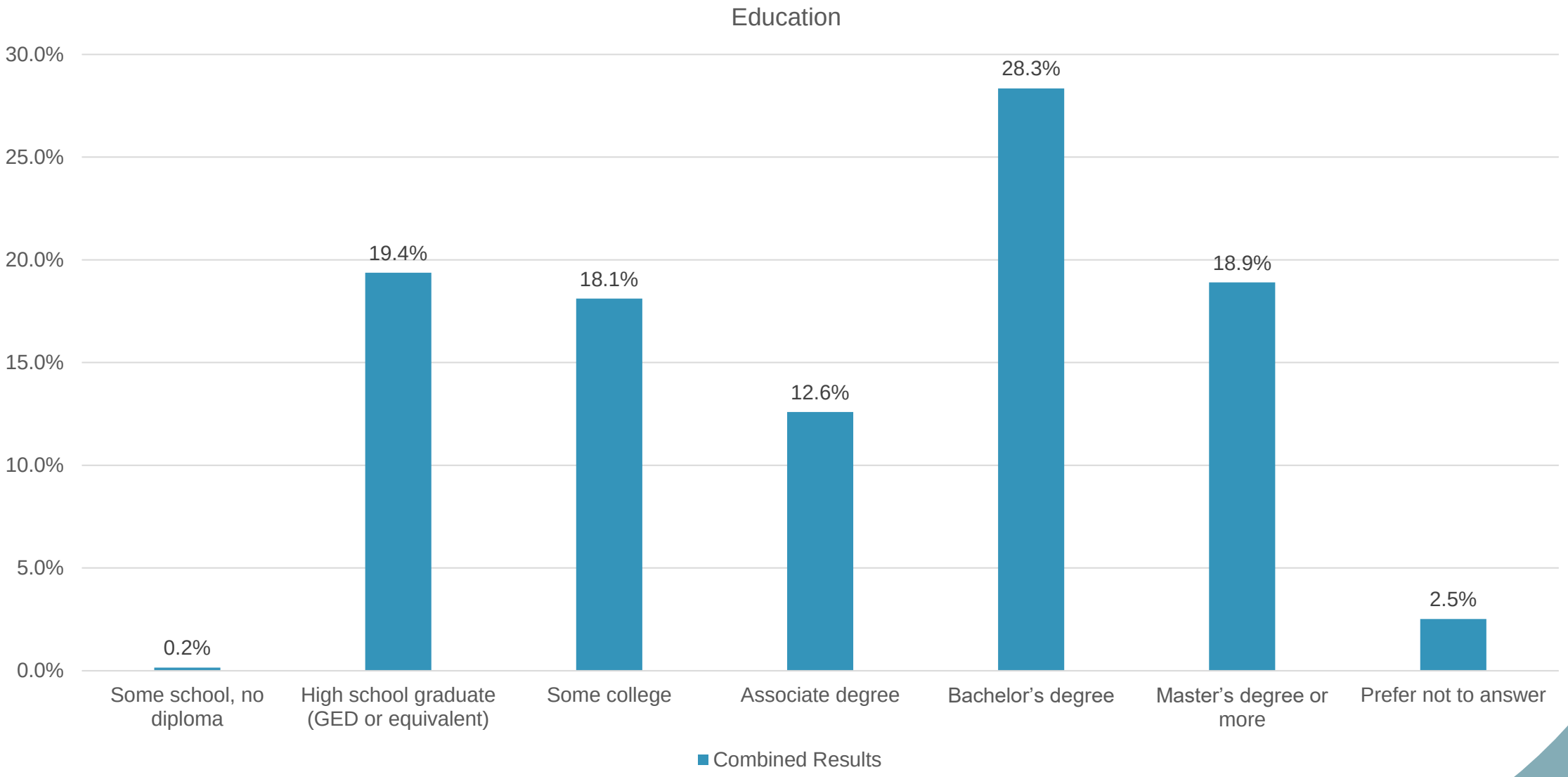
What is Your Race or Origin?



What is Your Ethnicity?



What is Your Highest Level of Education?



What is Your Annual Household Income?