COMMUNITY HEALTH NEEDS

2022 ASSESSMENT

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Reading Hospital
TOWER HEALTH
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LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Charles Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

Reading 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. Reading 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, Reading 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.

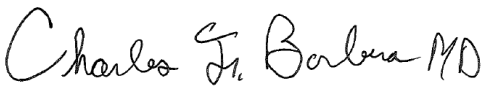
Reading Hospital is committed to advancing health and transforming lives throughout Berks County. As a leading health care provider, we strive to positively impact the health and well-being of our patients, as well as the broader communities we serve. Many of our programs and services have been developed 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 Reading 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,



Charles Barbera,
MD, MBA, MPH, FACEP

President and Chief Executive Officer,
Reading Hospital

Questions or comments regarding the CHNA can be sent via email to communitywellness@towerhealth.org or by calling 1-833-34-TOWER

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 Reading Hospital included input from those who represent the broad interests of the community. Representatives served by the hospital facilities, mainly those knowledgeable of public health issues, information related to the vulnerable, underserved, disenfranchised, hard-to-reach, and representatives of those populations served by each hospital. The CHNA documented what and where the need is, along with who is most affected.

In the fall of 2022, Reading Hospital will release our 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. Reading Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements.

Reading 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 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 Reading 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. Reading Hospital collected community and key informant surveys, community stakeholder 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 stakeholder interviews were dispersed community-wide 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.

Figure 1: Community Engagement

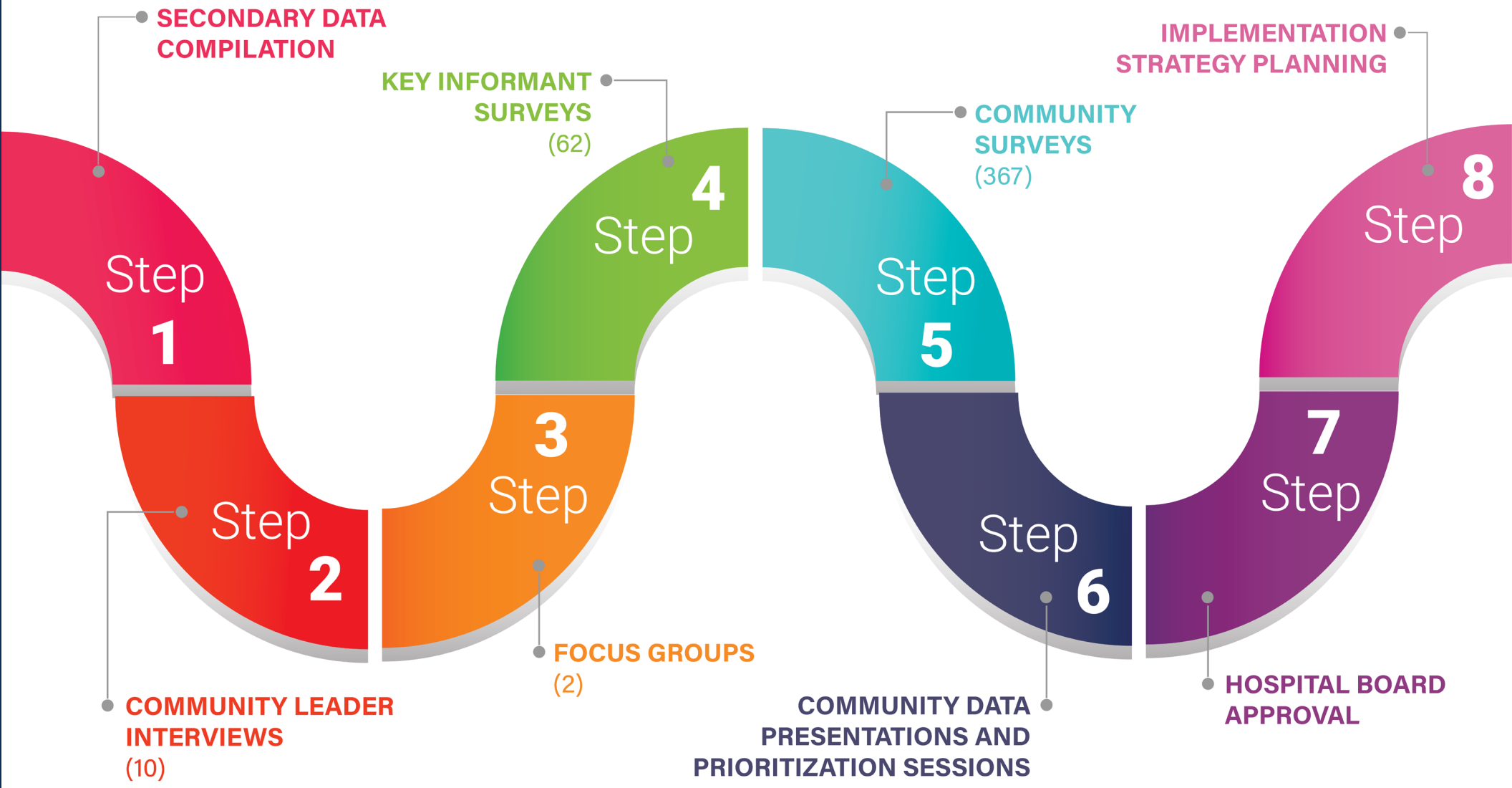
[1] Members of the working group consisted of Desha Dickson, Associate Vice President Community Wellness, Reading Hospital; Tanieka Mason, Senior Manager SDOH & Analytics, Reading Hospital; Courtney Powers, Program Manager, Community Wellness, Reading Hospital; Ha T. Pham, Senior Principal, Tripp Umbach; Barbara Terry, Senior Advisor, Tripp Umbach; and Julia Muchow, Project Assistant, Tripp Umbach.

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, policymakers, and health care payers, 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 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 Reading 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

READING HOSPITAL

WHO ARE WE?

Reading Hospital is a nationally recognized institution that has served the local community since 1867, and in its current location since 1926. With a tradition of clinical excellence and a commitment to low patient costs, we perform nearly 19,000 surgical procedures a year. Reading Hospital is home to many of our top-tier specialty care centers, including:

- McGlinn Cancer Institute
- Miller Regional Heart Center
- Reading HealthPlex for Advanced Surgical & Patient Care
- Emergency Services
- Level I Trauma Center
- Beginnings Maternity Center, housing the region's only Level III Neonatal Intensive Care Unit (NICU)

At Reading Hospital, advancing your health and wellness is our mission. When you enter our facilities, you can expect the highest quality health care in the region, as well as access to cutting-edge technology and experienced, caring medical professionals. More than 1,000 physicians and providers across 46 locations offer comprehensive care ranging from prevention, screenings, and education to the latest clinical services and treatments. Our community health programs provide essential resources to residents of Berks County and surrounding areas. Whatever your health care needs, we are committed to meeting them.

MISSION

The mission of Reading 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.

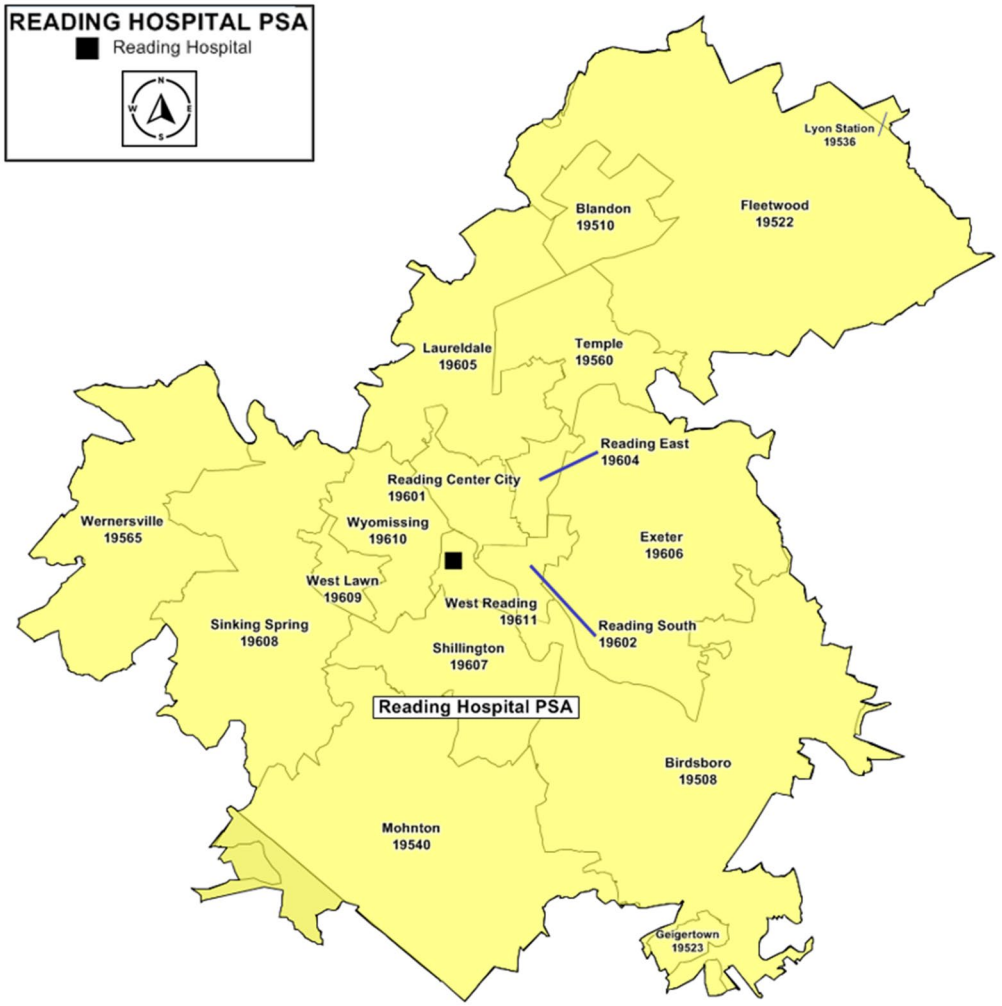
VISION

Reading 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. Reading Hospital's primary service area (PSA) includes 21 ZIP codes within Berks County.[3]

Reading Hospital PSA	
ZIP Codes	Town/Neighborhood
19508	Birdsboro
19510	Blandon
19522	Fleetwood
19523	Geigertown
19536	Lyon Station
19540	Mohnton
19560	Temple
19565	Wernersville
19601	Reading Center City
19602	Reading South
19603	Reading (NS)
19604	Reading East
19605	Laureldale
19606	Exeter
19607	Shillington
19608	Sinking Spring
19609	West Lawn
19610	Wyomissing
19611	West Reading
19612	Reading (NS)
19542	Monocacy Station (NS)



[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

Reading 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 is to determine 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 Reading Hospital. Specific metric information/measurable indicators can be obtained from the hospital's administrative department.

1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

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

STRATEGIES	ACTION STEPS
Increased cultural awareness	Conducted diversity and inclusion and cultural competency trainings
	Created a Diversity and Inclusion Council
Expanded/Promoted programs that educate students about careers in health care	Implemented and/or expanded career exploration programs, such as, medical explorers, shadowing and college and high school internships.
Streamlined access to care facilities	Opened an advanced access center across ambulatory and specialty care service lines.
Supported programs that provide care to vulnerable populations	Street Medicine program opened a telemedicine kiosk.
Enhanced the use of remote patient monitoring	Increased remote monitoring of patients.

2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH (SDOH)

Goal: Identify and address Social Determinants of Health (SDOH)

STRATEGIES	ACTION STEPS
Identified and addressed SDOH in the clinical environment	Completed 137,949 (December 15, 2021) SDOH screenings
Medical-Legal Partnership Program	Identified and resolved legal issues that had the potential of negatively impacting health.
Identified and removed transportation barriers	Implemented Ride Health. A complimentary transportation program to assist patients get to and from medical appointments.
Implemented community-based intervention initiatives	Implemented a Community Health Worker Program to work with vulnerable patients and close care gaps.

3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

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

STRATEGIES	ACTION STEPS
Encouraged community members to engage in physical activity	Promoted Bike Share Program to encourage bike riding as a form of exercise.
	Promoted Berks Trail Challenge to encourage community members to walk as a form of exercise.
Educated community on the importance of early disease detection	Provided free cancer screenings

4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

Goal: Improve access to screening, assessment, treatment, and support for behavioral health and reduce stigma related to treatment.

STRATEGIES	ACTION STEPS
Center of Excellence	Screened patients for opioid use disorder (OUD) and provide care coordination to remove barriers for patients seeking treatment.
Increased access to behavioral health	Construction on Tower Behavioral Health completed.
	Integrated therapists into primary care practices to screen for depression.
Promoted mental health screenings and training	Promoted Mindkare Kiosk and online mental health screenings.
	Provided Mental Health First Aid training.

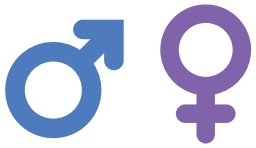
COMMUNITY AT A GLANCE

THE COMMUNITY WE SERVE

POPULATION

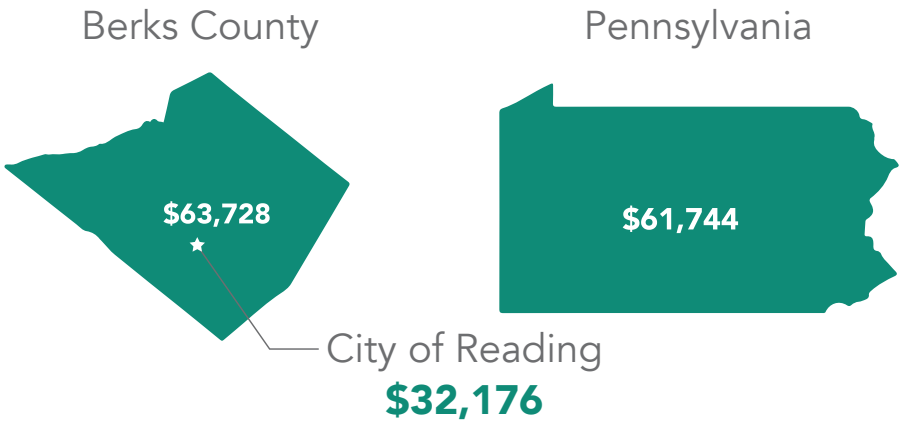
Source: U.S. Census Bureau 2020

GENDER



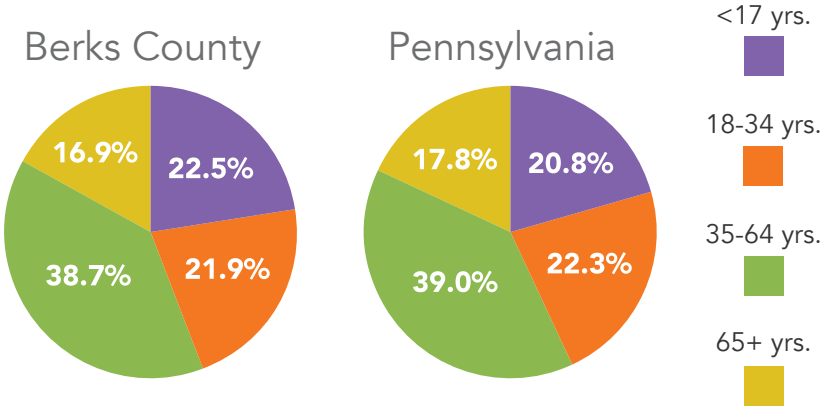
Source: U.S. Census Bureau 2019

MEDIAN HOUSEHOLD INCOME



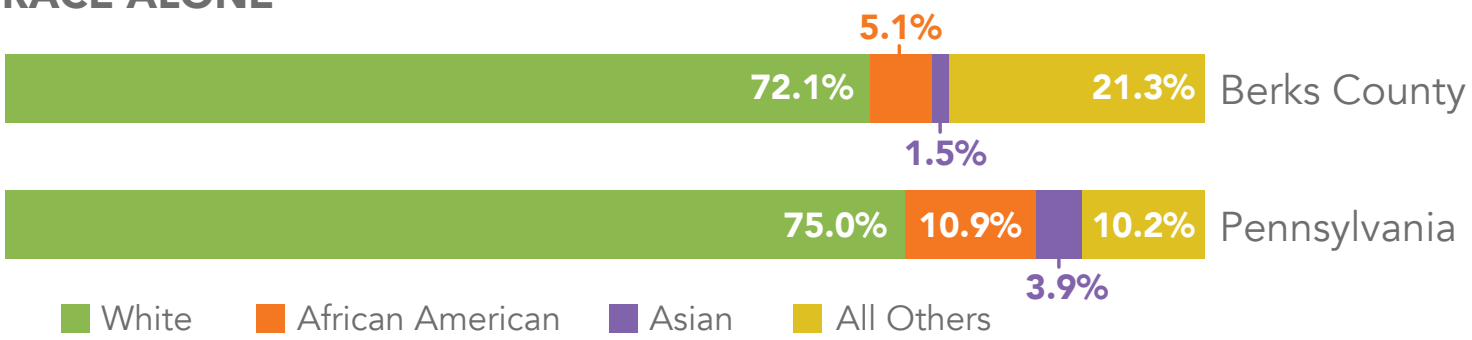
Source: U.S. Census Bureau 2019

AGE DISTRIBUTION



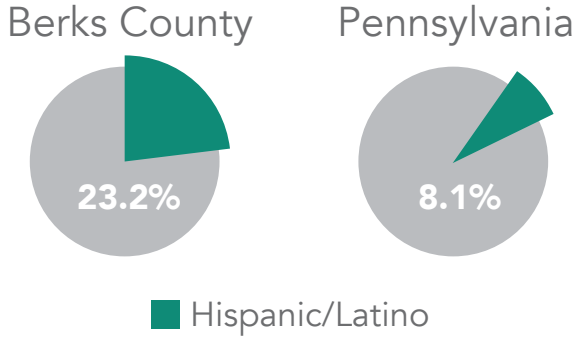
Source: U.S. Census Bureau 2019

RACE ALONE



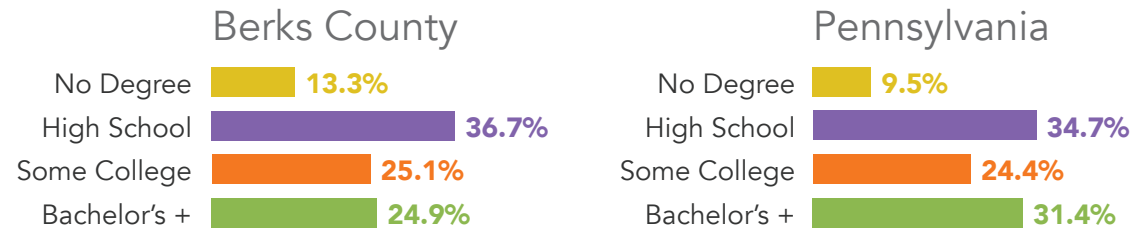
Source: U.S. Census Bureau 2020

ETHNICITY



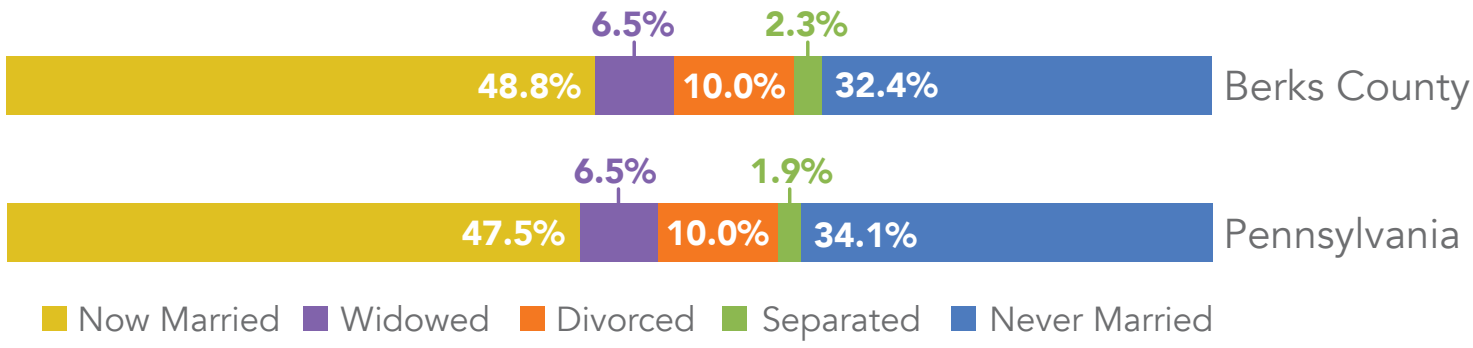
Source: U.S. Census Bureau 2020

EDUCATION



Source: U.S. Census Bureau. American Community Survey 2015-2019

MARITAL STATUS



Source: American Community Survey 2019

OUR ENVIRONMENT

VIOLENT CRIME

(per 100,000 population)

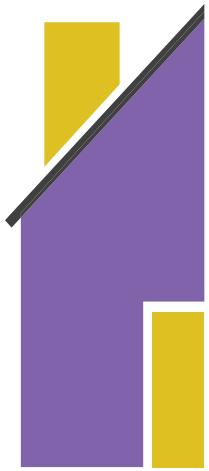
Berks County

299.9

Pennsylvania

315.6

Source: FBI Uniform Crime Reports 2020



HOUSING COST BURDEN

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

Berks County

29.5%

Pennsylvania

28.1%

SUBSTANDARD HOUSING

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

Berks County

29.4%

Pennsylvania

28.1%

Source: U.S. Census Bureau 2019

HOUSING OCCUPANCY BY RACE

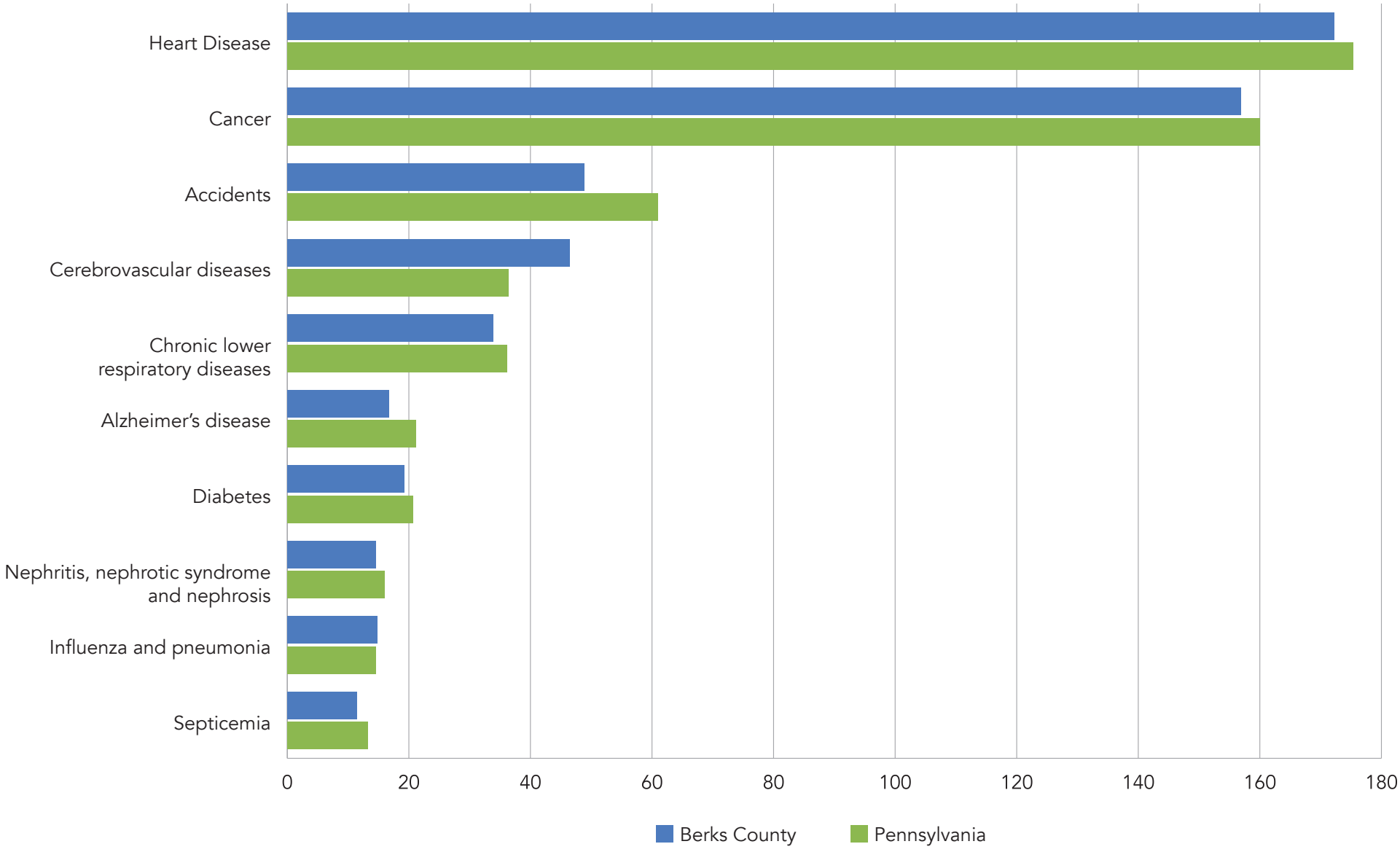
	Owner-Occupied Housing			Renter-Occupied Housing		
	Berks County	**Pennsylvania**	**U.S.**	**Berks County**	**Pennsylvania**	**U.S.**
White	75.6	73.3	69.5	24.4	26.7	30.5
Black	41.7	43.2	41.8	58.3	56.8	58.2
Asian	71.3	58.4	59.6	28.7	41.6	40.4
Native American or Alaska Native	40.1	52.3	54.3	59.9	47.7	45.7
Some other race	43.2	39.4	39.9	56.9	60.6	60.1
Multiple race	40.8	45.0	49.0	59.2	55.0	51.0

Source: U.S. Census Bureau 2019

KEY HEALTH FINDINGS

TOP CAUSES OF DEATH

(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

OVERALL DISEASE DEATHS BY RACE/ETHNICITY IN BERKS COUNTY

(ages 35 years+ per 100,000 population)

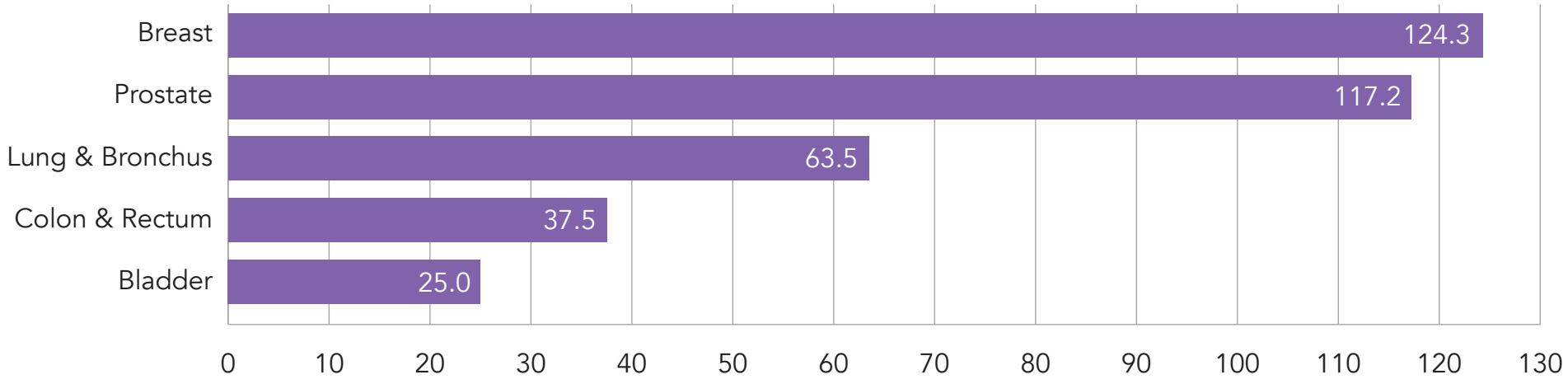
	Heart Disease	Stroke
White	336.0	105.0
Black	445.0	80.0
Asian/Pacific Islander	121.0	67.0
Hispanic	226.0	77.0

Source: Pennsylvania Department of Health 2019

OVERALL COMMON CANCERS IN BERKS COUNTY

MOST COMMONS CANCERS IN BERKS COUNTY

(per 100,000 population)

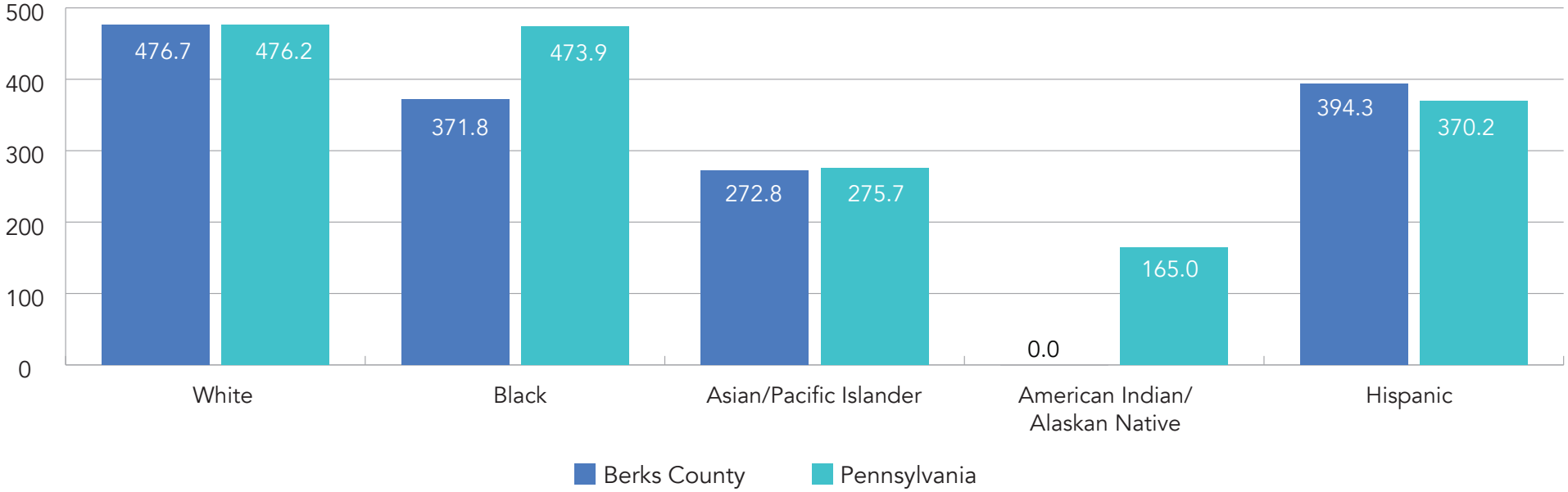


Source: Pennsylvania State Cancer Profiles 2014-2018

OVERALL CANCER INCIDENCE

CANCER INCIDENCE RATES BY RACE

(per 100,000 population)



CANCER INCIDENCE RATES IN BERKS COUNTY BY RACE

(per 100,000 population)

	Lung & Bronchus	Colon & Rectum Cancer	Breast Cancer (Females only)	Prostate Cancer (Men only)	Bladder
White	64.4	36.7	125.5	110.1	25.5
Black	46.3	30.3	82.6	172.3	-
Asian/Pacific Islander	-	-	88.3	-	-

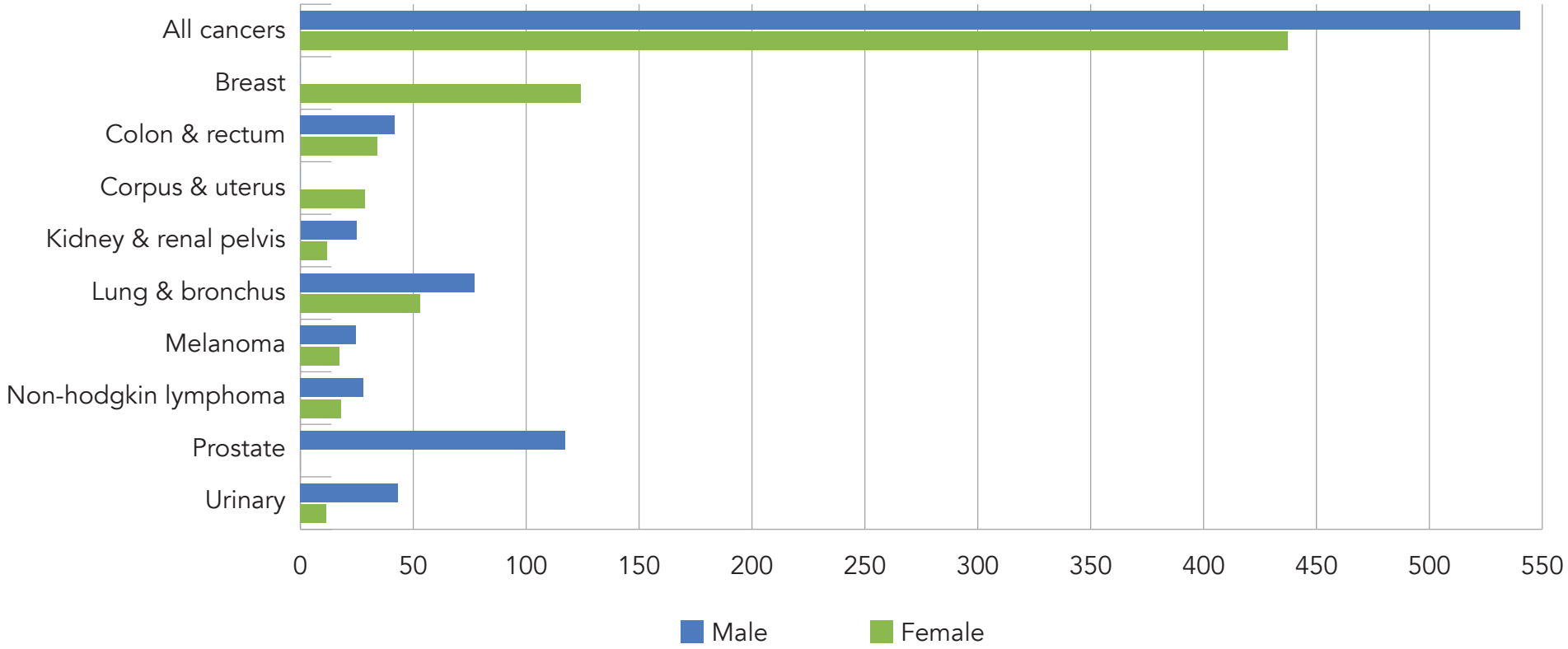
Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.

Source: Pennsylvania State Cancer Profiles 2014-2018

CANCER BY GENDER

CANCERS BY GENDER IN BERKS COUNTY

(per 100,000 population)



Source: Pennsylvania State Cancer Profiles 2014-2018

CANCER INCIDENCE RATES AND DEATH BY RACE AND ETHNICITY

(per 100,000 population)

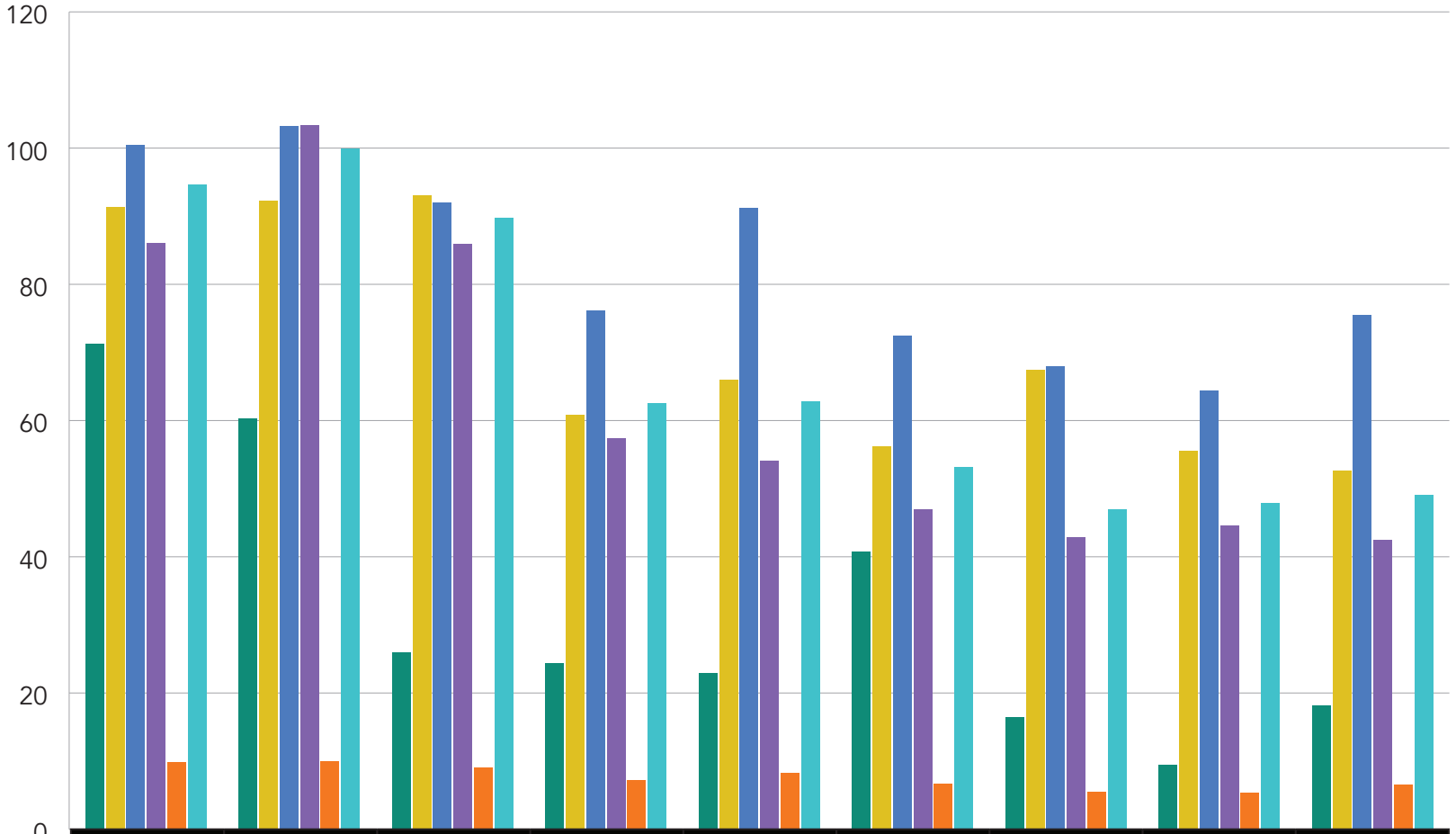
All Cancer Incidence by Race/Ethnicity			
	Berks County	Pennsylvania	U.S.
White	476.7	476.2	451.0
Black	371.8	473.9	444.9
Asian/Pacific Islander	272.8	275.7	291.7
American Indian/Alaskan Native	-	165.0	285.8
Hispanic	394.3	370.2	345.0

All Cancer Deaths by Race/Ethnicity			
	Berks County	Pennsylvania	U.S.
White	158.0	159.3	153.4
Black	173.0	190.5	173.6
Asian/Pacific Islander	82.5	90.2	95.6
American Indian/Alaskan Native	-	44.9	101.2
Hispanic	123.8	107.2	109.7

Note: Dash in the cell indicates that there is no data. 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



	19601	19602	19604	19605	19606	19607	19608	19609	19610
Asian	71.3	60.3	25.9	24.4	22.9	40.7	16.4	9.5	18.2
Black	91.3	92.3	**93.1**	60.8	**66.0**	**56.2**	**67.4**	**55.6**	**52.6**
Hispanic	**100.5**	**103.2**	**92.0**	**76.1**	**91.2**	**72.5**	**67.9**	**64.4**	**75.5**
White	86.1	**103.3**	85.9	57.4	54.1	46.9	42.8	44.6	42.5
Other Race	9.9	10.0	9.1	7.2	8.2	6.7	5.5	5.4	6.6
All Adults	**94.7**	**99.9**	**89.7**	**62.6**	**62.8**	**53.2**	**47.0**	**47.9**	**49.1**

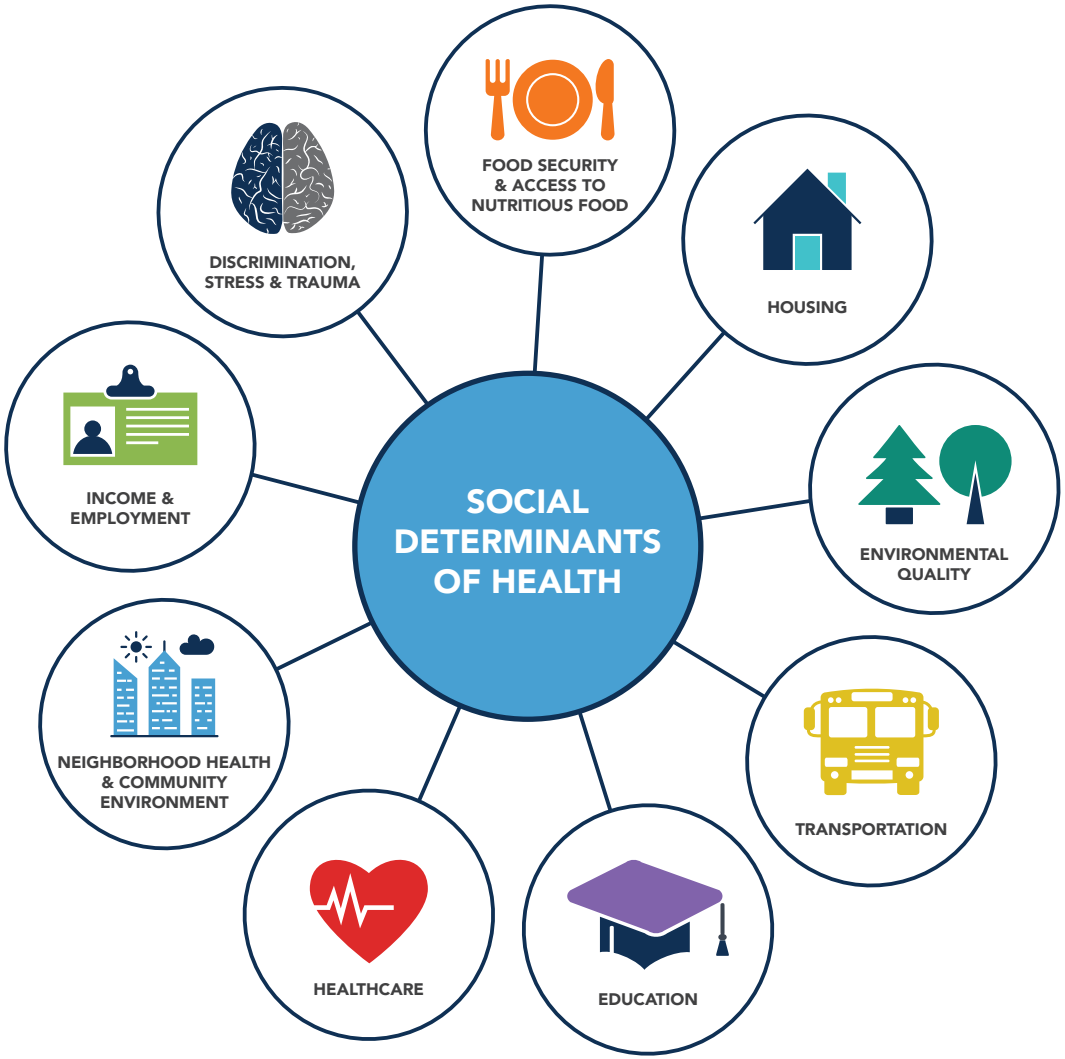
Note: The figures in red indicate high emergency room visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services


EMERGENCY

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

Figure 3: Influential Factors



The World Health Organization (WHO) defines social determinants of health (SDOH) as the economic and social conditions that influence individual and group differences in health status. Where we live, learn, work, and play are important factors that shape one's overall health standing. Communities with access to healthy foods, livable-affordable homes, quality education, and a safe/clean environment are healthier than their counterparts. Our social and physical environment 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), etc.

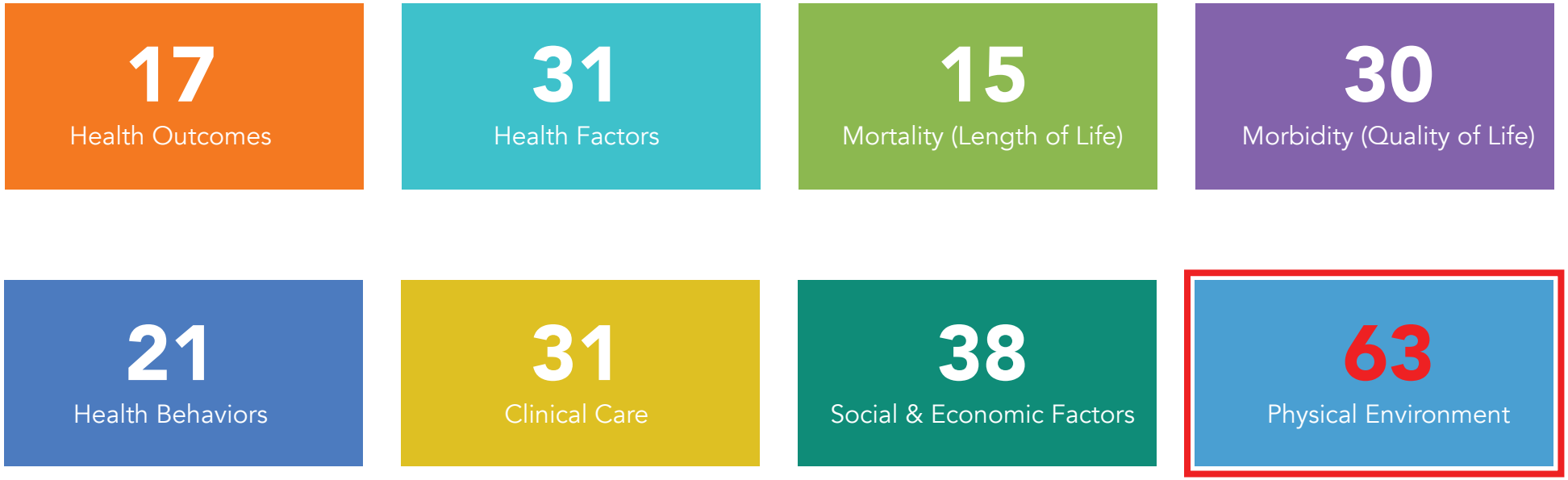
According to the Robert Wood Johnson Foundation, social inequalities such as poverty are linked to unhealthy behaviors like smoking, poor diet, and lack of exercise. However, community investments in proven programs and policy changes can reduce disparities, allowing residents to make it easier to make better healthier choices and reducing illnesses.

FACTORS THAT INFLUENCE OUR HEALTH

SDOH and individual choices play a vital role in one's overall health and well-being; however, those choices must be made available to yield a good outcome. SDOH plays a substantial role in providing residents with choices as everyone does not have access to the same options. Providing health equity provides an equal opportunity for individuals to live healthy lives.

According to County Health Rankings & Roadmaps, Figure 4 shows Berks County is ranked poorly in Physical Environment (63/67 counties) and above the median in Social and Economic Factors in 2021 (38/67 counties). Social and economic factors, such as income, education, employment, community safety, injury and death, social support, and children in poverty, can significantly affect how well and how long we live. Pennsylvania has 67 counties; a score of 1 indicates the "healthiest" county for the state in a specific measure.

Figure 4: County Health Rankings: Berks County
(1-67) (1=Healthiest)



Source: County Health Rankings and Roadmaps 2021

ADDRESSING SOCIAL DETERMINANTS OF HEALTH
COMMUNITY CONNECTION PROJECT (CCP)[4]

The following data represents a project that is under way at Reading Hospital to address SDOH.

HEALTH RELATED SOCIAL NEEDS

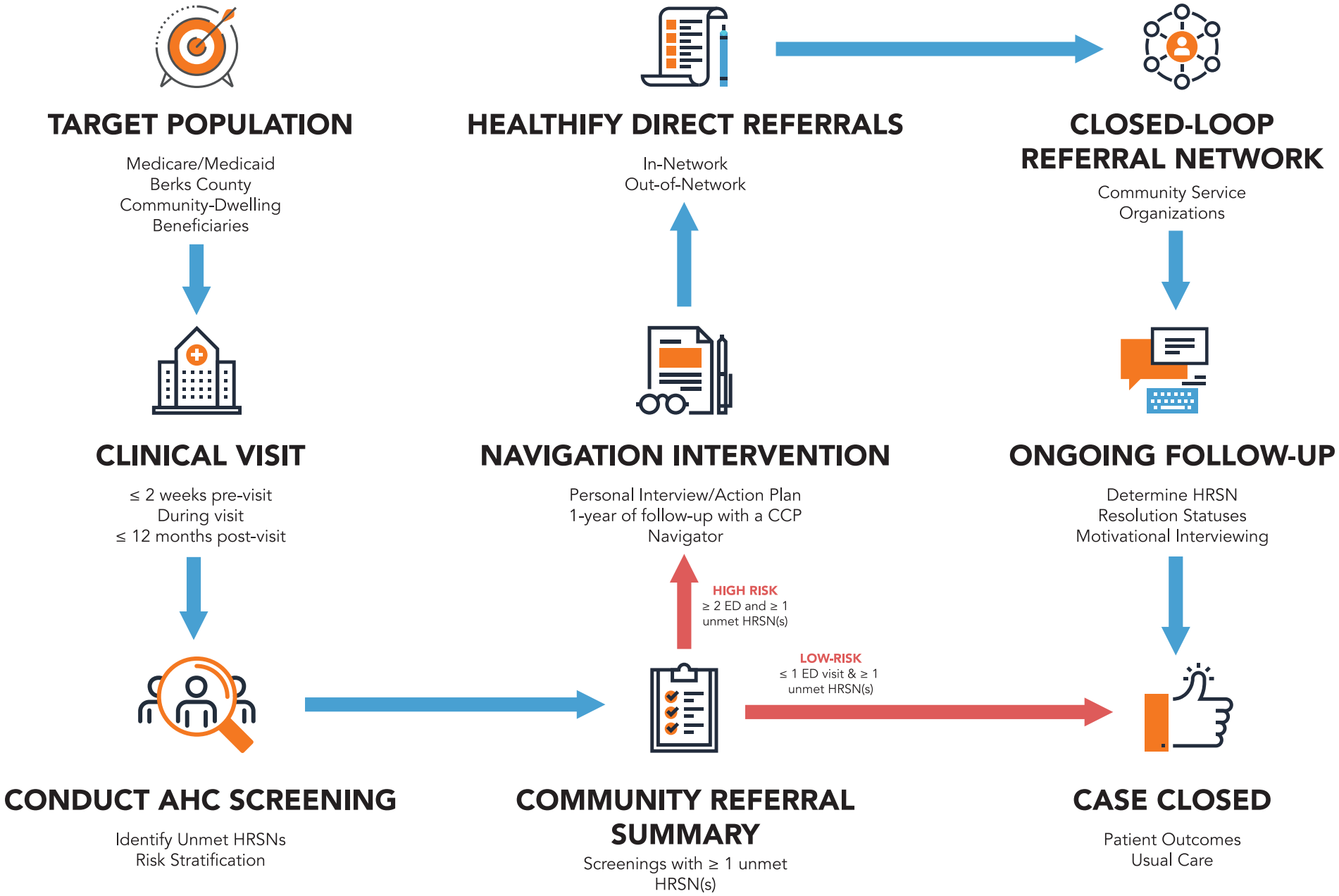
In past CHNA cycles at Reading Hospital, the community has identified barriers such as SDOH impeding their access to health care. As a response, Reading Hospital began to address SDOH through the CCP. The CCP is funded by the Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities (AHC) model cooperative agreement, which seeks to address housing instability, food insecurity, transportation, utilities, and interpersonal violence (safety) health-related social needs (HRSNs).

The project features a consortium comprising of leadership from clinical teams, community service organizations, managed care organizations, and the Pennsylvania State Medicaid Office. The CCP consortium works to build, maintain, and strengthen the community's capacity to address Medicare and Medicaid beneficiary needs. Reading Hospital provides screening, referral, and navigation services for Berks County beneficiaries utilizing an integration between Healthify Inc. and EPIC electronic health records. Healthify creates direct referrals and communicates important information amongst other community service partners, thus creating a closed-loop referral system. The integration also provides Reading Hospital with a wealth of data that can be leveraged to inform more equitable health practicing for our communities.

[4] The project described is supported by Funding Opportunity Number CMS-1P1-17-001 from the Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

CCP OVERVIEW

Figure 5: CCP Screening, Referral, Navigation Workflow

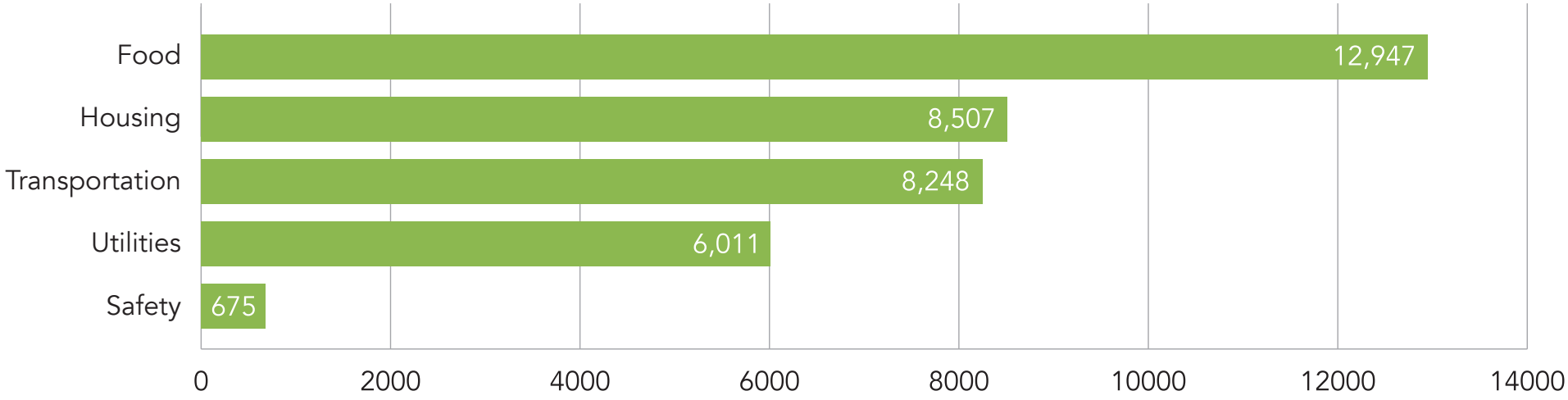


IMPLEMENTATION OUTCOMES/IMPACT

Since September 24, 2018, screenings, referrals, and navigation have been implemented across more than 22 clinical delivery sites such as the emergency department, inpatient units, hospital-outpatient based sites, ambulatory locations, and Berks Community Health Center (local federally qualified health center). More than 30 community service partners (CSP) such as food banks, a transportation municipality, housing/homeless shelters, and community action agencies are receiving referrals via Healthify. There is at least one CSP for each HRSN.

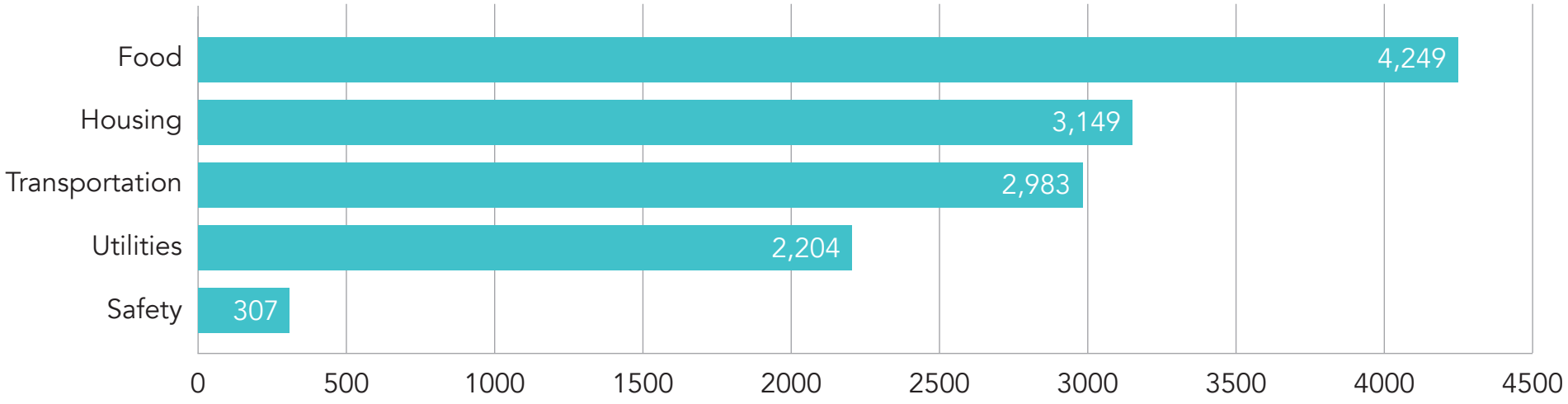
As of June 2021, Reading Hospital has completed 130,215 screenings for 49,221 beneficiaries. Figure 6 shows a breakdown of positive completed screenings by the HRSN identified. A third (n=42,646) of these screenings were high-risk, resulting in 6,184 unique navigation cases. HRSNs identified by unique navigation cases are shown in Figure 7.

Figure 6: Number of Screenings by HRSN May 2018-June 2021



Source: CMS AHC Data System

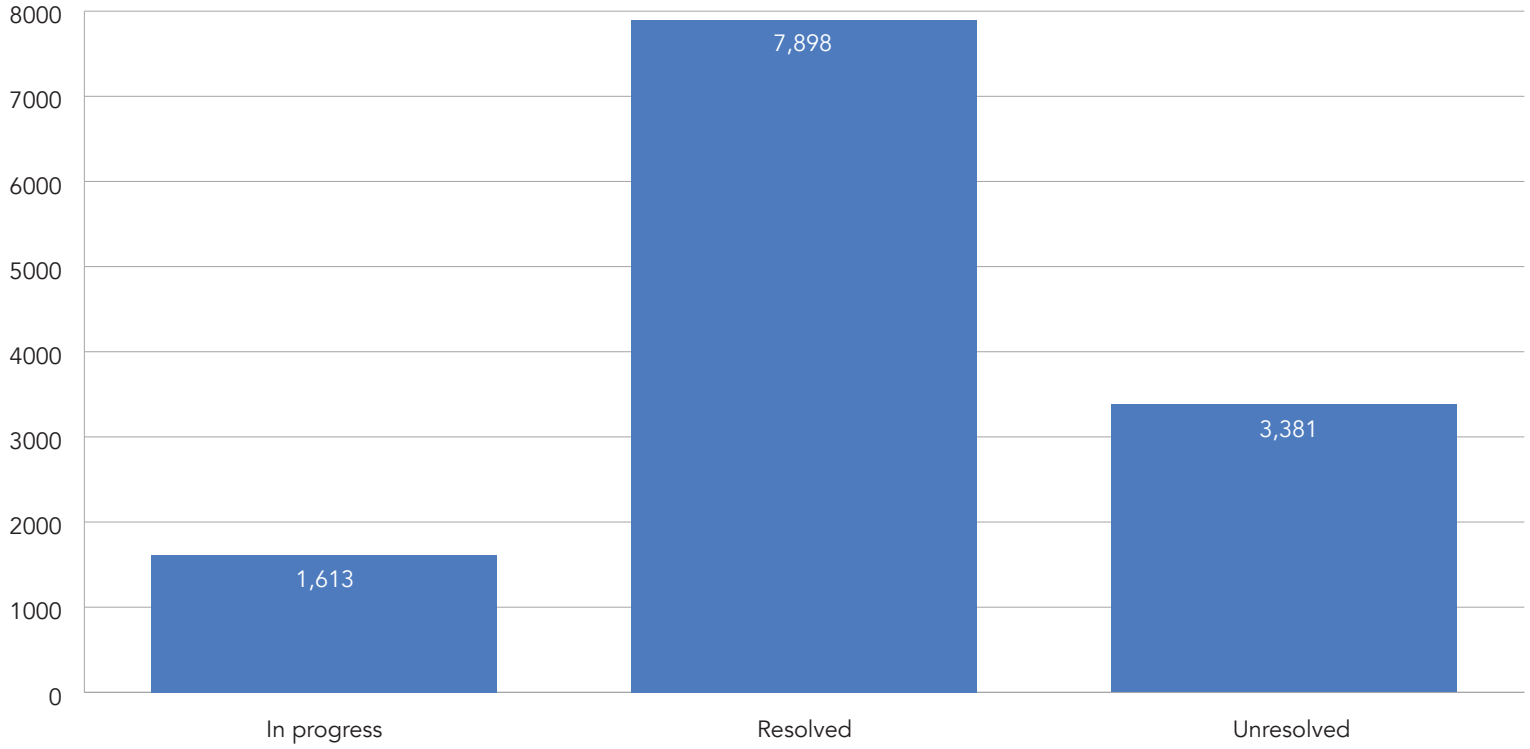
Figure 7: Number of Navigation Cases by HRSN May 2018-June 2021



Source: CMS AHC Data System

Community navigators provide up to one year of ongoing follow-up for beneficiary navigation cases to determine a resolution status for identified HRSNs. Needs left in progress are still pending a resolved or unresolved status. The beneficiary must state their need as resolved; however, a successful connection to a CSP who may resolve their needs may also determine a resolved status. As of September 14, 2021, 10,564 referrals were created for a variety of services. Unresolved statuses occur when beneficiaries opt out of services, are lost-to-follow-up, or have no available resources to resolve their needs.

Figure 8: Number of HRSNs by Resolution Status May 2018-June 2021



Source: CMS AHC Data System

As of June 30, 2021, Reading Hospital resolved 61% (n=7,898) of all HRSNs identified by navigation cases (Figure 8). Resolved cases are attributable to navigation follow-up and referral response. At least 64% of Healthify referrals were sent to CBOs who partner with CCP to receive referrals through Healthify's closed-loop referral system. This system reduces many communication barriers, helping all teams resolve needs effectively and efficiently. The CBO partnership and collaboration has positively impacted the opportunity to resolve beneficiary HRSNs whereas, beneficiaries who receive these services commonly express their gratitude for our clinical-community linkages.

EQUITY LENS: DEMOGRAPHICS SUMMARY

Demographic data such as education, race, ethnicity, sex, and age group was analyzed for 49,638 unique beneficiaries in which 131,589 completed screenings were conducted from May 2018 to July 2021. Table 9 displays data associated with unique beneficiaries with a completed screening and Table 10 displays data related to unique beneficiaries who accepted navigation. Note, beneficiaries who accepted navigation must also complete a screening.

Table 9: Number of Unique Beneficiaries with a Completed Screening

Number of Unique beneficiaries with a COMPLETED SCREENING (N=49,638) N (%)	
EDUCATION (N=40,497)	
LESS THAN HIGH SCHOOL GRADUATE	9966 (24.6)
HIGH SCHOOL GRADUATE	16708 (41.3)
SOME COLLEGE OR TWO-YEAR DEGREE	8821 (21.8)
FOUR-YEAR DEGREE	5002 (12.4)
RACE (N=36,169)	
BLACK OR AFRICAN AMERICAN	2683 (7.4)
WHITE	23015 (63.6)
MULTIPLE RACES	661 (1.8)
OTHER	9810 (27.1)
ETHNICITY (N=41,247)	
NOT HISPANIC, LATINX, OR SPANISH ORIGIN	24431 (59.2)
ANOTHER HISPANIC, LATINX, OR SPANISH ORIGIN	16816 (40.8)
SEX (N=48,784)	
FEMALES	30617 (62.8)
MALES	18167 (37.2)
AGE (IN YEARS)	
≤ 17	8781 (17.7)
18 – 64	19730 (39.7)
≥ 65	21127 (42.6)

Table 10: Number of Unique Beneficiaries Who Accepted Navigation

Number of Unique beneficiaries who ACCEPTED NAVIGATION (N=5,898) N (%)	
EDUCATION (N=5,350)	
LESS THAN HIGH SCHOOL GRADUATE	1667 (31.2)
HIGH SCHOOL GRADUATE	2197 (41.1)
SOME COLLEGE OR TWO-YEAR DEGREE	1165 (21.8)
FOUR-YEAR DEGREE	321 (6.0)
RACE (N=4,588)	
BLACK OR AFRICAN AMERICAN	547 (11.9)
WHITE	2077 (45.3)
MULTIPLE RACES	108 (2.4)
OTHER	1856 (40.5)
ETHNICITY (N=5,429)	
NOT HISPANIC, LATINX, OR SPANISH ORIGIN	2391 (44.0)
ANOTHER HISPANIC, LATINX, OR SPANISH ORIGIN	3038 (56.0)
SEX (N=5,710)	
FEMALES	3803 (66.6)
MALES	1907 (33.4)
AGE (IN YEARS)	
≤ 17	672 (11.4)
18 – 64	4214 (71.4)
≥ 65	1012 (17.2)

Source: AHC Monthly Monitoring Dashboard Report July 2021

Notable disparities were identified between the navigation and screening beneficiary population for some demographic characteristics (Table 11). The beneficiaries in the navigation population generally reported attaining education level of less than a high school graduate, Hispanic ethnicity, and age 18-to-64-years. These disparities highlight key characteristics of the most vulnerable beneficiaries who are accepting navigation.

Table 11: Demographic Disparities of Unique Beneficiaries in CCP

Demographics	Completed a Screening, n=49,638 N (%)	Accepted Navigation, n=5,898 N (%)
Less than high school graduate	9,966 (24.6)	1,667 (31.2)
Hispanic, Latinx, or Spanish origin	16,816 (40.8)	3,038 (56.0)
Age 18-64 years	19,730 (39.7)	4,214 (71.4)

IMPACT ON THE PATIENT

To determine how SDOH impacts health outcomes and utilization, McKinsey and Company conducted a Consumer SDOH Survey of 2,010 individuals in 2019. Survey results found that "respondents reporting higher inpatient or E.R. utilization were more likely to report unmet social needs." The positive impacts of addressing SDOH by the health care system and payer are benefiting patients in other ways. "Eighty-five percent of respondents reporting multiple unmet social needs indicated they would use a social program offered by their health insurer." (McKinsey & Company)

In 2021, a patient was screened by the CCP and determined to have an unmet food and transportation need. Through navigation services, she was referred to Helping Harvest and BARTA. It was also identified that the patient needed some additional assistance for infant care essentials therefore, she was connected to Hannah's Hope Ministries. All community-based organizations were able to provide her with services to meet her needs. During follow-up with a CCP Community Navigator, the patient stated that she is using one of Helping Harvest's food pantries, receving BARTA transportation services, and had received baby supplies through Hannah's Hope Ministries. She reported that all her needs were now resolved and there were no additional concerns to be addressed.

PULLING IT TOGETHER

Building on the vital work that has been underway, Reading 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 12 shows the top community health needs identified by focus group.

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

Facing the challenges of COVID-19, Reading Hospital used lessons learned to better understand the impact of the pandemic on the plethora of previously identified health needs and issues. The post-pandemic CHNA further helped the health system to realize the even wider gaps that resulted as related to accessing care; a lack of education and awareness of available health services and programs; an even greater digital divide and lack of access to technology; the increased demand for behavioral health services; and the limited capacity to provide quality and appropriate care due to limited language services.

Figure 13 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 13: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the contributors and barriers to people accessing equitable care?"

- Economic disparity
- Community fear and distrust
- Language barriers
- Shortage of diverse, ethnic providers
- Limited insurance coverage
- Lack of transportation
- Convenience of appointment
- Unconscious bias and stigmas

"Why are People Treated Differently?"

- Race/ethnicity – 54%
- Insurance coverage – 23%
- Non-English speaking – 23%

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the perceived barriers to accessing care and services?"

- Affordability
- Health literacy
- Lack of transportation
- Lack of insurance
- Cultural barriers

"What are the Barriers to a Quality Life"

- Economic disparities
- Cost of care/meds
- Lack of insurance
- Health literacy
- Mental illness

KEY INFORMANT SURVEYS

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

- Affordability
- Lack of transportation
- No insurance
- Health literacy

"What are the Barriers to a Quality Life?"

- High costs of care/meds
- Economic disparities
- Mental illness

COMMUNITY SURVEYS

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

- Lack of access to health care/PCPs
- Inconvenience/appointment scheduling
- Lack of jobs
- Lack of exercise

"What are the Most Important Health Issues?"

- Behavioral health/mental health
- Drug/alcohol use
- Lack of exercise
- Aging Issues (Arthritis, hearing/vision loss)
- Access to healthy foods

"What are the Barriers to a Quality Life?"

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

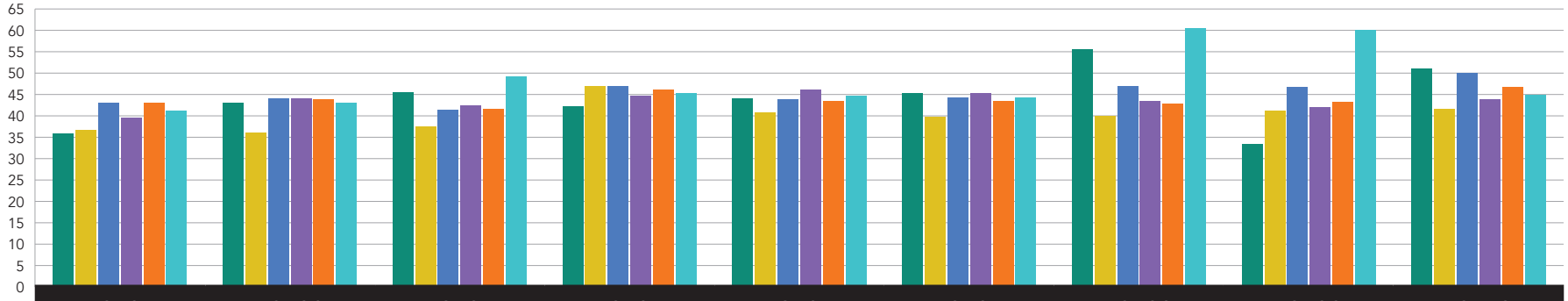
Figure 14 shows Berks County residents who have no health insurance coverage or coverage via Medicare. Over the last few CHNA cycles, we have seen the percentage of insured people steadily rise; however, efforts to improve access to care must continue.

Figure 14: 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 the City of Reading related to adults who obtain primary care visits by ZIP code.

Figure 15: Percentage of Adults with Primary Care Physician Visits by ZIP Code Summary



	19601	19602	19604	19605	19606	19607	19608	19609	19610
Asian	35.9	42.9	45.5	42.2	44.1	45.2	55.5	33.3	51.0
Black	36.6	36.0	37.5	46.8	40.7	39.8	40.0	41.2	41.6
Hispanic	42.9	44.0	41.3	46.9	43.9	44.3	46.8	46.6	50.0
White	39.5	44.1	42.3	44.7	46.0	45.2	43.5	41.9	43.9
Other Race	42.9	43.9	41.6	46.1	43.3	43.5	42.8	43.2	46.6
All Adults	41.2	43.0	59.1	45.3	44.7	44.2	60.4	60.1	44.8

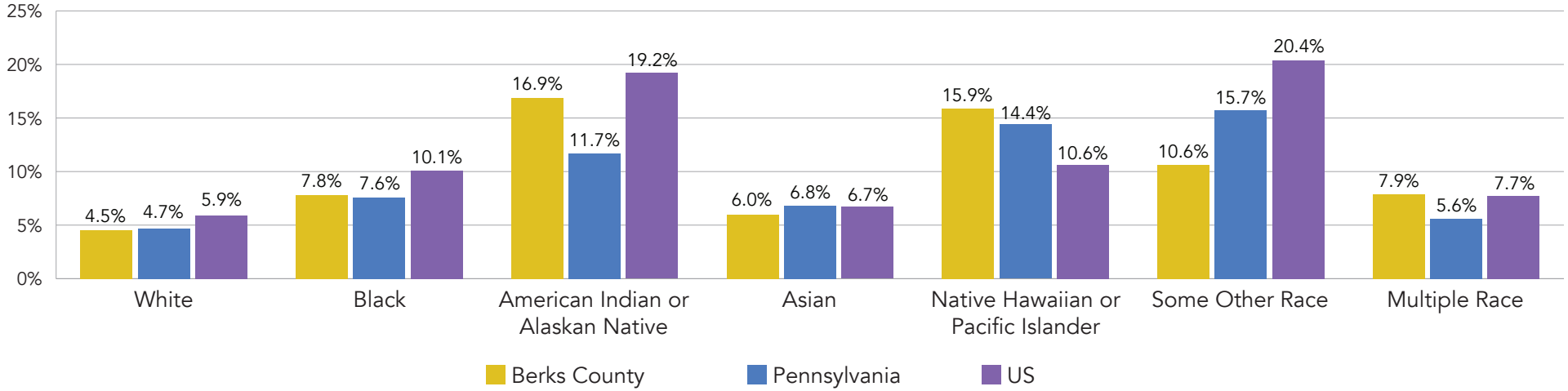
Note: The figures in red indicate low percentages of adults with primary care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[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.

Although the percentage of uninsured has increased over the past several years, Figure 16 shows more uninsured Blacks, Native Americans or Alaska Natives, Native Hawaiians or Pacific Islanders, and residents of multiple races as compared to the state.

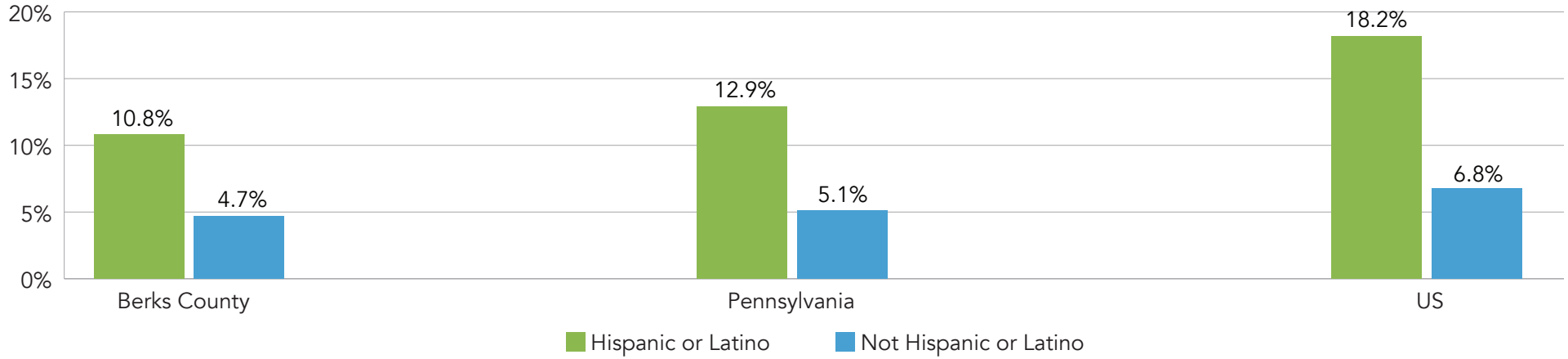
Figure 16: Percentage of Uninsured Population by Race



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

Figure 17 shows more uninsured Hispanic or Latinos when compared to the state and the nation.

Figure 17: Percentage of Uninsured Population by Ethnicity

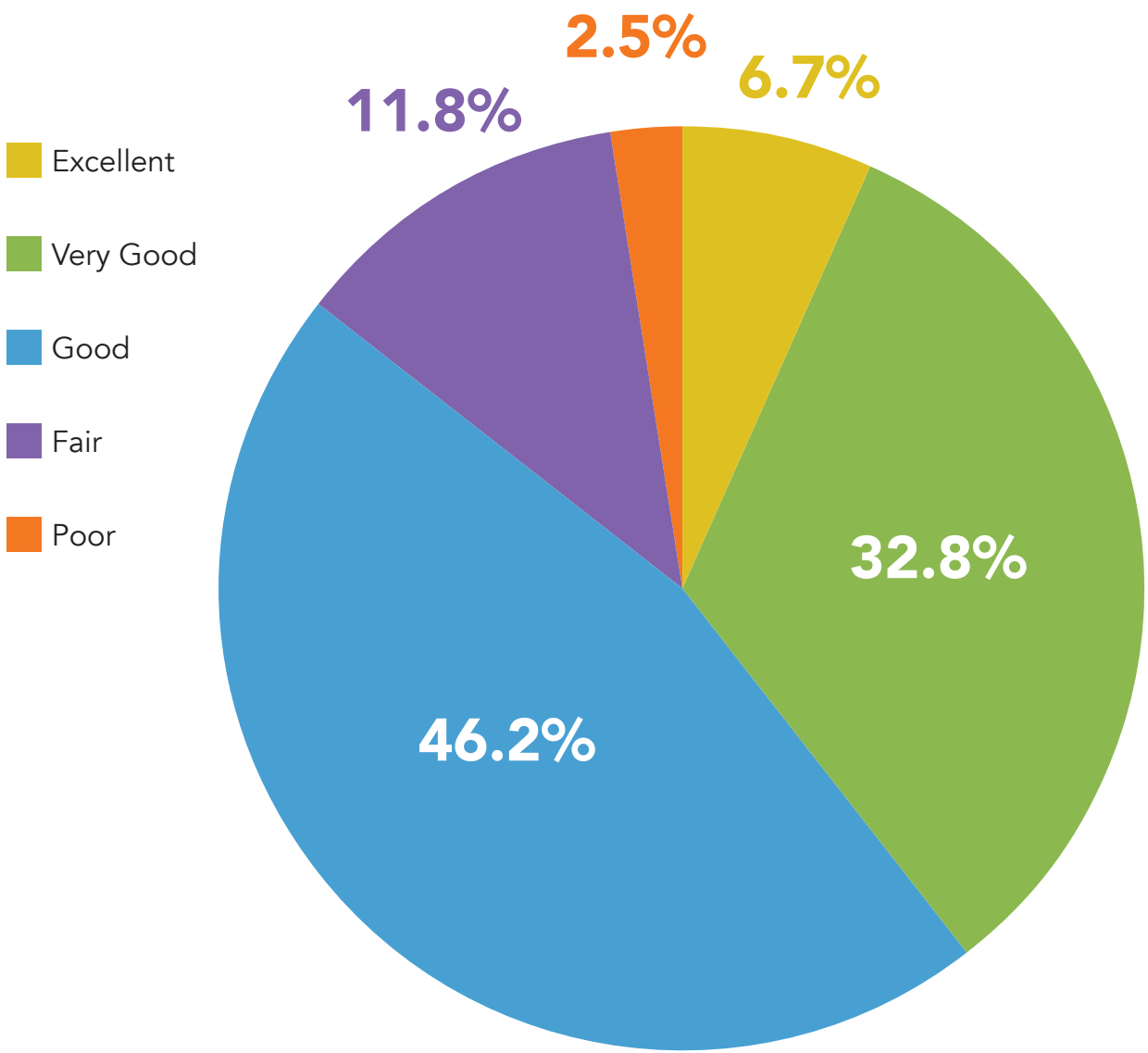


Source: U.S. Census Bureau, American Community Survey 2019

When asked to rate their health status, 86% (n=204) of community health survey respondents stated good, very good, or excellent health. 50% (n=124) noted the need for blood pressure screenings, and 40% (n=94) cited the need for cholesterol screenings for chronic disease management.

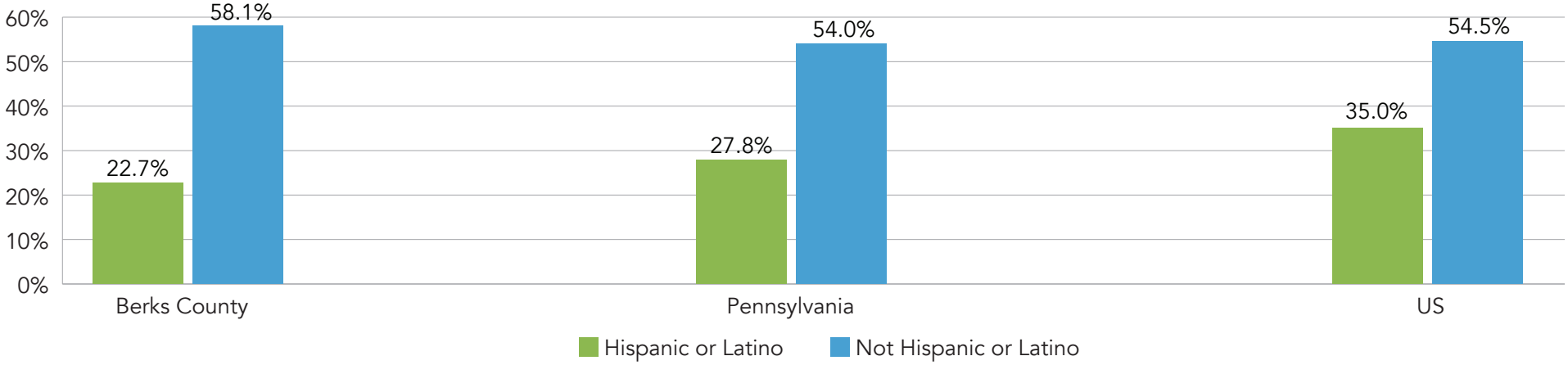
Figure 18 reported how respondents described their overall health.

Figure 18: 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. It is noted that income inequality has grown substantially over recent decades.

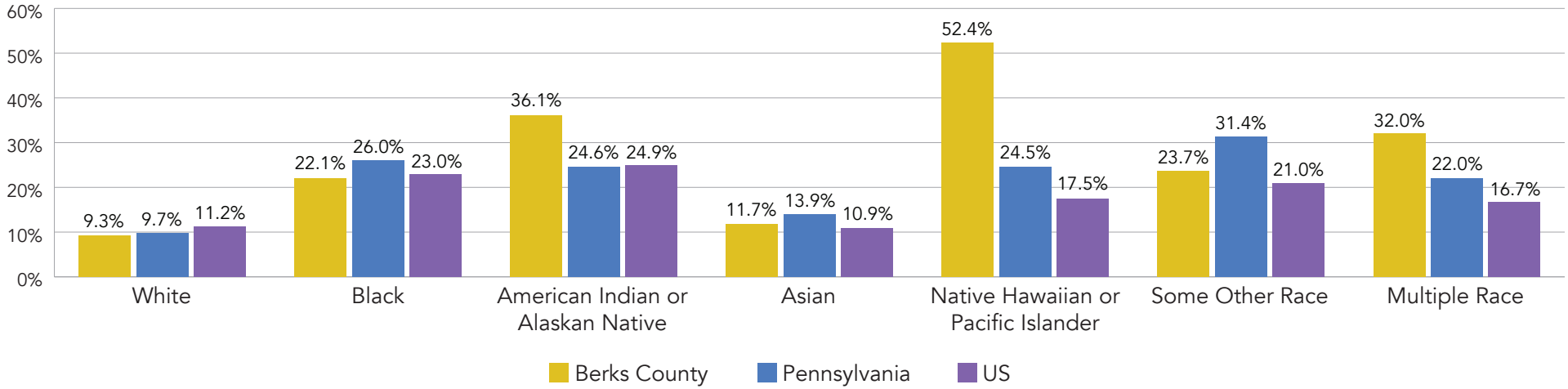
Figure 19: Families Earning More Than $75,000 by Ethnicity



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

Figure 20 reported the percentage of the population below 100% of the federal poverty line (FPL) by race.[6]

Figure 20: Population Below 100% FPL by Race

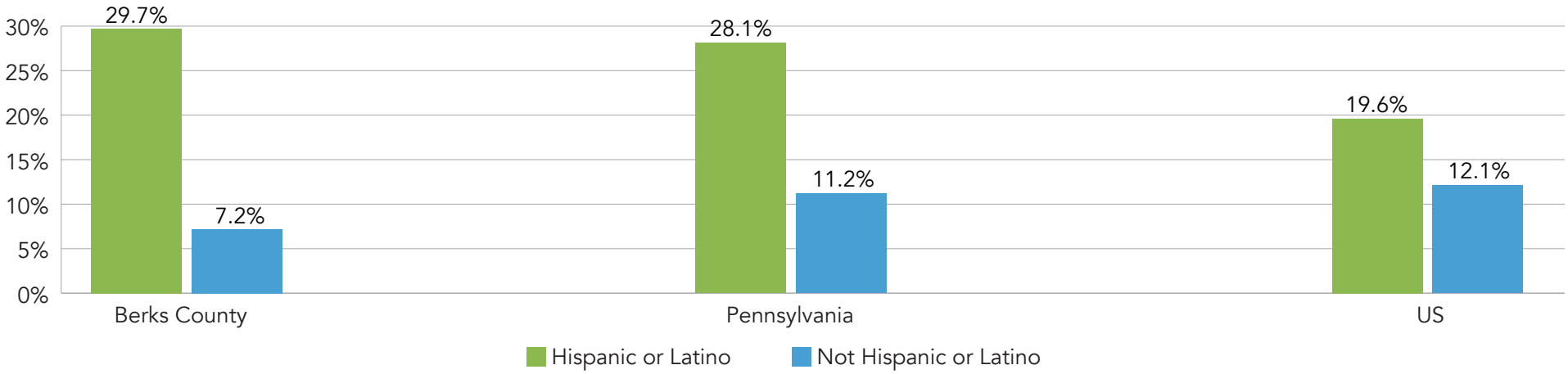


Source: U.S. Census Bureau, American Community Survey 2019

[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 4 living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2021 is $26,500.

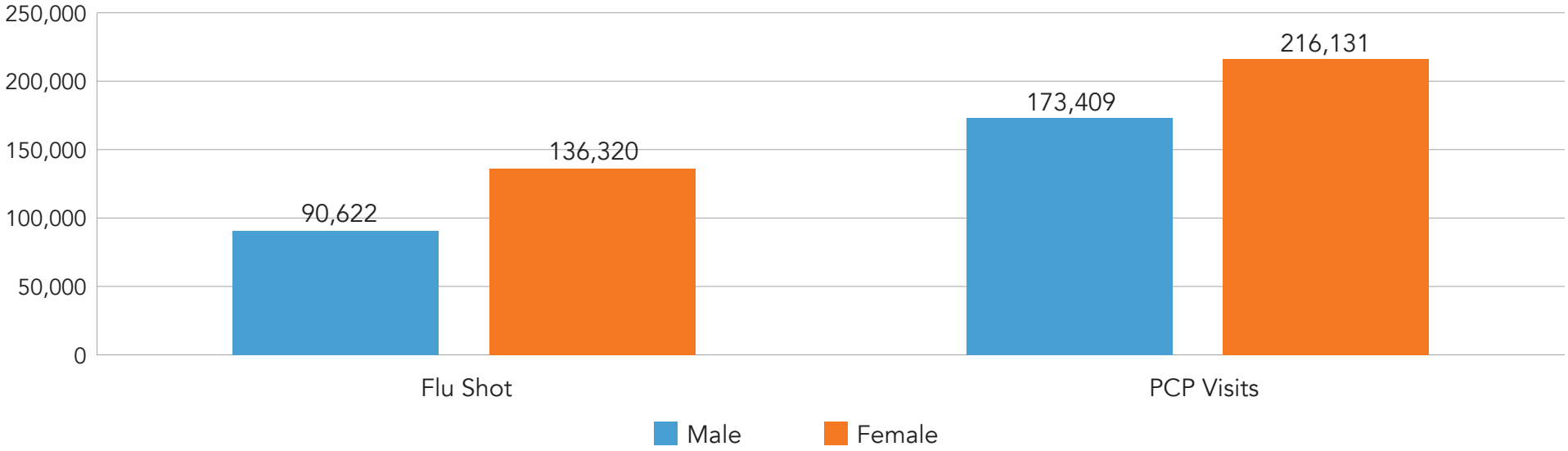
Figure 21 reports the percentage of the population below 100% of the federal poverty line by ethnicity.

Figure 21: Population Below 100% FPL by Ethnicity



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

Figure 22: Reading Hospital with Completed Health Screenings and Preventative Health Measures by Gender 2018-2020



Source: Epic Clarity

Table 23 shows patients who are potentially eligible for a mammography screening and were seen at Reading Hospital between 2018 and 2020. During this time, a 49% mammography screening rate has been achieved. Nearly half (n=174,766) of patients who are potentially eligible for a mammography screening and were seen at Reading Hospital between 2018 and 2020, had a completed screening. About 23% (n=40,607) of patients without a completed screening reside in the following top 5 ZIP codes: 19606, 19601, 19607, 19605, 19604.

Table 23: Overall Mammography Screenings 2018- 2020

	Mammography Complete	Mammography Eligible	Completion Rate
2018	47,326	96,479	49%
2019	60,548	119,218	51%
2020	66,892	138,795	48%

Source: Epic Clarity. The following information on race and ethnicity screening analysis was provided by Tanieka Mason, MPH Sr. Manager SDOH & Analytics, Community Wellness, Reading Hospital.

Table 24 highlights in red the various race categories where the mammography screening rate is less than the overall screening rate of 51.3%*

Table 24: Mammography Screenings by Race 2018 – 2020

	Mammography Complete	Mammography Eligible	Completion Rate
American Indian or Alaska Native	141	325	43.4%
Asian Indian, or Other Asian	1,658	3,176	52.2%
Black or African American	11,956	25,667	46.6%
Native Hawaiian or Other Pacific Islander	206	452	45.6%
White or Caucasian	146,583	278,388	52.7%
Other	11,579	27,806	41.6%
TOTAL	**172,123**	**335,814**	**51.3%**

*Total excludes 18,678 records of data marked as the patient refused, unknown, or missing.

Source: Epic Clarity

Table 25 highlights in red the ethnicity category where the mammography screening rate is less than the overall screening rate of 51.6%*

Table 25: Mammography Screenings by Ethnicity 2018 – 2020

	Mammography Complete	Mammography Eligible	Completion Rate
Hispanic or Latino	15,292	35,532	43.0%
Not Hispanic or Latino	153,453	291,464	52.6%
TOTAL	**168,745**	**326,996**	**51.6%**

*Total excludes 27,496 records of data marked as the patient refused, unknown, or missing

Source: Epic Clarity

Table 26 shows patients who are potentially eligible for a colonoscopy screening and were seen at Reading Hospital between 2018 and 2020 and completed a screening. During this time, a 31% colonoscopy screening rate has been achieved. About 22% (n=81,086) of patients without a completed screening reside in the following top 5 zip codes: 19606, 19601, 19607, 19608, 19605.

Table 26: Colonoscopy Screenings 2018- 2020

	Colonoscopy Completed	Colonoscopy Eligible	Completion Rate
2018	53,015	150,870	35.1%
2019	55,848	180,974	30.9%
2020	57,438	209,113	27.5%

Source: Epic Clarity.

Table 27 highlights in red the various race categories where the colonoscopy screening rate is less than the overall screening rate of 32%*

Table 27: Colonoscopy Screenings by Race 2018 – 2020

	Colonoscopy Completed	Colonoscopy Eligible	Completion Rate
American Indian or Alaska Native	103	454	22.7%
Asian Indian, or Other Asian	1,295	4,333	29.9%
Black or African American	5,976	35,427	16.9%
Native Hawaiian or Other Pacific Islander	81	601	13.5%
White or Caucasian	148,905	429,874	34.6%
Other	6,822	38,996	17.5%
TOTAL	**163,182**	**509,685**	**32.0%**

*Total excludes 31,272 records of data marked as the patient refused, unknown, or missing.

Source: Epic Clarity

Table 28 highlights in red the ethnicity category where the colonoscopy screening rate is less than the overall screening rate of 31.9%*

Table 28: Colonoscopy Screenings by Ethnicity 2018 – 2020

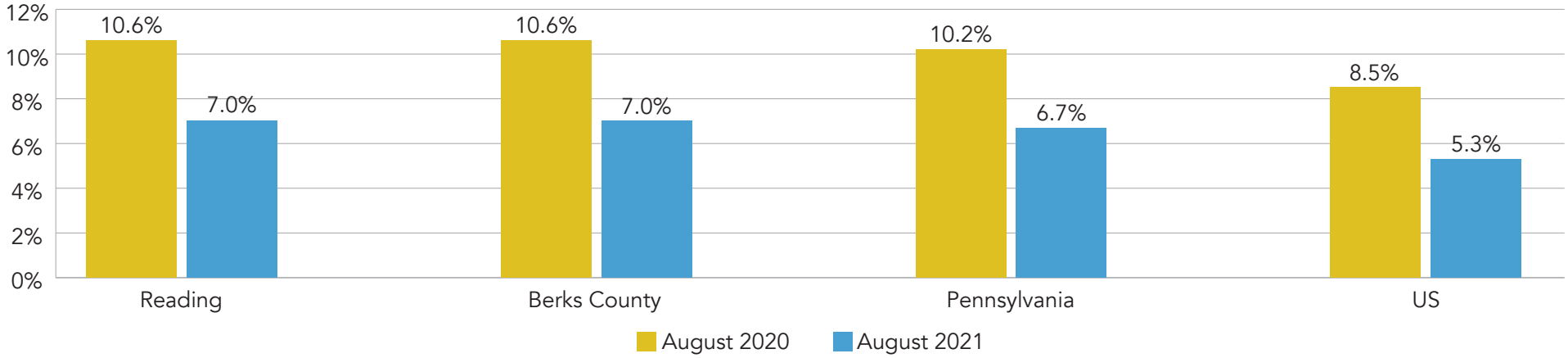
	Colonoscopy Completed	Colonoscopy Eligible	Completion Rate
Hispanic or Latino	8,980	49,371	18.2%
Not Hispanic or Latino	149,084	445,401	33.5%
TOTAL	**158,064**	**494,772**	**31.9%**

*Total excludes 46,185 records of data marked as the patient refused, unknown, or missing.

Source: Epic Clarity

Figure 29 illustrates the unemployment rate in Reading, Berks County, the state, and the nation.

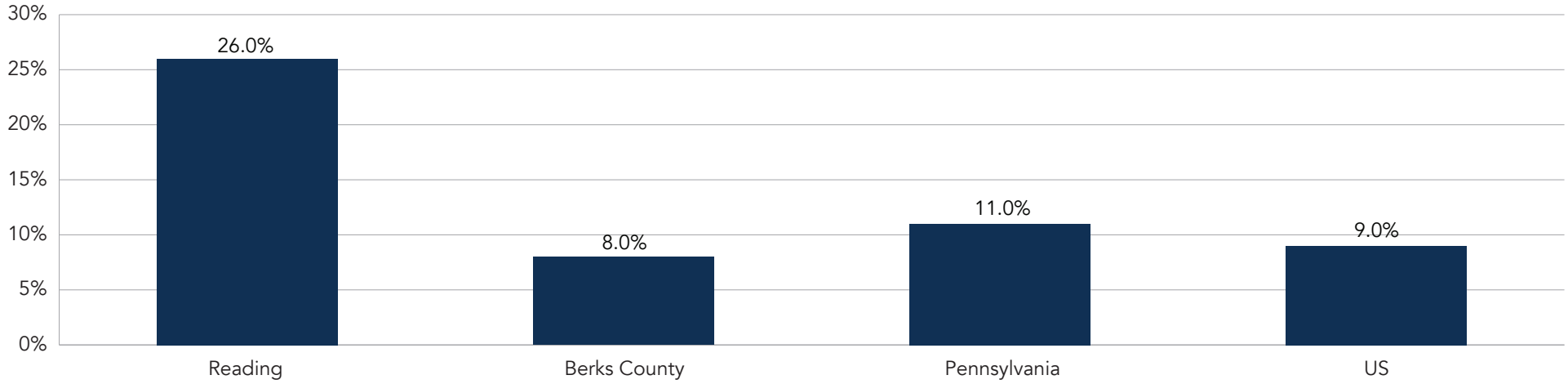
Figure 29: Unemployment Rates



Source: U.S. Department of Labor, Bureau of Labor Statistics 2020-2021

Figure 30 shows a higher rate of Reading residents not having a motor vehicle when compared to those in Berks County, Pennsylvania, and the state 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 30: Households with No Motor Vehicle



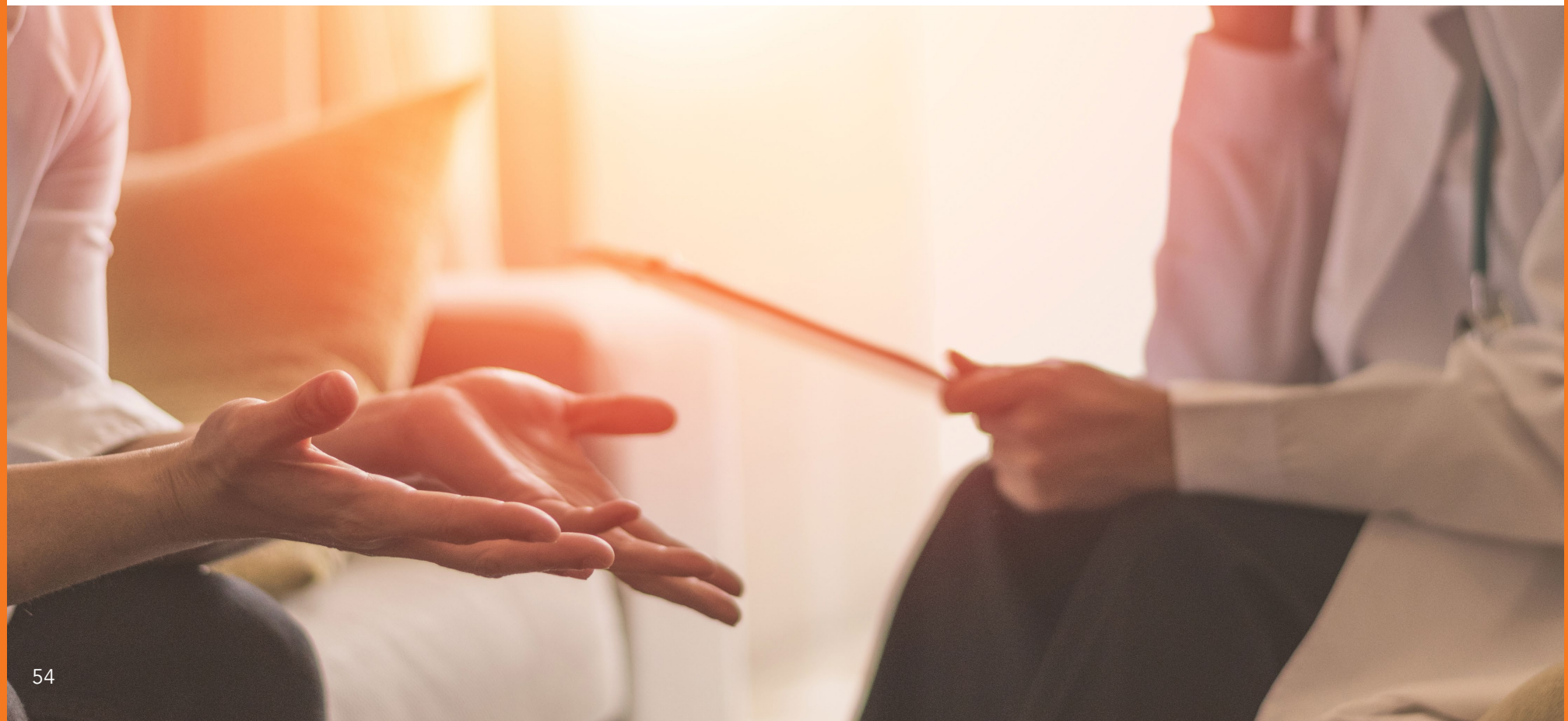
Source: Berks Vital Signs 2015-2019

B) BEHAVIORAL HEALTH

Improving access and adequacy of behavioral health services and programs has become a high priority for Reading Hospital's communities in the past several years as more than 60% of community survey respondents noted behavioral health as having the greatest impact on overall community health. The COVID-19 pandemic, social distancing policies, mandatory lockdowns, isolation, and the fear of getting sick made the need for access to behavioral health services even more evident.

Mental health 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.

Figure 31 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 31: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the contributors and barriers to people receiving behavioral health services?

- Lack of behavioral health/mental health services
- Lack of awareness of available services
- Shortage of behavioral health providers and services

KEY INFORMANT SURVEYS

"What are the perceived barriers to accessing behavioral health services?"

- Drug/alcohol use
- Lack of access to behavioral health/mental health services
- Awareness of available behavioral health services
- Lack of behavioral health care coordination

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the Perceived Barriers to Behavioral Health Services?"

- Inadequate behavioral health/mental health services
- Lack of awareness of available behavioral health/mental health services
- Poor integration and coordination of behavioral health services

COMMUNITY SURVEYS

"What are the Contributors and Barriers to Overall Health?"

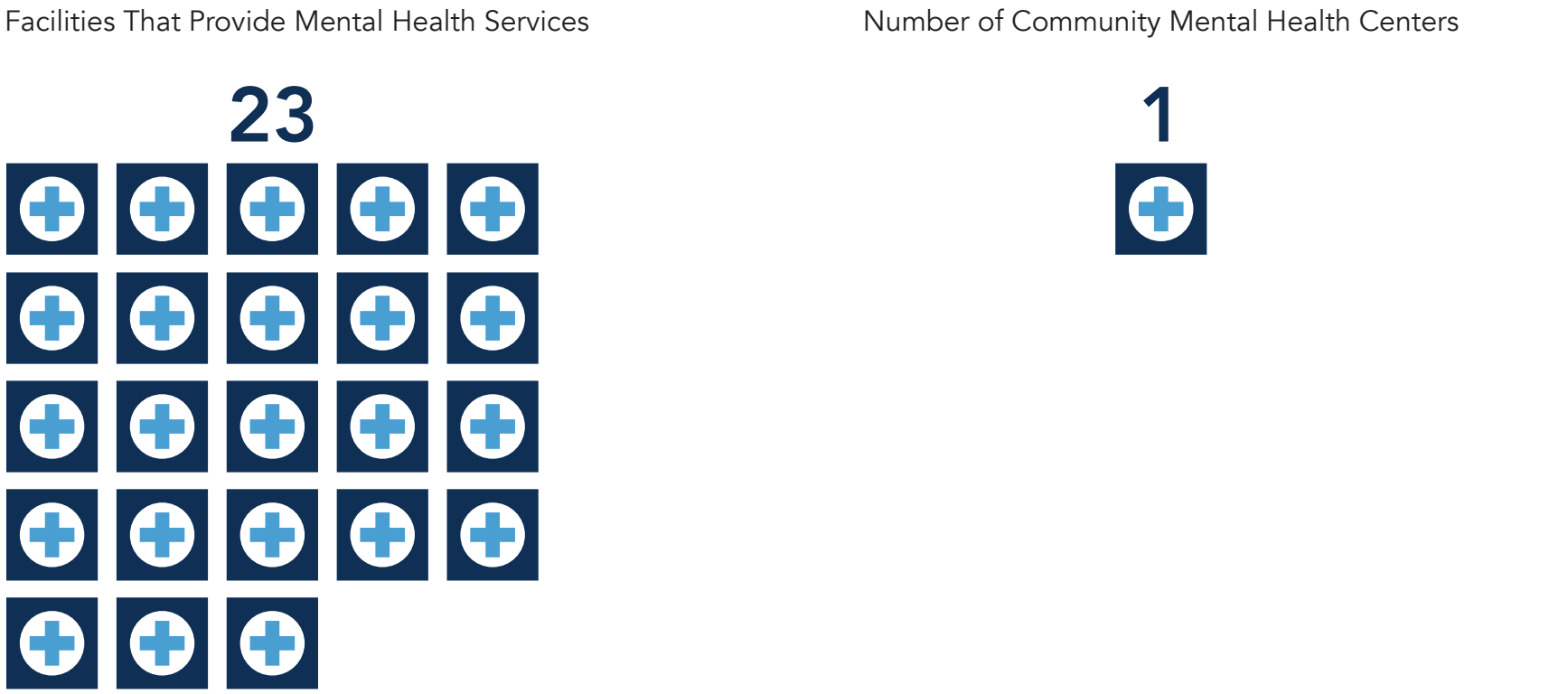
- Lack of access to behavioral health/mental health services
- Drug/alcohol use
- Awareness of available behavioral health/mental health services

Figure 32 illustrates the number of facilities that provide mental health services and the number of community mental health centers in Berks 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.

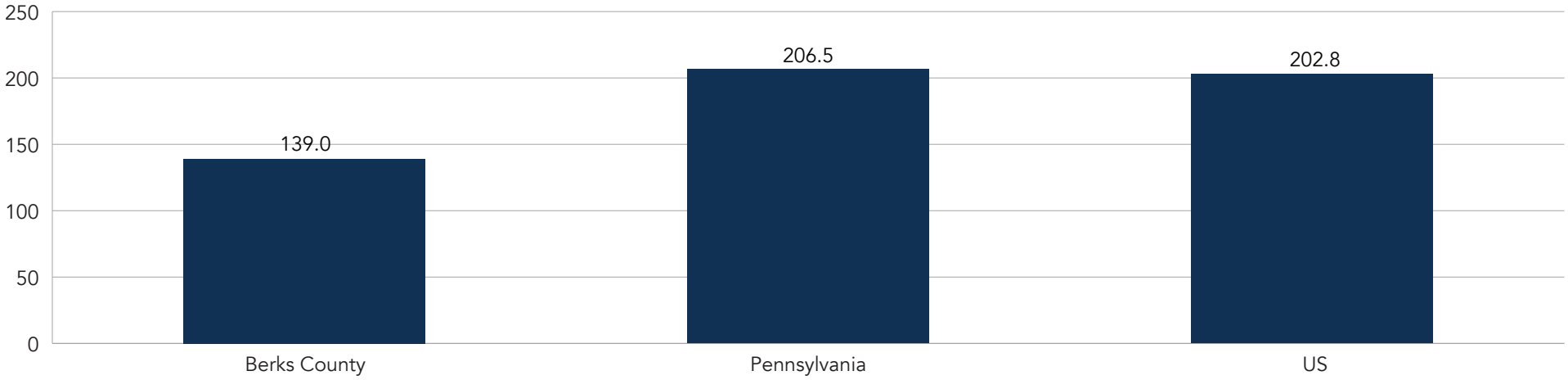
Figure 32: Mental Health Facilities and Centers in Berks County



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

Figure 33 illustrates the shortage in the number of mental health providers (per 100,000 population) in Berks County when compared to the state and the nation.

Figure 33: Mental Health Providers

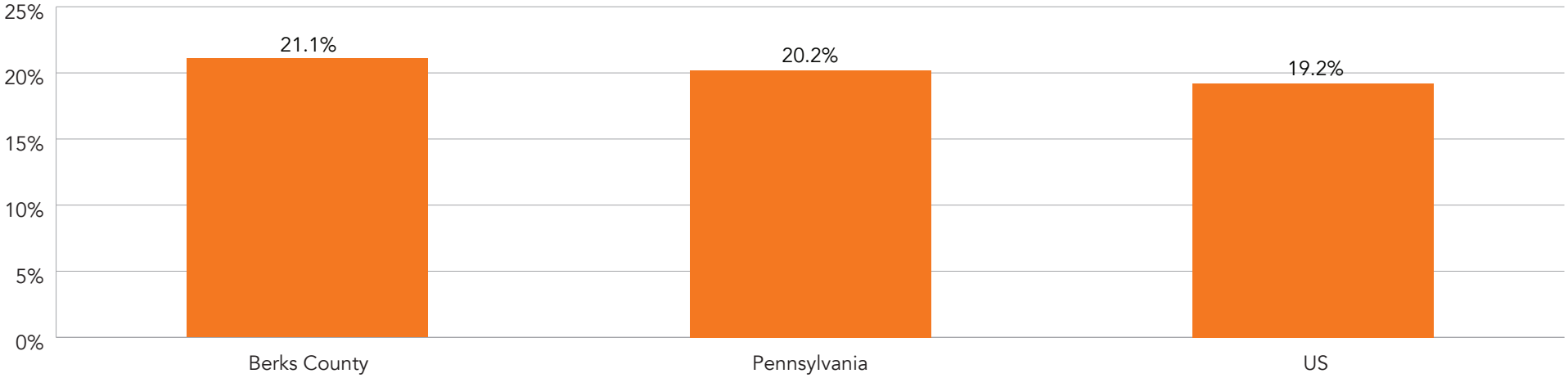


Source: County Health Rankings & Roadmaps 2019

Alcohol and tobacco use are root causes and can further 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 County when compared to the state.

Figure 34 illustrates the percent of adults who are heavy drinkers in Berks County, the state, and the nation.

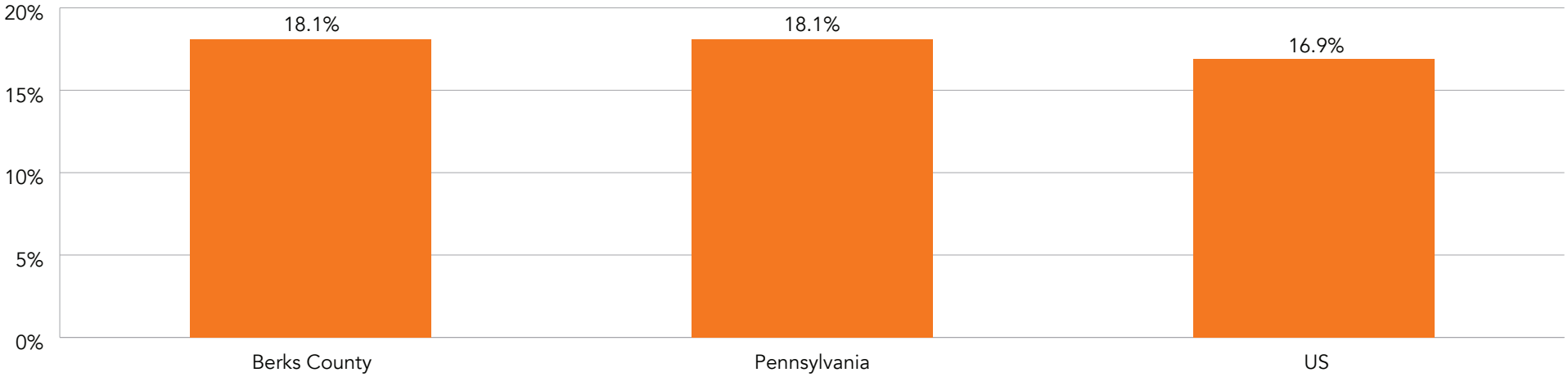
Figure 34: Alcohol Consumption (18 years and older who are Heavy Drinkers)[7]



Source: County Health Rankings & Roadmaps 2018

Figure 35 illustrates the percentage of adults who are binge drinkers in Berks County, the state, and the nation.

Figure 35: Alcohol Consumption (18 years and Older Who Are Binge Drinkers)[8]

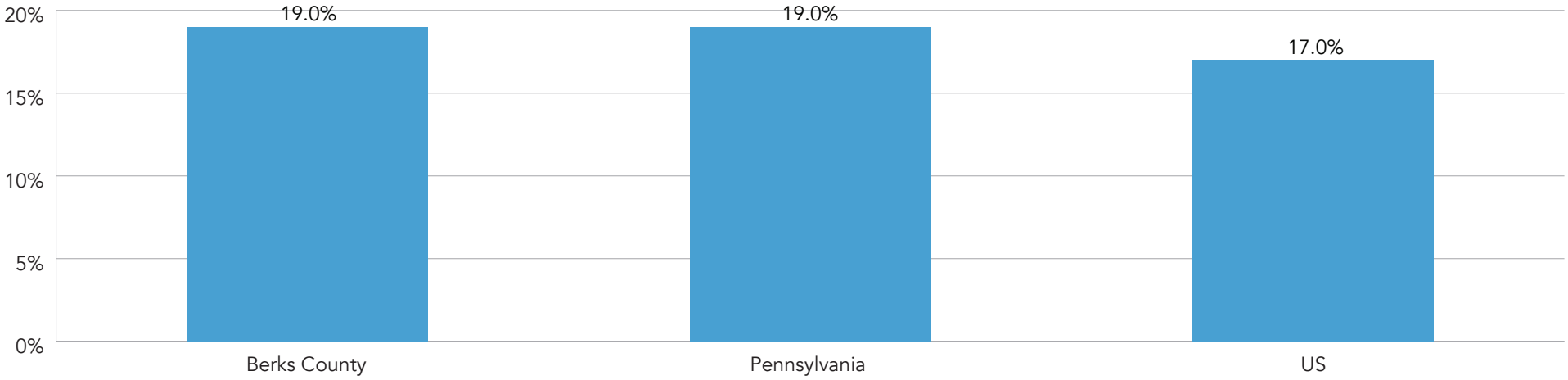


Source: CDC, Behavioral Risk Factor Surveillance System 2018

[7] 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.
[8] 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 36 shows adults 18 and older who smoke every day or some days in Berks County, the state, and the nation.

Figure 36: Tobacco Usage - Current Smokers[9]



Source: CDC, Behavioral Risk Factor Surveillance System 2018

[9] Smokers or current smokers are adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

C) HEALTH EDUCATION AND PREVENTION

Having access to health education programs that help people better understand how to manage an existing health condition and prevent further illness is paramount to good health. Health education and health literacy play a vital role in accessing care as knowledge empowers individuals to make informed health decisions and helps them effectively navigate today's complex health care delivery system.

Providing health education and understanding of health issues enables patients and families to successfully implement treatment plans as essential to managing chronic conditions and preventing complications or hospitalizations. By improving health literacy and education to the broad community on how to address and prevent chronic diseases and illness, the health organization's paradigm shifts from treating disease to a focus on wellness, healthy behaviors, and positive health outcomes.

Figure 37 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 37: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

Discussions related to Health Education

- Lack of awareness of available resources/services
- Where/how to access services
- Inconvenience of services
- Resources available in multi-languages
- Cultural practices

KEY INFORMANT SURVEYS

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

- Lack of education on available resources
- Limited services available
- Lack of prevention education

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the perceived barriers to accessing care and services?"

- Cultural barriers
- Language barriers
- Lack of knowledge of available education resources

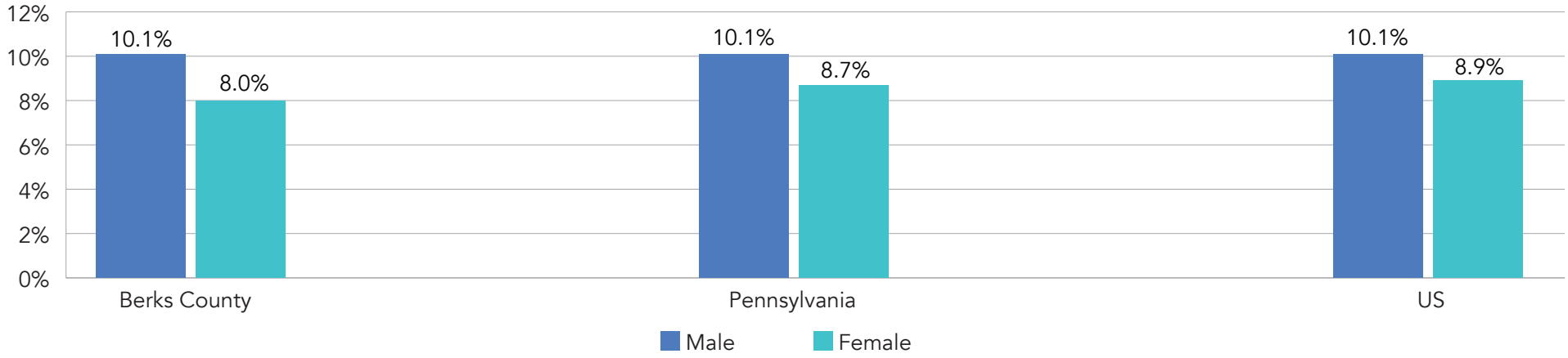
COMMUNITY SURVEYS

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

- Unhealthy lifestyles and behaviors
- Poor nutrition and eating behaviors
- Lack of exercise
- Lack of access to healthy foods
- More chronic disease education/information needed

Figure 38 shows the percentage of adults aged 20 and older, by gender, who have ever been told by a doctor that they have diabetes.

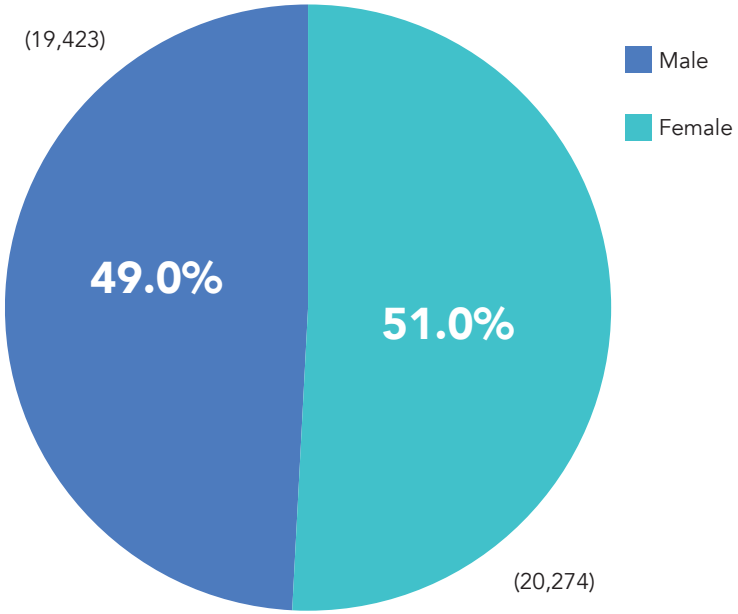
Figure 38: Diabetes by Gender



Source: U.S. Census Bureau 2017

Figure 39 shows the 2021 diabetes registry of patients at Reading Hospital by gender.

Figure 39: Diabetes Registry Patients by Gender



Source: EPIC Clarity

Table 40: 2021 Diabetes Registry Patients at Reading Hospital by Ethnicity

Ethnicity	Diabetes Registry Patients
Hispanic or Latino	6,056
Not Hispanic or Latino	31,780
Patient Refused	556
Unknown	1,291
Total	**39,683**

Source: Epic Clarity

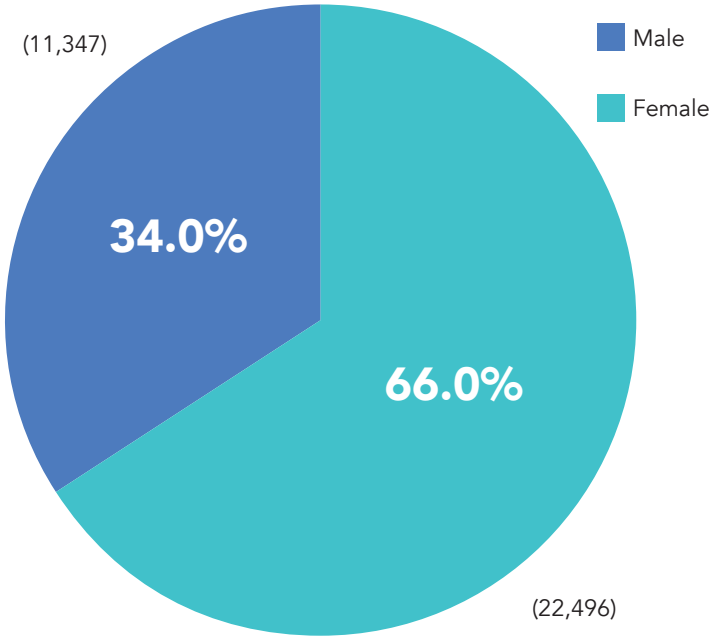
Table 41: 2021 Diabetes Registry Patients at Reading Hospital by Race

Race	Diabetes Registry Patients
American Indian or Alaska Native	51
Black or African American	4,444
Hispanic	8
Native Hawaiian or Other Pacific Islander	51
Other	4,779
Other Asian	392
Patient Refused	297
Unknown	699
Vietnamese	1
White or Caucasian	28,961
Total	**39,683**

Source: Epic Clarity

Figure 42 shows the 2021 asthma registry of patients at Reading Hospital by gender.

Figure 42: Asthma Registry Patients by Gender



Source: EPIC Clarity

Table 43: 2021 Asthma Registry Data at Reading Hospital by Ethnicity

Ethnicity	Asthma Registry Patients
Hispanic or Latino	7,774
Not Hispanic or Latino	24,252
Patient Refused	405
Unknown	1,408
Total	**33,839**

Source: Epic Clarity

Table 44: 2021 Asthma Registry Data at Reading Hospital by Race

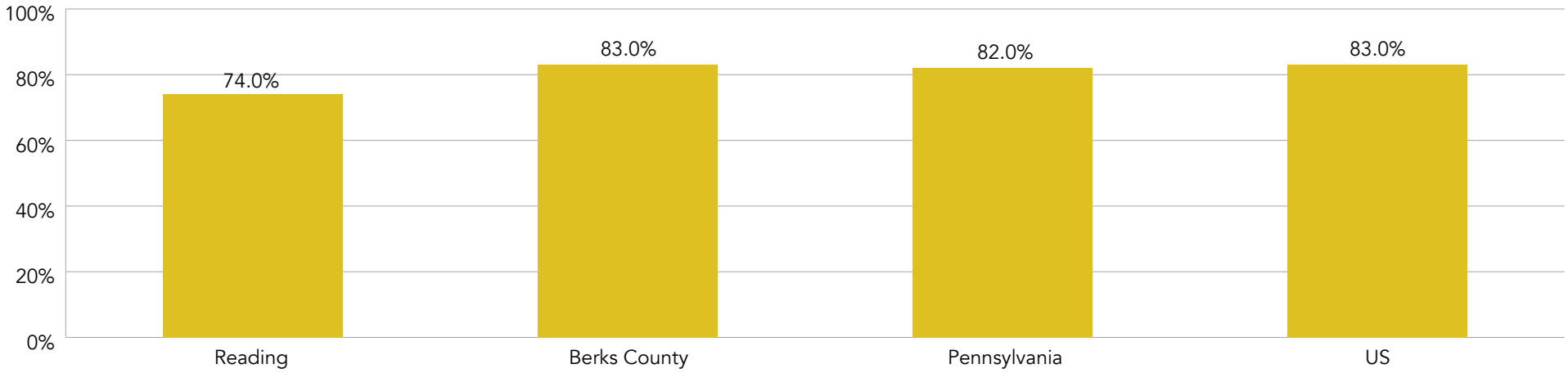
Race	Asthma Registry Patients
American Indian or Alaska Native	42
Black or African American	3,650
Hispanic	3
Native Hawaiian or Other Pacific Islander	37
Other	6,182
Other Asian	190
Patient Refused	316
Unknown	813
White or Caucasian	22,604
Total	**33,837**

Source: Epic Clarity


Patient Prescription Information
Health Conditions

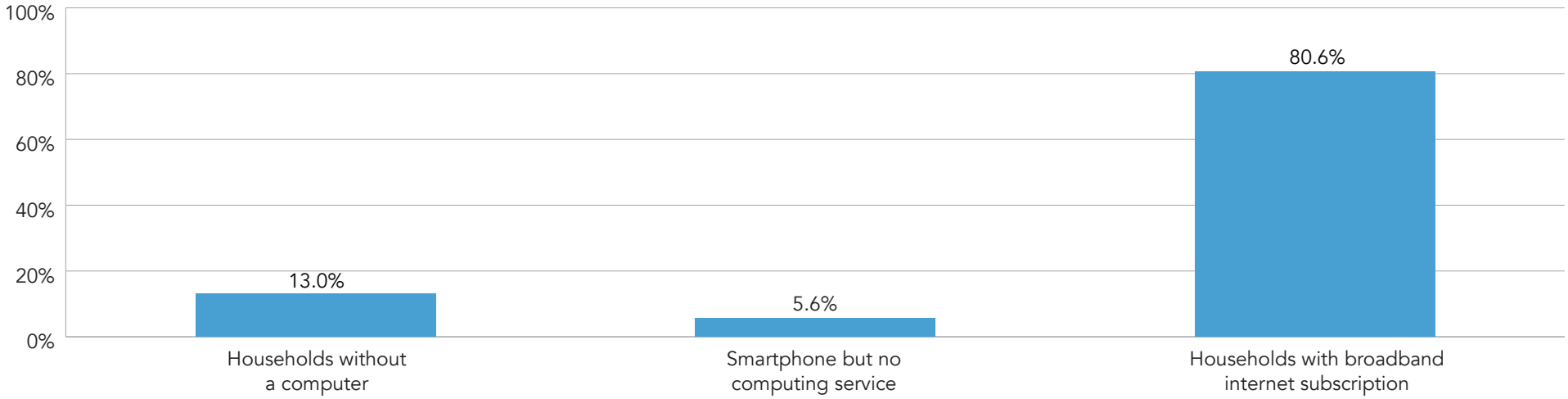
Figure 45 illustrates the percentage of residents in Berks County with/without internet or a computing device. Primary data indicated a lack of access to the internet among minorities and seniors. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet as a means of reaching targeted audiences. This avenue allows underserved or disenfranchised populations connection to obtain health education.

Figure 45: Percentage of Households in Berks County with Internet Connection



Source: Berks Vital Signs 2015-2019

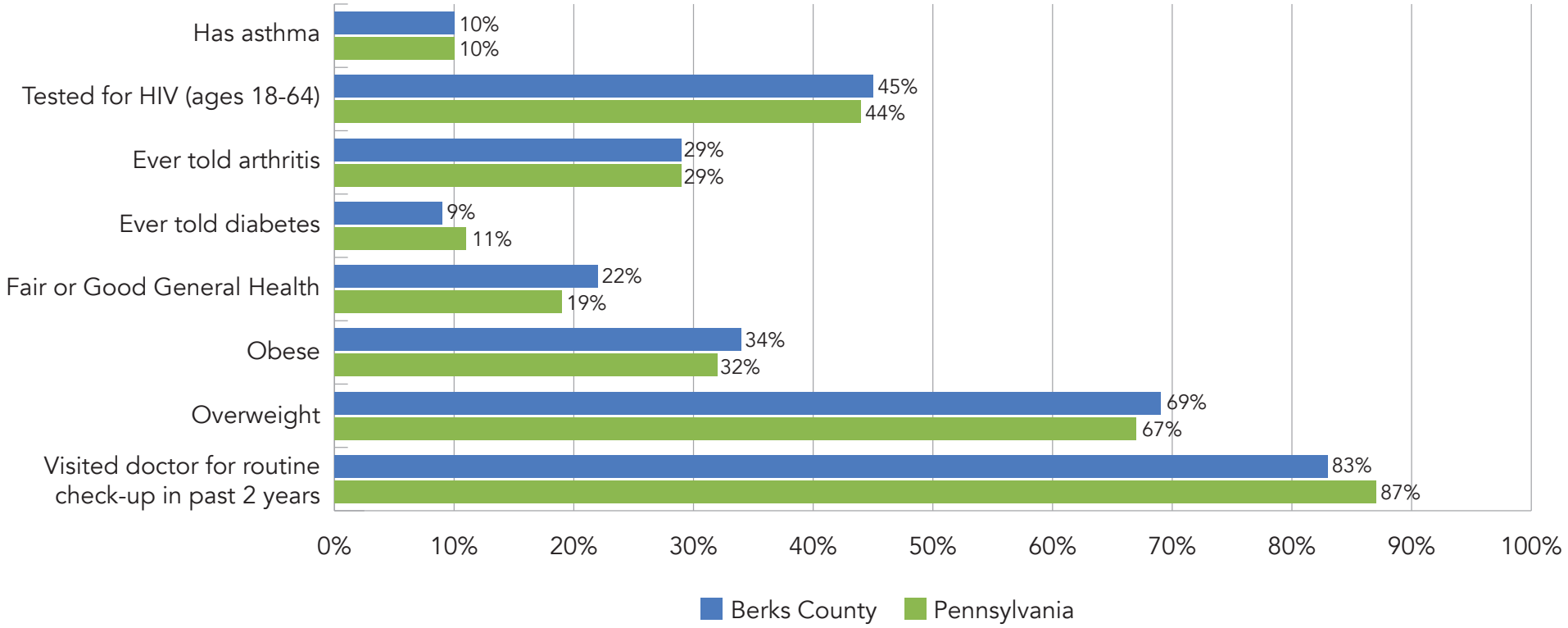
Figure 46: Percentage of Households in Berks County with Limited Technology



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

Figure 47 shows adult health risk behaviors, health outcomes, and general health in Berks County and Pennsylvania. Specifically, the graph depicts the obesity/overweight rate of individuals in Berks County exceeding the state rate.

Figure 47: Overall Adult Health Risks

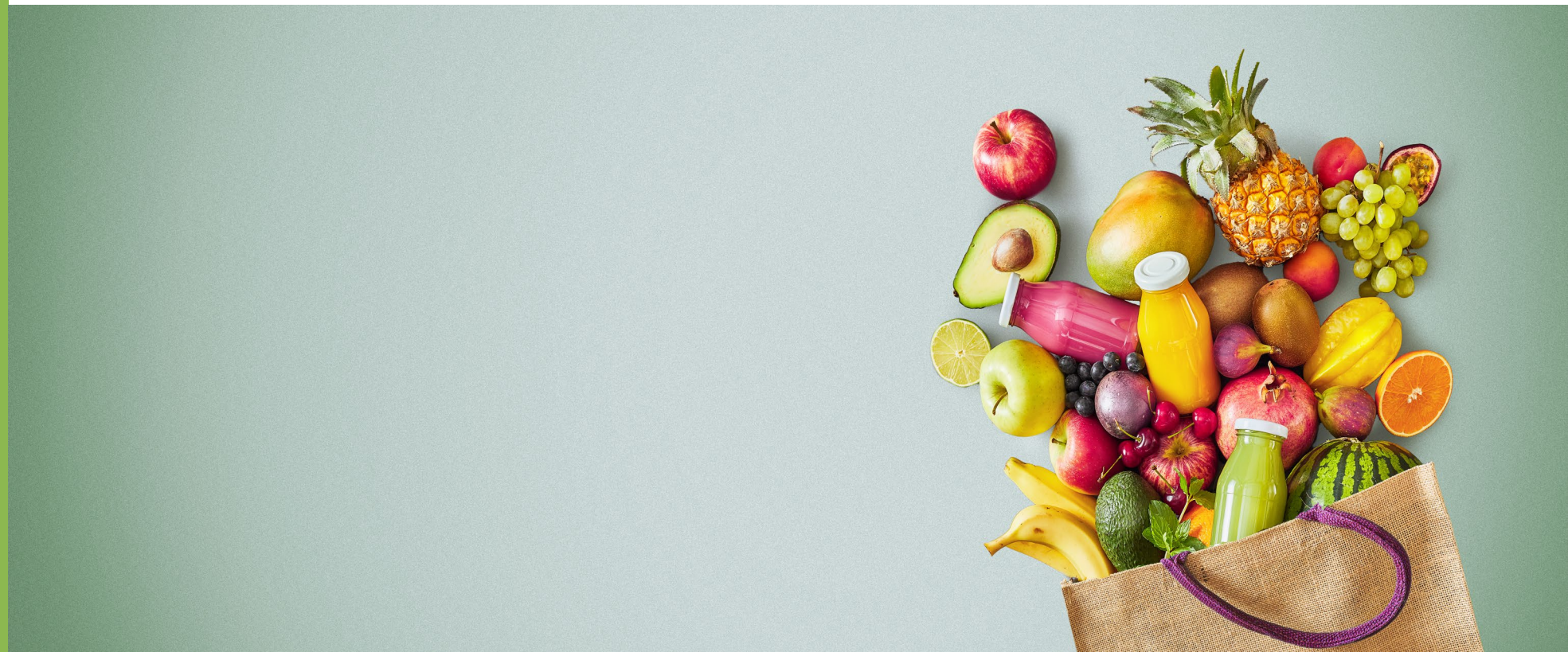


Source: Pennsylvania Department of Health 2017-2019

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 trade-offs 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.

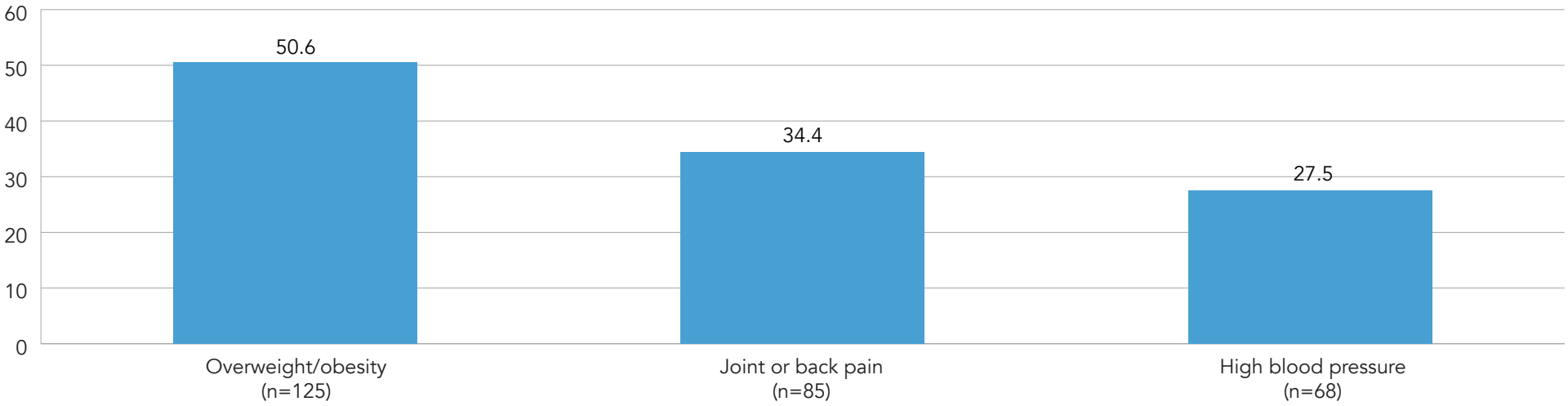
There are 39,480 food insecure people in Berks County.

Source: Feeding America 2019



Community health respondents in the Reading Hospital service area, when asked about the top challenges faced, reported overweight/obesity, joint or back pain, and high blood pressure.

Figure 48: Top Three Challenges Currently Faced



SM SNAP Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP)[10] reported the following in Berks County:

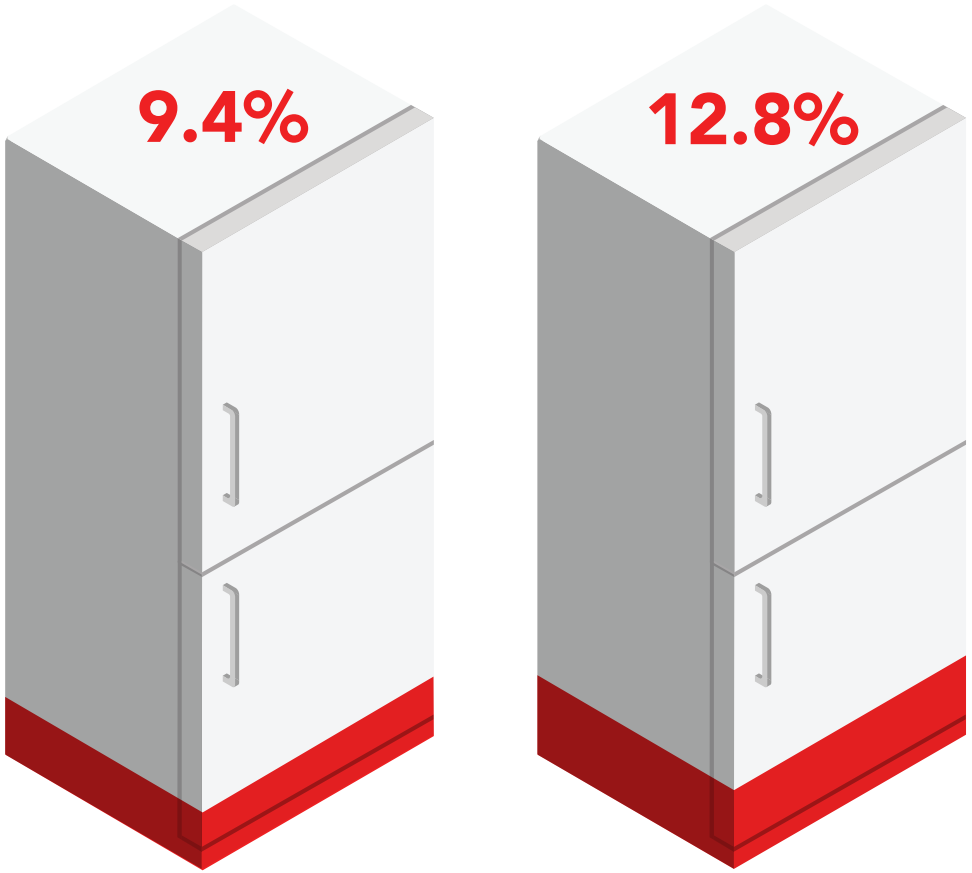
- 59,288 Berks County residents received $7,163,720 in SNAP benefits to help make ends meet in December 2018.
- 66% of those receiving SNAP are children, seniors, and persons with disabilities.
- 97% of benefits are redeemed by the end of the month.
- Low-income SNAP participants spend $1,400, or nearly 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 is also there to help those who are between jobs while they search for work

[10] 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 49: Food Insecurity in Berks County



Source: Feeding America 2019

"Helping Harvest Fresh Food Bank distributed **5.4 million pounds** of food valued at **$7.2 million** in Berks County in 2019. In 2020, those numbers rose dramatically to **9.1 million pounds** valued at **$12 million**."

Jay Worrall

President
Helping Harvest

Figure 50 from the community survey shows health behaviors for which people in the community need more information.

Figure 50: Top Health Behaviors for Which People Need More Information

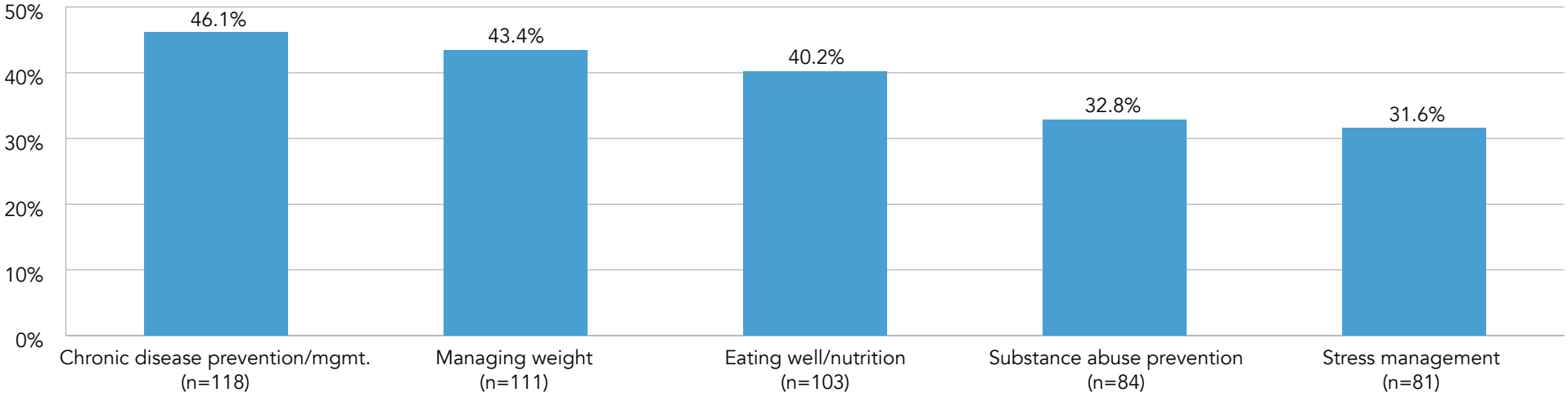
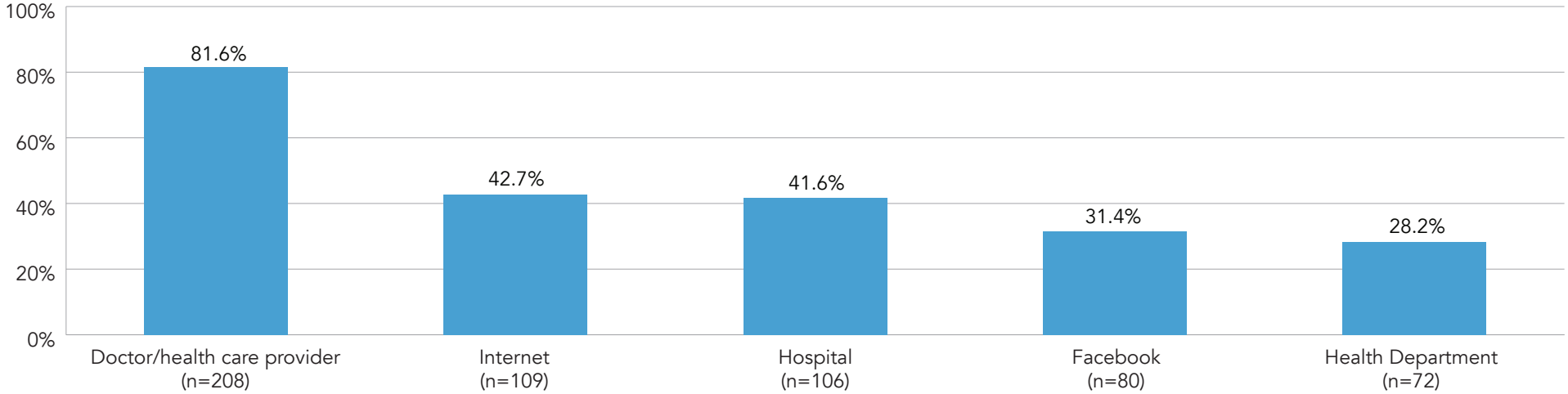


Figure 51 from the community survey reports how the community wants to receive health information.

Figure 51: Top Ways Community Wants to Receive Information



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 Reading Hospital communities. Interventions such as CCP 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.

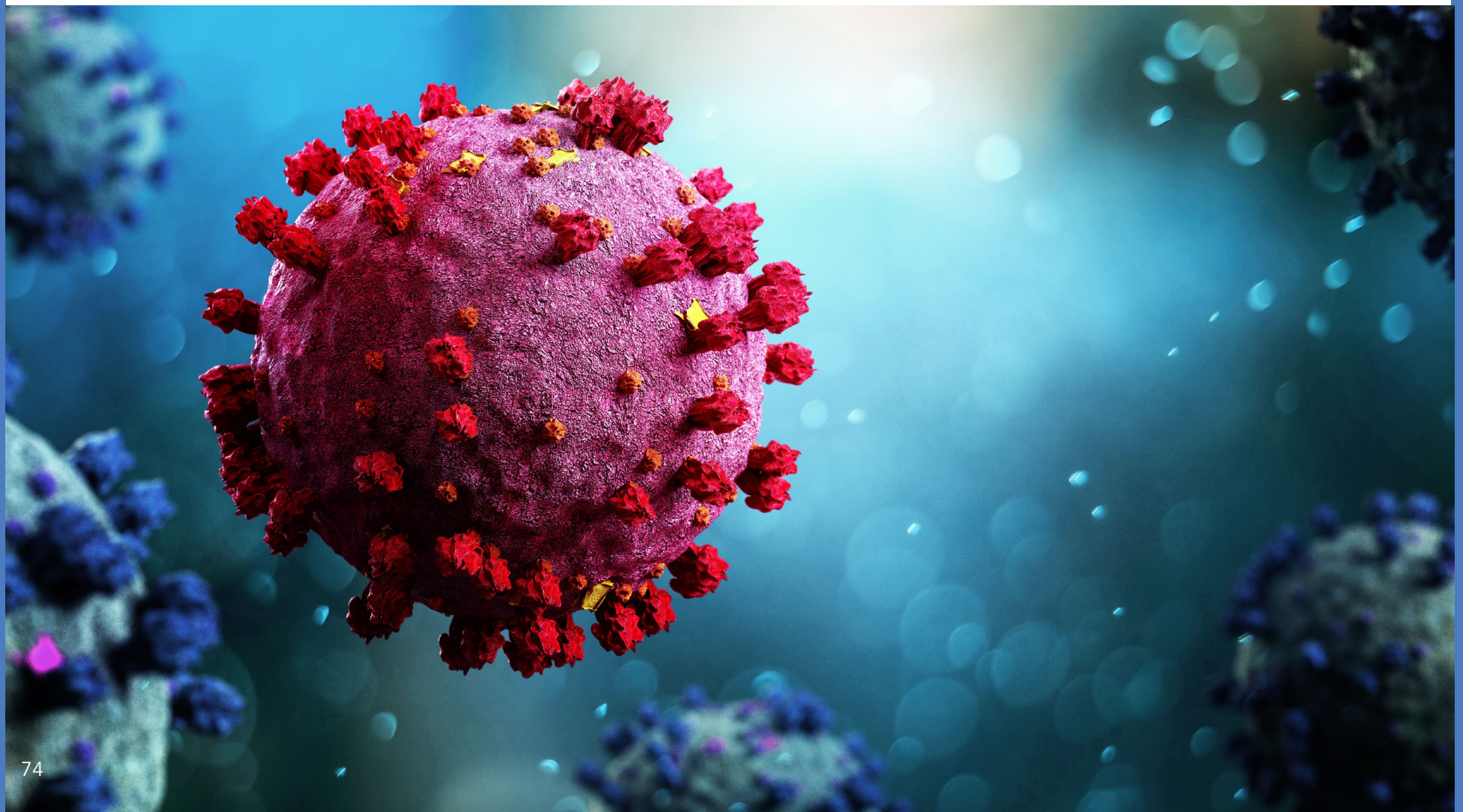
SOCIAL DETERMINANTS OF HEALTH

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.

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.

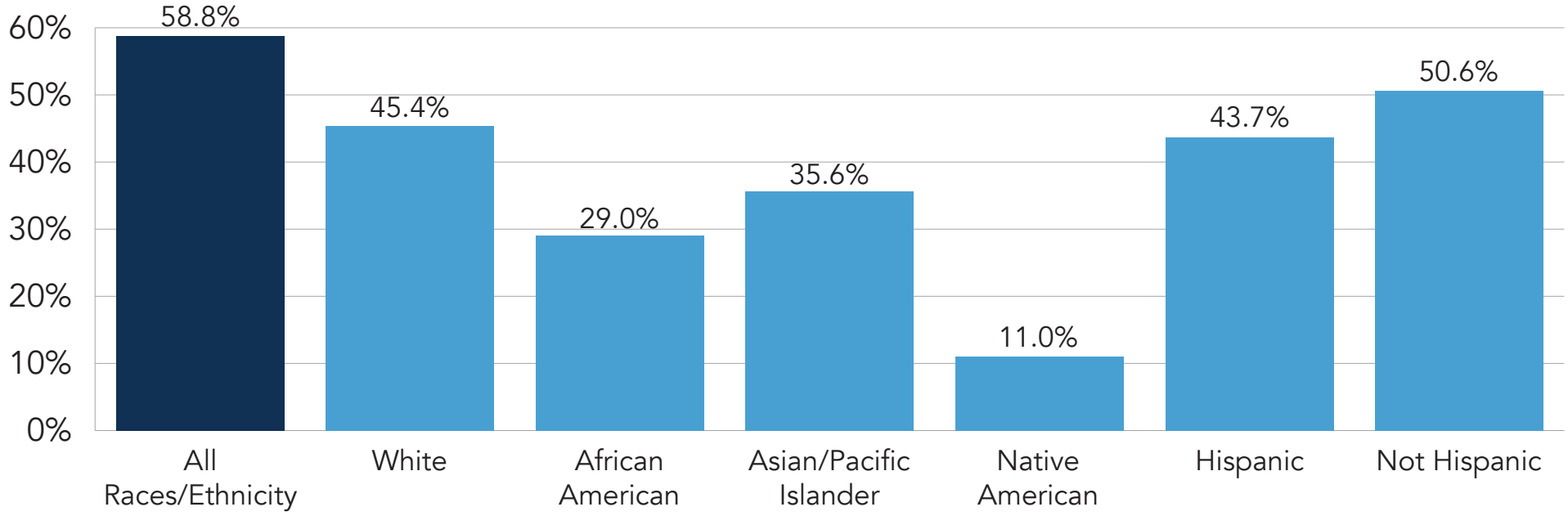
Race and ethnicity are markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased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



The effects of COVID-19 are far-reaching, long-lasting, and certainly have a global impact. In the United States, 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 than 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.

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 52: Full Vaccination Coverage for Race/Ethnicity in Berks County



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

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 healthy and productive lives in marginalized communities leads to many other health and social consequences.

It was reported that 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.

DISCRIMINATORY POLICIES

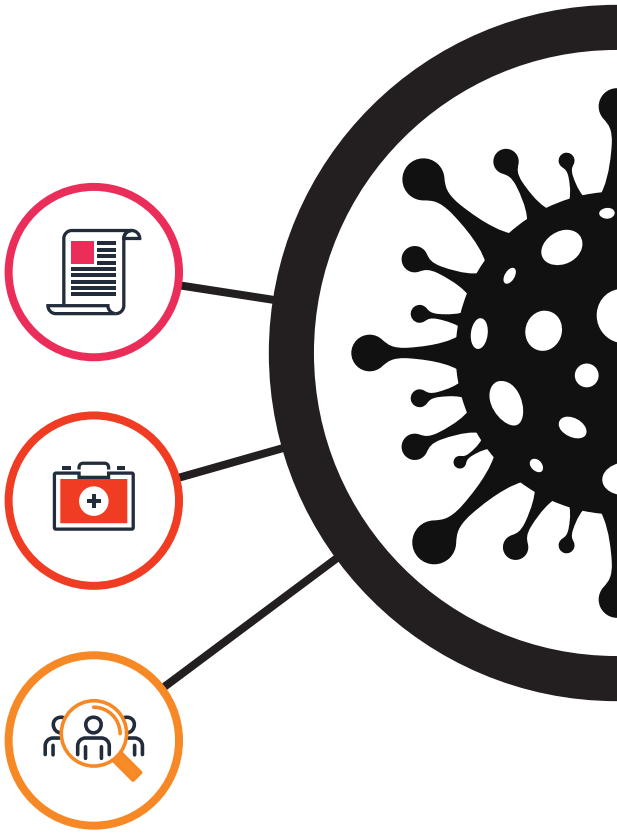
Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare.[11]

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.[12]

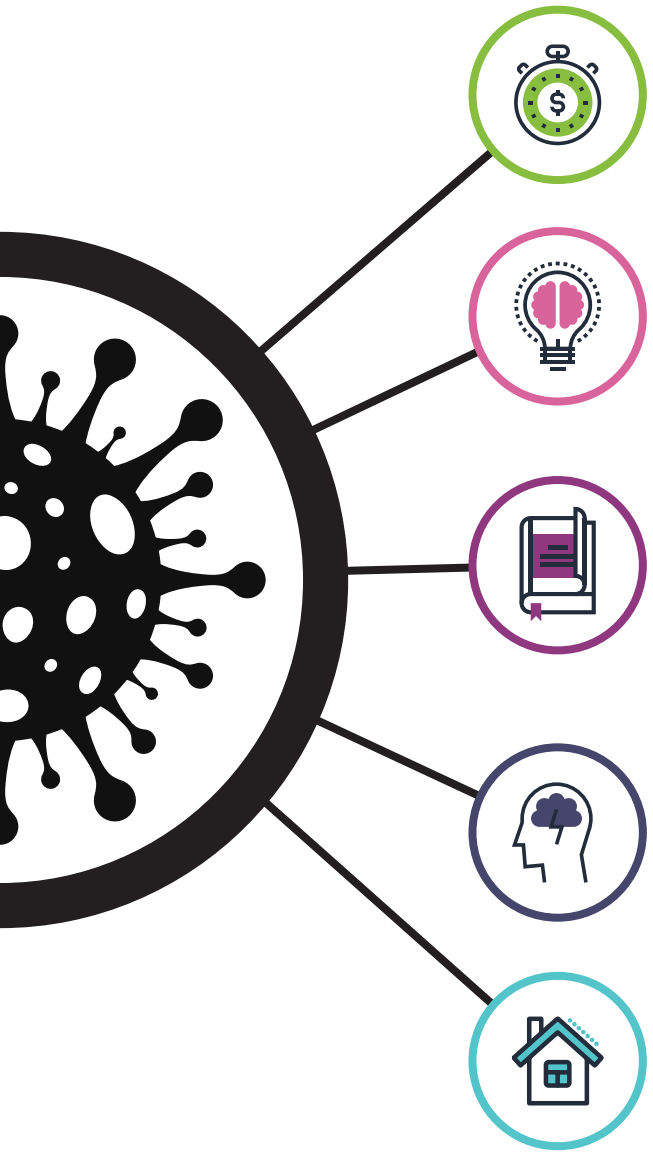
HISTORY OF RACISM & SOCIAL DISCRIMINATION

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.[11,13]



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

Figure 53: 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.[19]

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.[17,18]

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.[16]

CHRONIC STRESS

Stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications.[15]

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.[11,14]

Source: The Health Equality Initiative 2020

WHAT DID WE LEARN FROM THE COMMUNITY?

Capturing the perspectives and insights from the focus groups, stakeholder interviews, key informants, and community survey respondents, "What we heard from the community on equitable care" is portrayed as follows:

Figure 54: Listening to the Community

FOCUS GROUPS
(LEADERSHIP AND HEALTH EQUITY)

"What are the contributors and barriers to health equity?"

- Lack of awareness of available resources/services
- Where/how to access services
- Inconvenience of services
- Resources available in multi-languages
- Cultural practices

KEY INFORMANT SURVEYS

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

- Lack of education on available resources
- Limited services available
- Lack of prevention education

COMMUNITY STAKEHOLDER INTERVIEWS

"What are the perceived barriers to accessing care and services?"

- Cultural barriers
- Language barriers
- Lack of knowledge of available education resources

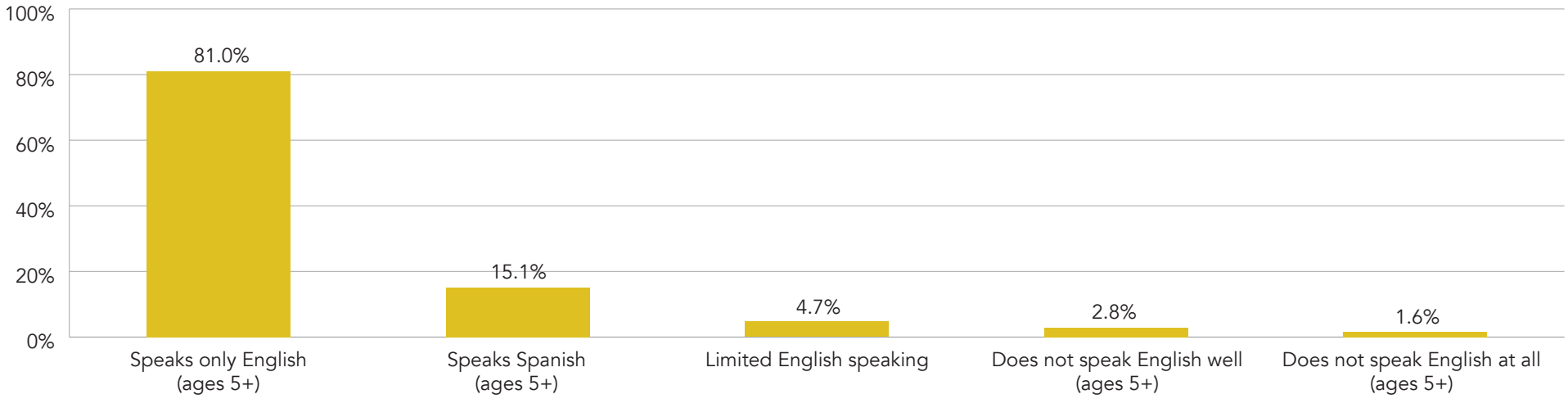
COMMUNITY SURVEYS

"What are the Barriers to Overall Health"

- Unhealthy lifestyles and behaviors
- Poor nutrition and eating behaviors
- Lack of exercise
- Lack of access to healthy foods
- More chronic disease education/information needed

Figure 55 reveals the percentages of residents who speak only English and Spanish and residents who are limited in English speaking.

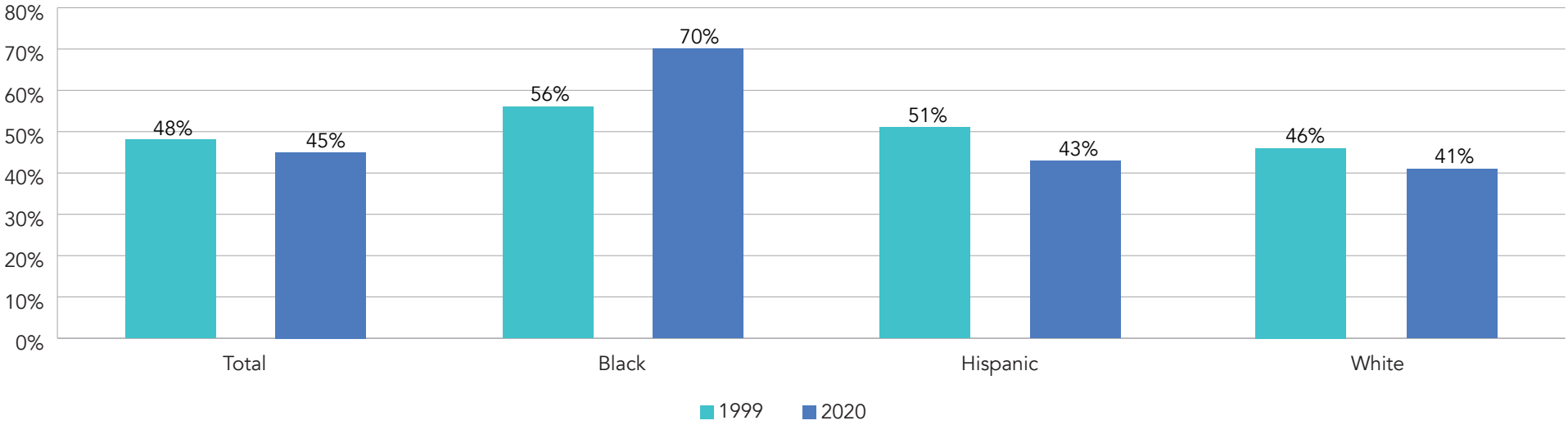
Figure 55: Households with Residents Speaking English Only, Spanish, and Limited English



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

Figure 56 reveals health care treatment in the years 1999 and 2020. This data highlights disparities in demographics that should be considered when providing health care services. Please click here for additional data related to the study conducted by KFF's The Undefeated Survey on Race and Health 2020.

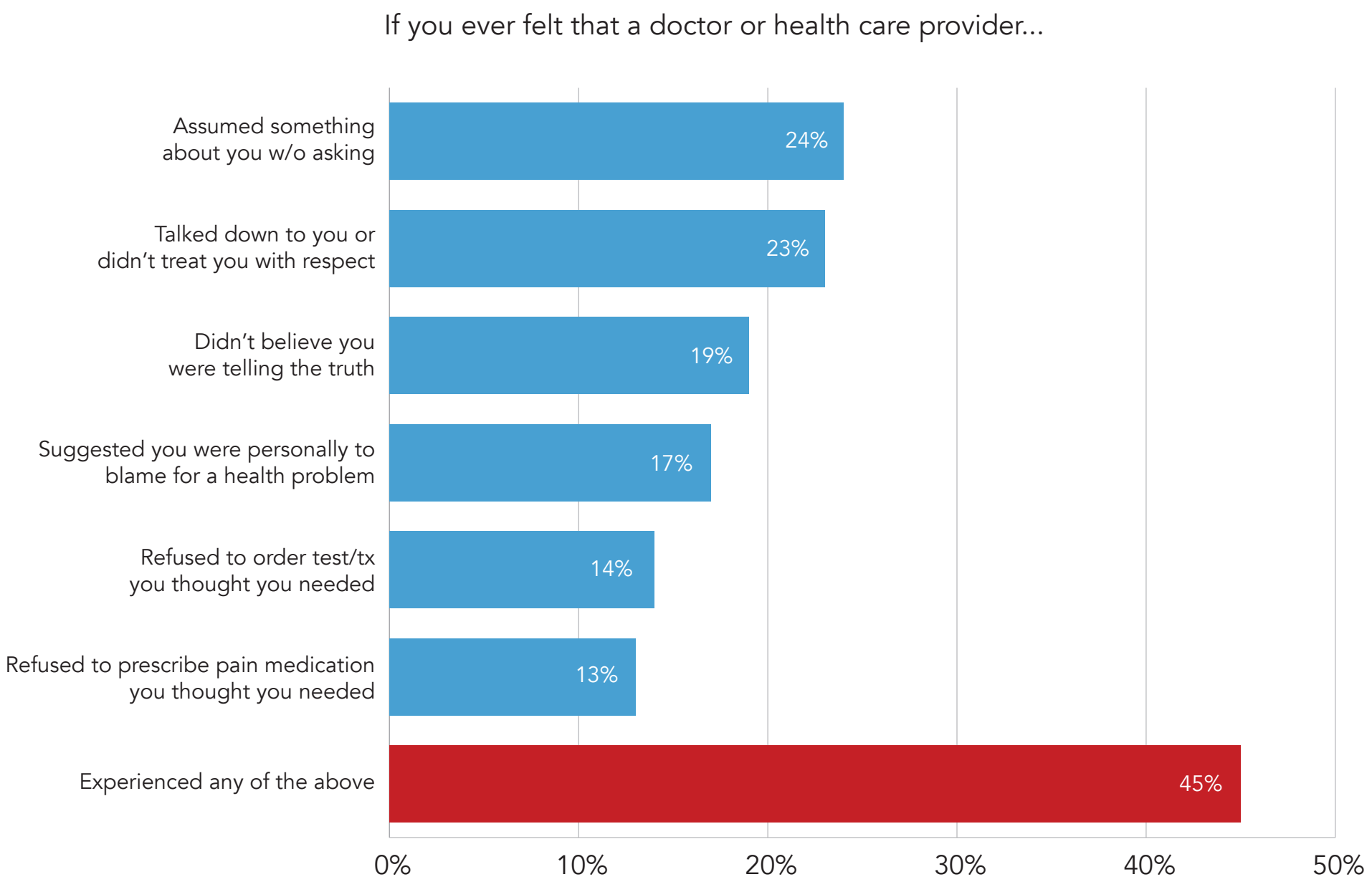
Figure 56: Percentage That Thinks the Health Care System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often



Source: KFF/The Undefeated Survey on Race and Health 2020

Figure 57 reports that nearly half of adults reported one of six negative experiences with health care providers in the last three years.

Figure 57: Percentage Reporting Yes to Negative Experiences With a Doctor or Health Care Provider

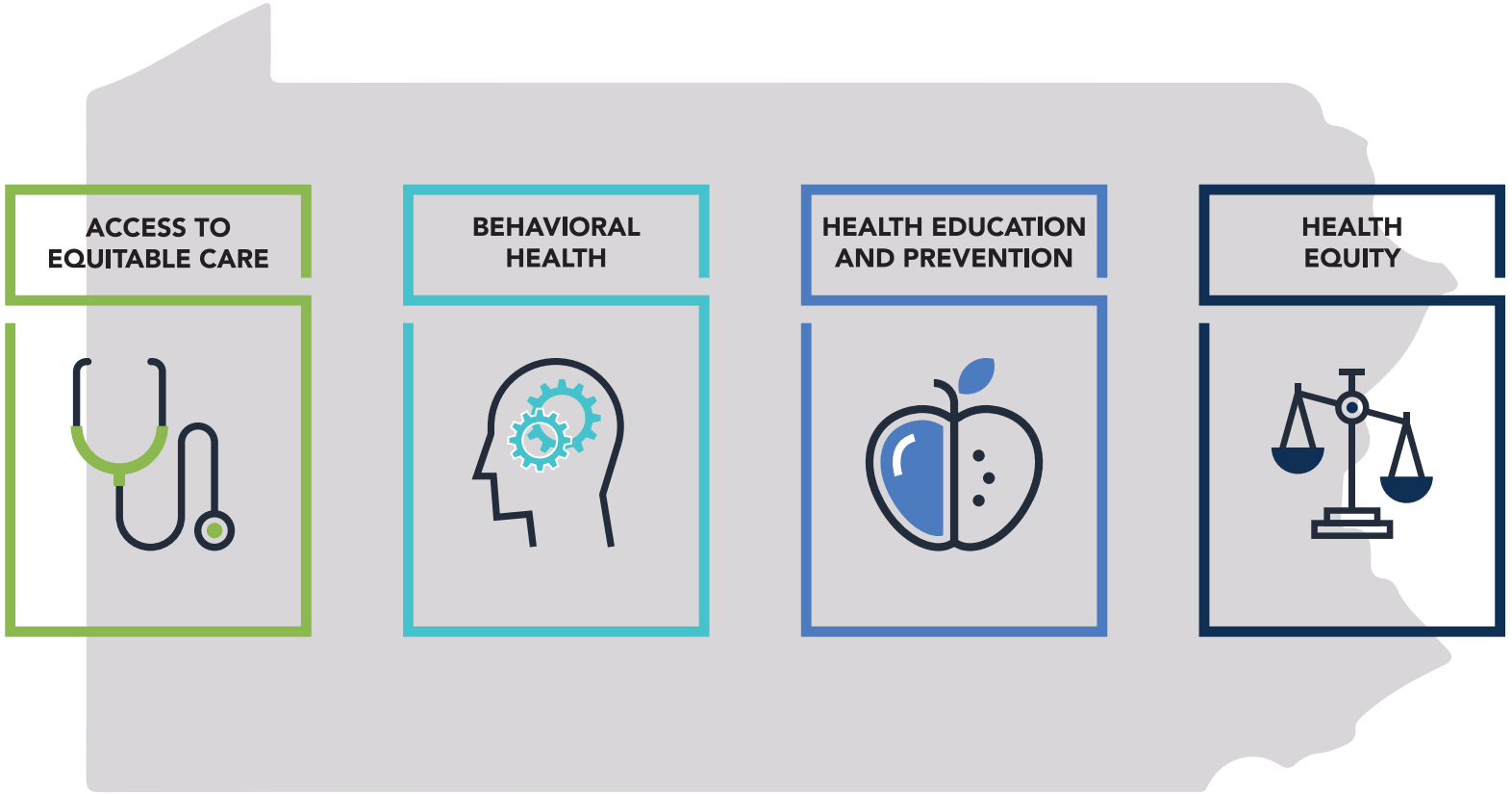


Source: KFF/The Undefeated Survey on Race and Health 2020

CHNA FOCUS AREAS FOR
READING HOSPITAL 2022

In 2021, key need areas were identified during the CHNA process through the gathering of primary and secondary data such as community stakeholder interviews, leadership and health equity focus groups, key informant surveys, a community survey, and a health provider inventory, which highlights organizations and agencies that serve the community.

Equitable care means delivering care that does not differ in quality according to characteristics of the patient or patient group such as age, gender, geographic location, cultural background, ethnicity, religion, and socioeconomic status. With health equity as an ongoing focus, "access to care" transformed to "access to equitable care" and was strongly emphasized through all aspects of primary data collection. The four identified areas of focus were:



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, Reading 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. Reading Hospital will engage and collaborate with our community partners on the development of the CHNA Implementation Strategy Plan.

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www.**towerhealth**.org

Reading Hospital

TOWER HEALTH

Advancing Health. Transforming Lives.