IMPLEMENTATION **STRATEGY**

2022

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Phoenixville Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

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LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Richard Newell, MPT, DPT

President and Chief Executive Officer,
Phoenixville Hospital

Phoenixville Hospital is committed to advancing health and transforming lives throughout Chester and Montgomery counties while meeting the changing health needs of our communities through the development of 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. Phoenixville 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. The data for this CHNA was collected regionally and reported for our hospital service area. Working with our strategic and community partners, Phoenixville Hospital has used the results of this assessment as a foundation to develop tactics to address each of the identified health priorities:

- Access to Equitable Care
- Behavioral Health
- Health Education and Prevention
- Health Equity

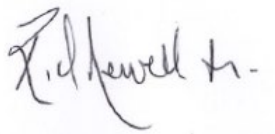
As a leading health care provider, we strive to positively impact the health and well-being of our patients, as well as the broader communities we serve. Many of our programs and services have been developed to address specific regional health needs or overcome barriers to care. These efforts continue to make a difference in the lives of individuals and families. We are grateful for our community partners who work 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 Phoenixville 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,



Richard Newell, MPT, DPT

President and Chief Executive Officer,
Phoenixville Hospital


Phoenixville Hospital
TOWER HEALTH
Emergency
South Entrance
North Entrance
Medical Office Buildings I & II
Cancer Center

ABOUT
THIS REPORT

IMPLEMENTATION STRATEGY (IS)

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

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

IRS MANDATE

The CHNA report is a complete review of primary and secondary data analyzing demographic, health, and socioeconomic data at the local, state, and national levels. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA), requiring that nonprofit hospitals conduct CHNAs every three years. Phoenixville Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements. Phoenixville Hospital is proud to present its 2022 ISP report and its findings to the community.

PHOENIXVILLE HOSPITAL

WHO ARE WE?

Phoenixville Hospital physicians, nurses, and staff provide comprehensive medical services through emergency room visits, inpatient admissions, outpatient procedures, and community outreach programs in a 144-bed facility. With 25,000 emergency room visits, 8,200 inpatient admissions, and more than 500 community outreach programs, Phoenixville Hospital provides many of top-tier services, including:

- Cancer Care
- Cardiac Rehabilitation
- Hand and Wrist Care
- Heart, Vascular, and Thoracic
- Interventional Radiology
- Joint Replacement
- Neuroscience
- Orthopedic
- Pregnancy and Birth
- Radiology/Imaging
- Rehabilitation
- Robotic Surgery Program
- Surgery
- Women's Health

MISSION

The mission of Phoenixville 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

Phoenixville 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. Phoenixville Hospital's primary service area includes nine ZIP codes within Chester and Montgomery counties.[1]

Phoenixville Hospital's Primary Service Area	
ZIP Codes	**Town/Neighborhood**
19403	Norristown
19426	Collegeville
19442	Kimberton
19453	Mont Clare
19460	Phoenixville
19464	Pottstown
19465	Pottstown
19468	Royersford
19475	Spring City
19404	Norristown (NS)
19407	Audubon (NS)
19408	Eagleville (NS)
19409	Norristown (NS)
19415	Norristown (NS)
19423	Cedars (NS)
19456	Oaks (NS)
19481	Valley Forge (NS)
19482	Valley Forge (NS)
19457	Parker Ford (NS)

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

OUR **FOCUS**

Phoenixville Hospital's 2022 Implementation Strategy is a key component of the community health needs assessment process as it delineates the strategies and goals designed to meet prioritized needs and sets the stage for action and execution of initiatives that effectively impact health outcomes and sustain improvements in health status across our communities.

Much of today's delivery of health care should acknowledge the social and economic factors that influence health. These factors, called social determinants of health (SDOH), include our race, income, education level, and livable home and community environments. Understanding the strong impact of SDOH requires us to step aside from our traditional health care approaches and to pursue innovative best practices to improve health. Therefore, the 2022 Implementation Strategy (IS) was built on accomplishments and lessons learned, as well as the challenges and complexities of 2019 CHNA and IS efforts.

A DEEPER PERSPECTIVE:
CHNA PRIORITIES

The 2022 IS has a deeper focus on the whole person, is patient- and community-centered, and supports the optimal use of a plethora of health care and human service resources to improve health. Community participants emphasized the need to improve access to equitable care and behavioral health and to expand health education and prevention. Inequities such as demographical differences highlight the importance of weaving an equity focus within all areas of health.

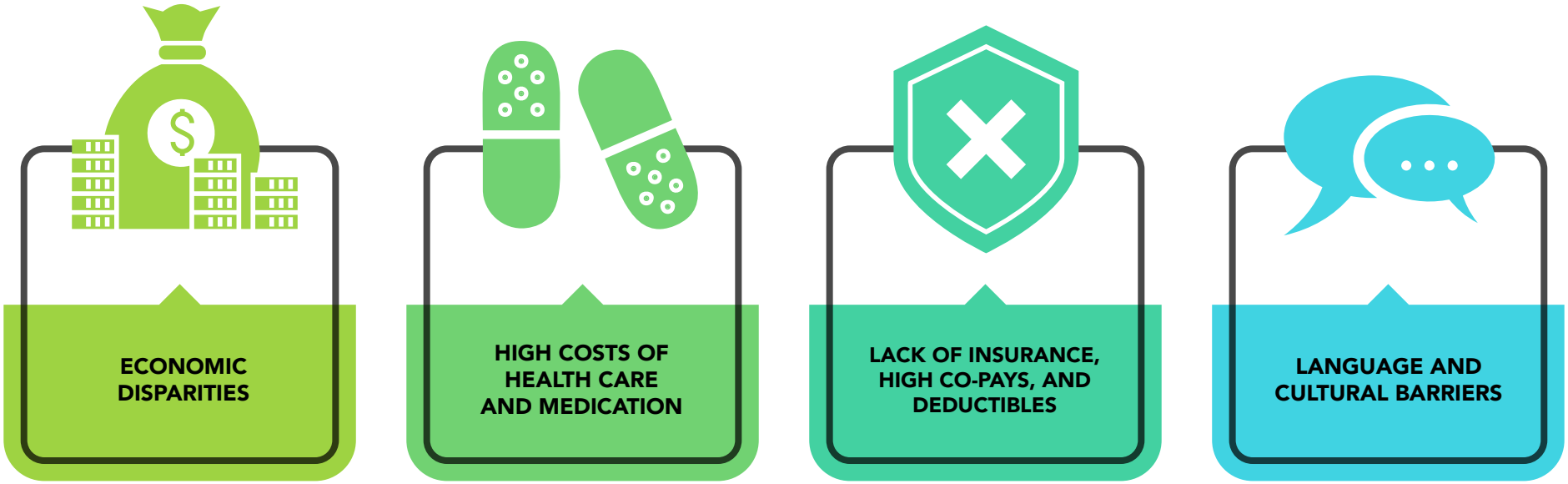
The effectiveness of the 2022 IS is strengthened as we translate our understanding and knowledge of what the community told us into dynamic policies and best practices. Community input guides our efforts to diligently understand past successes and pitfalls in continuously improving the health of our communities through the following areas of focus:

A) ACCESS TO EQUITABLE CARE

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

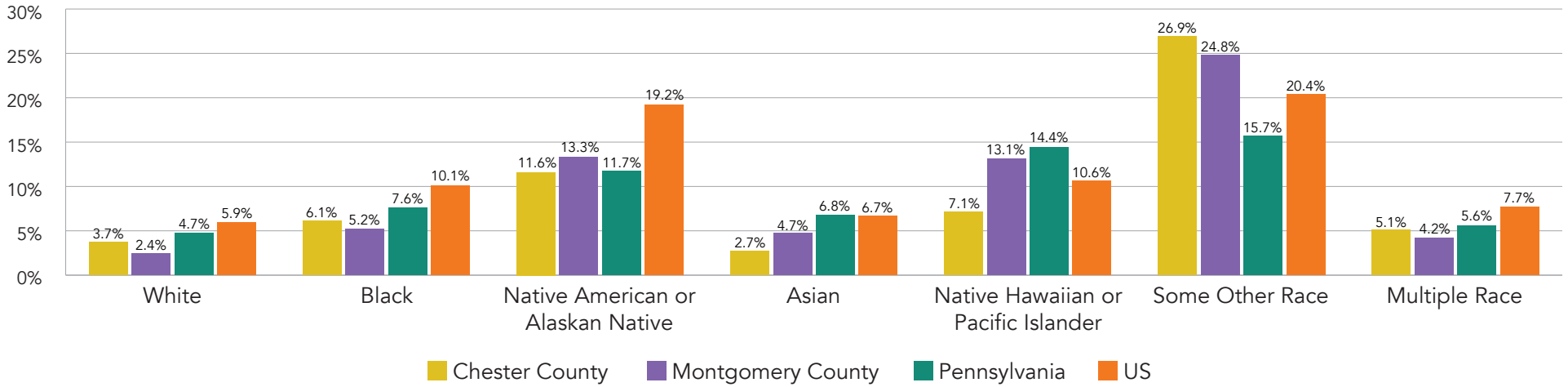
The pandemic further helped the health system to realize the even wider gaps that resulted as related to accessing care, such as the lack of knowledge regarding available health services and programs, the high costs of health care and insurance, the lack of trust, and the limited capacity to provide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

COMMENTS FROM PRIMARY DATA COLLECTION:



Although the percentage of uninsured has increased over the past several years, Figure 1 shows more uninsured Blacks, Native Americans or Alaska Natives, Native Hawaiians or Pacific Islanders, and residents of multiple races as compared to whites. The Healthy People 2030 target is to increase the portion of the population covered by health insurance to 92.1% overall. As of 2018, 89.0% of the population under 65 years had medical insurance.

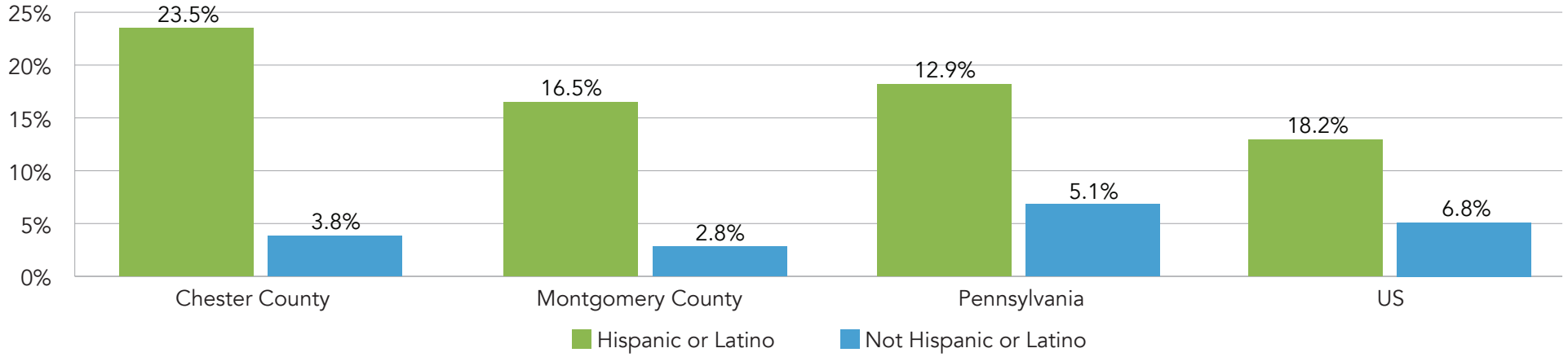
Figure 1: Percentage of Uninsured Population by Race



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

Figure 2 shows a higher percentage of uninsured Hispanic or Latinos when comparing data based on ethnicity within the counties.

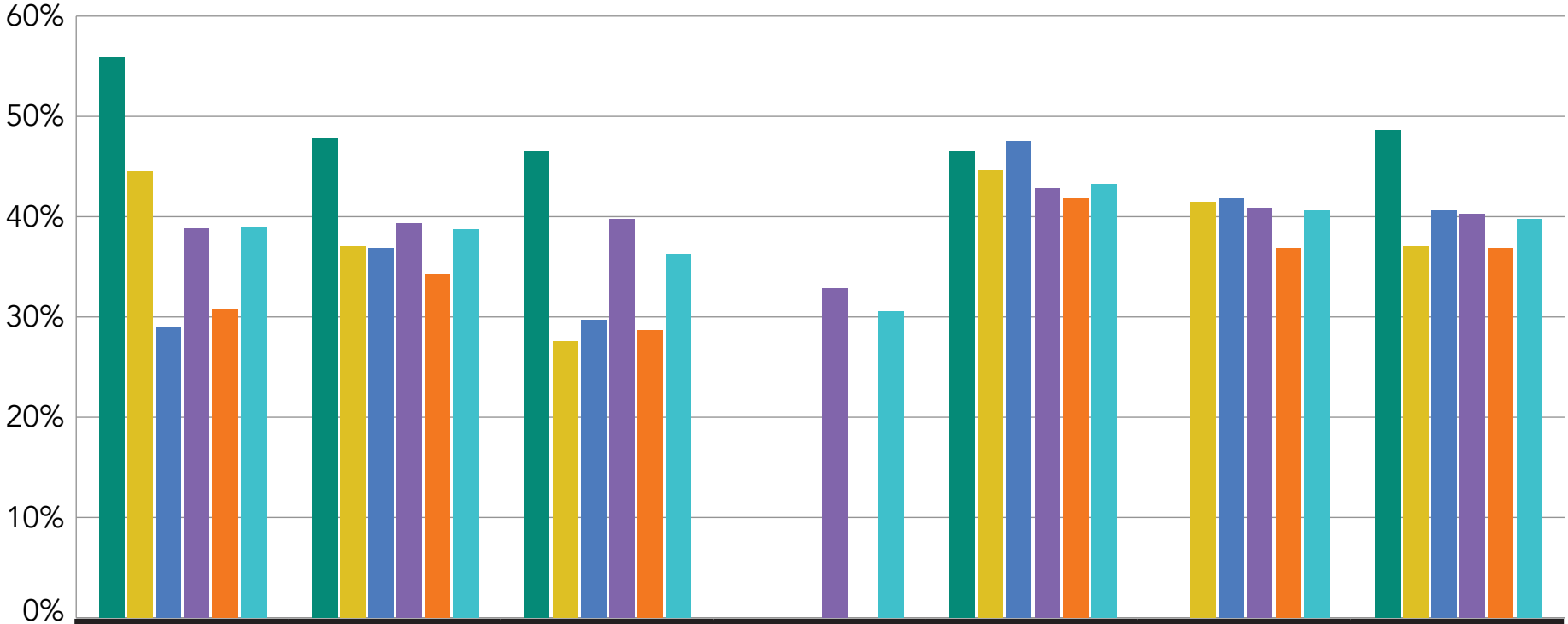
Figure 2: Percentage of Uninsured Population by Ethnicity



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

The PA Health Equity Analysis Tool (HEAT) provides a geographic perspective at the granular level to areas that have opportunities to improve equity.[2] The below figure depicts ZIP codes within Phoenixville Hospital's service area related to adults who obtain primary care visits.

Figure 3: Percentage of Adults with Primary Care Physician Visits by ZIP Code Summary



	19460	19403	19426	19442	19464	19465	19468
Asian	55.9	47.8	46.5	-	46.5	-	48.6
Black	44.5	**37.0**	**27.6**	-	44.6	41.5	**37.0**
Hispanic	**29.0**	**36.9**	**29.7**	-	47.5	41.8	40.6
White	**38.8**	39.3	39.8	**32.9**	**42.8**	40.9	40.3
Other Race	**30.7**	**34.3**	**28.7**	-	**41.8**	**36.9**	**36.9**
All Adults	**38.9**	**38.7**	**36.3**	**30.6**	**43.3**	**40.6**	**39.8**

Note: No data was available for ZIP codes 19453 and 19475. The red figures in bold indicate low percentages of adults with primary-care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.

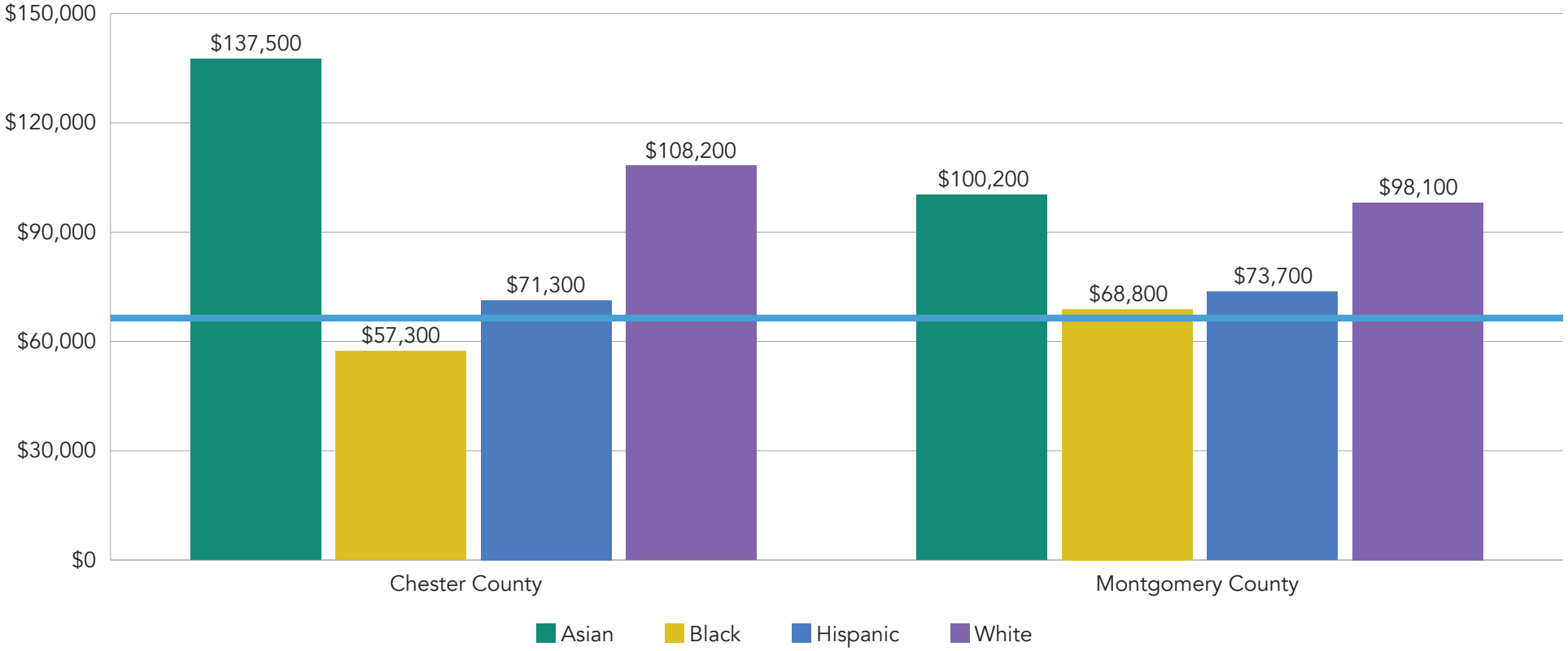
Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[2] 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.

Income inequality in our communities affects how long and how well we live and is particularly harmful to the health of poorer individuals. Economic and social insecurity often are associated with poor health. Inequalities in a community can accentuate differences in social class and status and serve as a social stressor. Communities with greater income inequality can experience a loss of social connectedness, as well as decreases in trust, social support, and a sense of community for all residents.

Poverty, unemployment, and lack of educational achievement affect access to care and a community's ability to engage in healthy behaviors. Without a network of support and a safe community, families cannot thrive. Ensuring access to social and economic resources provides a foundation for a healthy community.[3]

Figure 4: Median Household income by Race



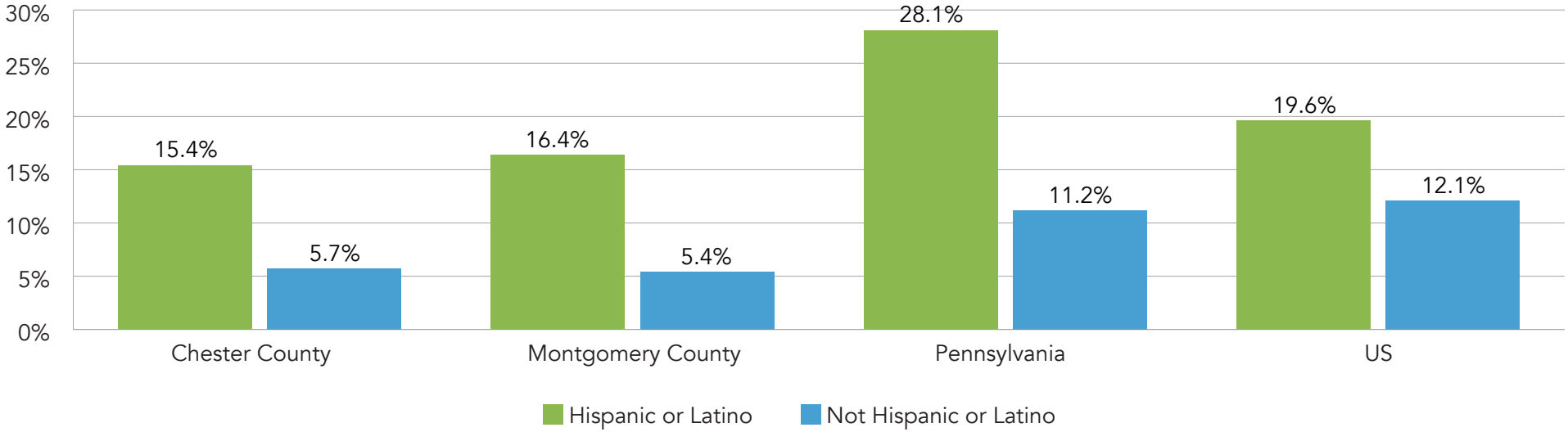
Note: The blue line indicates the median household income of Pennsylvanians of $64,900.

Source: County Health Rankings & Roadmaps 2020

[3] Federal poverty levels (FPL) are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage. For a family or household of four living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2019 was $25,750, in 2021 it was $26,500, and in 2022 it is $27,750.

Figure 5 reports the percentage of the population below 100% of the federal poverty line by ethnicity.

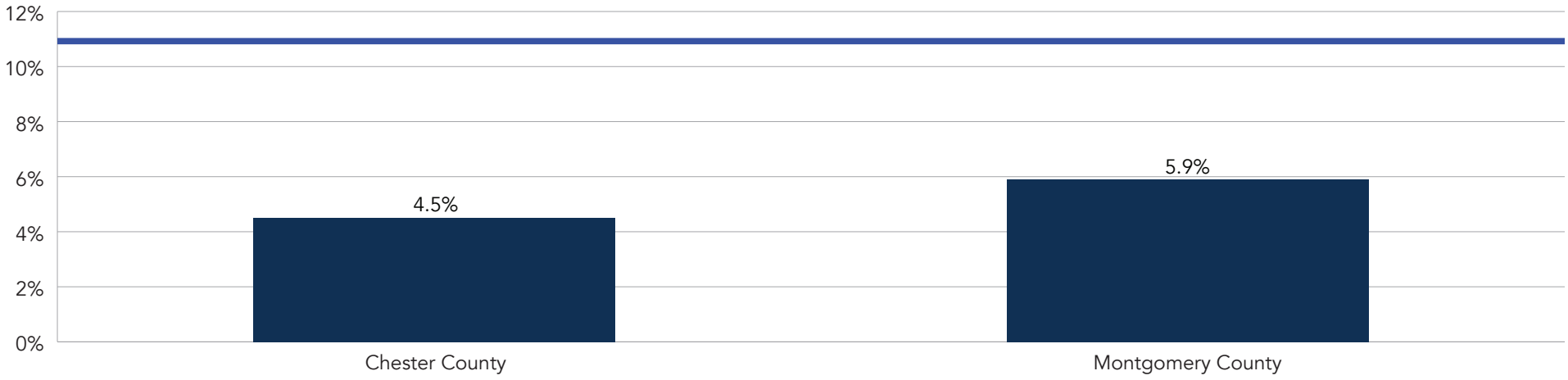
Figure 5: Population Below 100% FPL by Ethnicity



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

Figure 6 shows a higher rate of Montgomery County residents not having a motor vehicle when compared to those in Chester County 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 6: Households with No Motor Vehicle

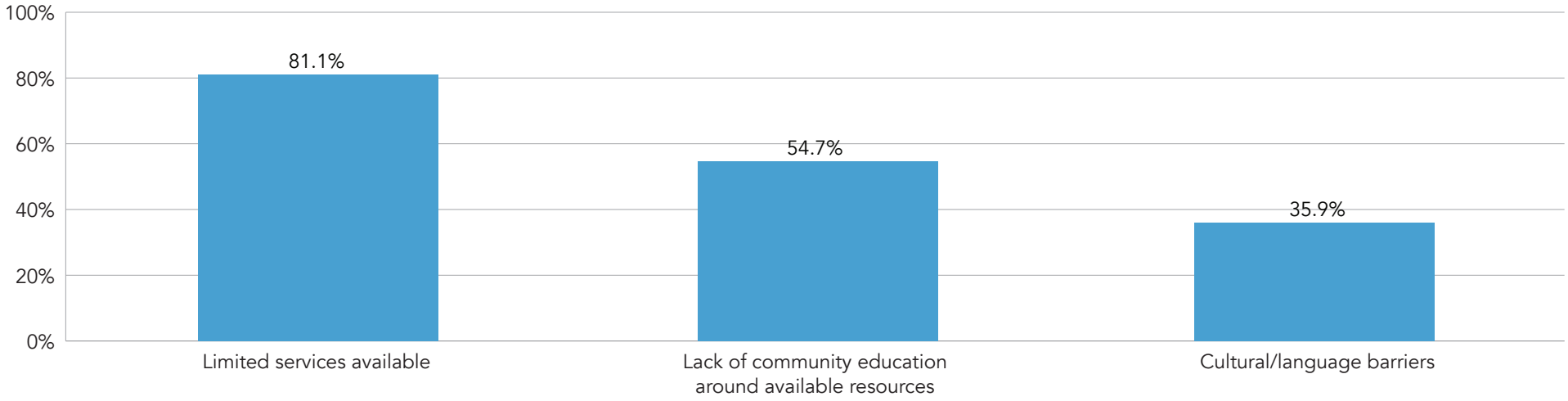


Note: The blue line indicates the rate in Pennsylvania of 10.9%

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

When key informants for the CHNA were asked what contributes to the transportation issues in their community, the top three responses were limited services 81.1% (n=43), lack of community education around available resources 54.7% (n=29), and cultural/ language barriers 35.9% (n=19).

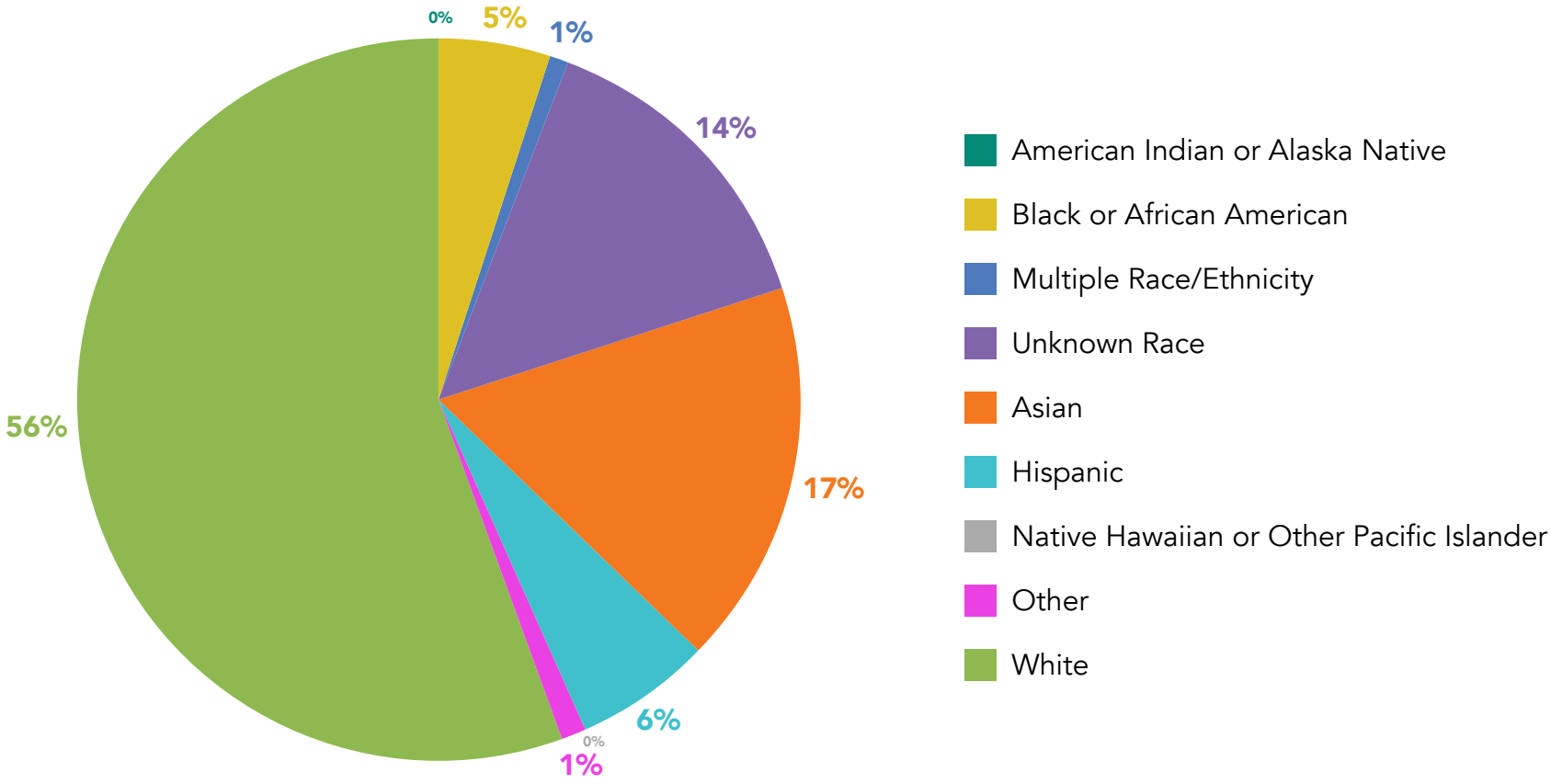
Figure 7: Contributors to Transportation Issues in the Community (Top Three Responses)



Diversity among physicians is limited. This lack of diversity often leads to mistrust in doctor-patient relationships. National studies have shown that Black patients have better health outcomes when seen by physicians of the same race. Increasing the supply of minority physicians has been proposed as an intervention that may help to enrich differences in health status.[5]

Figure 8 shows the national percentage of active physicians by race/ethnicity. Among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8% identified as Hispanic, and 5.0% identified as Black or African American. Note that 13.7% of active physicians are of Unknown Race, making that the largest subgroup after White and Asian.

Figure 8: Percentage of All Active Physicians by Race and Ethnicity, 2018



Source: Association of American Medical Colleges

[5] National Library of Medicine

GOAL:

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

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Nurse Outreach	Community health nurses will provide health information and resource referrals to vulnerable populations in community to address unmet health care needs	X	X	X	100 outreach visits per year	King Terrace Whitehall VA Housing Phoenixville Area Community Services Project Outreach First United Church of Christ
Ride Health	Utilize Ride Health platform to coordinate free transportation to and from appointments for eligible patients	X	X	X	10% increase in number of rides	Ride Health
Access to Telemedicine	Collaborate with community organizations serving seniors to provide technology education to older adults		X	X	Establish collaboration	Phoenixville Senior Center Senior Living Communities
	Provide telehealth education on advancements of health care, technology, and remote patient monitoring resulting in easier, faster access to care		X	X	Complete at least 2 educational programs per year	Phoenixville Senior Center Senior Living Communities

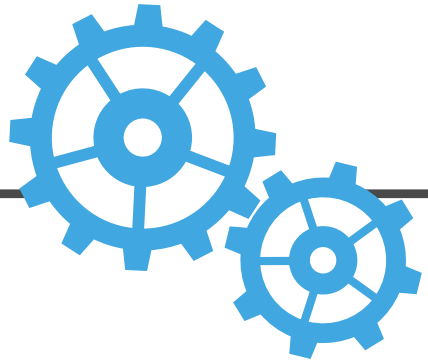
B) BEHAVIORAL HEALTH

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

COMMENTS FROM PRIMARY DATA COLLECTION:

LACK OF ACCESS TO BEHAVIORAL HEALTH/MENTAL HEALTH SERVICES

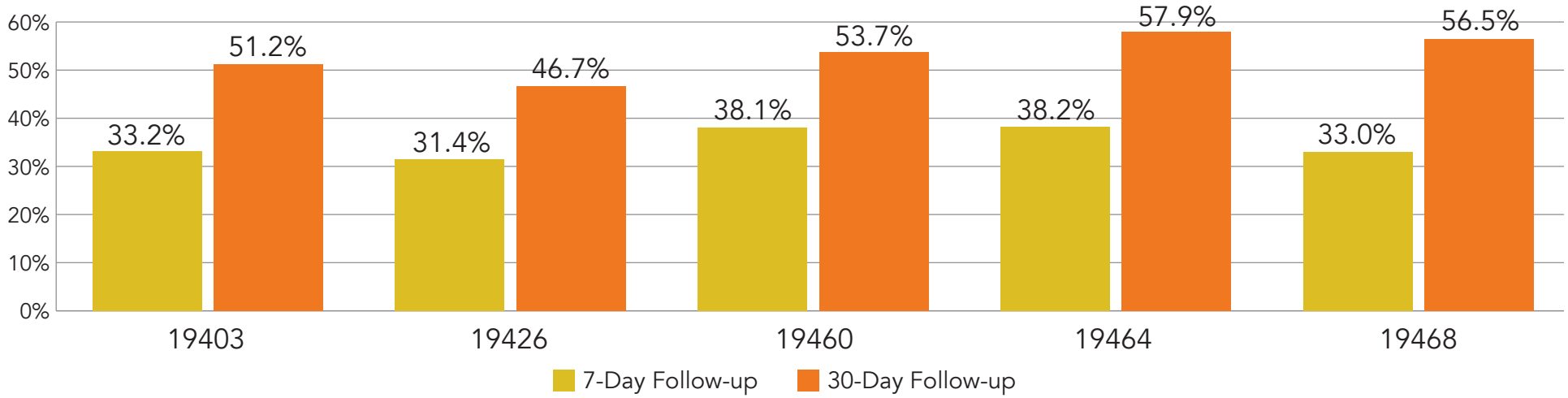
LACK OF ACCESS TO SUBSTANCE ABUSE (DRUG/ALCOHOL) SERVICES



NEED FOR COORDINATION OF HEALTH SERVICES

Figure 9 illustrates percentages of adults by ZIP codes for mental health admissions with either a seven-day or 30-day follow-up. Follow-up care after hospitalization for mental illness or intentional self-harm helps improve health outcomes and prevent readmissions. Recommended post-discharge treatment includes a visit with a mental health provider within 30 days after discharge. Ideally, patients should see a mental health provider within seven days after discharge.[6]

Figure 9: Percent of Readmissions by ZIP code



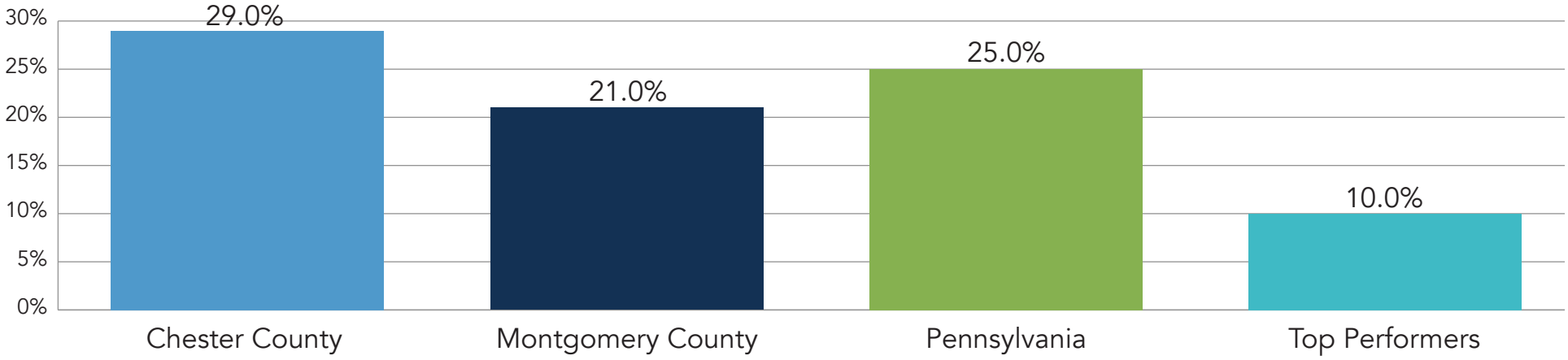
Note: No data was available for ZIP codes 19442, 19453, 19465, 19475, 19404, 19407, 19408, 19409, 19415, 19423, 19456, 19481, 19482, and 19457.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[6] Medicaid

Alcohol and tobacco use are root causes of and can further exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk. When analyzing driving deaths involving alcohol impairment, rates in Chester County are worse when compared to Montgomery County and the state. Comparing a county's value to top U.S. performers (10% of the nation's counties are doing better than this value for this measure) can provide information about how well the county is doing in the context of the nation. Figure 10 illustrates the percentage of driving deaths involving alcohol impairment in Chester and Montgomery counties, the state, and top performers.

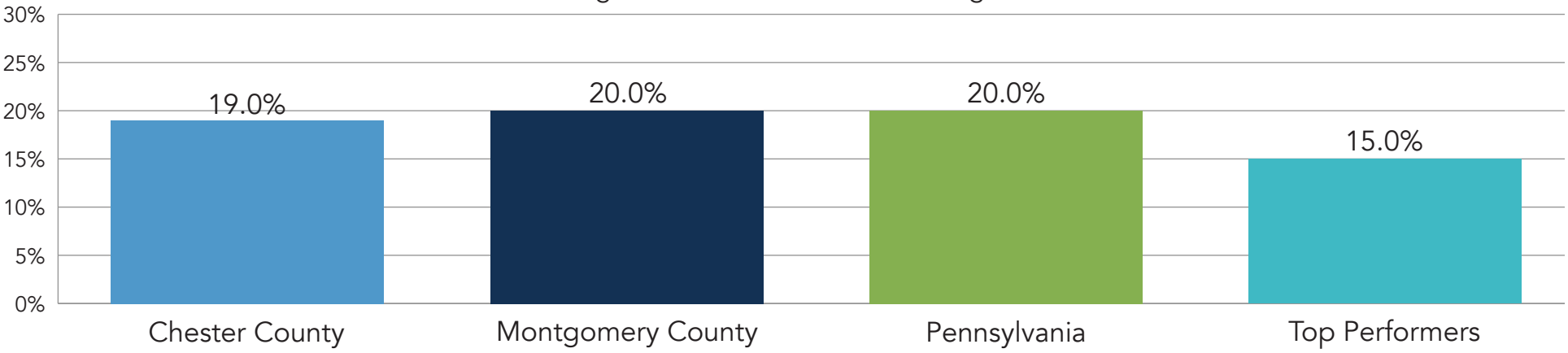
Figure 10: Driving Deaths and Alcohol Impairment



Source: County Health Rankings & Roadmaps 2016-2020

Figure 11 illustrates the percentage of adults in the past 30 days who reported binge drinking or heavy drinking in Chester and Montgomery counties, the state, and top performers.

Figure 11: Adult Excessive Drinking[7]

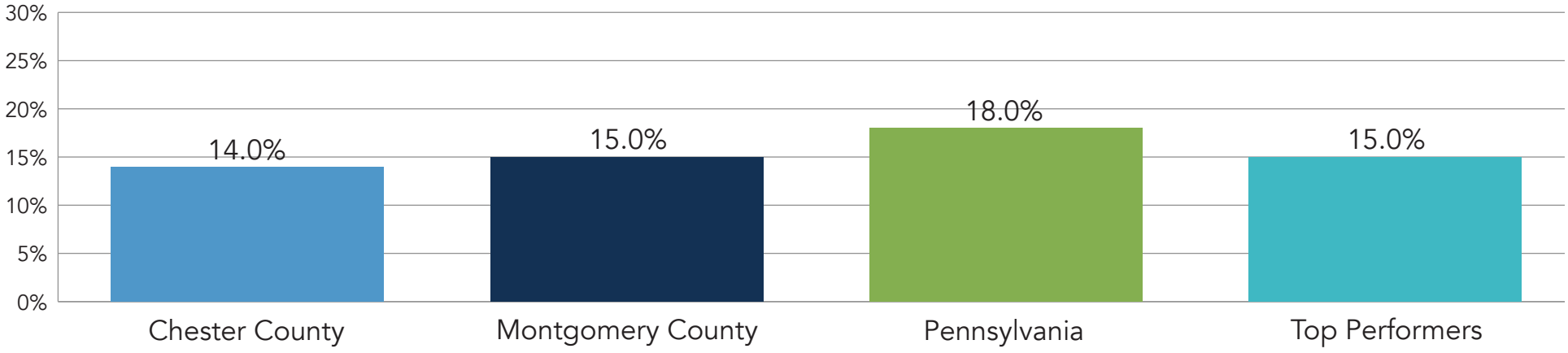


Source: County Health Rankings & Roadmaps 2019

[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. A binge drinker is an adult age 18 and older who reports having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Figure 12 shows adults 18 and older who smoke in Chester and Montgomery counties, the state, and top performers. Adult smoking is the percentage of the adult population in a county who report that they smoke every day or some days and have smoked at least 100 cigarettes in their lifetime. The prevalence of tobacco can alert communities to the adverse health outcomes and can be valuable for implementing needed cessation programs or the effectiveness of existing tobacco control programs.

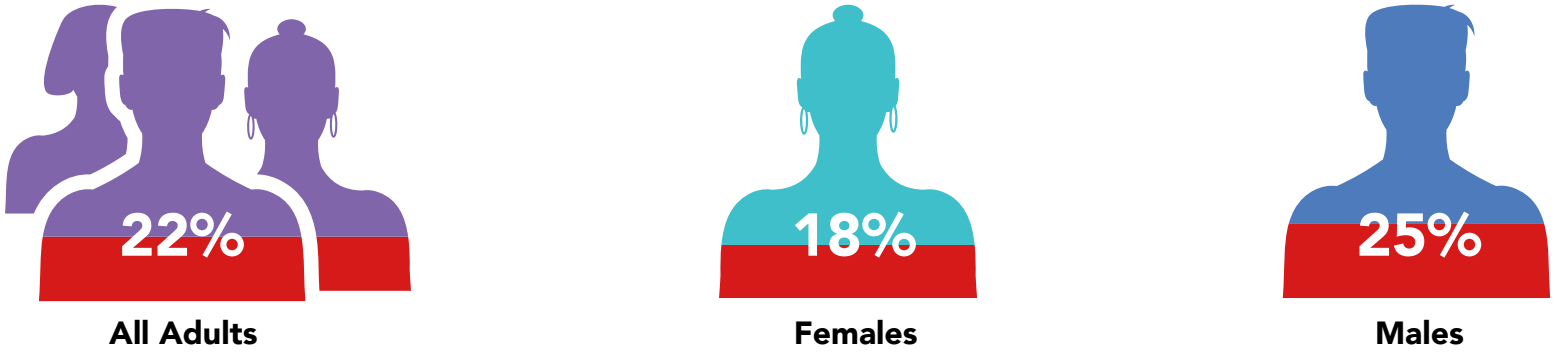
Figure 12: Adult Smoking — Current Smokers



Source: County Health Rankings & Roadmaps 2019

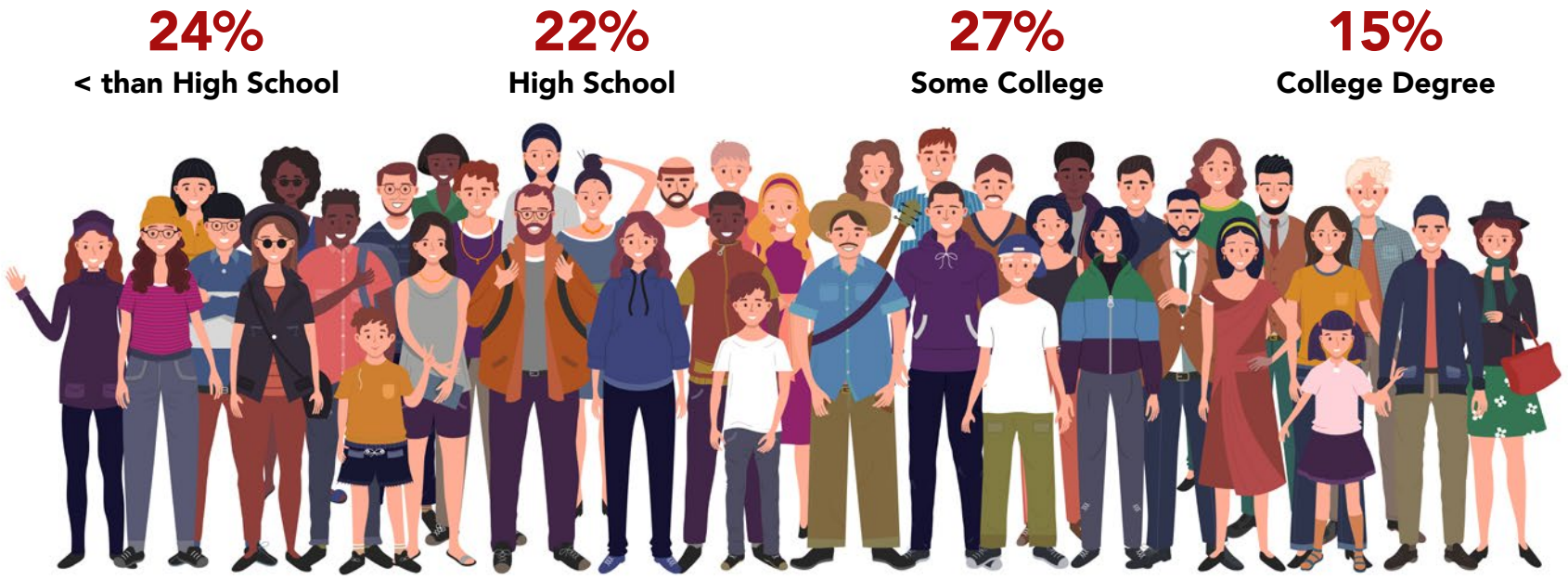
Figure 13 shows Pennsylvanians who have used an e-cigarette or electronic product.

Figure 13: Residents who have used an e-cigarette or other electronic vaping product, 2020



Source: Pennsylvania Department of Health, 2020

Figure 14: E-cigarette or electronic product, 2020



Source: Pennsylvania Department of Health, 2020

Figure 15: E-cigarette or electronic product, 2020

18-29 years old

43%

30-44 years old

34%

45-65 years old

14%

65 or older

6%

Source: Pennsylvania Department of Health, 2020

Figure 16: E-cigarette or electronic product, 2020

< than $15,000

25%

$15,000-$24,999

19%

$25,000-$49,999

27%

$50,000-$74,999

26%

$75,000+

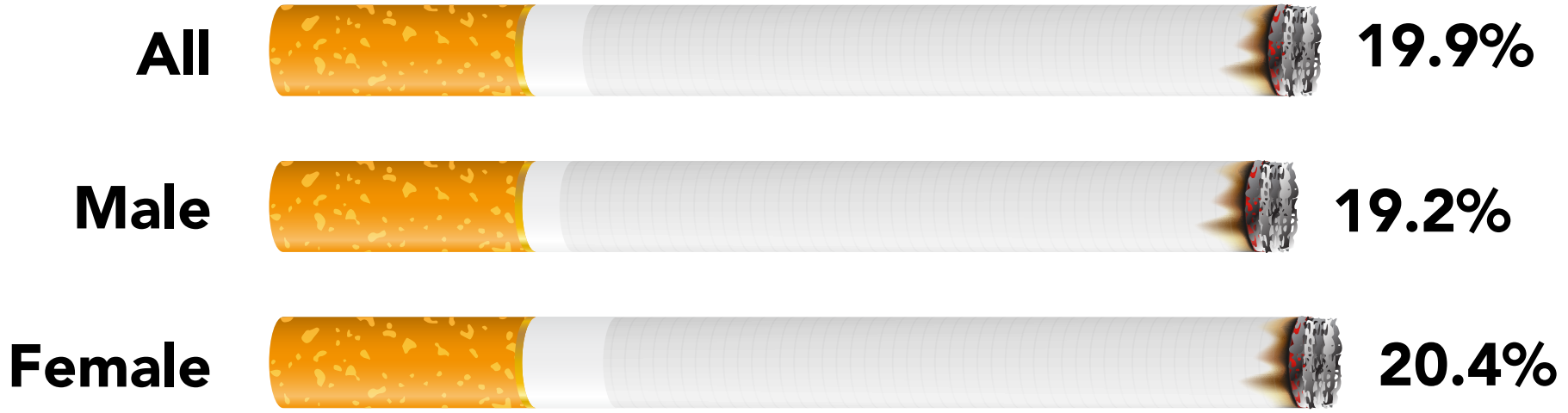
19%

Source: Pennsylvania Department of Health, 2020

Data shows that more than 700,000 high school students are current smokers. Additional information from the CDC shows that 23.6% of high school students reported current use of any tobacco product (cigarettes, electronic cigarettes, cigars, smokeless tobacco, hookah, pipe tobacco, and/or bidis). Figures show that e-cigarettes are the most popular tobacco product among youth as 19.6 % of high school students report current use.

Figure 17 shows the percent of Pennsylvania students in grades 6-12 using tobacco.

Figure 17: Tobacco use in Grades 6-12 (2019)



Source: Pennsylvania Department of Health, 2019

GOAL:

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

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Awareness of Behavioral Health Resources	Invite community organizations which provide behavioral health to participate in hospital community programs	X	X	X	Host 2 events per year	Behavioral health providers Community organizations Psychiatry program
Community Behavioral Health Programs	Provide programs on behavioral health issues to community	X	X	X	Host 4 programs per year	Community organizations
Outpatient Behavioral Health Services	Offer transitional service to allow patients to be discharged while establishing outpatient care		X	X	10% of patients discharged offered transitional care	Psychiatry program
Behavioral Health Social Media Campaign	Engage community members with monthly social media posts focused on behavioral health issues	X	X	X	Increase reach by 10%	
Tower Employee Wellness Initiatives	Explore expansion of Schwartz rounds, multidisciplinary forum for caregivers to discuss social and emotional issues that arise in caring for patients		X	X	Host 4 Schwartz rounds in 2023 Host 8 Schwartz rounds per year in 2024	
	Promote Rethink Care app to support employees' personal, professional, and parental needs	X	X	X	15% of staff actively using app	
	Implement Marvin Telemedicine Program to provide digital behavioral health services for hospital staff		X	X	95% use of service satisfaction rate reported	
	Launch Well-Being Index to assess provider burnout and develop resources to mitigate stressors		X	X	100% participation by residents and fellows 40% participation by physicians	Mayo Clinic
	Pet therapy for staff	X	X	X	Monthly visits from therapy dog	Pet Therapy organizations

MINDFULNESS

EMPOWERMENT • PRESENCE • WELLBEING • HEALTH

C) HEALTH EDUCATION AND PREVENTION

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

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

COMMENTS FROM PRIMARY DATA COLLECTION:

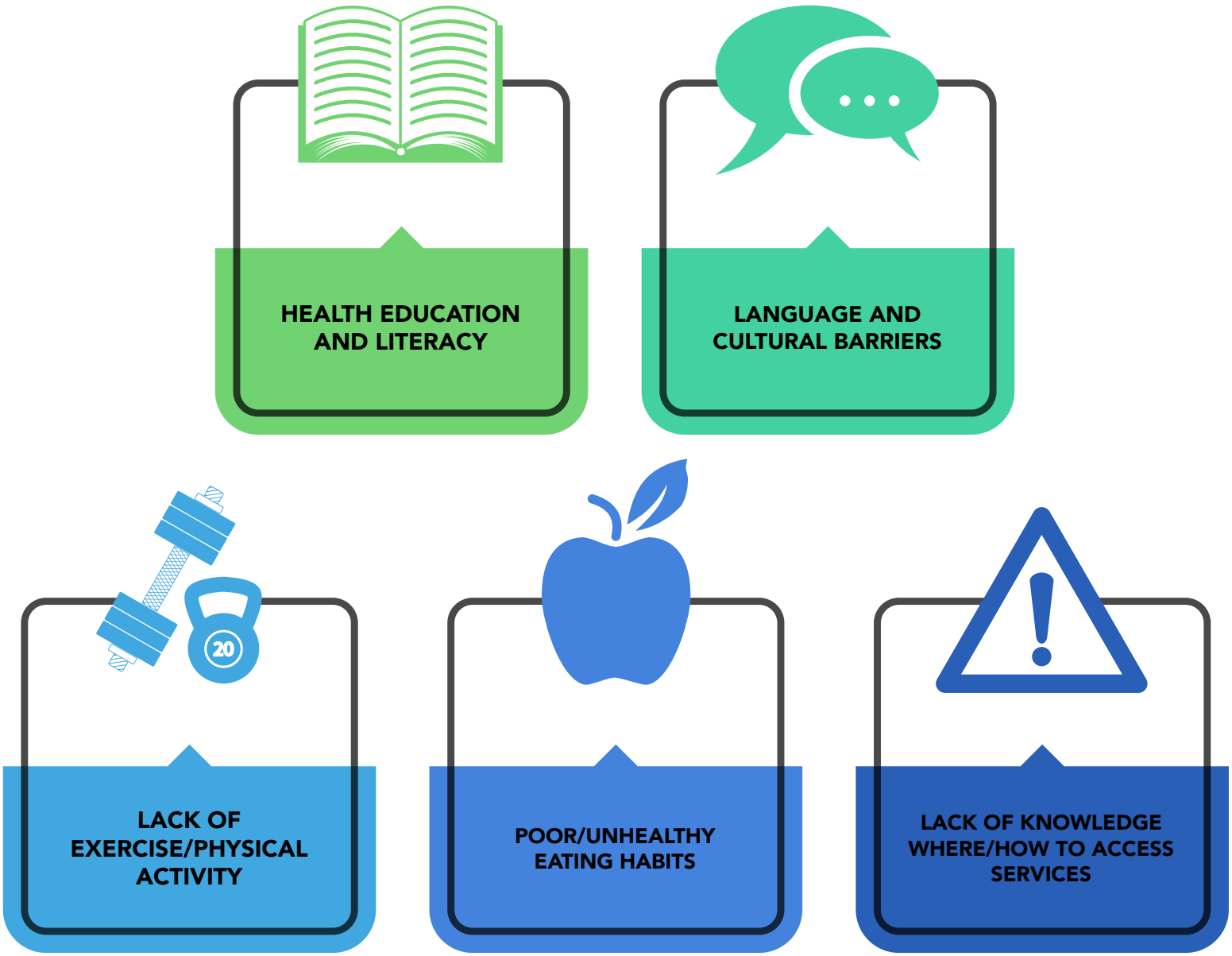
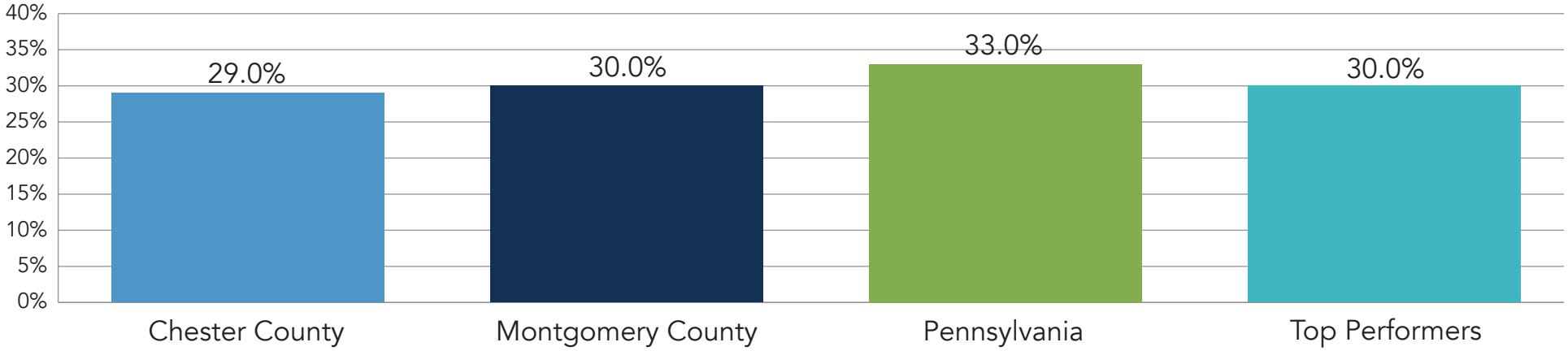


Figure 18 shows the percentage of the adult population 18 and older who reported having a BMI greater than 30.0.

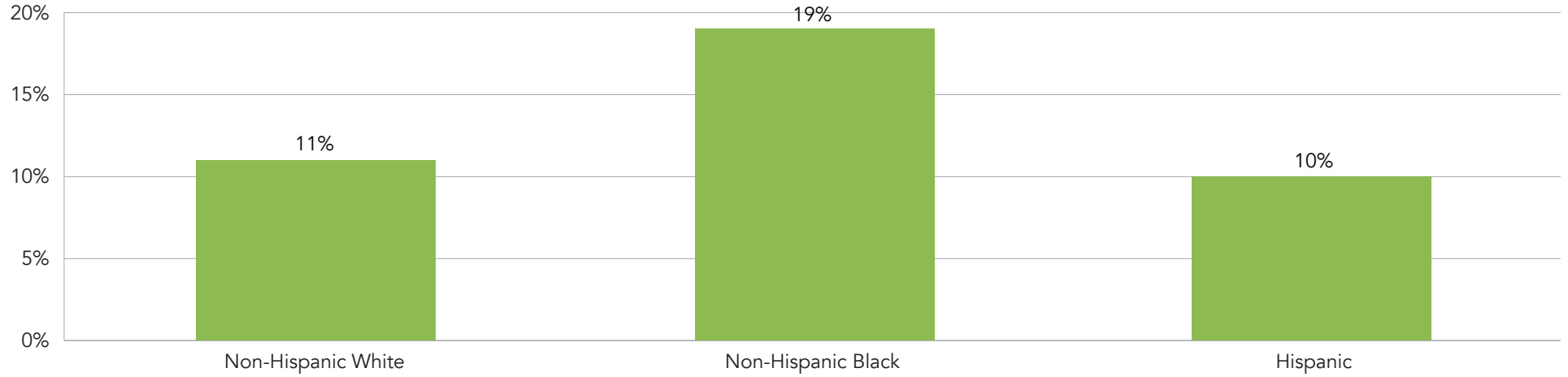
Figure 18: Obese Adults



Source: County Health Rankings & Roadmaps 2019

Figure 19 shows the percentage of adults by race and ethnicity who have been told by a doctor that they have diabetes.

Figure 19: Diabetes by Race/Ethnicity



Source: Pennsylvania Department of Health BRFSS

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

Figure 20: Top Three Challenges Faced

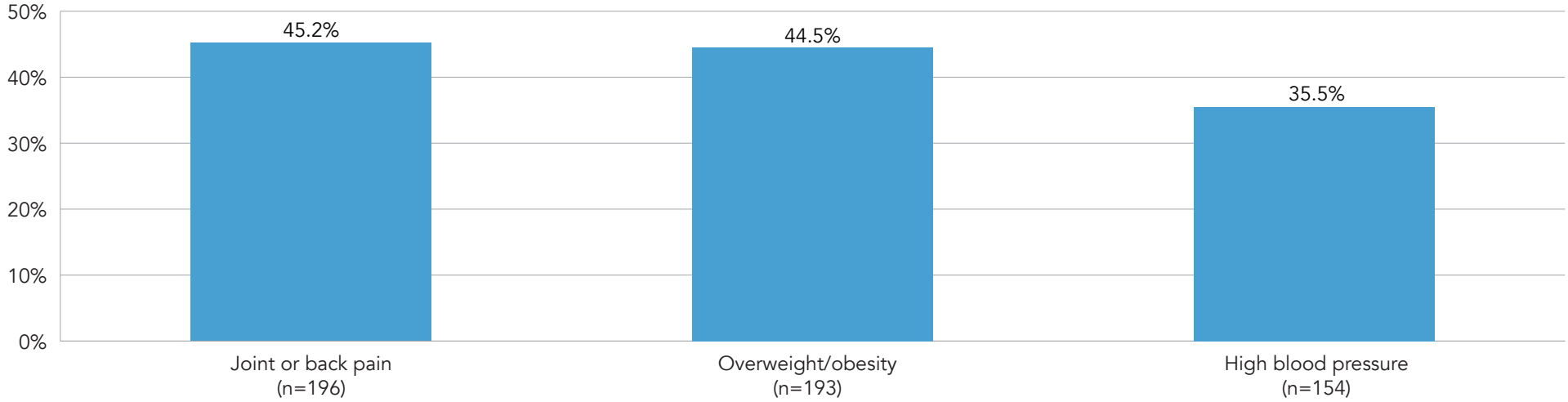
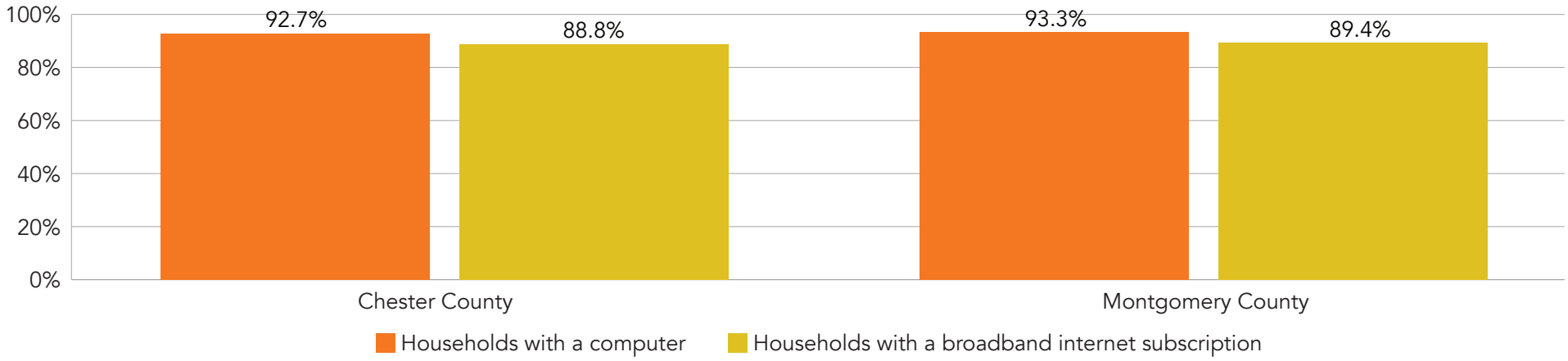


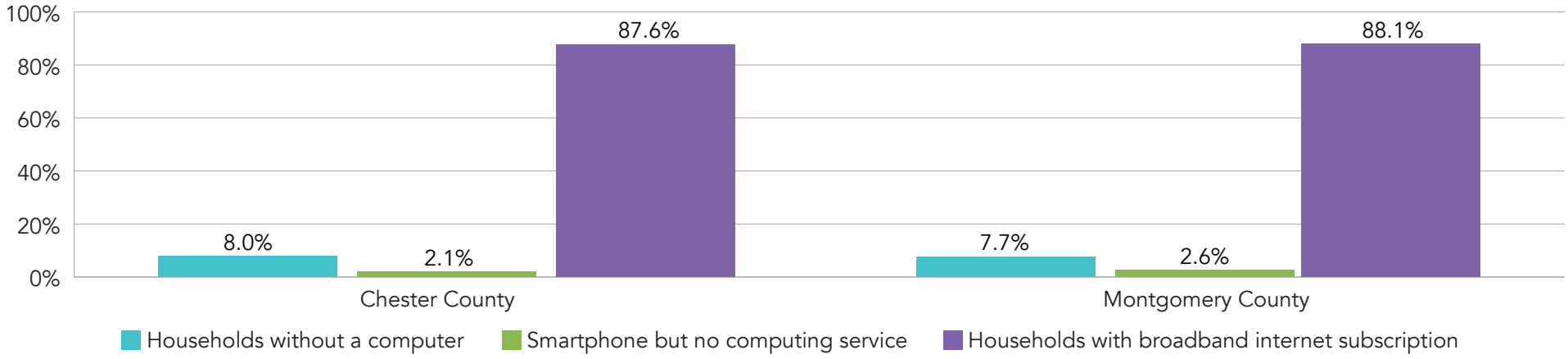
Figure 21 illustrates the percentage of residents in Chester and Montgomery counties with a computing device or internet service. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet to reach targeted audiences. This avenue allows underserved or disenfranchised populations access to health education.

Figure 21: Percentage of Households with Computer or Internet



Source: U.S. Census Bureau 2019

Figure 22: Percentage of Households with Limited Technology



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

The USDA refers to food insecurity as the "limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways." 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.

Source: Feeding America 2019

SM SNAP Supplemental Nutrition Assistance Program

The Supplemental Nutrition Assistance Program (SNAP)[8] reported the following in Chester and Montgomery counties:

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

Source: Coalition Against Hunger 2018

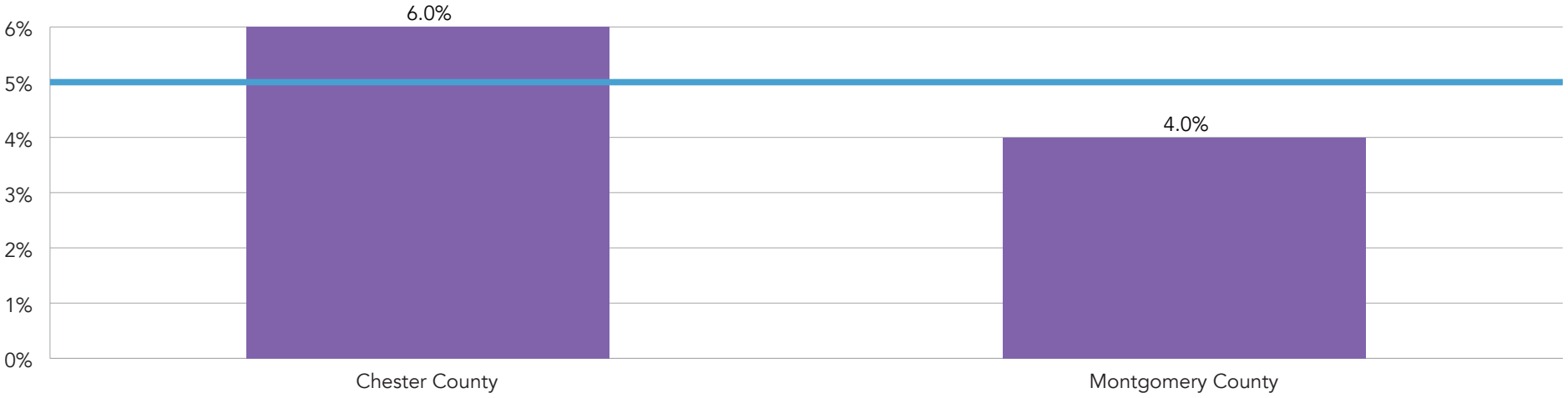
[8] SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move toward self-sufficiency.

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 who are experiencing food insecurity for the first time along with those who experienced food insecurity before the COVID-19 crisis.

Figure 23 reports the percentage of the population who are low-income and do not live close to a grocery store.

Figure 23: Limited Access to Healthy Foods



Note: The blue line indicates the overall rate in Pennsylvania of 5.0%.

Source: County Health Rankings & Roadmaps 2015

Figure 24 from the community survey shows health behaviors for which people in the community need more information.

Figure 24: Top Health Behaviors for Which People Need More Information

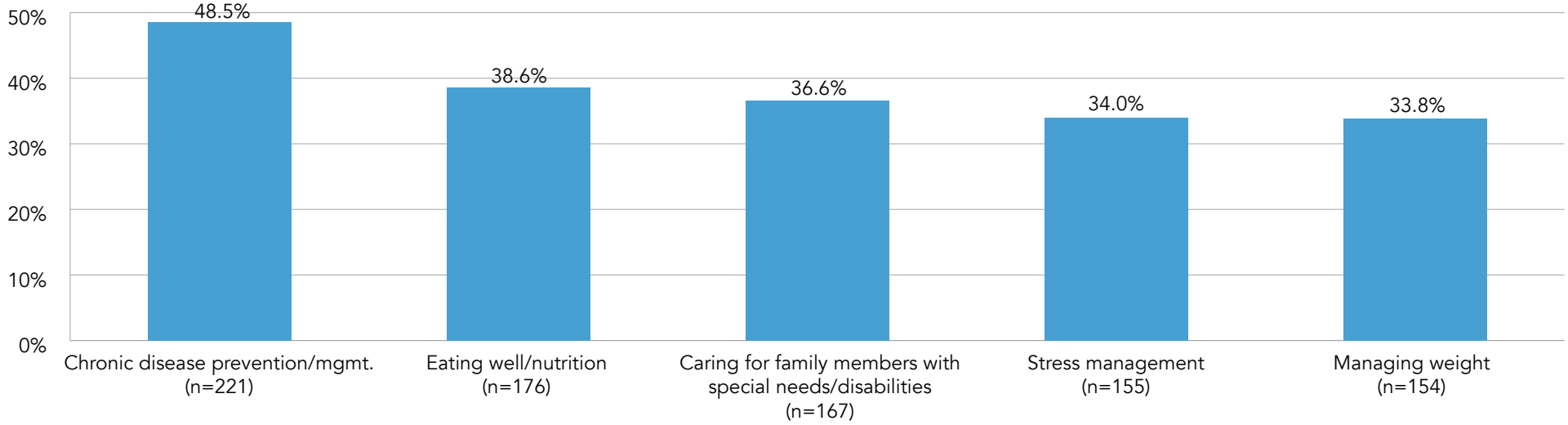
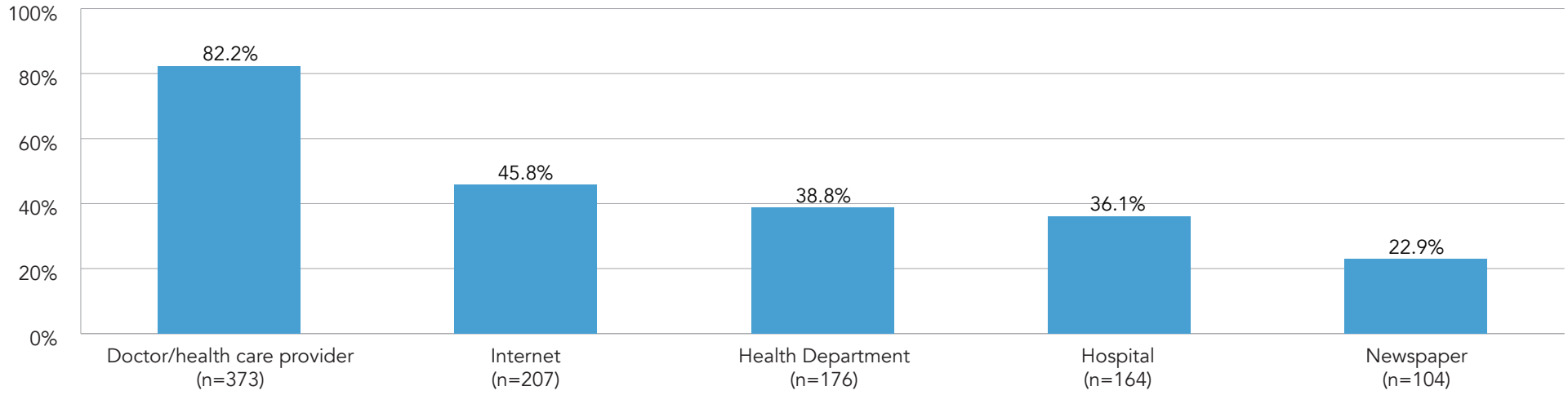


Figure 25 from the community survey reports how the community wants to receive health information.

Figure 25: Top Ways Community Wants to Receive Information



GOAL:

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

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Chronic Disease Education	Provide health education programs focused on older adult/senior population	X	X	X	10 programs per year	Phoenixville Senior Center Phoenixville YMCA Phoenixville Rec Department
	Provide chronic disease-specific education to other vulnerable populations including low-income, veterans, and others	X	X	X	10 programs per year	Community organizations
	Provide chronic disease education at nurse outreach sites	X	X	X	50 sessions per year	King Terrace Whitehall VA Housing Phoenixville Area Community Services Project Outreach First United Church
Spanish/Portuguese-speaking community-based outreach	Create a health survey for Spanish/ Portuguese community		X		Survey designed	
	Collaborate with organizations to deploy survey to Spanish and Portuguese community regarding health		X	X	100 community members complete survey	Alianza Kate's Casa St. Ann's PASD
	Develop and execute outreach plan based on survey results			X	Outreach plan designed	
Blood Pressure Screenings	Perform BP screenings and refer to appropriate follow up	X	X	X	500 blood pressure screenings completed 10% referred follow-up	King Terrace Whitehall VA Housing Phoenixville Area Community Services Project Outreach First United Church

GOAL:

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

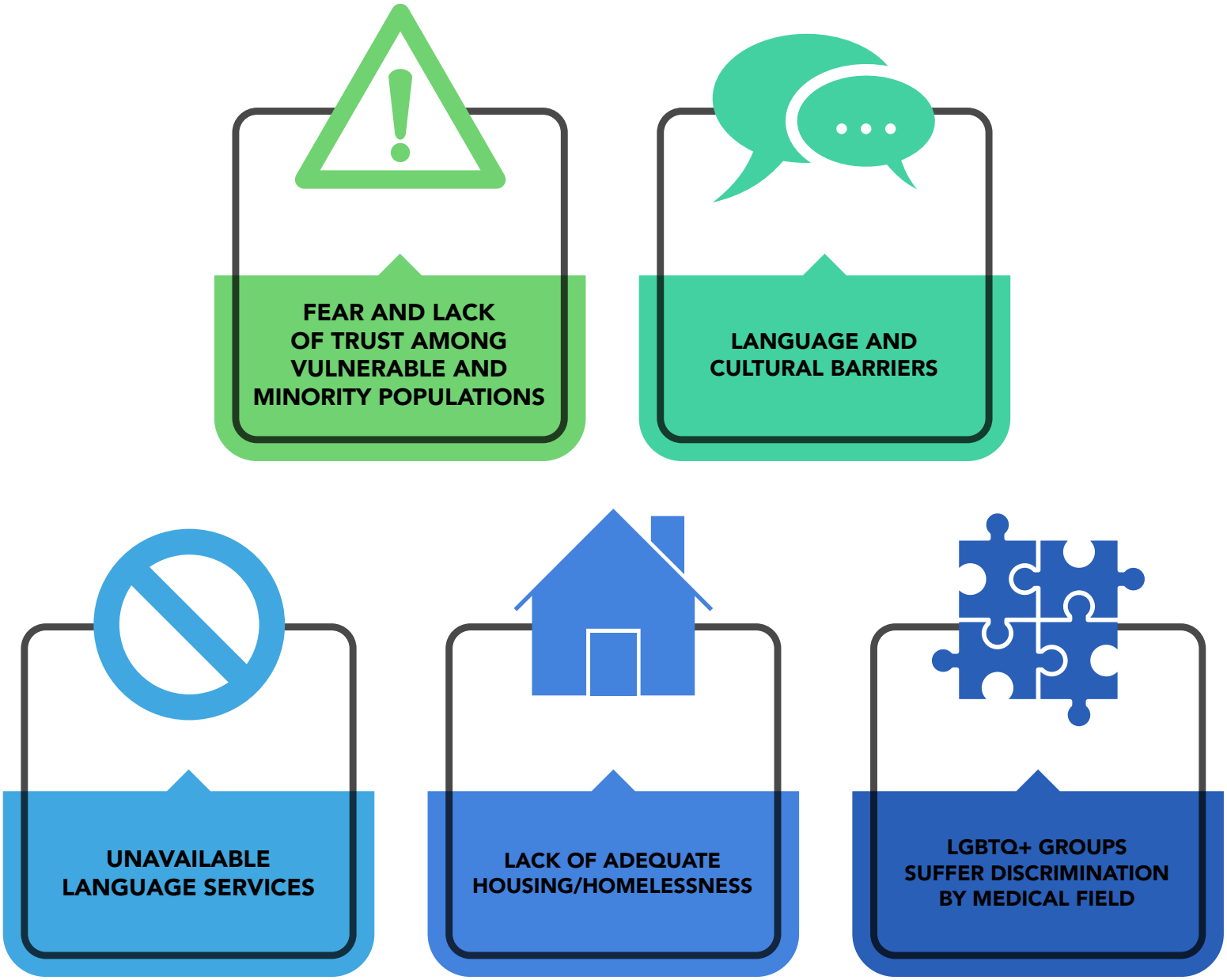
Strategy	Action Items	2022	2023	2024	Metrics	Partners
Cancer Prevention Education and Screening	Provide tobacco cessation/vaping education to students and parents	X	X	X	Offer two parent programs per year Offer six student programs per year	Local school districts
	Partner with Reading Hospital to host Mobile Mammography Coach for screening events		X	X	Offer two mobile screening events per year	Reading Hospital Mobile Mammography Coach
	Provide information on cancer prevention and screening at hospital and community events	X	X	X	Two events per year	Community organizations
Vaccine Partnership	Partner with organizations to provide vaccine clinic to the community	X	X	X	Host 6-10 vaccine clinics per year	Community vaccine partners
Tower Employee Wellness Initiatives	Conduct Know Your Numbers Campaign (BMI, BP, lipids, A1C) through Virgin Health app		X	X	30% of staff participating in campaign	
	Engage employees with PCP		X	X	65% of staff attest to establishing care with PCP	
	Encourage engagement with Virgin Health platform for wellness-based education and activities	X	X	X	50% of staff enrolled in platform by 2024	

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 diverse and disparate populations, 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 have a very dramatic impact on the capacity to provide quality health care and the quality of life for Phoenixville Hospital's communities. Interventions that improve health equity and reduce disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently. **Addressing SDOH is paramount to creating a healthier community.**

COMMENTS FROM PRIMARY DATA COLLECTION:

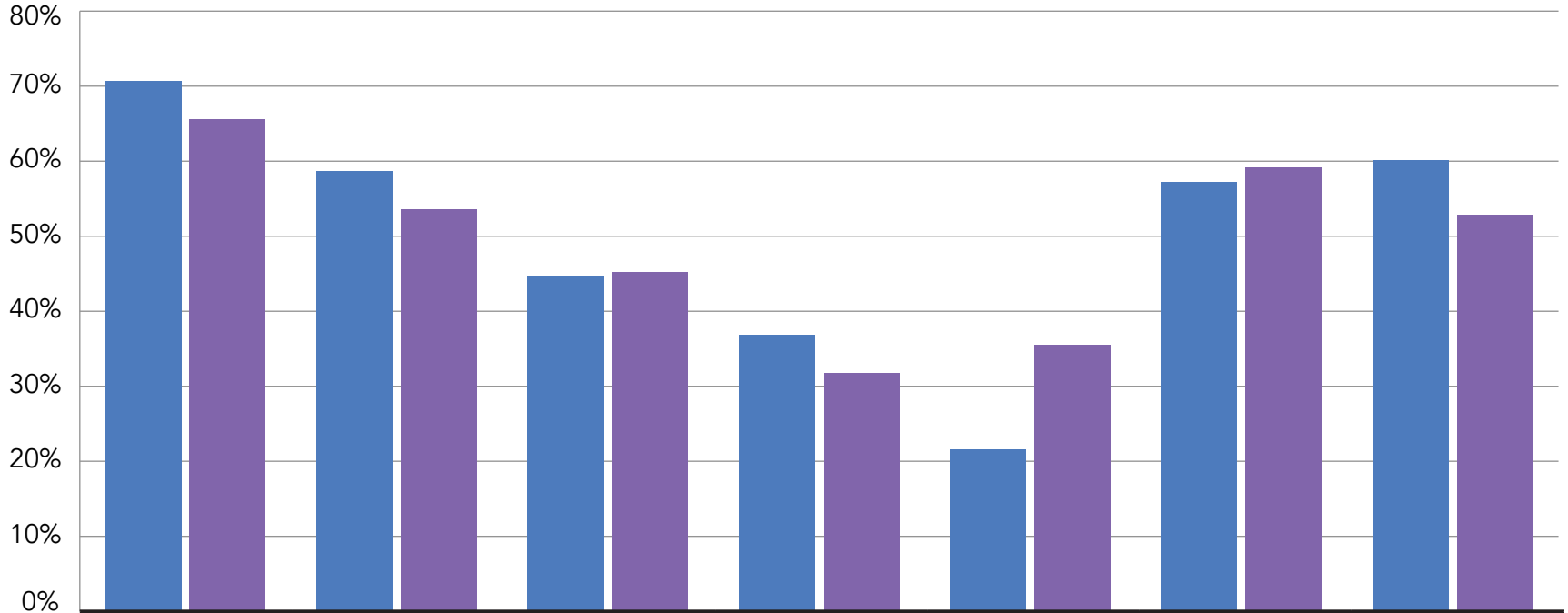


COVID-19 AND HEALTH EQUITY

The effects of COVID-19 are far-reaching and long-lasting. The Centers for Disease 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. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC). 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.

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.

Figure 26: Full Vaccination Coverage for Race/Ethnicity



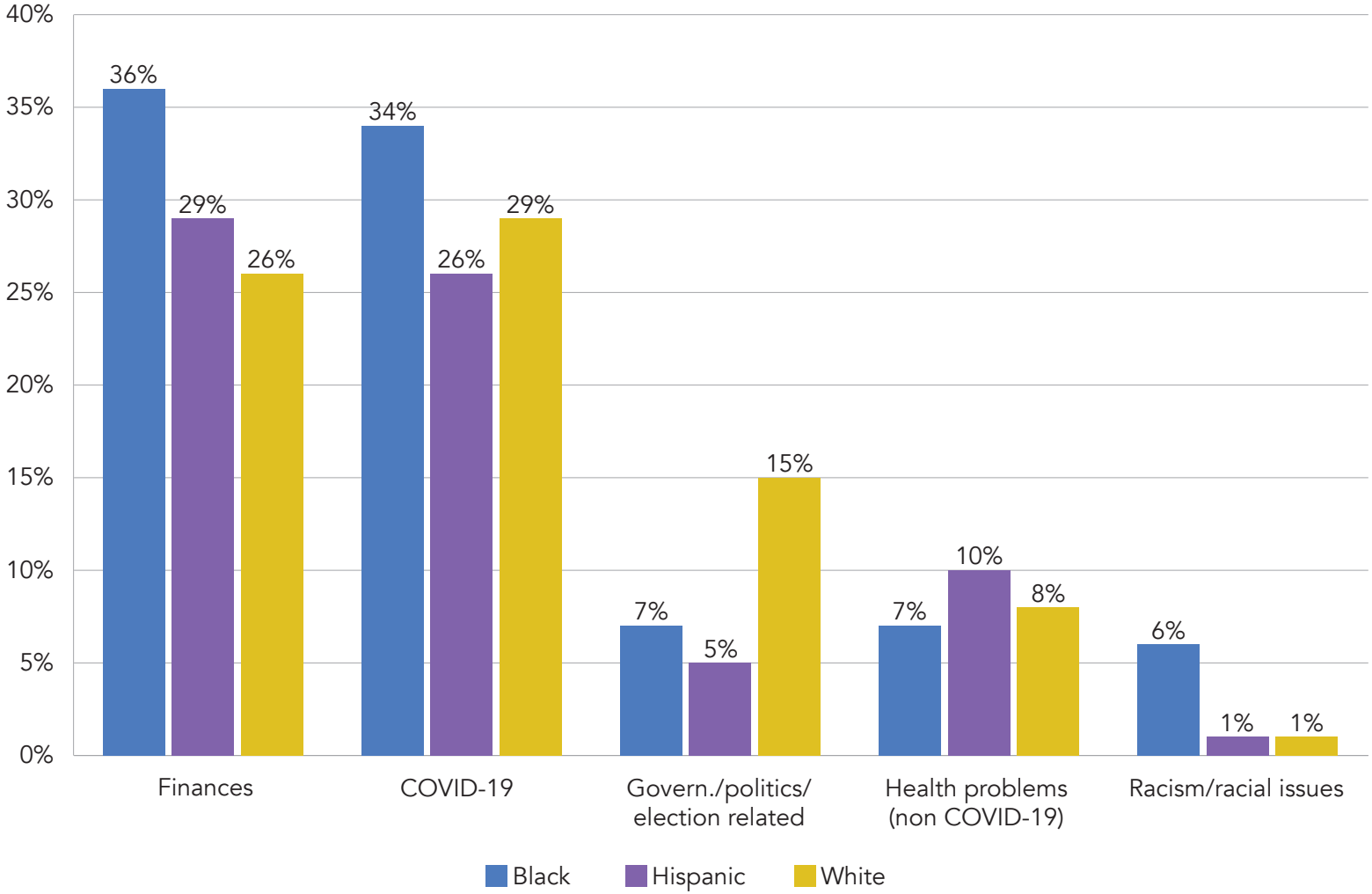
	All Races/Ethnicity	White	African American	Asian/Pacific Islander	Native American	Hispanic	Not Hispanic
Chester County	70.6%	58.7%	44.6%	36.8%	21.5%	57.2%	60.1%
Montgomery County	65.6%	53.6%	45.2%	31.7%	35.5%	59.2%	52.8%

Source: The PA Department of Health

CONTRIBUTORS TO HEALTH EQUITY

Figure 27 depicts the largest concerns families face, broken down by race/ethnicity. More than one-third of Black adults cite financial issues and a similar share (34%) cite concerns related to the COVID-19 pandemic. These are also the top two concerns mentioned by white and Hispanic adults, though Black adults are 10 percentage points more likely than white adults to name financial challenges among their top concerns (36% vs. 26%). Notably, 6% of Black adults cite issues related to racism as being among their top concerns. Please click here for additional data related to the study conducted by Kaiser Family Foundation's (KFF) The Undefeated Survey on Race and Health 2020.

Figure 27: Biggest Concerns Facing Individuals and Families 2020



Source: KFF/The Undefeated Survey on Race and Health

GOAL:

Increase health equity by addressing Social Determinants of Health and providing culturally competent care.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Health Equity Council	Establish and convene council	X	X	X	Council Created	
	Complete Health Equity Assessment and review Transformation Action Plan	X			Assessment completed TAP reviewed	
	Create Health Equity Action Plan and Evaluation Plan to identify and address disparities through actionable strategies		X		Health Equity Action Plan adopted Evaluation Plan created Baseline data report compiled 4 priority strategies identified	
	Create Health Equity Dashboard report to communicate plan and progress		X	X	Progress shared annually	
Certified Medical Interpreter Training	Provide Bridging the Gap Medical Interpretation training annually	X	X	X	Two new bilingual hospital staff trained per year Five community members trained per year	Community organizations
Diversity, Equity, & Inclusion (DE&I) Council	Offer educational opportunities for staff	X	X	X	Monthly educational programs	

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Phoenixville Hospital
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