IMPLEMENTATION STRATEGY

2022

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Temple Health
Chestnut Hill Hospital

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John Cacciamani, M.D.

President and Chief Executive Officer,
Temple Health-Chestnut Hill Hospital

LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Chestnut Hill Hospital is committed to advancing health and transforming lives throughout Montgomery and Philadelphia 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. Chestnut Hill Hospital 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, Chestnut Hill 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 Chestnut Hill 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,

JOHN CACCIAMANI, M.D.

President and Chief Executive Officer,
Temple Health-Chestnut Hill Hospital

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 Chestnut Hill 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.

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

The CHNA along with the Implementation Strategy Report (ISR) 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. Chestnut Hill Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements. Chestnut Hill Hospital is proud to present its 2022 ISP report and its findings to the community.

CHESTNUT HILL HOSPITAL

WHO ARE WE?

Located in the Chestnut Hill section of Philadelphia, Temple Health-Chestnut Hill Hospital is a 148-bed, community-based, university-affiliated teaching hospital committed to excellent patient-centered care. Chestnut Hill Hospital provides a full range of inpatient and outpatient, diagnostic and treatment services for people in northwest Philadelphia and eastern Montgomery County. With more than 300 board-certified physicians, Chestnut Hill Hospital's specialties include minimally invasive laparoscopic and robotic surgery, cardiology, gynecology, oncology, orthopedics, urology, family practice, and internal medicine. Chestnut Hill Hospital is accredited by The Joint Commission and is affiliated with university hospitals in Philadelphia for heart and stroke and its residency programs.

- Emergency Medicine
- Cancer Care
- Radiology/Imaging
- Laboratory
- Nutrition
- Rehabilitation
- Sleep Disorder Services
- Surgery
- Older Adult Behavioral Health
- Orthopedics
- Podiatry
- Adult Weight Loss Surgery
- Women's Health

MISSION

The Mission of Chestnut Hill 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

Chestnut Hill will be an innovative, leading regional hospital 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. Chestnut Hill Hospital's primary service area includes 11 ZIP codes within Philadelphia and Montgomery counties.

Chestnut Hill Hospital's Primary Service Area

ZIP Codes	Town/Neighborhood
19031	Flourtown
19038	Glenside
19118	Chestnut Hill
19119	Mt. Airy
19128	Roxborough
19138	West Oak Lane
19144	Germantown
19150	Cedarbrook
19462	Plymouth Meeting
19422	Blue Bell
19444	Lafayette Hill

OUR
FOCUS

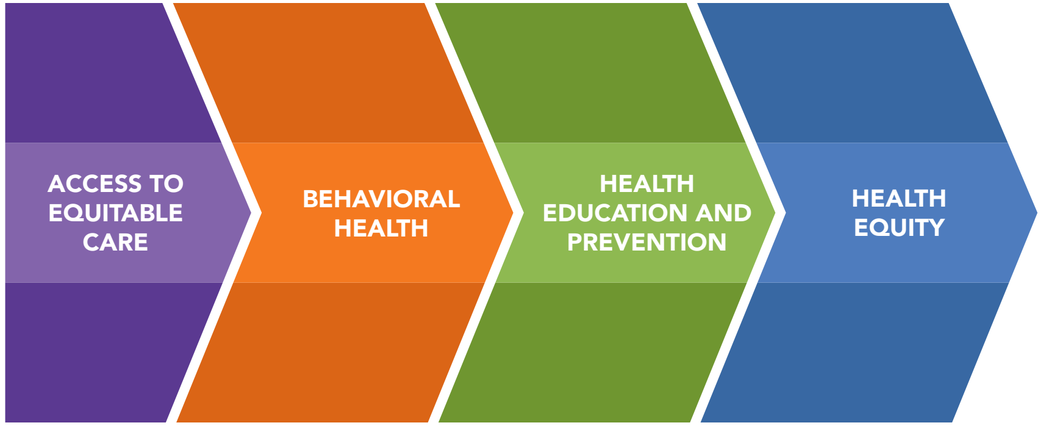
Chestnut Hill Hospital's 2022 Implementation Strategy is a key component of the community health needs assessment process as it delineates the strategies and goals designed to meet prioritized needs and sets the stage for action and execution of initiatives that effectively impact health outcomes and 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 ISP was built on accomplishments and lessons learned, as well as the challenges and complexities of 2019 CHNA and ISP efforts.

IMPLEMENTATION STRATEGY
CHNA HEALTH PRIORITIES

The 2022 ISP 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.

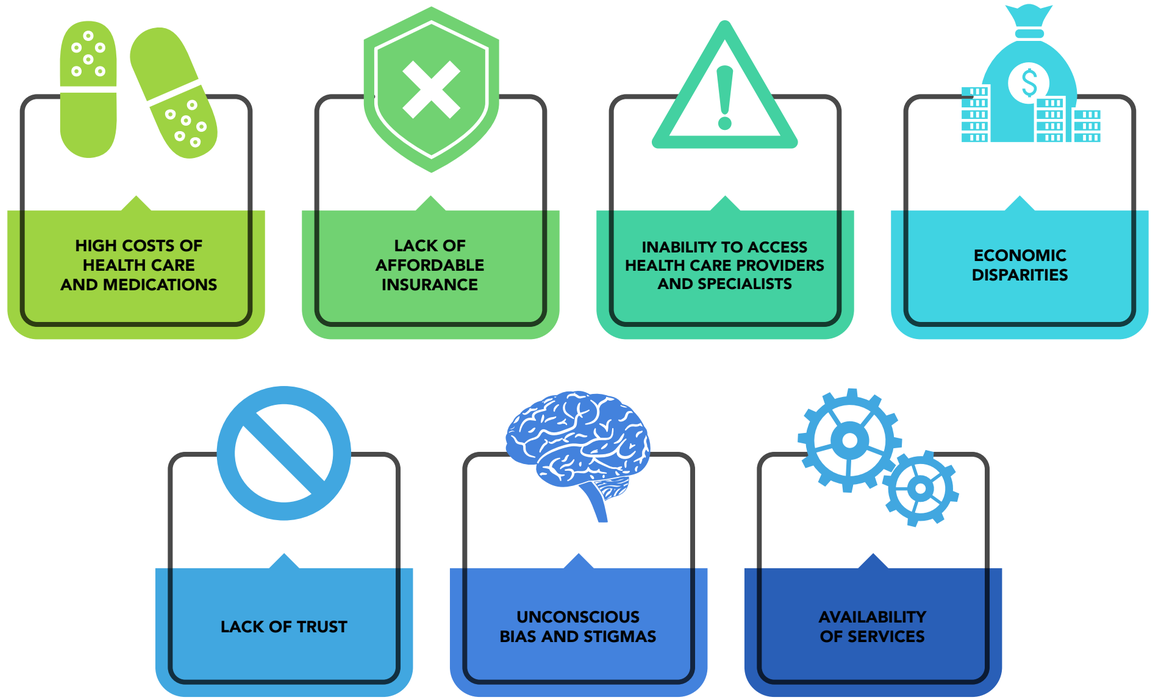
The effectiveness of the 2022 ISP is strengthened as we translate our understanding and knowledge of what the community told us into dynamic policies and best practices. Community input guides our efforts to diligently understand past successes and pitfalls in continuously improving the health of our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



A) PLAN TO INCREASE ACCESS TO EQUITABLE CARE

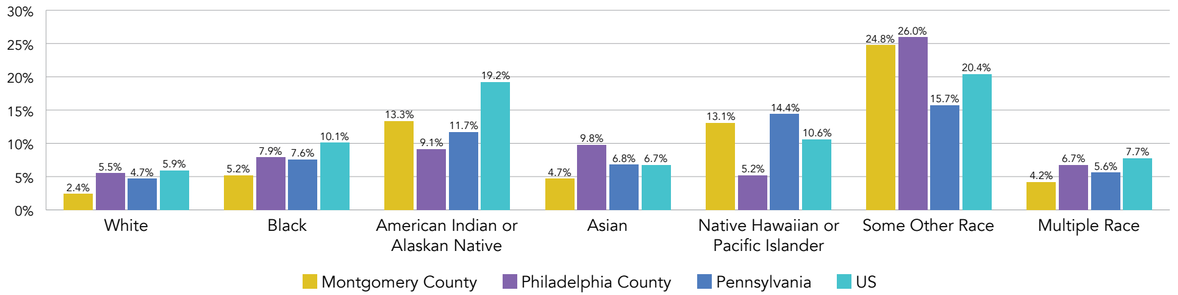
Facing the challenges of COVID-19, Chestnut Hill Hospital used lessons learned to better understand the impact of the pandemic on the many previously identified health needs and issues. The pandemic further helped the hospital to realize the even wider gaps that resulted as related to accessing care,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

COMMENTS FROM PRIMARY DATA COLLECTION:



Although the percentage of uninsured has increased during 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 in Montgomery and Philadelphia counties. The Healthy People 2030 target is to increase the portion of the population covered by health insurance to 92.1% overall.

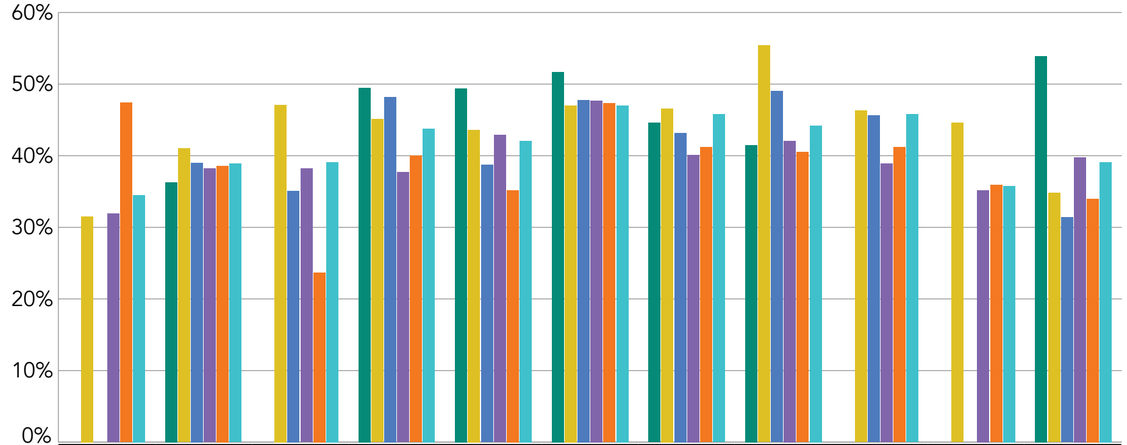
Figure 1: Uninsured Population by Race



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.[1] The below figure depicts ZIP codes within Chestnut Hill's service area related to adults who obtain primary-care visits.

Figure 2: Percentage of Adults with Primary-Care Physician Visits by ZIP Code Summary



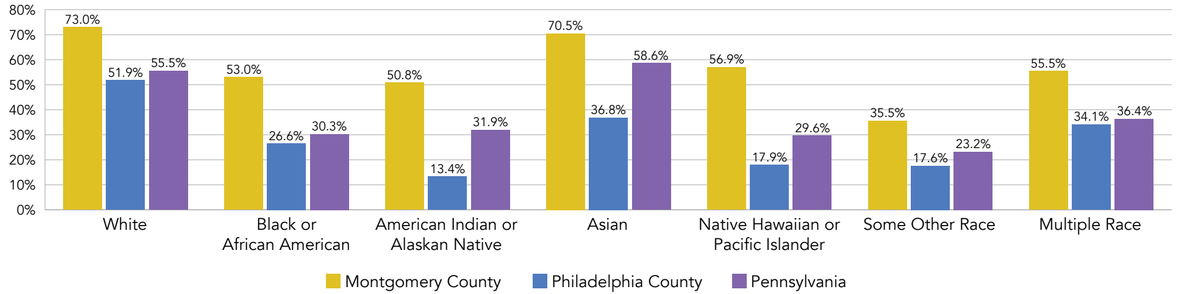
	19031	19038	19118	19119	19128	19138	19144	19422	19150	19444	19462
Asian	-	**36.3**	-	49.5	49.4	51.7	**44.6**	**41.5**	-	-	53.9
Black	**31.5**	41.0	47.1	45.1	43.6	47.0	46.6	55.4	46.3	44.6	**34.8**
Hispanic	-	39.0	**35.1**	48.2	**38.7**	47.8	**43.2**	49	**45.6**	-	**31.4**
White	**31.9**	**38.2**	**38.2**	**37.7**	42.9	47.7	**40.1**	**42.1**	**38.9**	**35.2**	39.8
Other Race	47.4	**38.6**	**23.7**	**40.0**	**35.2**	47.3	**41.2**	**40.5**	**41.2**	35.9	**34.0**
All Adults	**34.5**	**38.9**	**39.1**	**43.8**	**42.1**	**47.0**	**45.8**	**44.2**	**45.8**	**35.8**	**39.1**

Note: 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

[1] 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.

Figure 3: Families Earning More Than $75,000 by Race Alone

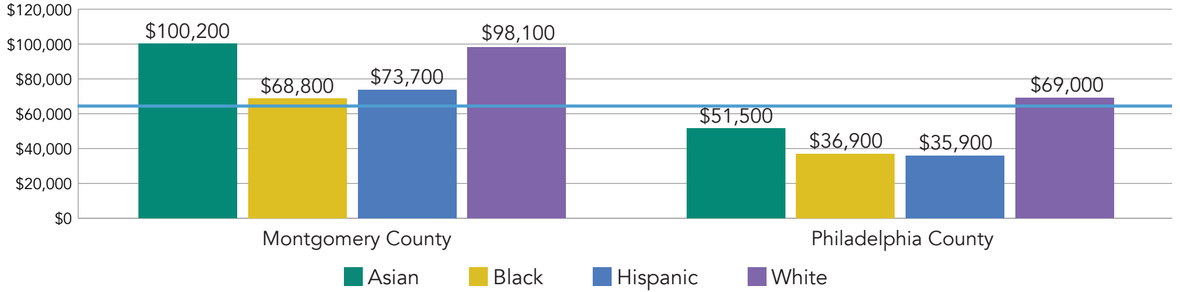


Source: U.S. Census Bureau, American Community Survey 2019

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.[2]

Figure 4: Median Household income by Race



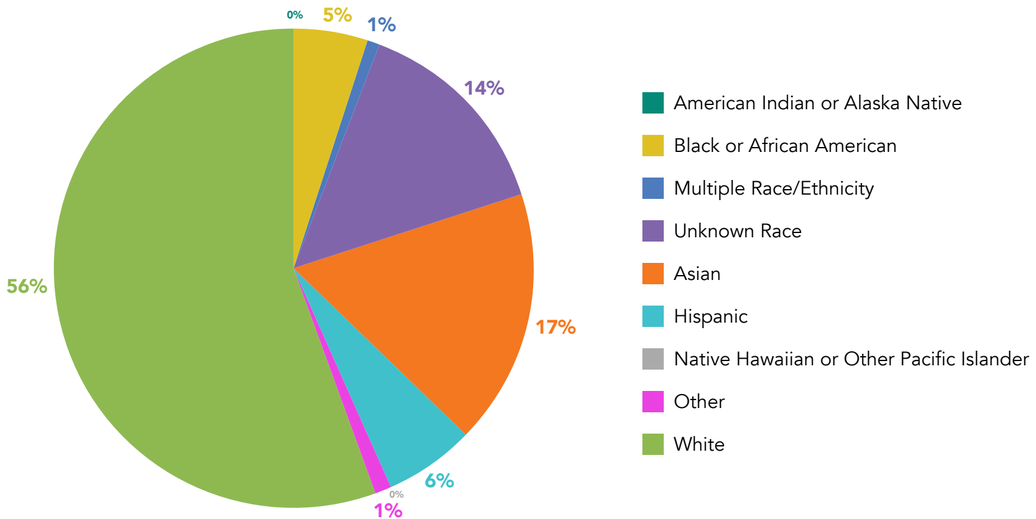
Note: The blue line indicates the median household income of Pennsylvanians of $64,900.
Source: County Health Rankings & Roadmaps 2020

[2] 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.

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 might help to enrich differences in health status.[3]

Figure 5 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 the race of 13.7% of active physicians is Unknown, making that the largest subgroup after White and Asian.

Figure 5: Percentage of all Active Physicians by Race and Ethnicity, 2018



Source: Association of American Medical Colleges

[3] 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
Patient Portal	Promote patient portal to encourage patients to manage individual health	X	X	X	Increase number of portal users by 3% annually	
Online Appointment Scheduling	Implement online appointment scheduling for additional clinical services		X	X	Online appointment scheduling for employed primary care physician offices established 500 encounters	
Free Clinical Interventions	Provide clinical services to homebound and at-risk population though volunteering at neighborhood clinics		X	X	Establishment of homebound partner 2 community engagements conducted per year 10 people served per event	
Ride Health/Cab Vouchers	Utilize Ride Health and Cab Voucher processes to coordinate free transportation to and from appointments for eligible patients	X	X	X	500 rides provided each year	Ride Health/Cab Vouchers
	Conduct internal education campaign to increase awareness and utilization	X	X	X	Annual education completed	
Increase Access to Care among Community-Based Organizations	Provide financial support to community organizations	X	X	X	2 programs funded	Philadelphia Interfaith Hospitality Network
Addressing SDOH	Provide acute care and health screening services to community members	X	X	X	Number of community members served each year	Face to Face Germantown

B) PLAN TO INCREASE BEHAVIORAL HEALTHCARE ACCESS

Improving access and adequacy of behavioral health services and programs has become a high priority for Chestnut Hill Hospital's communities in recent years. More than 48% 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. "Social distancing policies, mandatory lockdowns, isolation periods, and anxiety of getting sick, along with the suspension of productive activity, loss of income, and fear of the future, jointly influence the mental health of citizens and workers" (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, especially those on the front line; migrant workers; and workers in contact with the public.

COMMENTS FROM PRIMARY DATA COLLECTION:

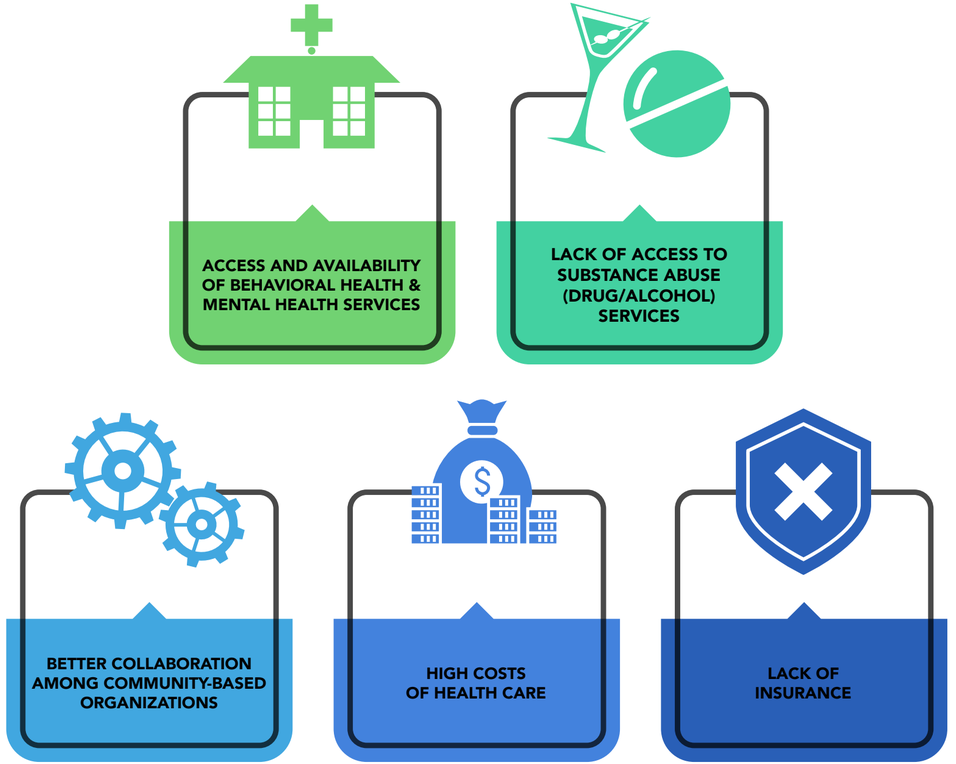
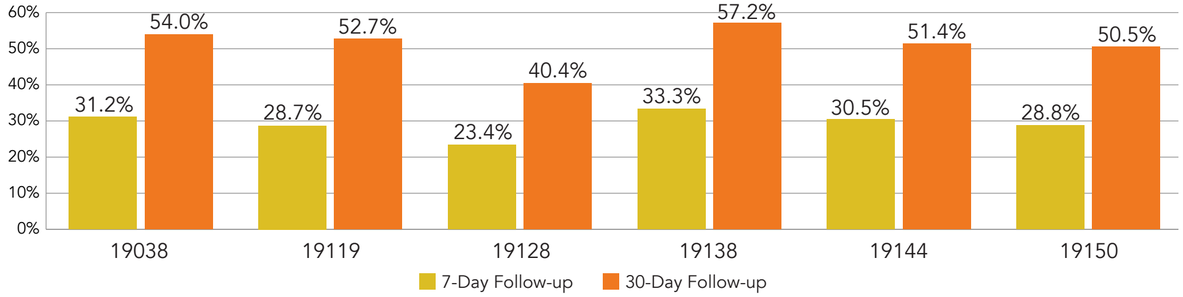


Figure 6 illustrates percentages of adults by ZIP codes of mental health admissions with either a seven-day or 30-day follow-up. Follow-up care after hospitalization for mental illness or intentional self-harm helps improve health outcomes and prevent readmissions. Recommended post-discharge treatment 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.[4]

Figure 6: Percent of Readmissions by ZIP code



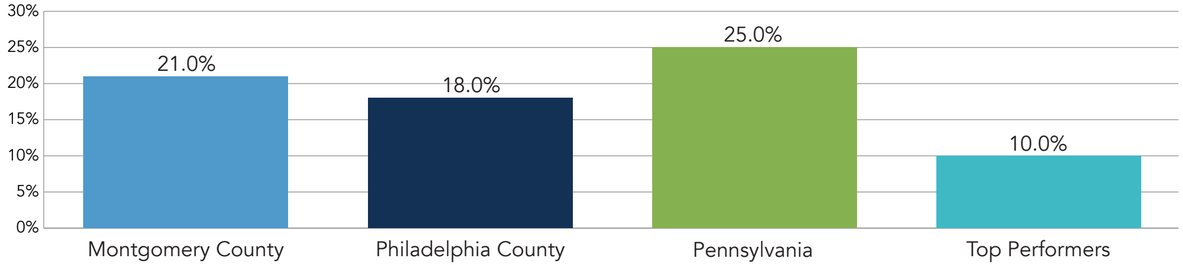
Data was not available for ZIP codes 19031, 19118, 19462, 19422, and 19444.
Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[4] 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 Montgomery County are higher when compared to Philadelphia County but are below the state average. 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 7 illustrates the percentage of driving deaths involving alcohol impairment for Montgomery and Philadelphia counties, the state, and top performers.

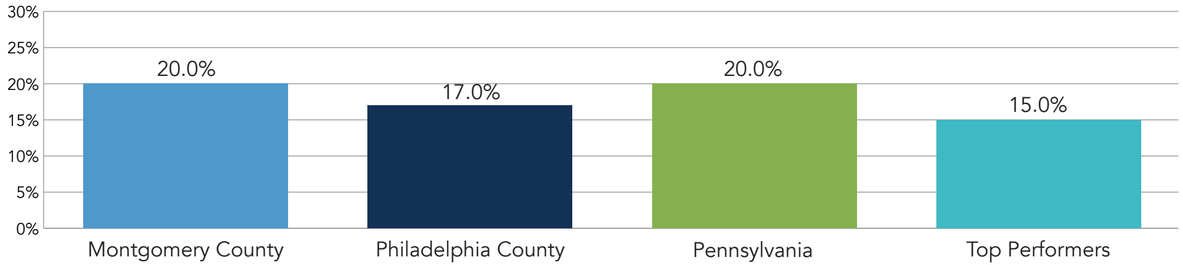
Figure 7: Driving Deaths Involving Alcohol Impairment



Source: County Health Rankings & Roadmaps 2016-2020

Figure 8 illustrates the percentage of adults in the past 30 days who reported binge drinking or heavy drinking for Montgomery and Philadelphia counties, the state, and top performers.

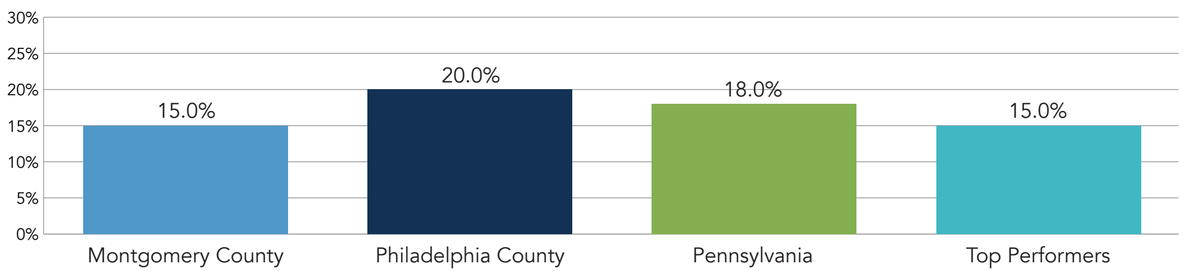
Figure 8: Adult Excessive Drinking[5]



Source: County Health Rankings & Roadmaps 2019

Figure 9 shows adults 18 and older who smoke. Adult smoking is the percentage of the adult population in a county who both report that they smoke every day or some days and have smoked at least 100 cigarettes in their lifetime. More Philadelphia County residents smoke when compared to Montgomery County and the state. The prevalence of tobacco can alert communities to adverse health outcomes and can be valuable for implementing needed cessation programs or evaluating the effectiveness of tobacco control programs.

Figure 9: Adult Smoking — Current Smokers



Source: County Health Rankings & Roadmaps 2019

[5] Heavy drinking is defined as having more than two drinks per day for men and more than one per day for women during 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.

GOAL:

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

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Telepsychiatry Services	Implement Telephychiatry services in Emergency Department		X	X	Track patient encounters Increase utilization by 3% annually	
Workplace Violence Committee	Establish committee to address workplace violence	X	X	X	Committee established Recurring meetings conducted	
	Develop a Workplace Violence Policy and communicate standards with staff	X	X	X	Policy created Standards communicated annually	
	Track incident reporting	X	X	X	Increase reporting of incidents by 3% each year	
Expand Behavioral Health Services	Identify partners to support expansion		X	X	Partners identified	Area Health Systems
	Develop partner agreements and referral processes		X	X	Partner agreements approved Referral process created	
	Track patients referred		X	X	12 referrals per year	
Employee Wellness Initiatives	Conduct Schwartz Rounds, multidisciplinary forum for caregivers to discuss social and emotional issues that arise in caring for patients	X	X	X	Host 9 Schwartz Rounds per year	The Schwartz Center for Compassionate Healthcare
	Promote RethinkCare 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	X	95% use of service satisfaction rate reported	
	Launch Well-Being Index to assess provider burnout and develop resources to mitigate stressors	X	X	X	100% participation by residents and fellows 40% participation by physicians	Mayo Clinic

C) PLAN TO STRENGTHEN HEALTH EDUCATION AND PREVENTION

Health education programs help people better understand how to manage an existing health condition and prevent further illness, which is paramount to good health. Health education and health literacy empowers individuals to make informed health decisions and helps them effectively navigate today's complex health care delivery system.

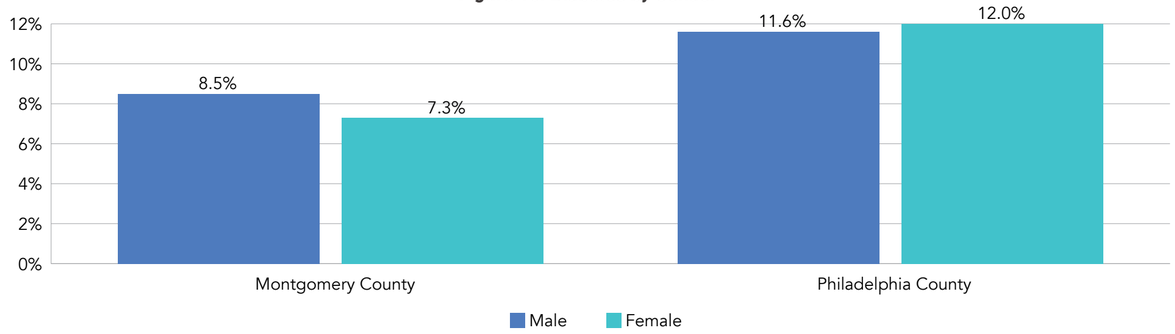
Providing health education increases understanding of health issues and enables patients and families to successfully implement treatment plans as essential to managing chronic conditions and preventing complications or hospitalizations. By improving health literacy and education to the broad community 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.

COMMENTS FROM PRIMARY DATA COLLECTION:

- LACK OF ETHNIC AND DIVERSE PROVIDERS TO SERVE A DIVERSE POPULATION
- UNEDUCATED AND LOW LEVELS OF HEALTH LITERACY
- LACK OF EDUCATION & AWARENESS OF AVAILABLE RESOURCES
- ACCESS TO HEALTHY FOODS
- LACK OF EXERCISE & INADEQUATE PHYSICAL ACTIVITY
- LACK OF PREVENTIVE CARE & CHRONIC DISEASE MANAGEMENT (OVERWEIGHT/OBESITY, UNHEALTHY LIFESTYLES AND BEHAVIORS)
- STRESS AND WEIGHT MANAGEMENT

Figure 10 shows the percentage of adults aged 20 and older, by gender, who have ever been told by a doctor that they have diabetes.

Figure 10: Diabetes by Gender



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

When asked about top challenges faced in the Chestnut Hill service area, results from the community survey respondents reported overweight/obesity, joint or back pain, and high blood pressure.

Figure 11: Top Three Challenges Faced

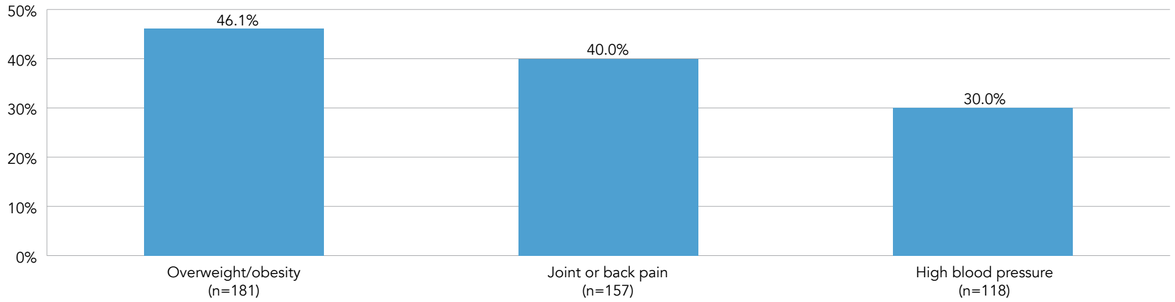
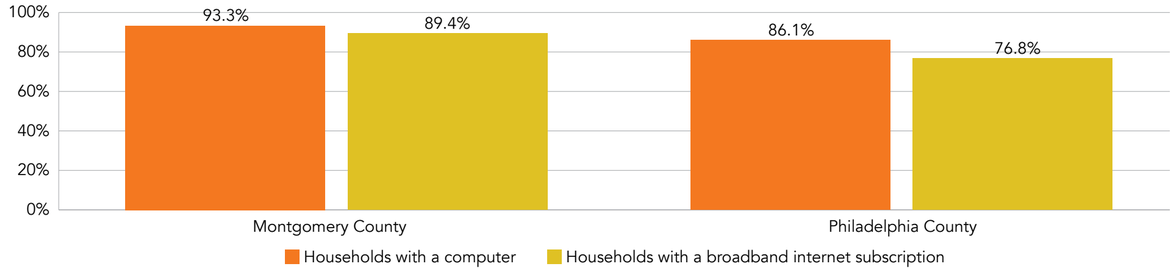


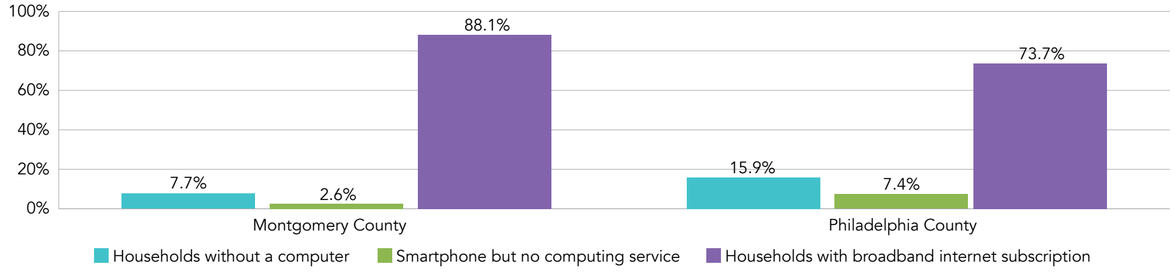
Figure 12 illustrates the percentage of residents in Philadelphia and Montgomery counties with a computing device or internet service. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet as a means of reaching targeted audiences. This avenue allows underserved or disenfranchised populations who may lack web access to obtainable health education.

Figure 12: Percentage of Households with computer or internet



Source: U.S. Census Bureau 2019

Figure 13: Percentage of Households with Limited Technology



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

There are **226,890** food-insecure people in Philadelphia County and **56,820** in Montgomery County.

Source: Feeding America 2019

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 paying housing or medical bills or purchasing nutritionally adequate foods. Lack of access to healthy foods impacts chronic diseases such as obesity/overweight, diabetes, and high blood pressure.

SNAP Supplemental Nutrition Assistance Program

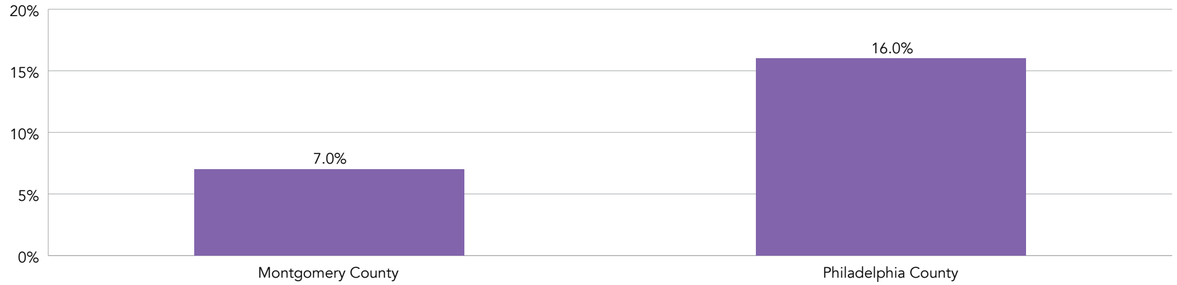
The Supplemental Nutrition Assistance Program (SNAP)6 reported the following in Philadelphia and Montgomery counties:

- 467,647 Philadelphia County residents received $61,547,164 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

Figure 14 reports the percentage of the population who lack consistent access to food. Food insecurity is related to negative health outcomes such as weight gain and premature mortality.

Figure 14: Consistent Access to Foods



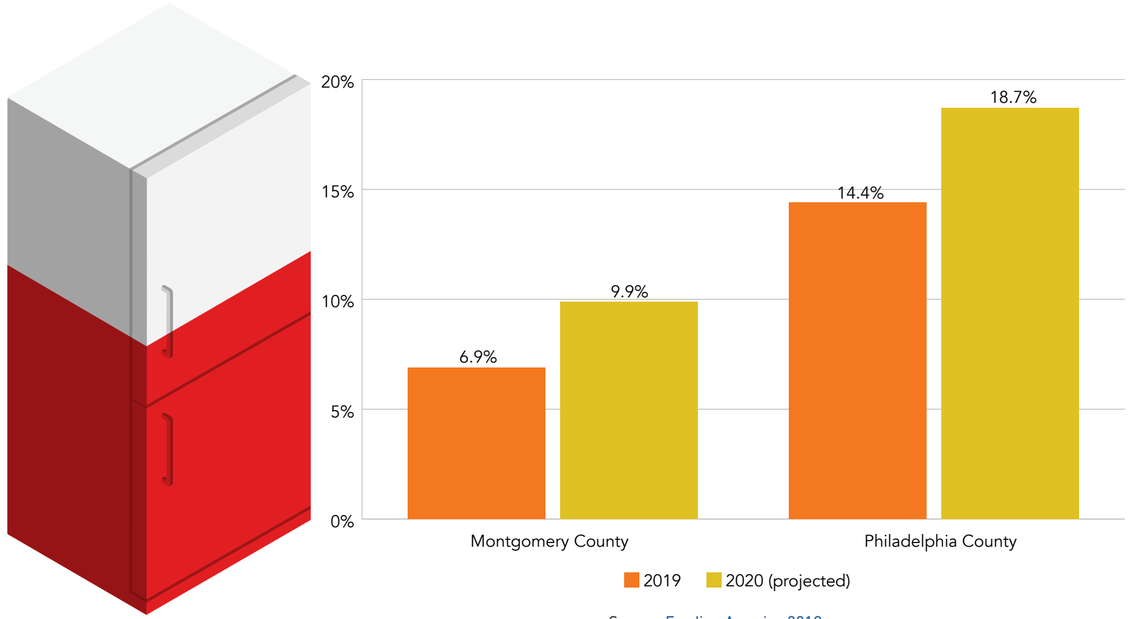
Source: County Health Rankings & Roadmaps 2015

[6] 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

COVID-19's spread across the United States in early 2020 created economic hardships. 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 15: Food Insecurity[7]

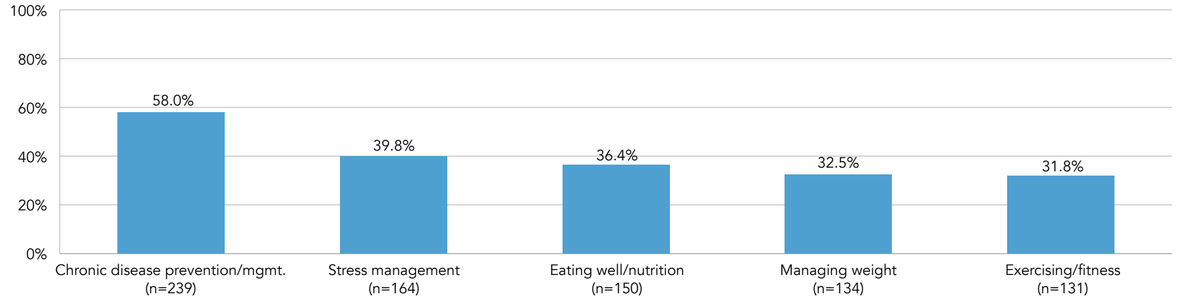


Source: Feeding America 2019

[7] The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life.

In Figure 16 the community survey shows health behaviors for which people in the community need more information.

Figure 16: Top Health Behaviors for Which People Need More Information



When community residents were asked to select statements that best applied to them, the top five responses included: I received or plan to receive the COVID-19 shot 84.8% (n=317), I receive the flu shot each year 81.3% (n=304), I use sunscreen or protective clothing for a planned time in the sun 60.2% (n=225), I exercise at least three times per week 48.4% (n=181), and I eat at least five servings of fruits and vegetables each day 34.8% (n=130).

Figure 17: Self-Assessment Statements (Top Five)

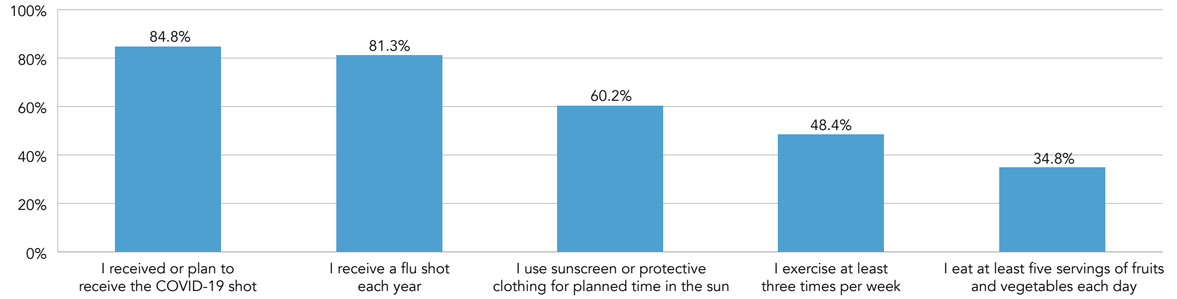
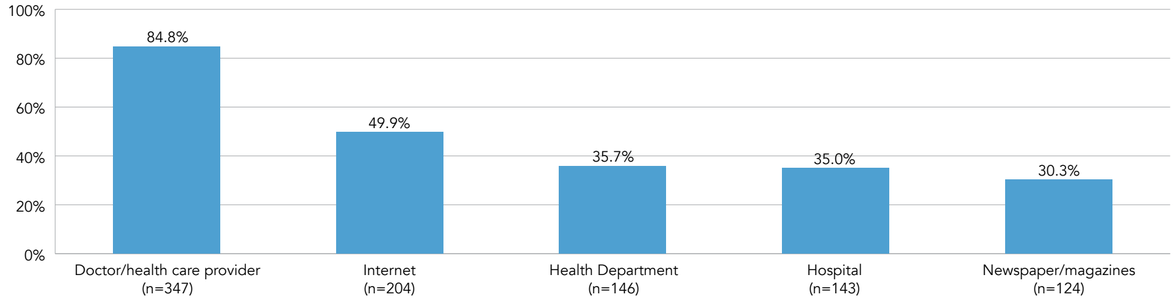


Figure 18 from the community survey reports how the community wants to receive health information.

Figure 18: Top Ways Community Wants to Receive Information



GOAL:

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

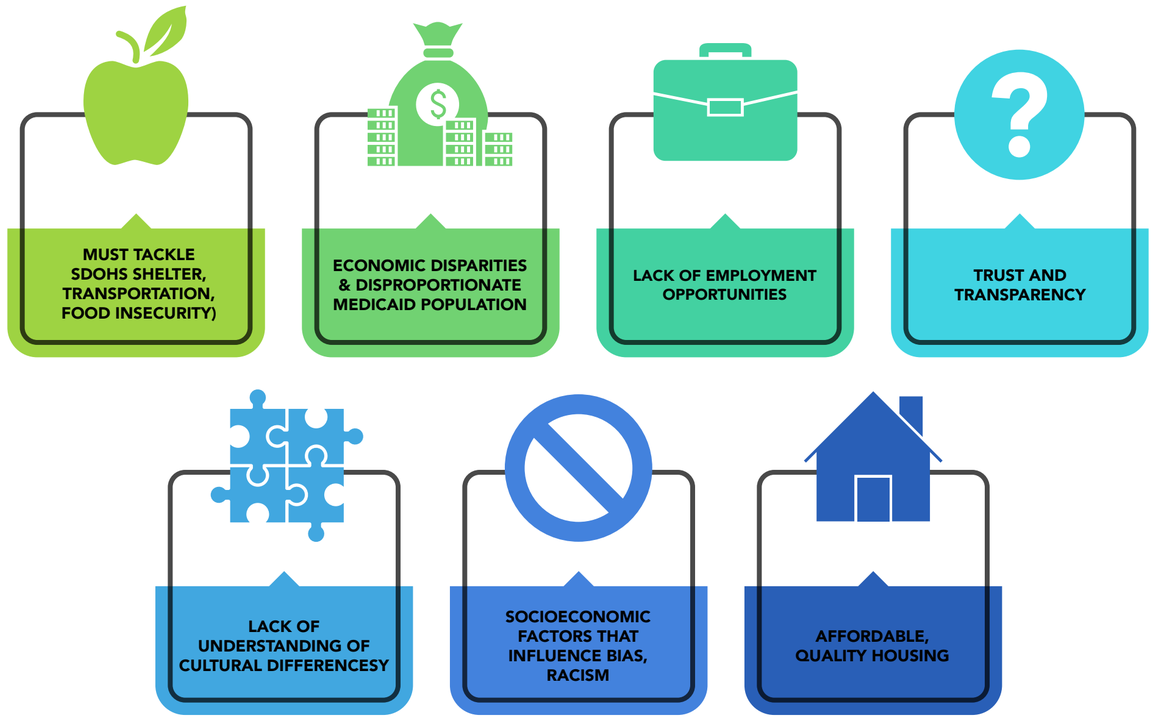
Strategy	Action Items	2022	2023	2024	Metrics	Partners
Increase Support Group Programming	Launch Weight Loss Surgery Support Group to encourage maintenance of healthy lifestyle after surgery	X	X	X	12 sessions held per year 120 community members reached Increase attendance by 3% annually	
Increase Health Education Programming	Host monthly virtual education programs	X	X	X	24 programs per year 500 community members reached Increase attendance by 3% annually	
	Host health education events and free screenings for local congregations	X	X	X	2 programs hosted annually 200 of community members reached 100 health screenings completed	Area Religious Organizations
	Partner with Philadelphia Public School system to provide health education to at-risk youth and families	X	X	X	Health education programming approved 8 programs each year 200 students reached each year	Local Public Schools
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) PLAN TO ADVANCE HEALTH EQUITY

Understanding and addressing the needs of diverse and disparate populations is a significant challenge for health care organizations. A critical aspect of improving health equity and decreasing health disparities 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 Social Determinants of Health 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 to improve the quality of life for Chestnut Hill Hospital 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.

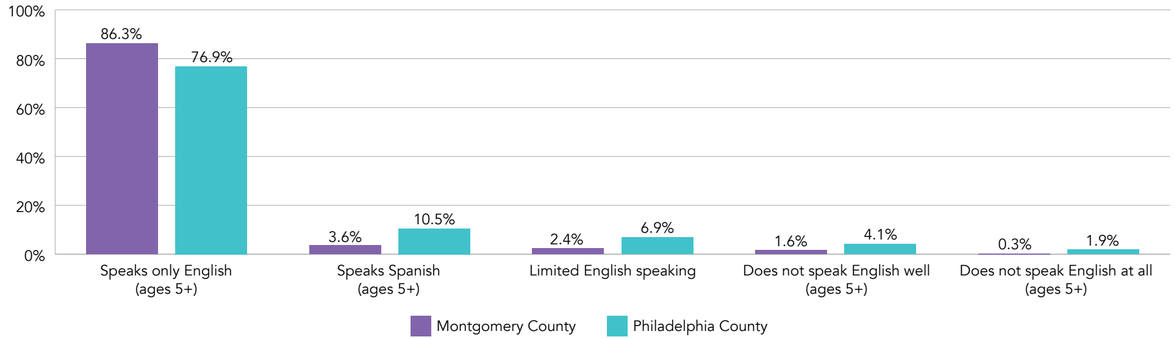
COMMENTS FROM PRIMARY DATA COLLECTION:



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 COVID-19 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.

Figure 19 reveals the percentages of residents who speak only English and Spanish and residents who are limited in English speaking.

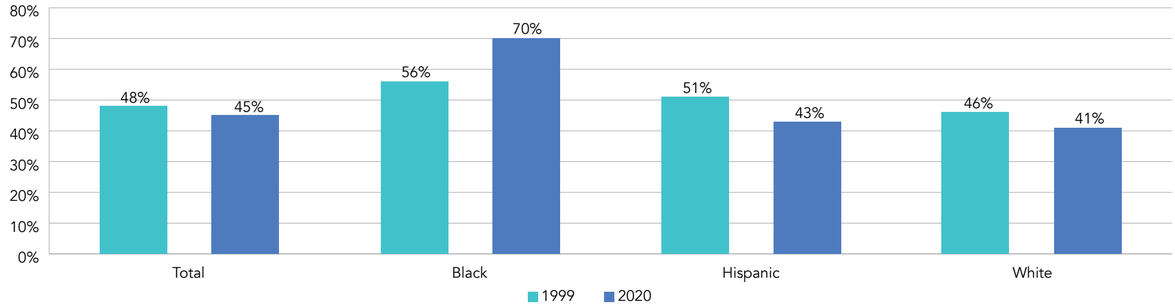
Figure 19: Households with Residents Speaking English Only, Spanish, and Limited English



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

Figure 20 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.

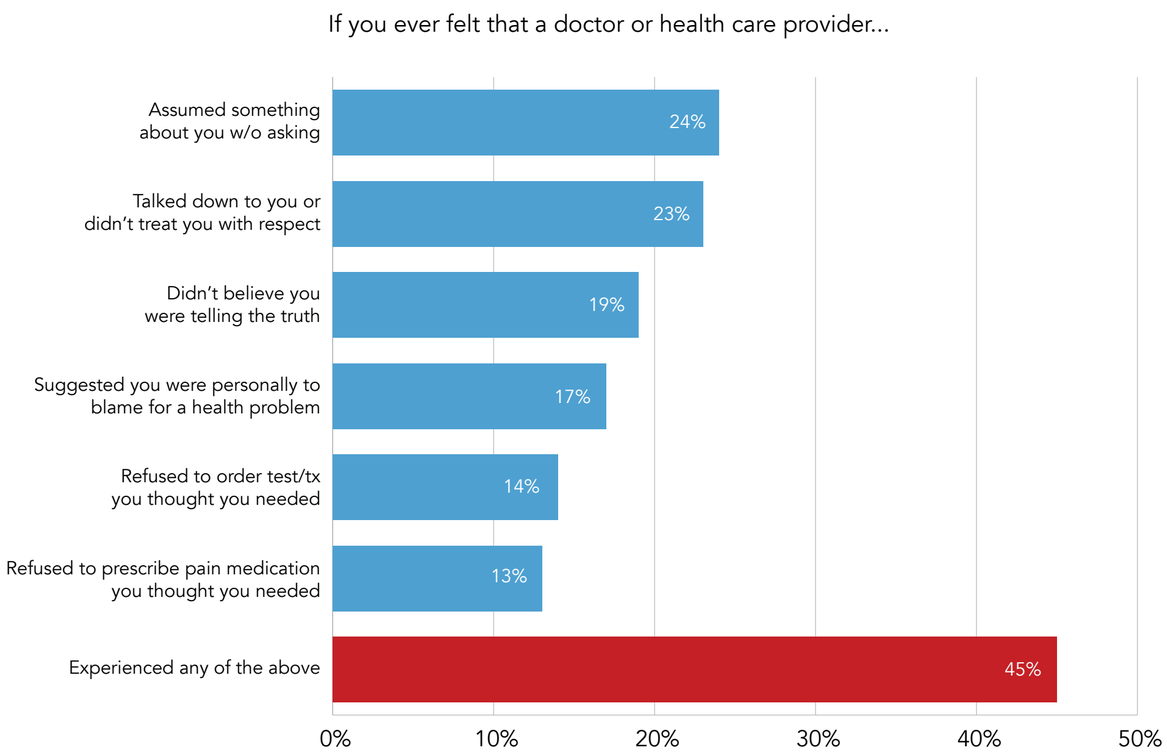
Figure 20: Percentage That Thinks the Health Care System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often



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

Figure 21 reports that nearly half of adults reported one of six negative experiences with health care providers in the last three years.

Figure 21: Percentage Reporting Yes to Negative Experiences with a Doctor or Health Care Provider



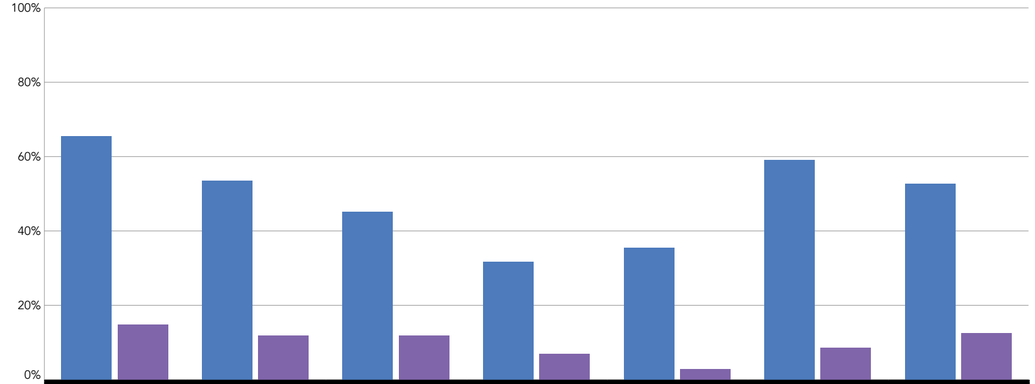
Source: KFF/The Undefeated Survey on Race and Health 2020

LESSONS LEARNED FROM COVID-19 AND HEALTH EQUITY

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

Figure 22: Full Vaccination Coverage for Race/Ethnicity



	All Races/ Ethnicity	White	African American	Asian/Pacific Islander	Native American	Hispanic	Not Hispanic
Montgomery County	65.6%	53.6%	45.2%	31.7%	35.5%	59.2%	52.8%
Philadelphia County	14.8%	11.9%	11.9%	6.9%	2.8%	8.6%	12.6%

Source: The PA Department of 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 convened	
	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	
Diversity & Inclusion Training for Employees	Host Let's Talk Virtual Speaker Series focusing on diversity and inclusion topics	X	X	X	Host 12 Let's Talk events per year	
	Develop and implement annual mandatory education focusing on Health Equity	X	X	X	100% completion rate for employees	
	Provide implicit bias education and training during Employee Orientation and via a self-guided online module	X	X	X	100% completion rate for employees	

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