



**COMMUNITY  
HEALTH NEEDS  
2022 ASSESSMENT**

**HEALTH IS WHERE WE LIVE, LEARN AND WORK**



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## LETTER FROM THE CEO

### OUR MESSAGE TO THE COMMUNITY

Temple Health–Chestnut Hill 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. Chestnut Hill Hospital completed the 2022 Community Health Needs Assessment (CHNA), which identifies our region's health priorities and determines our 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, Chestnut Hill 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.

### John Cacciamani, M.D.

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



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

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

I would like to offer my sincere thanks to the citizens and stakeholder participants throughout all the 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,

A handwritten signature in black ink, appearing to read 'John Cacciamani'.

### JOHN CACCIAMANI, M.D.

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



Questions or comments  
regarding the CHNA  
please call 215-248-8200



## 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 Chestnut Hill 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, those with 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, Chestnut Hill 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. 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 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 due to the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts among providers, public health agencies, and community organizations to improve the communities' overall health and ensure access to essential services.

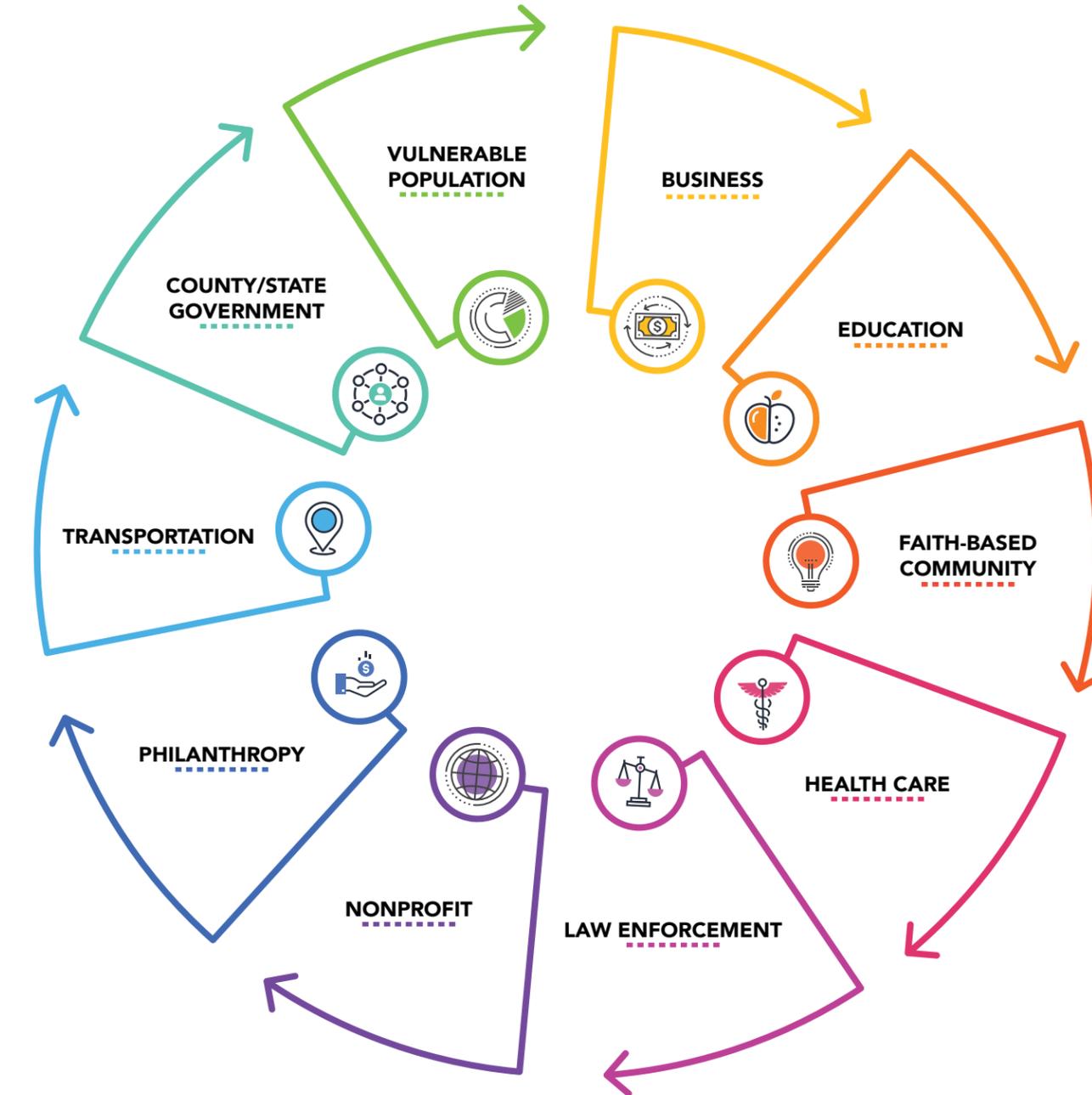
## CHNA PROCESS — COMMUNITY ENGAGEMENT

The CHNA process began in February 2021, and the collection of quantitative and qualitative data concluded in September 2021. As part of this needs assessment, a vast number of residents, educators, government, health care professionals, and health and human services leaders in Chestnut Hill 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. Chestnut Hill 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<sup>1</sup> to collect, analyze, and identify the results to complete the hospital's assessment.

Figure 1: Chestnut Hill Hospital's Community Engagement



<sup>1</sup> Members of the working group consisted of Catherine Brzozowski, Marketing and Public Relations Director, Chestnut Hill Hospital; Ha T. Pham, Senior Principal, Tripp Umbach; Barbara Terry, Senior Advisor, Tripp Umbach; and Julia Muchow, Project Manager, 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 the current health status of the population. 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 Chestnut Hill Hospital<sup>2</sup>



<sup>2</sup> 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.

# Temple Health-Chestnut Hill Hospital

## WHO ARE WE?

Located in the Chestnut Hill section of Philadelphia, 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.

- Adult Weight Loss Surgery
- Cancer Care
- Emergency Medicine
- Laboratory
- Nutrition
- Older Adult Behavioral Health
- Orthopedics
- Podiatry
- Radiology/Imaging
- Rehabilitation
- Sleep Disorder Services
- 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 healthcare 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 PSA	
ZIP Codes	Town/Neighborhood
19031	Flourtown
19038	Glenside
19118	Chestnut Hill
19119	Mt. Airy
19128	Roxborough
19138	West Oak Lane
19144	Germantown
19150	Cedarbrook
19422	Blue Bell
19444	Lafayette Hill
19462	Plymouth Meeting



# EVALUATION OF 2019 CHNA IMPLEMENTATION STRATEGY

Chestnut Hill Hospital has worked during 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 Chestnut Hill Hospital. Specific metric information/measurable indicators can be obtained from the hospital's administrative department.

## 1 HEALTH PRIORITY: ACCESS TO HEALTH CARE

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

STRATEGIES	ACTION STEPS
Increased cultural awareness, diversity, and inclusion	Conducted cultural awareness trainings
Streamlined access to care facilities	Implemented the Tower Access Project
My Tower Health	Implemented Patient Portal for faster access to test results, request med refills, communicate directly with provider and view after-visit summary.
Telemedicine	Implemented Telemed Visits for primary care and urgent care in our region
Ride Health/Cab Voucher Program	Implemented Ride Health Program

## 2 HEALTH PRIORITY: SOCIAL DETERMINANTS OF HEALTH (SDOH)

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

STRATEGIES	ACTION STEPS
Identified and addressed SDOH in the clinical environment	Screened for SDOH in identified clinical areas
Supported community organizations addressing SDOH in the community	Provided funding for community organizations that support SDOH

**Goal 2: Address transportation barriers.**

STRATEGIES	ACTION STEPS
Implemented a transportation program	Assessed operations for transportation program for patients who qualify
	Developed a workflow, implementation plan, and guidelines for a transportation program and implemented

## 3 HEALTH PRIORITY: DISEASE PREVENTION AND MANAGEMENT

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

STRATEGIES	ACTION STEPS
Provided screening and education to the primary service areas, particularly focusing on vulnerable populations	Conducted hypertension screenings; risk assessments for heart and stroke
	Conducted diabetes education program
	Provided disease specific and wellness education
	Provided mammogram screenings
	Participated in the state Healthy Women program providing mammograms and pap smears to uninsured women
Tower Wellness Programs	Implemented short- and long-term wellness initiatives

## 4 HEALTH PRIORITY: ACCESS TO BEHAVIORAL HEALTH SERVICES

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

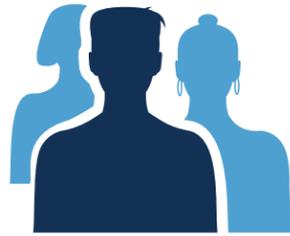
STRATEGIES	ACTION STEPS
Warm handoff	Provided warm handoff for Chestnut Hill Hospital patients
Increased awareness of CHH Senior Behavioral Health Unit	Implemented outreach/awareness campaigns
	Coordinated available services and beds; provide census updates as needed to community agencies and providers

**Goal 2. Decrease stigma related to behavioral health.**

STRATEGIES	ACTION STEPS
Crisis Prevention Intervention Training	Conducted staff and community workshops
Provided education to local business community on how to handle mental health issues in the workplace	Identified instructor and conduct workshops with local business groups.

# COMMUNITY AT A GLANCE

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



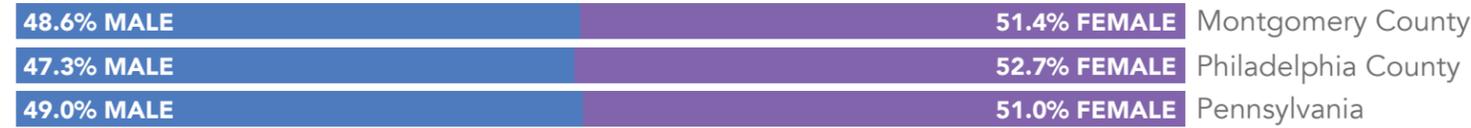
## POPULATION



Source: U.S. Census Bureau 2020

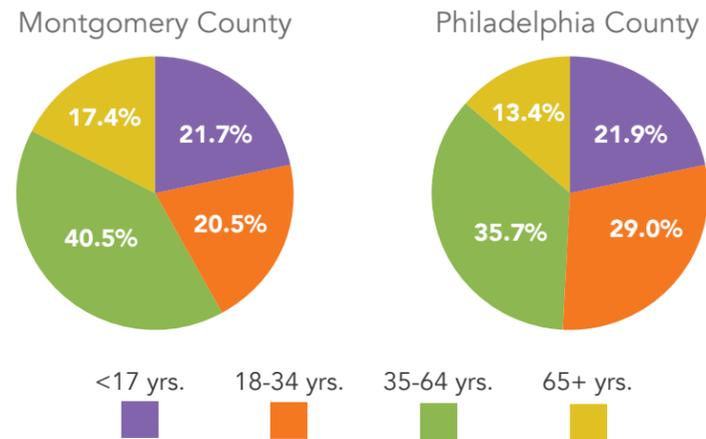


## GENDER



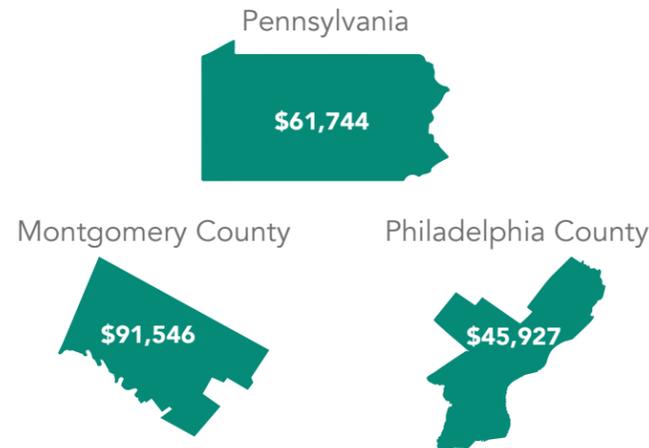
Source: U.S. Census Bureau 2019

## AGE DISTRIBUTION

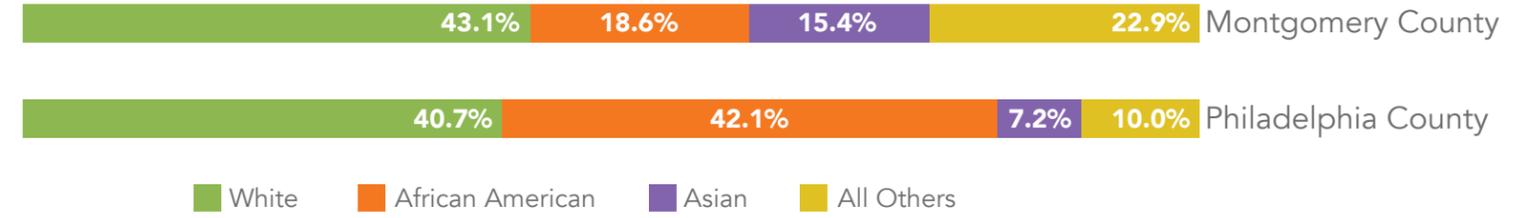


Source: U.S. Census Bureau 2019

## MEDIAN HOUSEHOLD INCOME

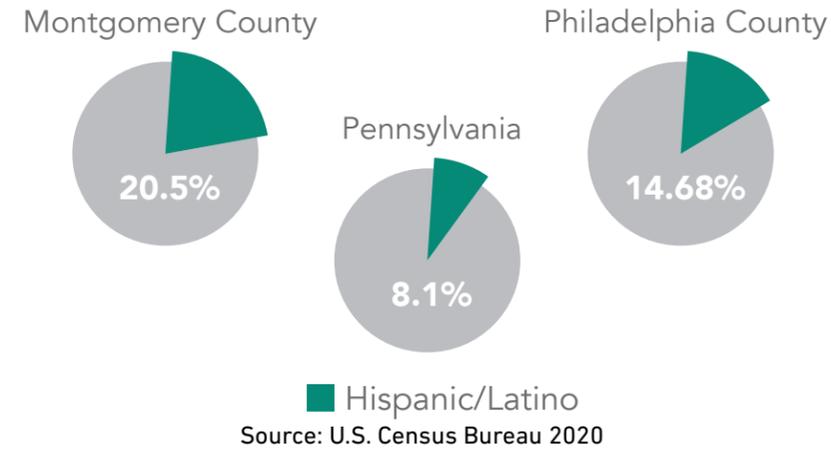


## RACE



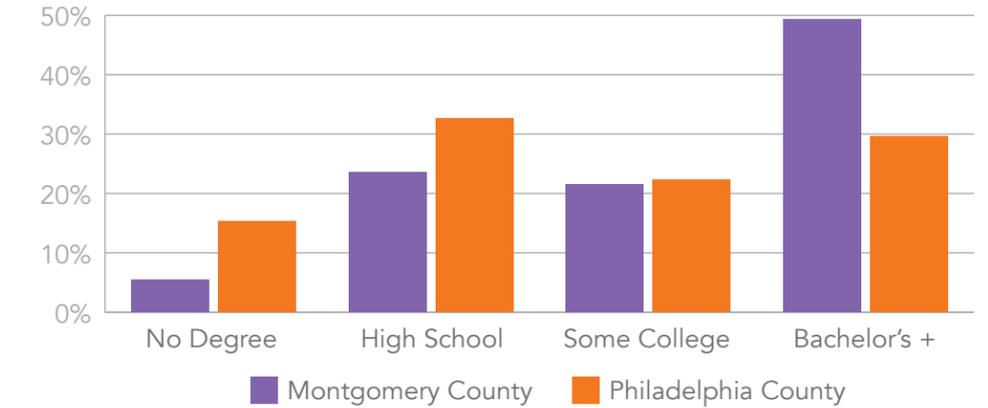
Source: U.S. Census Bureau 2020

## ETHNICITY



Source: U.S. Census Bureau 2020

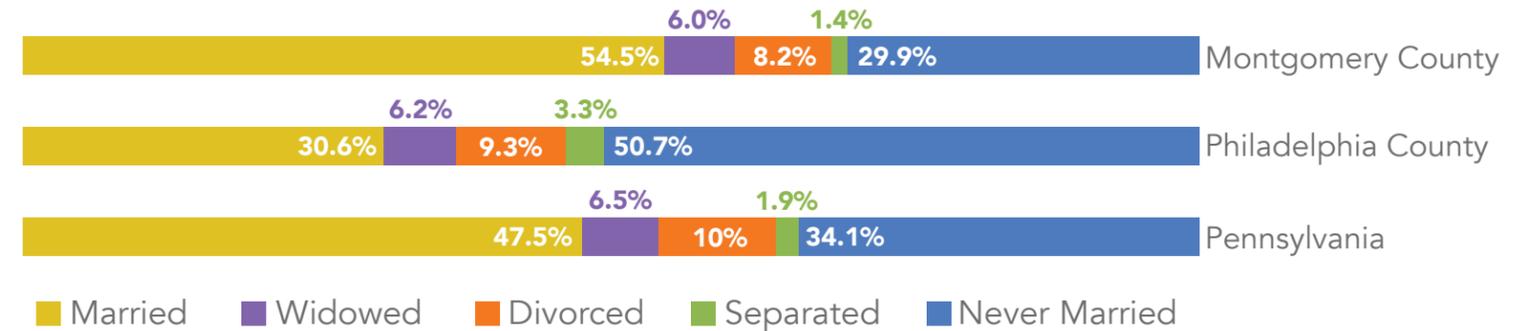
## EDUCATION



Source: American Community Survey 2019



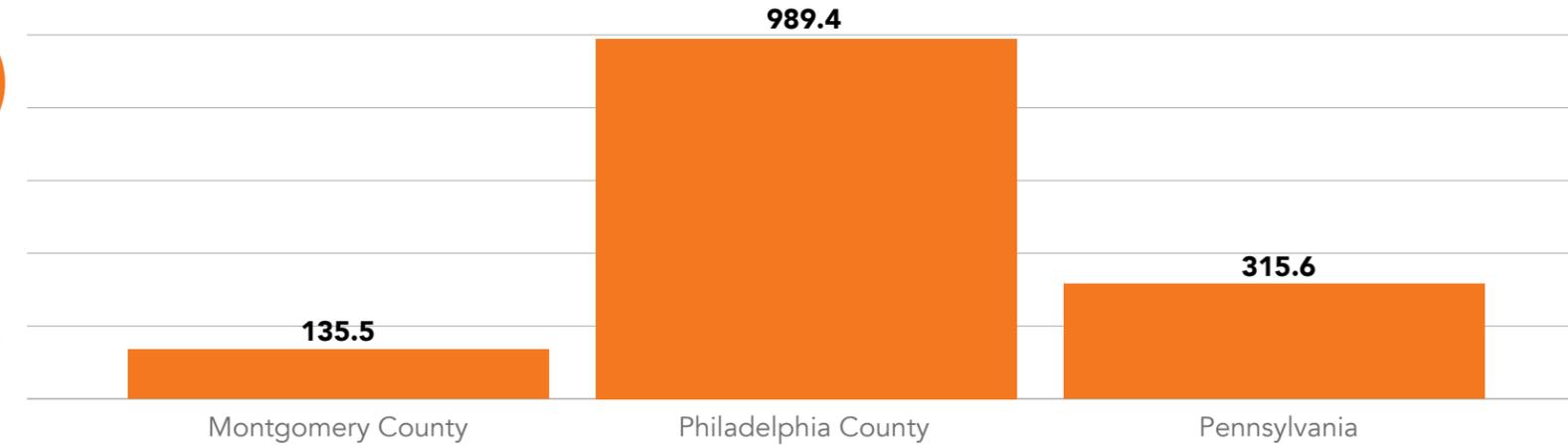
## MARITAL STATUS



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

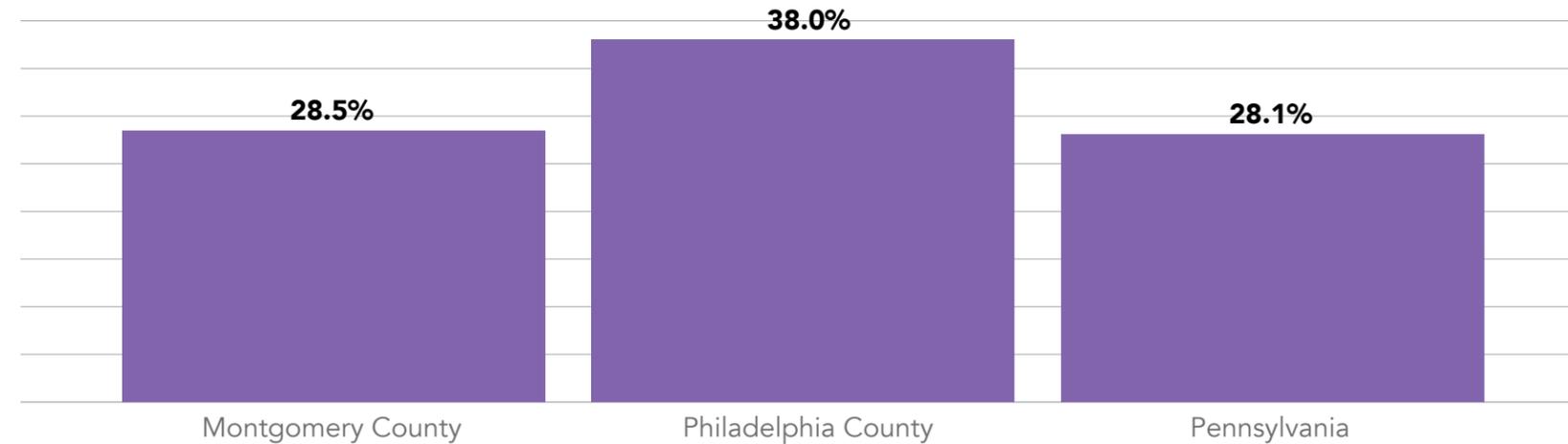
## OUR ENVIRONMENT

### VIOLENT CRIME (per 100,000 population)



Source: FBI Uniform Crime Reports 2020

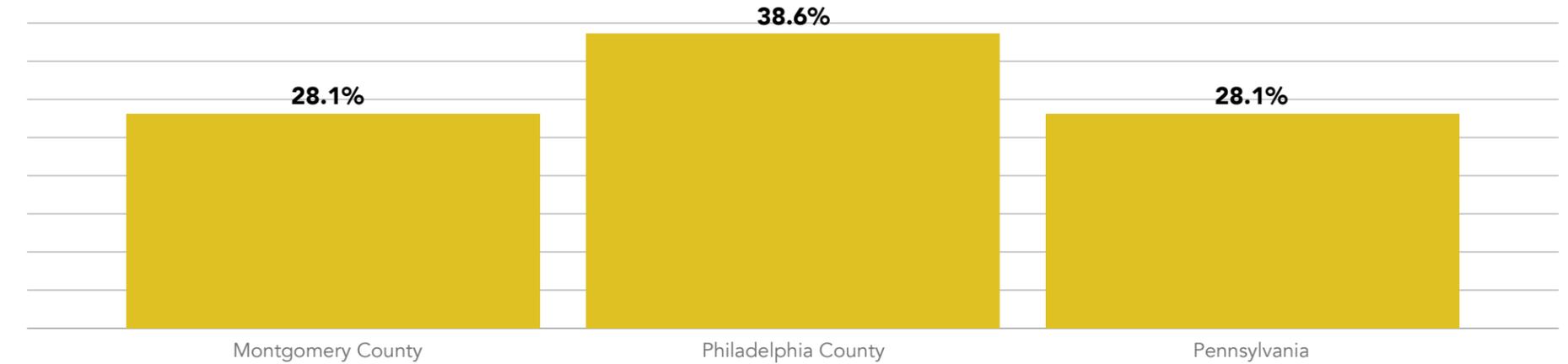
### HOUSING COST BURDEN (Households where housing costs are 30% or more of total household income)



Source: U.S. Census Bureau 2019

### Substandard Housing

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



Source: U.S. Census Bureau 2019

### HOUSING OCCUPANCY BY RACE

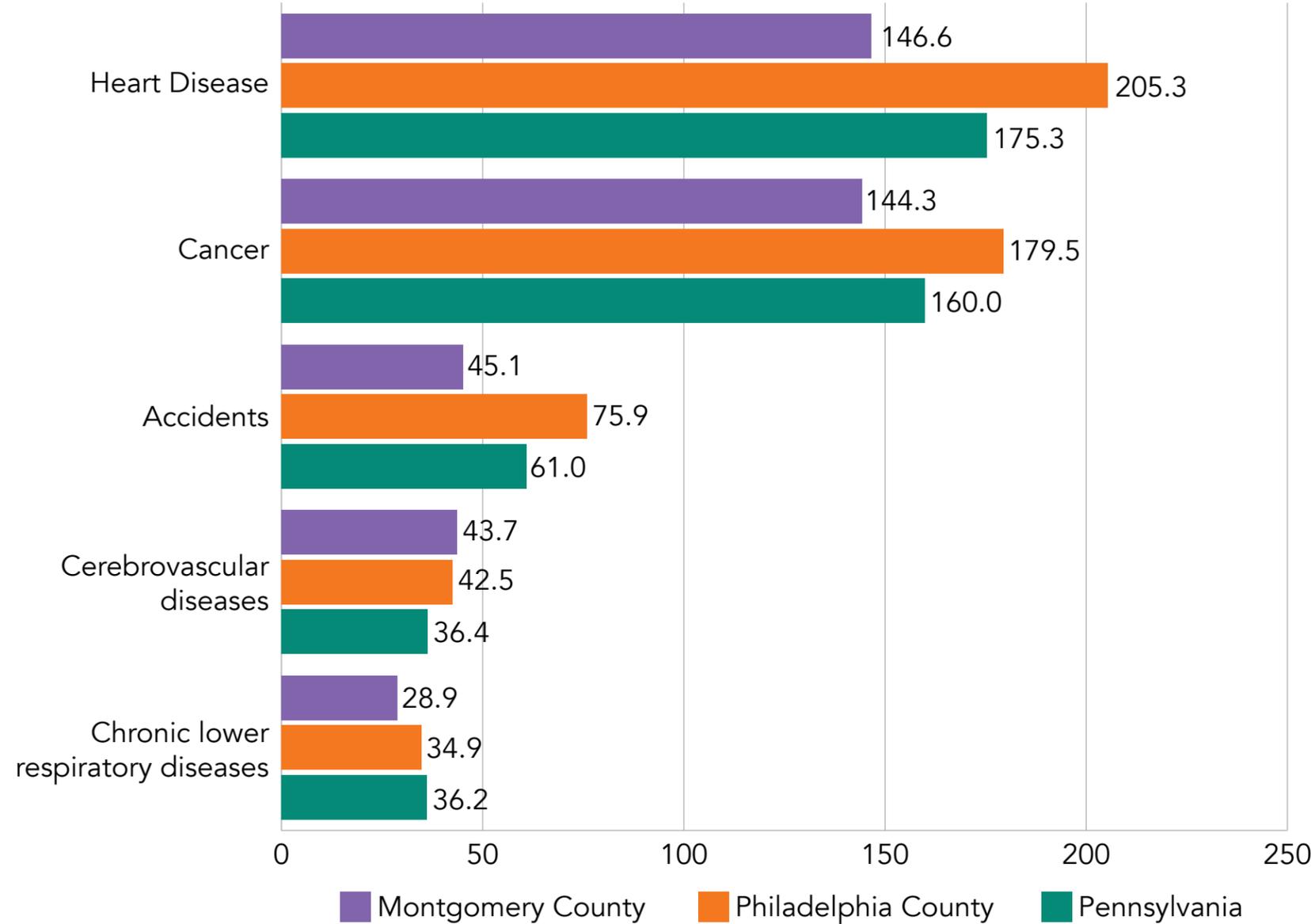
	Owner Occupied Housing (Percent)				Renter Occupied Housing (Percent)			
	Montgomery County	Philadelphia County	PA	U.S.	Montgomery County	Philadelphia County	PA	U.S.
<b>White</b>	76.0%	58.5%	73.3%	69.5%	24.1%	41.5%	26.7%	30.5%
<b>Black</b>	46.7%	48.4%	43.2%	41.8%	53.3%	51.6%	56.8%	58.2%
<b>Asian</b>	62.8%	54.4%	58.4%	59.6%	37.2%	45.6%	41.6%	40.4%
<b>Native American or Alaska Native</b>	50.2%	50.0%	52.3%	54.3%	49.9%	50.1%	47.7%	45.7%
<b>Some other race</b>	29.7%	44.8%	39.4%	39.9%	70.3%	55.3%	60.6%	60.1%
<b>Multiple race</b>	48.8%	43.2%	45.0%	49.0%	51.2%	56.8%	55.0%	51.0%

Source: U.S. Census Bureau 2019

## KEY HEALTH FINDINGS

### TOP FIVE LEADING CAUSES OF DEATH

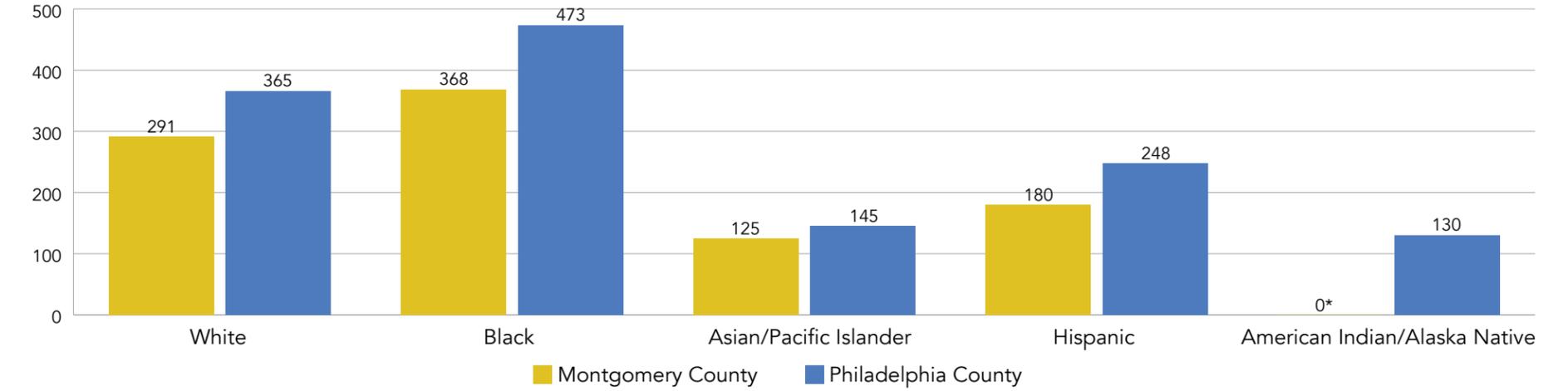
(per 100,000 population)



Source: Pennsylvania Department of Health 2014-2019

### OVERALL HEART DISEASE DEATHS BY RACE/ETHNICITY BY COUNTY

(ages 35 years+ per 100,000 population)

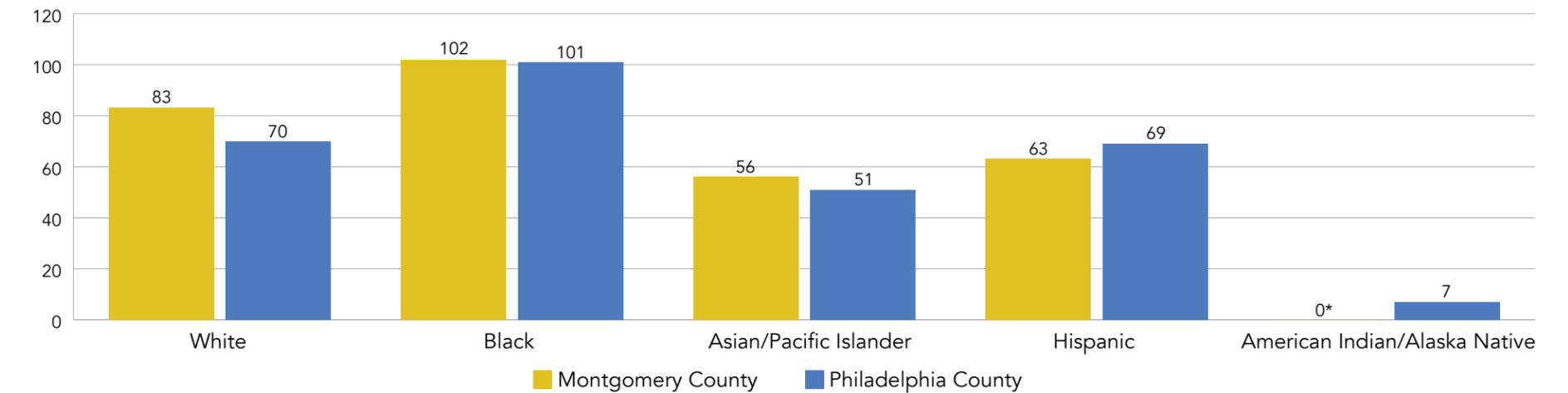


Note: \*Insufficient data

Source: [Pennsylvania Department of Health 2019](#)

### OVERALL STROKE DEATHS BY RACE/ETHNICITY BY COUNTY

(ages 35 years+ per 100,000 population)



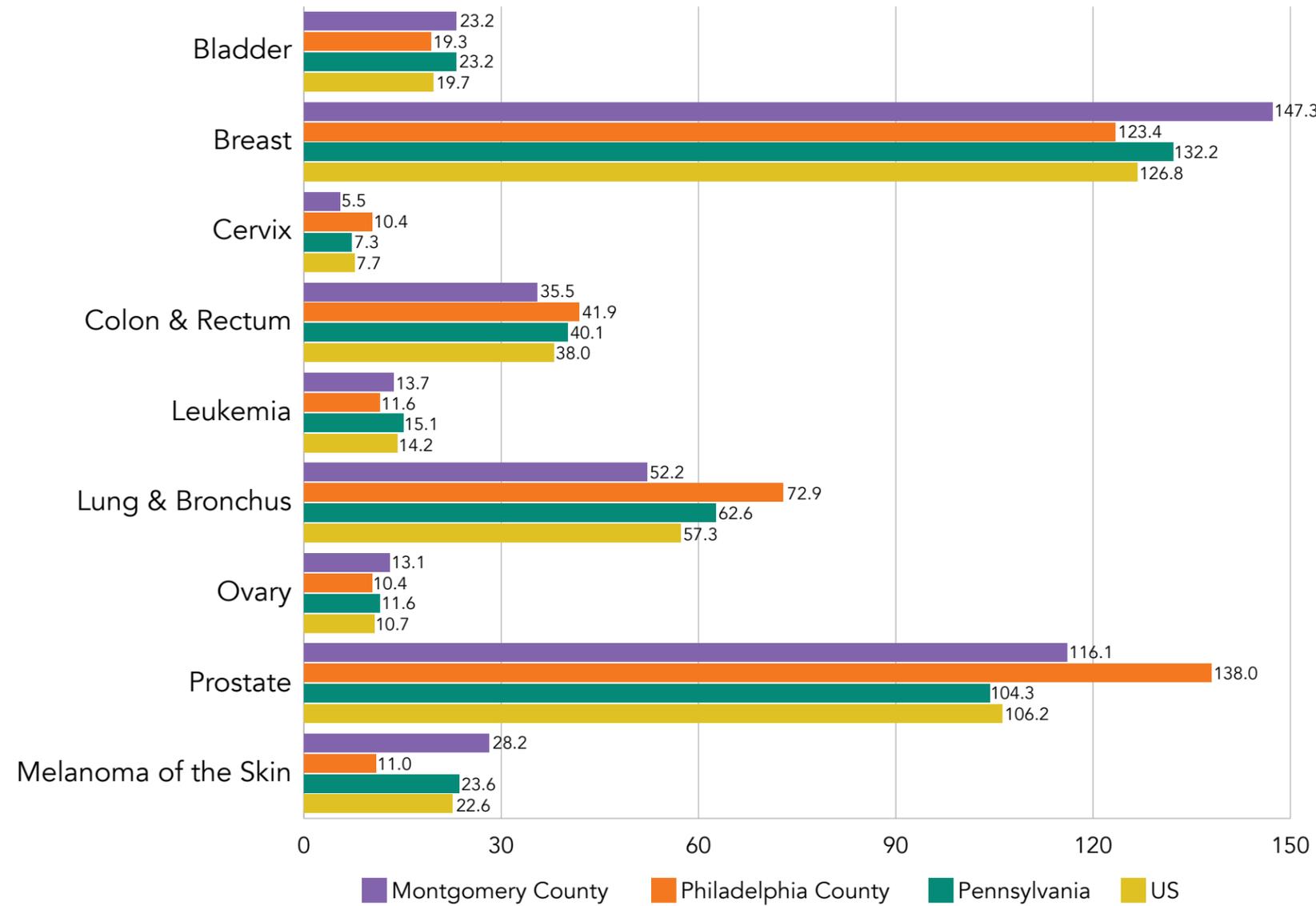
Note: \*Insufficient data

Source: [Pennsylvania Department of Health 2019](#)

## OVERALL COMMON CANCERS BY COUNTY

### COMMON CANCERS BY COUNTY

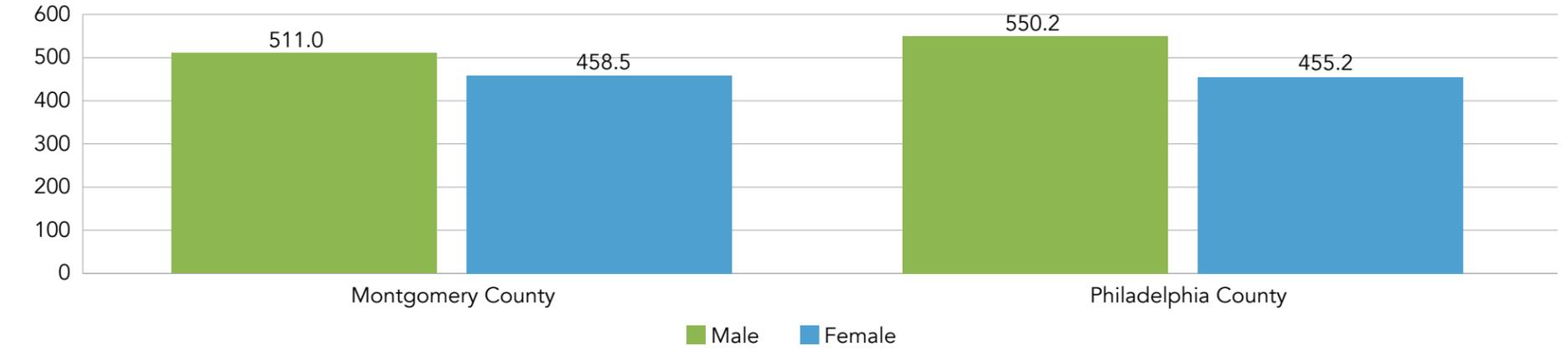
(per 100,000 population)



## OVERALL CANCER INCIDENCE

### ALL CANCERS INCIDENCE RATES BY GENDER

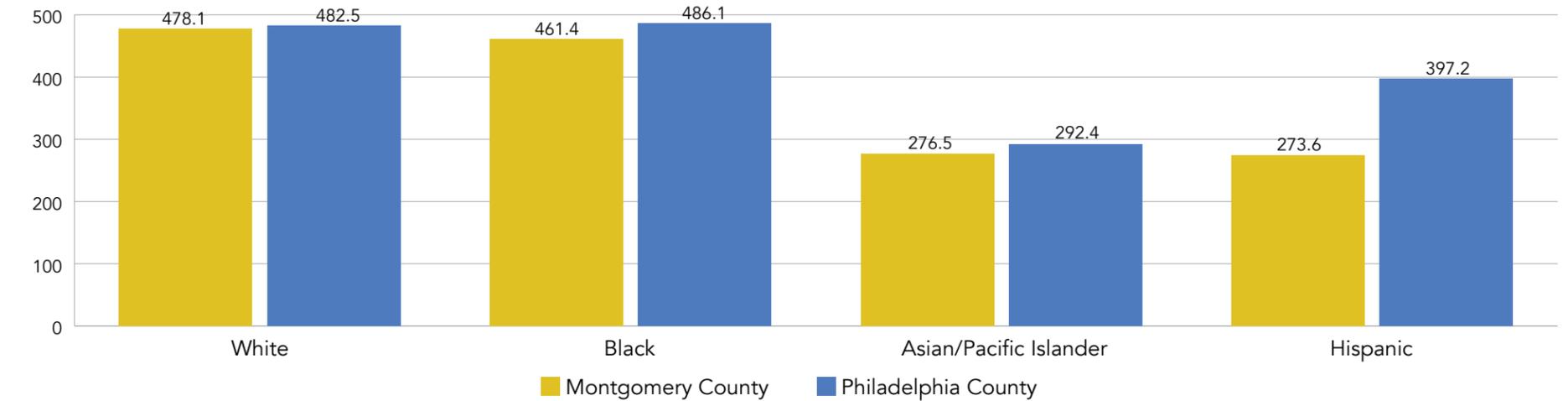
(per 100,000 population)



Source: [Pennsylvania State Cancer Profiles 2014-2018](#)

### ALL CANCERS INCIDENCE RATES BY RACE/ETHNICITY

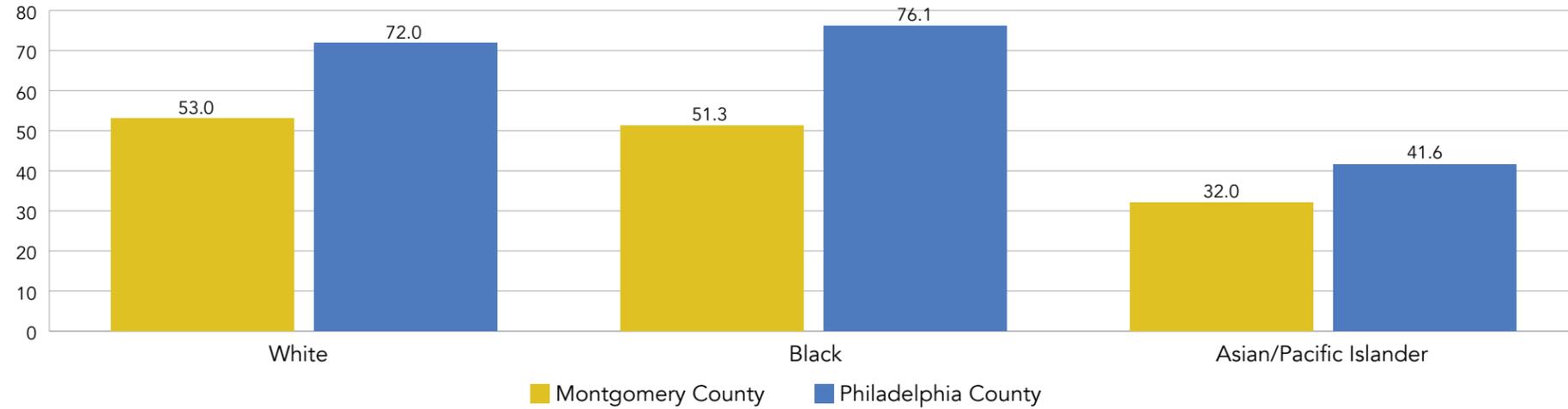
(per 100,000 population)



Source: [Pennsylvania State Cancer Profiles 2014-2018](#)

### LUNG AND BRONCHUS CANCER INCIDENCE RATES BY RACE

(per 100,000 population)

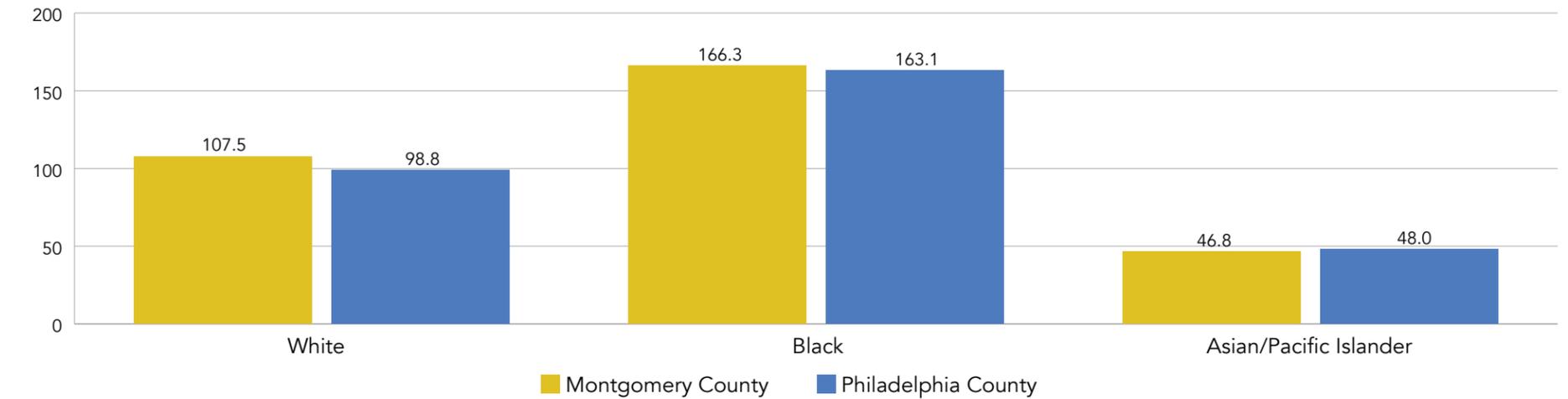


Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.

Source: Pennsylvania State Cancer Profiles 2014-2018

### FEMALE BREAST CANCER INCIDENCE RATES BY RACE

(per 100,000 population)

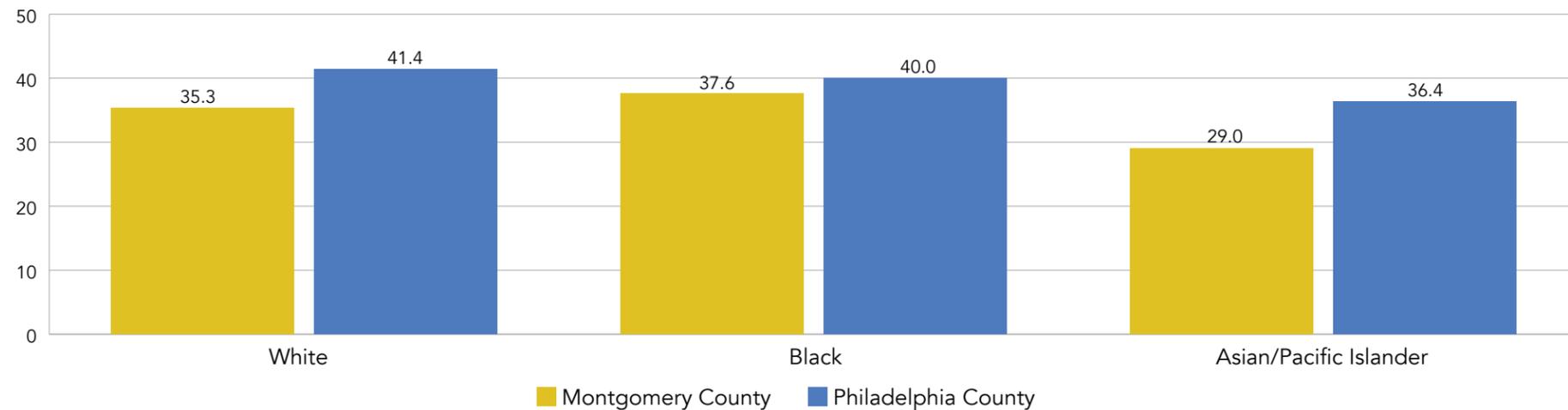


Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.

Source: Pennsylvania State Cancer Profiles 2014-2018

### COLON AND RECTUM CANCER INCIDENCE RATES BY RACE

(per 100,000 population)

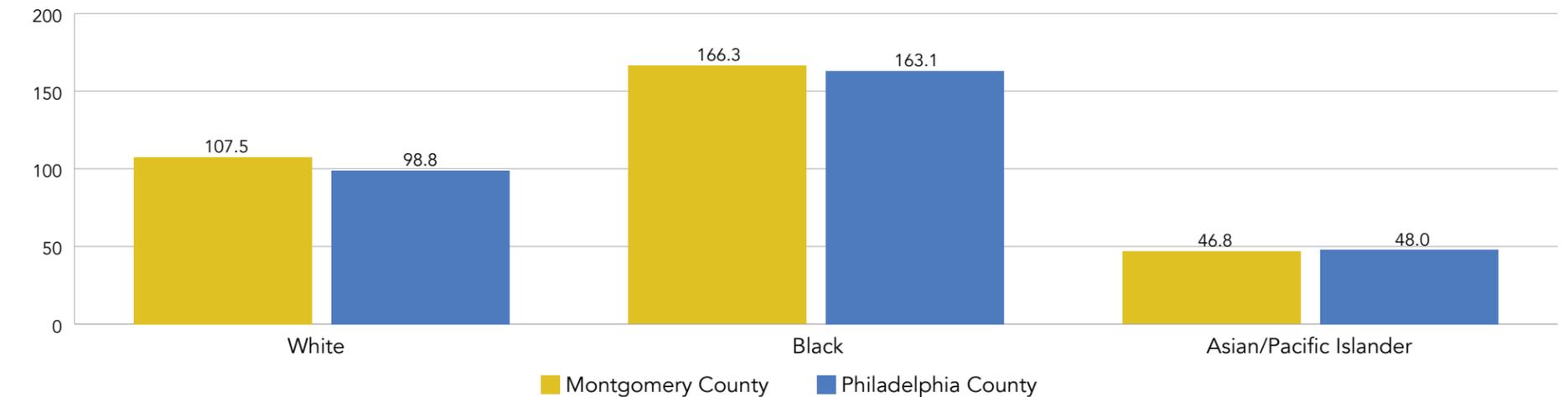


Note: Race categories include Hispanic. For example, white rate figures include Hispanic data.

Source: Pennsylvania State Cancer Profiles 2014-2018

### MALE PROSTATE CANCER INCIDENCE RATES BY RACE

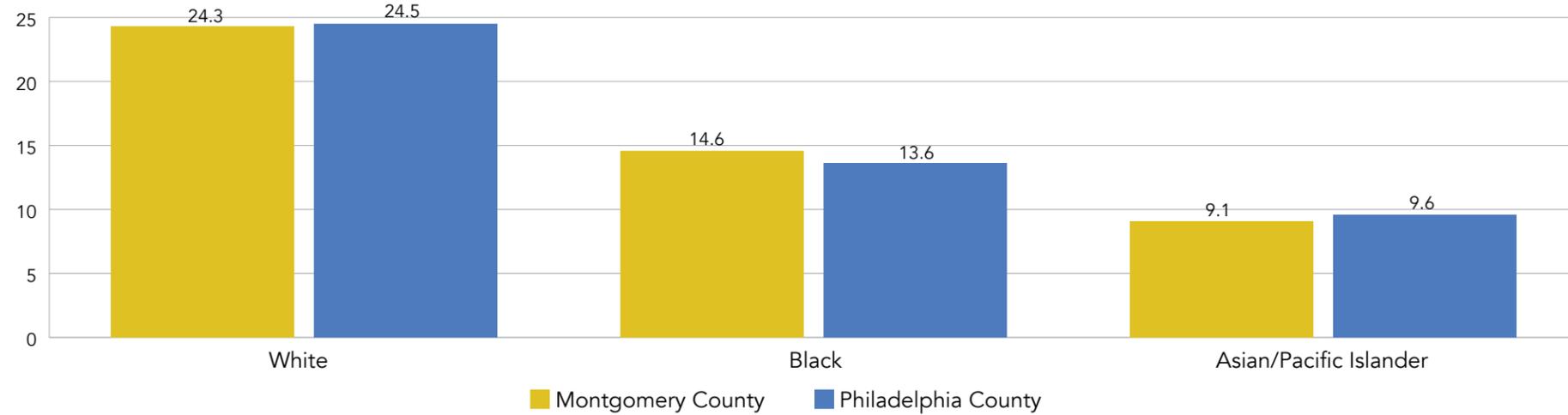
(per 100,000 population)



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

Source: Pennsylvania State Cancer Profiles 2014-2018

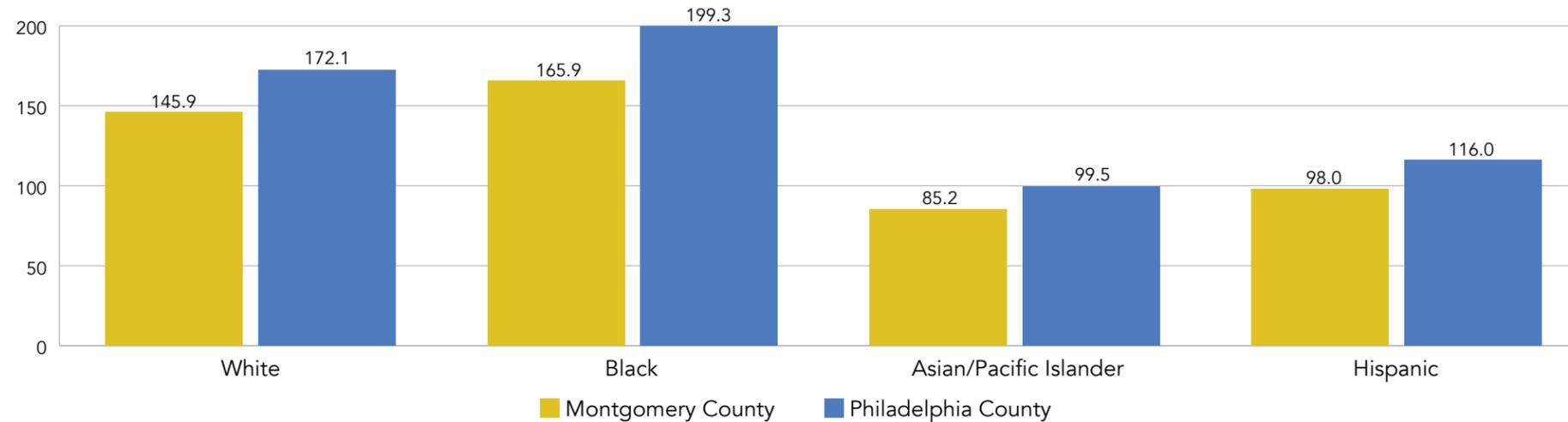
**BLADDER CANCER INCIDENCE RATES BY RACE**  
(per 100,000 population)



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

**OVERALL CANCER DEATH RATES**

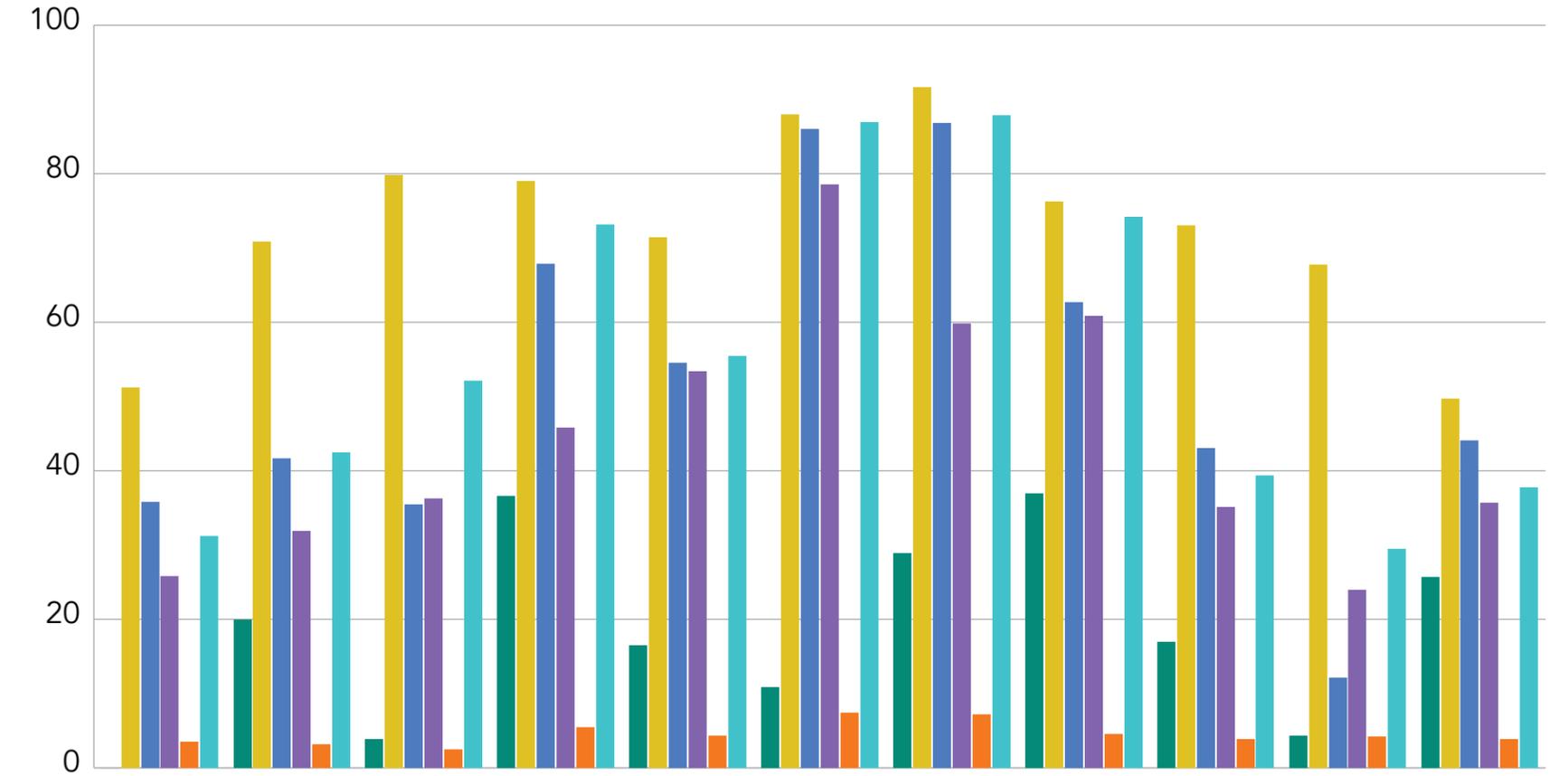
**ALL CANCER DEATH BY RACE AND ETHNICITY**  
(per 100,000 population)



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

**ADULT EMERGENCY ROOM VISITS PER 1,000/MONTHS ZIP CODE SUMMARY<sup>3</sup>**

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



	19031	19038	19118	19119	19128	19138	19144	19150	19422	19444	19462
Asian	0.0	19.9	3.9	36.6	16.5	10.9	28.9	37.0	17.0	4.3	25.7
Black	<b>51.2</b>	<b>70.9</b>	<b>79.8</b>	<b>79.0</b>	<b>71.4</b>	<b>88.0</b>	<b>91.7</b>	<b>76.2</b>	<b>73.0</b>	<b>67.7</b>	<b>49.7</b>
Hispanic	<b>35.8</b>	41.7	35.5	67.9	54.5	86.0	86.8	62.7	<b>43.0</b>	12.1	<b>44.1</b>
White	25.8	31.9	36.3	45.8	53.4	78.5	59.8	60.8	35.1	24.0	35.7
Other Race	3.5	3.2	2.5	5.5	4.3	7.4	7.2	4.5	3.8	4.2	3.8
All Adults	<b>31.2</b>	<b>42.5</b>	<b>52.1</b>	<b>73.2</b>	<b>55.4</b>	<b>87.0</b>	<b>87.9</b>	<b>74.2</b>	<b>39.4</b>	<b>29.5</b>	<b>37.8</b>

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](#)

<sup>3</sup> 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.

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

Figure 3: Influential Factors



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.

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

[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 environments have strong impacts on our overall health aside from our traditional health care settings. Social and environmental factors include our race, income, education level, and livable home environment (i.e., community), 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

According to [County Health Rankings & Roadmaps](#), Figure 4 shows Montgomery County is ranked poorly in physical environment (64/67 counties) and Philadelphia County ranked poorly in health outcomes (67/67), health factors (67/67), mortality (65/67), morbidity (67/67), health behaviors (49/67), clinical care (64/67), and social and economic factors (67/67). 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.

It is important to note that the information presented in the data is a generalized snapshot of the county and does not display the nuances and specific characteristics of the Montgomery County ZIP codes identified in Chestnut Hill's primary service area.

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



Source: County Health Rankings and Roadmaps 2021

# COMMUNITY HIGHLIGHTS

## OVERCOMING THE CHALLENGES OF COVID-19 TO REACH VULNERABLE NEIGHBORHOODS

In the spring of 2021, our region was grappling with low COVID-19 vaccination numbers, especially among predominately Black communities. Chestnut Hill Hospital partnered with New Covenant Church of Philadelphia and Grace Baptist Church of Germantown to support education and information efforts that would encourage vaccination rates.

Jenice Baker, MD, emergency medicine, presented “What you Need to Know About the Vaccine,” live on a Facebook feed to over 1,000 church members and shared to thousands more. The engagement was well-received with Dr. Baker fielding a question-and-answer segment after the newsfeed. Following the discussion, the video was viewed an additional 1,000 times. New Covenant pastor Bob Oliver took the lead and demonstrated to his reluctant congregation the ease of getting the vaccine on video. As a result of the church partnership, more than 500 people from at-risk communities received COVID-19 vaccinations at Chestnut Hill Hospital.



Chestnut Hill Hospital also partnered with two local Community Development Corporations to ensure that business owners, frontline food service, restaurant employees, and the elderly in the community were given priority to access vaccinations. Informational ads on the vaccine were placed in local newspapers and pushed out on digital media. More than 5,000 community members were vaccinated at CHH.

The pandemic did not deter Chestnut Hill Hospital from addressing the community’s interest in health education. Physicians and clinical staff provide more than 20 free and accessible health information presentations via Zoom to thousands in the community. Topics covered a spectrum of issues from disease prevention to stress management and weight management. Participants reported being better informed and empowered to make decisions about their health. In addition, the *Healthy Woman* newsletter, a free publication with health and wellness information and a complete list of events, reached more than 60,000 households in neighboring communities.

## HEALTH SCREENINGS AND PREVENTIONS

Chestnut Hill Hospital participates in the Pennsylvania Breast and Cervical Cancer Early Detection Program, a free program of the Pennsylvania Department of Health. In 2021, 34 women from immediate and farther-reaching neighborhoods which also included ZIP codes 18934, 19150, 19120, 19150, 19144, 19121, and 19004 received care at the Chestnut Hill Hospital Women’s Center as part of the state program.

Additionally, Chestnut Hill Hospital’s Free Mammogram program created with funds from events for people in need provided 12 free screenings for women from ZIP codes 19128, 19138, 19002, 19119, 19046, 19050, 19126, 19038, 19150, and 19144.

Flu prevention for at-risk populations did not take a back seat to COVID-19 vaccination during the pandemic. Chestnut Hill Hospital partnered with Northwest Interfaith Hospitality Network to provide flu shots for beneficiaries of its support services during a food and diaper pickup. Medical residents administered more than 30 flu vaccinations to protect local community members.

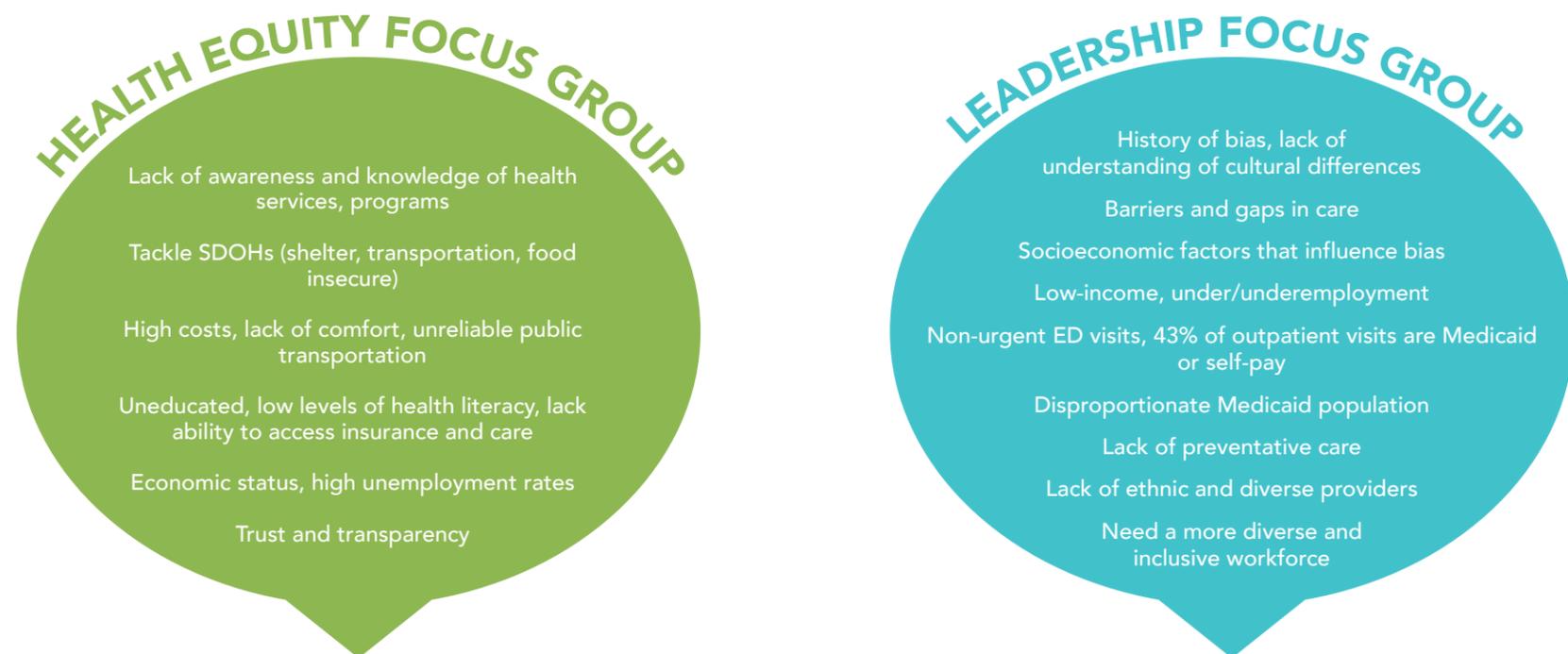
Chestnut Hill Hospital medical residents participated in The Health Outreach Project that offers free health services to people in poor and socially vulnerable communities through weekly clinics practicing their commitment to providing culturally sensitive patient-centered care. Residents volunteering at the Salvation Army clinic worked with adults in a substance use disorder rehabilitation center. Another clinic site was the Eliza Shirley Shelter for mothers and their children where students help to provide acute care services and run programs that they developed, like Jump Into Reading for the children and a workout class called Move It With Mommy and Me.

A wellness clinic at St. Raymond’s House in Philadelphia, which provides permanent supportive housing for adults with chronic health conditions, is run by residents providing weekly services. Residents monitor blood pressure, blood sugars, set health goals, make medical appointments, and help residents better manage their health issues.

# PULLING IT TOGETHER

Building on the vital work that has been underway, Chestnut Hill Hospital places an unrelenting focus on what actions should take place 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 5 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, Chestnut Hill 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 hospital 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 6 delineated 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 6: Listening to the Community



### FOCUS GROUPS

(LEADERSHIP AND HEALTH EQUITY)

#### “What are the Contributors and Barriers to People Accessing Equitable Care?”

- Low-income, under/underemployment
- Non-urgent ED visits and 43% of outpatient visits Medicaid or self-pay
- Lack of knowledge, awareness of health services, and clinics
- High costs, unreliability of public transportation
- Uneducated and low levels of health literacy
- Inability to access insurance and care

#### “Why are People Treated Differently?”

- Race/ethnicity 75%
- Education-13%
- Insurance coverage 13%



### COMMUNITY STAKEHOLDER INTERVIEWS

#### “What are the Perceived Barriers to Accessing Care and Services?”

- Lack of insurance
- Affordability
- Lack of transportation

#### “What are the Barriers to a Quality Life?”

- Economic disparities
- Cost of health care/meds
- Lack of insurance
- Advocacy for policy change



### KEY INFORMANT SURVEYS

#### “What are the Perceived Barriers to Accessing Care?”

- High cost of healthcare/medication
- Lack of insurance
- Lack of transportation
- Availability of services

#### “What are the Barriers to a Quality Life?”

- High costs of health care/meds.
- Economic disparities
- Perceptions of difficulties in navigating the health system



### COMMUNITY SURVEYS

#### “What are the Perceived Barriers to Accessing Care and Services?”

- Lack of access to health care providers/specialists
- Lack of affordable health care
- Fear
- Lack of transportation
- Lack of insurance

#### “What are the Most Important Health Issues?”

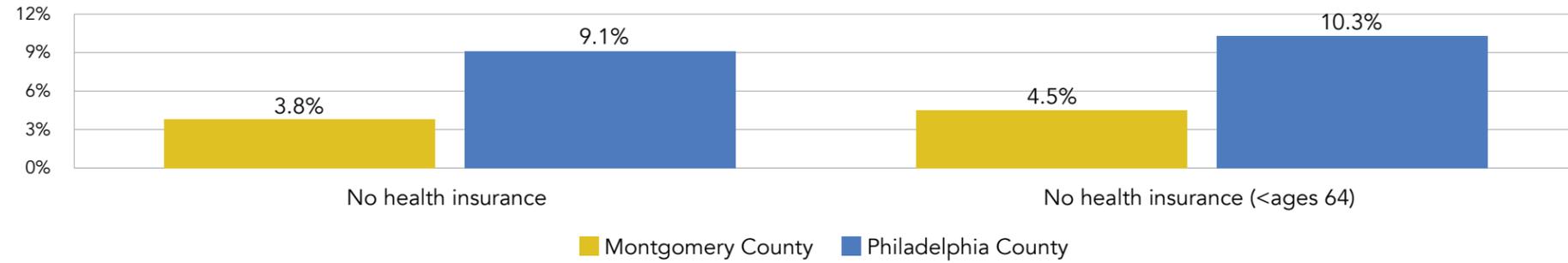
- Behavioral Health/Mental Health
- Aging Issues (Arthritis, joint/back pain)
- Drug/Alcohol use
- Lack of exercise
- High blood pressure

#### “What are the Barriers to a Quality Life?”

- Affordable health care
- Elder care options
- Higher paying jobs
- Health education

Figure 7 shows Philadelphia and Montgomery County residents who have no health insurance coverage or coverage via Medicare. During the last two CHNA cycles, we have seen the percentage of insured people steadily rise; however, efforts to improve access to care must continue.

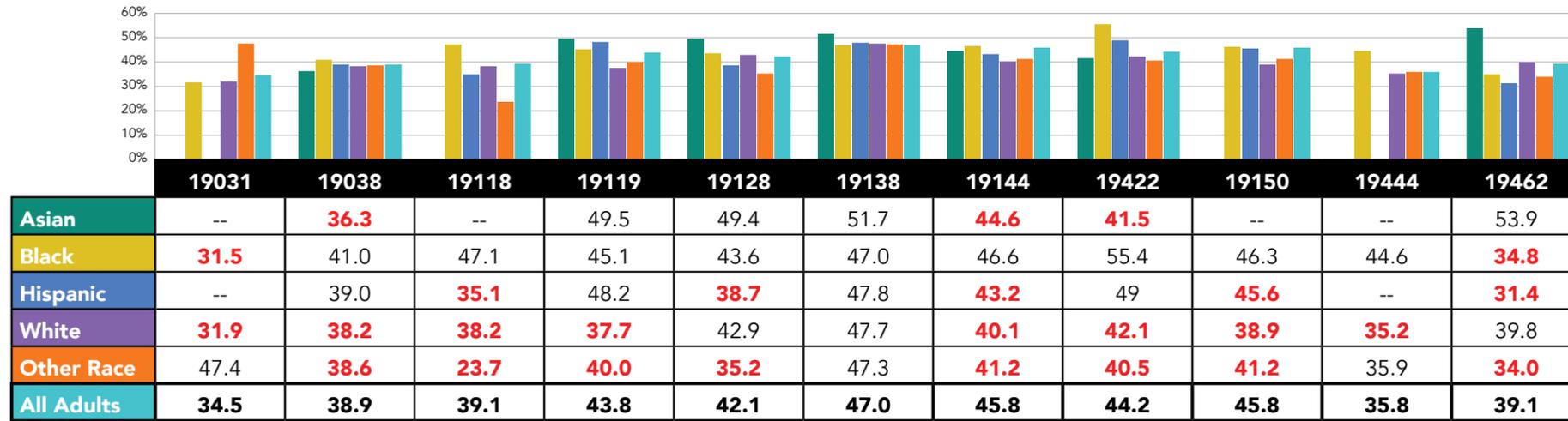
Figure 7: Percentage of Population with No Health Insurance Coverage



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.<sup>4</sup> The below figure depicts ZIP codes within Chestnut Hill's service area related to adults who obtain primary care visits.

Figure 8: Percentage of Adults with Primary Care Physician Visits by ZIP Code Summary



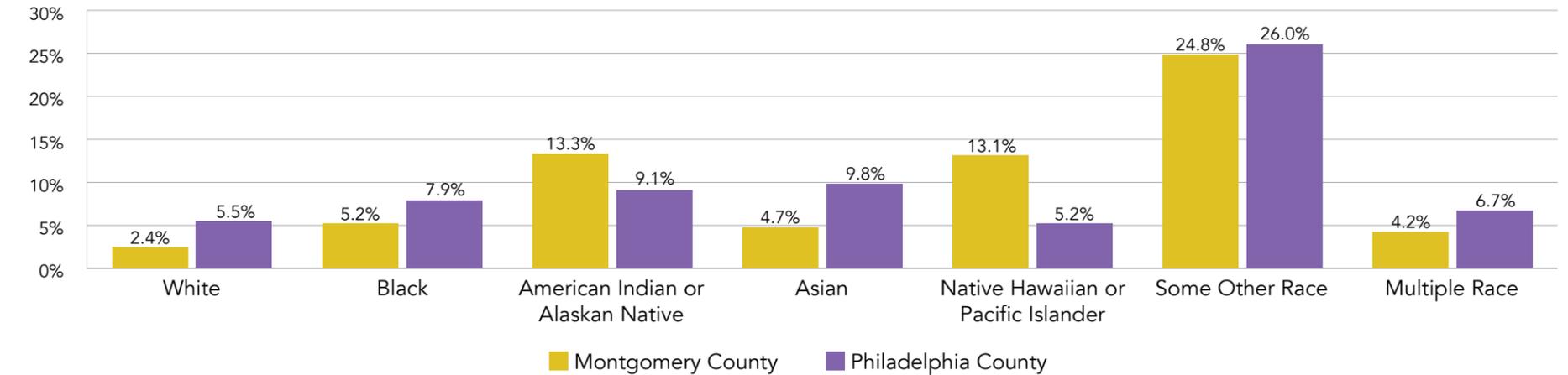
Note: The figures bolded in red indicate low percentages of adults with primary care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

<sup>4</sup> 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 during the past several years, Figure 9 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 to have health insurance to 92.1% overall. As of 2018, 89.0% of the persons under 65 years have medical insurance.

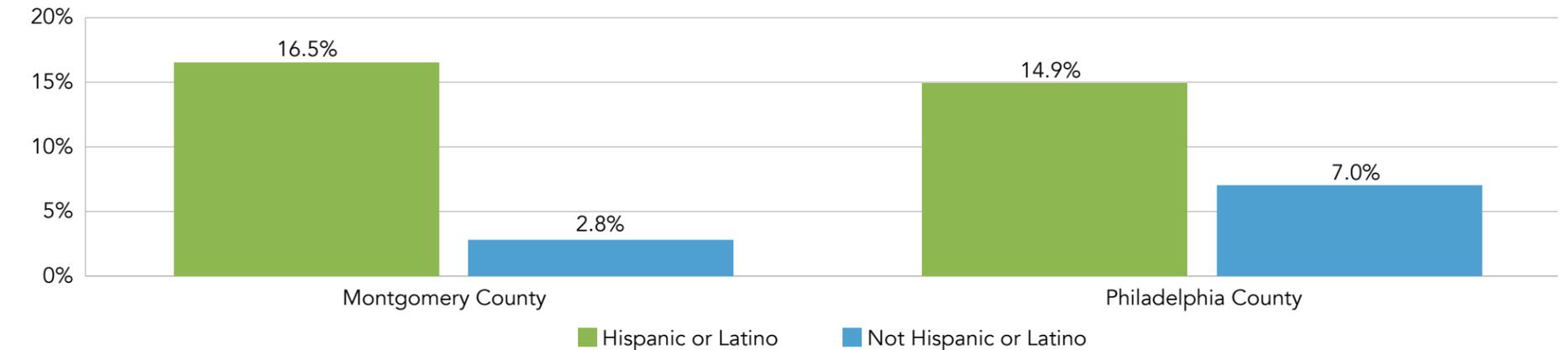
Figure 9: Percentage of Uninsured Population by Race



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

Figure 10 shows more uninsured Hispanic or Latinos in the counties.

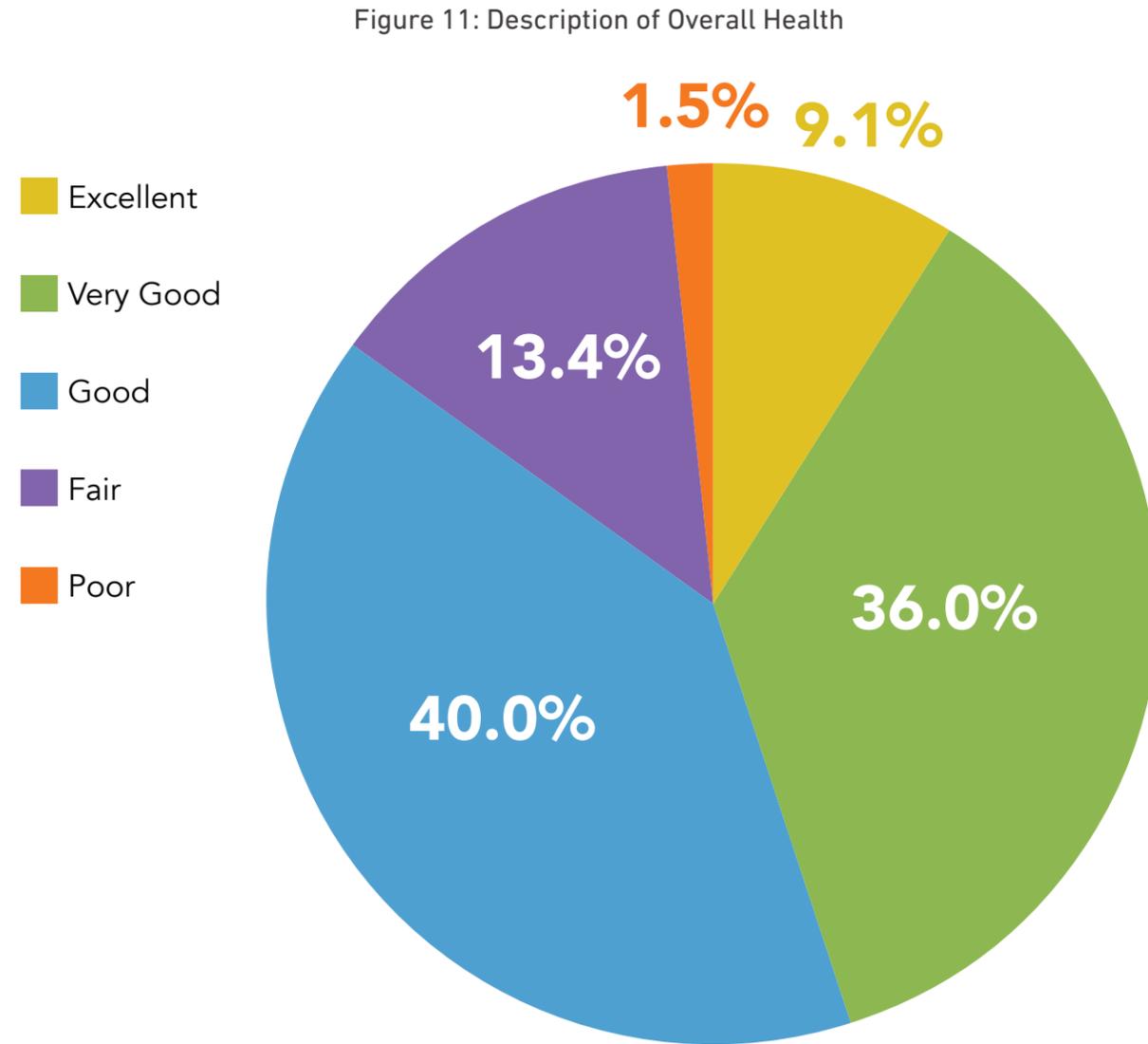
Figure 10: Percentage of Uninsured Population by Ethnicity



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

When asked to rate their health status, 85.1% (n=336) of community health survey respondents stated good, very good, or excellent health (Figure 11). Slightly more than 57.8% (n=225) noted the need for blood pressure screenings and 46.5% (n=181) cited the need for cholesterol screenings to keep themselves and their family healthy.

Figure 11 reported how respondents described their 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 12: Families Earning More Than \$75,000 by Ethnicity

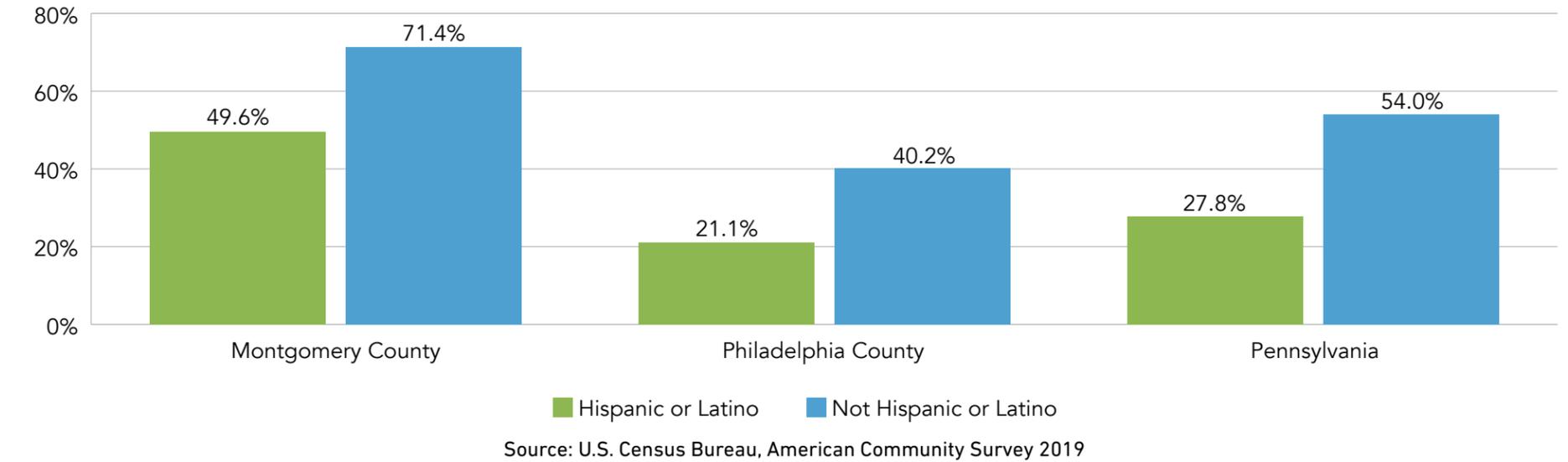


Figure 13: Families Earning More Than \$75,000 by Race Alone, Percent

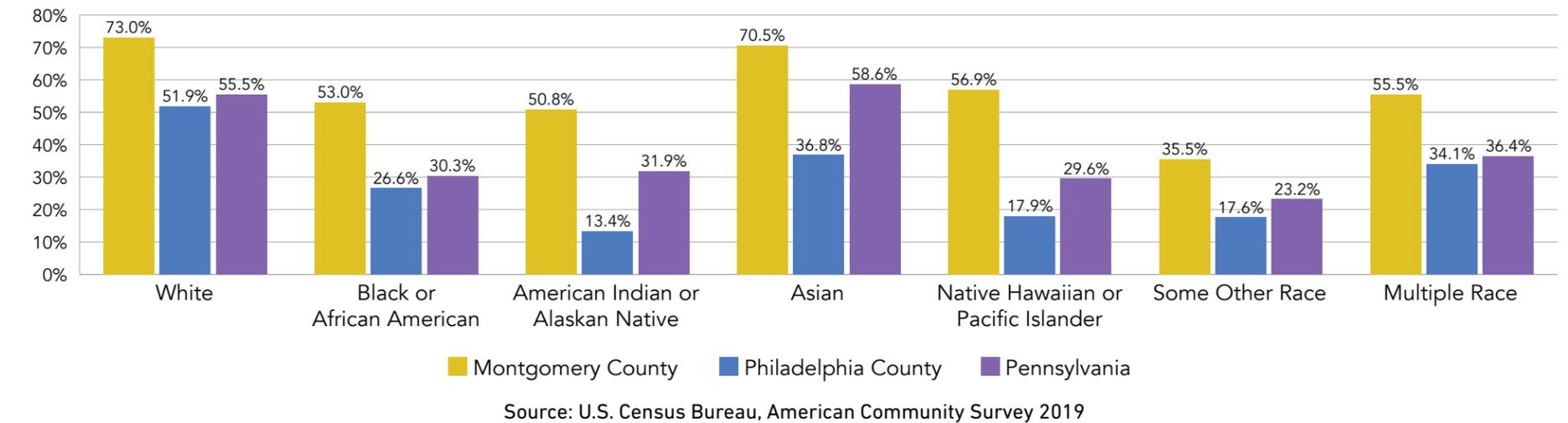
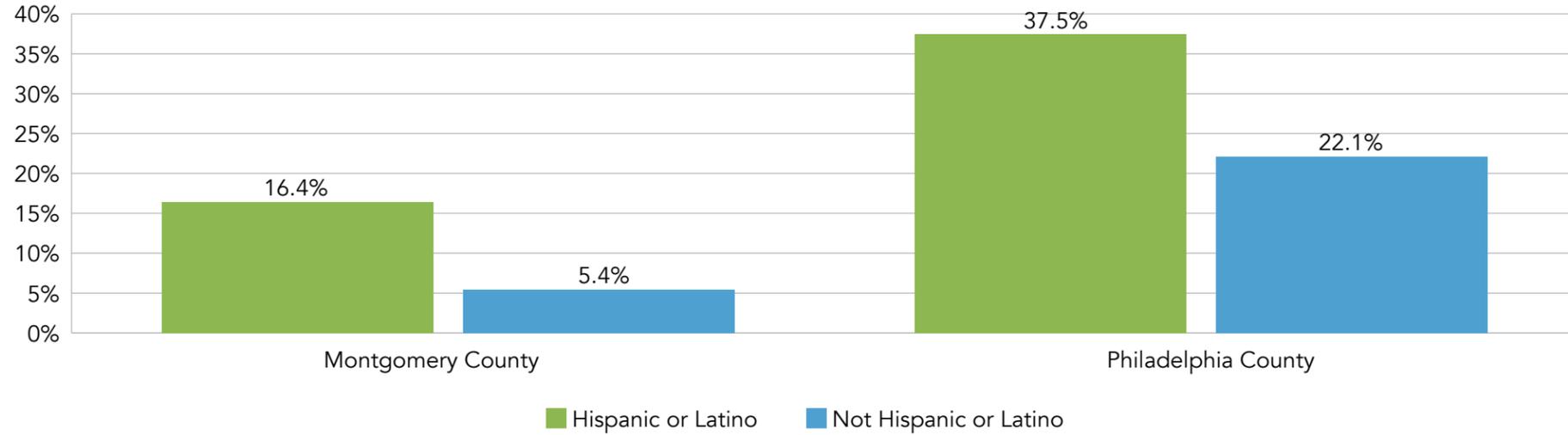


Figure 14 reports the percentage of the population below 100% of the federal poverty line by ethnicity.

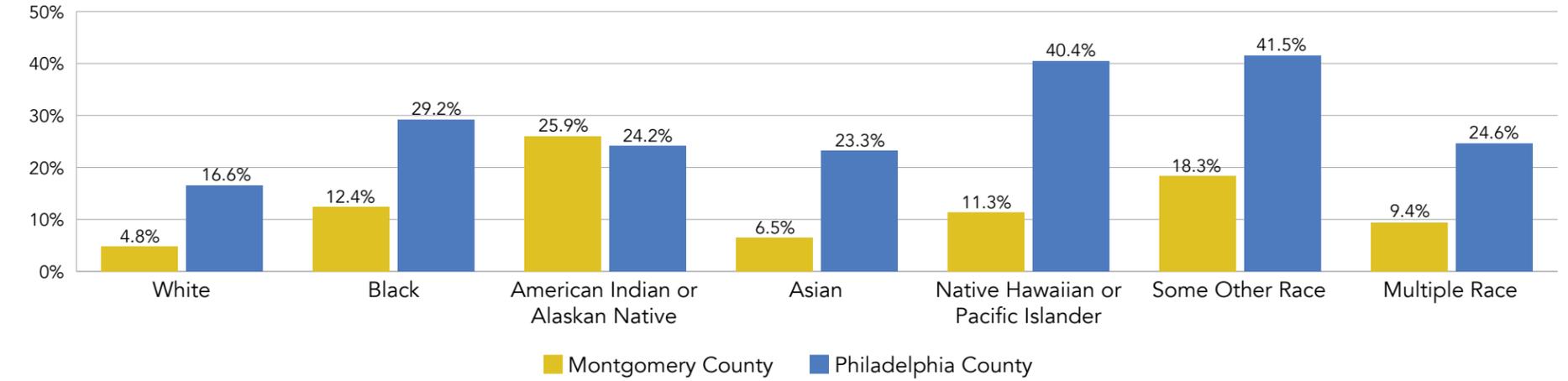
Figure 14: Population Below 100% FPL by Ethnicity



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

Figure 15 reports the percentage of the population below 100% of the federal poverty line (FPL) by race.<sup>5</sup> [The Healthy People 2030](#) target is to reduce the proportion of people living in poverty to 8.0 percent. In 2018, 11.8% of people were living below the poverty threshold.

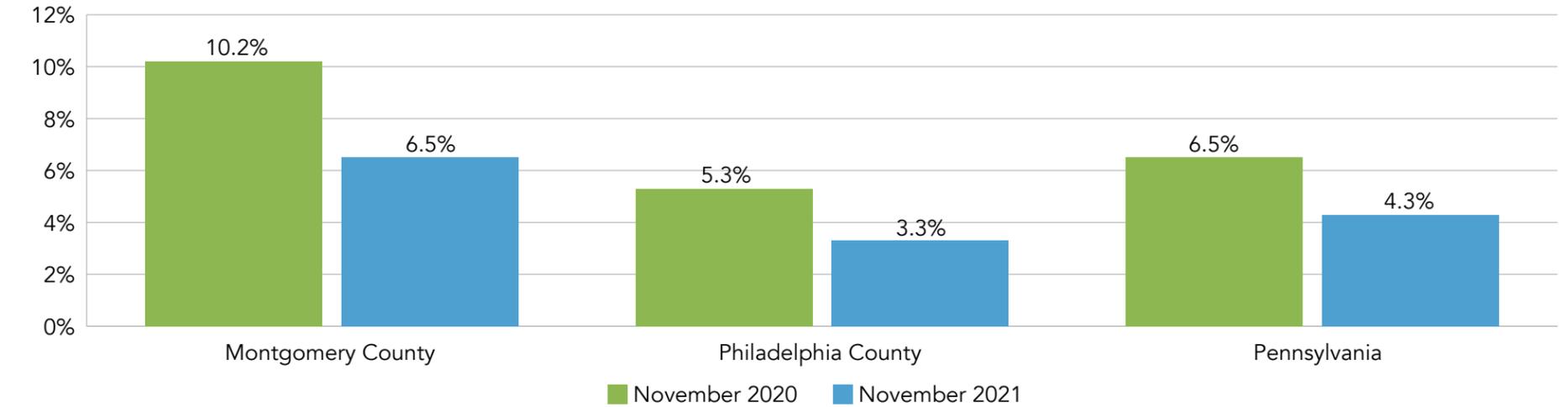
Figure 15: Population Below 100% FPL by Race



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

Figure 16 illustrates the unemployment rate in Philadelphia, Montgomery, and the state.

Figure 16: Unemployment Rates



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

<sup>5</sup> 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.

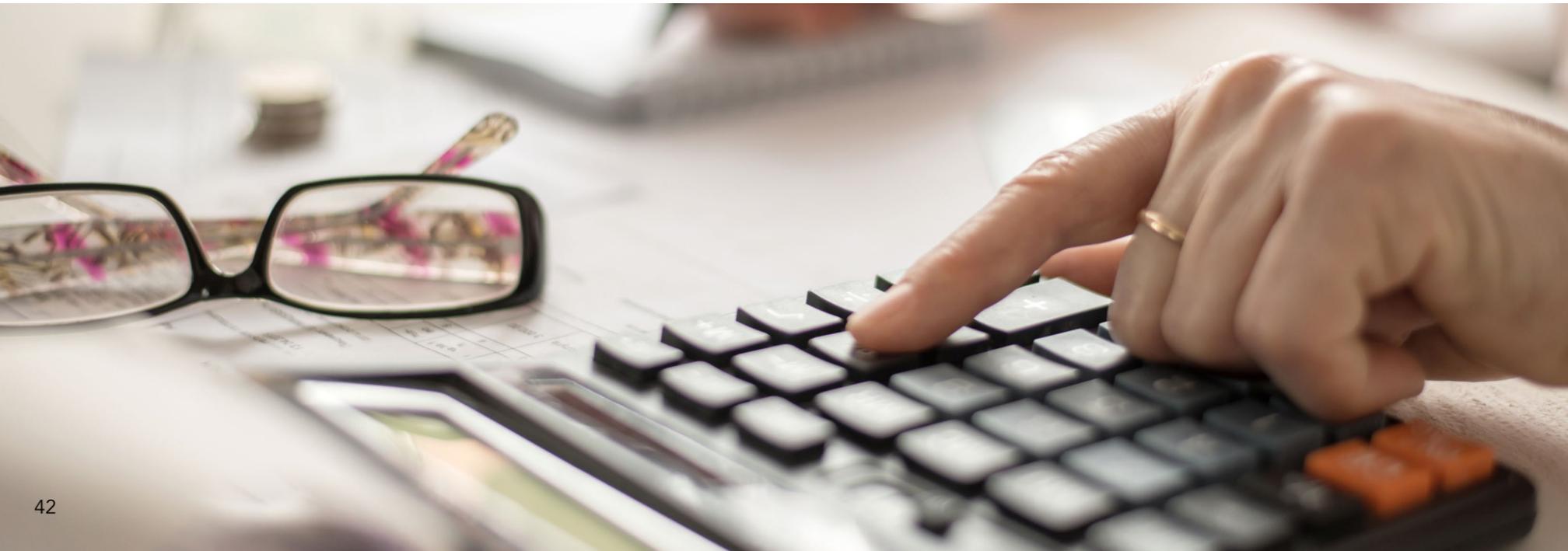


Figure 17 shows a higher rate of Philadelphia County residents not having a motor vehicle when compared to those in Montgomery for the years 2015-2019. Lack of reliable transportation can hinder one's ability to get to and from medical appointments, meetings, work, or things needed for daily living.

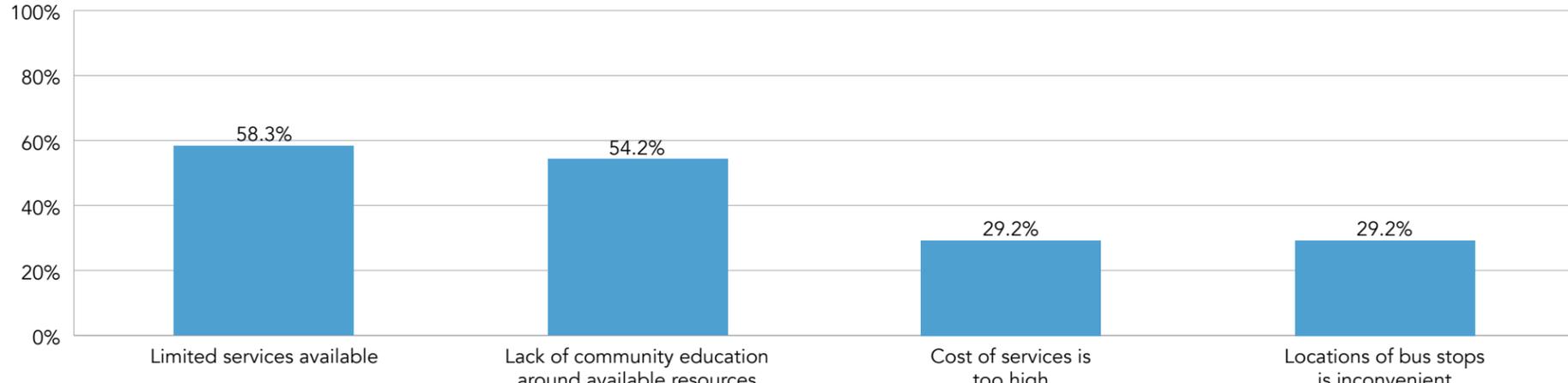
Figure 17: Households with No Motor Vehicle



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

When key informants were asked what contributes to the transportation issues in their community the top three responses include: limited services 58.3% (n=14), lack of community education around available resources 54.2% (n = 13), and cost of services is too high 29.2% (n=7) alongside the location of bus stops is inconvenient 29.2% (n=7).

Figure 18: Contributions to Transportation Issues in the Community (Top Four Responses)



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 19: Self-Assessment Statements (Top Five)

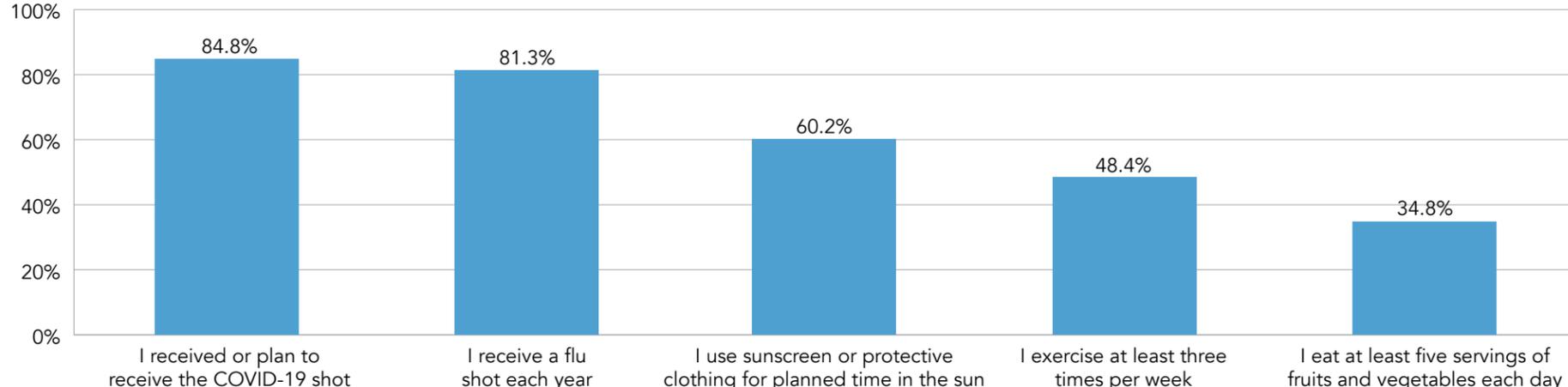
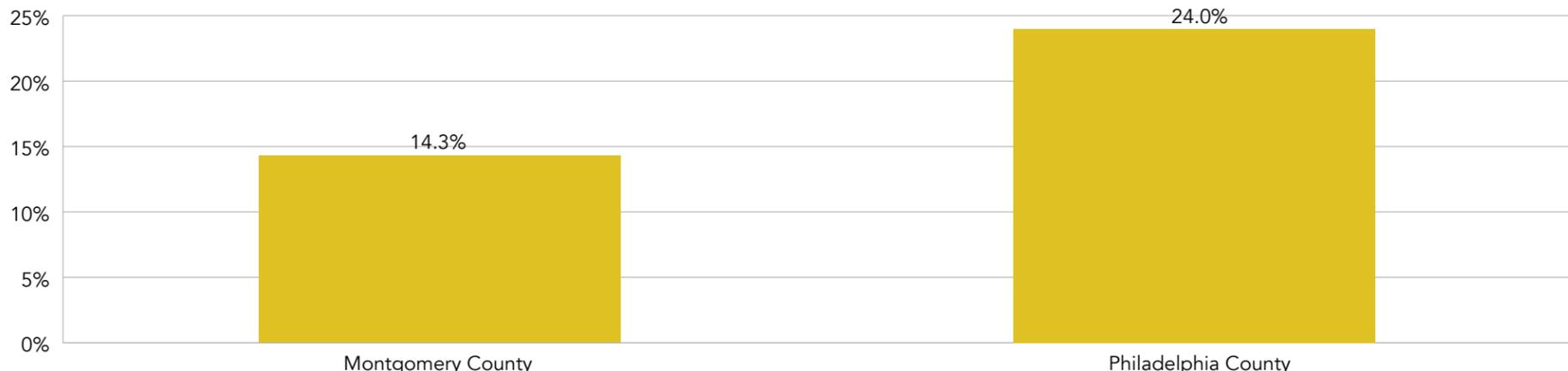


Figure 20 reports the percentage of respondents who listed their health as poor or fair.

Figure 20: Poor or Fair Health – Age-adjusted



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

## B) BEHAVIORAL HEALTH

Improving access and adequacy of behavioral health services and programs has become a high priority for Chestnut Hill Hospital's communities in the past several years as 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 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 21 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 21: Listening to the Community



### **FOCUS GROUPS** (LEADERSHIP AND HEALTH EQUITY)

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

- Access/availability of Behavioral Health/Mental Health Services
- Lack of insurance
- High costs of healthcare



### **KEY INFORMANT SURVEYS**

**"What are the Perceived Barriers to Accessing Care?"**

- Lack of access to Behavioral Health/Mental Health services
- Better collaboration among community-based organizations



### **COMMUNITY STAKEHOLDER INTERVIEWS**

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

- Limited access to Behavioral Health/Mental Health services
- Substance abuse



### **COMMUNITY SURVEYS**

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

- Lack of access to Behavioral Health/Mental Health services
- Lack of access to drug and alcohol services

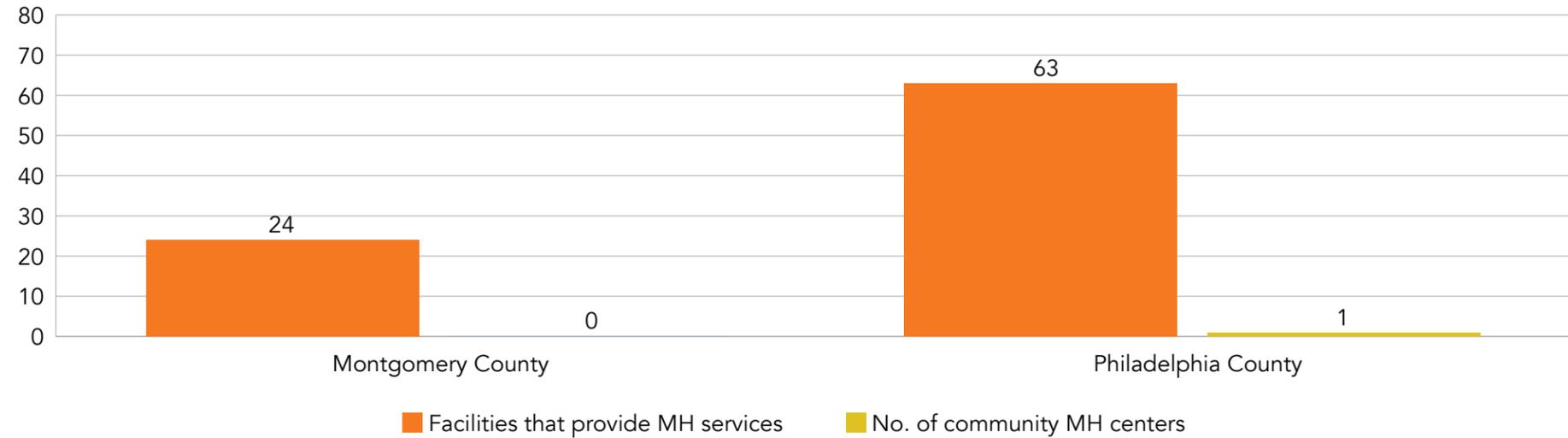


Figure 22 illustrates the number of facilities that provide mental health services and the number of community mental health centers in Montgomery and Philadelphia County.

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.

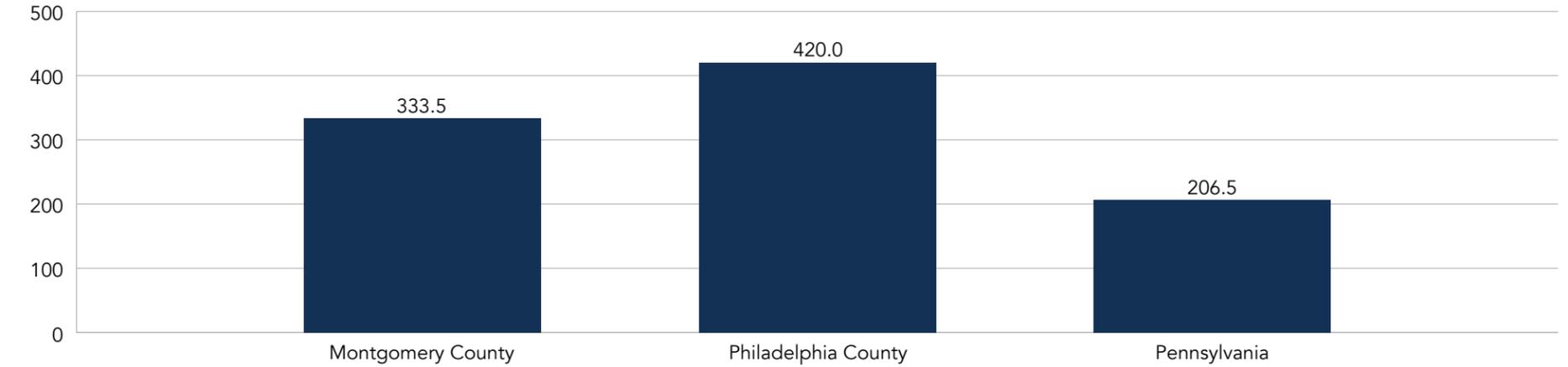
Figure 22: Mental Health Centers and Providers



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

Figure 23 illustrates the shortage in the number of mental health providers (per 100,000 population) in Philadelphia, Montgomery counties, and the state.

Figure 23: Mental Health Providers



Source: County Health Rankings & Roadmaps 2019

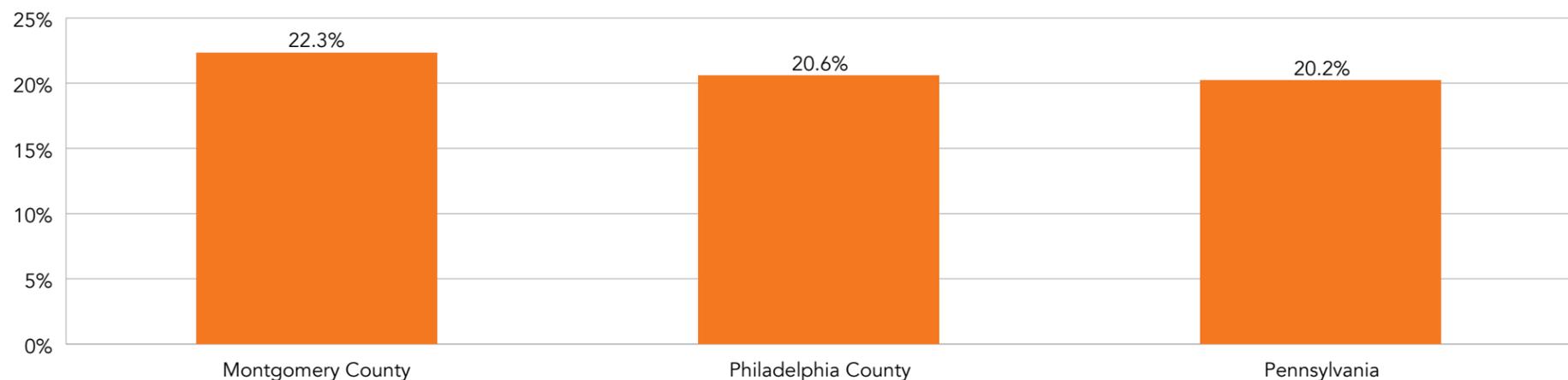




Alcohol and tobacco use are root causes and can further exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk when compared to the United States. When analyzing alcohol consumption, rates are worse or the same in Philadelphia County and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

Figure 24 illustrates the percent of adults who are heavy drinkers in Montgomery County, Philadelphia, and the state. Heavy drinking is defined as having more than two drinks per day for men and more than one per day for women, over the past 30 days.

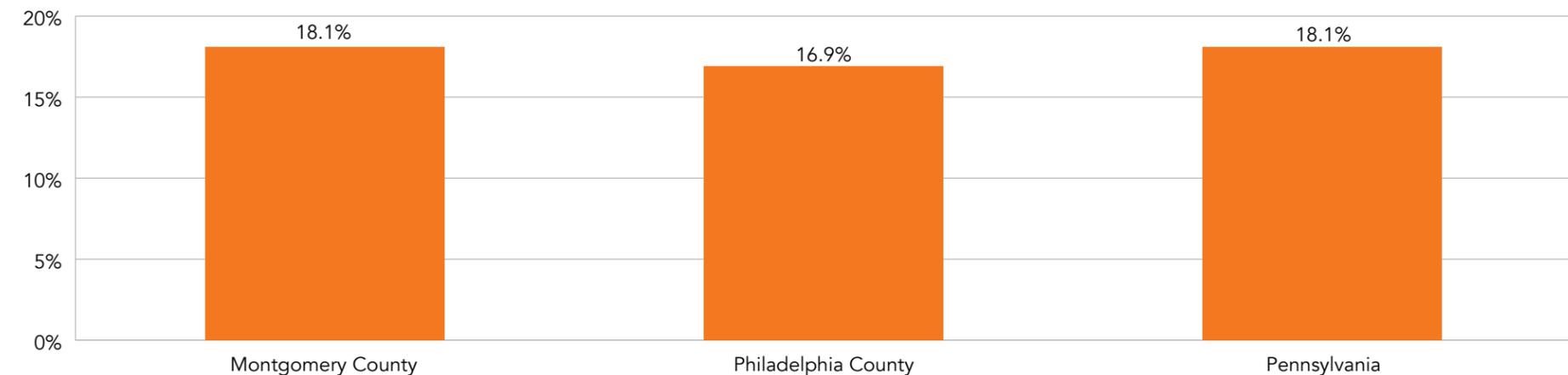
Figure 24: Alcohol Consumption (18 years and older who are heavy drinkers)



Source: CDC, Behavioral Risk Factor Surveillance System 2018

Figure 25 illustrates the percentage of adults who are binge drinkers in Philadelphia and Montgomery counties, and the state. 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.

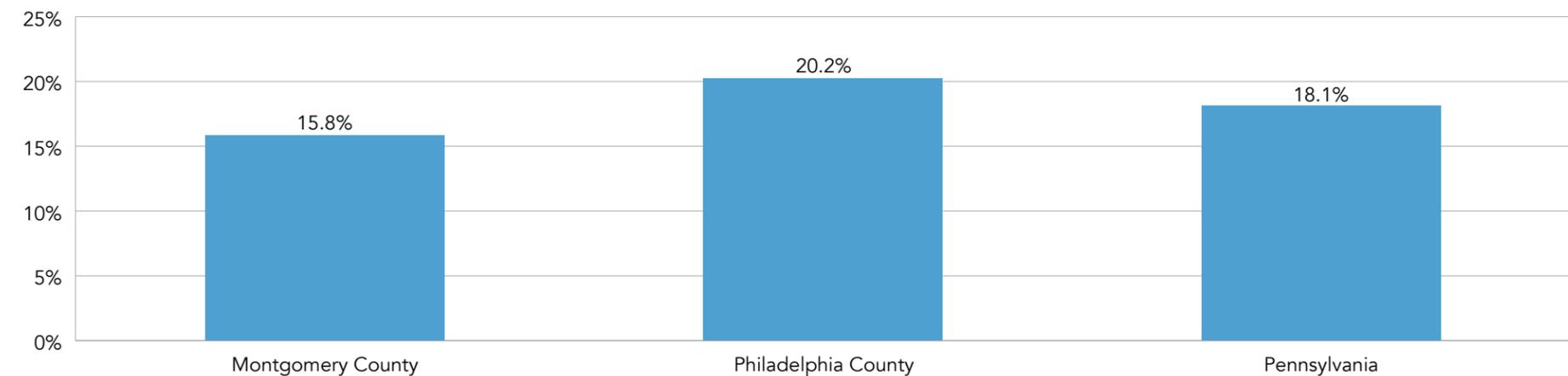
Figure 25: Alcohol Consumption (18 years and Older Who Are Binge Drinkers)



Source: CDC, Behavioral Risk Factor Surveillance System 2018

Figure 26 shows adults 18 and older who smoke every day or some days in Philadelphia and Montgomery counties and the state. Smokers are adults aged 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

Figure 26: Tobacco Usage — Former/Current Smokers



Source: CDC, Behavioral Risk Factor Surveillance System 2018

## 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 27 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 27: Listening to the Community



### **FOCUS GROUPS** (LEADERSHIP AND HEALTH EQUITY)

#### **“What are the Contributors and Barriers to People Accessing Equitable Care?”**

- Lack of ethnic/diverse providers to serve a diverse population
- Need a more diverse and inclusive workforce
- Uneducated/low levels of health literacy and
- Inability to access insurance and care



### **KEY INFORMANT SURVEYS**

#### **“What are the Perceived Barriers to Accessing Care and Services?”**

- Lack of education/awareness of available resources
- Poor eating habits
- Lack of access to healthy foods
- Lack of exercise/inadequate physical activity
- Community health education



### **COMMUNITY STAKEHOLDER INTERVIEWS**

#### **“What are the Perceived Barriers to Accessing Care and Services?”**

- Community health education
- Lack of preventive care
- Health literacy for high levels of chronic diseases



### **COMMUNITY SURVEYS**

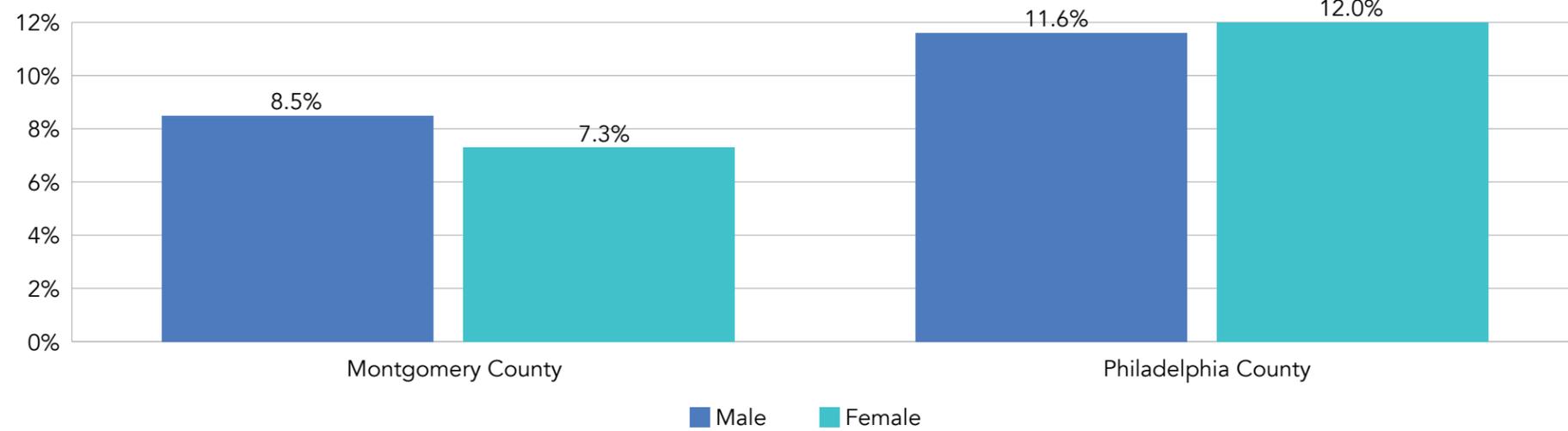
#### **“What are the Perceived Barriers to Accessing Care and Services?”**

- Need for prevention/chronic disease management (Overweight/obesity, unhealthy lifestyles, and behaviors)
- Access to healthy foods
- Stress management
- Weight management
- Lack of exercise



Figure 28 shows the percentage of adults aged 20 and older, by gender, who have ever been told by a doctor that they have diabetes.

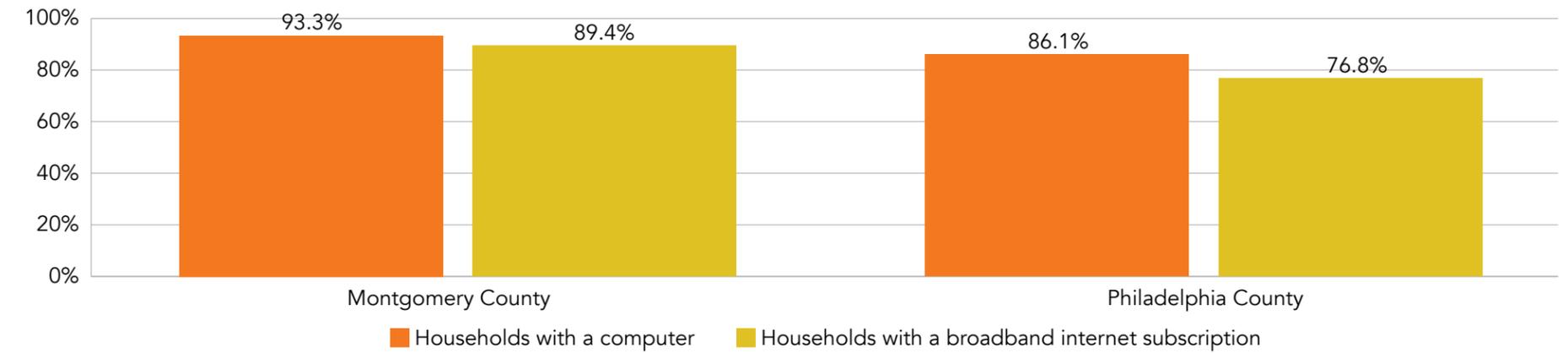
Figure 28: Diabetes by Gender



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

Figure 29 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 information.

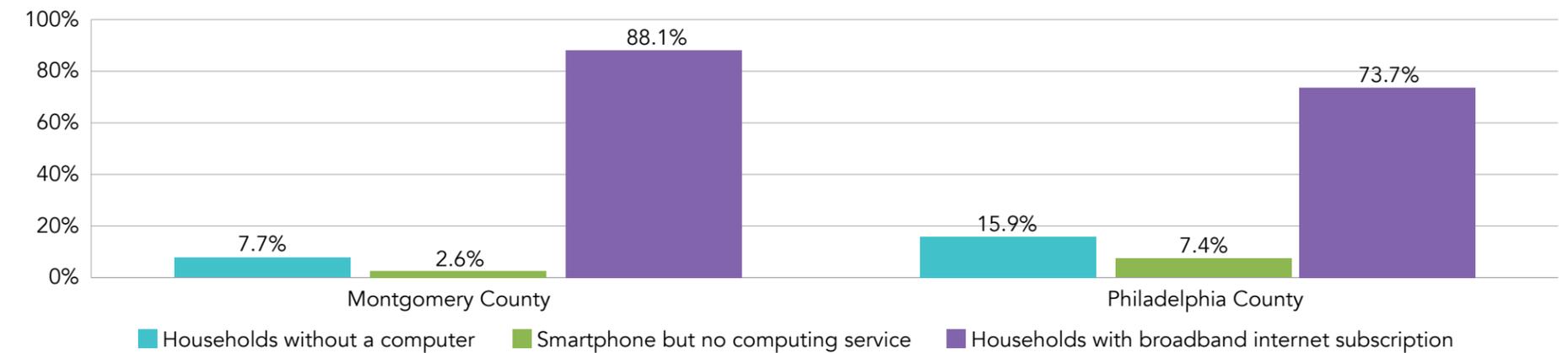
Figure 29: Percentage of Households with Computer or Internet



Source: U.S. Census Bureau 2019

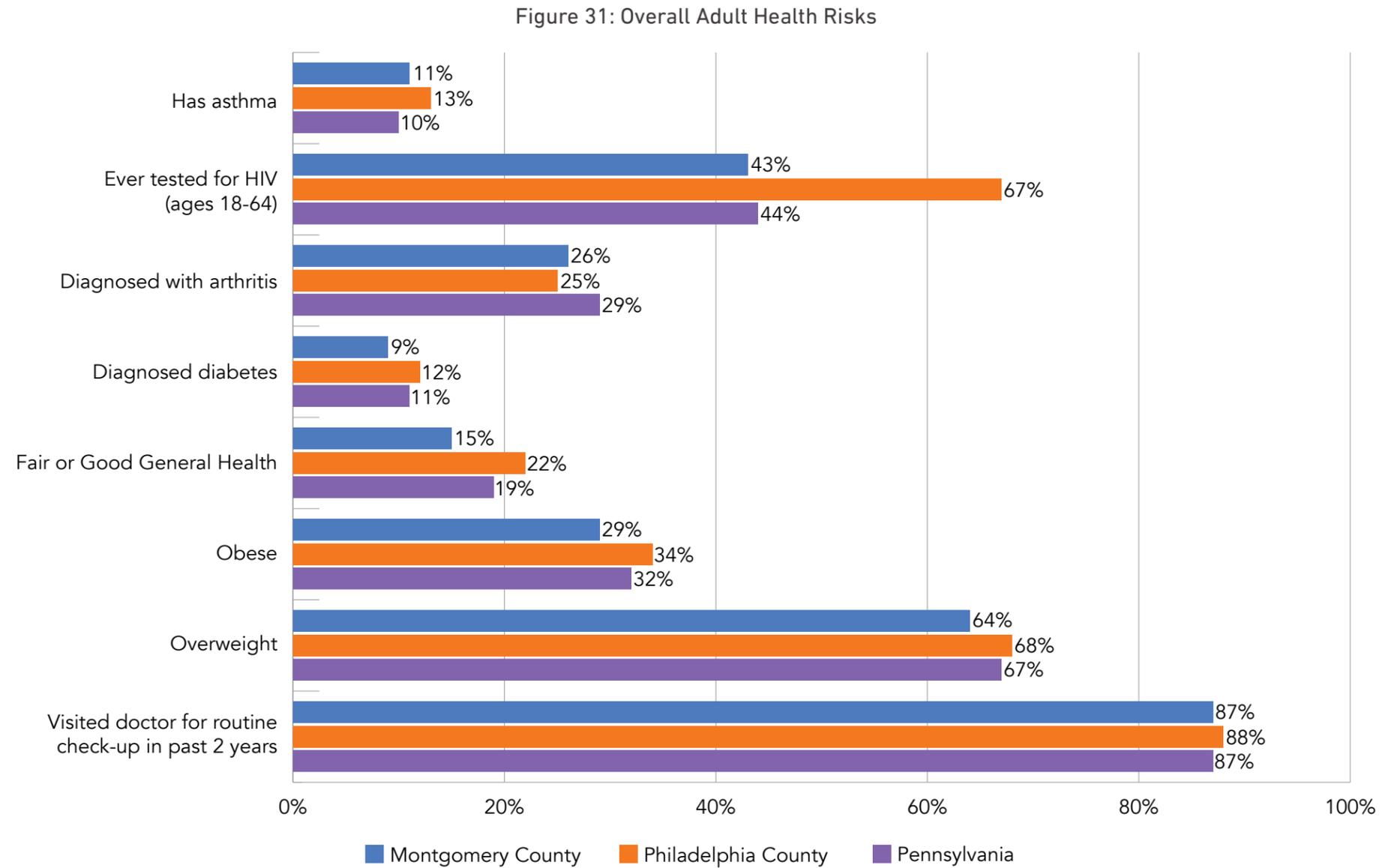


Figure 30: Percentage of Households with Limited Technology



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

Figure 31 shows adult health risk behaviors, health outcomes, and general health in Philadelphia and Montgomery counties, and Pennsylvania. Specifically, the graph depicts asthma, diabetes, obese/overweight rates of individuals in Montgomery and Philadelphia County have exceeded the state rate.



Source: Pennsylvania Department of Health 2017-2019

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

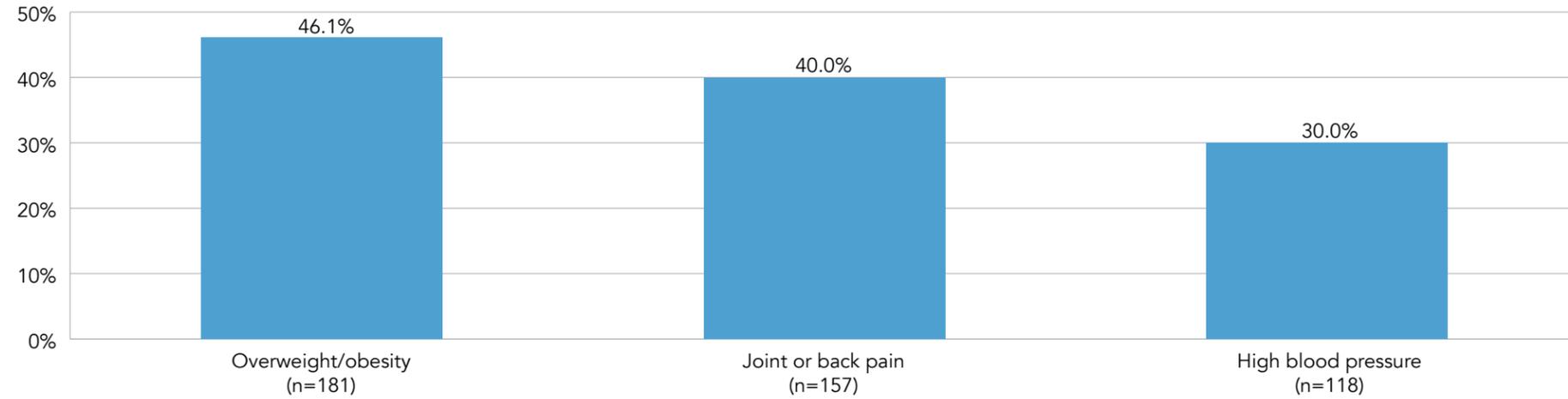
Source: [Feeding America 2019](#)

The USDA refers to food insecurity as the 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.



When asked about top challenges currently faced in the Chestnut Hill service area, respondents in Figure 32 report overweight/obesity, joint or back pain, and high blood pressure as the top three challenges faced.

Figure 32: Top Three Challenges Faced



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

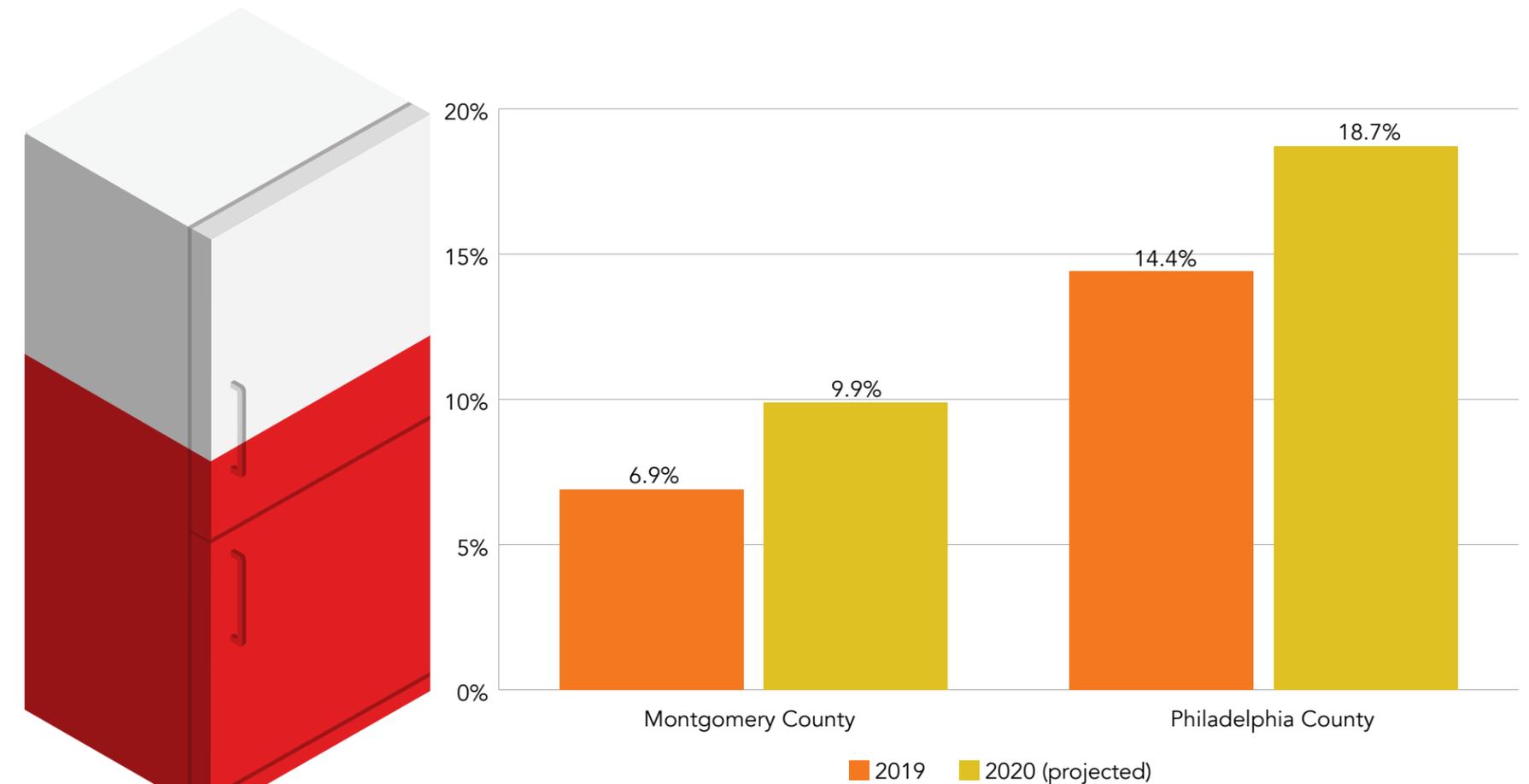
- 467,647 Philadelphia County residents received \$61,547,164 in SNAP benefits and 50,742 Montgomery County residents received \$6,201,417 in SNAP benefits to help make ends meet in December 2018.
- Low-income SNAP participants spend \$1,400, or nearly 25%, less in annual medical costs than low-income adults who don't participate in SNAP.
- SNAP boosts wages for workers who do not earn enough to afford a basic diet and is also there to help those who are between jobs while they search for work.

Source: Coalition Against Hunger 2018

## 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 improvements that may have occurred as millions of people for the first time are experiencing food insecurity along with those who experienced food insecurity before the COVID-19 crisis.

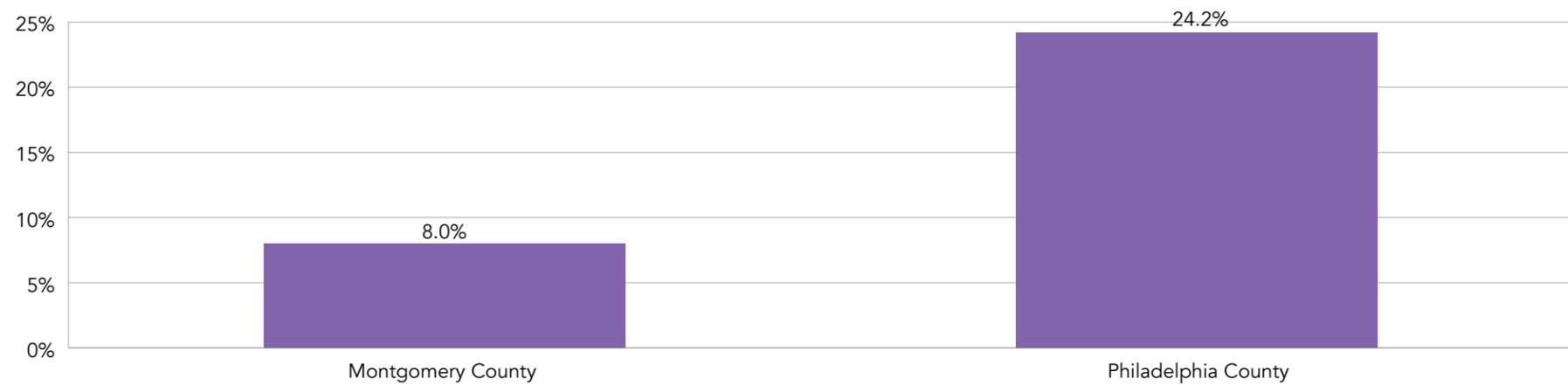
Figure 33: Food Insecurity



Source: Feeding America 2019



Figure 34: Child Food Insecurity



Source: [Feeding America 2019](#)

Figure 35: Limited Access to Healthy Foods



Source: [County Health Rankings & Roadmaps 2015](#)

Figure 35 reports the percentage of the population who are low-income and do not live close to a grocery store.

In Figure 36, the community survey shows health behaviors for which people in the community need more information.

Figure 36: Top Health Behaviors for Which People Need More Information

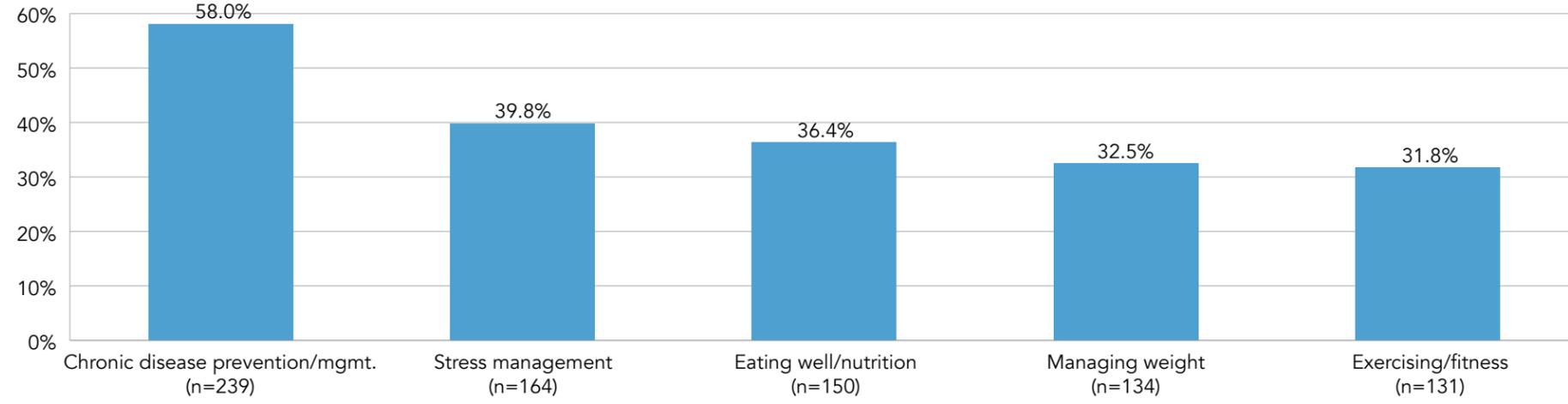
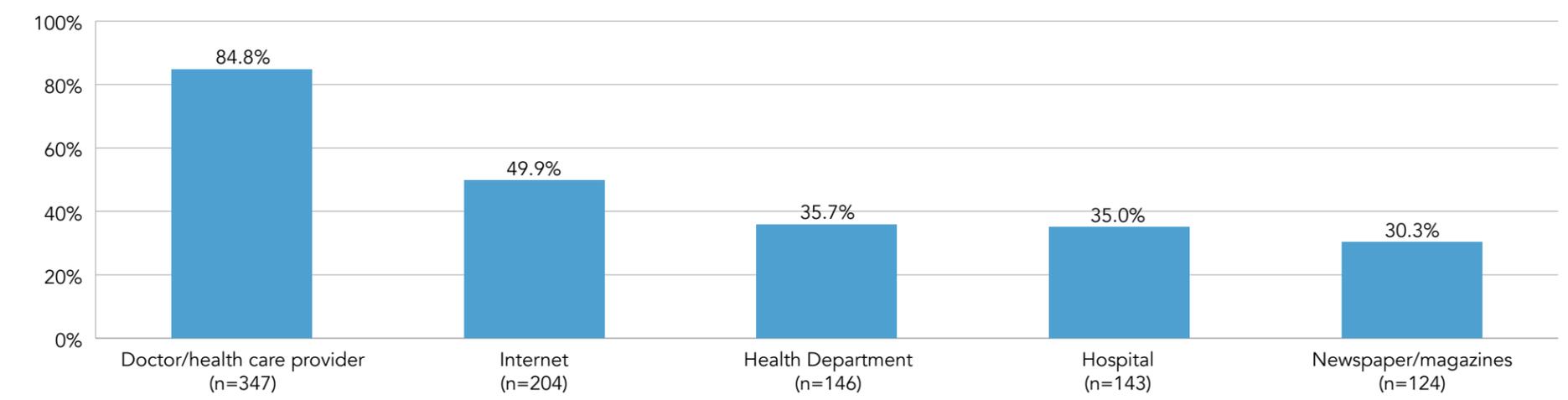


Figure 37 from the community survey reports how the community wants to receive health information.

Figure 37: 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 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.



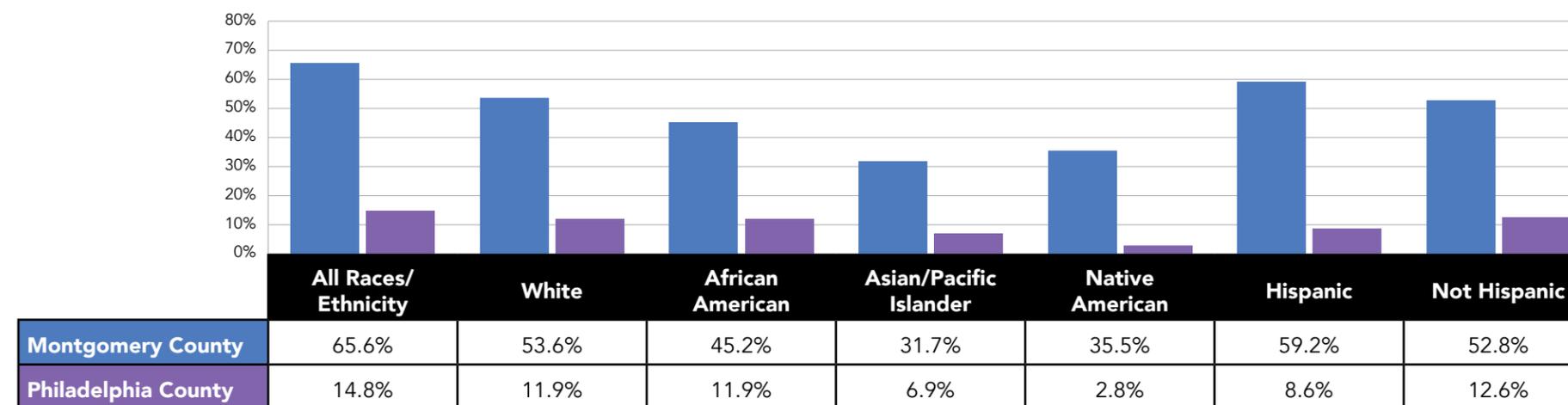
## LESSONS LEARNED FROM COVID-19 AND HEALTH EQUITY

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

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

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

Figure 38: Full Vaccination Coverage for Race/Ethnicity



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

Source: [The PA Department of Health](#)

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

## DRIVERS OF DISEASE INEQUITIES

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

Independent drivers of disease inequalities and a multi-sectorial approach are needed to reduce the impact of COVID-19 and other health issues among marginalized, disenfranchised, vulnerable, and underserved communities. (See Figure 39).

- 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.
- 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.
- 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.

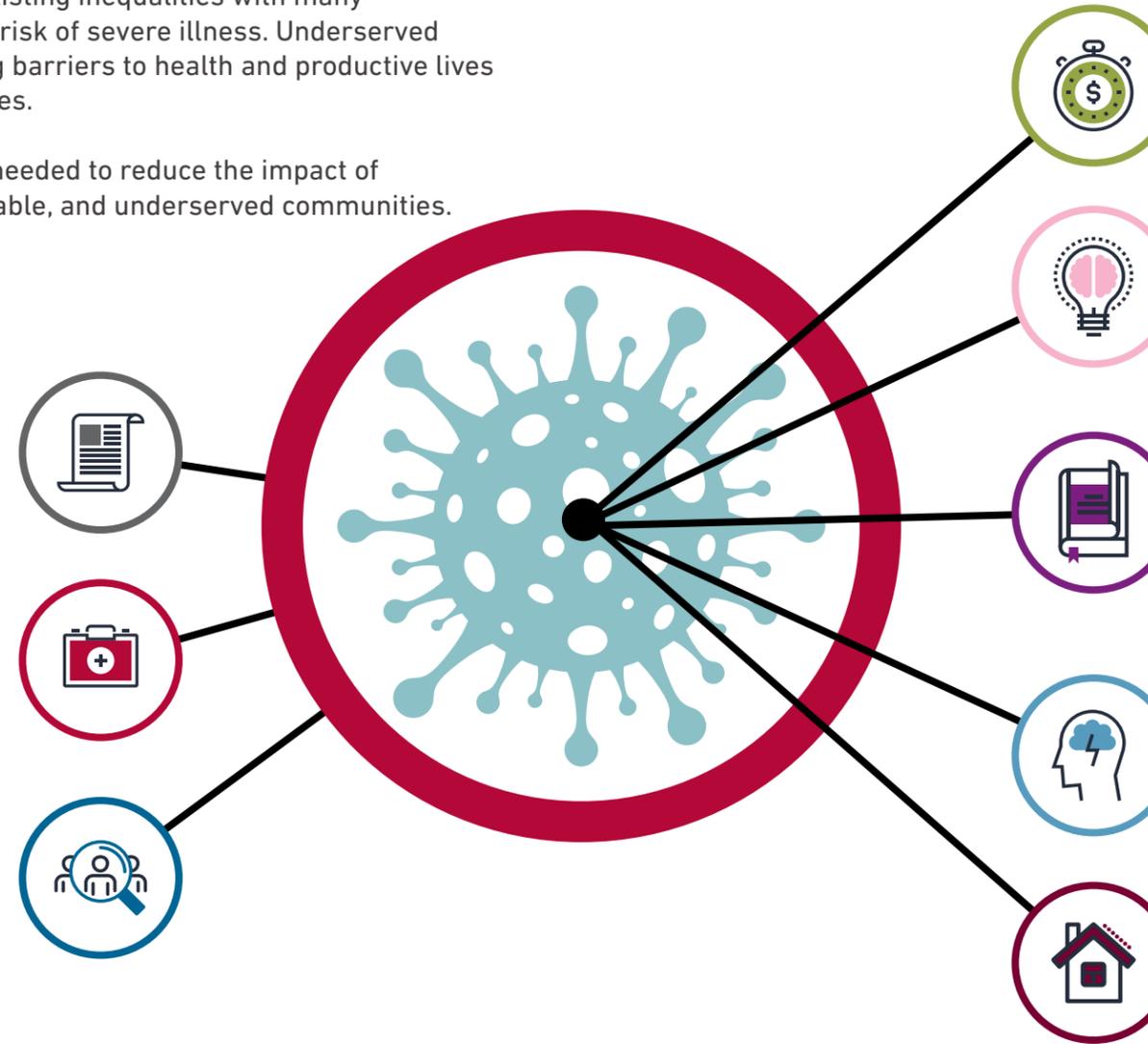


Figure 39: COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities (The Health Equality Initiative)

- POVERTY**  
Living in poverty, health is one of many priorities.
- 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.
- 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.
- CHRONIC STRESS**  
Stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications.
- 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.

## WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 40 delineates the responses collected from the leadership and health equity focus groups, key informant surveys, community stakeholder interviews, and community surveys.

Figure 40: Listening to the Community



### FOCUS GROUPS (LEADERSHIP AND HEALTH EQUITY)

**“What are the Contributors and Barriers to People Accessing Equitable Care?”**

- Must tackle SDOHs (shelter, transportation, food insecurity)
- Disproportionate Medicaid population
- High costs, unreliability of public transportation
- Poor economic status
- Lack of employment opportunities
- Lack of trust and transparency



### KEY INFORMANT SURVEYS

**“What are the Perceived Barriers to Accessing Care?”**

- Economic disparities
- Lack of transportation
- No insurance
- Racism
- Availability of services
- Inconvenient location of bus stops



### COMMUNITY STAKEHOLDER INTERVIEWS

**“What are the Perceived Barriers to Accessing Care and Services?”**

- History of bias
- Lack of understanding of cultural differences
- Socioeconomic factors that influence bias



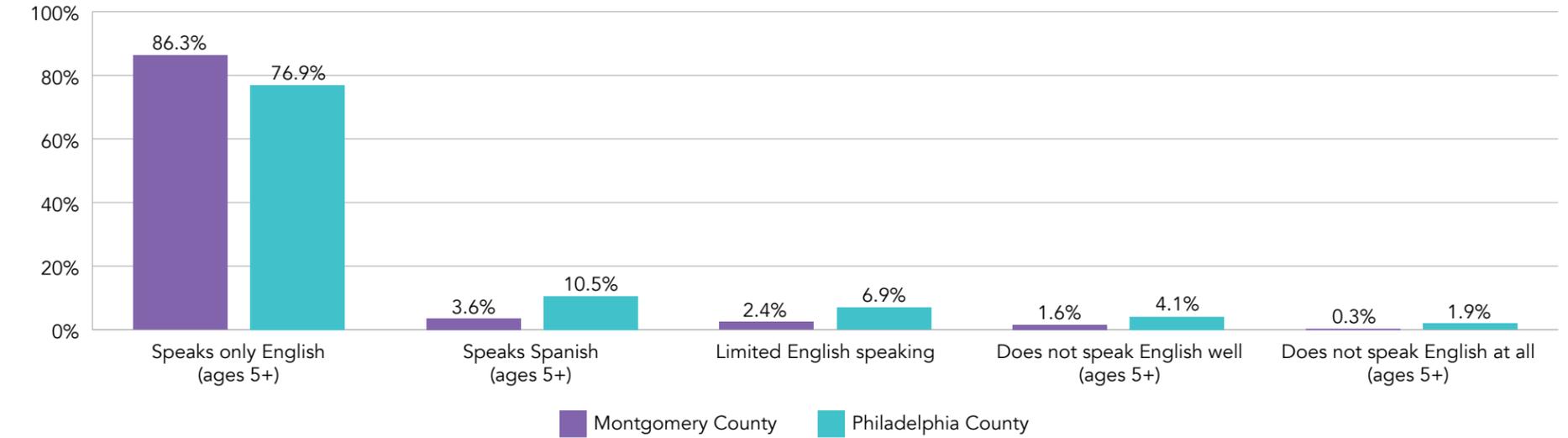
### COMMUNITY SURVEYS

**“What are the Perceived Barriers to Accessing Care and Services?”**

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

Figure 41 reveals the percentages of residents who speak only English and Spanish and residents who are limited in English-speaking.

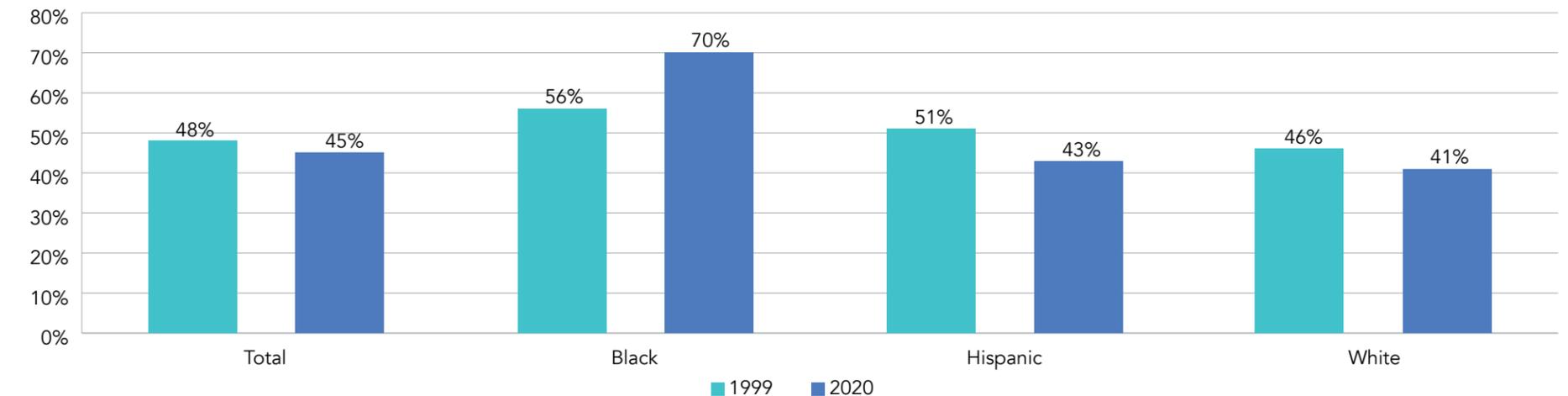
Figure 41: Households with Residents Speaking English Only, Spanish, and Limited English



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

Figure 42 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 Undeclared Survey on Race and Health 2020.

Figure 42: Percentage That Thinks the Health Care System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often

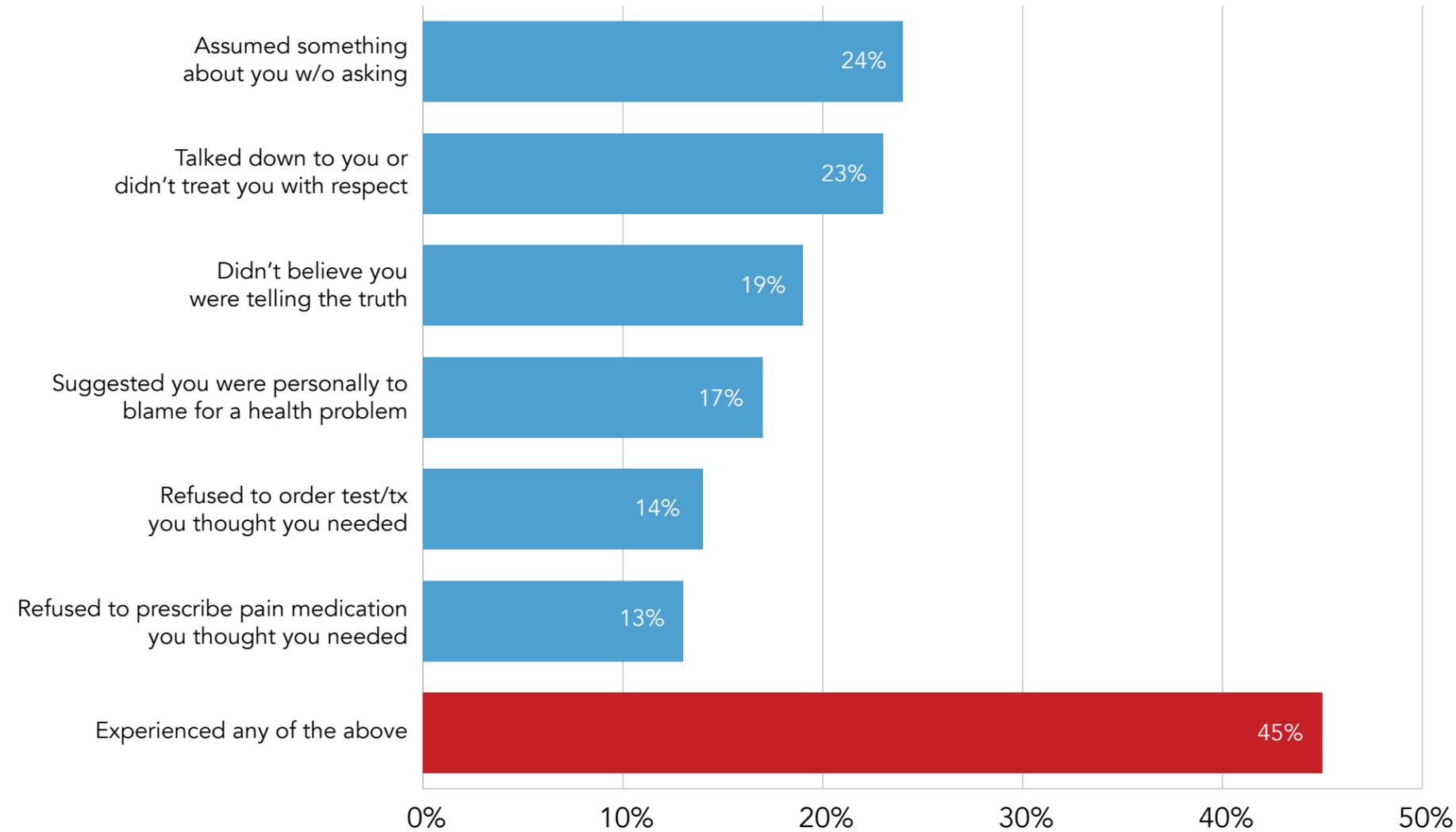


Source: KFF/The Undeclared Survey on Race and Health 2020

Figure 43 reports that nearly half of adults reported one of six negative experiences with health care providers in the last three years.

Figure 43: Percentage Reporting Yes to Negative Experiences With a Doctor or Health Care Provider

If you ever felt that a doctor or health care provider...



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

## CHNA FOCUS AREA FOR CHESTNUT HILL HOSPITAL 2022

In 2021, key need areas were identified during the CHNA process through the gathering of primary and secondary data such as community leader 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 hospital may provide an abundant amount 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, Chestnut Hill 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 leader interviews, and provider interview processes. Chestnut Hill Hospital will engage and collaborate with our community partners on the development of the CHNA Implementation Strategy Plan.

## CONTACT

Office: 8835 Germantown Avenue, Philadelphia, PA 19118

Phone: 215-248-8200

[Templehealth.org/ChestnutHill](https://www.templehealth.org/ChestnutHill)

