Wills Eye Hospital

2025

REGIONAL

Community Health Needs Assessment

FOR SOUTHEASTERN PENNSYLVANIA

Table of Contents

This excerpt, taken from a report covering all of southeastern Pennsylvania, focuses on the service areas and populations served by Wills Eye Hospital.

Executive Summary

Identifying and addressing the unmet health needs of local communities is a fundamental responsibility of hospitals and health systems across the United States. The Affordable Care Act (ACA) formalized this role by requiring tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three years and implement strategies to address the most pressing priorities identified. This assessment serves as a cornerstone of community benefits planning and social accountability for not-for-profit hospitals and health systems. By gaining deeper insights into service needs and gaps, organizations can develop ACA-mandated implementation plans that respond effectively to high-priority concerns.

Recognizing that many hospitals and health systems serve overlapping communities, a group of local hospitals and health systems has again collaborated on a Southeastern Pennsylvania (SEPA) Regional CHNA (rCHNA), covering Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This ongoing collaboration ensures a consistent, data-driven approach while offering opportunities to refine and enhance the assessment process. By working together, participating organizations aim to strengthen the impact of the CHNA, fostering multi-sector partnerships and community-driven solutions that drive meaningful and sustainable change. Additionally, this collaborative model reduces the burden on community members while leveraging shared knowledge and resources.

The 2025 rCHNA is specifically designed to advance health equity and foster authentic community engagement. Beyond guiding hospital and health system strategies, the rCHNA plays a vital role in amplifying the voices of community members and providing localized health indicators that are essential for nonprofits and community-serving organizations. These data and insights support grant writing, program development, and evaluation efforts, ensuring that organizations working to improve community health have the evidence they need to advocate for funding and implement impactful initiatives.

PARTNERING HEALTH SYSTEMS AND HOSPITALS

- **Children's Hospital of Philadelphia**
  - Children's Hospital of Philadelphia
  - Middleman Family Pavilion at CHOP, King of Prussia
- **ChristianaCare – West Grove**
- **Doylestown Health**
- **Grand View Health: Grand View Hospital**
- **Jefferson Health**
  - Jefferson Einstein Montgomery Hospital
  - Jefferson Einstein Philadelphia Hospital
  - Jefferson Abington Hospital
  - Jefferson Bucks Hospital
  - Jefferson Frankford Hospital
  - Jefferson Hospital for Neuroscience
  - Jefferson Lansdale Hospital
  - Jefferson Methodist Hospital
  - Jefferson Torresdale Hospital
  - Jefferson Moss Magee Rehabilitation Center City (Magee Rehabilitation)
  - Jefferson Moss Magee Rehabilitation – Elkins Park (Moss Rehab)
  - Rothman Orthopedic Specialty Hospital
  - Thomas Jefferson University Hospital
- **Main Line Health**
  - Bryn Mawr Hospital
  - Bryn Mawr Rehabilitation Hospital
  - Lankenau Medical Center
  - Paoli Hospital
  - Riddle Hospital
- **Penn Medicine**
  - Chester County Hospital
  - Hospital of the University of Pennsylvania
  - Hospital of the University of Pennsylvania – Cedar Avenue
  - Penn Presbyterian Medical Center
  - Pennsylvania Hospital
- **St. Christopher's Hospital for Children**
- **Temple University Health System**
  - Fox Chase Cancer Center
  - Temple University Hospital
  - Temple University Hospital – Episcopal Campus
  - Temple University Hospital – Jeanes Campus
  - Temple University Hospital – Northeastern Campus
- **Trinity Health Mid-Atlantic**
  - Mercy Catholic Medical Center, Mercy Fitzgerald Hospital Campus
  - Nazareth Hospital
  - St. Mary Medical Center and St. Mary Rehabilitation Hospital
- **Wills Eye Hospital**

OUR COLLABORATIVE APPROACH

In collaboration with the Steering Committee—comprising representatives from partnering hospitals and health systems—the project team, consisting of staff from the Health Care Improvement Foundation (HCIF) and the Philadelphia Association of Community Development Corporations (PACDC), developed a collaborative, community-engaged approach. This methodology involved collecting and analyzing both quantitative and qualitative data while incorporating secondary data sources to comprehensively assess the region's health status.

The HCIF team and quantitative consultant compiled, analyzed, and aggregated over 70 health indicators encompassing: access to care, community demographic characteristics, chronic disease and health behaviors, disabilities, injuries, maternal, infant and child health, mental and behavioral health, and social and economic conditions. Additionally, HCIF, in collaboration with hospitals, health systems, and community-based organizations (CBOs), conducted a general population survey with six core questions and demographic queries to better understand community health experiences across all counties. The survey was offered in English and seven additional languages and analyzed at county and sub-geography levels to reflect diverse community perspectives.

HCIF, guided by a Qualitative Team composed of Steering Committee representatives, led the qualitative components of the assessment, which included:

- **General Population Focus Groups:**
  30 community conversations engaging residents from geographic communities across five counties.
- **Diverse Language Focus Groups:**
  Two sessions facilitated in partnership with SEAMAAC to engage Latine and Asian populations.
- **Youth Engagement:**
  15 focus groups capturing insights from youth across all counties.
- **Spotlight Topic Discussions:**
  10 discussions with community organizations and government agencies on key topics, such as health and social services integration, aging, primary care access, maternal health, caring for uninsured and undocumented populations, culturally appropriate mental health care, and housing.
- **Targeted Focus Groups:**
  10 discussions on specific health concerns, including cancer care, vision care, disabilities, and maternal health.
- **Key Informant Interviews:**
  15 interviews with subject matter experts from health systems, local government, and CBOs to explore spotlight topics in-depth.

A qualitative data expert facilitated adult discussions, analyzed findings, and synthesized key themes. Additionally, a trained youth facilitator led youth conversations to ensure meaningful engagement of young voices in the assessment process.

The project team also conducted or supported targeted primary data collection to address specific community needs, focusing on:

- Cancer
- Disability/Rehabilitation
- Maternal Health
- Older Adults
- Vision
- Youth Voice

Reports and summaries from other community engagement efforts were integrated into the assessment. For example, findings from a local PCORI grant initiative (PC3) informed the cancer focus area section.

HCIF staff aggregated top priorities from general community conversations, youth engagement, and survey data. These findings were presented to the Steering Committee, which conducted a grouping exercise to categorize concerns into 12 general population priorities and 8 youth-focused priorities.

Using the Hanlon ranking method, each participating hospital and health system rated the identified needs. Average ratings were calculated, and community health priorities were organized based on:

- Magnitude of the health issue based on population impact
- Severity of the issue within hospital and health system catchment areas
- Effectiveness of potential interventions
- Feasibility of implementing solutions

Potential solutions for each of the community health priorities, based on findings from the qualitative data collection, were also included. Using this updated information, the Steering Committee and project team developed a collaborative, community-engaged approach that involved collecting and analyzing quantitative and qualitative data and aggregating data from a variety of secondary sources to comprehensively assess the health status of the region.

The assessment resulted in a list of priority health needs that will be used by participating hospitals and health systems to develop implementation plans outlining how they will address these needs individually and in collaboration with other partners. In the below summary, participant solutions are provided for insight on community driven ways to address the priorities.

COMMUNITY HEALTH PRIORITIES:
General Population

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
1. Trust and Communication	• National surveys (from ABIM, AcademyHealth, and IHI) indicate declining patient trust in healthcare institutions, often due to provider burnout, high turnover, disparities in treatment, and financial barriers, which disproportionately affect uninsured and minoritized communities. Community conversations reinforced this issue in the region. • Patients feel rushed during short appointments and unheard by providers, leading to concerns about potential medical errors, particularly with conflicting prescriptions. • ER staff have the most pronounced communication issues, which are closely linked to long wait times and patient frustration. • Poor front-desk interactions, including last-minute appointment cancellations and unprofessional behavior, contribute to negative patient experiences and decreased trust.	• Desire for more empathetic, respectful, and culturally responsive care and support staff. • Suggestions included more social workers in hospitals and improved communication about healthcare changes. • Ensure benefit notices and appointment information are received on time, not after due dates, and provide regular updates on healthcare changes and medication protocols. • Adjust mechanisms for healthcare and social service staff to provide consequences when institutions or workers drop the ball on paperwork or communication. • A dream solution expressed by multiple participants was a system where everyone receives the same quality of care, regardless of insurance status.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
2. **Racism and Discrimination in Health Care**	• People of color, immigrants, people with disabilities, people with mental illness, people with substance addiction, LGBTQ+ individuals, and other minority groups continue to **experience discrimination and institutional barriers to health care**. • **Insufficient health care staff from diverse and representative backgrounds** play a major role in this issue – people do not see themselves reflected in the healthcare workforce; can lead to not "feeling seen." • **Intersecting identities** lead to exponential impacts on discrimination and racism, and subsequent trauma. • The **political climate** in the United States contributes to feelings of vulnerability within marginalized communities.	• Participants called for healthcare professionals to update their knowledge and attitudes beyond outdated textbooks. • Strong calls for in-person translation services and recruitment of bilingual providers. Languages mentioned: Spanish, Arabic, French, several African languages. • Participants suggested that providers should reflect the communities they serve — racially, culturally, and linguistically. • Address the way patients with substance use or mental health needs are often denied full treatment, especially pain management. • Recognize and address structural racism — such as how funding, communication, and service offerings exclude or deprioritize certain communities.
3. **Chronic Disease Prevention and Management**	• **Community gyms and recreation spaces that are well maintained and free/affordable**, were recognized as desirable neighborhood resources, along with safe neighborhoods, and support disease prevention & management. • **Limited access to healthy food options and limited food education** were noted as some of the greatest barriers to maintaining health and preventing or improving health conditions. • Some participants shared knowledge of and experiences with **Long COVID**, while a significant number were unfamiliar with the condition. Millions of adults in the U.S. have been affected by Long COVID. Participants are still generally concerned about acute COVID-19 infection. • **People with disabilities, who are not all older adults, face barriers to disease prevention and management** due to accessibility issues and require greater advocacy.	• Increase access to local fitness centers and programs that accept health insurance. • Promote community gardens and green spaces for physical activity and healthy eating. • Provide consistent access to nutritional education for both children and adults. • Offer more accessible chronic disease screenings and follow-up care, especially for older adults. • Ensure health centers and providers are open during evenings/weekends to improve access.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
4. **Access to Care (Primary and Specialty)**	• **Prevailing barriers** in accessing care include: **inadequate health insurance coverage** (insurance not accepted, high out-of-pocket costs, no dental coverage), **limited transportation/accessibility of offices/hospitals** (primarily an issue in non-urban settings and amongst older adults), **extended wait times for appointments** (prompting use of ER and urgent care more often), **closures of local hospitals**, and **specialists not covered by insurance or not available for appointments/too far**. • In addition to hospital closures, **pharmacy closures** present challenges related to obtaining prescriptions, resulting in increased utilization of prescription deliveries. • Some pandemic-era changes to access have persisted, including more pervasive **telehealth services**, **increased interaction with health portals**, and **virtual health-related programming**.	• Extend clinic hours to evenings and weekends. • Reduce wait times for appointments, especially for urgent needs. • Simplify the referral and authorization process, which often delays care. • Provide local urgent care and dental options, especially in rural or underserved areas. • Address insurance instability (frequent changes to accepted plans or providers).
5. **Healthcare and Health Resources Navigation**	• Community members' lack of awareness of resources is reflective of both **community needs and a lack of knowledge.** • The perception of a lack of resources where some might exist is **indicative of a need to improve information dissemination and methods of accessing that information**. Participants frequently felt compelled to share resources and experiences with one another, when needs and complaints arose about health services among the focus group members. • **Navigating insurance policies, coverages, web platforms, related resources and healthcare costs prove challenging** – especially for older adults who feel less confident with technology use and the transition to Medicare. • **Mentorship for medical decision-making**, particularly for older adults who live alone, can promote social support, advocacy, and safety.	• Expand non-emergency medical transportation options, particularly for older adults and rural residents. • Provide help navigating insurance plans, applications, and renewals (e.g., in-person or phone-based support). • Create centralized, updated lists of services and locations (e.g., food vouchers, clinics). • Provide tech support or training for those who struggle with using healthcare portals or telehealth.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
6. **Mental Health Access**	• Community members shared the **quantity and availability of mental health providers are insufficient** to meet ever increasing needs (particularly post-pandemic). • Additionally, health **insurance coverage for mental health services and providers is inadequate**. • **Stigma** around this topic was cited as a barrier – especially in ethnic minority communities. • The **intersection of mental illness, substance use, and/or homelessness** was recurring concern. • The general population expressed **significant concerns related to youth mental health** – which is reflected in the youth prioritization. • Mental health **needs for older adults** focus on grief support and opportunities for community-based social engagement.	• Increase the number of behavioral health providers, especially in rural areas. • Reduce wait times and eliminate long delays between referrals and services. • Normalize seeking help by reducing cultural stigma around mental health through community education. • Offer telehealth mental health options for those without transportation. • Provide trauma-informed mental health support tailored to children, youth, and families.
7. **Substance Use and Related Disorders**	• Community members shared concerns about **substance use in their communities, co-occurring mental illness**, the potential **implications on youth**, and the association with **poor neighborhood safety**. • Drug overdose rates continue to be high due to **opioid epidemic**. • **Community-based services** to treat substance use are perceived as **insufficient** in number by some, and/or are not well-known by others. • **Prevention and education measures** can serve **as protective factors** against misuse and abuse; questions arose regarding the usefulness and impact of policing related to substance use.	• Expand community-based rehabilitation programs as alternatives to incarceration. • Provide trauma-informed care and education during health visits, especially for youth. • Increase provider training to eliminate bias toward individuals with histories of substance use. • Offer drug education at the provider level (not just in schools) with resources for both youth and families. • Reduce stigma through culturally competent and empathetic behavioral health care.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
8. Healthy Aging	• Community members raised concerns about **older adult isolation**, impacting **mental health**, food access, and healthcare interactions. Senior centers and community services were frequently mentioned. • **Transportation barriers** contribute to **food insecurity** and **limited community engagement**. Free ride programs often involve long waits, indirect routes, and lengthy travel. • **Limited digital literacy** and unfamiliarity with technology restrict older adults' access to healthcare and social services. • **Medicare transitions** are often confusing, causing **missed benefits**.	• Improve transportation services for older adults to attend appointments, social events, and access groceries. • Provide free or subsidized exercise classes (e.g., Tai Chi) to support mobility and wellness. • Increase availability of nutritious foods by offering more options and ability to share restrictions in senior food distribution programs. • Establish or re-open senior centers and day programs for social engagement and resource access. • Offer help with documentation and paperwork (e.g., birth certificates, benefits forms). • Create anonymous and accessible reporting systems for elder abuse or neglect.
9. Culturally and Linguistically Appropriate Services	• **Language barriers are the greatest contributing factor to healthcare access** issues for immigrants and ASL speakers. Language issues lead to misunderstandings between patients and healthcare providers or can dissuade patients from attending appointments altogether. • Provision of **high-quality language services (oral interpretation and written translation) is critical** for providing equitable care to these communities; inquiring of patients at the time of appointment-setting about interpreter needs is ideal. • Beyond language access, **cultural and religious norms influence individual beliefs about health**; stigma can create barriers to seeking help, particularly mental health services. • Undocumented individuals may be discouraged from seeking medical help due to **fear or lack of health insurance**.	• Hire bilingual/multilingual providers and translators (languages mentioned: Spanish, Arabic, French, African dialects). • Provide in-person interpreters, especially during complex or urgent health interactions. • Ensure all signage, forms, and digital tools are translated into key community languages. • Train providers in culturally responsive care that respects beliefs and traditions of immigrant communities.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
10. Food Access	• Maintaining diets consisting of fresh produce and healthy foods is **consistently difficult and cost prohibitive**. Cheaper fast food and corner store options are also more convenient, readily accessible, and more prevalent – particularly in urban neighborhoods. Likewise, large grocery stores may require transportation to access them. • A **lack of food literacy and longevity of poor dietary habits** over time also contribute to food choices. • Local food banks/pantries serve as an **indispensable community resource**. When available, community gardens offer neighborhoods opportunities to grow their own food in the company of neighbors. • Older adults have enjoyed **meal delivery services**, as a part of their benefits. • Immigrants and ethnic minorities face challenges with finding **foods that are culturally relevant to them**.	• Maintain and expand community gardens, fresh food access, and local markets. • Offer nutritional education for both children and parents. • Increase oversight of food stamp benefit security (e.g., prevent theft and fraud). • Improve quality of food provided at pantries or senior meal programs – not just quantity.
11. Housing	• The overall health of homeless individuals was also of concern to community members, feeling as though **resources were not readily available** and that homeless individuals contributed to sentiments around neighborhoods being unsafe. • A growing **lack of affordable housing** has led to a year's long waiting list for subsidized housing, as well as evictions, and individuals sleeping in places not meant for human dwelling (e.g., cars, outdoors). This phenomenon is **pervasive across counties**, but particularly in Philadelphia. • Housing for certain sub-groups, such as **older adults and veterans**, was also noted as priorities.	• Invest in affordable housing and shelters, especially for people experiencing homelessness or with substance use challenges. • Improve transitional housing and reentry programs to prevent homelessness post-incarceration. • Ensure stable housing for vulnerable groups to support health management (e.g., medication, food access).

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
12. **Neighborhood Conditions (e.g., blight, green space, air/water quality, etc.)**	• Availability of green spaces, dog parks, libraries, and health centers (with parks, walking trails, gyms, pools) contribute significantly to positive perceptions about neighborhood conditions; named as **desired neighborhood features.** • Lack of overall neighborhood safety, caused by criminal activity, community violence, or road conditions, are risk factors for **poor mental health and limited physical activity outside.** • Uncollected trash build-up and littered streets negatively impact neighborhood morale and contribute to air pollution that can preclude some from opening their windows • Community events were praised as **opportunities to foster neighborly connections** and cohesion. • Local pride from residents who have lived in the area for several decades, particularly in Philadelphia, contribute to **vested interests in improvement**, and informed perspectives on neighborhood history and nature of changes.	• Increase investment in neighborhood clean-up efforts (e.g., trash removal, illegal dumping). • Expand tree canopy and green spaces to reduce heat and support walkability. • Maintain and rebuild parks and rec centers to offer both safety and engagement for youth. • Improve sidewalks and streets for better mobility and pedestrian safety. • Recognize the mental health impacts of environmental stressors like blight and noise.

COMMUNITY HEALTH PRIORITIES:
Youth

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
1. **Youth Mental Health**	• Youth community members and partners recognize **mental health as the primary health concern** in the region. • Youth mental health was prioritized at **12 of 15 youth meetings**. • The top issues raised in youth voice meetings included: access to **mental health services**, needing more support and resources related to **coping skills**, the negative impacts of **social media**, and overall feelings of **loneliness**. • The age-adjusted suicide rate for the region is 11%, with 1**8% of youth across the five counties seriously considering suicide**.	• **Peer-led support spaces** in schools like "Relationships First" circles where trained student leaders facilitate discussions. • **Early emotional support**: Incorporating social-emotional learning (SEL) from a younger age, not just in high school. • **Accessible mental health resources in schools** beyond overwhelmed counselors. • **Parent/community education** on youth mental health, potentially offered at school events like back-to-school nights. • **Mandated parenting education/training** to better equip caregivers. • **Reducing stigma** through community awareness and generational conversations.
2. **Lack of Resources/ Knowledge of Resources**	• Youth **prioritized help with health resources at 30% of youth meetings**. • Youth community members and partners expressed that **navigating healthcare services and accessing health resources, such as mental health programs and reporting outlets, is a significant challenge**. This difficulty arises from a general lack of awareness, fragmented systems, and resource constraints. • Youth shared feelings of **not having anyone to talk to**, or report "bad things" to. • Effective navigation involves not only providing information but also addressing transportation needs. **Many individuals, especially youth, encounter substantial obstacles in finding a trusted adult and obtaining transportation to healthcare services.**	• **Community events** (e.g., Healthy Kids Day) that attract families with incentives (bounce houses, food) while sharing resources. • **More community-based outreach** instead of only web-based referrals. • **Increased transportation access** or bringing services closer to communities (e.g., having more rec centers or clinics locally). • **Youth-friendly formats** like social media campaigns to spread resource awareness. • **Cultural and language access**: Hiring bilingual staff and making materials culturally relevant.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
3. **Substance Use and Related Disorders**	• Youth community members and partners identified **substance use as a health priority at 9 of the 15 youth community conversations**. • **Substance use disorders frequently co-occur with mental health conditions, posing significant challenges** for individuals and communities. These conditions are often linked to issues such as community violence and homelessness. • Key issues raised include the **prevalence of binge drinking, along with increasing use of cigarettes, marijuana, and vaping** among young people. • Youth noted **increased exposure to, and trauma, due to drugs**. • Discussions highlighted **the need for better support in navigating drug and behavioral issues, accessing treatment, and addressing exposure to trauma** related to substance use.	• **Youth-focused recovery spaces:** Suggestion of AA-style meetings for adolescents. • **Safe reporting systems** where youth can help others (e.g., calling for overdose support) without fear of punishment. • **Integrated recovery and workforce development programs:** Pairing mental health support with skill-building and community service. • **CIT (Counselor-in-Training) programs** and volunteer work for youth as alternatives to substance use and ways to build confidence and responsibility.
4. **Bullying**	• Youth community members and partners identified **bullying as a prevalent issue**. Bullying adversely impacts mental health and negatively affects youth's academic performance and social well-being. • Social media has a significant impact on youth, contributing to issues like **cyberbullying** and **unrealistic comparisons**. • Instances of racial profiling, discrimination, sexual harassment, and inappropriate behavior were mentioned highlighting the need for more **inclusive and respectful youth interactions**.	• **Social media etiquette education** starting at young ages to combat online bullying. • **Safe spaces in schools** to talk about feelings, led by peers or trained youth facilitators. • **Early interventions** to prevent verbal and cyberbullying from escalating. • **Support for immigrant and bilingual children** facing bullying due to language barriers.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
5. **Gun Violence**	• Youth community members and partners recognize **gun violence as a significant concern** in the region – with young people having easy access to guns and engaging in violent activities. • Violence driven by community disadvantage **disproportionately impacts** various communities in Philadelphia. Poverty, lack of resources, and inadequate support systems are compounding threats to youth's overall wellbeing and safety. • Trauma associated with exposure to gun violence is widely felt among youth. Challenges in **accessing the necessary mental health supports** to address those negative impacts were also reported. • Youth from immigrant communities, and LGBTQ+ communities are at **higher risk** of interpersonal violence, including intimate partner violence (IPV), sexual assault, and sex trafficking.	• **Reallocation of funding:** Instead of heavy spending in one area, directing more toward youth mental health and education. • **Safe community spaces** where youth can express fears and ideas (e.g., community art like the "community plate" activity). • **Community involvement and cleanup events** to reclaim and uplift neighborhoods. • **Critical feedback on ineffective policing** and calls for greater investment in actual youth-centered prevention and safety measures.
6. **Access to Physical Activity**	• Youth community members and partners widely associate the word "health" with **exercise** and **physical activity**. • 6 out of 15 youth meetings prioritized **physical activity and places** to engage in physical activity. • Access to outdoor **green spaces** and recreation areas like parks and trails are lower in some neighborhoods. The negative impact of such lack of spaces on mental and physical health was shared by youth community members. • 13% of of general population community survey respondents reported that places to be active such as **parks are rarely or never available**.	• **Community gardens and step challenges** tied to school programs. • **Block parties and community clean-ups** that include physical activity components. • **Rec centers and gym access** where youth feel welcome and included. • **Peer involvement at gyms** and modeling healthy physical routines in neighborhood spaces.
7. **Activities for Youth**	• Youth community members and partners emphasized the **importance of extracurricular activities**, which were a priority in 11 out of 15 meetings. • About 92% of youth in the region participate in activities outside of class, but they expressed a need for **more accessible programs**, especially in underserved areas. • Opportunities like summer camps, leadership programs, libraries and STEM clubs were **highly desired** across the five counties.	• **Volunteering and leadership opportunities** like CIT programs, community cleanups, or school clubs. • **Skills-based training with incentives** (e.g., small stipends or "training pay") even before official working age. • **Reviving youth programs** (e.g., Girl Scouts, Boy Scouts) and emphasizing mentorship. • **Creative expression projects** like community plates or mural work to connect youth to their environment and voice.

COMMUNITY HEALTH PRIORITIES	KEY FINDINGS	POTENTIAL SOLUTIONS
8. **Access to Good Schools**	• Access to quality schools was discussed widely among youth. While some counties have ample funding, others have **limited resources**, affecting clubs, programs, and mental health support. • Youth generally appreciate opportunities provided by their schools but highlight significant gaps in **mental health resources**, relevant education, teaching methods, and overall student well-being. Key attributes of **good schools** discussed include: – Quality of Education – Mental Health & Support Systems – Qualified Educators – Supportive Environment & Policies – Resources and Facilities – Diversity, Equity, and Inclusion	• **Support for bilingual learners** and anti-bullying efforts to ensure comfort in school environments. • **Creating welcoming and identity-affirming clubs** for students of all backgrounds. • **Better sexual health and emotional learning programs** that students feel engaged in. • **Training for teachers and school staff** to be culturally competent and approachable.

Introduction

Identifying and addressing unmet health needs of local communities remains a core aspect of the care provided by hospitals and health systems across the U.S. The Affordable Care Act (ACA) formalized this role by mandating that tax-exempt hospitals conduct a Community Health Needs Assessment (CHNA) every three years and implement strategies focused on emergent priorities from the assessment. Federal requirements for the CHNA include:

- A definition of the community served by the facility and a description of how the community was determined.
- A description of the process and methods used to conduct the CHNA.
- A description of how the facility solicited and took into account input received from persons who represent the broad interests of the community it serves.
- A prioritized description of the significant health needs of the community identified through the CHNA and a description of the process and criteria used in identifying and prioritizing those needs.
- A description of resources potentially available to address the significant health needs identified through the CHNA.

This assessment is central to not-for-profit hospitals and health systems' community benefit and social accountability planning. By better understanding the service needs and gaps in a community, an organization can develop implementation plans—also mandated by the ACA—that more effectively respond to high-priority needs.

At the request of local non-profit hospitals and health systems, the Health Care Improvement Foundation (HCIF) continued its effort to collaboratively develop a regional Community Health Needs Assessment (rCHNA) for the Southeastern Pennsylvania (SEPA) region in 2025. Building on the success of previous assessments in 2019 and 2022, the 2025 rCHNA maintains the regional collaborative model while integrating new partners and expanding its data collection approach to enhance community representation.

The 2025 rCHNA includes all five counties of the SEPA region—Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. Notably, this year's assessment includes the participation of ChristianaCare - West Grove, St. Christopher's Hospital for Children, and Wills Eye Hospital, further strengthening the breadth and depth of regional collaboration. As in prior years, participants recognize the CHNA as a key tool for health systems, multi-sector partners, and communities to work together toward meaningful and positive community change.

Several enhancements distinguish the 2025 rCHNA from previous iterations:

- **Community-Based Survey Expansion:** A community-based survey was conducted in eight languages to improve accessibility and inclusivity, ensuring a broader representation of community voices in the assessment process.
- **Piloting of Diverse Language Sessions:** In response to the diverse linguistic needs of SEPA communities, the 2025 rCHNA piloted facilitated discussions in multiple languages, increasing engagement and cultural responsiveness.
- **Youth-Focused Priorities:** Recognizing the unique challenges faced by young people, the 2025 rCHNA includes a dedicated youth-focused priority list, incorporating input from youth-serving organizations, schools, and young residents.
- **Expansion of Spotlights:** The assessment features an expanded set of Spotlights, providing in-depth analyses of specific health topics, populations, or geographic areas. These Spotlights highlight key trends, disparities, and innovative community initiatives addressing pressing health concerns.

While the basic structure and format of the report remain consistent with prior assessments, the 2025 rCHNA reflects an evolving and deepening commitment to health equity, community engagement, and data-driven decision-making. The continued collaborative approach allows for shared learning, increased efficiencies, and a reduced burden on communities participating in multiple assessments.
As the SEPA region continues to navigate ongoing public health challenges and disparities, the 2025 rCHNA serves as a vital resource for guiding collective efforts toward improved health outcomes and a stronger, more equitable healthcare system for all.

Wills Eye Hospital

WillsEye Hospital

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT VISITS:	EMERGENCY DEPT. VISITS:
4	68	144	140,896	15,739

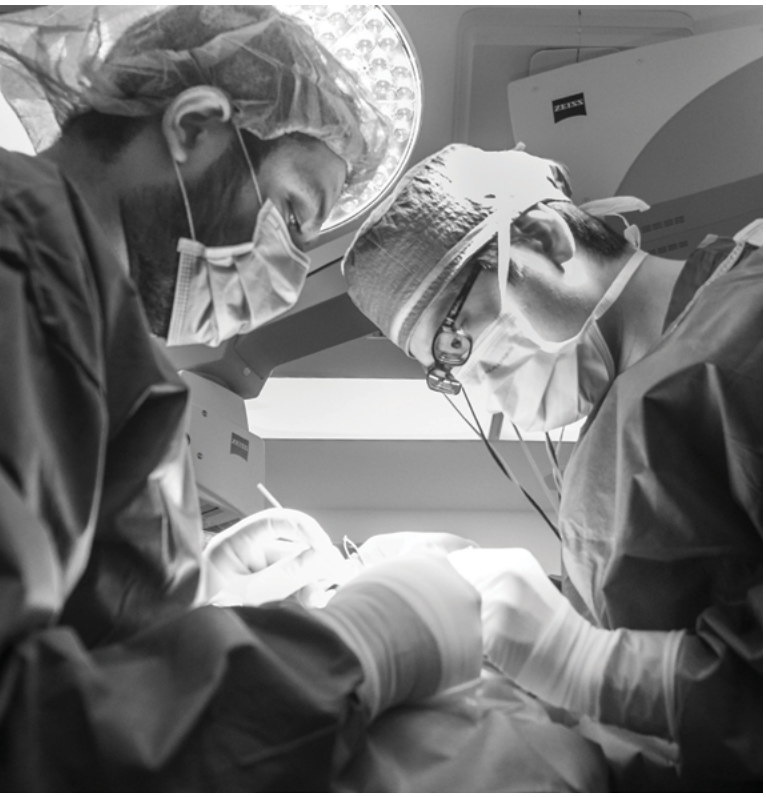
MISSION:

"Skill with Compassion", Wills Eye Hospital's long-standing motto, encapsulates the hospital's driving principle: to cure eye disease through state-of-the-art treatments and advancements in scientific knowledge while embracing empathy not only for each individual patient, but for entire communities in need.

HISTORY AND OVERALL PURPOSE

In 1832, Wills Eye Hospital was founded with the bequest of James Wills, Jr., a Quaker merchant, who left $116,000 in trust to the City of Philadelphia to establish a hospital or asylum for indigent blind and lame. In 1834, the first eye hospital in the world, Wills Eye Hospital, opened its doors. The establishment of Wills Eye Hospital played a vital role in instituting ophthalmology as a distinct branch of medicine in the United States and pioneering advances in the prevention and treatment of eye diseases.

The governing body of Wills Eye Hospital is the Board of Directors of City Trusts, which was established in 1869 by Pennsylvania legislature to administer all funds left in trust to the City of Philadelphia, including the bequest from James Wills, Jr. The Wills Eye Committee of the Board of Directors of City Trusts is responsible for overseeing all matters relating to Wills Eye Hospital and works closely with the Chief Executive Officer and Ophthalmologist-in-Chief on all policy, organizational changes, and major operational matters.



WILLS EYE FACILITIES AND CORE SERVICES

Today, Wills Eye Hospital's dedication to improving the vision health of all residents in Philadelphia and around the world is faithful to its founder's vision. Wills Eye Hospital is composed of 140,000 square foot facility that houses four inpatient beds, operating rooms, examination rooms, state of the art diagnostic testing facilities, an ophthalmic library, teaching facilities including a surgical training lab, research spaces and the Vickie and Jack Farber Vision Research Center.

Wills Eye Hospital provides primary and subspecialty eye care including clinical expertise in cataracts, cornea, glaucoma, retinal disease, neuro-ophthalmology, oculoplastic surgery, ocular oncology, pediatric ophthalmology, and ocular pathology. The breadth of clinical expertise and surgical capabilities makes Wills Eye Hospital a worldwide referral center.

- The **Cataract and Primary Eye Care Service** is the hub of Wills Eye. Approximately 22,000 patients are seen each year. Wills physicians perform routine eye exams and refer any serious complications to the hospital's subspecialty services. Each year thousands of patients also undergo cataract surgery at Wills Eye, benefiting from the experience of world-class surgeons consistently rated as America's best.
- The **Cornea Service** is a leading center for corneal transplants and the treatment of corneal diseases and conditions. More than 400 corneal transplants are performed at Wills Eye each year. In addition to corneal transplants, physicians in the Cornea Service diagnose and treat corneal dystrophies, abrasions, scars, congenital corneal problems and complex cataract surgery.
- The **Glaucoma Service** is the country's largest, and treats patients with the newest laser and surgical techniques, as well as drug therapies available. The Glaucoma Service Diagnostic Laboratory provides advanced computerized techniques to uncover the earliest signs of glaucoma in suspected patients. It also charts the progression of the condition, including the slightest change in the optic nerve, in patients who have already been diagnosed.

- The physicians on the **Neuro-Ophthalmology Service** have a long history of investigating and treating optic neuritis, thyroid-related eye disease, ischemic optic neuropathy, blepharospasm, and hemifacial spasm.
- The **Oculoplastics & Orbital Surgery Service** is one of the largest of its kind in the country. Oculoplastic surgery is a subspecialty of ophthalmology that focuses on problems surrounding the eyeball (the lids, the orbit and the lacrimal system). The service also includes a cosmetic surgery unit.
- The **Ocular Oncology Service**, one of the largest in the world, serves a large national and international patient population. The physicians are leaders in the diagnosis and treatment of ocular oncology, particularly melanoma and retinoblastoma, and have developed new techniques to save eyes that, in the past, would have been removed.
- The **Ocular Pathology Department** is the backbone of teaching at Wills Eye. It conducts ongoing research into the broad spectrum of ocular diseases. It features state-of-the-art technology, and is a center of activity for Wills Eye residents and fellows, as well as for Thomas Jefferson University medical students.
- The **Pediatric Ophthalmology Service** treats the unique ocular problems of children. This includes strabismus (crossed eyes) and amblyopia (lazy eye). Physicians also perform cataract surgery on infants as early as a few weeks old. The pediatric contact lens service at Wills Eye fits and stocks lenses exclusively for children.
- The **Retina Service** was the first subspecialty service at Wills Eye. Today, the Retina Service is one of the largest in the United States and an average of 15,000 patients are diagnosed and treated each year. All vitreoretinal diseases are treated at Wills Eye, including macular degeneration, diabetic retinopathy, uveitis, and retinitis pigmentosa.
- In partnership with Thomas Jefferson University Hospital, Wills Eye also operates one of the few 24/7 dedicated **Eye Emergency Departments**, treating almost 16,000 cases each year.
- Wills Eye's **Ophthalmology Training Programs** are recognized worldwide for setting the highest standard in the field. Our residency program consistently ranks as the best in the nation, with 24 residents (8 per year / 3 years) and 32 advanced clinical and research fellows. Wills Eye alumni hold key leadership positions in prestigious medical centers both in the U.S. and globally, reflecting the program's influence and reach. Additionally, Wills Eye's Online Knowledge Portal provides Continuing Medical Education credits to over 8,000 users across 141 countries, further expanding its impact on global ophthalmic education.

ACCOLADES RECEIVED

- **Top-Ranked Eye Care:** Wills Eye Hospital has been consistently ranked among the Top 2 Eye Hospitals by *U.S. News & World Report*.
- **Nation's Leading Experts:** Wills Eye is a frequent standout on Castle Connolly Medical Ltd.'s Annual Top Doctors list, boasting the highest number of "Top Docs" in Ophthalmology of any hospital nationwide.
- **Premier Residency Program:** Wills Eye's residency program, in partnership with the Sidney Kimmel Medical College at Thomas Jefferson University, is consistently recognized as the best in the nation, setting the standard in ophthalmic training.
- **Global Influencers in Ophthalmology:** Wills Eye physicians regularly earn spots on the "Power 100: World's Most Influential Ophthalmologists," underscoring their leadership and impact in the field.

PARTNERSHIPS AND AFFILIATIONS

Even though Wills Eye Hospital and Jefferson Health System are separate corporate entities and share no ownership or governance, they have had a strong partnership since 1972. Wills Eye Hospital is the Department of Ophthalmology for Sidney Kimmel Medical School at Jefferson University and is the home of the nationally top ranked residency program in Ophthalmology. Many of the Wills Eye physicians have duel medical staff appointments at Wills Eye Hospital and Jefferson Health and academic faculty appointments at Sidney Kimmel Medical School at Jefferson University, making it one of the largest and most productive academic departments of ophthalmology in the country.

Wills Eye also has many global partnerships through the Wills Eye Center for Academic Global Ophthalmology (CAGO). CAGO is dedicated to leadership in ophthalmology by bridging the gaps in education, research, and clinical care that exist across the globe in an effort to prevent blindness worldwide. The most effective strategy to transform eye care around the world is to support and strengthen local partners who are committed to the long and arduous task of building up eye care delivery systems for their own country.

Wills Eye is extremely fortunate to have identified dedicated international ophthalmologists and organizations who are up to this challenge:

- Haitian University Eye Hospital, Port au Prince, Haiti
- Himalayan Cataract Project
- Kabgayi Eye Hospital, Rwanda
- Kibuye Hope Hospital, Burundi
- LV Prasad Eye Institute, India
- Project Orbis
- Rwanda International Institute of Ophthalmology (RIIO)
- Global Eye Project, Fonds-des-Blancs, Haiti
- Southern Eye Clinic, Serabu, Sierra LeoneSurgical Eye Expedition (SEE) International Tenwek Hospital, Kenya
- Vision Plus Clinique, Cap-Haitien, Haiti

Impact of Prior Community Health Needs Assessment and Implementation

The following vision health needs of children and adults in underserved areas of Philadelphia were identified based on the results of the 2022 CHNA in order of priority:

1. Low awareness of vision threatening conditions and associated risk factors and the importance of routine eye exams
2. Creating a sustainable model for vision screenings and adherence to follow-up care in community centers in underserved areas
3. Routine pediatric vision screenings in children under 17 and low adherence to obtain glasses or follow-up care with a pediatric ophthalmologist
4. Lack of city-specific data on eye and vision health for residents of Philadelphia

Many of these needs were not unexpected and are being addressed by some of our existing programs.

- The **Wills Eye Vision Screening Program for Children** is a crucial initiative that provides vision screenings to K-5 students in urban Philadelphia schools, assessing visual acuity and color vision to enhance student vision through eyeglass prescriptions and referrals to pediatric ophthalmology at Wills Eye Hospital. Early detection of vision problems is vital for academic success, making this program essential for students in need.
- Wills Eye is dedicated to raising awareness and improving healthcare access for marginalized communities through initiatives like the annual "**Give Kids Sight Day**," which offers free eye screenings to up to 1,000 children each year. Supported by over 500 volunteers, this event has provided free eye care to more than 12,000 children since 2009.

Additionally, several new initiatives were started to raise awareness of vision threatening diseases such as diabetic eye disease by screening high risk patients, educating patients on preventive care and risk factors and connecting patients with appropriate follow up care.

- Established "**Wills Eye on Diabetes Day**", a one-day, annual event for diabetics in the community to be screened for diabetic eye disease at no cost. This day will also be used to educate diabetics on healthy living, provide resources for insurance, and preventive care. Free follow up care will be offered to patients who don't have insurance and test positive for eye disease. In 2024, our program was shared with Scheie Eye Institute at the University of Pennsylvania Health System and Temple University Hospital and they held their own events simultaneously, and increased the access to care by offering other locations and more physicians. In 2025, we hope to expand to additional hospitals and centers to help more patients receive the care they need.
- Educate the next generation about the importance of the field of ophthalmology and eye and vision care by working with adolescent mentoring programs or job fairs and exposing adolescents to the colligate and non-colligate career opportunities in ophthalmology.
- A recently established medical clinic named the Hansjörg Wyss Wellness Center in South Philadelphia provides clinical and educational outreach to the surrounding immigrant population. Its goal is to create a full-spectrum primary care clinic with social services, wellness activities, and other community-focused programming. In late May 2021, Wills Eye formed a community clinic to provide specialized and sustainable ophthalmic services to the population served by the Wyss Wellness Center primarily composed of immigrants from SE Asia, Central and South America, West Africa, and Eastern Europe. To date, the clinic has been very successful in provisioning needed ophthalmic care to a multitude of underserved immigrant families (primarily those from South America and Southeast Asia).

Service Area Demographics

ESTIMATED POPULATION

4,203,459

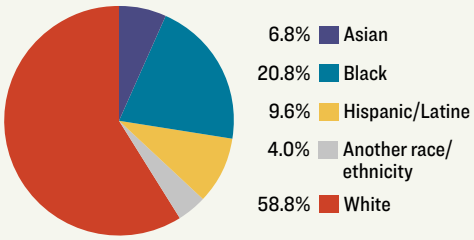
MEDIAN HOUSEHOLD INCOME

$91,123

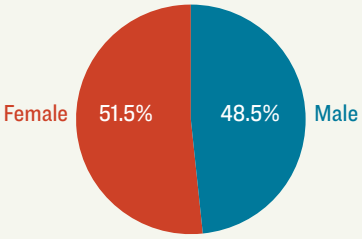
NOT FLUENT IN ENGLISH

2.5%

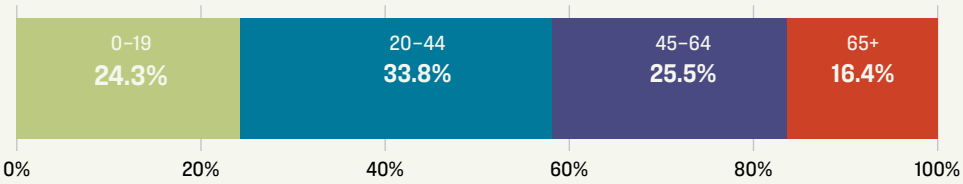
RACIAL COMPOSITION



SEX



AGE DISTRIBUTION



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Wills Eye defines our targeted service area as all the ZIP codes in the Greater Philadelphia region. Wills Eye sees patients from all 50 states and throughout the world. They also have physician offices in Paoli, PA, King of Prussia, PA, Plymouth Meeting, PA, and Rittenhouse area of Philadelphia in addition to the hospital/clinic location in Center City Philadelphia.

Partner Organizations

In addition to the participating hospitals and health systems, the organizations below provided support to the rCHNA process in significant ways – through the provision of data, offering county and community specific insight, informing plans for community engagement, hosting community conversations, community survey translation, outreach, and dissemination.

Local Health Departments

- Chester County Health Department
- Delaware County Health Department
- Montgomery County Office of Public Health
- Philadelphia Department of Public Health

Community Hubs

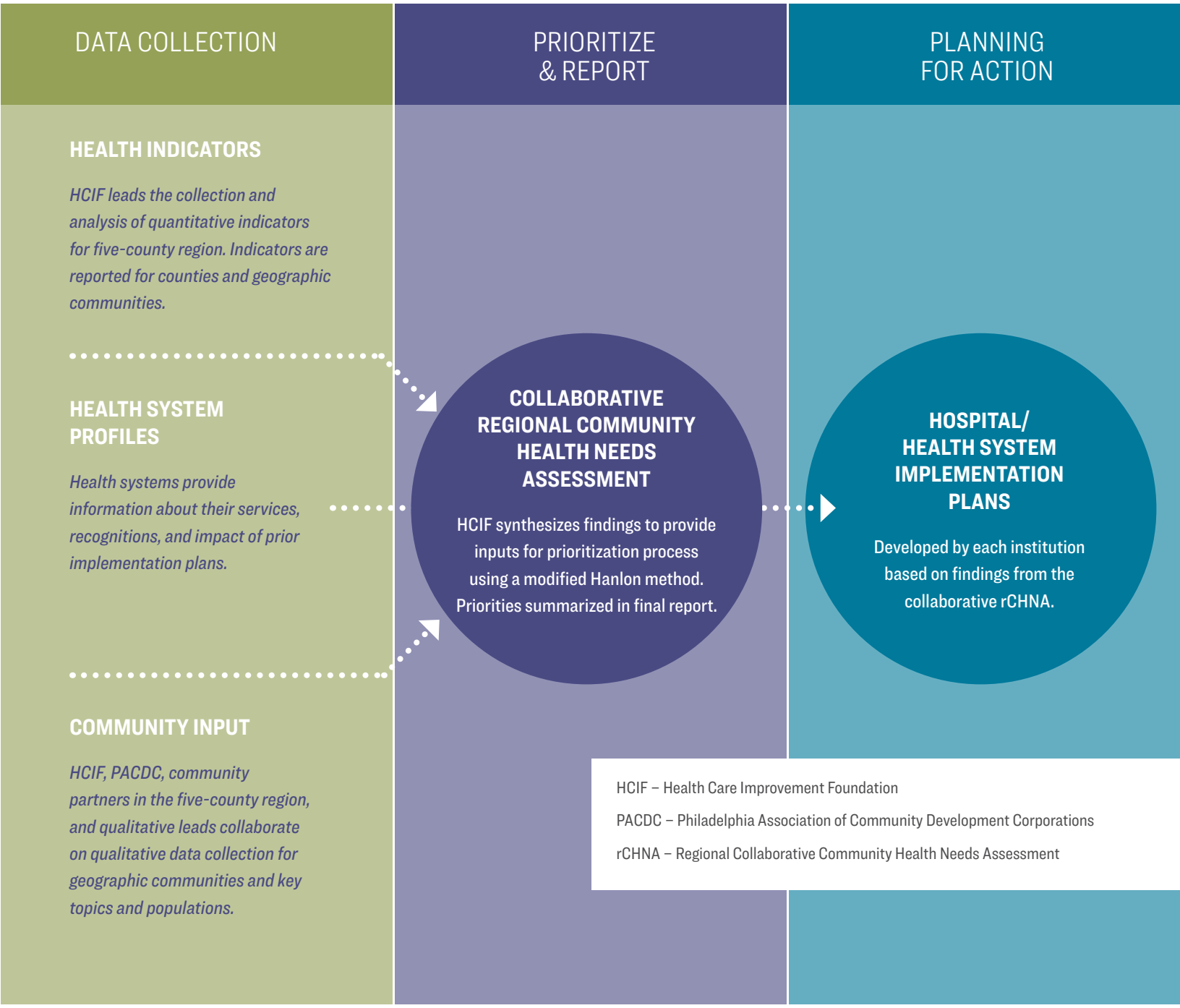
- Bucks County Health Improvement Partnership (BCHIP)
- HealthSpark Foundation
- Philadelphia Association of Community Development Corporations (PACDC)
- SEAMAAC
- The Foundation for Delaware County

Community Conversation Host Sites

- Bucks
  - Bucks County Opportunity Council
  - Family Service Association of Bucks County
  - Immigrant Rights Action
  - United Way of Bucks County
  - YWCA Bucks County
- Chester
  - Brandywine Valley Active Aging
  - Charles A. Melton Center
  - Honey Brook Food Pantry
  - The Garage Community and Youth Center
  - United Way of Southern Chester County
- Delaware
  - ChesPenn Health Services
  - Middletown Free Library
  - Multicultural Community Family Services
  - The Helen Kate Furness Free Library
  - Wayne Senior Center
- Montgomery
  - Abington Township Public Library
  - Bethel Deliverance International Church
  - George Washington Carver Community Center
  - Lansdale Area Family YMCA
- Philadelphia
  - ACHIEVEability
  - Awbury Arboretum
  - Congregation Temple Beth 'El
  - Esperanza College of Eastern University
  - Friends Center
  - Greener Partners
  - Netter Center for Community Partnerships
  - New Kensington Community Development Corporation
  - Northeast Family YMCA
  - Paseo Verde South
  - Philadelphia Association of Community Development Corporations
  - Philadelphia Chinatown Development Corporation
  - Southwest Community Development Corporation
  - Tacony Mayfair Sons of Italy

Our Collaborative Approach

Hospitals/health systems and supporting partners collaboratively developed the community health needs assessment process and report to identify regional health priorities and issues specific to each participating institution's service area. Based on these priorities and issues, hospitals/health systems produce independent implementation plans to respond to unmet health needs. These plans may involve further collaboration or coordination to address shared priorities.



HCIF – Health Care Improvement Foundation

PACDC – Philadelphia Association of Community Development Corporations

rCHNA – Regional Collaborative Community Health Needs Assessment

GOVERNANCE

A Steering Committee, composed of representatives from participating hospitals/health systems and supporting partner organizations, guided the development of the rCHNA. The Steering Committee met regularly to plan, provide feedback, and reach consensus on key decisions about approaches and strategies related to data collection, interpretation, and prioritization. Staff from the Health Care Improvement Foundation (HCIF) and Philadelphia Association of Community Development Corporations (PACDC) comprised the project team.

Steering Committee Representatives

Name	Title	Institution
Jeanne Franklin, MPH, PMP	Public Health Director	Chester County Health Department
Falguni Patel, MPH	Director, Community Impact	Children's Hospital of Philadelphia
Kathleen Lane, MPH	Associate Director, Government Affairs	Children's Hospital of Philadelphia
Sarah Ingerman, MSW	Policy Manager	Children's Hospital of Philadelphia
Katie W. Coombes	Community Benefit Program Manager	ChristianaCare
Erin Booker	Chief Biopsychosocial Officer	ChristianaCare
Jacqueline Ortiz, M.Phil.	VP Health Equity and Cultural Competence	ChristianaCare
Pauline M. Corso	Regional Executive Director SEPA	ChristianaCare
Rosemarie Halt, MPH	President	Delaware County Board of Health
Monica Taylor, PhD, MS	Vice Chair	Delaware County Council
Kellye Remshifski, MS, CHES, NBH-HWC	Director of Community Health & Wellness	Doylestown Health
Laura Steigerwalt	Senior Director of Human Resources	Doylestown Health
Millie Johnson, CHES*	Education Outreach Liaison	Doylestown Health
Joanne Craig	Chief Impact Officer	Foundation for Delaware County
Jill Laudenslager	Vice President and Chief Nursing Officer (CNO)	Grand View Health
Wendy Kaiser	Director of Marketing and Communications	Grand View Health
Cassidy Tarullo Burrell, MPP	Project Manager	Health Care Improvement Foundation
Kelly Rand, MA CPH	Senior Director, Community Health and Impact	Health Care Improvement Foundation
Lauren Eckel, MPH, CHES	Project Manager	Health Care Improvement Foundation
Meghan Smith, MPH	Senior Project Manager	Health Care Improvement Foundation
Sehrish Rashid, MPH, MA	Senior Project Manager	Health Care Improvement Foundation
Abigail O. Akande, PhD, CRC	Qualitative Consultant	Health Care Improvement Foundation
David Martin, PhD	Quantitative Consultant	Health Care Improvement Foundation
Dani Perra, MPH	Program Manager, Community Health Benefits & Engagement, Jefferson Collaborative for Health Equity	Jefferson Health
U. Tara Hayden, MHSA	Vice President, Community Health Equity, Jefferson Collaborative for Health Equity	Jefferson Health
Katie Farrell	Chief Administrative Officer	Jefferson Health (Abington – Lansdale)
Sue Smith Lamar, M Ed., RN	Ambulatory Nurse Manager, Community Health	Jefferson Health (Abington – Lansdale)
Brandi Chawaga, M.Ed.	Director, Community Wellness	Jefferson Health (Einstein Montgomery)
Joan Boyce	Senior Director, Government Relations & Public Affairs	Jefferson Health (Einstein Philadelphia)

Name	Title	Institution
Tricia Nichols MSN, RN, NEA-BC, CPXP	Patient Experience Director	Jefferson Health (North)
Debbie Mantegna, MSN, RN	System Director, Community Health & Outreach	Main Line Health
Debbie McKetta, MS, CLSSGB	System Director, Diversity, Respect & Inclusion (DRI)	Main Line Health
K.C. Maskell	Director, Strategy & Business Development	Main Line Health
Rosangely Cruz-Rojas, DrPH	VP and Chief Diversity & Equity Officer	Main Line Health
Feba Cheriyan, MPH	Epidemiology Research Associate	Montgomery County Office of Public Health
Ruth Cole, RN, MPH	Director, Division of Clinical Services	Montgomery County Office of Public Health
Ajeenah Amir	Director of Civic Engagement and Community Partnerships	Penn Medicine
Courtney Summers, MSW	Administrator, Division of Community Health	Penn Medicine
Heather Klusaritz, PhD, MSW	Chief, Division of Community Health Department of Family Medicine and Community Health	Penn Medicine
Kristen Molloy	Corporate Director, Government and Community Relations	Penn Medicine
Laura Kim	Associate Director, Community Relations	Penn Medicine
Rose Thomas, MPH, CHES	Director of Operations, Center for Health Equity Advancement and Program for LGBTQ+ Health	Penn Medicine
Chad Thomas, MPH, PMP	Community Health Education Coordinator	Penn Medicine (Chester County Hospital)
Michele Francis, MS, RD, CDCES, LDN	Director, Community Health & Wellness Services	Penn Medicine (Chester County Hospital)
Garrett O'Dwyer, MPH	Associate Policy Director	Philadelphia Association of Community Development Corporations
Frank Franklin, PhD, JD, MPH	Deputy Health Commissioner	Philadelphia Department of Public Health
Megan Todd, PhD	Chief Epidemiologist	Philadelphia Department of Public Health
Claire Alminde, MSN, RN, CPN, NEA-BC	Chief Nursing Officer	St. Christopher's Hospital for Children
Ed Bleacher II, MBA, CHFP, CRCR, FHFMA	Chief Financial Officer	St. Christopher's Hospital for Children
Joanne Ferroni	Assistant Vice Provost for Anchor Partnerships, , Office of University and Community Partnerships of Drexel University	St. Christopher's Hospital for Children
Maura Heidig	Director of Population Health	St. Christopher's Hospital for Children
Renee Turchi, MD, MPH	Pediatrician-in-Chief	St. Christopher's Hospital for Children
Lakisha Sturgis, RN, BSN, MPH, CPHQ	Director, Community Care Management, Temple Center for Population Health	Temple Health
Marybeth Taylor, MPH	Community Benefit & Special Projects Manager	Temple Health
Allison Zambon, MHS, MCHES	Program Manager, Office of Community Outreach and Engagement	Temple Health (Fox Chase Cancer Center)
Joann Dorr, RN, BSN	Regional Director, Community Health and Well-Being	Trinity Health Mid-Atlantic
Stacy Ferguson, MHSc	Regional Senior Community Benefit Director, CHWB Director South, Project Manager, The Healthy Village at Saint Francis	Trinity Health Mid-Atlantic

* Some institutions experienced staffing transitions during the year; this list represents all those who represented an entity during the rCHNA planning process.

METHODS: DATA COLLECTION AND ANALYSIS

Health Indicators

HCIF and the Steering Committee reviewed and finalized the list of quantitative health indicators. The list of indicators from the 2022 report provided a starting point, and indicators were removed and added based on the following considerations:

- **Availability of the data source.** Some indicators were not included due to discontinued data sources, lack of updated data, or inaccessibility of the data.
- **Uniqueness.** Some indicators that were redundant with other measures were removed.
- **Granularity and quality of the data.** For new indicators, those with data available at the ZIP code level for all five-county ZIP codes and for which data quality and completeness could be verified were prioritized. For some indicators of strong interest, if only county-level data were available, those estimates were included as well.
- **Current interest.** Additional indicators related to disability, housing, and youth were added to this assessment.

Data were gathered, cleaned, organized and analyzed primarily by quantitative data consultant, David Martin, PhD; University of Virginia, with support from the Pennsylvania Department of Health, Philadelphia Department of Public Health and HealthShare Exchange.

Data Collection & Analysis

Data collection began with the use of the United States Census Bureau's American Community Survey (ACS) data. This dataset provided essential demographic and population information, enabling the calculation of rates and proportions for various indicators. ACS data was particularly useful for deriving rates requiring total population values (e.g., total population, population by age group, population by race/ethnicity, etc.). Where available, estimates were collected in both absolute numbers and percentages/rates, along with accompanying measures of error, such as margins of error (MOE) and confidence intervals (CI), ensuring robust statistical backing for any subsequent analysis. Data sources were accessed between June 2024 through April 2025.

Data was gathered and analyzed at both the Zip Code Tabulation Area (ZCTA) and county levels to allow for comparisons and aggregation to the hospital service area (HSA) and geographic community area (GCA) levels. The most recent 5-year estimates were utilized (2018–2022 and 2019–2023).

Following the compilation of census data, additional indicators were sourced from the Behavioral Risk Factor Surveillance System (BRFSS), CDC/ATSDR Social Vulnerability Index, Pennsylvania Department of Health, County Health Rankings, and others. If data was missing for either the estimates or measures of variation, estimates were calculated using available data from the source and census data.

When aggregating data to HSA or GCA, indicator values were calculated with weights based on the size of the affected population in each ZIP Code (e.g., age groups such as 65+, 18-64, or total population).

Depending on the availability of the data, indicators were summarized at these levels:

- County level – For all five counties
- Geographic community level – These represent clusters of ZIP codes grouped into 46 distinct geographic communities, based on guidance from Steering Committee members. Geographic communities were developed for the 2022 assessment, with no changes made to the groupings in 2025.

Community Survey Analysis

Community survey results were analyzed to ensure all respondents were eligible due to age and provided ZIP codes included in the rCHNA service area. Survey responses were assessed for quality and completeness. One survey option was removed from reported results due to unreliable response counts: Question - "Thinking about the community where you live, how available are the following resources?", Response: Public Transportation.

For the GCA profiles, responses were aggregated into the corresponding geography based on respondents ZIP code. GCAs with fewer than 35 responses were combined with adjacent GCAs, prioritizing those with similar demographics. Combined responses are noted within the respective profile. Lastly, each survey question was examined by calculating the percentage of respondents selecting each response, ranking the top three most selected responses by percentage, and reporting those values.

Software

Data was either manually transposed in Microsoft Excel, downloaded directly from data sources websites, or gathered from the tidycensus (1.6.7) package (a product which uses the Census Bureau Data API) in R (4.4.1) and RStudio (2024.09.0). All Excel files were then merged and appended in RStudio using the tidyverse package (Version 1.3.0).

Health Indicators

This assessment features over 70 health indicators from varied data sources, aggregated at various levels. The table below presents information about the included indicators.

Indicator	Details	Year(s)	Source
ABOUT THE COMMUNITY			
Population	Total population size	2023	American Community Survey, Census Bureau (5-yr)
Age distribution by sex		2022	American Community Survey, Census Bureau (5-yr)
Race/ethnicity		2022	American Community Survey, Census Bureau (5-yr)
Educational attainment	High school as highest education level (26+ years)	2022	American Community Survey, Census Bureau (5-yr)
Income	Median household income	2022	American Community Survey, Census Bureau (5-yr)
Social Vulnerability Index	Percentile ranking of 4 socioeconomic indicators	2022	CDC/ATSDR Social Vulnerability Index
Foreign-born status	Born outside of United States	2022	American Community Survey, Census Bureau (5-yr)
Ability to speak English	Speak English less than "very well" (5+ years)	2022	American Community Survey, Census Bureau (5-yr)
Disability status	With a disability	2022	American Community Survey, Census Bureau (5-yr)
Leading causes of death	Top 5 causes	2023	Vital Statistics, PA Department of Health, County Health Rankings **
GENERAL			
All-cause mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Life expectancy by sex	Years	2022	Vital Statistics, PA Department of Health **
Years of potential life lost before 75	Years	2022	Vital Statistics, PA Department of Health **

Indicator	Details	Year(s)	Source
CHRONIC DISEASE & HEALTH BEHAVIORS			
Adult obesity prevalence	Body mass index 30-99.8 among adults 18+ years	2021	Behavioral Risk Factor Surveillance System
Diabetes prevalence	Told by a doctor that they have diabetes	2021	Behavioral Risk Factor Surveillance System
Diabetes-related hospitalization	Rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Chlamydia	Rate per 100,000	2020-2022	Pennsylvania Department of Health, Bureau of Communicable Diseases
Flu vaccinations	Adults	2021	County Health Rankings, Mapping Medicare Disparities Tool
Hypertension prevalence	Told by a doctor that they have high blood pressure	2021	Behavioral Risk Factor Surveillance System
Hypertension-related hospitalization	Rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Potentially preventable hospitalization	Rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Premature cardiovascular disease mortality	Death before 65 years, rate per 100,000	2022	Vital Statistics, PA Department of Health **
Major cancer incidence	Prostate, breast, lung, colorectal cancers; rate per 100,000	2022	Vital Statistics, PA Department of Health **
Major cancer mortality	Prostate, breast, lung, colorectal cancers; rate per 100,000	2022	Vital Statistics, PA Department of Health **
Mammography screening	Mammogram in the past 2 years among women 50-74 years	2022	Behavioral Risk Factor Surveillance System
Colorectal cancer screening	Fecal occult blood test, sigmoidoscopy, or colonoscopy among adults 50-75 years	2022	Behavioral Risk Factor Surveillance System
DISABILITIES			
Disability status	With a disability	2022	American Community Survey, Census Bureau (5-yr)
Hearing difficulty	Deaf or having serious difficulty hearing	2022	American Community Survey, Census Bureau (5-yr)
Vision difficulty	Blind or having serious difficulty seeing, even when wearing glasses	2022	American Community Survey, Census Bureau (5-yr)
Cognitive difficulty	Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions	2022	American Community Survey, Census Bureau (5-yr)
Ambulatory difficulty	Having serious difficulty walking or climbing stairs	2022	American Community Survey, Census Bureau (5-yr)
Self-care difficulty	Having difficulty bathing or dressing	2022	American Community Survey, Census Bureau (5-yr)
Independent living difficulty	Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping	2022	American Community Survey, Census Bureau (5-yr)
Poverty status	Poverty status of those with a disability in the past 12 months	2022	American Community Survey, Census Bureau (5-yr)

Indicator	Details	Year(s)	Source
INFANT & CHILD HEALTH			
Asthma hospitalization	Children <18 years, rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council * +
Infant mortality	Deaths before age 1 per 1,000 live births	2022	Vital Statistics, PA Department of Health **
Lead levels in children	>=5 µg/dL	2021	CDC
Low birthweight births	Percent low birthweight (<2,500 grams) births out of live births	2022	Vital Statistics, PA Department of Health **
Pre-term births	Percent preterm (before 37 weeks gestation) births out of live births	2022	Vital Statistics, PA Department of Health **
Child Opportunity Index	Composite score, measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development.	2021	Institute for Equity in Child Opportunity & Healthy Development at Boston University School of Social Work; diversitydatakids.org
BEHAVIORAL HEALTH			
Adult binge drinking	5+ (men) or 4+ (women) alcoholic drinks on one occasion in past 30 days	2021	Behavioral Risk Factor Surveillance System
Adult smoking	Current smoker status	2021	Behavioral Risk Factor Surveillance System
Drug overdose mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Opioid-related hospitalization	Rate per 100,000	2023	Pennsylvania Health Care Cost Containment Council *
Substance-related hospitalization	Rate per 100,000	2023	Pennsylvania Health Care Cost Containment Council *
Poor mental health (adults)	Poor mental health for 14+ days in past 30 days (adults)	2021	Behavioral Risk Factor Surveillance System
Suicide mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Youth binge drinking	5+ alcoholic drinks in a row on ≥1 days in past 30 days among teens	2023	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey
Youth ever attempted suicide	Suicide attempt ever among teens	2023	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey
Youth mental health	Depressed/sad most days or sad/hopeless almost every day 2+ weeks in past 12 months among teens	2023	Youth Risk Behavior Surveillance System, Pennsylvania Youth Survey
Youth smoking	Smoked cigarettes in past 30 days among teens	2023	Youth Risk Behavior Surveillance System
Youth vaping	Used electronic vapor products in past 30 days among teens	2023	Youth Risk Behavior Surveillance System
INJURIES			
Fall-related hospitalization	Ages <64; rate per 100,000	2021-2023	Pennsylvania Health Care Cost Containment Council *
Gun-related emergency department utilization	Rate per 100,000	2023	HealthShare Exchange
Homicide mortality	Rate per 100,000	2022	Vital Statistics, PA Department of Health **
Mortality due to gun violence	Rate per 100,000	2021	Vital Statistics, PA Department of Health **

Indicator	Details	Year(s)	Source
ACCESS TO CARE			
Health insurance (public) status - Adults	Adults 19-64 years with Medicaid	2022	American Community Survey, Census Bureau (5-yr)
Health insurance (public) status - Children	Children <19 years with public insurance	2022	American Community Survey, Census Bureau (5-yr)
Health insurance status - Population	Population without insurance	2022	American Community Survey, Census Bureau (5-yr)
Health insurance status - Children	Children <19 years without insurance	2022	American Community Survey, Census Bureau (5-yr)
High emergency department utilization	5+ visits in 12 months, rate per 100,000	2023	HealthShare Exchange
SOCIAL & ECONOMIC CONDITIONS			
Poverty status - Population	Population in poverty	2022	American Community Survey, Census Bureau (5-yr)
Poverty status - Children	Children <18 years in poverty	2022	American Community Survey, Census Bureau (5-yr)
Commute	Commute greater than 60 minutes	2022	American Community Survey, Census Bureau (5-yr)
Employment status	Adults 19-64 years unemployed (not in labor force)	2022	American Community Survey, Census Bureau (5-yr)
Food insecurity	Population experiencing food insecurity, county-level only	2022	Feeding America
Homeownership	Proportion of households that are owner-occupied	2022	American Community Survey, Census Bureau (5-yr)
Household type – older adults	Householders living alone who are 65+ years	2022	American Community Survey, Census Bureau (5-yr)
Household type – same sex couples	Same sex couple households; rate per 1,000	2022	American Community Survey, Census Bureau (5-yr)
Household type – single parent	Single parent households	2022	American Community Survey, Census Bureau (5-yr)
Households receiving food assistance	Households receiving Supplement Nutrition Assistance Program (SNAP) benefits	2022	American Community Survey, Census Bureau (5-yr)
Housing cost burden - severe	Households who spend >50% of income on housing	2022	American Community Survey, Census Bureau (5-yr)
Housing occupancy status	Vacant housing units	2022	American Community Survey, Census Bureau (5-yr)
Income Inequality	Assesses income or wealth distribution within a population	2022	American Community Survey, Census Bureau (5-yr)
Violent crime rate	Rate per 100,000	2022	PA Uniform Crime Reporting System

* Data analysis conducted by the Philadelphia Department of Public Health.

** These data were supplied by the Bureau of Health Statistics & Registries, Pennsylvania Department of Health, Harrisburg, Pennsylvania.

+ Data only available for geographic communities in Philadelphia County.

COMMUNITY INPUT

Overview

A critical complement to the quantitative data represented by the health indicators is qualitative data that capture the perspectives, priorities, and ideas of those who live, learn, work, and play in local communities. Building on the qualitative data collection approach developed for the 2019 and 2022 rCHNA, the Steering Committee and project team sought to expand, enhance, and refine strategies to thoughtfully gather and incorporate community input into the 2025 rCHNA. A subset of the Steering Committee, as well as several additional representatives from participating health systems, formed a Qualitative Team to guide the planning process. HCIF also engaged an expert in qualitative data collection and analysis as a consultant to serve as Qualitative Lead, Abigail Akande, PhD; Penn State - Abington College, as well as a trained youth facilitator, Briana Bronstein, PhD; Widener University.

Recognizing that no single data collection effort could comprehensively reflect the unique experiences and specific needs of all communities in the region, the approach was grounded in mixed methods which incorporated focus group discussions, interviews, surveys, and a wide array of secondary sources. The core of the primary data collection process again focused on hearing from community residents and staff from local organizations who serve these communities, as well as more closely examining particular topics and populations. However, several changes were made in order to accommodate situational realities, as well as increase the depth and breadth of coverage:

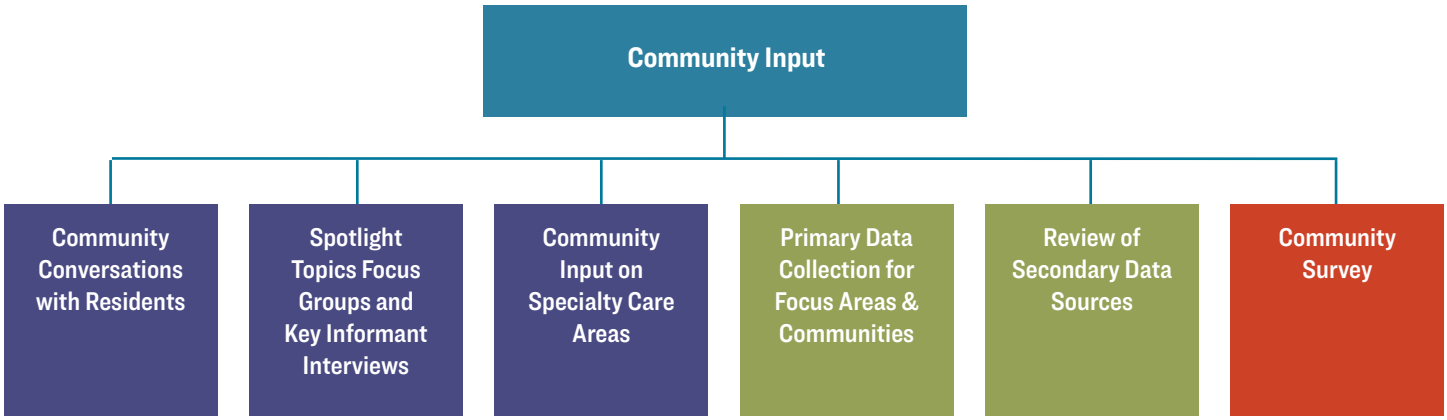
- Primary data collection was undertaken by the project team June 2024 – April 2025. To offer the greatest level of accessibility, both in person and virtual sessions were held in each county.
- Focus group-style, 90-minute "community conversations" were held to gather input from residents of the region. Building on the trust built through prior rCHNAs, the team used a "trusted messenger" approach. The Steering Committee guided the selection of community-based organizations reaching important populations within the region. The identified organizations were then compensated with a small stipend for their help with the recruitment of eight to ten individuals. The organizations were also provided with organizationally specific write ups of qualitative data and geographic information from the community survey for use in evaluation and grant efforts. The number of conversations increased to 30: Bucks (5), Chester (4), Delaware (5), Montgomery (4), and Philadelphia (12). This method also increased engagement and diversity of participants.
- To capture the insights of those who provide important health, human, and social services in each of the counties, 60-minute group discussions centered on "spotlight" topics were conducted with organization and local government agency representatives. A list of topics was generated by the Steering Committee based on priorities from past CHNAs. Spotlights were divided into two categories – Care and Community. Two meetings were held in each county concurrently except for Montgomery County where only one meeting was held. An additional 15 key informant interviews were held with community-based organization leaders and subject matter experts. Additional questions were asked to each group on community-based organizations capacity to handle the increase in social needs screening occurring due to new federal requirements. A special session with new mothers and expecting mothers was held to better understand the community perspective on maternal health.

SPOTLIGHT TOPICS

Care	Community Issues
Maternal Health	Housing
Older Adults and Aging in Place	Better Integration of Health and Social Services in the Community
Caring for Uninsured and Undocumented Individuals	Increase Community Member Capacity to Serve as Care Navigators
Culturally Appropriate Mental Health	Involve Community in Solutions and Implementation
Primary Care Access	Preventative Care and Education in the Community

- The project team either undertook directly or supported partners with targeted primary data collection to better understand the needs of particular communities or populations. These focus areas and communities were specific to different types of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) and other areas identified by the steering committee:
  - **Cancer:** In addition to cancer-related information gathered from community conversation and spotlight discussions described above, partner cancer center board members they conducted.
  - **Disability:** HCIF worked with a subcommittee of rehabilitation facilities to develop and administer an online survey of people with disabilities and held three focus groups with individuals living with disabilities.
  - **Older Adults:** New to the rCHNA in 2025, HCIF thematically analyzed the community conversations held in senior centers and communities as well as the community conversations. Responses from adults over 65 were extracted from a larger dataset of the general population to better identify their specific needs and were compared with broader community trends.
  - **Vision:** New to the rCHNA in 2025, HCIF staff held three community conversations with people specifically focused on vision care. Support for the qualitative guide came from the Wills Eye hospital.
  - **Youth Voice:** In the 2025 round, HCIF staff again used the trusted partner approach and provided a small stipend to youth serving organizations to help with recruitment. Additionally, a trained youth facilitator led each of the 15 conversations.
- Secondary data in the form of reports and summaries from other community engagement efforts were important inputs for this report. A full list of sources incorporated is included in the "Resources" section.
- Community Survey: As part of this assessment, an additional quantitative component was incorporated to complement community input, providing a more comprehensive picture of local health needs and priorities. HCIF, in collaboration with hospital systems and community-based organizations (CBOs), conducted a general population survey consisting of six core questions along with demographic information to ensure broad representation across all counties. To enhance accessibility and inclusivity, the survey was administered in English and seven additional languages. The data collected was then analyzed at both the county and sub-geographic levels, allowing for a deeper understanding of the diverse experiences and needs of different communities.

The graphic below summarizes the major components of community input for the assessment:



QUALITATIVE DATA COLLECTION AND ANALYSIS

The Qualitative Team guided the development of discussion guides (see online Appendix) for both the community conversations and the spotlight discussions. These were adapted from those used for the 2022 rCHNA and included questions addressing community assets; community health challenges and barriers (including those related to social determinants of health, access to care, COVID-19); specific needs of older adults, children and youth, and additional underrepresented groups; and potential solutions for particular needs.

Values guiding participant engagement included respecting community members' time and expertise (one expression of this was providing community members with $25 Visa gift cards for their participation) and ensuring that voices of minoritized communities were well-represented in the discussions. With these values in mind, Steering Committee members contributed suggestions of partner organizations for outreach (to participate in meetings themselves or assist with community member engagement), which were organized into a centralized partner database. HCIF conducted outreach based on this database, researched additional organizations, and employed a snowball technique to elicit other potential partners for Town Hall meetings, which were larger gatherings held for the entire county and in some Philadelphia meetings. However, for most Philadelphia-based meetings, a trusted messenger approach was prioritized. This approach involved partnering with embedded community organizations to engage participants who might not typically attend such meetings.

When meetings were held in person, they took place in trusted community venues, ensuring accessibility and cultural relevance. Culturally appropriate food was provided, and incentives were offered not only to individual participants but also to the hosting venues. This strategy enabled engagement in settings such as YMCAs, food pantries, homeless shelters, and other spaces serving minoritized populations, fostering a more inclusive and participatory process.

To promote these discussions, Steering Committee members, PACDC, partner organizations, and HCIF utilized varied outreach methods, including phone and email outreach, social media posts, intranet outreach, listserv posts, and community flyer distribution. The Qualitative Lead facilitated all community conversations and the Maternal Health conversation, with technical support provided by the HCIF team. These discussions were recorded and transcribed for later analysis, with access to the recordings and transcripts limited to the project team and the Qualitative Lead. Transcripts were imported as Word documents into NVivo software to manage, code, and interpret qualitative data.

The Qualitative Lead consultant identified recurrent themes from these transcripts, created a set of codes, coded for these themes, and generated summaries featuring themes and accompanying quotes. To ensure confidentiality, participants were assigned numbers in the transcripts to replace names, and care was taken to avoid disclosing any individual's identity in the summaries. Participant quotes are presented verbatim to preserve authenticity and reflect the diverse ways participants express their experiences and perspectives. While Philadelphia's individual meetings are represented in the full report, Bucks, Chester, Delaware, and Montgomery's discussions were analyzed at a county level. Individual write ups of the conversations held in those counties can be found in the appendix.

For Spotlight and Focus Area discussions, transcripts were also coded using deductive coding based on the qualitative guides. Coding teams, made up of HCIF masters or doctorly prepared staff, met regularly to ensure agreement on codes, and summaries were generated featuring key themes and illustrative quotes.

Based on the coding, consultants identified significant overlap in common themes across geographic communities and spotlight topics. To minimize redundancy and ensure summaries were based on an adequate sample size, the Qualitative Leads developed the following summary structure for inclusion in the report:

- **Geographic Communities** – County-level summaries for Bucks, Chester, Delaware, and Montgomery Counties, as well as five summaries for distinct geographic sections of Philadelphia County (individual summaries for each of the 26 Community Conversations are available in the online Appendix).
- **Spotlight Topics** – Aggregated topic summaries across counties.

Summaries are organized around key sections of the discussion guide. Within each section, themes are generally presented in order of greatest frequency of mention. However, in some cases, related topics are grouped together for clarity and coherence. The themes are accompanied by illustrative quotes to capture participants' voices as authentically as possible.

DETERMINING AND PRIORITIZING COMMUNITY HEALTH NEEDS

Top priorities gathered in the general community conversations, youth conversations and extrapolated from the general population survey were aggregated by HCIF staff and presented to the Steering Committee for voting on how best to group concerns. This grouping exercise led to 12 general population priorities and 8 youth focused priorities, representing three categories: health issues, access and quality of healthcare and health resources, and community factors.

Once the grouping process was completed, the Steering Committee used the Hanlon Method to prioritize the categories. The Hanlon Method is a structured and systematic approach widely used in public health to prioritize community health needs based on severity, impact, feasibility, and resource availability. Below is a detailed account of the process used to implement the Hanlon Method for prioritization in this assessment.

The first step involved identifying and listing key community health priorities. These priorities were determined through extensive engagement with community members via live meetings and a community needs survey. The resulting priority list was recorded in Column A of the assessment spreadsheet.

To understand the extent of each health issue, we assessed the proportion of the population affected by each identified priority. A quantitative consultant provided statistical data, which was used to populate Column B. The detailed data sources and calculations were available to health systems for reference. This step involved evaluating how serious each identified issue is for the population served by the health system. The assessment was conducted on a 0 to 10 scale, where 0 represents a minimally serious issue, 5 represents moderate seriousness, and 10 represents the most serious health concerns. The ratings were entered in Column C of the assessment tool. This rating process helped determine the urgency and potential health impact of each problem.

Priorities Identified by the Community	**Magnitude or extent of the problem for the population** *Magnitude of health priority based on size of population(s) impacted - from 0 - 5 based on % of population affected by the problem*	**Seriousness** *Is the problem considered serious? 0-10*	**Effectiveness** *Can the problem be easily solved?*	**Pertinence** *Is it relevant to intervene in the problem; is the intervention approprate*	**Economic Feasibility** *Is there economic feasibilty for the intervention?*	**Acceptibility** *Does the community accept/ want an intervention in the problem?*	**Resources** *Are there resources available for the intervention?*	**Legality** *Does the law allow the intervention?*
	5 – Greater than 40%	0 – Not at all serious	0.5 – Problem is very difficult to solve	0 – It is **NOT** relevant to intervene	0 – There are **NO** resources or resources can **NOT** be found to address the issue	0 – The community **does not** want hospitals and health systems to take action on this issue	0 – There are **NO** resources to address this issue	0 – The intervention is **NOT** legal
	4 – 30-39.9%	5 – Moderately serious	1 – Problem needs moderate effort to solve	1 – It is relevant to intervene	1 – There are resources or resources can be found to address the issue	0 – The community wants hospitals and health systems to take action on this issue	1 – There are available resources to address this issue	1 – The intervention is legal
	3 – 20-39.9%	10– Most serious	1.5 – Problem has an easy solution					
	2 – 10-19.9%							
	1 – 1-9.9%							
	0 – <1%							
ADULT								
Access to Primary and Specialty Care	**3**							
Mental Heath Access	**3**							
Trust and Communication	**5**							
Healthcare Resources Navigation	**4**							
Food Access	**1**							
Neighborhood Conditions	**1**							
Healthy Aging	**2**							
Housing	**2**							
Chronic Disease Prevention & Management	**4**							
Culturally & Linguistically Appropriate Services	**1**							
Substance Use and Related Disorders	**2**							
Racisim and Discrimination in Healthcare	**5**							
YOUTH								
Youth Mental Health	**4**							
Activities for Youth	**1**							
Substance Use and Related Disorders	**1**							
Access to Good Schools	**2**							
Lack of Resources/ Knowledge of Resources	**2**							
Gun Violence	**1**							
Access to Physical Activity	**1**							
Bullying	**2**							

An essential component of the Hanlon Method is assessing the feasibility of addressing each issue. In this step, we evaluated the level of difficulty in implementing solutions for each problem. Using a predetermined scale:

- 0.5 was assigned if the problem is very difficult to solve.
- 1 was assigned if the problem requires moderate effort to solve.
- 1.5 was assigned if the problem has an easy solution.

These ratings were recorded in Column D to reflect the complexity of addressing each issue.

To further refine our prioritization, we performed a PEARL assessment, which considers the following feasibility factors:

Propriety: Is intervention appropriate and relevant?

Economics: Is there economic feasibility or financial support?

Acceptability: Will the community accept and engage with the intervention?

Resources: Are sufficient resources (funding, staffing, infrastructure) available?

Legality: Can the intervention be legally implemented?

Each factor was rated as 0 (No) or 1 (Yes) and documented in Columns E through I to determine the feasibility of each intervention. This assessment ensured that selected priorities were not only urgent but also actionable.

With all relevant data entered, the final score for each health priority was calculated using an embedded formula. This final step provided a ranked list of community health needs based on magnitude, severity, feasibility, and potential for intervention. The scoring process ensured that decision-makers had a clear, evidence-based understanding of the most pressing and actionable health issues in the community. Those scores were then aggregated and shared back with the Steering Committee with their ranking and standard deviation.

The Hanlon Method provided a transparent and data-driven approach to prioritizing community health needs in the 2025 rCHNA. By integrating quantitative data, expert assessments, and community perspectives, this approach facilitated an equitable and strategic prioritization process. The final prioritized list will guide the allocation of resources, program development, and policy initiatives to address the most significant health challenges in the region.

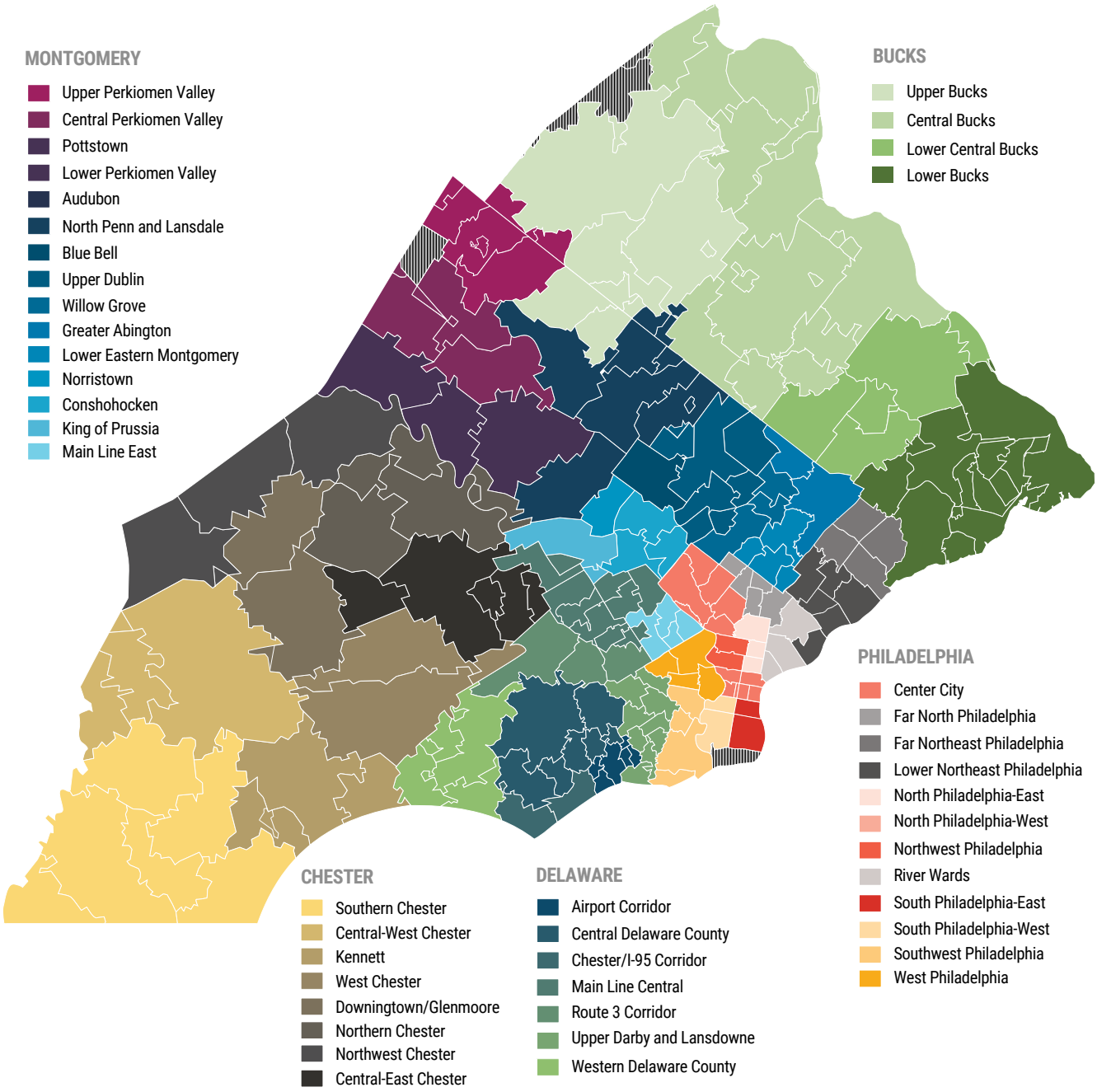
This structured prioritization process ensures that health interventions are both impactful and feasible, ultimately improving health outcomes for the communities served by the regional health system.

FINAL REPORT

- The final CHNA report was drafted by the HCIF team and presented to the hospital/health systems for review and revision.
- This report was presented and approved by the Board of Directors of each hospital/health system.

About the Service Area

The overall service area includes Bucks, Chester, Delaware, Montgomery, and Philadelphia and represents a diverse population of 4,206,741. All ZIP codes in the five counties were grouped into 46 distinct geographic communities, as shown below. In the next section, each quantitative county profile is followed by relevant summaries of qualitative data collected through geographic community conversations in that county, as well as quantitative profiles of the geographic communities within each county.



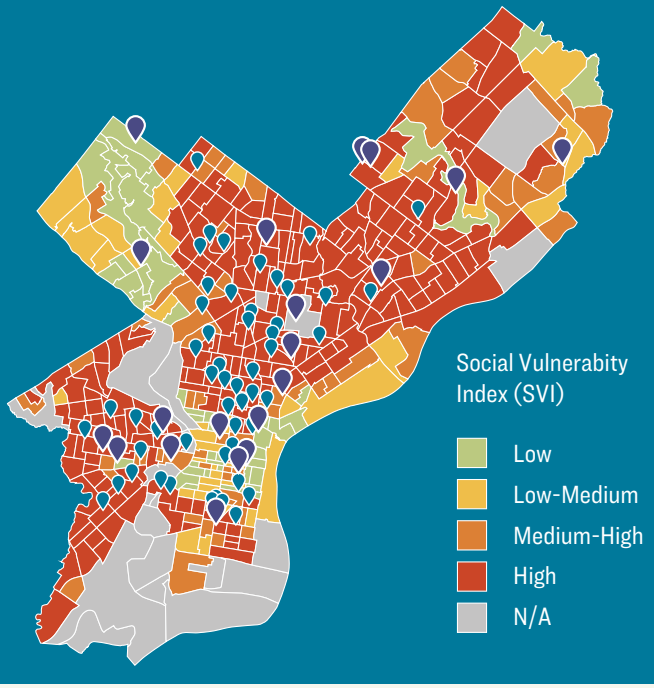
Philadelphia County

SOCIAL VULNERABILITY INDEX (SVI)*

*SVI is a measure developed by the CDC to identify communities that may need support before, during, or after disasters. This measure is made up of a combination of 16 different U.S. Census variables, which are grouped into four themes (socioeconomic status, household charateristics, racial & ethnic minority status, and housing type & transportation), and cover major areas of social vulnerability.

HOSPITAL HEALTH CENTER

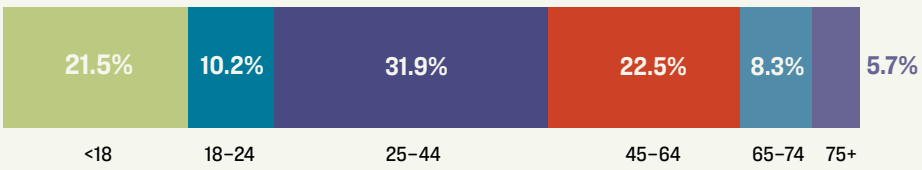
There are 21 hospitals and 23 health centers in Philadelphia County.



Demographics

AGE DISTRIBUTION

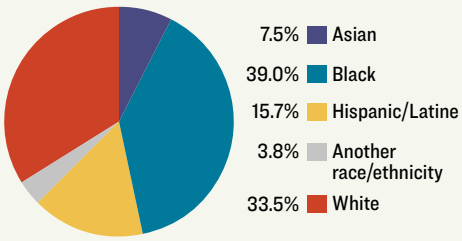
Philadelphia County has an estimated population of 1,582,432 with the largest proportion of residents between the ages of 25 - 44.



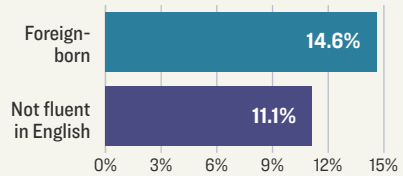
SEX

RACE/ETHNICITY/LANGUAGE

39% of residents are non-Hispanic Black. Non-Hispanic White residents make the next largest population, comprising 34% of the county's residents.



Nearly 15% of residents are foreign-born and about 11% speak English less than "very well."



HOUSEHOLDS

Median Household Income
$57,537

Homeownership
52.0%

Severe Housing Cost Burden
% spending >50% of household income
21.0%

High School as Highest Education
30.3%

Household Food Insecurity
15.2%

Single Parent Households
48.0%

Same Sex Couples
per 1,000 households
6.0

Commute Greater than 60 minutes
13.3%

Philadelphia County

Health

LEADING CAUSES OF DEATH- All Ages

1	Heart Disease
2	Cancer
3	Accidents
4	COVID-19
5	Cerebrovascular Diseases

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

13.2%

Depressed/Sad Most Days in the Past 12 Months

46.0%

Binge Drinking

9.6%

Cigarette Smoking

8.0%

Vaping

37.5%

Exposure

Lead Levels in Children (<16 years old)

5.6%

PEOPLE WITH DISABILITIES

Percent of Population

16.8%

Poverty Status in the Past 12 Months

39.0%

Percent who have difficulty with:

Hearing	3.1%
Vision	3.6%
Cognition	7.8%
Ambulatory	8.8%
Self-care	3.9%
Independent Living	6.9%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

31.3

Violent Crime Rate per 100,000

1,047.3

Gun-related ED Utilization per 100,000

34.7

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

2,111.9

This measure reflects limited access to primary care as individuals may rely on emergency departments non-emergency health needs due to barriers like insurance, trust, clinician shortages, etc.

Flu Vaccinations (Adult)

47.0%

This measure is a strong indicator of overall community vaccination levels because they reflect access to healthcare, public trust in vaccines, and the effectiveness of outreach efforts in promoting immunization.

Chlamydia per 100,000

1,082.5

This measure is a good marker for STIs in a community because it is the most commonly reported bacterial infection, often asymptomatic, and indicates the overall level of STI transmission, screening, and prevention efforts in a population.

Income Inequality

0.44

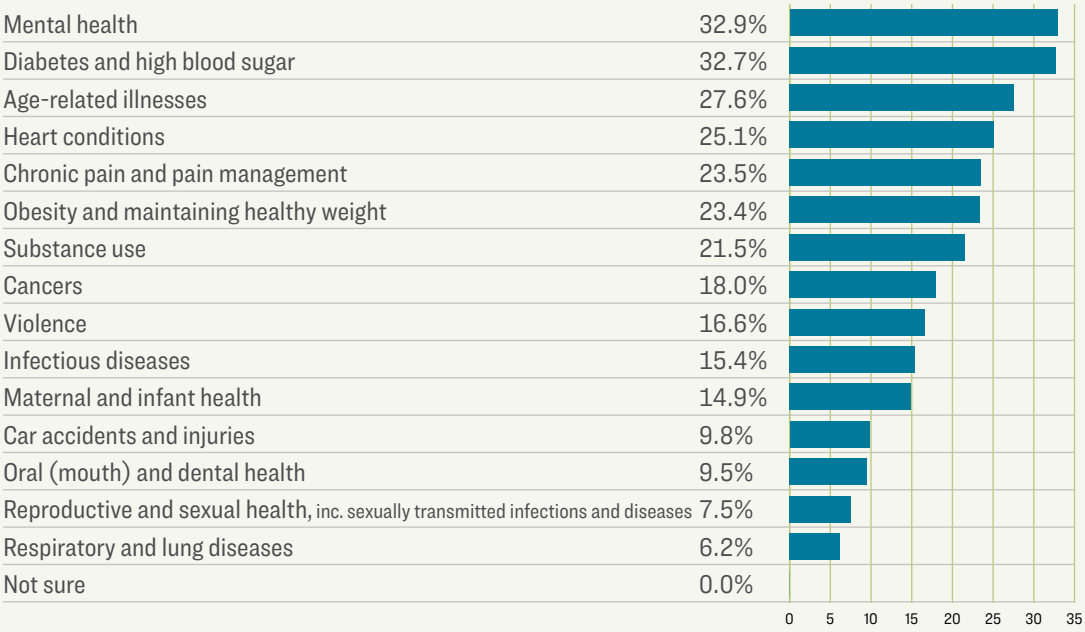
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Philadelphia County

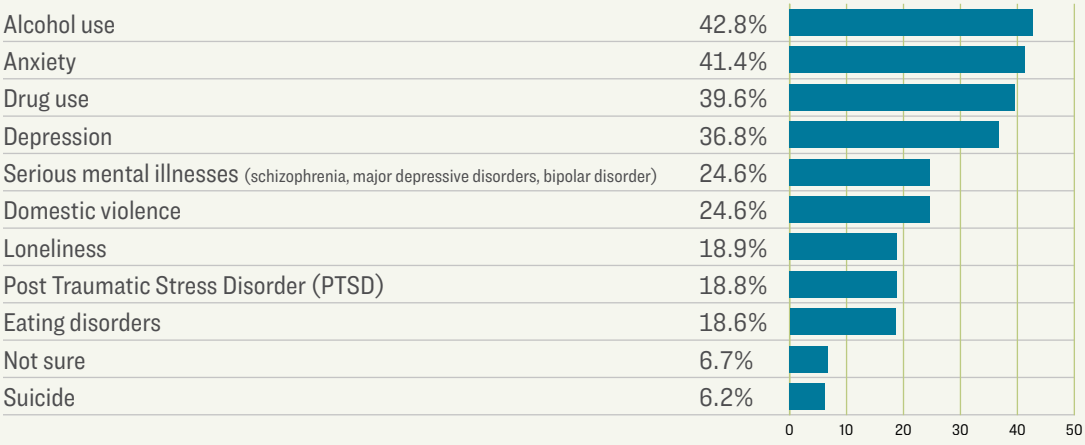
County Survey Results

Number of Respondents: 1,347

Thinking about yourself or other ADULTS in the community where you live, what are the top 3 HEALTH problems?



Thinking about yourself or other ADULTS in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

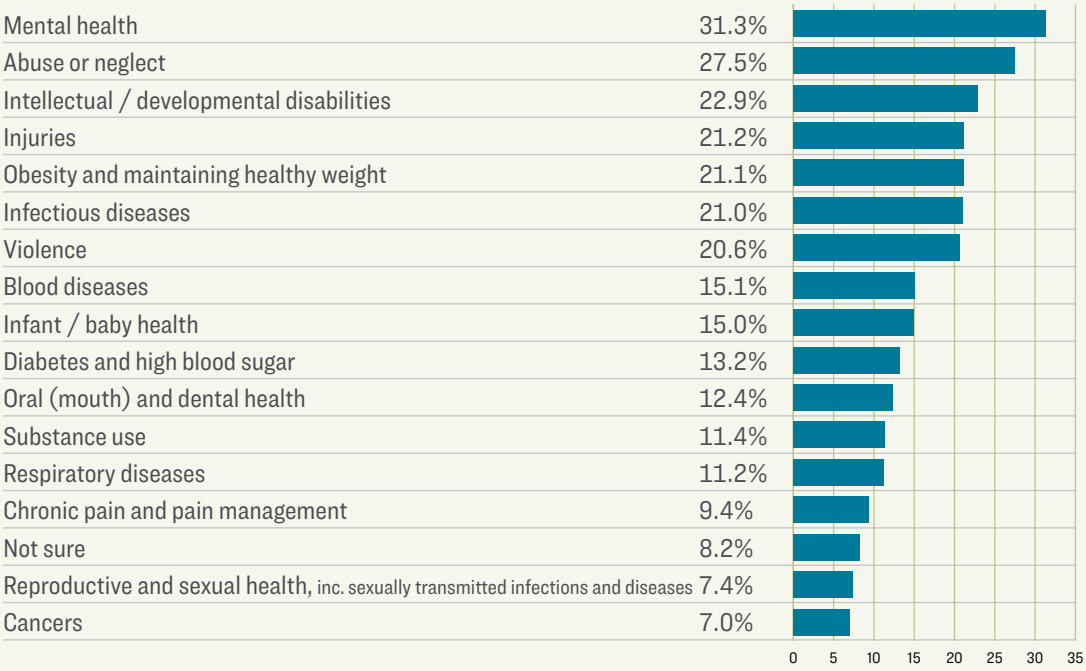


Philadelphia County

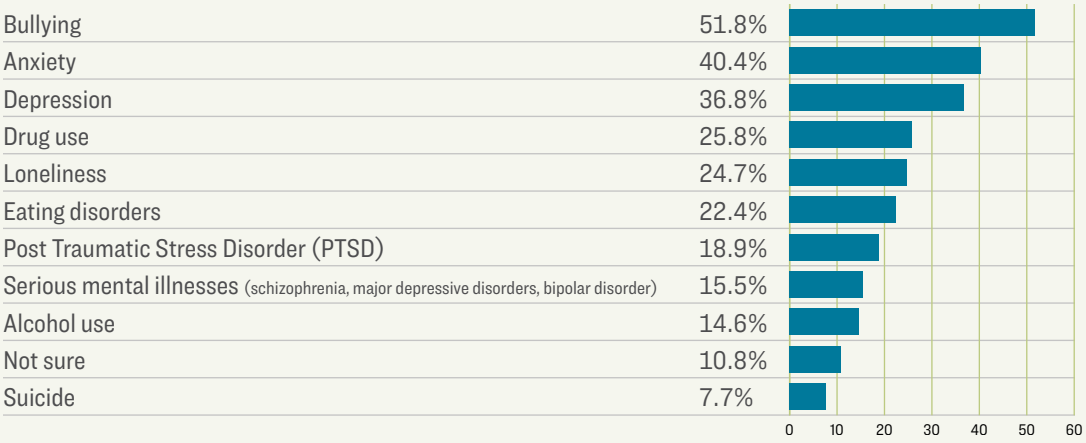
County Survey Results

Number of Respondents: 1,347

Thinking about your or other CHILDREN in the community where you live, what are the top 3 HEALTH problems?



Thinking about your or other CHILDREN in the community where you live, what are the top 3 MENTAL HEALTH and SUBSTANCE USE problems?

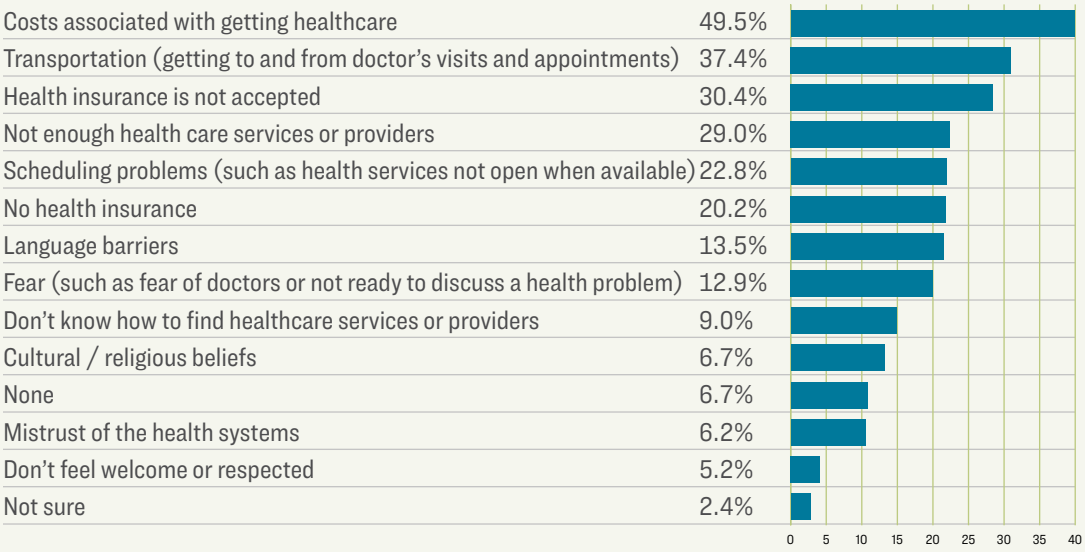


Philadelphia County

County Survey Results

Number of Respondents: 1,347

Thinking about the community where you live, which barriers prevent access to health care? (Select all that apply)



Thinking about the community where you live, how available are the following resources?

	Never Available	Rarely	Sometimes	Often	Always Available	Not Sure
Affordable healthy foods	4.2%	17.0%	31.0%	25.5%	18.5%	3.9%
Affordable housing	8.8%	23.6%	29.3%	19.8%	13.6%	5.1%
Clean outdoor environment	5.5%	18.2%	28.5%	26.9%	17.3%	3.6%
Good paying jobs	6.2%	17.9%	30.5%	26.0%	13.5%	5.9%
Good schools	3.4%	16.1%	28.8%	24.9%	20.9%	5.9%
Health care services	1.7%	6.5%	25.2%	34.2%	28.7%	3.8%
Mental health services	3.3%	18.6%	26.0%	25.8%	17.9%	8.5%
Places to be active such as parks	2.6%	10.0%	27.0%	27.8%	29.5%	3.1%
Safe neighborhood	2.9%	6.2%	20.9%	31.3%	35.2%	3.5%
Services that support people as they age	2.5%	11.1%	26.6%	26.4%	23.3%	10.2%
Substance use services	5.2%	15.1%	23.2%	26.1%	17.4%	13.1%

Philadelphia County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

Overall health, wellness, and physical activity were greatly attributed to the presence of parks, trees, and playgrounds. Recreation centers, gyms, fitness classes, and free health workshops improved quality of life, when made available.

ON GREEN SPACE AND RECREATION

"They're like walking groups... To like foster community for people that may be new, or... trying to live a healthier lifestyle and I noticed a couple of years ago that we didn't have anything like that in my area."

"The library near me offers nutrition workshops at times, or workshops that touch on health and wellness."

"Since I've been home like 2 months I've been trying to go on as many of the walks in different parks."

"I'm part of the CDC [community development corporation], they're offering free yoga and free Pilates classes."

FOOD RESOURCES

Community members noted the significance of food banks, community gardens, and community refrigerators. These resources increased access to produce and horticultural education.

ON FOOD RESOURCES

"I got five bags of spinach, they had unlimited corn. So, we got about eight [things] of corn and peppers. Tomatoes on the vine. I never buy tomatoes on the vine because they're expensive in the supermarket. And since that has been going on, and me and my family have been eating a lot healthy again."

"They have fresh vegetables and canned goods, meats, sometimes drinks, they get fruit cups. It's helpful for the community but not just there, there's other areas where they have food banks around."

A SENSE OF COMMUNITY

Camaraderie among neighbors was important for social support. Senior centers, generations of families within neighborhoods, and immigrant communities facilitated relationships.

ON A SENSE OF COMMUNITY

"I like their friendliness. People are friendly and friendly environment where everybody kind of happy."

"If I don't go to church, I don't feel good. But I'm very happy that every Sunday I'm able to go to church."

"I have to say as a hairdresser, a lot of [the older adults], their neighbors are very good to them. I have neighbors that will actually bring the ladies in to get their hair done."

COMMUNITY ASSETS

PUBLIC TRANSPORTATION

Residents in North and Southwest Philadelphia noted reliable and affordable public transportation options. Bike lanes and bike share programs helped people to transport themselves.

ON PUBLIC TRANSPORTATION

"It's one thing our neighborhood has — it may lack in other things, but we have awesome public transportation in the area."

"I don't catch the bus but a lot of people say the transportation is pretty good as far as with all the trolleys and the buses."

COMMUNITY CHALLENGES

LIMITED HEALTHCARE ACCESS

Several barriers to healthcare were noted, some related to insufficient insurance coverage and high out-of-pocket expenses. Other barriers included long waiting times for appointments, geographic distance, and the inconvenience of appointments being confined to normal business hours. It was also noted that sometimes available health resources were underutilized.

There were issues related to culture, such as language barriers between service providers and healthcare recipients, discrimination, a lack of cultural sensitivity, and poor customer service.

In North Philadelphia, there was concern raised regarding the succession of pharmacy closures over the course of several years, leading to delays in prescription fulfillment and unfavorable prescription delivery services.

ON LIMITED HEALTHCARE ACCESS

"Nobody has enough money anywhere really. And people have to work multiple jobs because their jobs don't pay enough or their jobs don't give them benefits."

"Doctor office is closing too early."

"But then it's also a hindrance because you have to stay within a certain type of income level to be able to like keep that. And that also holds people back from actually moving forward..."

"I think providers need to be more culturally responsive and competent when interacting with people... And unfortunately, a lot of them have a lot of biases and prejudice against people who are not Caucasian."

"...a lot of the people don't take advantage of the resources that you have in the area. It's a lot of resources and people just don't know or they're just not taking advantage of the resources. So, you got like the health clinic which is a few blocks from here. It's a free health clinic for... when you don't have, medical. And then, another thing is a lot of people don't have medical so they can't seek these options."

"...when I was working full-time, my biggest option was having availability on the weekends to go to a doctor... I didn't go to a doctor for years because I had to take off from work, and I didn't get holidays or anything. So, I just didn't go."

COMMUNITY CHALLENGES

BEHAVIORAL HEALTH ISSUES

Residents discussed the need for more resources dedicated to supporting mental health, people with substance use disorders, and homeless individuals. Personal safety concerns were related to crime in neighborhoods, loud street activity at night, and perceptions of significant rates of mental illness.

ON BEHAVIORAL HEALTH ISSUES

"Providers, when people have substance abuse challenges or mental health challenges, they're treated differently and I really don't think that's fair."

"...lack of safety, but it's also affecting your emotional health, not feeling safe, but also your physical health because you're not walking as much as you would like."

"And I mean, go to the subway station and you will see that there is not enough help for people, especially that are using heroin. And they are forced to live outside and use drugs outside and it's not safe for anybody involved."

FOOD DESERTS

The proliferation of fast-food restaurants and corner stores within walking distance to residents have been described as congruent with "concentrated poverty," grocery stores that are too expensive and too far, and a lack of financial literacy. Also, food stamp eligibility was described as too restrictive. In Northeast Philadelphia, they "don't have some of the ones that other neighborhoods have, that offer more healthy foods."

ON FOOD DESERTS

"Food is very expensive. Healthy eating is way more expensive than fast food."

"...at one point, I think the city had a project to have the healthy food in corner stores and I don't know if that's still going on or how successful that is."

"But they're so easy to access and a lot of kids, that's not just kids, adults too. They run in all the junk food and the greasy foods and all that at them corner stores."

ENVIRONMENTAL HAZARDS

Abandoned vehicles with overgrowth, delayed pick-up of piles of trash, and issues with infrastructure were noted. Aged buildings lacked air conditioning and uneven sidewalks were left in disrepair.

ON ENVIRONMENTAL HAZARDS

"And there's been a huge proliferation of wildlife raccoons, squirrels from all the trash that's left out... there's a big problem with raccoons in South Philadelphia right now. So, that's also a health issue."

"Terrible sidewalks, terrible streets. It impedes good walk ability and also the lack of canopy — trees to keep it from being so hot."

SPECIAL POPULATIONS

CHILDREN AND YOUTH

Concerns were raised about the need for better nutrition options. Convenience stores and limited access to school meals in the summer were identified as problematic. There was a need for extracurricular activities, outside of video games, with the goal of "keeping them out of trouble" – related to criminal activity, victimization, and drug use. The closures of recreation centers and libraries in southwest Philadelphia were cited as reasons. Although a West Philadelphia mother noted that the quality of a particular recreation center depended on the recreation leader and their level of community engagement. It also depended on the zip code. Single parenthood was believed to be a contributing factor to difficulties that youth faced, as well as social media use.

Community gardens were educational and nutritional resources for youth. Today's youth were more inclined to seek support for their mental health, although there was a need for more mental health providers, mentors for youth, and outreach mechanisms that can dissuade youth from fear of stigmatization.

ON CHILDREN AND YOUTH

"So, they shut down rec centers and parks and then the things that are available, no transportation."

"So, their caregivers allow them to eat this food. And I see a lot of overweight children and I know when I was younger, we weren't overweight..."

"Me going to therapy to deal with the things that had happened growing up to deal with the things that have been happening my whole life. That wasn't cool to say, you know what I mean? It was something that you talk to a certain sector of people about. It was taboo. At this point, I got young girls coming to me who are like who is your therapist? I need a therapist too."

"And as a Black boy mom, we need more men... services and we are lacking a lot of men, especially Black men working in the mental health field in the local Philadelphia area."

"Social media is a really big issue for young people now, especially in Philly because... beefs have moved on to social media and so kids are shooting each other because of something they posted on TikTok..."

"But I know there are a lot of programs as I won't mention opposition or whatever, but there are programs just for that, but a lot of kids aren't coming. So, they're not getting the numbers for the funding for them to continue"

"And it's also a part of the displacement... we've witnessed in our community has been systematic, regardless as to how much community effort is put forth. There is the elephant in the room that is working against community efforts... for example, the pools haven't been opened. This is the 4th maybe 5th year... so there's intentional disinvestment."

"...we have this awareness and we have this education and we are able to look at our own selves as parents and see when your child is struggling and being able to reach out, but not everybody is able to do that without education and resources."

"My daughter started in 6th grade going to therapy. We had a house fire over Cottman Avenue, so we were displaced for almost a year, and that triggered all of the mental health. You know? And so, no one in school did anything. They didn't offer anything... My daughter has all her diagnoses finally by the time she was in college... But it took all those years through middle school, high school."

SPECIAL POPULATIONS

OLDER ADULTS

Senior living options fostered a sense of community, as did senior recreational centers. And free meal delivery services proved helpful. In North Philadelphia, food banks, supermarkets, and banks were less accessible due to limited transportation. Limited transportation options made it difficult to access health appointments in a timely manner. But paratransit services were helpful. Crime and unsafe neighborhoods deterred older adults from using public transportation. Residents of South Philadelphia were encouraged by the various options for activities, including bingo, walking, running, and dancing. Indoor activities were important for hot weather days.

Technological advancements in healthcare sometimes served as barriers for older adults. But free community health clinics provide accessibility.

There were concerns that unkept sidewalks and older buildings with narrow halls could make wheelchair use difficult. Intersecting factors such as crime, noise pollution, dementia, trash build-up, and pests could limit their desire to go out and hinder having guests. The "social structure breakdown" of families have led to increased isolation and loneliness among older adults, compared to immigrant families where "...there's many generational families and generations live together, and which is very helpful for the older [adults]." A lack of advocacy in healthcare has had a disproportionately negative impact on older, Black Americans.

ON OLDER ADULTS

"Our phones are computers now. Right? And so depending on how tech savvy you are, it can be difficult..."

"And ladies play the drums and dancing and pool and even have a religious thing every once in a while but it's good, something to get the heck out of the house."

"...because of the crime and the violence... we don't wanna go out, we don't wanna go anywhere."

"...seniors need to have a place where they can get to easily, quickly... not to have to get on one or two buses to get where they need to go."

"...when we had whole blocks of occupied homes, we had more of a sense of family, and we knew who our elders were and checked on them. There's some... blocks where there's so few houses on the blocks that people are so disjointed and... far away from one another, and that makes you vulnerable."

"...very concerned to educate our elders... so that they're not victims of heat stress, or even heat stroke. And many of our elders don't have the financial wherewithal to purchase air conditionings."

"Usually they send them to physical therapy, or they bounce them around the different doctors, but they never get to the root cause of what may be the underlying health conditions."

"...for others it's like they have to rely on social security, because retirement funds weren't able to be built from a young age like mine up until they retire. Many people didn't have the financial education through their familial background to know that that's going to be a very big aspect of their life one day, but just retirement... I watched my grandmother right now, struggle in her retirement."

ADDITIONAL POPULATIONS

There were concerns among community members about the prevalence of homeless individuals, the hidden homeless – those with unstable housing who may not necessarily be found on the streets – and how their feminine hygiene and healthcare needs are met. More shelters are needed, as "multimillion properties being built" are juxtaposed with people on the street in South Philadelphia.

Immigrants required English language services and support with pursuing employment. Reliable financial and food resources were especially important for those who are undocumented.

People with disabilities (PWD) faced accessibility challenges, including recreational activities and community mobility. Community-based services for children with autism didn't match the need in North Philadelphia. Young adults with neurodivergence had unique needs that are more complex for families to meet. And community workshops were not accessible for the Deaf and hard of hearing.

Mental health services were needed for the LGBTQ+ community, "because of being afraid to be who they are." There were issues related to suicidal ideation, suicide, and hate crimes. This was especially true in the Black community. Societal stigma can also act as a barrier for pursuing healthcare services.

"

HOMELESSNESS

"And [the homeless] don't bother you but they're so prevalent that you just step over them..."

"But if I brought it up to my council person but what she said is that when the city has tried, these individuals don't wanna go to facilities because they feel like they're attacked."

FOOD BANKS

"...I can see the line, if this place gave out food, the line would be around the corner. Literally, that's how desperate people are just to get some decent food."

PWDS

"I wanted people with disability to be able to come to a fitness center that didn't look therapeutic. And the disability community was saying, we ain't going to the Carousel House. So, when I went to the Carousel House, I said, I don't blame them. It was bombed out with equipment that didn't even work."

"People with disabilities are definitely suffering the most... We need just more services."

"I've particularly noticed in this neighborhood that it's just something unaddressed. And in the 3 local elementary schools, there's so many autistic children that they've had to open autistic support classrooms in all the elementary schools around here. So I'm like, so if you guys know, there's this many children with this issue, why are we not, you know, talking about it on a larger scale?"

"There was a gentleman in Starbucks today that was coloring, and he had all his books and all his art supplies and everything, and every 15 minutes or so, he would get up, he would run around, he would yell, and you knew he was by himself. And I felt horrible... Somebody had to drop him off because he had all this stuff all over the whole big table, and nobody was there taking care of him... and people were looking, which I [couldn't] care less about, but I don't want to go up and ask if he needs me to help him. And the baristas are like, 'What do we do?'"

"

ACCESS TO CARE

Residents have experienced unanswered and unreturned phone calls to healthcare providers, making appointment-setting difficult. Differences in coverage between those with state sponsored and private insurance coverage made some services inaccessible. Co-pays and out-of-pocket expenses served as deterrents for those with limited incomes. Those with income limits also faced access issues. A lack of upfront transparency with healthcare costs was described as "a huge limiting factor." Also, appointments were set too far into the future for symptoms/ concerns that needed immediate attention, particularly when specialists were needed. There was a desire for more substance use treatment facilities that offered extended stays that were covered by insurance. Quality of care in rehabilitation centers and instances of re-traumatization from staff were a concern. North Philadelphia respondents were not aware of any mental health facilities in their area. Hospitals have been diminishing in number. Yet, telehealth services have provided more options, especially as residents found that many providers were not accepting new patients. Accessibility didn't always take into account neurodevelopmental disabilities and related accommodations in health settings.

ON ACCESS TO CARE

"...I don't get no answer. I want to give my new number so they can send me an email when my next doctor's appointment is and uh, nothing, no response or, you know, nothing I can't get through over there and, and even the, the specialist they sent me to up on Broad Street, they never returned my call and no answer. No answer. Nothing. It's terrible over there. That's the worst hospital in the city."

"If I gotta figure out whether I'm gonna feed me and my kids with this, my last $100 or I'm gonna go to the doctor's clinic tomorrow. I feed me and my kids... and try to heal myself and still showing up to work often. But because I gotta make sure that me and my family is ok."

"Some doctors is not available until like three months later. So, if you really need to go to the urgent care, there's a whole bunch of them in the city."

"I just think that the way the healthcare is set up, you can make a dollar or two cents over and you lose your health care..."

"...unfortunately, a lot of places are lacking workers, so they're just hiring anybody and nobody's being held accountable for the way they treat any patients."

"...it really just kind of depends on if you - where you work, if they have a good health care plan, then it's easy. If they don't, then it becomes very costly for you. And then when you go to retire, a lot of folks are stuff, but I can't retire because I need the medical."

"...we just need universal health care in this country..."

"A lot of pharmacies don't have a lot of the popular medications, especially like Metformin and stuff like that."

TRUSTWORTHINESS

Community members with established relationships with their providers and consistent communication tended to have more trust. This was also true of individuals with histories of serious medical conditions that had good outcomes. Others mistrusted providers through what they perceived as low-quality insurance plans, who were not good listeners, or because of historical, discriminatory health practices in America.

ON TRUSTWORTHINESS

"I say, yes, because I'm on my second pacemaker. And whenever I go to that local hospital, they're always great."

"Yeah, I feel there's mistrust to me like that everything wants to make money is not like really caring about people what's going on."

"It all depends on what kind of insurance you have. So, you might not get the best. It's a kind of like a tier thing. If you have this kind of insurance, you'll get this kind of health care. For me personally I won't say I don't trust any of my doctors, but I get a second opinion... It all depends on what your insurance is and whether or not a provider can make money off of that."

"...some doctors take time to explain. And so, at least you build that trust."

"I feel like my doctor is cool as an individual. But if I'm being honest like, I don't really have a lot of trust in the healthcare system overall. Just from personal experience. Studying history as a African American woman, and what the medical establishment has done..."

COVID-19 PANDEMIC

Post-COVID, respondents have engaged more with technology in health spaces (e.g., accessing health portals, virtual appointments). There were differing levels of comfort with this, based on technological savvy, habits, time savings, language proficiency, lack of trust, purpose of the visit, and convenience. But most appreciated the option and considered health services to be better post-COVID because of it. Some individuals felt that virtual appointments should cost less or have lower co-pays.

For the most part, COVID-19 was still a concern due to variants and personal experiences and losses. Although it was not considered as threatening, precautions should still be taken. Many individuals found security in repeated vaccinations/boosters. Generally, there was some awareness among respondents of Long COVID, either having heard of it or knowing someone with it.

ON COVID-19 PANDEMIC

"Don't ask me to go check my lab test and all this stuff. I ain't got time for that... that's driving me crazy trying to even understand."

"I do appreciate for like the follow up appointments, those being virtual..."

"Every single other week I'm getting a letter about my information being leaked. So, I know that with a lot of the telehealth, they say it's not recorded and it may not be, but who's to say who's watching on the other side..."

"Well, for me COVID took a family member from me and my mother had it. So, I don't think we're done with it. I really feel that it's not just getting started but it's going to be around for a while and we just got to learn how to contain it."

"...she has long term COVID. She almost died from it. Went to a coma for like three months."

"...in larger political spheres, myths and disinformation about what COVID precisely is and how different strains can continue to affect and disable people's efforts to regain normalcy..."

"My cousin had and it's been a year and he still had some respiratory issues and problems. And then a friend of mine's son, it's probably been almost a year, he still can't get his taste back."

"COVID is not a concern to me... I got all my shots, and then I don't work. I'm on disability. I don't go many places but to the doctor and back, so I'm good."

DIVERSE LANGUAGE PERSPECTIVES

Two community conversations were held in Spanish and Burmese to increase diversity and equity in the voices and perspectives shared in this assessment.

Burmese-Speaking Respondents

A clean environment contributes to overall well-being. Access to public health benefits is important. In the South Philadelphia area, residents appreciated the presence of food pantries, public transportation, and the convenience of resources that are geographically close (e.g., schools, grocery stores, places of worship, other Asian residents).

Language barriers can lead to loneliness, difficulty with self-advocacy, miscommunication, and decreased productivity at work – making it difficult to obtain and maintain employment. Respondents tend to have to rely on the help of others to community with health providers, including setting appointments. Interpreters are hard to find, leading to misunderstandings with healthcare professionals. Dentists most often do not provide interpreters. Community members are unaware of how and where to access services for substance use disorders or mental illness.

Respondents generally have trust in their providers. One person shared about an experience where she did not feel heard and decided to find another doctor. Providers also become impatient when there are language difficulties. These experiences can make them feel anxious about accessing healthcare. A lack of childcare limits access as well.

Technology-use has facilitated appointment scheduling, checking test results, and messaging providers. There are some difficulties, as most respondents had no experience with telehealth appointments and/or unreliable internet access. Most, and generally older, respondents would prefer to receive healthcare in-person.

Community resources that are working well include health literacy initiatives, nutrition education for older adults and parents, and relationships with neighbors. Suggestions for what is needed include community gardens, opportunities for recreation and physical activity, social activities, preventative health measures, and food resources.

Spanish-Speaking Respondents

Community centers offer activities for the whole family, including yoga, dance, and swimming. Someone mentioned programs offered by their church, including a 3-day camp. Local clinics and social services are accessible and have helped individuals with multiple health conditions. However, two local parks are considered unsafe, due to people using substances there and broken bottles. More recreational activities are needed to meet the needs of people who work during the day, that provide affordable childcare, and that cater to Spanish speakers. A concern was raised about trash build-up and related hygiene issues.

For some, healthcare has been accessible and with Spanish-speaking providers and social workers. For others, language does serve as a barrier and interpreters are not always provided. They've experienced a lack of empathy, lack of advocacy, and bullying. There's also a fear that sometimes health providers are not telling them the whole truth because of misconceptions about their education levels or biases against those perceived as being undocumented. There is a lack of trust when it comes to medical costs for those who do not have health insurance. Vision services are generally more affordable than dental. Individuals who are uninsured and underinsured tend to experience advanced health conditions that require treatments that they can't afford.

Regarding the integration of technology, most community members had mixed or negative feelings. Some perceived the technological applications to be more convenient for health providers than the consumers. Current community resources include smoking cessation programs. One respondent spoke to the need for HIV/AIDS prevention and education. Another discussed the need to address suicide prevention and depression (especially since COVID) in the Hispanic community. Culturally, there is a tendency to not ask for help with these kinds of issues because of shame. There is concern for individuals who are selling and using drugs and not getting help. There are "Block Captains" in place to provide community support. However, one respondent felt that residents aren't listened to unless they sound like they are American when they call.

Suggestions included having Spanish speakers in leadership within the municipality and soliciting representatives to meet with the city council. They acknowledged it would be beneficial to include American allies. The focus group itself was praised as a useful experience that should continue regularly.

SUGGESTED ACTIONS

Philadelphia County

What is already working well to improve health in your community?

Preventative health services in schools.	"I think that school-based clinics, health clinics are really promising direction to be moving. A lot of folks can't afford the healthcare, don't have the time or the access to it for whatever reason. So, if we can help young people stay healthier in the place they already are, that would be really helpful."
Health navigators.	"Pennie is the healthcare marketplace for Pennsylvania. They have been extremely helpful. They have people to help you navigate. They're all licensed..."

What are the most important issues to address to improve health in your community?

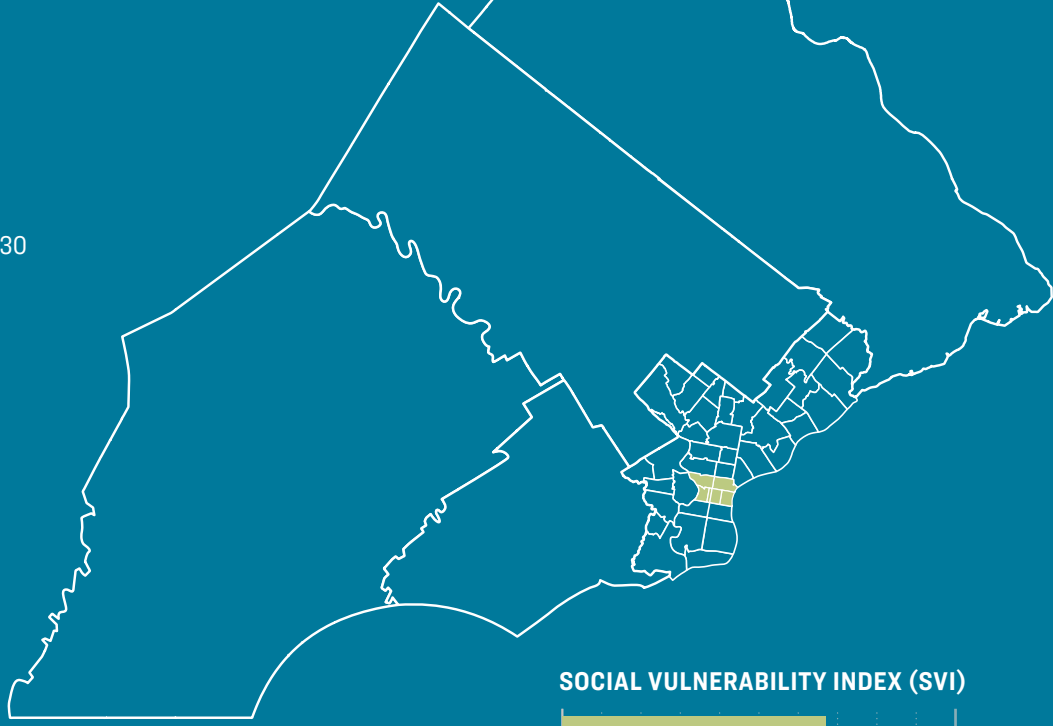
Genuine care.	"How about just listening to your patient? They so busy over talking and not actually listening to what the patient is saying."
Cultural diversity among health professionals.	"I would like to see the healthcare people in my neighborhood to look like me because I think culturally they would understand my culture..."
More efficient emergency services.	"Like when you go to an emergency system, you sit too long...The care is so slow."
Biopsychosocial and holistic health approaches.	"I would like a doctor that believes in more holistic health. Not just giving you a whole bunch of pharmaceuticals, but that doesn't mind giving me herbs or telling me what vitamin therapy to use or just even using food therapy and everything. Nutrition therapy."
Accessibility through community-based services.	"One of the key changes I would like to see. I would like to see the hospital instead of having the people in the community come to them. I think they should have more things come out into the community. And the reason why I say that is because they have no concept of the community in which they serve, because they don't come out the walls."
Effective programming for youth needs reliable funding, such as the library system.	"And, sadly, [the library] has had to cut a lot of programs, especially with funding. Our funding went way down, and that's a big draw for kids and families to come in and spend time together. They still have the after-school program where the kids can come in there and spend time, but the actual programs that we used to have, we just don't have, like, used to."

Center City

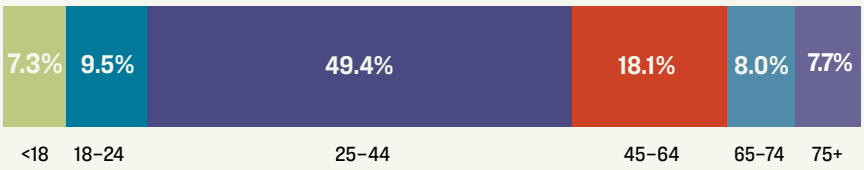
ZIP Codes: 19102, 19103, 19106, 19107, 19123, 19130

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Penn Medicine
- Thomas Jefferson University Hospital
- Wills Eye Hospital

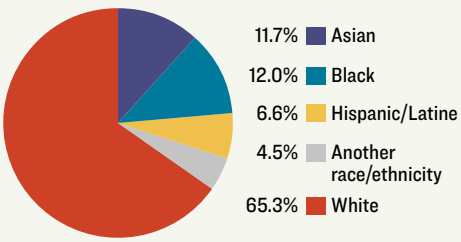


AGE DISTRIBUTION

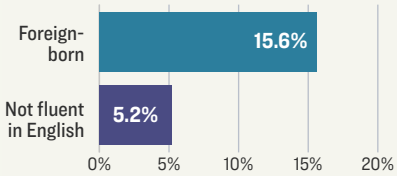


SEX

RACE/ETHNICITY/LANGUAGE



11.7% Asian
12.0% Black
6.6% Hispanic/Latine
4.5% Another race/ethnicity
65.3% White



POPULATION

109,338

MEDIAN HOUSEHOLD INCOME

$102,263

EDUCATIONAL ATTAINMENT

8.6% High school as highest education level

PEOPLE WITH DISABILITIES

10.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Center City	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	637.5	953.0
	Life expectancy: Female (in years)	79.9	77.1
	Life expectancy: Male (in years)	75.2	70.4
	Years of potential life lost before 75	6,476	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	23.6%	32.4%
	Diabetes prevalence	7.4%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	197.0	301.0
	Hypertension prevalence	21.0%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	52.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	888.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	30.2	68.0
	Major cancer incidence rate (per 100,000)*	194.8	218.9
	Major cancer mortality rate (per 100,000)*	51.2	69.4
	Colorectal cancer screening (adults age 45-75)	73.9%	66.7%
	Mammography screening (women age 50-74)	82.2%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	2,629.3	716.1
	Infant mortality rate (per 1,000 live births)	4.5	6.6
	Percent low birthweight births out of live births	8.8%	11.4%
	Percent preterm births out of live births	10.0%	11.2%
	Child Opportunity Index**	61.9	25.4
BEHAVIORAL HEALTH	Adult binge drinking	23.9%	18.9%
	Adult smoking	8.5%	16.2%
	Drug overdose mortality rate (per 100,000)	60.4	75.7
	Opioid-related hospitalization rate (per 100,000)	578.0	622.0
	Substance-related hospitalization rate (per 100,000)	969.5	1,017.9
	Poor mental health for 14+ days in past 30 days	14.8%	18.4%
	Suicide mortality rate (per 100,000)	11.9	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,027.0	1,929.0
	Homicide mortality rate (per 100,000)	8.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.2%	26.7%
	Children <19 years with public insurance	26.7%	61.5%
	Population without insurance	3.7%	7.3%
	Children <19 years without insurance	0.8%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	12.1%	22.1%
	Children <18 years in poverty	12.3%	27.0%
	Adults 19-64 years unemployed	3.1%	8.0%
	Householders living alone who are 65+ years	48.3%	36.9%
	Households receiving SNAP benefits	7.6%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	15.1%	19.3%
	Vacant housing units	11.2%	9.8%
	Single parent households	28.9%	48.0%
	Commute greater than 60 minutes	8.1%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 233

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Diabetes and high blood sugar

Chronic pain and pain management

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Alcohol use

Anxiety

Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)

Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Substance use services

Affordable housing

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

No health insurance

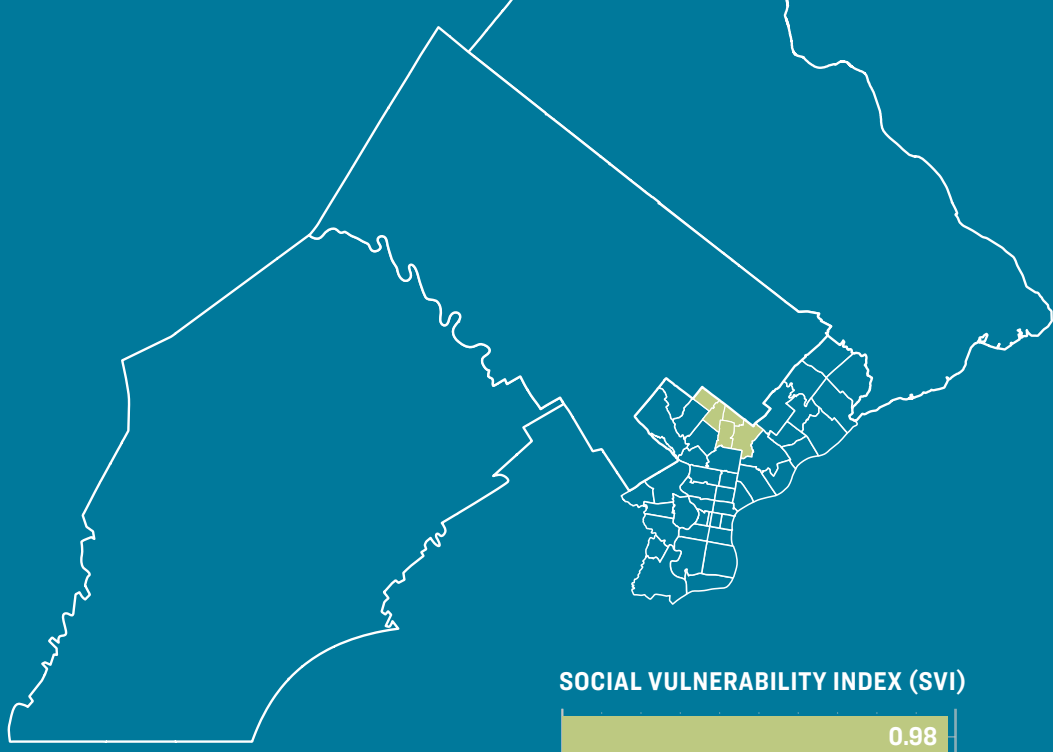
Transportation (getting to and from doctor's visits and appointments)

Far North Philadelphia

ZIP Codes: 19120, 19126, 19138, 19141, 19150

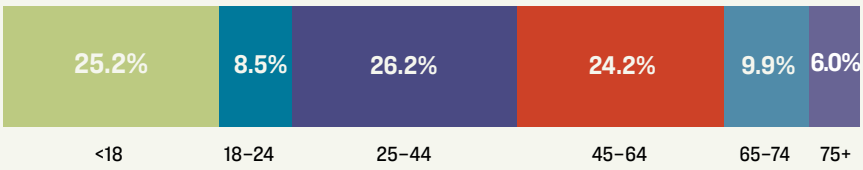
This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital



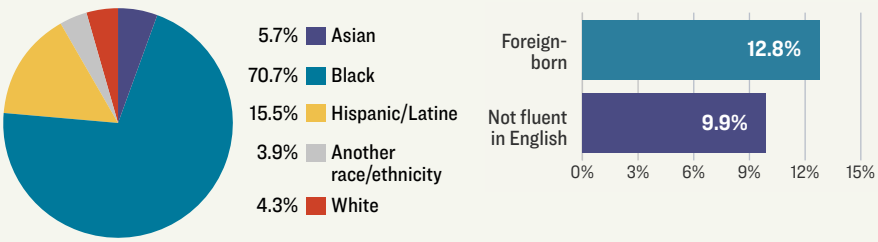
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

178,629

MEDIAN HOUSEHOLD INCOME

$51,294

EDUCATIONAL ATTAINMENT

36.4% High school as highest education level

PEOPLE WITH DISABILITIES

21.8%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Far North Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,015.5	953.0
	Life expectancy: Female (in years)	77.2	77.1
	Life expectancy: Male (in years)	68.2	70.4
	Years of potential life lost before 75	20,857	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	39.6%	32.4%
	Diabetes prevalence	19.6%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	462.0	301.0
	Hypertension prevalence	41.9%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	153.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,848.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	72.8	68.0
	Major cancer incidence rate (per 100,000)*	251.4	218.9
	Major cancer mortality rate (per 100,000)*	79.5	69.4
	Colorectal cancer screening (adults age 45-75)	66.6%	66.7%
	Mammography screening (women age 50-74)	80.3%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,314.5	716.1
	Infant mortality rate (per 1,000 live births)	5.6	6.6
	Percent low birthweight births out of live births	15.9%	11.4%
	Percent preterm births out of live births	13.5%	11.2%
	Child Opportunity Index**	18.7	25.4
BEHAVIORAL HEALTH	Adult binge drinking	14.1%	18.9%
	Adult smoking	19.6%	16.2%
	Drug overdose mortality rate (per 100,000)	79.5	75.7
	Opioid-related hospitalization rate (per 100,000)	410.3	622.0
	Substance-related hospitalization rate (per 100,000)	844.8	1,017.9
	Poor mental health for 14+ days in past 30 days	19.1%	18.4%
	Suicide mortality rate (per 100,000)	10.1	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,132.0	1,929.0
	Homicide mortality rate (per 100,000)	36.9	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	32.9%	26.7%
	Children <19 years with public insurance	71.7%	61.5%
	Population without insurance	9.2%	7.3%
	Children <19 years without insurance	5.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	24.6%	22.1%
	Children <18 years in poverty	34.9%	27.0%
	Adults 19-64 years unemployed	11.5%	8.0%
	Householders living alone who are 65+ years	32.4%	36.9%
	Households receiving SNAP benefits	34.8%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	21.5%	19.3%
	Vacant housing units	7.1%	9.8%
	Single parent households	67.7%	48.0%
	Commute greater than 60 minutes	16.1%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 102

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Diabetes and high blood sugar

Mental health

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Drug use

Alcohol use

Anxiety

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Depression

Anxiety

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

No health insurance

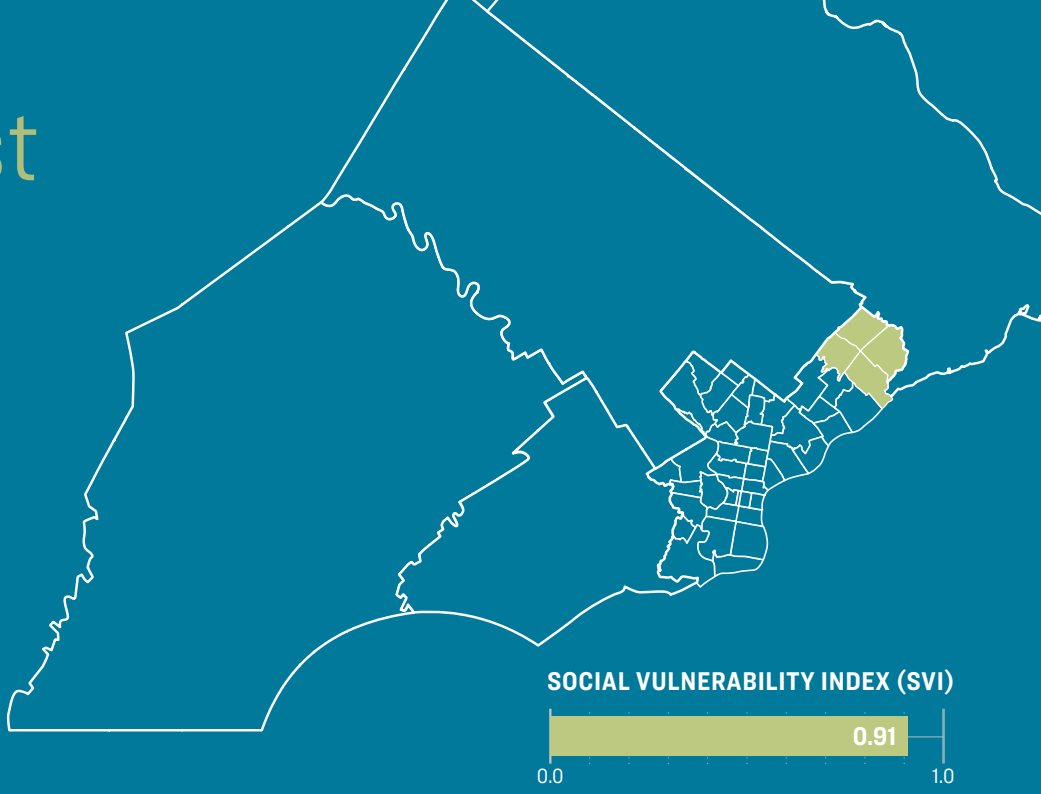
Transportation (getting to and from doctor's visits and appointments)

Far Northeast Philadelphia

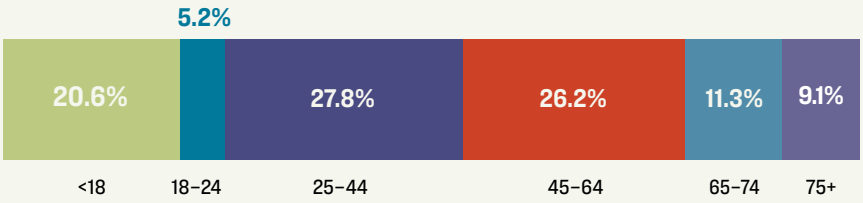
ZIP Codes: 19114, 19115, 19116, 19154

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

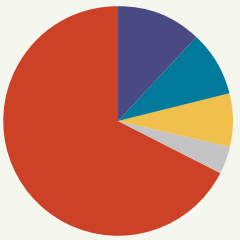


AGE DISTRIBUTION

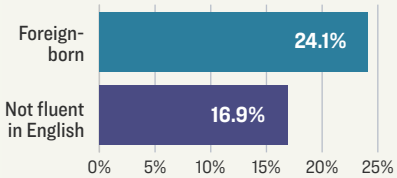


SEX

RACE/ETHNICITY/LANGUAGE



12.2% Asian
9.0% Black
7.6% Hispanic/Latine
3.9% Another race/ethnicity
67.3% White



POPULATION

135,125

MEDIAN HOUSEHOLD INCOME

$76,469

EDUCATIONAL ATTAINMENT

35.6% High school as highest education level

PEOPLE WITH DISABILITIES

17.1%

LEADING CAUSES OF DEATH – All Ages

1 Heart Disease
2 Cancer
3 COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Far Northeast Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,171.5	953.0
	Life expectancy: Female (in years)	79.7	77.1
	Life expectancy: Male (in years)	74.1	70.4
	Years of potential life lost before 75	10,111	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.6%	32.4%
	Diabetes prevalence	12.2%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	220.0	301.0
	Hypertension prevalence	30.4%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	45.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,119.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	45.9	68.0
	Major cancer incidence rate (per 100,000)*	313.0	218.9
	Major cancer mortality rate (per 100,000)*	88.8	69.4
	Colorectal cancer screening (adults age 45-75)	69.4%	66.7%
	Mammography screening (women age 50-74)	78.8%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	873.7	716.1
	Infant mortality rate (per 1,000 live births)	1.9	6.6
	Percent low birthweight births out of live births	8.4%	11.4%
	Percent preterm births out of live births	10.4%	11.2%
	Child Opportunity Index**	37.1	25.4
BEHAVIORAL HEALTH	Adult binge drinking	19.1%	18.9%
	Adult smoking	14.9%	16.2%
	Drug overdose mortality rate (per 100,000)	49.6	75.7
	Opioid-related hospitalization rate (per 100,000)	401.1	622.0
	Substance-related hospitalization rate (per 100,000)	486.2	1,017.9
	Poor mental health for 14+ days in past 30 days	16.2%	18.4%
	Suicide mortality rate (per 100,000)	12.6	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,878.0	1,929.0
	Homicide mortality rate (per 100,000)	8.9	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	16.2%	26.7%
	Children <19 years with public insurance	43.6%	61.5%
	Population without insurance	5.7%	7.3%
	Children <19 years without insurance	3.5%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	10.3%	22.1%
	Children <18 years in poverty	11.9%	27.0%
	Adults 19-64 years unemployed	4.7%	8.0%
	Householders living alone who are 65+ years	32.2%	36.9%
	Households receiving SNAP benefits	17.1%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	14.5%	19.3%
	Vacant housing units	4.1%	9.8%
	Single parent households	30.6%	48.0%
	Commute greater than 60 minutes	14.2%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 73

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Age-related illnesses
- Heart conditions
- Mental health

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Depression
- Anxiety
- Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Intellectual / developmental disabilities
- Abuse or neglect

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Affordable healthy foods
- Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Scheduling problems (such as health services not open when available)
- Health insurance is not accepted

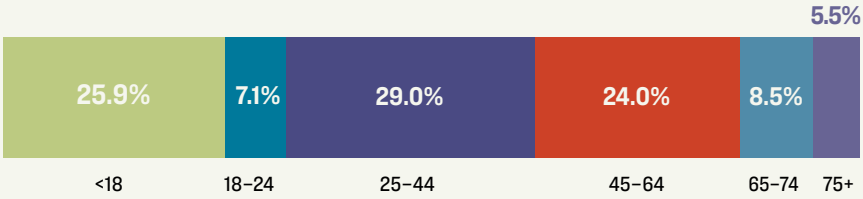
Lower Northeast Philadelphia

ZIP Codes: 19111, 19135, 19136, 19137, 19149, 19152

This community is served by:

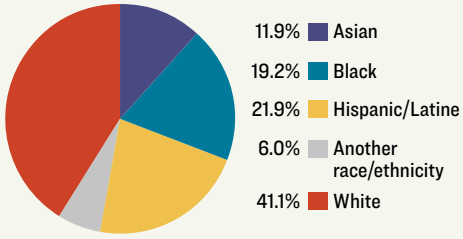
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

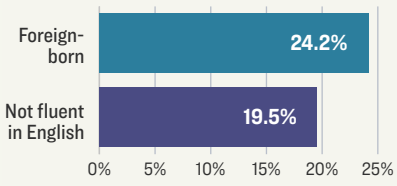
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

239,850

MEDIAN HOUSEHOLD INCOME

$58,399

EDUCATIONAL ATTAINMENT

37.6% High school as highest education level

PEOPLE WITH DISABILITIES

18.9%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Lower Northeast Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	943.5	953.0
	Life expectancy: Female (in years)	77.4	77.1
	Life expectancy: Male (in years)	71.0	70.4
	Years of potential life lost before 75	24,192	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.0%	32.4%
	Diabetes prevalence	13.4%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	364.0	301.0
	Hypertension prevalence	30.9%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	69.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,511.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	57.5	68.0
	Major cancer incidence rate (per 100,000)*	221.4	218.9
	Major cancer mortality rate (per 100,000)*	64.6	69.4
	Colorectal cancer screening (adults age 45-75)	62.2%	66.7%
	Mammography screening (women age 50-74)	76.0%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	2,354.3	716.1
	Infant mortality rate (per 1,000 live births)	5.2	6.6
	Percent low birthweight births out of live births	9.3%	11.4%
	Percent preterm births out of live births	9.3%	11.2%
	Child Opportunity Index**	20.1	25.4
BEHAVIORAL HEALTH	Adult binge drinking	18.7%	18.9%
	Adult smoking	18.8%	16.2%
	Drug overdose mortality rate (per 100,000)	75.5	75.7
	Opioid-related hospitalization rate (per 100,000)	527.8	622.0
	Substance-related hospitalization rate (per 100,000)	684.6	1,017.9
	Poor mental health for 14+ days in past 30 days	19.0%	18.4%
	Suicide mortality rate (per 100,000)	12.9	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,081.0	1,929.0
	Homicide mortality rate (per 100,000)	20.4	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	28.6%	26.7%
	Children <19 years with public insurance	62.0%	61.5%
	Population without insurance	9.2%	7.3%
	Children <19 years without insurance	5.2%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	18.9%	22.1%
	Children <18 years in poverty	25.2%	27.0%
	Adults 19-64 years unemployed	8.6%	8.0%
	Householders living alone who are 65+ years	30.7%	36.9%
	Households receiving SNAP benefits	37.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	18.1%	19.3%
	Vacant housing units	5.7%	9.8%
	Single parent households	51.1%	48.0%
	Commute greater than 60 minutes	15.8%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 134

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Chronic pain and pain management

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Drug use

Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Intellectual / developmental disabilities

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Health insurance is not accepted

Transportation (getting to and from doctor's visits and appointments)

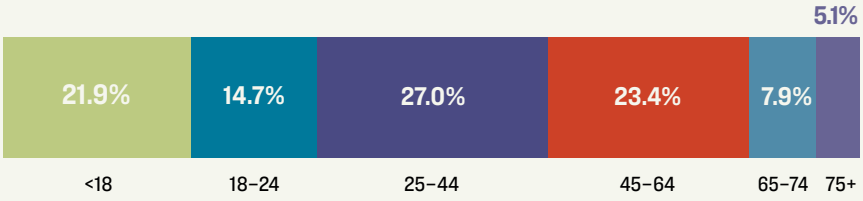
North Philadelphia-East

ZIP Codes: 19122, 19133, 19140

This community is served by:

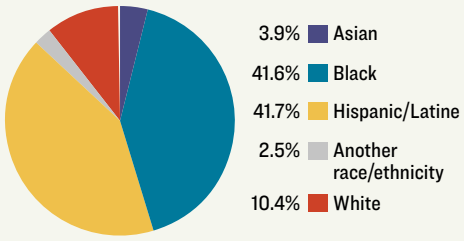
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

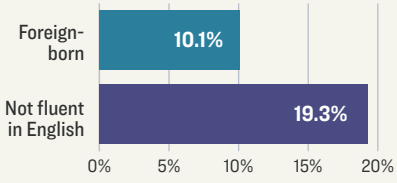
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

102,536

MEDIAN HOUSEHOLD INCOME

$38,555

EDUCATIONAL ATTAINMENT

37.1% High school as highest education level

PEOPLE WITH DISABILITIES

32.5%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	North Philadelphia-East	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,034.8	953.0
	Life expectancy: Female (in years)	76.5	77.1
	Life expectancy: Male (in years)	65.7	70.4
	Years of potential life lost before 75	13,660	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	38.8%	32.4%
	Diabetes prevalence	18.0%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	631.0	301.0
	Hypertension prevalence	33.8%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	162.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,553.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	84.8	68.0
	Major cancer incidence rate (per 100,000)*	187.3	218.9
	Major cancer mortality rate (per 100,000)*	59.5	69.4
	Colorectal cancer screening (adults age 45-75)	57.8%	66.7%
	Mammography screening (women age 50-74)	74.8%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	6,287.1	716.1
	Infant mortality rate (per 1,000 live births)	9.0	6.6
	Percent low birthweight births out of live births	14.3%	11.4%
	Percent preterm births out of live births	13.7%	11.2%
	Child Opportunity Index**	9.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	16.9%	18.9%
	Adult smoking	22.1%	16.2%
	Drug overdose mortality rate (per 100,000)	125.8	75.7
	Opioid-related hospitalization rate (per 100,000)	848.5	622.0
	Substance-related hospitalization rate (per 100,000)	1,550.7	1,017.9
	Poor mental health for 14+ days in past 30 days	23.1%	18.4%
	Suicide mortality rate (per 100,000)	11.7	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,244.0	1,929.0
	Homicide mortality rate (per 100,000)	53.6	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	46.0%	26.7%
	Children <19 years with public insurance	74.2%	61.5%
	Population without insurance	10.5%	7.3%
	Children <19 years without insurance	4.0%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	36.5%	22.1%
	Children <18 years in poverty	48.5%	27.0%
	Adults 19-64 years unemployed	12.4%	8.0%
	Householders living alone who are 65+ years	30.5%	36.9%
	Households receiving SNAP benefits	50.9%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	23.6%	19.3%
	Vacant housing units	12.1%	9.8%
	Single parent households	66.6%	48.0%
	Commute greater than 60 minutes	15.4%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 74

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Heart conditions

Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Alcohol use

Anxiety

Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Abuse or neglect

Violence

Injuries

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Loneliness

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Good paying jobs

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Fear (such as fear of doctors or not ready to discuss a health problem)

Transportation (getting to and from doctor's visits and appointments)

No health insurance

North Philadelphia-West

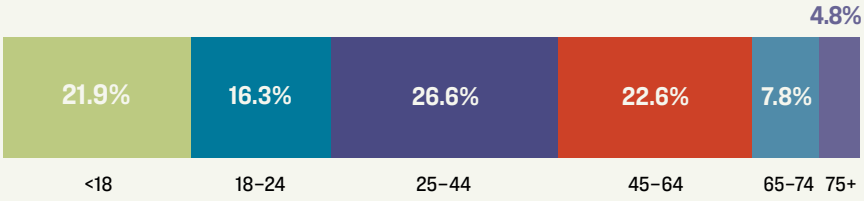
ZIP Codes: 19121, 19132

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

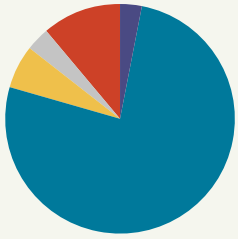
SOCIAL VULNERABILITY INDEX (SVI)

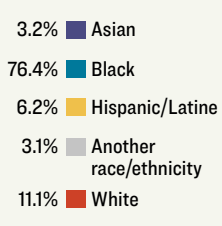
AGE DISTRIBUTION

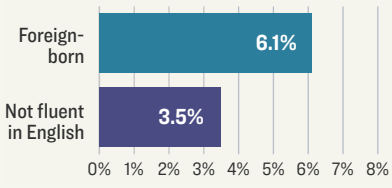


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

70,111

MEDIAN HOUSEHOLD INCOME

$33,817

EDUCATIONAL ATTAINMENT

37.8% High school as highest education level

PEOPLE WITH DISABILITIES

25.6%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	North Philadelphia-West	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,270.8	953.0
	Life expectancy: Female (in years)	71.4	77.1
	Life expectancy: Male (in years)	62.5	70.4
	Years of potential life lost before 75	11,777	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	40.1%	32.4%
	Diabetes prevalence	17.5%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	717.0	301.0
	Hypertension prevalence	37.7%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	197.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,963.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	122.7	68.0
	Major cancer incidence rate (per 100,000)*	225.4	218.9
	Major cancer mortality rate (per 100,000)*	87.0	69.4
	Colorectal cancer screening (adults age 45-75)	64.0%	66.7%
	Mammography screening (women age 50-74)	78.4%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	6,403.2	716.1
	Infant mortality rate (per 1,000 live births)	15.6	6.6
	Percent low birthweight births out of live births	16.4%	11.4%
	Percent preterm births out of live births	15.6%	11.2%
	Child Opportunity Index**	8.8	25.4
BEHAVIORAL HEALTH	Adult binge drinking	15.6%	18.9%
	Adult smoking	22.1%	16.2%
	Drug overdose mortality rate (per 100,000)	122.7	75.7
	Opioid-related hospitalization rate (per 100,000)	747.4	622.0
	Substance-related hospitalization rate (per 100,000)	1,700.2	1,017.9
	Poor mental health for 14+ days in past 30 days	23.3%	18.4%
	Suicide mortality rate (per 100,000)	4.3	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,991.0	1,929.0
	Homicide mortality rate (per 100,000)	67.0	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	40.6%	26.7%
	Children <19 years with public insurance	77.5%	61.5%
	Population without insurance	6.6%	7.3%
	Children <19 years without insurance	5.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	36.7%	22.1%
	Children <18 years in poverty	49.5%	27.0%
	Adults 19-64 years unemployed	14.7%	8.0%
	Householders living alone who are 65+ years	48.0%	36.9%
	Households receiving SNAP benefits	44.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	26.8%	19.3%
	Vacant housing units	18.4%	9.8%
	Single parent households	84.0%	48.0%
	Commute greater than 60 minutes	16.1%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 62

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Diabetes and highblood sugar

Violence

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Depression

Alcohol use

Anxiety

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Abuse or neglect

Mental health

Violence

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Bullying

Drug use

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Good schools

Clean outdoor environment

Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

No health insurance

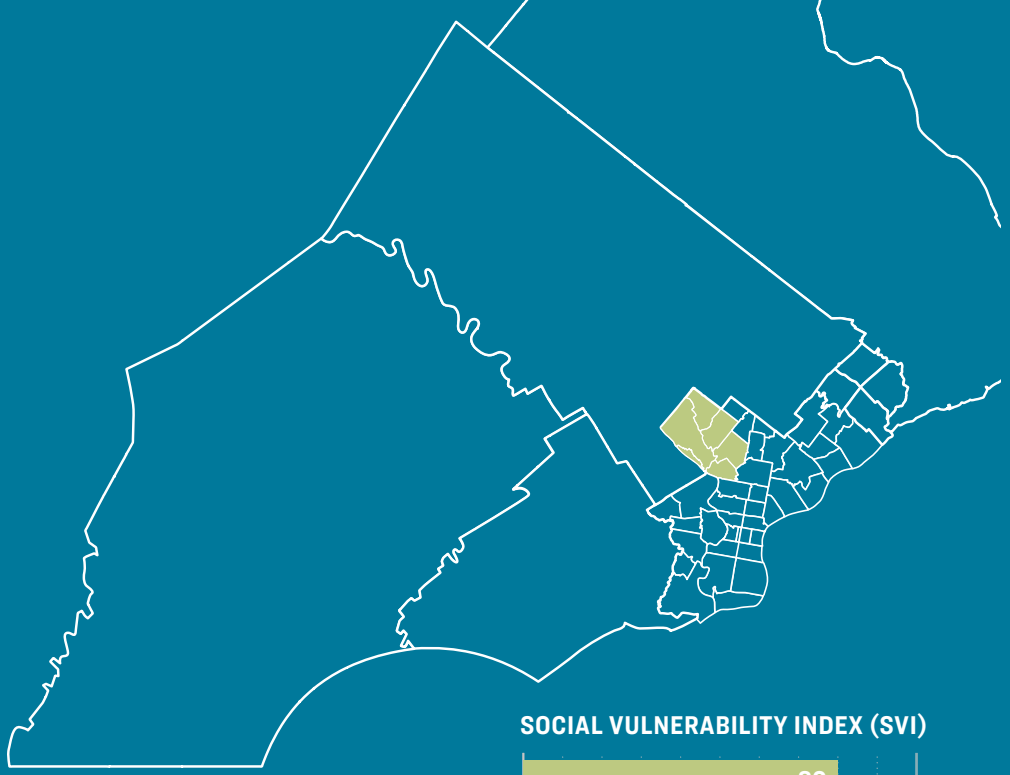
Transportation (getting to and from doctor's visits and appointments)

Northwest Philadelphia

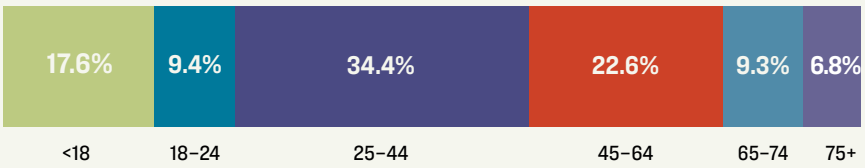
ZIP Codes: 19118, 19119, 19127, 19128, 19129, 19144

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

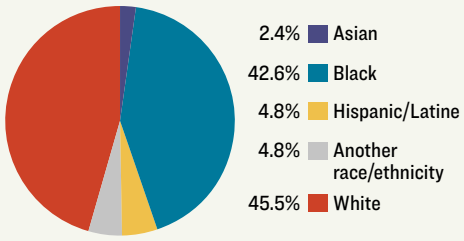


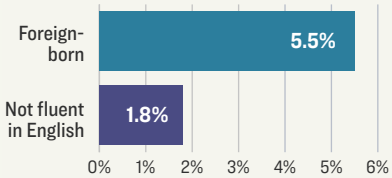
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

142,506

MEDIAN HOUSEHOLD INCOME

$74,333

EDUCATIONAL ATTAINMENT

20.5% High school as highest education level

PEOPLE WITH DISABILITIES

18.2%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Northwest Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	884.9	953.0
	Life expectancy: Female (in years)	79.6	77.1
	Life expectancy: Male (in years)	72.5	70.4
	Years of potential life lost before 75	11,856	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.0%	32.4%
	Diabetes prevalence	10.7%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	337.0	301.0
	Hypertension prevalence	28.2%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	89.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,410.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	59.6	68.0
	Major cancer incidence rate (per 100,000)*	209.8	218.9
	Major cancer mortality rate (per 100,000)*	60.3	69.4
	Colorectal cancer screening (adults age 45-75)	72.1%	66.7%
	Mammography screening (women age 50-74)	82.1%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	2,113.0	716.1
	Infant mortality rate (per 1,000 live births)	3.2	6.6
	Percent low birthweight births out of live births	10.1%	11.4%
	Percent preterm births out of live births	9.1%	11.2%
	Child Opportunity Index**	39.9	25.4
BEHAVIORAL HEALTH	Adult binge drinking	21.3%	18.9%
	Adult smoking	11.8%	16.2%
	Drug overdose mortality rate (per 100,000)	44.2	75.7
	Opioid-related hospitalization rate (per 100,000)	747.4	622.0
	Substance-related hospitalization rate (per 100,000)	1,700.2	1,017.9
	Poor mental health for 14+ days in past 30 days	16.3%	18.4%
	Suicide mortality rate (per 100,000)	11.2	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,991.0	1,929.0
	Homicide mortality rate (per 100,000)	30.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	18.2%	26.7%
	Children <19 years with public insurance	45.9%	61.5%
	Population without insurance	3.8%	7.3%
	Children <19 years without insurance	2.3%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	14.4%	22.1%
	Children <18 years in poverty	15.9%	27.0%
	Adults 19-64 years unemployed	6.7%	8.0%
	Householders living alone who are 65+ years	38.3%	36.9%
	Households receiving SNAP benefits	19.0%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	16.1%	19.3%
	Vacant housing units	7.6%	9.8%
	Single parent households	48.6%	48.0%
	Commute greater than 60 minutes	13.4%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 103

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Diabetes and high blood sugar

Mental health

Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Alcohol use

Drug use

Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Intellectual / developmental disabilities

Injuries

Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Depression

Anxiety

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Good paying jobs

Affordable housing

Substance use services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

Health insurance is not accepted

River Wards

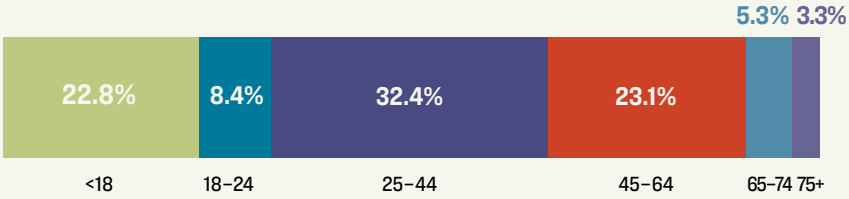
ZIP Codes: 19124, 19125, 19134

This community is served by:

- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- St. Christopher's Hospital for Children
- Temple University Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

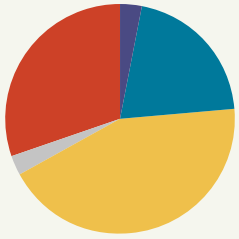
SOCIAL VULNERABILITY INDEX (SVI)

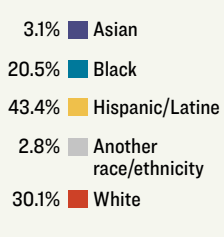
AGE DISTRIBUTION

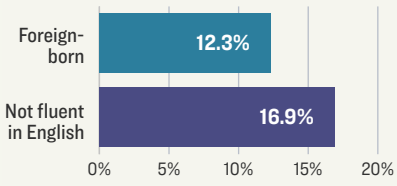


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

157,749

MEDIAN HOUSEHOLD INCOME

$57,816

EDUCATIONAL ATTAINMENT

35.9% High school as highest education level

PEOPLE WITH DISABILITIES

27.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Accidental poisoning** (including unintentional drug or alcohol related use)
3. **Cancer**

SUMMARY HEALTH MEASURES

Category	Measure	River Wards	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	843.1	953.0
	Life expectancy: Female (in years)	74.4	77.1
	Life expectancy: Male (in years)	67.5	70.4
	Years of potential life lost before 75	21,612	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	34.8%	32.4%
	Diabetes prevalence	13.5%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	508.0	301.0
	Hypertension prevalence	28.4%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	86.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,214.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	87.5	68.0
	Major cancer incidence rate (per 100,000)*	188.9	218.9
	Major cancer mortality rate (per 100,000)*	56.4	69.4
	Colorectal cancer screening (adults age 45-75)	59.0%	66.7%
	Mammography screening (women age 50-74)	74.9%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,914.9	716.1
	Infant mortality rate (per 1,000 live births)	9.1	6.6
	Percent low birthweight births out of live births	10.8%	11.4%
	Percent preterm births out of live births	11.4%	11.2%
	Child Opportunity Index**	14.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	20.3%	18.9%
	Adult smoking	19.8%	16.2%
	Drug overdose mortality rate (per 100,000)	119.8	75.7
	Opioid-related hospitalization rate (per 100,000)	1699.5	622.0
	Substance-related hospitalization rate (per 100,000)	2,188.3	1,017.9
	Poor mental health for 14+ days in past 30 days	20.5%	18.4%
	Suicide mortality rate (per 100,000)	13.3	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,736.0	1,929.0
	Homicide mortality rate (per 100,000)	41.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	37.6%	26.7%
	Children <19 years with public insurance	74.5%	61.5%
	Population without insurance	8.9%	7.3%
	Children <19 years without insurance	4.6%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	31.9%	22.1%
	Children <18 years in poverty	45.9%	27.0%
	Adults 19-64 years unemployed	6.7%	8.0%
	Householders living alone who are 65+ years	36.2%	36.9%
	Households receiving SNAP benefits	40.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	20.6%	19.3%
	Vacant housing units	9.0%	9.8%
	Single parent households	68.7%	48.0%
	Commute greater than 60 minutes	11.5%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 112

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Substance use
- Mental health
- Diabetes and high blood sugar

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Drug use
- Alcohol use
- Depression

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Mental health
- Abuse or neglect
- Blood diseases (such as lead poisoning, anemia, and sickle cell)

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Depression
- Drug use

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Clean outdoor environment
- Good paying jobs

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

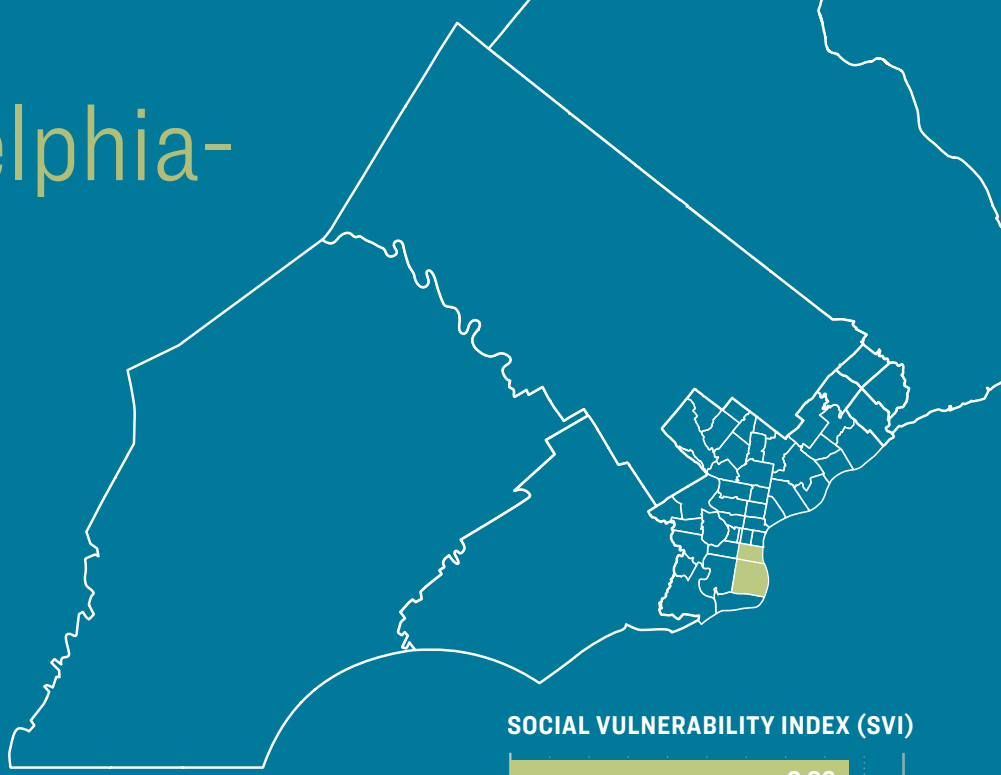
- Costs associated with getting healthcare
- No health insurance
- Health insurance is not accepted

South Philadelphia-East

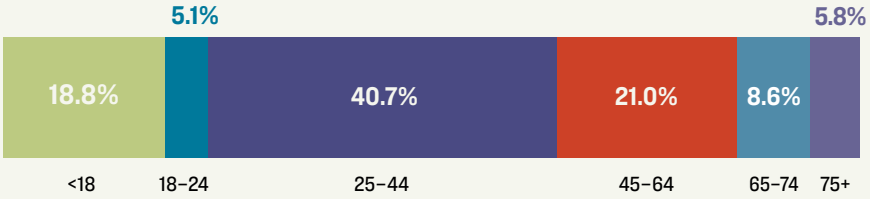
ZIP Codes: 19147, 19148

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Penn Medicine
- Thomas Jefferson University Hospital
- Wills Eye Hospital

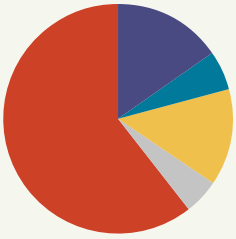


AGE DISTRIBUTION

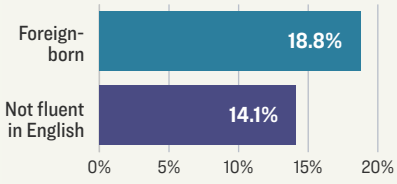


SEX

RACE/ETHNICITY/LANGUAGE



15.4% Asian
5.7% Black
13.5% Hispanic/Latine
5.0% Another race/ethnicity
60.5% White



POPULATION

89,242

MEDIAN HOUSEHOLD INCOME

$91,809

EDUCATIONAL ATTAINMENT

21.1% High school as highest education level

PEOPLE WITH DISABILITIES

14.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	South Philadelphia-East	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	828.6	953.0
	Life expectancy: Female (in years)	79.0	77.1
	Life expectancy: Male (in years)	72.8	70.4
	Years of potential life lost before 75	6,991	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	26.5%	32.4%
	Diabetes prevalence	9.9%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	272.0	301.0
	Hypertension prevalence	24.9%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	43.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,062.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	36.9	68.0
	Major cancer incidence rate (per 100,000)*	219.2	218.9
	Major cancer mortality rate (per 100,000)*	74.9	69.4
	Colorectal cancer screening (adults age 45-75)	66.7%	66.7%
	Mammography screening (women age 50-74)	78.9%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	1,698.1	716.1
	Infant mortality rate (per 1,000 live births)	2.7	6.6
	Percent low birthweight births out of live births	7.3%	11.4%
	Percent preterm births out of live births	8.5%	11.2%
	Child Opportunity Index**	52.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	21.7%	18.9%
	Adult smoking	13.3%	16.2%
	Drug overdose mortality rate (per 100,000)	52.6	75.7
	Opioid-related hospitalization rate (per 100,000)	463.0	622.0
	Substance-related hospitalization rate (per 100,000)	630.7	1,017.9
	Poor mental health for 14+ days in past 30 days	16.2%	18.4%
	Suicide mortality rate (per 100,000)	16.8	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,356.0	1,929.0
	Homicide mortality rate (per 100,000)	19.0	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	14.9%	26.7%
	Children <19 years with public insurance	44.8%	61.5%
	Population without insurance	8.3%	7.3%
	Children <19 years without insurance	4.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	14.8%	22.1%
	Children <18 years in poverty	20.8%	27.0%
	Adults 19-64 years unemployed	5.9%	8.0%
	Householders living alone who are 65+ years	35.0%	36.9%
	Households receiving SNAP benefits	16.7%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	14.2%	19.3%
	Vacant housing units	8.2%	9.8%
	Single parent households	33.4%	48.0%
	Commute greater than 60 minutes	9.7%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 106

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Substance use

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Abuse or neglect

Violence

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Clean outdoor environment

Substance use services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Language barriers

No health insurance

South Philadelphia-West

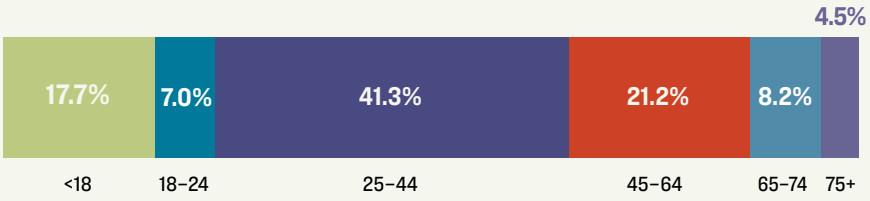
ZIP Codes: 19145, 19146

This community is served by:

- Children's Hospital of Philadelphia
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Penn Medicine
- Thomas Jefferson University Hospital
- Wills Eye Hospital

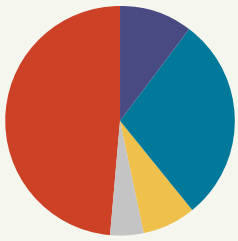
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

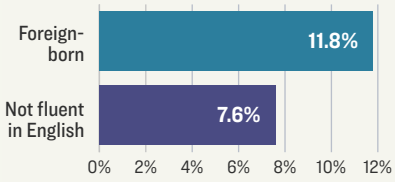


SEX

RACE/ETHNICITY/LANGUAGE



10.5% Asian
28.9% Black
7.5% Hispanic/Latine
4.6% Another race/ethnicity
48.5% White



POPULATION

84,410

MEDIAN HOUSEHOLD INCOME

$84,996

EDUCATIONAL ATTAINMENT

24.0% High school as highest education level

PEOPLE WITH DISABILITIES

15.2%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	South Philadelphia-West	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	907.5	953.0
	Life expectancy: Female (in years)	74.9	77.1
	Life expectancy: Male (in years)	71.9	70.4
	Years of potential life lost before 75	8,231	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.1%	32.4%
	Diabetes prevalence	10.9%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	374.0	301.0
	Hypertension prevalence	27.5%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	70.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	1,606.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	69.9	68.0
	Major cancer incidence rate (per 100,000)*	252.3	218.9
	Major cancer mortality rate (per 100,000)*	77.0	69.4
	Colorectal cancer screening (adults age 45-75)	68.3%	66.7%
	Mammography screening (women age 50-74)	80.9%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,292.4	716.1
	Infant mortality rate (per 1,000 live births)	5.4	6.6
	Percent low birthweight births out of live births	8.6%	11.4%
	Percent preterm births out of live births	8.4%	11.2%
	Child Opportunity Index**	40.3	25.4
BEHAVIORAL HEALTH	Adult binge drinking	21.0%	18.9%
	Adult smoking	13.8%	16.2%
	Drug overdose mortality rate (per 100,000)	61.6	75.7
	Opioid-related hospitalization rate (per 100,000)	588.0	622.0
	Substance-related hospitalization rate (per 100,000)	888.5	1,017.9
	Poor mental health for 14+ days in past 30 days	17.0%	18.4%
	Suicide mortality rate (per 100,000)	11.8	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,503.0	1,929.0
	Homicide mortality rate (per 100,000)	22.5	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	17.5%	26.7%
	Children <19 years with public insurance	45.0%	61.5%
	Population without insurance	5.7%	7.3%
	Children <19 years without insurance	3.3%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	15.4%	22.1%
	Children <18 years in poverty	22.6%	27.0%
	Adults 19-64 years unemployed	7.9%	8.0%
	Householders living alone who are 65+ years	37.7%	36.9%
	Households receiving SNAP benefits	19.7%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	14.4%	19.3%
	Vacant housing units	11.5%	9.8%
	Single parent households	45.6%	48.0%
	Commute greater than 60 minutes	10.0%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 82

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Diabetes and high blood sugar

Substance use

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Anxiety

Depression

Alcohol use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Violence

Obesity and maintaining healthy weight

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Affordable housing

Affordable healthy foods

Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

Fear (such as fear of doctors or not ready to discuss a health problem)

Southwest Philadelphia

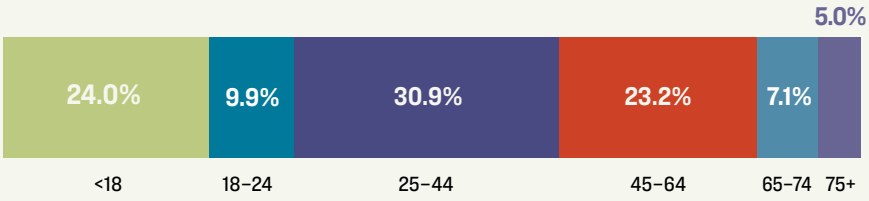
ZIP Codes: 19142, 19143, 19153

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Penn Medicine
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

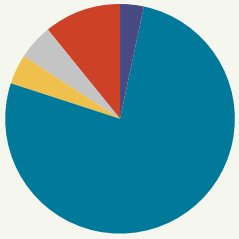
SOCIAL VULNERABILITY INDEX (SVI)

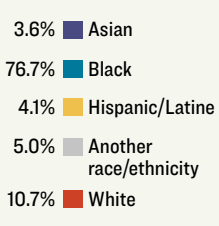
AGE DISTRIBUTION

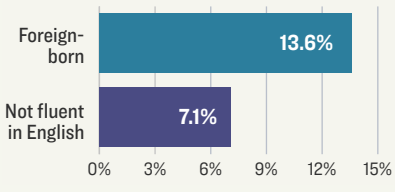


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

106,427

MEDIAN HOUSEHOLD INCOME

$47,309

EDUCATIONAL ATTAINMENT

35.1% High school as highest education level

PEOPLE WITH DISABILITIES

20.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	Southwest Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	1,010.1	953.0
	Life expectancy: Female (in years)	75.3	77.1
	Life expectancy: Male (in years)	68.1	70.4
	Years of potential life lost before 75	12,098	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	39.3%	32.4%
	Diabetes prevalence	17.9%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	584.0	301.0
	Hypertension prevalence	39.1%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	173.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,364.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	89.3	68.0
	Major cancer incidence rate (per 100,000)*	187.0	218.9
	Major cancer mortality rate (per 100,000)*	85.5	69.4
	Colorectal cancer screening (adults age 45-75)	64.7%	66.7%
	Mammography screening (women age 50-74)	78.8%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	4,630.9	716.1
	Infant mortality rate (per 1,000 live births)	5.3	6.6
	Percent low birthweight births out of live births	14.7%	11.4%
	Percent preterm births out of live births	13.5%	11.2%
	Child Opportunity Index**	14.5	25.4
BEHAVIORAL HEALTH	Adult binge drinking	15.1%	18.9%
	Adult smoking	20.5%	16.2%
	Drug overdose mortality rate (per 100,000)	66.7	75.7
	Opioid-related hospitalization rate (per 100,000)	492.4	622.0
	Substance-related hospitalization rate (per 100,000)	1,018.5	1,017.9
	Poor mental health for 14+ days in past 30 days	20.0%	18.4%
	Suicide mortality rate (per 100,000)	12.2	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,503.0	1,929.0
	Homicide mortality rate (per 100,000)	43.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	34.9%	26.7%
	Children <19 years with public insurance	68.2%	61.5%
	Population without insurance	7.2%	7.3%
	Children <19 years without insurance	4.1%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	26.4%	22.1%
	Children <18 years in poverty	33.2%	27.0%
	Adults 19-64 years unemployed	10.9%	8.0%
	Householders living alone who are 65+ years	41.8%	36.9%
	Households receiving SNAP benefits	34.5%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	23.8%	19.3%
	Vacant housing units	11.8%	9.8%
	Single parent households	66.1%	48.0%
	Commute greater than 60 minutes	15.7%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 117

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

Diabetes and high blood sugar

Mental health

Heart conditions

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Alcohol use

Depression

Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

Mental health

Intellectual / developmental disabilities

Violence

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

Bullying

Anxiety

Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

Good paying jobs

Affordable housing

Mental health services

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

Costs associated with getting healthcare

Transportation (getting to and from doctor's visits and appointments)

No health insurance

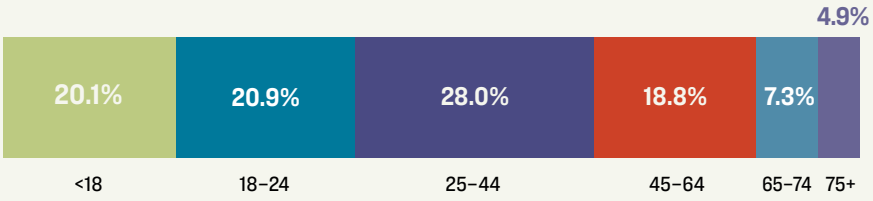
West Philadelphia

ZIP Codes: 19104, 19131, 19139, 19151

This community is served by:

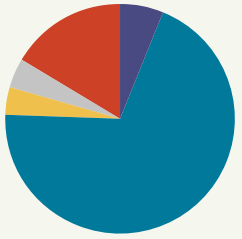
- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Jefferson Einstein Philadelphia Hospital
- Jefferson Health - Northeast
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Penn Medicine
- Thomas Jefferson University Hospital
- Trinity Health Mid-Atlantic
- Wills Eye Hospital

AGE DISTRIBUTION

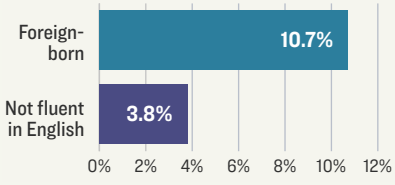


SEX

RACE/ETHNICITY/LANGUAGE



6.3% Asian
69.3% Black
4.0% Hispanic/Latine
4.2% Another race/ethnicity
16.2% White



POPULATION

177,389

MEDIAN HOUSEHOLD INCOME

$44,460

EDUCATIONAL ATTAINMENT

30.0% High school as highest education level

PEOPLE WITH DISABILITIES

20.0%

LEADING CAUSES OF DEATH – All Ages

1. **Heart Disease**
2. **Cancer**
3. **Accidental poisoning** (including unintentional drug or alcohol related use)

SUMMARY HEALTH MEASURES

Category	Measure	West Philadelphia	Philadelphia County
GENERAL	All-cause mortality rate (per 100,000)	958.9	953.0
	Life expectancy: Female (in years)	75.4	77.1
	Life expectancy: Male (in years)	68.5	70.4
	Years of potential life lost before 75	19,080	166,936
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	36.2%	32.4%
	Diabetes prevalence	15.4%	13.5%
	Diabetes-related hospitalization rate (per 100,000)	540.0	301.0
	Hypertension prevalence	35.6%	31.3%
	Hypertension-related preventable hospitalization rate (per 100,000)	149.0	68.0
	Potentially preventable hospitalization rate (per 100,000)	2,300.0	1,303.0
	Premature cardiovascular disease mortality rate (per 100,000)	77.2	68.0
	Major cancer incidence rate (per 100,000)*	178.7	218.9
	Major cancer mortality rate (per 100,000)*	63.7	69.4
	Colorectal cancer screening (adults age 45-75)	67.0%	66.7%
	Mammography screening (women age 50-74)	80.3%	79.2%
INFANT & CHILD HEALTH	Asthma hospitalization rate <18 years (per 100,000 <18 years)	3,929.4	716.1
	Infant mortality rate (per 1,000 live births)	14.4	6.6
	Percent low birthweight births out of live births	13.0%	11.4%
	Percent preterm births out of live births	13.0%	11.2%
	Child Opportunity Index**	17.0	25.4
BEHAVIORAL HEALTH	Adult binge drinking	16.4%	18.9%
	Adult smoking	17.5%	16.2%
	Drug overdose mortality rate (per 100,000)	63.7	75.7
	Opioid-related hospitalization rate (per 100,000)	437.5	622.0
	Substance-related hospitalization rate (per 100,000)	980.3	1,017.9
	Poor mental health for 14+ days in past 30 days	20.5%	18.4%
	Suicide mortality rate (per 100,000)	8.5	11.5
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	2,780.0	1,929.0
	Homicide mortality rate (per 100,000)	41.2	31.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	27.4%	26.7%
	Children <19 years with public insurance	58.9%	61.5%
	Population without insurance	6.2%	7.3%
	Children <19 years without insurance	2.9%	4.1%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	26.6%	22.1%
	Children <18 years in poverty	34.1%	27.0%
	Adults 19-64 years unemployed	8.2%	8.0%
	Householders living alone who are 65+ years	46.1%	36.9%
	Households receiving SNAP benefits	29.3%	27.4%
	Households that are housing cost-burdened (% spending >50% of household income)	25.2%	19.3%
	Vacant housing units	15.7%	9.8%
	Single parent households	73.2%	48.0%
	Commute greater than 60 minutes	12.6%	13.3%

"--" Estimates are unavailable or unreliable due to low sample size within a community

* "Major" cancer defined as: prostate, breast, lung, colorectal cancers

**The Child Opportunity Index (COI) measures and maps the quality of resources and conditions, at the census tract level, that matter for children's healthy development. It is a composite score of 44 indicators, and scores range from 1 (lowest opportunity) to 100 (highest opportunity).

COMMUNITY SURVEY

Number of Respondents: 188

ADULTS

Thinking about yourself or other adults in the community where you live, what are the TOP 3 HEALTH problems?

- Chronic pain and pain management
- Diabetes and high blood sugar
- Age-related illnesses

Thinking about yourself or other adults in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Anxiety
- Alcohol use
- Drug use

CHILDREN

Thinking about your or other children in the community where you live, what are the TOP 3 HEALTH problems?

- Infectious diseases (such as Covid-19, influenza, pneumonia, and measles)
- Blood diseases (such as lead poisoning, anemia, and sickle cell)
- Mental health

Thinking about your or other children in the community where you live, what are the TOP 3 MENTAL HEALTH and SUBSTANCE USE problems?

- Bullying
- Anxiety
- Depression

COMMUNITY

Thinking about the community where you live, how available are the following resources? Results reflect the top 3 responses for "Never" and "Rarely Available".

- Affordable housing
- Good paying jobs
- Clean outdoor environment

Thinking about the community where you live, which barriers prevent access to health care? Results reflect the top 3 choices.

- Costs associated with getting healthcare
- Health insurance is not accepted
- Transportation (getting to and from doctor's visits and appointments)

PHILADELPHIA COUNTY
Neighborhood Perspectives

Far North Philadelphia

COMMUNITY ASSETS

Respondents spoke of support for one another by engaging in organized **physical fitness activities**, that also helped to foster a sense of community. “They’re like walking groups. Or you know, there’s groups of people they get together. To like foster community for people that may be new, or maybe new, to trying to live a healthier lifestyle…” Other community-based recreational activities and resources, including bike lanes, were valued as well. “The library near me offers nutrition workshops at times, or workshops that touch on health and wellness. And they’re free, so if I can take advantage of it, I try to.”

One community member acknowledged the **incentives** (e.g., gift cards, movie screenings) provided by her health insurance, although she “NEVER” took advantage of them.

COMMUNITY CHALLENGES

Work obligations—even on weekends—can make it hard to stay motivated to exercise or cook at home. One respondent spoke of limitations due to not having a car, especially when needing to grocery shop, and compared her experiences to her home country. “And one day I’d walk like a mile plus. And then one of the hottest days, carrying like 3 bags. And it was, it was hard.” **Public transportation** was not available.

- “And when we get to the healthcare system it’ll be the kind of the same issue, whereas in the country that I’m in, I go to one place, and all my doctors are like in two buildings next to each other. Whereas if I’m here and I had the same healthcare needs, I’d have to go to like all over the city to get the same.”

Healthcare barriers also included cost, particularly for residents with complicated health needs. “Access to specialists, and I’d be broke before I got halfway through.” There was also discussion of **mental health resources** being insufficient in the area. “I do know, in my neighborhood and surrounding areas mental health is not adequate, as it is in other zip codes, because I live in a zip code of low poverty is what they call it… things like that is not here.” Some residents complained of red tape, difficulty changing **insurance companies**, and complications with having to appeal bills with their health insurance companies. “It can be really, really messy.”

CHILDREN AND YOUTH

Community members agreed on the importance of having **activities** readily available for youth. Recent programming that youth have actively participated in include free ice skating, karate, and programming at the local library. Activities like this are perceived as significant protective factors against **criminal activity**. Yet these resources can be improved upon. “Some rec centers in philadelphia are trash.” Conversely, “…it can be complicated, based on where you’re at. But I’ve seen really nice recreation centers that may also be in unsafe zip codes. So that can be a problem, too. You’ve got this gem in your neighborhood, but you’re afraid to let your child walk to the recreation center.”

Concerns were raised about **neglected parks** and their abandoned renovations.

- “…we have a playground that was high on the rebuild at one point and somehow fell off. It’s not high on the list now, so I don’t know… The bathroom hasn’t worked since I’ve lived in the city… I think 30 years.”

OLDER ADULTS

Older adults need to be a part of the conversations about their **own well-being and their needs**.

- "I think one of the things that can really help support their population is like actually canvassing or like listening to what that group wants... I think a lot of times like it's easy to make assumptions."
- "If you're not affiliated with a church or a recreation center, there really isn't a lot for folks."

Resources and activities should reflect the **cultural preferences** of the community members that they are targeting.

- "...like my dad, he's in his seventies, and he loves line dancing as well... Like in my neighborhood there's a lot of people from the Caribbean and things like that. So getting together like maybe cooking classes. Or, you know, like we mentioned, like the line dancing."

Some concerns about older adults included their **limited access to transportation**, subsequently having to walk in areas that are not safe, taking the bus at night, and isolation. Regarding one recreation center, "It's not like it's in front of a bus or a trolley route like you really need to drive. So, I guess accessibility is a thing as well..."

ADDITIONAL POPULATIONS

People with disabilities face **mobility and accessibility** challenges due to structural issues in their physical environments.

- "But we kind of realized that... people that... have walking issues where they use like any kind of like motorized [chairs] or vehicles, or even people that use... walking sticks and things of that nature. There were so many things that are deemed accessible because of distance. But when you look at, okay, like are the curbs level...? Can a wheelchair come up on this ramp...?"

Attitudinal and structural barriers in healthcare spaces can limit access and effective service provision for patients with disabilities.

- "And there's also the issue, too, again, like going back to the special needs community like, I've had issues with my son when he was younger where it's like, okay, we set the appointment to get the blood drawn. But you know he's in such a frenzy because the lights are so bright. And you know, I think like there's just not a lot of accommodations for all walks of life. So sometimes it seems like the access is there but when you really get to these appointments, or you're trying to get to these appointments that's when there are all these other barriers."

Members of **ethnic minority groups** shared how shame and stigma can deter people from seeking assistance with their mental health.

- "A lot of different communities [won't be] seen going into going to a mental health setting. Both in all the Asian cultures we dealt with, but [also] in the African American community."

Respondents identified a need for mental health support among **LGBTQ+ residents**, suggesting webinars as a method of information-sharing. Stigma may also discourage their pursuit of health-related services because of a fear of being judged at doctors' offices.

- "Webinars that can speak on the LGBTQ community, which I see there's a great need for mental health services in my community, because of being afraid to be who they are. And it causes suicidal ideation."

TRUST AND COMMUNICATIONS

Regarding their **sense of trust** of healthcare providers, one community member responded skeptically, lacking faith in providers' cultural sensitivity. But trust can also be fostered after navigating a health system, with positive experiences, over a long period of time.

- "I feel like my doctor is cool as an individual. But if I'm being honest like, I don't really have a lot of trust in a healthcare system overall. Just from personal experience. Studying history as an African American woman, and what the medical establishment has done in terms of... our reproductive rights, and you know, experimentation on African Americans in general. But I will say also that you know medical malpractice is one of the leading causes of death in the country, too. So, you know, I just think that, like our medical system, really needs to be revamped."
- "I think there's a discrepancy between the way uninsured patients are treated and patients with insurance. I remember my younger days when I was a struggling student, and I was treated like a number. But there's a lot of people in this country who are against the idea of universal healthcare."
- "... I'm at a stage in my life where I actually like the doctors that I have. And I trust them. So, with that said, I have had virtual meetings. I see a nutritionist on Zoom, with the hospital that I choose to see, for most of my appointments."

ADDITIONAL CONSIDERATIONS

Children and families addressing **neurodivergence** faced challenges with trying to find sufficient community-based resources.

- "...we've been able to like reach a lot more families that have been affected by autism, and really any kind of developmental disability. But I've particularly noticed in this neighborhood that it's just something unaddressed in the three local elementary schools. There's so many autistic children that they've had to open autistic support classrooms in all the elementary schools around here. So, I'm like, so if you guys know, there's this many children with this issue, why are we not, you know, talking about it on a larger scale?"

Respondents shared concerns about having to sometimes wait months for medical appointments, especially when a specialist needs to be seen. **Long waits** in the emergency room, canceled appointments, and interruptions in continuity of care were also named as barriers to healthcare access.

- "I had to go sit in the emergency room, in which I ended up sitting there for five hours and they never called my name."
- "You would get a different dentist every time you went. So... every time you went you would... have a different plan for how to solve the major problems. So nothing ever really got solved because you know there wasn't any continuity in the care... you're sort of limited to going to somebody."

Some community members were still concerned about **COVID-19**. And one was familiar with Long COVID. "But from what I know about it, it's kind of like where you have perpetual COVID." Post-COVID, health services have improved, in part due to the convenience of telehealth.

SUGGESTED ACTIONS

Perhaps recreational programming that is geared toward the **whole family** will appeal to more community members.

- "I think parents are willing to drive their kids there and wait, or pick them up, depending on... what the circumstances are."

More **transparency** is needed from healthcare providers.

- "I would say, for like doctors to be more transparent when it comes to informed consent. Like when you're going through like different procedures and things like that. I think like a lot of things are kind of just especially if it's routine, they're kind of just like pushed on the general public."

Appointment-setting can be made easier, by allowing patients to do so virtually.

- "Being able to access and make appointments through a portal instead of having to go through a call center. I mean they have a portal that theoretically has that capability, but they don't have them."

North Philadelphia, East of Broad

COMMUNITY ASSETS

Recreational centers, such as the "Y" and health centers, were named as valuable community resources. **Public transportation** was described as "AWESOME" for the area. One respondent noted the presence of new "**senior buildings**" and related programming.

- "I'm going to say the local fitness centers... they're open to accepting the health insurance... so that helps."

COMMUNITY CHALLENGES

Limitations in access to health services were the prevailing topic of discussion around challenges. Doctors' offices closing early, limited proficiency across various languages among health providers, and an overall lack of cultural responsiveness were mentioned. For instance, French, Spanish, Arabic, and "different language(s) from Africa" are important. Additionally, respondents spoke of **poor customer service and bias** against certain consumers, especially those who lack self-advocacy. "...When people have substance abuse challenges or mental health challenges, they're treated differently and I really don't think that's fair... if a person is receiving substance abuse treatment when they go to the doctor and if they're in severe pain, they won't give them the full of the pain medication. And I've witnessed that myself..." there is a perceived lack of education among community members about **matters of mental health**, which may limit the pursuit of services. And some residents lamented **slow receipt of health benefits** and inadequate support for **homeless individuals**. "I want to say we're also lacking a lot of shelters. We don't have shelters." One respondent had trouble having her mother's prescription filled in Philadelphia but was able to find the medication in another county and for hundreds of dollars cheaper.

- "The big thing it was like I applied and then it was like for four months, I had no benefits at all. Because they said they didn't receive my information. They just took me off completely. I had nothing, no benefits, no income, no nothing, social security, everything was just like wiped out the whole thing. No medical, no nothing and it was like for four months and it was like the only saving grace was the senior building that I lived in and friends that I knew that helped me."
- "I've noticed with the health system... they want you to turn this paperwork on time, half the time when you get that letter, it arrives after the due date and then you're not aware that it was due. You know, back in the day they used to give you a call, they would be in the morning and sometimes you're calling this number constantly. No one answers the phone... it's like nobody is being held accountable for their actions, but yet they're penalizing the consumer in a sense."
- "...So lack of education and also cultural biases on the whole health care system itself and how mental health is looked at as something negative. So, I think there needs to be a lot more coverage on that and on the education of that."
- "...I think providers need to be more culturally responsive and competent when interacting with people because unfortunately some of them are still operating from the old medical model, old books 20 years ago. And unfortunately, a lot of them have a lot of biases and prejudice against people who are not caucasian."
- "The intake people, the people that greet you at the door, they're not nice... I'm always speaking up but if you don't have somebody there with any heart to speak up, they treat you like crap."

Neighborhood challenges were named, including the presence of **crime and lack of safety**, an abundance of **trash** on the streets, and **crumbling infrastructures**. "...Health-wise like there's asbestos in these schools and it affects these students' health and where they can't even show up to school anymore and they have to do online school. And it's kind of a challenge for parents, for families where they have to keep watch of those children and keep them." **Addiction-related homelessness** also contributed to feelings of being unsafe and evoked empathy among respondents.

- "Terrible sidewalks, terrible streets. It impedes good walkability, and also the lack of canopy, trees, to keep it from being so hot."

CHILDREN AND YOUTH

Gun violence in Philadelphia neighborhoods and schools were of great concern, personally impacting one respondent. "I've had three of my sons shot, the oldest one was murdered but I think that we have to do a better job at protecting our youth." The impact of **social media** was also discussed by a college student, as having a negative impact on mental health and being used to **cyberbully**. There is a need for **role models** for youth, as some can look to older adults who are setting poor examples. "For me, like I said, I grew up watching a lot of the old guys. I looked up to selling drugs and stuff so they made it seem cool. That plays a big factor on the kids today too, just trying to fit in."

Respondents expressed gratefulness for the availability of meals in schools that are of good quality, especially for those students who do not have reliable, **healthy sources of food** at home and in their neighborhoods. Perhaps there is also a need for **parenting support**, as respondents discussed issues around discipline and structure in the home. "I look at the children now, coming home 10:00 o'clock or 11:00 o'clock... a baby in the stroller and she was holding one waiting for a bus. Those kids should have been washed and in bed by 8:00 o'clock." There is also a concern about families' knowledge of health issues and insufficient **health education programs** on mental and physical health matters. Children are using and abusing stronger drugs at younger ages.

Extracurricular, summer, and job **programs for youth** and families are present but underutilized. "So, the plus is we have programs available, but some of our kids aren't buying into the program that's available."

OLDER ADULTS

Recreational programs, such as Tai Chi, are a necessary resource. But not all programs are affordable, covered by health insurance, or available by public transportation. **Public transportation** to doctor visits is also needed. Another issue of health access is directly related to **language barriers** and disproportionately impacts older adults. "...especially for the Latino community in this area, the older generations, a lot of them don't even speak English."

- "Having a way for seniors to be able to communicate abuse or any type of mistreatment because they're definitely a vulnerable population."

Food banks provide necessary access to sustenance, but the quality of the food is sometimes questionable. "...a lot of places that's giving food to seniors and to even the young, but I feel like... some of the foods that they're getting that are not necessarily healthy foods. It's like, yeah, it's free but it's bad."

Older adults, who are also **immigrants**, face additional barriers related to accessing personal records from their countries of origin, which can delay qualification for different types of health and social services. "...getting their documentation, getting their birth certificate, trying to run down a baptismal certificate to say this is who I am trying to get school records. so, seniors need a lot of help with that..."

ADDITIONAL POPULATIONS

Respondents raised concerns about the **LGBTQ+** population, **homelessness**, **substance use**, and being poorly treated in their community. Regarding those experiencing homelessness and substance use, "...they get moved from one place, then they go to another. it seems like the problem is not being solved." Gentrification was named as a related problem, because "there's all the people that are being pushed out of the area so that is a big health issue also..." and it's due to their **disadvantaged socioeconomic backgrounds**.

- "Same sexual preference. Sometimes those group of folks are mistreated... I think there needs to be some more training for the providers, that access to health care... shouldn't be based on someone's sexuality."
- "...racism is really big in the Latino community."
- "To add to that I actually heard someone homeless that said that they had to really commit a crime so they could get locked up so that they would have access to the insurance."

Medical deportation was identified as a violation of rights and barrier for immigrants who are undocumented and hospitalized, which can deter them from seeking necessary treatment.

ADDITIONAL CONSIDERATIONS

Accessing **dental care** can be difficult, depending on the type of coverage. "...try to find a dentist and that's a real big one. My mom's been trying to find an insurance company for the past two years. Every time she finds one, 'oh we don't take that card no more.' So, that's a challenge... no warning." A college student spoke of being covered under her parents' health insurance, but not their dental insurance. "Based off of my parents' insurance, I get everything but I don't get dental and they said like, you have to find that on your own. So, now I'm wondering should I transfer for my own insurance?"

The limited availability of general health **appointments** can lead to worsening health conditions. "So, if you need something like right away, sometimes you don't get an appointment until maybe four months down the line, five months down the line and then the condition has gotten worse."

Regarding the concept of **trustworthiness** among health professionals, perspectives were generally negative. There's a lack of trust related to perceived biases against patients based on insurance type, concerns about being unethically motivated by incentives from pharmaceutical companies, and billing for unneeded services. This issue came up again regarding experimental treatments and feeling like a "GUINEA PIG."

- "For me personally I won't say I don't trust any of my doctors, but I get a second opinion."
- "But they're not telling you in the beginning what these side effects, what can happen to you and all of this. But it's like you're their Guinea pig and you're helping and putting money in your pockets and they're not helping you."

Post-COVID experiences in healthcare were varied, with some community members preferring in-person services and others appreciating the convenience and resource-savings of virtual appointments. Comfort with telehealth services was positively correlated with **technology** savviness. COVID-19 is still concerning for some, it "did not go away." And respondents believe that people should still take "common sense" precautions.

- "What I don't like is the virtual doctor appointment. How they want to diagnose you over the...phone. Make it make sense... Don't ask me to go check my lab test and all this stuff."
- "I do appreciate for like the follow up appointments, those being virtual because sometimes when you have to go in person... it's almost like those meetings where... you could have just sent this in an email. So, that's a plus for the virtual being able to do like the follow up appointments."
- "Well, for me COVID it took a family member from me and my mother had it. So, I don't think we're done with it."
- "COVID doesn't worry me as much as crime does. The crime that's going on to it affects me worse than thinking of any disease."

SUGGESTED ACTIONS

Some suggestions offered to improve community health and conditions included **expanded doctors' visits** through evenings and weekends, **cultural sensitivity**, more **affordable housing** options, and fully covered **universal healthcare**. Medical **social worker**s were recommended for patients to have a "person talk to them one on one," along with **mentors** for youth. Youth programming should also be informed in part by input from youth themselves. Lastly, patients could benefit from clearer information regarding the explanation of benefits and **costs** incurred.

- "So, nutritional education for parents to help those kids I think it is a priority and going back to what you were saying, peer pressure is a big thing."
- "What I would love to see sometimes when they come to the doctor. I would love to see drug education. I would love to see sexual education... I would love for providers besides having... a 800 number. I would love to see more behavioral services if needed for the child and the family when they come in to teach them."
- "So, I think we need better like role models out there—especially the men because the young men tend to follow older men..."
- "I know we don't say good touch, bad touch, anymore, but this is appropriate and this is not appropriate. And I think that providers can play a pivotal role in that because you can have a health educator."

North Philadelphia, West of Broad

COMMUNITY ASSETS

An **urgent care facility** was recently built in the area, although more would be helpful. "We recently had an urgent care that opened in the area we could have used, that we can use more urgent care centers in the area that people can actually get to, they can actually reach…" Some respondents also reflected on **positive healthcare experiences**.

- "I personally stay pretty healthy, because I'm able to get to the health resources that I need. I'm able to get there. So for myself and my family we stay pretty healthy."
- "I think the other amazing thing for the 21 and 32 ZIP code areas is that we have two public health centers… these health centers have accommodated the needs of generations of people in our communities."

Outdoor recreational spaces were valued, such as the nearby zoo, Fairmount Park, and the Schuylkill River. "…The playgrounds we have. I feel as though [we have] some of the better playgrounds in our neighborhood…" There's also a local reservoir that children in the community enjoy, and a track where **neighbors meet**. "…we put neighbor back in neighborhood…" Residents also share information with one another, such as upcoming health screenings and yoga classes.

- "Fortunately, like on my block, there's still a lot of folks who've been there generations, and we still tight, we still look out for each other."
- "I do like the community gardens that that develop. I like the community green spaces that begin to develop in the different neighborhoods where people can learn how to grow food…"

Food pantries providing boxes of food have proven beneficial to community members, especially older adults. "…we also have agencies throughout the neighborhood that will supply food at certain times during the month…"

COMMUNITY CHALLENGES

Community members desired easy **access to health centers** that were local to them, but they're no longer available in their neighborhood. Health centers and doctor visits required **public transportation**, which was deemed inconvenient.

Financial limitations made it difficult to prioritize **healthy foods**, even though the desire was there, and local supermarkets were described as subpar. **Environmental conditions** were also described as unfavorable.

- "…just the financial wherewithal to have the right kinds of food to eat. And the environment around us sometimes is just not healthy…There are not as many trees as there are in some other areas of the city where the area was planned with trees."
- "I have vouchers from PCA for vegetables and things of that nature, but we don't have anywhere around us where we can use those vouchers, we don't have a farm. We don't have a Produce Junction in our area. If we had something along those lines where we have access to healthier foods, maybe people would, I don't know, be healthier…"
- "You get a lot of old meats and frozen, you know, nothing fresh… generic brands!"

Distance was not the only barrier to adequate health care but **cost** as well. **Acquiring medication** was also difficult because pharmacies were rare in their area. Chain **pharmacy** stores used to be in the community, but sometimes didn't carry the prescription medications that were needed. "…a lot of times they didn't have the medicine that the patients need or the residents. So, it was a lot of negative things with the pharmacies."

- "I can simply say a lack of health insurance can be a barrier for sure."
- "I remember when we had many, many small family-owned pharmacies. Many of them were even Black-owned pharmacies…"

Unsafe neighborhoods contributed to poor mental health. And local **mental health** resources were either unavailable or not well known.

- "Just seeing what's going on in the neighborhood, I mean, when you don't feel safe in your own area. That can contribute to your mental health…I mean, I'm not aware of any place in the area that you can go to, where you can get help."
- "We don't have any place to go or call for mental health services."

CHILDREN AND YOUTH

The issues of **youth mental health** were raised, along with limited access to mental health support that has been a problem for many years. "... just nowhere for you to feel safer when you can go talk to someone. And I think that's the problem with a lot of the youth. They have nowhere to go." There may be discrepancies between actual services available and awareness of these services.

- "I'm not sure that the youth are aware of the free programs that are available at the local recreation centers in the neighborhood."
- "... in the rec centers here, they're old buildings, lack air conditioners, lack activities for the kids... they need to be tore down and rebuild again."
- "... the pools haven't been opened. This is the 4th, maybe 5th year."

OLDER ADULTS

Older adults needing access to banks or healthy grocery options required **transportation**, which was problematic for them. "It really means traveling. And for seniors that would mean getting access to someone to take you where you need to go." **Comprehensive support services for older adults** were lacking. "...what I've been seeing they are building a lot of senior complexes and things like that. But they don't offer them anything they need."

People moving out of the neighborhood contributed to the **isolation of older adults**, which has made them vulnerable.

- "But when we had the population of people, when we had whole blocks of occupied homes, we had more of a sense of family, and we knew who our elders were and checked on them. There's... some blocks where there's so few houses on the blocks that people are so disjointed and far further and far away from one another, and that makes you vulnerable."

Concerns were raised about **medical care** not being thorough enough, with health professionals treating symptoms instead of the actual causes of conditions. "Usually, they send them to physical therapy, or they bounce them around the different doctors, but they never get to the root cause of what may be the underlying health conditions."

SOCIAL DETERMINANTS OF HEALTH

Historical and systemic legacies in the community were found to create hardships for residents, past and present. Those who had lived in the neighborhood for decades also spoke of how some **social conditions worsened** over time with "intentional disinvestment", while others had improved with recent development. Hospitals and schools closed, drugs became pervasive, and safety deteriorated. "...institutional racism in my perspective is a big barrier. A lot of the legacies from like redlining and poverty and lack of jobs that kind of create a lot of problems. The schools are poor in some regards and... now you have gentrification coming in."

- "...for maybe like 20 something years, there was no supermarket... There's nowhere people can get no food. And then it went through a period where it was a lot of vacancy."

Community members have inadvertently jeopardized their health benefits by **earning too much in wages**, making gainful employment counterintuitive. "...when her income went up a little bit, she was no longer eligible for health coverage!"

ADDITIONAL POPULATIONS

Medical **appointment times** were too far into the future, with some waiting for 3-6 months to be seen. Switching health systems didn't seem to solve this issue, as respondents have also faced barriers due to high co-pays, insurance premiums, and ambulance costs. "...between June and July, $1,500 just for co-pay."

- "...when you're offended by one healthcare system, and you say, well, I'm not going to go back there anymore, and you shift to go to another health system. And [the] Philadelphia region has many health systems. But things happen at all of them. And and that's really really unfortunate..."
- "I think it doesn't matter if you have healthcare or not. There's always a wait, no matter where you go. That's why people choose urgent care..."

When questioned about levels of **trustworthiness** for healthcare providers, respondents associated trust with the length of time spent in waiting rooms and how much time and attentiveness their health providers invested in them. Trust was also correlated with providers who fostered safe spaces, "feeling like you can tell your health provider anything."

ADDITIONAL POPULATIONS (continued)

Regarding post-COVID **integration of technology** into healthcare, most respondents agreed that technology use has been helpful. Some, particularly older adults, have had a more difficult time adjusting. "I'm trying to keep up with the technology, even though I'm 68." The latter would prefer to have providers explain test results verbally, rather than accessing results independently through a portal. Most respondents were still concerned about **COVID-19**. And four people were somewhat familiar with **Long COVID**. "It occurred to me within the past couple of weeks that maybe that's part of what I'm experiencing. I may have to have a conversation with my doctor about that."

- "Not for me, because I always make sure, well, I'm going to put this way - I got my 6th shot."
- "COVID is a great concern for me, because I only had the first two shots. When I went to get the second, I reacted horribly... So it is a concern for me, because I'm not able to get a booster shot."
- "...it's a great concern for me, too, because I've had COVID 4 times, and I have a breathing disorder."

SUGGESTED ACTIONS

Services and activities for older adults require greater organization and follow-through. They need **advocates**.

- "...we got five senior buildings in our neighborhood and all they do like [to] sit outside... They don't have anybody... so a social worker in there who could help them with some of the problems they might have... that's one of the things that they always complain when they come into our office is that they have nothing to do"
- "I'm gonna stress that I think we gotta do way more investment and bring in health services to directly to people houses directly to the places where our seniors are living at. Gotta have a more door-to-door approach."
- "I had a situation where I had to, you know, really put my foot down to get my mom a CAT scan. And he didn't want to do it."

There's an expressed need for more providers from diverse, ethnic backgrounds.

- "...free tuition for Black students starting, targeting them in middle school. They start a partnership with the local universities, the local hospitals, and they be placed on a track to become doctors."

Northeast Philadelphia

COMMUNITY ASSETS

Free access to **physical fitness and recreation programs** and spaces were valued by community members, especially when there were options for both indoor and outdoor activities.

- "...one of the things that the CDC just did and I'm part of the CDC, is they're offering free yoga and free Pilates classes... And so, we have pop-up events, and we have a lot of people that have been coming to them. So, we're hoping that if it grows, we're going to continue doing that."
- "Riverfront North is building a trail... when it's all said and done, you'll be able to drive all the way to King of Prussia on a bicycle. It's going to be a 30-mile bike trail. So, it's slow coming, but people are starting to use it more."
- "Just about every playground around here has been redone or in the process of being redone."

Philadelphia's non-emergency inquiries and service requests line, via 311, has provided residents with a mechanism for addressing environmental issues efficiently. General efforts toward neighborhood cleanliness were appreciated. "The cleaning of the neighborhood was really nice when they came around."

- "I called for five things, at least for a couple vehicles that were out here. They came, they did all of them across the street, they cleaned up. So, it is working..."
- "So she's [the mayor] trying to push for cleaning the neighborhood and, which increases our health."
- "We had street cleaners come down the street for the first time..."
- "...the CDC pays for Ready, Willing, and Able. It is a group that, you may have lost your job, you've got divorced, you're just getting out of jail, you're recovering, and they teach you finances, cooking, how to maintain a job, what to do. We pay for them three times a week, and they clean from Cottman Avenue all the way to Harvest Avenue."

Respondents spoke of the availability of free, community-based **behavioral health and self-help groups**. Those mentioned were affiliated with local churches. "There's so many different ones for people who don't have insurance."

COMMUNITY CHALLENGES

Community members cited **limited healthy food options** as a barrier to optimal health. Apparently, efforts to establish healthier options in their neighborhood did not meet success. And **affordable supermarkets** with quality food items are limited.

- "We did have one store open that had healthy things. It was a juice bar, but they closed down. So, there's really not a lot of healthy options in the area unless you make it yourself."
- "And recently, a bakery opened up, so it's really a lot of good stuff. They're only open one day a week, and that's probably because they're uneasy about keeping it open the whole week..."
- "There's nothing in the 19135."

Lacking a sense of safety in their neighborhood, respondents limited their physical activity outdoors.

- "I want to say that staying healthy would be walking, walking the neighborhood, and there's a walk path and all that other stuff around them, but if you just want to walk outside of your house, which I do my whole life, it appears like there's a danger factor now. And that affects my health, because I'm not as free to walk as I do."
- "So, we walk every day, me and my niece, and some days we don't walk because I get done too late. So, we don't want to walk when it's dark, because of that reason, we'll walk when it's light."
- "And also not being able to walk alone, where I used to always walk alone, never think about it. And even carrying mace and stuff, I still don't feel safe."

COMMUNITY CHALLENGES (continued)

Substance use was cited as a visible problem. And "a lot of it goes along with being houseless."

- "Drug abuse. Substance, you want to call it. That's affecting everyone."

Access to **mental health services** was challenging. Community members felt that health insurance companies did not regard mental health as important as physical health. And those who had sought out services locally were not satisfied. Concerns were raised about the mental health status of people in their community experiencing homelessness. Some participants were aware of the 988 hotline, and some were not.

- "There aren't really many walk-in places other than, like, when my husband had to go to a hospital. Which was sort of traumatic for him."
- "And unfortunately, the mental health facilities, when you go there and you tell them, look, this is what's happening, they tell you there's nothing left we can do for you. And my daughter had a friend who committed suicide..."
- "That's why my daughter stayed at the main hospital in the city, because she's so afraid to try to switch somewhere around here because she doesn't think that she'll get help in a timely matter."

CHILDREN AND YOUTH

Recreational areas in the neighborhood have recently been renovated and utilized by local youth. But more support is needed to lead organized activities.

- "...we just had in the 19135 area, Keystone and Tyson, they just redid the basketball courts. And it's nice that every night, there's somebody there. And there's been no trouble. The only thing, we need the lights on later because they're pulling their cars in there... So, we need to get the lights on. They're redoing Vogue, which is again in the 19135 area. So, they are trying. There's a soccer group that they're looking for coaches to have kids and adults play soccer at Roosevelt Playground. Again, that's through Parks and Rec. So, Parks and Rec does a lot around here for us."
- "Plus a lot of the rec centers when my children were younger, they could go and play different sports. But now nobody wants to get the sports teams together. The kids don't show up. They don't want to play. So, the younger kids now, it's really hard for them to belong to a group."

Concerns were raised by participants about **inadequate mental health services** for young people, not following through with comprehensive treatment when needed.

- "I don't think the health care system understands mental health. And they treat it as a cold and it's not. And they really should do something where the children have a wrap around in school. You really do need somebody to follow you. Family can only do so much, and it's hard."
- "My daughter started in 6th grade going to therapy. We had a house fire over Cottman Avenue, so we were displaced for almost a year, and that triggered all of the mental health. You know? And so, no one in school did anything. They didn't offer anything."
- "My daughter has all her diagnosis finally by the time she was in college, she got all the right diagnosis. But it took all those years through middle school, high school."

Respondents spoke of youths' **overreliance on technology**, and how it has limited social interactions. There were also concerns that this behavior was being modeled by young parents.

There was an expectation for **local political leaders** to have more of a vested interest in supporting youth, similar to how community members felt they were advocating for older adults. "I noticed when we have a community meeting, the politicians always be there and always talk about, 'we're doing this for seniors, we're doing that for seniors'... and I know they're doing it probably to get votes from the seniors, but I never hear them say, 'we're doing this for the kids.'"

Respondents also mentioned a recent loss of **funding for local libraries**, which negatively impacted youth programming. "We've had to cut a lot of programs, especially with funding. Our funding went way down, and that's a big draw for kids and families to come in and spend time together. They still have the after-school program where the kids can come in there and spend time, but the actual programs that we used to have, we just don't have, like, used to."

- "So, the library really does a lot for the kids, not as much as pre-COVID, but they're still doing it."

OLDER ADULTS

Residents felt that older adults were supported by local politicians.

- "The politicians do a lot of senior expos, and they help them… and they go to the senior meetings and give them money so that they can get out and do things like that. So, I think the politicians help the seniors."

Physical fitness programs were available in the community at a low cost or for free for older adults.

However, older adults could benefit from enhanced transportation services. For instance, the free SEPTA service that transports them to medical appointments was not efficient. "If you're coming to doctor's appointment, you're either getting to the doctor and sitting there for two hours or getting done your appointment and sitting there for two hours." A resident who used a similar service through her insurance had the same experience. "And it's not a big bus that I have to wait three hours for. And I'm a senior."

SOCIAL DETERMINANTS OF HEALTH

The proximity of **neighbors who smoke** was identified as problematic, limiting use of shared outdoor spaces in order to minimize exposure to second-hand smoke.

- "… living in a row home and having renters come in continually and evolving door of renters, it seems every renter we've had in the last 10 years has smoked. And we're a smoke-free home. And my husband's mom died of lung cancer. So, that's a big issue for me having to shut my windows, because they're constantly out on the deck that adjoins and they're constantly smoking… don't want it in my home."

The disparity in cost between healthy food options and **unhealthy food options** was directly correlated with health outcomes, such as diabetes. This was true for pricing in local restaurants and supermarkets.

- "… French fries are a $1.99 for extra-large, but if you want a cup of fruit, it was $5.99 for the fruit."
- "And our large supermarkets, I believe. Also, we don't have some of the ones that other neighborhoods have that offer more healthy foods."

ADDITIONAL CONSIDERATIONS

Access to **mental health** services appeared to be based in part on the type of health insurance that someone had, which also created issues with affordability. "I only know when I tried to go to one, it was really hard to get one with regular [insurance company] because I belong to a private group. So if you get it at work, it's a different thing. Nobody wanted to take me because my [insurance company] was an individual plan… and I paid $1,500 a month to [insurance company]… And then my copay with them was $60 a time."

As some respondents shared about different resources that they were familiar with locally, others seemed to be hearing about them for the first time, indicating a need for better **dissemination of information**. "Well, that sounds like a barrier to health then… the lack of knowledge of what resources are even available." A local, printed newsletter was accessible to some but not others and has been used to share information about community-based resources. This was cited as a tool that needed enhancement, such as widespread delivery.

Respondents had mixed thoughts about services at **local hospitals**. There were concerns raised about hospital **staffing issues** since COVID, that have contributed to longer wait times and lower quality services. **Urgent care centers** were reliable for fast service. "… If I have to go to a local emergency room, I will not go to one in our neighborhood, which is a horrible thing to say. I will travel out of our neighborhood to go to an emergency room, and I don't like having to do that. But I've been overnight in an emergency room in the past. That's how busy they've been, because of the lack of staff." Another community member shared a different experience. "And I've been to some of the local ERs that were wonderful… it depends on what you're there for."

ADDITIONAL CONSIDERATIONS (continued)

When asked about feelings of **trustworthiness** regarding relationships with health providers, respondents were positive. Two referenced critical health needs related to pacemakers, mammograms, and the significance of longevity in relationships with healthcare providers.

- "...the one hospital I am established with, they're very good with their care."
- "I say, yes, because I'm on my second pacemaker. And whenever I go to that local hospital, they're always great. I was like, test everything. I think they're really good."

Participants were asked about their post-COVID experiences with the **integration of technology** in health services, and responses were mixed. This was based on convenience, whether someone had questions to ask of their provider, and comfort with technology use.

- "I love it. Having a portal, I like being able to get my results before my doctor."
- "I'm not very happy, and it's not their fault, but I have difficulty with portals. But that's me. I just like to know that there's a person at the other end speaking."
- "I'm fine with the portals because you do get your information. Sometimes the doctor doesn't get back to you, so then you can call them. I'm not fine with the [telehealth] appointments because if there is something wrong, they don't see you, they're not taking your blood pressure."

Respondents were still concerned about **COVID-19**, staying current on booster shots. "I'm nervous because I can't get any vaccines. So, if I get it, I have customers that are in their 90s. So, I'm very afraid that I'm going to give it to them." One community member indicated that they had experienced "effects from **Long COVID.**"

SUGGESTED ACTIONS

The option of having medical appointments outside of **traditional business hours** would improve accessibility for community members who cannot afford to take time off of work for doctor visits.

- "I know when I was working full-time, my biggest option was having availability on the weekends to go to a doctor... I didn't go to a doctor for years because I had to take off from work, and I didn't get holidays or anything. So, I just didn't go."

The frustration with long **emergency room waits** can be alleviated with better communication from health providers and access to healthy food during late hours.

- "I think when you're waiting in the ER, it would be nice for somebody to communicate with you. I was in there, and the guard actually was coming and telling me because he saw that I was very upset."
- "...in the ERs at night, a place to go eat... their cafeterias are closed at 6 o'clock. And you're in an ER, you have the vending machine. ... last time, I had a $20 bill. The machine wouldn't take it, and nobody would give me change."

A suggestion was made for **co-located physical and mental health services**, in order to facilitate access. "I think they should include mental health in the hospitals instead of having to go separately to different locations."

Respondents discussed the need for day programs for **adults with intellectual disabilities** in their community.

- "...what do you do with somebody that has the mentality of a five-year-old when if you could take them to a place during the day... like a camp, and there's nothing in that age group. [Person's name] is like, 40 and above, there's nothing there. That's why, I guess, they end up on the street."
- "There was a gentleman in [a coffee shop] today that was coloring, and he had all his books and all his art supplies and everything, and every 15 minutes or so, he would get up, he would run around, he would yell, and you knew he was by himself. And I felt horrible, because you just dropped him off there. Somebody had to drop him off because he had all this stuff all over the whole big table, and nobody was there taking care of him. Nobody was helping him, and people were looking, which I could care less about, but I don't want to go up and ask if he needs me to help him, and the baristas are like, 'what do we do'"?

River Wards

COMMUNITY ASSETS

Neighborhood aesthetics played a positive role in respondents' perspectives of their communities. **Green spaces** and periodic **street cleaning** were noted as examples of this. **Relationships** with neighbors, churches, community health workers, and the presence of police officers contributed to positive health outcomes. **Community gardens** provided a "healing tranquility" for families to convene and get away from the typical noise of the city.

COMMUNITY CHALLENGES

Challenges within the community included the **unhoused population's** insufficiently met needs, poor air quality, litter, and access to **unhealthy food** options. Not all respondents feel **safe** in their neighborhoods, and some noted a "lack of transportation," and "difficulty finding jobs."

- "How is the quality of the housing? So even, you know, some people are not necessarily houseless, but the quality of the place where they live may not be great."
- "...they don't have any trash cans out there. Everyone else throws stuff on the ground."

CHILDREN AND YOUTH

A local **playground** is unsafe to access because of the need to cross multiple major roads to reach it. However, the number of youth sports and sports-related **activities** have increased, "keeping them out of trouble and giving them something to do." One resident raised concerns about the implications of **parents** working outside of the home with older children lacking supervision. "...in today's society they got to work when they got to work. With kids who are grown, they got too much free time." Parents may benefit from more support. "...A lot of parents they talk about, 'I'm your best friend.' You not my best friend. You are, you're my son. I'm your mother." And concerns were raised about youth spending too much time playing **video games** and on **social media**.

- "...single parents. [If] they work from home... they're trying to focus on kids but trying to do their jobs..."

OLDER ADULTS

Issues raised regarding older adults included **unaffordable health insurance** and **insufficient income** in older adulthood. Accessing doctor appointments with **physical disabilities** have proved challenging. "I was here seven months, and my service coordinator was supposed to set me up with medical transport... she still ain't do her job. I had to buy a truck. I got to go on a stretcher to go to the doctor's. I called up and complained, she won't give me a supervisor's number." Being placed on hold for 30 minutes or more and facing confusion with transitioning health benefits at retirement age, residents expressed that older adults might need support with **accessing community services**.

- "...because now you living off of one income or, you know, a, a set monthly income and that's barely enough to take care of just yourself..."
- "I don't know what to do. I don't want to pay the premium. It's so overwhelming to me right now. I don't know what to do."

Respondents acknowledged the need to be **technologically savvy** nowadays, and that older adults can have a harder time with this.

SOCIAL DETERMINANTS OF HEALTH

Concerns about the inefficiency of **substance use disorder programs** were raised. The length of stay and geographic settings of behavioral health programs should be reconsidered to encourage long-term recovery. Respondents acknowledged how **poor mental health** coincides with **substance use disorders** and that it can serve as a form of coping for certain life circumstances. And high treatment cost can serve as a barrier.

- "...they need drug treatment or better drug treatment. Not only... about whether the person get clean but they don't keep them long enough. What is 30 days? What is 60 days? Give me six months, nine months a year and get them away from the area... You see that repeated behavior? So, what are you going to do to change it?"

ADDITIONAL CONSIDERATIONS

Poor customer service that limits healthcare access was noted by respondents. “I can’t get through over there and, and even the, the specialist they sent me to up on [ ] street, they never returned my call and no answer. No answer. Nothing. It’s terrible over there.” Lack of affordability of **deductibles and co-pays** was another issue raised.

Most respondents spoke positively of their telehealth experiences, using technology to check for follow-up appointments, to access medical records, and for the convenience of not having to leave home.

Post-COVID, community members expressed a persistent concern about the virus. Although, there was a general lack of awareness of Long COVID.

- “...everybody coughing and sneezing, you just don’t know. It could be COVID...”
- “...COVID is real, it was real when it came out. Um, it is real now, a lot of people don’t just because you’re not hearing about it. It’s still different, rare variants.”

SUGGESTED ACTIONS

The community would like to see “more libraries. Yeah, I used to always hang out with the library.”

Residents acknowledged the need to be more civically engaged for their own well-being and to vote for policies that support their interests.

- “What I’m noticing when it comes to getting things done in your community, we need to come together in numbers.”

South Philadelphia

COMMUNITY ASSETS

There's a **sense of community** cultivated by community activities, such as neighborhood holiday celebrations and time spent together at local parks. **Cultural ties** related to countries of origin and religion also support the sense of community among residents.

- "What's going down in FDR Park is wonderful. Try to get down there. There's a great sense of community. They're doing a great stuff with youth and different cultures and communities and just to get that rust bit and see grass and see trees, it's very important for your mental health. And it also helps your physiological, your breathing your lungs. So, whenever you can try to immerse yourself in nature."
- "I agree with community. I think that's one of the strengths of South Philly specifically is we have so many groups of immigrants that have, I think in general, stronger community ties than what mostly white suburban neighborhood would have. And so I see a lot of my neighbors spending time together and looking out for each other. I live next to a church that is really active with people. And I see a lot of programs happening there that seem to all be helping people stay healthy."

There was an appreciation for resources and organized activities to **promote physical fitness** among community members, such as a Philadelphia bike share program that offered free trial periods. And efforts by the mayor to clean every part of the city raised community members' spirits about their surroundings. "So, last week, I don't know if anyone is talking about the **cleanliness of the city**, which also adds to health outcomes. Mayor Parker almost finished this one city initiative cleaning every neighborhood very deeply for one week. I've been following it very closely and it's really been successful really at the street cleaning program."

Gaining **access to healthcare** was deemed "easier than in other places," because "we have a lot of major medical systems, hospital systems..." **Community health navigators** facilitated access for those who faced complications. "where you get your care, you can ask for a community health worker. They are pretty much the liaison between a mixture of what a social worker and a doctor can do... they can work with you with language barriers, health literacy."

COMMUNITY CHALLENGES

Stated challenges to obtaining and maintaining optimal health included barriers to **healthy eating and physical activity**, such as cost, "time, not having enough time to go to the gym or to exercise," and fast-food restaurants and discount stores where "you can get stuff really cheap but it tends to be cheap and unhealthy. And what seems to be healthy tends to be too costly."

For one respondent, the reliance on **technology to navigate health services** and insurance policies caused an immense amount of stress, after her insurance was canceled and needed to be "reinstated retroactively" or she would have to wait for open enrollment several months later. Related concerns and sentiments of mistrust were raised from the perspective of Spanish-speaking **immigrants**. "There are folks from Guatemala who have moved to the area in the last few years and when they come here because they can't communicate and they try to speak to them in Spanish... But also there's not cultural sensitivity for the most part, almost everywhere. The systems are made not for the community to use it, but for the corporations who want them not to use to make more money, unfortunately."

The problem of **food insecurity** resonated with residents, as the cost of healthier food options and geographic distance served as obstacles. And poor food choices were recognized for their long term, negative impacts on physical health. "I work with a community group that has community fridges and pantries around South Philly. And every time I go there to put food in, it's gone in 30 seconds. Every time I walk in that, there's a really long line. Affording food, having enough food, being able to get to even a grocery store is really hard."

- "People are stressed out, they're trying to make ends meet, inflation is out of control. Good food, healthy food is very expensive. So, what's the default setting? People go to McDonald's for $2 to get a hamburger and fries. And what's the default of that? Hypertension and diabetes and obesity, which causes all kinds of issues. So, it's just a spiral."

Substance use within the community raised concerns about the mental health of community members and overall neighborhood safety. These were also contributing factors to feeling less inclined to engage in physical activity outside of the home, along with feelings of anxiousness.

- "And I know, personally I don't walk on certain blocks because I know that gun violence is an issue there. So, it makes me more likely to stay home or just not to walk around. And I mean, go to the subway station and you will see that there is not enough help for people… And they are forced to live outside and use drugs outside and it's not safe for anybody involved."
- "I run at 5:30 in the morning but I run with the group. So, that's an issue if you have to run or do something early before you can go to work, it's usually going to be dark so that you're going to be concerned about the safety."
- "I mean, you're accosted if you don't have your wits about you every second of every moment you're out on the street or on the sidewalk, you can be killed by anyone at any time. And it never was like that before. People had empathy. People had self-respect. People had respect for each other, and they had respect for where they live. So, it's like the breakdown in society. And I hate to say it, the political climate has normalized hate and has normalized divisiveness and that's where we are on our side today. I've never seen this in my life. And it's sickening and it has become a health issue because the anxiety that you feel every day…"

Communities were criticized for **discarding trash** carelessly, creating a public health concern. "So, if people had more pride of where they lived, I don't think we would have… trash, it really leads to poor, bad health outcomes, trash maggots, mosquitoes. And there's been a huge proliferation of wildlife raccoons, squirrels from all the trash that's left out. So, there's a lot of - there's a big problem with raccoons in South Philadelphia right now. So, that's also a health issue."

CHILDREN AND YOUTH

Youth have been observed engaging in **high-risk behaviors**, such as smoking "all sort of things" in subway stations and in parks. Underfunded and under-resourced schools and **social media** were also topics of concern. "Kids end up then without a mentor when they really need one or they just need someone that they feel like cares about them because they can't always get that at home if their parents have to work multiple jobs or if they don't live with their parents."

Also, "Beefs have moved on to social media and so kids are shooting each other because of something they posted on TikTok."

There appeared to be a disconnect between **youth programming** available in the community and the type of programming youth wanted or needed, which can affect future funding within their community. "There are more programs for the youth… but it's hard to reach them. So, it just has to be a change in how they're making the approach or at least sending out the invitation. But I know there are a lot of programs, but… a lot of kids aren't coming. So, they're not getting the numbers for the funding for them to continue."

- "In my experience in people that I've talked to, especially for younger people of color. The increased funding and presence of police has led to negative life outcomes and thereby negative health outcomes. Because often that is different from community care and turns more into just like frequent incarceration, unnecessarily, frequent violence against a lot of people but particularly young people of color…"

OLDER ADULTS

The need for **recreation spaces** in the community was a recurring theme for older adults. "I kind of like the fact that they have the senior centers for the older folks… they can get out to bingo, a lot of them doing line dancing… They have a lot of walking groups now that they can go on a walk. They have some running groups."

- "But that's positive that Philadelphia really has a nice big budget set aside for aging and PCA - Philadelphia Corporation on Aging."

Meal delivery services were also important for older adults who faced mobility and transportation issues that varied as the seasons changed. In addition, "the only thing is the heat. They're not coming outside, they're staying in their homes, they're not venturing outside at all which is, that's not good for health."

- "I think a difficulty that I notice especially amongst older adults has to do again with **accessibility**, especially for wheelchair users. Most I guess particularly on sidewalks that are sometimes broken and craggy or which have bumps and levels that are just not accessible and then in buildings themselves which have too narrow alleys to be used by a wheelchair person…"

Distinct differences were noted between older adults in immigrant families and those in American families, related to the propensity to have **family support**. "...The social structure breakdown that [person's name] had said about the families... I've seen the Indonesian communities are more tight knit and there's many generational families and generations live together and which is very helpful for the older... and if that's a great thing and I see the cultures, the Mexican culture Spanish speaking, the Indonesian community, Asian community, I feel they're more tighter knit."

ADDITIONAL POPULATIONS

Various intersecting social factors were identified for negatively impacting health outcomes in the community.

- "...with **queer and trans people** being considered less employable, incomes are lower and accessibility to health services are thereby diminished."
- "Health care is being debated by old white men. I mean, they took away **women's right to choose** out of the majority of states and left it to the states. And now women who don't have transportation or they can't afford it, it's going to cost them more money to go to another state to get an abortion."
- "And I see it every day and then all of my **neighbors are very lonely** because their kids live so far away and there's no one there to help them with the day to day."
- "There are multimillion properties being built but there is over 10 to 20,000 **homeless people** in the street..."

For members of the community who are **not American citizens**, eligibility for health insurance could be difficult because they no longer had access to identification documents that they needed.

- "...for a lot of people that aren't citizens, it's very difficult for them to obtain birth certificate, social security cards and stuff. So, it's almost impossible to get insurance if you don't have an ID, so that could be a challenge."

ADDITIONAL CONSIDERATIONS

Described as a "huge limiting factor" was the lack of transparency with **healthcare costs**. This impacted community members' ability to make informed choices about their health. "You might be able to get to the doctor, but it's going to put you in debt. And then potentially keep you from continuing care you need because you can't afford it because insurance is terrible in this country. So, I think that it would help if we could do something about health care costs." Some individuals with "good jobs" still had trouble affording insurance. And older adults of retirement age couldn't retire because of health care costs.

The demand for **mental health services** outpaced the availability of mental health providers. "...My insurance covers mental health, which has been great... but again, everybody needs it right now especially. And so there's not enough people accepting new patients."

Community members expressed that the **fear of experiencing discrimination** in healthcare settings was a reason for a lack of trustworthiness. These biases were perceived to indicate a need for more **cultural sensitivity training**, with an increase in staff numbers. "...People tend to express a fear of micro or macro aggression even within health care settings where there should be more competencies. And further, I think with the utmost empathy as fear of mistreatment by people who are overworked and under supported..." Although one respondent shared a contrasting perspective about her experiences. "I've always felt heard, valued, respected. I never had an instance, I guess I'm fortunate. I never had an instance where I did not feel that way."

Regarding post-COVID use of **telehealth and technology** integration into health communications, the reviews were mostly unfavorable among this group. A lack of tech savviness and accessibility issues were cited as hurdles.

- "Yeah. I'd rather talk to a live person. It is helpful to be able to go into the portal. Sometimes when you don't want to have to be on the phone... sometimes it's a little difficult for me to navigate..."
- "It's only negative because I'm not tech-savvy."
- "And so in addition to not being exactly tech-savvy, the way that websites are designed is not always the most accessible... so many websites are just not built in a way that is conducive to softwares like that, which are extraordinarily helpful for people with different disabilities."

ADDITIONAL CONSIDERATIONS (continued)

Seven respondents were still concerned about **COVID-19**. This was due to persistent viral mutations and fears of contagion, pre-existing conditions, the spread of misinformation about COVID-19, and perceptions of insufficient safeguards on the part of the government.

- "...especially in larger political spheres, myths and disinformation about what COVID it precisely is and how different strains can continue to affect and disable people efforts to regain normalcy which just seek to continue putting people back into workplace to be laborers in dangerous situations, making people expendable. Yeah. A lack of value on the human life at stake."
- "The original form of vaccine is still not strong enough... It's hard to keep track of what's happening..."

Three respondents were familiar with **Long COVID** and discussed its implications on quality of life. "My cousin had and it's been a year and he still had some respiratory issues and problems. And then a friend of mine's son, it's probably been almost a year, he still can't get his taste back. And he's a cook so it's really challenging. So, that's the thing that's going to interfere with his mental health, his livelihood that can affect him, his finances and stuff."

SUGGESTED ACTIONS

Some thoughts from respondents on how to implement improvements in healthcare experiences included school-based health services, enhancements to housing services, universal healthcare, and further development of a diverse healthcare workforce.

- "...community centers after school time would be really important to help kids just have something that makes, that is a good use of their time that keeps them safe, makes them feel cared about, makes them feel confident and just keeps them from getting mixed up and some less pleasant stuff."
- "I think that school-based clinics, health clinics are really promising direction to be moving. A lot of folks can't afford the healthcare..."
- "But I feel that a really big issue, the major warehouses that can be turned into shelters with simple funding..."
- "...we just need universal health care in this country... not everybody has a job and your health care should not depend on that. So, that would make a huge difference."
- "...overhauling insurance in general is prescribing food as medicine. I think that health care providers should heavily subsidize healthy foods for folks and deliver it to them and make it as low barrier as possible."
- "Workforce development programs... they don't really exist anymore. But if there are workforce development programs for healthcare assistants along with the school, you can get a student to... become staff..."

Southwest Philadelphia

COMMUNITY ASSETS

Friendly neighbors (i.e., being welcomed, inviting small talk), **family support**, and **clean neighborhoods** contribute to overall good health. This includes community members attending church together. Being able to "sleep in peace," not being stopped on the street, and no seemingly random knocking at the door provide a sense of safety. Violence in the neighborhood seems to have subsided. A wide variety of public transportation options and access to an abundance of free produce were noted as well. "So, we got... tomatoes on the vine. I never buy tomatoes on the vine because they're expensive in the supermarket. And since that has been going on, and me and my family have been eating a lot healthy again." Community members also obtain free produce through community gardening. There is also a walk-in clinic open to all (including undocumented individuals) that provides a variety of services additional to those that are health-related, such as assistance with filing taxes, food, and for a short while, bus passes sponsored by a local councilperson.

- "The church is very good... If I don't go to church, I don't feel good. But I'm very happy that every Sunday I'm able to go to church."

COMMUNITY CHALLENGES

On the other hand, options for purchasing **healthy foods** are limited and not as convenient as the corner stores in the neighborhood. "I don't do the corner stores per se. I don't even let my children do the corner stores. But they're so easy to access and a lot of kids, that's not just kids, adults too. They run in all the junk food and the greasy foods and all that at them corner stores... some people don't drive. So, they don't have anywhere to get to but the corner store or maybe their children, grandchildren go to the store for them."

- "I just wanna add, that's another thing that people do need food. And some people do, like when I go, I wait an hour before they open so that once they open, I'm getting in and out... But if you don't go when they first giving out the food, it can be three hours, so that's how hungry people, or at least for the food banks in my area... But when I'm driving back, I can see the line, if this place gave out food, the line would be around the corner. Literally, that's how desperate people are just to get some decent food."

A respondent described their apartment building as "fine," but their neighborhood as "high crime." Although she is within walking distance to a local discount store, she prefers to drive to ensure safety and acknowledged that this has an adverse effect on her physical and mental health. Access to proper grocery stores requires a vehicle, which makes them inconvenient to most.

- "...there's a lot of access to fast food."

Concerns were raised about "mental health, alcoholism and the second-hand smoke and high blood pressure. That's a big issue in the community." **Access to health services** is impeded by a lack of knowledge and inadequate health coverage. "...A lot of the people don't take advantage of the resources that you have in the area. It's a lot of resources and people just don't know... so, you got like the health clinic which is a few blocks from here. It's a free health clinic for... when you don't have, medical."

Some **neighborhoods have been neglected**. "A vacant house right next door. 40 years vacant... I'll complain about it to no avail. I got a school bus at the corner. It's been here for two years. I called 911 or wherever it is to no avail."

CHILDREN AND YOUTH

Parks and libraries have been closing, along with vocational training programs. Youth would have to access programming, but at a greater geographical distance. "So, it's a lot of stuff in the area, but it's just the point of getting to there or getting the kids involved in there. I don't know because they're so used to going to the rec centers and all in the area." There were concerns raised about children being less active nowadays and eating **unhealthy foods**. A positive observance was the extended school lunch programs, to provide young people with better options.

- "And the unhealthy eating options are, I guess affordable. So, their caregivers allow them to eat this food. And I see a lot of overweight children and I know when I was younger, we weren't overweight, that and things to do, but I don't know why their guardians won't, I guess, make them go because I was made to go to activities at least until I got to college, and I could do my own thing. But an after-school activity was mandatory whereas there are things to do."

OLDER ADULTS

Senior living options and the provision of **transportation** for older adults are helpful resources. They also appreciated the **meal delivery** service for older adults and people with disabilities, covered by healthcare. There are also several local **recreational programs**, accessible by bus. "Bingo. And ladies play the drums and dancing and pool and even have a religious thing every once in a while, but it's good, something to get the heck out of the house."

ADDITIONAL POPULATIONS

Homelessness was mentioned by respondents as being an issue in the area. "So, where I live at there's a high homeless population... I do see the homeless outside."

ADDITIONAL CONSIDERATIONS

Experiences regarding access to healthcare were mixed. Factors impacting decision-making included **long appointment waits**, **unaffordable co-pay** amounts, and doctors' walk-in policies for **patients without appointments**. Long-time residents lamented the on-going **closure of hospitals**. "When I first came to Philadelphia, [I used to see] hospitals all over the city."

- "For me, if I can't see my primary care, then I'll just go to urgent care. So, it's good that they have them around everywhere and I could just get in and get out."
- "It's not difficult for me. It's pretty easy."
- "Some doctors is not available until like three months later. So, if you really need to go to the urgent care, there's a whole bunch of them in the city...Not to wait months and months to be seen, that's too long."

Regarding access to mental services, **social stigmas** serve as a barrier. But for some, **virtual visits** help to combat this issue.

- "...it's like a pride thing, like a lot of people that I know they like, no... they won't seek their help and that's not good because if you know you need the help, you're worrying about what people think about you or what they gonna say about you instead of getting that help."
- "And you also have some of the doctor's offices do virtual. They do Zoom. So, it's not always about going into the facility."

Respondents were asked about levels of **trust** for their healthcare providers. One person indicated that there was a lack of trust, although others identified issues related to trust. Trust is built when "doctors take time to explain," when they don't make patients wait in their waiting rooms for hours past their appointment times, and when there are open lines of communication.

Telehealth services post-COVID had been utilized by respondents and described as "very convenient." They prefer the convenience, compared to having to go into the office and pay for transportation. All but one of the participants still considered **COVID-19** to be a concern. In addition to being sick, concerns were raised about missing work and having lost several neighbors to the disease. No one in the group was familiar with Long COVID.

SUGGESTED ACTIONS

Having healthcare providers from more **diverse backgrounds** was important to community members. "I would like to see the healthcare people in my neighborhood to look like me [African American] because I think culturally they would understand my culture..."

A need for improvements to **emergency services** was mentioned, particularly related to long wait times. "Like when you go to an emergency system, you sit too long and sometime people line them all over. The care is so slow."

Lastly, respondents requested general support for **housing** and low-income households that is more expedient. "I feel like if they have a job and they're looking to move, they should work more with people like that, that want to have low income, like housing and stuff like that instead of making them wait years and years. It's like they need something now. Why do they have to wait 3-4 years just to move and stuff like that?"

West Philadelphia

COMMUNITY ASSETS

Most community members who participated in this discussion had lived in the area for decades and reflected a lot on community assets from years ago. Generally, they found it **difficult to highlight community assets**. But they also expressed a **sense of pride** in where they live and its history and hoped that conditions would improve. One participant mentioned that community members would come together, "people like gym teachers, personal trainers and everything that would teach you..." and engage youth in **physical activities**.

- "...they're about to revamp that whole playground, which they really need to do. Because like some of the stuff was there like when I was a kid and we're talking about that, I'm talking like 1980s. So, the only thing that was really worthwhile going there was just a swimming pool and the basketball court."

COMMUNITY CHALLENGES

There is a lack of **green space and trees**, and that was not always the case. "I'm 74 years old and we used to have trees. We had a tree line for a mile, we didn't cut them down, the city did."

Respondents also expressed concerns about the **lack of grocery stores** and **unhealthy food options**. And a teacher lamented that **schools needed to improve**. "So, if you talk generational, our schools in West Philadelphia are not the best." Students in West Philadelphia do not always have access to opportunities that are comparable to those in other schools. Lost opportunities can perpetuate dangerous cycles. "Our children, our young people aren't working and if they are, they're selling, okay, because that's what they feel they need to do to be in the neighborhood or to be a part of the community and no one is offering them and our young mothers [support]..."

- "I mentioned earlier about how there was so much excitement around a grocery store coming into the neighborhood that I had been living in for maybe four years we had a very low-quality store. The meat was decrepit. There was no fresh produce."
- "I'm just going to be candid and honest. And looking and observing our communities, our communities are not healthy. Our communities are sick. Our communities are toxic."

Public transportation was regarded as unreliable, and particularly unsafe for bus drivers. There is a culture of individuals and whole families boarding buses and not paying. And there's a concern about the implications of these behaviors moving forward.

- "Oh, my God public transportation, what about it?... How will you get there and will you get there on time?"

CHILDREN AND YOUTH

There were disparities noted in the ways that families address **disabilities among their children**. "The one thing about autism on the spectrum is we that are African American, we put our people up in the room and we say, well, that's how he is and you go to the other side where you deal with our caucasians, they going to go get it, they're going to get the help." Parents and schools need more support for and education on such matters.

Some individuals noted that the taboo associated with **mental illness** may be fading.

- "At this point, I got young girls coming to me who are like who is your therapist? I need a therapist too. So, when you start thinking about actually healing, right? Then you want to do things that are better for you, then you want to eat better. You want to take care of yourself physically, you want to take care of yourself emotionally, because you're taking care of yourself mentally."
- "I'm seeking it for my six-year-old now, because gun violence nowadays is ridiculous. Lost her father to gun violence... We're losing a lot of kids and we just don't have, they don't count like grief counselors it's hard to find nowadays and I feel like mental health and grief counseling is a big thing nowadays in Philadelphia."

CHILDREN AND YOUTH (continued)

Efforts are being made to engage youth in **community gardening**, alongside their parents. This is helping to bring quality food into homes. Generally, perspectives about **recreational programs** for youth varied, and quality seemed to be based on specific neighborhoods, perceptions of biases on the part of local political leaders, and systemic discriminatory practices rooted in local history.

- "You know what I like and I see in West Philadelphia, they're starting to have a lot of farming programs for youth and I have seen them where youth become little farmers or entrepreneurs. And it's one group that's teaching a parent and a separate group, so they could continue to teach the child."
- "And I will say on a positive note, my rec center is definitely doing a better job with breaking all different types of programs for youth, sports, swimming. You know, it really depends on the rec leader and how much they really want to engage with the community. Because they do listen to the community if it's a good rec leader and determining what we need, what type of program we need."
- "We need more consistent mental health services for youth."
- "And as a Black boy mom, we need more men's services and we are lacking a lot of men, especially Black men working in the mental health field in the local Philadelphia area. And I can speak to this, because I had sought out services for my child, because we experience trauma, and it's not we have been assigned a lot of females. And my son can't relate to them and that's what we're lacking."
- "I'm going to say the representatives and even some council people of the communities, they finger pick who they are going to help. When it comes down to the schools and the youth in our community you don't see no gardens or nothing else in some of our community…I've been employed for the Philadelphia school district. And I watched them categorize the children. I watched them place the children and I watched them label the children."

OLDER ADULTS

The **paratransit** services for older adults and people with disabilities were described as unreliable, with drivers arriving late and with no mechanism of communication existing between drivers and customers. "I guarantee these seniors and now they having a fit, because most time they got to go to dialysis…" Drivers sometimes do not assist customers with boarding and de-boarding. "We had to start reporting them to tell put in the ride. Please tell the driver to get off… but they're supposed to get off anyway, even if they may not need help. You have to tell them to get off the vehicle. Come to the door… you're not supposed to be even riding for more than 50 minutes, people on there two hours."

Other transportation services have proven helpful for facilitating activities of daily living. "I just am so excited that the advantage insurance that you pay after Medicare and Medicaid or whatever they have the insurance where you get your ride to your doctor's appointment and you get your ride back and the senior citizens are so excited… it's just so exciting to me to see them excited about something, because they can go right next two doors down to… Shoprite and buy their groceries…"

But one respondent got emotional as she spoke of **isolated older adults** with dementia, "They're not coming out of their homes, because they are afraid and I get that but trash has built up on Ludlow Street… but the trash is running over to the point where we can't even walk down the street. It's embarrassing." Several weeks of uncollected trash, and unauthorized dumpster use, prohibited residents from opening their windows in the summer heat.

Concern was raised about the comprehensive way that **technology** is being integrated into health services and the fact that many older adults may not have the necessary equipment or skills and may also lack the motivation to learn.

- "…we're not going back to paperwork. So, in order to continue to navigate in this world, you're going to have to conform to change."

SOCIAL DETERMINANTS OF HEALTH

Some individuals may be disincentivized to earn a **livable wage** because of a fear of losing their health benefits. "I just think that the way the healthcare is set up, you can make a dollar or two cents over and you lose your health care and people can even the working class cannot afford the copayments."

Whole health was acknowledged for its importance in fully capturing a person's wellness needs and social determinants of health. For instance, one respondent mentioned that "isolation has to do with food deserts." In other words, a lack of social support, inaccessible transportation, and/or geographic location have limited access to healthy food options.

ADDITIONAL CONSIDERATIONS

People with disabilities were described by respondents as being "left out." More services and resources are needed for people with a variety of functional limitations in their community.

- "...people with challenges and disability, because they are the voiceless hidden community and they are not ready, in the community there is not readily services [for] them. I tried three years to bring about a state-of-the-art fitness center for people with disabilities. And I got turned away..."
- "...they seem as expendable. Which is so crazy."

Substance use concerns included unwillingness by those in need to seek out services and low-quality services that need improvement.

- "We have people that get hospitalized, and they are re-traumatized from the hospitalization... a lot of places are lacking workers, so they're just hiring anybody and nobody's being held accountable for the way they treat any patients... And I got to be honest, this is what I did for a living. I was a mental health worker and I was also an admission counselor."

When asked about how **healthcare experiences have changed** since the COVID-19 pandemic, most respondents spoke about improved access through telehealth. One shared concern related to recent security breaches, and another expressed pleasure with more attentive and person-centered care.

- "I'm getting a letter every day, whether it's from my health insurance, my phone telling me there has been a [breach] of information... I opened one last week for my health insurance company. Every single other week I'm getting a letter about my information being leaked. So, I know that with a lot of the telehealth, they say it's not recorded and it may not be, but who's to say who's watching on the other side, because these hackers, they are amazing. And so, that's the concern I have about just the breach, the confidentiality."
- "...there are new things that make sure that they spend more than five minutes with the patient. So, they're spending more equitable time, they're spending the time more equitably when they're listening to them. So, I'm finding that it has gotten better. I don't know if that's across the board, I just know that in the market segment that I work in the providers that we work with that has been finding that across the board that the patients are feeling more equitable with the time that the doctor is spending with them to really go through like whatever the health care needs and their concerns are.

SUGGESTED ACTIONS

Respondents discussed the importance of **advocacy and self-advocacy** for patients of all ages, but especially older adults and people with disabilities who may not be able to speak up for themselves when needed.

- "And I know when I go to the meetings just like with something like this, the room should be packed. This is our neighborhood, but we want to change things, but we want to talk about it. I don't talk to anybody that don't vote. Because the bottom line is that's the only way it's going to change. But showing up and saying, they've been talking about this bus revolution for so long."
- "I think it's important to have a doctor that listens to you, because they have doctors when you go and you're complaining you're there, because for a reason. Well, anyway, and it's for a reason and you tell us for some type of pain you might have like, recently I had pain in my shoulder, they would wake me up. So, I went to the doctor. He said you slept on it. No, no, I said that's not it. So, I went to [an] orthopedic doctor, she took the X rays. I got spur in both of my shoulders."

More **holistic and non-pharmacological approaches** to healthcare were requested. "not just giving you a whole bunch of pharmaceuticals, but that doesn't mind giving me herbs or telling me what vitamin therapy to use or just even using food therapy and everything, nutrition therapy."

- "...back in December, I was diagnosed with a tear in my right shoulder. And the first thing they said, you want the shots? Absolutely none. What's your next choice? They said physical therapy, I said I'll do physical therapy."

SPOTLIGHT TOPICS

As part of the Regional Community Health Needs Assessment (rCHNA), a series of focus group discussions were conducted across each county with representatives from community-based organizations, local government agencies, healthcare providers, and community leaders. These discussions centered on a set of "spotlight" topics selected by the Steering Committee. Topic selection was guided by previous rCHNA priorities and shaped by input from community partners, ensuring alignment with pressing regional health needs.

In addition to general focus groups, key informant interviews were conducted to explore the topics in greater depth. The Steering Committee also revisited a set of community-driven solutions identified in the previous CHNA cycle to understand progress made and barriers encountered since that time.

Given the critical importance of maternal health in the region—and recognizing the sensitivity of this issue, which often limits open discussion in larger forums—a dedicated focus group of pregnant people and new mothers was convened to better understand the lived experience of maternal health in the community.

The Spotlight Topics discussed included:

- **Caring for Uninsured & Undocumented Community Members**
- **Culturally Appropriate Mental Health Care**
- **Housing**
- **Maternal Health**
- **Older Adults & Aging in Place**
- **Primary Care Access**
- **Community-Identified Solutions:**
  - Better Integration of Health and Social Services
  - Increasing Community Member Capacity to Serve as Care Navigators
  - Integrating Preventative Care and Education into the Community
  - Involving the Community in Decision-Making and Implementation

SPOTLIGHT TOPIC

Caring for the Uninsured and Undocumented

Uninsured and undocumented individuals in Southeastern Pennsylvania continue to face significant and intersecting barriers to health care access. While local clinics and community-based organizations strive to meet the needs of these populations, they do so within the constraints of limited funding, workforce shortages, and a fragmented safety net.

To better understand the current landscape, the Health Care Improvement Foundation conducted a series of group discussions and key informant interviews in 2024 with leaders and staff from community-based organizations across Bucks, Chester, Delaware, and Philadelphia Counties. These conversations explored how challenges have evolved, which strategies are working, and what solutions should be prioritized moving forward.

These findings build upon the 2022 Regional Community Health Needs Assessment (rCHNA), which highlighted the complex and varied barriers to care experienced by immigrant, refugee, and heritage communities across the region. The 2022 assessment identified key issues including language barriers, lack of culturally responsive care, fear related to immigration enforcement, and economic hardships exacerbated by the COVID-19 pandemic. It also underscored the critical role of trusted community-based organizations in navigating these challenges and the under-resourced nature of many of these groups. The 2024 conversations reinforce and expand on these findings, offering updated perspectives on current needs and strategies from those working most closely with undocumented and uninsured populations.

Challenges and Barriers

Uninsured and undocumented individuals in Southeastern Pennsylvania face numerous, intersecting barriers to accessing care. Delayed treatment due to cost, fear of deportation, and limited system knowledge often results in preventable health crises. Language and cultural mismatches further complicate care, especially for mental health and Indigenous language speakers. Even when resources exist, families are deterred by confusing eligibility rules, limited interpretation services, and a pervasive fear of immigration consequences. Providers report that individuals often turn to emergency rooms or unsafe alternatives after prolonged avoidance of care, reflecting a fragmented and overburdened safety net.

DELAYED AND EMERGENCY-ONLY CARE

Over the past few years, barriers to care for uninsured and undocumented residents have not only persisted but, in many cases, worsened. Participants reported more severe delays in care, increased fear among immigrants, and systemic issues that limit access to preventive services.

Many individuals are arriving at emergency departments with advanced illness or severe dental issues after avoiding care for years. In some counties, emergency Medicaid approvals have become more restrictive post-pandemic, making it harder to treat even eligible children.

Access to eye care is another unmet need, especially for children and adults whose work depends on good vision.

One participant from Bucks County said,

"They're not seeking care until it's dire. I see it a lot also with dental. I can't imagine the amount of pain some of the individuals are in until they're actually seeking care. I hate to bring this up, but there's also underground dentist that they just pull teeth and make things so much worse."

A Delaware County participant explained,

"I just processed some emergency medical assistance for a woman who now has terminal cancer. It probably would have been treatable. She probably could have survived this diagnosis. It is now very likely that she will not."

Another participant from Bucks recounts,

"Someone comes into our office and they need help navigating, enrolling a child in school or getting eyeglasses for a child. It's hard enough to navigate in English, let alone with all these additional barriers."

LANGUAGE AND CULTURAL BARRIERS

Language and cultural barriers continue to limit access to care. Even when interpretation services exist, they're often deemed too expensive or unavailable for outpatient behavioral health.

Even when interpretation services are technically available, cost remains a significant obstacle. Hospitals and inpatient facilities often avoid using services like LanguageLine due to expense, which in turn restricts access to care for those who are not English-speaking.

Regional dialects can further complicate communication, particularly for Indigenous language speakers from Central and South America, where even Spanish-language interpretation may fall short.

One participant from Delaware County said,

"We cannot get people in...we have made the decision to start bringing in folks to do just basic mental health education as a stop gap for the ability to get people into actual talk therapy treatment."

A Bucks County participant explains,

"The inpatient facilities, they won't take them majorly because if they only speak one language and they don't want to use the language line because it's too expensive for the hospital."

A Chester County participant shares,

"The migrant population is not just Spanish speaking... in places like Guatemala, they speak Mayan. So we've increased usage of LanguageLine, but you really need bicultural staff who carry a different kind of sensitivity."

FEAR OF IMMIGRATION CONSEQUENCES

Fear plays a significant role—many families avoid applying for programs they may be eligible for due to concerns about immigration status or public charge consequences. This mistrust prevents people from accessing even basic preventive care.

According to one Philadelphia participant,

"There is still that fear... that if they submit something, that there will be repercussions for that."

A Chester County participant explains,

"Fear of applying for insurance because of deportation concerns."

SYSTEM NAVIGATION CHALLENGES

Understanding how to navigate the health care system is a major challenge. People are often unaware of what services exist, what they qualify for, or how to access them. This confusion can lead to paying out-of-pocket unnecessarily or going with-out care entirely.

Many undocumented individuals work physically demanding jobs in construction, agriculture, food ser-vice, and domestic labor. These roles often result in preventable injuries or chronic pain, yet workers fre-quently forgo care due to cost, lack of transportation, or fear of exposing their immigration status.

Unfamiliarity with U.S. health sys-tems—compounded by language, documentation, and cultural barriers—leads to missed opportunities, unnecessary costs, and worsened health.

A Chester County participant said,

"They don't know what questions they ask. They don't know what they're eligible for."

A Bucks County participant added,

"It's hard enough to navigate in English and it's even harder when you have all these additional barriers on top."

Another Bucks County participant explained,

"We have to send them to the hospital instead because they need care and the hospital can't really turn them away... It's often a crush injury or diabetic foot wound that's been festering for who knows how long."

Special Populations

Certain groups—including children, youth, people with disabilities, and those with serious mental illness—face unique vulnerabilities. Preventive care, dental, mental health, and physical therapy services were all cited as high-need areas for these groups, services that are often not available through emergency Medicaid or free clinics.

CHILDREN AND YOUTH

For children, delays in dental and medical care can lead to long-term health issues and exclusion from school due to missing records.

A provider in Delaware County shared,

"We are seeing kids with heart conditions from lack of dental care. At 16 years old, they have high blood pressure, and it's due to poor dental care."

In another example from the same county,

"Kids are being forced out of school because they can't provide timely dental records."

ADULTS WITH DISABILITIES OR MENTAL ILLNESS

For adults with disabilities or mental illness, a lack of guidance around in-surance eligibility and disability doc-umentation often results in gaps in care.

"They have a family member who's an adult who no longer can be covered on their family insurance plan… they really don't know what to do."

What's Working Well

Despite the barriers, community-based providers continue to deliver impactful care through a variety of locally driven strategies.

FREE AND SLIDING-SCALE CLINICS

Free and sliding-scale clinics are the most consistently used resources. Free community clinics were frequently cited as trusted places that treat patients regardless of status.

The free medical and dental clinic in Doylestown

"Can accommodate individuals. They have a psychiatric nurse practitioner who still volunteers at the clinic."

A Chester County participant adds,

"It's a totally free clinic…they'll serve them completely free, including all the way up through and to surgery."

STRATEGIC USE OF EMERGENCY MEDICAID

Even within the safety-net landscape, documentation status often deter-mines access to care. Some participants noted that individuals who are documented, even if experiencing homelessness, are more likely to re-ceive timely care or qualify for assistance.

In some counties, Emergency Medicaid or mental health funding is used strategically to serve undocumented patients with urgent needs—particularly children in need of dental care.

A Bucks County participant says,

"If they're a citizen… even if they're homeless, it's pretty straightforward. We usually just apply and get the insurance within a month."

Another Bucks County participant explains,

"Our funding isn't prioritized whether they're documented or not. Let's say they can get 10 days, and I preauthorize it for that."

A Delaware County participant adds,

"We are very focused…to qualify for emergency Medicaid so they can get their full mouth done in one visit."

BILINGUAL BENEFITS COORDINATORS

Organizations that have hired bilingual staff, especially for benefits coordination, report improved follow-through and reduced fear.

A Philadelphia participant asserts,

"We onboarded somebody, a bilingual benefits coordinator a few months ago, and he's been super helpful. He does basic screenings with people to see if they're eligible for medical assistance, and then he assists them in putting through the application."

COLLABORATIVE PARTNERSHIPS SUPPORT ACCESS TO LABS AND PREVENTIVE CARE

Collaborative relationships with private partners and public health entities help fill critical service gaps. In some communities, partnerships with organizations like LabCorp enable free lab testing, while the state Department of Health supports vaccination and pharmacy supplies.

Two Chester County participants share:

"LabCorp is great… there's some type of relationship between Saint Agnes and LabCorp and they get their lab work done. That's a great channel."

"We work with the Department of Health in administering flu shots… they bring those. We give them to everybody."

COMMUNITY SUPPORTS

Community-Based Programs Support Programs that are tailored to vulner-able groups like adolescent mothers, offering comprehensive wraparound services including prenatal care and transportation—both of which are often inaccessible to undocumented and uninsured families. Such community-rooted solutions offer a life-line for pregnant teens and young mothers navigating complex systems without traditional support.

Most patients rely on word-of-mouth and trusted organizations for healthcare information. Community groups, churches, and clinics serve as primary entry points into care.

Participants also highlighted prescription assistance as one of the few widely used financial support tools.

A Chester County participant explains,

"YoungMoms of Kennett Square works with women between 16 and 21 with an unplanned pregnancy… they provide transportation to their prenatal appointments. It's an incredible organization."

A Philadelphia participant says,

"Most of it, as usual, is word of mouth."

"The nurse practitioners go on to -- I think it's GoodRx, and they get all kinds of coupons and things. And they'll print it out and give it to them."

Suggested Actions and Solutions

Participants offered several concrete recommendations for improving access and sustainability. Many emphasized the urgent need for more navigators, care coordinators, and community health workers, especially those who speak the languages of the communities they serve.

EXPAND AND SUSTAIN COMMUNITY-BASED NAVIGATION AND CARE COORDINATION:

Participants overwhelmingly called for an increase in navigators, community health workers (CHWs), care coordinators, and promotoras who reflect the communities they serve—linguistically and culturally. These roles are essential for helping individuals navigate complex healthcare systems, apply for benefits, and access resources. Sustained funding and the ability to bill for these services are critical for long-term impact.

- **"We need someone to help with all of the above in the home language with transportation, getting to appointments, accessing... benefits for their children... and being able to understand and navigate."**
- **"We need to find a way... how about we start being able to bill for services when we're helping people to get insured?"**
- **"So, one grant once a year... is not going to solve this problem... What's going to be a more realistic solution is a grant every couple of years... and insurance companies covering and allowing health systems to bill."**
- **"Programs like promatoras, programs like community health workers... that can help people navigate are two good things."**

INTEGRATE HEALTH INSURANCE AND SYSTEMS EDUCATION INTO TRUSTED COMMUNITY NETWORKS:

Many participants noted that people often lack foundational knowledge about health insurance, eligibility, and coverage options. Traditional education efforts—like flyers—are insufficient. Education should be embedded within trusted community institutions and delivered by peers or local advocates who can explain concepts in accessible, relevant ways.

- **"We need to be doing education around health insurance and what plans are... the problem is they don't know the questions to ask."**
- **"That information is not readily accessible... all the health literacy stuff... we need to target the community at large."**
- **"Trusted community members... providing the care is really, really important."**
- **"We onboarded somebody, a bilingual benefits coordinator... he assists them in putting through the application... a really long process, a really confusing process."**

STRENGTHEN CROSS-SECTOR COLLABORATION AND REFERRAL SYSTEMS:

Improving access requires better coordination among hospitals, schools, and community-based organizations. Clear, proactive referrals to food, housing, dental care, and other supports must become standard practice, especially for uninsured or underinsured individuals.

- **"It would be great if hospitals had a brochure listing food cupboards, dental help, and prenatal care in the area."**
- **"Referrals go from community health workers… they're usually agency agnostic."**
- **"Warm handoffs to housing resources, food resources, other healthcare institutions, making specialty appointments…"**

ADDRESS FINANCIAL BARRIERS AND ENHANCE AFFORDABILITY.

High out-of-pocket costs, even for insured individuals, remain a major barrier to care. Participants emphasized the need for financial assistance with copays, deductibles, pharmaceuticals, and self-insured plan costs. Policy solutions could include subsidies, expanded eligibility, and support for Pennie (the PA Health Insurance Marketplace).

- **"Finding ways to provide financial assistance for copays, deductibles, and for pharmaceuticals is a really important component."**
- **"If we can get some assistance to bring down the cost of being self-insured through the Pennie system… that would also be a benefit."**
- **"We've got folks choosing to be uninsured and then choosing to utilize services based on being uninsured."**

INVEST IN LONG-TERM INFRASTRUCTURE AND POLICY CHANGE.

Finally, sustainable impact requires investment in workforce development and policy changes that support billing, staffing, and accountability. Short-term grants or pilot programs are insufficient. A long-term strategy to embed equity-focused services into the healthcare infrastructure is needed.

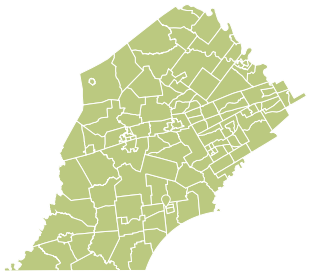
- **"If we're talking about all these health systems in our county… how about we start being able to bill for navigation services where we're getting people out of poverty and into housing."**
- **"So, placing AmeriCorps workers in community-based healthcare settings… calling [patients] and telling them, 'Hey, do you know that you're eligible for Medicare?'"**

County-Specific Perspectives

BUCKS

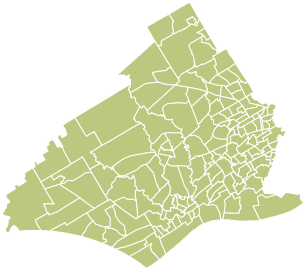
In Bucks, access to mental health care is a major concern, especially for individuals needing culturally competent, bilingual providers. There is also significant fear around seeking help, including domestic violence, due to immigration status. Preventive care is underutilized, and individuals often turn to emergency departments for primary care needs. There are reports of people seeking unsafe dental care from unlicensed providers. Major barriers include language access, transportation, and lack of patient navigation services, especially in a client's home language.

CHESTER



Chester County is home to a large migrant workforce in the mushroom industry, many of whom are undocumented and live with chronic fear of deportation, which discourages care-seeking. Working conditions were described as physically taxing, with individuals in the mushroom industry experiencing chronic health issues tied to repetitive labor, poor ventilation, and long hours. Yet without insurance or documented employment, many avoid care entirely—even when vision problems, injuries, or pain interfere with their ability to work. There is a lack of prenatal care, contributing to poor maternal and infant health outcomes. High demand for preventive and maternal health services outpaces the capacity of local clinics. The cost of caring for the uninsured places significant strain on providers, who are unable to bill for essential services like navigation and social support. The lack of insurance literacy and difficulty navigating programs like Medicaid or Pennie further contribute to unmet needs.

DELAWARE



Dental health was described as a public health crisis among undocumented children, many of whom suffer from severe decay, pain, and related school absenteeism. The state's restrictions on Emergency Medical Assistance (EMA) and the complexity of the application process delay urgently needed care. Access to mental health services is extremely limited, particularly for Spanish-speaking clients, with few bilingual providers and long waits. Some families face Child Protective Services threats over delayed school-required health records. While nonprofits attempt to fill gaps, demand often overwhelms available resources.

MONTGOMERY

The Montgomery County Office of Public Health's 2024 Community Health Assessment (CHA) noted that language access, immigration concerns, and workforce shortages remain critical barriers for immigrant and undocumented residents. Faith-based and volunteer-run clinics like Saint Agnes Nurses Center are vital resources, but operating hours are limited, and capacity is low, often turning people away. Mammograms and other preventative screenings are hard to obtain for undocumented patients, and volunteers report reliance on word-of-mouth to find care, leading to misinformation and frustration. Interpretation and navigation support is inconsistent, and referral options are limited despite strong community need.

PHILADELPHIA

Philadelphia has a relatively robust network of safety-net providers, yet demand outpaces supply. Many uninsured and undocumented residents fear that applying for benefits could jeopardize their immigration status, a belief that persists despite outreach efforts. There are federally qualified health centers (FQHCs) and community health worker models that are effective but under-resourced. Access to preventive care, housing, and employment services remains critical. Housing insecurity, fear of documentation requests, and poor system navigation persist as major barriers.

SPOTLIGHT TOPIC

Older Adults and Aging in Place

Across Southeastern Pennsylvania, older adults, caregivers, and community members emphasized the need to support aging in place through coordinated housing, health, and social systems. Participants voiced a clear preference for remaining in their homes and communities as they age, underscoring the importance of having accessible, reliable supports in place.

As one participant shared,

"I think that most adults want to age in place if they're able. As long as they know there are supports around them, and they know what they are and how to access them, and if we do a better job of that as a community, people will be more actively engaged in their community. But if we don't, we kind of leave them until they can't live alone or they can't stay by themselves, and they can't afford to have someone come in and help them out a little bit or whatever. It's a crisis."

To encourage the physical, emotional, and economic benefits of allowing older adults to remain in their homes and communities, structural barriers, such as inadequate housing accessibility, limited in-home care options, and underfunded services, need to be addressed. These challenges are often compounded by the complex realities many older adults face.

"For older adults, obviously, there's comorbidity," another participant noted. **"You're dealing with somebody who may be having physical health issues as they age, they're also trying to age in place and keep their independence and have to manage all the dynamics of all their doctors and specialists if they have multiple issues, mental health issues, et cetera, et cetera."**

Despite these challenges, promising examples of local programs, cross-sector partnerships, and innovative housing models show how older adults can thrive with the right support in place. Participants shared practical strategies to advance independence in aging, including improving access to home modifications, expanding caregiver support, strengthening transportation networks, and investing in community-based services that promote connection and well-being.

Challenges and Barriers:
Access to Healthcare

Older adults face significant barriers to healthcare, from navigating insurance complexities and scheduling appointments to accessing hands-on support for paperwork and medical equipment. Language and technology challenges make it harder to use online portals or follow medical instructions, while limited Medicare-accepting providers and poor integration between health systems delay essential care. Those with serious mental illness often struggle to secure placement in senior facilities, which may refuse them or send them to hospitals without allowing them to return. Transportation issues, including unreliable public transit and long paratransit wait times, further restrict access, contributing to worsening health outcomes.

NAVIGATING HEALTHCARE SYSTEMS

Seniors and older adults face significant barriers in navigating healthcare systems, including language difficulties, tech challenges like using MyChart, struggles with appointment scheduling, and the need for hands-on support with tasks like filling out forms or using medical equipment, as well as understanding instructions for self-monitoring tools.

A participant from Philadelphia stated:

"Navigating the system continues to be a massive barrier. People figuring out which insurance they need to do and, things like that, yeah."

Another Philadelphia participant said:

"It is getting more difficult to get a staff member and make an appointment there. It takes a longer time, at least 30 minutes. And many places now only accept appointments for a month in advance, so we cannot make it at the moment. So, they say clients should call them every day to get an appointment, but it's not feasible for the seniors, especially speaking other languages. They cannot use the phone, or they are afraid to make phone calls. And this can be a particular challenge for seniors who speak other languages. So, they're not going, so their health issue is getting worse."

A Philadelphia participant added:

"And also, not fully understanding the instructions. One of the people I worked with was given a tool to monitor his blood pressure at home, and he got home, and he didn't understand how to use the machine."

A participant from Delaware County expressed a similar sentiment:

"There are some people that do require hands-on help as far as like, 'can you please come to me and help me fill out this form?' 'Can you please come to me and take these papers that I've gathered, and fax them for me?', because they might not be able to get to a fax machine, they might not be able to get to the post office. So, I feel like when it comes to aging, a lot of times, we think, oh, this is enough for some people. But it is not quite enough for them."

MENTAL ILLNESS

Older adults with serious mental illness struggle to find placement in senior living facilities, which sometimes refuse them or send them to hospitals during crises without allowing them to return, contributing to rising behavioral health issues, suicide rates, and unnecessary hospitalizations, all worsened by gaps in integration between Medicaid, Medicare, and behavioral health systems.

A participant from Bucks County has experienced this with clients, stating:

"We have difficulty getting placement for older adults who may have a serious mental illness and cannot live independently, and so they need to go into a senior living facility. A lot of facilities will not accept those folks, they just, they can't, or they won't for different reasons."

A Chester County participant said:

"We are definitely seeing, I believe, an increase in older adults who are experiencing behavioral health crises and who are completing suicide, especially older men. So, there's something that we're missing there, right?"

A Philadelphia participant expressed:

"And also, not fully understanding the instructions. One of the people I worked with was given a tool to monitor his blood pressure at home, and he got home, and he didn't understand how to use the machine."

A participant from Delaware County expressed a similar sentiment:

"I think one of the biggest issues we've seen is the lack of integration, especially between Medicaid, Medicare, and the health systems, and behavioral health. We see a lot of issues on our end where folks are -- there's significant gaps in behavioral health and cultural competency on the mental health side, where folks end up being institutionalized because of the lack of addressing those needs."

TRANSPORATION CHALLENGES

Older adults face significant transportation challenges in accessing medical care and attending appointments, including unreliable public transit, long wait times for paratransit services, difficulties navigating insurance barriers for specialized transport, and a lack of accessible infrastructure like sidewalks and sheltered bus stops.

A Bucks County participant shared:

"For our clientele, access to transportation, getting to their doctors, even access to paying for their medications. Those are all big barriers to care for them, unless they're working with us, where we can help them with those barriers."

A participant from Philadelphia has experienced the same transportation barrier, stating:

"Public transportation is an issue. For those who can get on and off a trolley or a bus, you know, those things are pretty good. But if you require something like paratransit, that goes door to door, they might get you to the doctor an hour ahead of time, and then you wait an hour before you see your doctor. You spend a minute with the doctor, and then you might wait an hour for it to come back and get you. It's long."

MEDICARE

Finding Medicare providers is challenging, and there's a lack of integration between Medicaid, Medicare, and health systems. While Medicare programs provide essential support such as socialization and care management, access is often limited by financial barriers and the requirement to switch doctors.

A Chester County participant said:

"It's very difficult to find providers who are accepting Medicare for mental health services and that includes outpatient therapy."

A participant from Delaware County shared their perspective on Medicare programs, saying:

"LIFE (Living Independence for the Elderly) is this one stop shop kind of program where they have centers in the county, and at those centers you get that, you know, socialization, but also all you can get all your care. You can have therapy there, they have haircuts and dentistry that come in at times. They manage your medications, your doctor's appointments. The barrier with that one, is you also have to change your doctor, and some people aren't into that. And some people might not meet the, they're over the limitations financially."

Aging in Place

Aging in place presents significant challenges for many older adults, as homes are often not designed to meet their changing needs, and necessary supports can be difficult to access. Barriers such as limited mobility, lack of awareness about available resources, and social isolation can make it hard for individuals to remain safely and comfortably in their homes as they age. These challenges can lead to declining physical and mental health, especially when older adults lack strong support systems or struggle to stay connected to their communities.

ACCESSIBILITY

Many homes are not designed for aging in place, often lacking first-floor bedrooms or bathrooms, accessible entrances, or wide hallways for mobility devices. In-home supports and home modifications can help, but they're often expensive, hard to navigate, and not well known, leaving many older adults without the resources to safely remain in their homes.

A participant from Chester County expressed:

"This idea of aging in place is really challenged by the fact that most of us live in houses that are not built, designed to do that. There's not a full bedroom on the 1st floor. There's not a full bathroom on the 1st floor. We don't have hallways that are wide enough to accommodate walkers and wheelchairs and other mobility devices."

A Philadelphia participant agreed, stating:

"Accessibility is by far one of the biggest issues. You know, and depending on the style of rowhome, you know, Southwest Philly has the type of house where the basement is on ground level, and they build up the front lawn. So, you have to go up a flight of stairs, you're essentially going up a flight of stairs before you get into the front door. That can be a hardship for people. Then other style rowhomes, they're smaller, right on the sidewalk. There's no room for ramps or any sort of equipment to help people get into the house."

IN-HOME SUPPORTS AND REPAIRS

In-home supports can be expensive. While one participant noted a successful experience receiving aid for the cost and labor of installing the supports, other participants stated that it's unclear where to look or how to begin the process of receiving similar help.

Home repairs can also be expensive, and complicated to coordinate. One participant shared that there are programs to assist with this, but they need to be marketed more.

A participant from Philadelphia County said:

"I think it was PHDC or one of the home repair programs where they needed a stair lift put in, and to get their bathtub fixed and someone did comment and do that for them for free. So, I think there was a long waiting list, but I did hear success."

A Delaware County participant added:

"We need kind of a general overall social service support and an organization to kind of connect and help people specifically with in-home supports, affordability for in-home support. Many people need them, they have no way to pay for them. Don't even know where to begin, how to start the process"

A Philadelphia County member said:

"I think the, I think it's called the Home Modification Program, could be marketed more. That is designed to help people age in place. And so, if that's a public program, people should be taking advantage of it."

LONELINESS AND ISOLATION

Older adults aging in place often experience loneliness and isolation due to a lack of support, limited mobility, and barriers to accessing community resources. These challenges can lead to mental and physical decline, especially when individuals are disconnected from social engagement and support systems.

A participant from Delaware County said:

"It's the ones that maybe we don't know about who may be homebound or a little more isolated or, for whatever reason, don't know or aren't accessing these services."

A Delaware County member added:

"There is an epidemic of loneliness because people are in their house. They don't have the ability to get out of their house."

A Bucks County member said:

"Lots of times older adults are put through the process of a 302 [involuntary commitment for psychiatric placement] because they have a change in mental status that comes on quickly that is likely related to an organic dysfunction of the brain, whether it's dementia, Alzheimer's or something of the like. It really doesn't fall under the mental health purview but there's individuals who don't have their natural supports, or their only natural support, for example, a spouse or somebody else, is unable to care for that individual. So, a lot of times we see an emergency situation where an individual might be isolated alone or lack of natural support and they're really decompensating."

Resources for Older Adults

ACCESS TO PROGRAMS AND SERVICES

Senior centers play a crucial role in supporting older adults by offering opportunities to stay active, socially connected, and engaged, yet many of their programs and services go underutilized. This underuse is often due to stigma, limited awareness, or barriers to access, such as difficulty navigating complex systems, leaving some older adults unaware of available resources or hesitant to seek help, ultimately missing out on services that could enhance their well-being.

A participant from Bucks County said:

"With any population that's vulnerable, I think lack of access to services, lack of social support or connections is an issue. Talking about elder abuse or intimate partner violence in later life, not even recognizing what's happening to them as abuse, or that there are places like A Woman's Place that they can contact for help. So, I guess that would be education and awareness."

A Delaware participant stated:

"We do have an ongoing grief and loss support group, and we have a caregiver group that's run by a social worker, like, off-site in the library. And we can refer people to these, but it's hard to get people to show up. It's not a fun group that they're excited to go to."

Planning

WILLS

Senior centers play a crucial role in supporting older adults by offering opportunities to stay active, socially connected, and engaged, yet many of their programs and services go underutilized. This underuse is often due to stigma, limited awareness, or barriers to access, such as difficulty navigating complex systems, leaving some older adults unaware of available resources or hesitant to seek help, ultimately missing out on services that could enhance their well-being.

A Delaware County member said:

"In the case that they're not able to age in place, they have to be moved, or the family has to move them somewhere. Instead of finding an option where they can stay, and have supports put in place, and that can they be paid for. We just don't have that developed safety net. So, I wish there was that. I wish it was better and wasn't just crisis mode. I feel like, in general, people wait until, you know, it's too late for everything."

Another Delaware County member added:

"We've had programs to help people plan all of their living wills and understanding all of their long-term care insurance and policies and how that works. And they're very, very beneficial, you know, very necessary. But in general, we found that most people who were coming to these programs in their 70s or 80s had not done any preplanning, and really still did not have any clue or plans for budgeting, for saving, for what's available. They just did not know."

A member of Philadelphia County said:

"A lot of people don't have wills, you know? We did a will workshop in our office a couple of months ago, and I was shocked by the amount of seniors that came in for the workshop, who did not have a will. They had gotten so far in life without having anything. They had children. They had a home. But yet they didn't have a will."

What's Working Well

Senior centers and faith-based organizations are effectively supporting older adults by offering inclusive programs that promote physical activity, social connections, and overall well-being. Senior centers provide a range of services, including health, wellness, nutrition, and benefit programs, helping reduce isolation and enrich lives. Some faith-based organizations offer targeted outreach through elder care social workers who assist older adults with navigating systems, finding in-home care, and accessing low-income housing. These services are widely available and inclusive, benefiting older adults regardless of background.

SENIOR CENTERS

Senior centers offer inclusive programs that help older adults stay active, connected, and supported, and can reduce isolation.

A participant from Delaware County stated:

"There are a lot of resources for people to get out, be active, have a full range of health, wellness, socialization, nutrition, eating programs, connecting them to benefits, etcetera. There are a lot of things. You just have to, like, look and get yourself there. There's a lot around here, and I think they most do take advantage."

A Philadelphia participant said:

"Being part of a senior center enriches people. Enriches their lives."

FAITH-BASED ORGANIZATIONS

Faith-based organizations provide a variety of social services to older adults.

A member from Philadelphia County stated:

"Catholic Housing and Community Services, which is under the archdiocese of Philadelphia, they work specifically with seniors. They have outreach to different parishes and locations in the area. So, they have an elder care social worker in each area that helps to navigate the system, helps to find good in-home care or housing benefits if they qualify. And they also have built up their housing for seniors, low-income housing for seniors as well. But they have a specific program all throughout the city and the county specific for senior care. And again, nondiscriminatory, any senior that needs it."

Suggested Actions and Solutions

Participants offered solutions to improve care and health outcomes for older adults, spanning both hospital systems and community-based organizations. A central theme was the need for stronger collaboration among providers, many of whom are doing meaningful work independently but without alignment. Suggestions included better coordination of resources, improved hospital discharge planning that considers patients' social needs, and stronger referral pathways between health systems and community support. Participants also pointed to successful models, like one-stop shops for older adult care, and suggested their replication. Other ideas included investing in affordable, health-integrated housing and promoting will creation to prevent future property issues like tangled titles. These solutions highlight the need for a more integrated and proactive approach to aging services.

Improve coordination and resource sharing among organizations and hospitals, along with creating a centralized access point for resources, could help eliminate duplication of efforts and ensure individuals fully benefit from available programs.

- **"We're all working in our own silos. We're all doing great programming, and everybody's meeting a lot of needs, but we're not pooling our resources and sometimes I feel like we're duplicating the same resource and missing another one. And it's just sometimes when we have tried, you know, partnerships, it seems very difficult. It is difficult."**
- **"I think [hospitals] have a lot of the roles and abilities in place. I just think they use it only internally. They have social workers. They have social services. It's just really for admission and discharge, or creating their own programs. And when somebody's discharged, they refer them to their own program that they want them to go to, which is fine, but I just don't know why we're not pooling. You know, everybody has their own kind of expertise. And so, they certainly would be the ones I would say that would be appropriate to do the pain management group. But maybe we're more appropriate to do a caregiver's group. But that it's all kind of coordinated and centralized somehow. So, I think they can definitely do a lot more out in the community."**

Hospitals should provide patients with discharge information and ensure they have access to necessary resources, such as food, housing, and a safe living environment.

- **"If someone's getting discharged from the hospital, it's important to send them home with information on what they're supposed to be doing next to monitor their health, and for the hospital to be aware as well of what kind of environment are they going back to? Do they have food? They need meals to be delivered? What is their housing situation? Is it a safe, secure place for them to live? Just working with people as they're being discharged, for example, from hospitals to be set up in a healthy and safe way."**

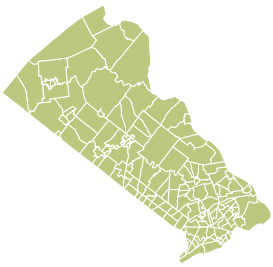
Replicate a "one-stop shop" model for older adult care, where multiple services are integrated into a single location with added support like transportation and comfortable spaces, could enhance convenience and accessibility for older adults in all healthcare practices.

- **"There is a doctor's office in a shopping center in West Philadelphia, and they have couches, they have coffee stations. They pick you up to bring you there, and take you home afterwards. They encourage people to hang out there if they want to. They have multiple doctors on site. So, there's a podiatrist, there's an optometrist. And they'll organize your appointments so they're back-to-back to back, so it's only one trip to the one-stop shop. They specialize in older adults. I think that is ingenious and should be a model for all practices that focus on older adults."**

Expand and invest in affordable housing programs, particularly through prescriptive housing initiatives that link healthcare and housing, could improve community health outcomes and leverage funding opportunities like Pennsylvania's PHARE Program to create more accessible housing solutions.	• **"Looking at innovation, we know in other parts of the country, and I think some places in PA, they've done what they call prescriptive housing. The idea of investing in housing from the health care side. We'll have a return on investment by keeping people healthy, and in the community. Also looking at funding opportunities, I know PA Housing Affordability Fund's PHARE Program just released an update where there's additional funding available for capital construction if it's tied to a health care entity. So, looking at that as an option to help create more affordable accessible housing."**
To prevent future tangled titles, there should be a greater focus on promoting will creation and proactive planning among organizations who work with older adults.	• **"A lot of people don't have wills, you know? ...So, I think that this could be something that is marketed and done way more of. The city's been focused on tangled titles, you know, houses where there's not a clear owner. They're doing all this outreach to get all of these tangled titles cleared. But there's no effort to prevent future tangle titles. It's so much harder to fix the problem than it is to prevent the problem. Get wills. I know community legal services are doing wills. But there should be such a bigger effort."**
Reframe activities for older adults to focus on shared interests and social engagement, rather than labeling them as support groups, can address the stigma often associated with support groups while still fostering strong participation and connection.	• **"So we did actually create a men's group, but we didn't call it a support group. We called it like a "lunch bunch." Like, just a group for men to have lunch together in a separate space led by the social worker. It was just you know, guided, structured, focused topics. It was just, hey, what's life like after you retired, how are you spending your time, and what advice do you give? It took off, and it really surprised us. We actually have a core group of men who come twice a month, have lunch together, and really look forward to just kind of eating and hanging out with each other.** **So, I just think its finding the hook to get people to try these things, because once they do, you know, they love it and they find meaning. I think, whether it's hospitals or social communities, we have to work together to kind of make it more appealing and enticing. And anything with food is going to be a big perk."**

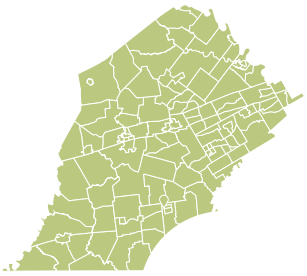
County-Specific Perspectives

BUCKS



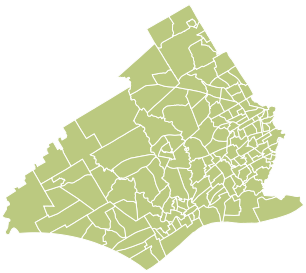
Participants in Bucks County highlighted significant barriers to healthcare access and transportation for older adults, with many emphasizing the financial difficulties that prevent older adults from affording essential medications. Mental health services were a major concern, particularly the stigma around seeking help. Several participants noted that the complexity of navigating systems for benefits and services posed a challenge, especially for older adults who lack digital literacy. A key issue for Bucks County was the increasing unaffordability of both housing and healthcare, which many residents on fixed incomes find increasingly out of reach.

CHESTER



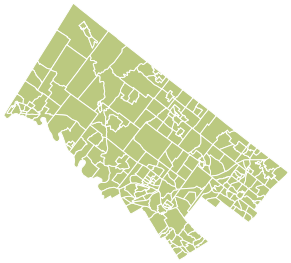
In Chester County, participants stressed the growing need for services that are culturally and linguistically appropriate, reflecting the county's shifting demographics. Digital literacy was a significant barrier, preventing older adults from accessing telehealth and online resources. A common concern was the fragmentation of services, with residents unsure of where to go for help or how to qualify for assistance. The lack of affordable in-home care options was a central issue, making it difficult for older adults to age in place and putting additional strain on families.

DELAWARE



Delaware County participants emphasized the importance of community-based supports, such as senior centers and local food access programs, as vital resources for older adults. Transportation remained a key barrier, particularly for low-income older adults in more rural or isolated areas. The growing challenges around mental health and substance use among older adults were frequently mentioned, along with concerns about elder abuse and financial exploitation. Many participants called for stronger protective services and educational programs to support families and prevent mistreatment.

MONTGOMERY



In Montgomery County, discussions centered around the need for enhanced caregiver support, as many families felt overwhelmed by the demands of caring for aging loved ones without adequate outside assistance. Affordability of housing and long-term care was a pressing issue, with many older adults feeling the financial strain from rising costs. Social isolation was another key concern, particularly among older adults living alone and without nearby family support. Participants also called for better coordination between healthcare providers and social services to streamline care and improve overall service delivery.

PHILADELPHIA

Conversations in Philadelphia County reflected the unique challenges of urban living, with concerns around neighborhood safety and the suitability of housing structures for older adults. Rowhomes, often with stairs at the front door and narrow hallways, were noted as particularly difficult for older adults. Access to primary care and in-home health services was also limited, especially in lower-income neighborhoods. Participants emphasized the need for more affordable and accessible services, both in terms of healthcare and housing, to better meet the needs of older adults in the city.

SPOTLIGHT TOPIC

Primary Care Access

The lasting impacts of the COVID-19 pandemic, coupled with recent hospital closures and health system mergers, have altered the landscape of primary care provision in the Southeastern Pennsylvania region over the past 3 years and will likely continue to shift going forward.

To understand ongoing and emergent needs and identify opportunities to improve access to primary care across the Southeastern Pennsylvania region, four county-based discussions and four key informant interviews were conducted with leaders and staff from with knowledge of local healthcare needs across Bucks, Chester, Delaware, and Philadelphia Counties. In the 2022 rCHNA, the topic of "Access to Care" discussed with Delaware County community-based organization representatives. This spotlight represents an expansion of that discussion, with a focus specifically on primary care access, offering updated perspectives on current needs and strategies.

Access to primary care is influenced by myriad factors – social and cultural (language, connectedness, trust, citizenship), economic (income, employment, insurance status), physical environment (transportation, walkability), and local health care infrastructure (hospitals, primary care physicians). These factors, and more, are reflected in the insights shared below – as well as reflected in the county and geographic community profiles.

Challenges and Barriers:
Scheduling and Availability

The most common responses to questions about barriers to primary care access were connected to the perceived lack of available appointments – particularly long wait times to schedule appointments.

SIGNIFICANT WAIT TIMES

Participants shared that although there is generally good awareness of the importance of having a primary care physician and regular checkups and screenings, community members experience significant wait times when trying to schedule appointments. This experience is increasingly common for current patients and has been exacerbated for new patients.

A participant from Philadelphia said:

"They're just overwhelmed…like they want to find a PCP. But their PCP, you know, they had one year ago, but that person retired or left, and they were told that the rest of the primary care providers weren't taking new patients, and so it just kind of fell off their plate."

STAFFING SHORTAGES

This is also a challenge for hospitals, health systems, and clinics as many have experienced staffing shortages following the pandemic, an increase in physician retirements, and decreasing interest in primary care as a profession (many medical students are choosing specialties). Certain areas in the region have fewer providers than others – particularly the more rural areas. Certain types of clinics and centers experience unique challenges either related to their patient population or their organizational structure – such as Federally Qualified Health Centers (FQHC).

A participant who works at a local FQHC shared the following:

"…I've been trying to advocate for caps on our providers' new patient intake because that is causing us to be booking patients out for six months in the future because we can't turn people [away]…we're a safety net provider. And so there's sort of this weird dichotomy or tension between, well, we wanna serve everybody, but at the same time, if we serve everyone, then we can't provide quality or quick care, if you will, to anyone, really, even our patients that have been coming here for years. And I don't know what the answer is to that, but it is just as frustrating from the inside as it is from the outside, unfortunately."

Delaware County-based participants highlighted:

"We rely heavily on the clinics. We do not have, in Delaware County, many options. I feel like a broken record. We are sending people into Philadelphia."

A participant from Chester County also shared the varied availability of providers throughout the area:

"Chester County is a big county. So, it really depends on where you're asking. I know there are not enough [providers] in the general greater Coatesville area. There are very few private practices there. There's some urgent care in Downingtown. There's some urgent care in Parkesburg. But as far as a primary provider, there's almost nothing."

SCHEDULING

With fewer providers, and more people seeking primary care, wait times at appointments can present additional challenges, especially for people who may be taking time out of their workday for the appointment.

A participant from Chester County shared:

"And now you're waiting an hour and a half to see your doctor, and that's really hard. It's especially hard for people who have a hard time getting paid time off for a doctor's visit, and they really can't afford to sit around for an hour and a half. They've got to get back to work."

Use of Emergency Departments and Urgent Care

In response to barriers with wait times and scheduling appointments, many participants shared that their community members and clients are increasingly using emergency departments and urgent care in place of primary care.

URGENT CARE USE

Although costs may be higher at urgent care or emergency departments, the perception is that "at least they'll be seen" as opposed to waiting months for a primary care appointment.

Wait times at hospitals and urgent cares continues to increase as more people utilize these services instead of primary care.

Additionally, seeking care from providers who do not know your medical history can result in increased costs (such as unnecessary or redundant tests).

A participant from Chester County addressed this:

"Even if you have insurance and a primary care physician, it can be really challenging to get in and get an appointment. And so then, you end up going to urgent care, which is a lot more expensive."

One participant from Philadelphia shared:

"I think the hospitals are overrun because they know they can go there...Unfortunately, I have the opportunity several times to experience different hospitals, and their waiting rooms are just [packed]. So you're talking, almost waiting a whole day just to get care."

"You don't necessarily have the same comprehensive health history with them that you have with your regular provider. And so it costs more money. There's not the same necessary knowledge of your history or something, and that just makes it very -- nobody's benefiting from that, except maybe someone who's getting paid more."

MISCONCEPTIONS ABOUT PRIMARY CARE

Misconceptions about the role of primary care – and the need to be seeking care regularly – result in the persistent usage of urgent care and emergency departments. This may also stem from concerns related to health care costs – not knowing what's covered and what isn't.

Participants from Chester County discussed the need for community education about the different roles that primary care and urgent/emergency care serve:

"What ends up happening too is there's an education challenge for folks. So, some people, because healthcare is expensive, they just don't go when it could be something that could be solved by seeing your primary care provider before it became an emergency. And then you ended up in the emergency room or urgent care....because folks don't see necessarily their primary care provider as someone to go to before it becomes urgent...That is something that our health systems could help our community to understand, is that the emergency room should not be your first line of defense, it should be used for emergencies and that when you are first experiencing a challenge to go see your primary care provider."

AVOIDANCE IN SEEKING CARE

Community members' negative experiences (bias, discrimination, historical injustices) with certain hospitals and health systems diminished overall trust, leading to avoidance in seeking care with those systems or only using hospital emergency rooms, not primary care.

When describing the closure of a local hospital, a participant from Chester County described community members' reluctancy to seek care:

"...because when they had an emergency, they needed to use the hospital for emergency care...even if they had access to the resources to go to the hospital, because of cultural competency or other comfort levels...but otherwise, they tended not to go to that hospital."

"One of the issues is that many of our lower income and particularly minoritized lower income folks do not feel quite as comfortable going to some of the other hospital options in the county just due to due to issues of again race and cultural competency."

A participant from Delaware County echoed a similar sentiment:

"But what I would say is that it was interesting when the hospital closed, many of our lower income community members, when asked, you know, 'what the negative impact of that hospital closing would have on them', they said 'very little', because they didn't interface with that hospital for a variety of reasons, many of which would be cultural comfort, and so they use the hospital for emergency care."

Accessibility

The inability to physically and logistically access primary care providers was frequently shared as a barrier to care. Issues ranged from the availability and reliability of public transportation, lack of walkability, and the accessibility of offices themselves for people with disabilities.

GREATER DISTANCES

Parts of the region have experienced hospital and office closures, resulting in greater distances to reach care. Additionally, areas with limited or no public transportation, and lower numbers of community members with access to private transportation, face increased barriers to accessing primary care.

A participant from Chester County described:

"Because many of our clients cannot get to the nearest hospital in any direction. And so that becomes a significant limiter. If they have private transportation, it's still a distance, but they can get there at least whenever they need to, I think. Sometimes people forget that there's issues with public transportation, right? One is time, the other one is cost, right? But we usually solve for cost, but you can't solve for time."

ACCESS TO PUBLIC TRANSPORTATION

Proximity to, and reliability and cost of, public transportation impacts accessibility to care across the region, with some counties such as Bucks and Chester experiencing significant challenges. Community-based organizations continue to identify solutions to reduce these barriers.

A participant from a community-based organization in Bucks County described collaborating with SEPTA:

"[SEPTA] can provide you up to 50 SEPTA key cards for free. So that's something we've been using for our clients because we had clients that really wanted to go to Northeast Philadelphia or Philadelphia for care and we'd be like, listen, we can only transport you through Bucks. So that has been really helpful when they can't use BCT or can't use us. We're now giving them SEPTA passes and they can get to and from whether it's for an infusion or whatever they have going on."

LONG ROUTES TO CARE

In some counties although the area lacks comprehensive public transportation, there are services available such as Chesco Connect, Coatesville LINK, and SCCOOT. However, these routes can be long and indirect, depending on where a patient needs to go.

Participants from the Chester County region shared:

"So TMACC, who is the organization that runs the SCCOOT bus and the Chesco Connect, they're working on a new route system. So, I can't speak for them, but there is a new route system where they're trying to combine their long route, which runs from Southern Chester County. It runs from Westchester through Oxford and then back again... for a patient to jump on in Westchester to get something out in Oxford, I think -- I don't remember what the ride time is... but it's a very long route."

PROXIMITY TO PROVIDERS

Community members prefer local, neighborhood primary care options, particularly for those who use public transportation or who have limited physical mobility. In addition to variations in accessibility across the region, proximity to primary care providers varies within the same county, such as Philadelphia, with providers concentrated in specific neighborhoods as op-posed to being dispersed throughout the county.

A participant from Philadelphia described this here:

"There are so many health resources in Center City and places like that but just having things that are more on a neighborhood level is very important and especially people who rely on transportation or can't walk very far to get to where they need to go."

BARRIERS FOR PEOPLE WITH DISABILITIES

In addition to the accessibility of an office's location, the accessibility of an office itself such as the width of hallways and doors or the limitations of medical equipment present significant barriers. This issue is particularly pronounced for people with disabilities and those who are caregivers to people with disabilities.

A participant from Delaware County shared:

"I can tell you that from what I know, my wife uses a wheelchair, and it was incredibly difficult. And we have to use pretty much hospital-based or hospital-affiliated practices because a lot of the smaller practice physicians, they're in small offices."

Additional mentions of specific subpopulations struggling with accessibility are highlighted later in this section of the report.

Fear

In addition to logistical and accessibility barriers, participants across discussions expressed fear as a common deterrent to seeking primary care services. Issues related to fear ranged from not wanting to know "what's wrong", fear of how much care/services will cost, to fear of not having insurance or documentation. Fear may be more prevalent in minoritized communities.

FEAR OF DIAGNOSIS

The fear of not wanting to know what's wrong, and hoping "it goes away," frequently results in significant health situations.

A particularly profound example of the extent to which "fear" impacts care was described by a participant from Delaware County:

"And you know we had a situation where a woman had skin cancer on her leg, and she just ignored it until one day at our after-school program, her leg started to bleed, and she couldn't get it to stop. And you know that she had, she had, like the front of her shin removed...And it was all fear. She knew something was terribly wrong, and when she first knew something was terribly wrong, or something was wrong, you know. That situation would, you know, could have changed, could have been much more minor than go out on disability, you know? Because you couldn't walk, and you had, you know, air oxygen being pumped onto the front of your leg. You know those kinds of situations, and that was the extreme situation. But that is happening in my office, and I think is very prevalent in the African American community."

COSTS

Uncertainty about costs is a common reason to delay care, often resulting in overutilization of emergency departments, or advanced health situations. Subsequent costs may be even more than necessary if care had been sought earlier, when issues arise. The need for clarity and education around costs, insurance coverage, financial support are necessary to reduce delays in care.

A participant from Delaware County described this experience:

"What folks tell me is they're worried about that back-end bill. But then they wait and wait and wait. Like a person who just admitted herself to the emergency room, turns out she just has very, very severe acid reflux. Well, now she has an almost $20,000 bill because she went to the hospital and they did a workup, whereas she could have been seen by a primary care doctor, and I think that that would have alleviated that. But some clarity in what the charges are...I think, would be huge."

Care Coordination

Challenges with care coordination were another common barrier among the discussion participants. This was frequently mentioned in relation to community events, health fairs, and pop-up screenings – specifically confusion regarding what someone should do after a screening or test, where do they go next, and whether that's primary care or a specialist.

LACK OF COORDINATION

Although there is great benefit to community health outreach, without proper care coordination, community members are left without knowing what to do next or may not receive the proper follow up care in a timely manner.

A participant from Philadelphia shared:

"We also are seeing it a lot with specialty care where people go to the like neighborhood health fairs and health screenings and find out that they need a colonoscopy, or, you know, they [have] high blood pressure. So, they really need to go in and see their PCP. And maybe get referred to a cardiologist and all of that. They get these tests, and the health systems go to them and say you need to come see us, and then they say "We're actually not scheduling, because that's a year out.'"

INSURANCE BARRIERS

When community members seek out primary care, they may be using inaccurate or outdated lists of providers who accept their insurance even within the same system or office. Often these are the lists shared through insurance portals, which can cause confusion and delays in care.

A discussion participant from Philadelphia, who also works at an FQHC, shared how this impacts both health centers and patients:

"We're finding out that insurances also sometimes cause barriers because they will list certain primary care doctors. And then if someone tries to come to us for primary care, we're like, 'Well, we're not your primary care doctor.' And they're like, 'Why? I've been going to you for so many years.' It's like, well, they listed someone else, and now there's this whole snafu we have to go through with insurance."

Special Populations: People with Disabilities

LACK OF ACCESSIBLE EQUIPMENT

In addition to barriers related to physically accessing primary care spaces (such as halls and doorways wide enough for wheelchairs), participants shared that at smaller, more local practices, the medical equipment cannot accommodate people with disabilities. This can lead to increased utilization of hospitals or specialty care because those facilities may have more accessible equipment. One participant mentioned that finding accessible dental care is particularly challenging.

Describing this experience, a Delaware County participant shared:

"And the other thing is very difficult to find, because I accompany my wife when she goes for primary care, because a lot of times, even if you can get in and they have wide enough hallways, they do not have medical tables or chairs that somebody using a mobility device can get into... So it leads to a lot more of hospital visits than if there were appropriate facilities to get her into — X-ray machines, MRIs, stuff like that. We wouldn't have to go to the hospital but in a lot of cases, the hospital's the only accessible place."

KNOWLEDGE OF RESOURCES

Compounding the physical barriers faced by people with disabilities are issues related to cultural competency and the need for more providers and care teams to "understand the principles of disability and the independent living philosophy" which are critical to providing compassionate and quality care to this community. Additionally, there needs to be greater education and awareness amongst providers about the resources available to people with disabilities, and the role providers play in securing those resources – such as Medicaid waivers.

A representative from Philadelphia County highlighted:

"We think that community first should be always the option, keeping people in their home, instead of in an institution. I also think there's opportunities to educate the health care systems, including the PCPs on, in particular folks that are enrolled in Medicaid waivers, on what services are available. As an example, I know home modifications were mentioned earlier through the city program, but the Medicaid waivers also cover some of those things. So, if a doctor deems somebody, [it's] a medical necessity for them to be able to continue to stay in their home and live independently, the waivers could cover the cost of a Stairglide or a vertical platform lift or extra lighting in the home. And there's an array of services that are available under these waivers, that the physicians just don't know about, and can help improve and reduce the risk that they're facing today in their own home."

Language and Health Literacy Access Issues

LANGUAGE BARRIERS

Many medical offices and clinics use translation services, such as LanguageLine, but this service is costly, is not always implemented with fidelity, and its usage may be accompanied by discrimination or frustration. These barriers can alienate patients who do not speak English.

A participant from Delaware County shared the following:

"But that said, I have advocated long for the ability to have LanguageLine available. LanguageLine is costly…but the ability to have it as a county-sponsored resource or something like that would go a long [way] — but partnered with that needs to be training on how to use it. So, a lot of places have LanguageLine, but the people are greeted with, 'Oh, you need that?'"

HIRING CHALLENGES

Certain clinics primarily hire bilingual staff in order to best serve their community – which can present challenges in hiring physicians and maintaining enough staff to serve growing needs. Participants also expressed that community members would be more likely to seek out services if they knew the staff was bilingual.

Discussing this dual barrier and opportunity, a participant from Chester County noted the experience at their organization:

"It's very difficult to find primary care providers who are able to work in our setting. It's a community health setting. So, if you're able to accept the position, and then, for us, we also have [to] hire bilingually. So, again, we're going back to that, not about us without us, right? So, hiring from within your community."

LOW LITERACY SUPPORT

Support is needed for individuals with lower literacy levels — in both verbal and written communication/education. The use of infographics was shared as a potential solution.

A participant from Chester County explains:

"It's a health literacy challenge, right? So, if I am not of a high education level, so if I have challenges with literacy, you have to say things very, very simply. You need to use infographics; you need to use 4th to 6th grade language. And it's very difficult for us to do that in the healthcare arena. It's really hard to take these really difficult concepts and make them something that you're not too high of an education level, but you are also not so simple that you're not getting the full concept."

Solutions to Address Primary Care Access Issues

Issues with primary care access are vast in the Southeastern Pennsylvania region, impacting every county and diverse community populations. To address these challenges, discussion participants offered targeted solutions and highlighted some successful approaches already implemented in their communities. Solutions reflect opportunities for partnership between hospitals and health systems, community organizations, health clinics, and government.

IMPROVE TRANSPORTATION OPTIONS:

Encourage partnerships with transit providers to subsidize costs, provider vouchers, include transportation as part of health navigation, or innovate new solutions such as healthcare system-specific shuttles or individual drivers employed by the systems. Additionally, identify if routes need improvement (specifically related to time and distance) and if routes adequately connect community members to health care locations.

- **"Again, pie in the sky, right? If we had all this money in the world, if somehow Chester County could create, and through TMACC or another organization, some type of healthcare shuttle service, 'Uber Health', that kind of a thing, but that the drivers are part of an organization or system, not just, 'I'm Kate. I drive for Uber. I'll go pick up.' Because patients don't always trust that kind of a resource. So, it has to be built in such a way that it's a trusted resource for the patients to utilize in order to access primary care and the hospital systems. If we were able to do that, that would be huge."**
- **"One solution would be to have stronger transportation and have more things covered by insurance or generally just having navigators who at a nonprofit level and all kinds of levels, but just help people to navigate accessibility through transportation to their health provider."**

FOSTER STRONGER RELATIONSHIPS BETWEEN HOSPITALS/ HEALTH SYSTEMS AND COMMUNITY CLINICS:

As noted above, increased usage of emergency departments and urgent care for issues better suited to be addressed by primary care is an ongoing challenge. To address this, participants recommended hospitals and health systems and community clinics and FQHCs work more closely to connect community members with local primary care providers. This could be particularly impactful for those with Medicaid insurance, who may have limited options based on their insurance status. Additionally, community members may be more comfortable seeking care with local, community-based providers – especially those who distrust large systems, speak a language other than English or who have limited transportation options. Shifting usage of emergency departments and urgent cares to primary care will also reduce the burden on emergency departments – both in terms of patient volume and patient needs.

- **"The community health centers could be an opportunity for health systems, to maybe lessen the burdens in their emergency room by making sure that they're partnering with primary care providers like a community health center. Community health centers, if you are an FQHC, which is a federally qualified health center, you're able to accept Medicaid, and there are other primary care providers who do not accept Medicaid. So, if you are a person who is in poverty or you have a chronic health condition and you rely on Medicaid for your insurance, then making sure that the health systems are partnering with providers, like community health centers that are able to accept Medicaid, is really important. It does help, not only the patient, but then helps the health system as well. And that does, I think, increase access at your emergency room because you're preventing and using primary care as a preventative service."**
- **"We see a lot of folks there that don't have, you know, regular PCPs, and that that is a potential target for contacting people who have left, you know, been discharged from the emergency department that we could do work to try to connect them to a primary care provider within the system."**

ENHANCE HEALTH NAVIGATORS & COMMUNITY HEALTH WORKER PROGRAMS:

Participants expressed the value of health navigators and community health workers as successful strategies to foster community engagement, encourage prevention, and support patients' complex needs. These roles should be well-positioned to coordinate screening follow-ups and connection with primary care providers.

- **"More investment in community health worker type programs, especially for at risk populations, to target opportunities to reduce that risk again. Like, the example about you go to a blood pressure monitoring [event] and there should be a follow-up, but the follow-up never occurs. Perfect opportunity where a navigator or community worker can fit in to make sure that there's follow through, and coordination."**

FOCUS ON EQUITY AND ACCESSIBILITY:

Participants offered examples of what's working well for their communities and clients around equity and accessibility – such as community-based clinics and diverse language services. When discussing solutions, participants shared the need to continue offering services and resources (or expanding existing services) in multiple languages, address building layouts and physical accessibility, invest in accessible equipment, train staff in practices and concepts such as trauma-informed care and cultural humility, and hire diverse staff to reflect the local communities.

- **"I think that what is working, in Southwest [Philadelphia] there's a large African, West African population, and there's an organization that has a health clinic and I think that you know that the West African population, you know, is way more comfortable going to that clinic. Even though it's a little rough around the edges, and it's not in a pristine building. And you know that kind of thing, I think that there's more of a trust because they're going to somebody like them than there is to go to a brand [new] facility that, you know, is all pristine, but has a mix or of ethnicities working there."**
- **"Every office has a bilingual staff member, and we have a very, very nice and expensive translation system. So, we have these monitors that will directly talk to them in pretty much any language you can possibly think of."**
- **"So I think with LanguageLine, we always want to pair the training about how and why it's important to use it. But if we are asking small organizations…small practices that are in existing office buildings to adapt, we need to be providing them some ability to do so. There needs to be funds to widen those hallways. I shouldn't be surprised, but I am. And LanguageLine should be available."**
- **"I think in terms of solutions, there are educational resources out there to equip health care professionals to understand the principles of disability and the independent living philosophy and what that means."**

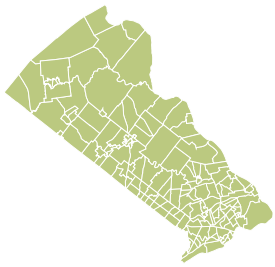
INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS IN THE REGION:

Participants recommended offering incentives or an alternate type of financial funding (either from healthcare systems or federal funding) to encourage medical students and residents to go into the field of primary care, in coordination with education around the benefits of the field itself. With providers retiring across the region, and fewer clinicians moving into primary care, without funding or incentives to close the gaps in providers, primary care access for community members will continue to suffer.

- **"It's hard to afford primary care providers. They're not specialty providers. Their income is maybe a little bit less than some of the specialty folks. So, education and encouraging education of primary care providers would be wonderful. Providing some kind of an incentive for someone to become a primary care provider would be amazing. I don't know that that's something that we would be able to get specifically from the health systems. However, there could be opportunities to encourage healthcare providers to become primary care providers, in some federal funding or partnership funding way of doing things so that we can have more providers from our community to provide care."**

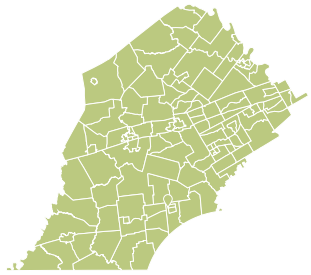
County-Specific Perspectives

BUCKS



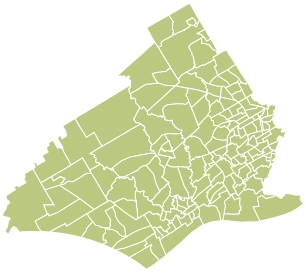
In Bucks County, transportation and logistics to primary care offices and hospitals remains a significant barrier to care – especially when community members seek care in Philadelphia. A partnership between community-based organizations and SEPTA to provide free key cards for clients has proven to be successful and should be expanded to additional organizations. Appointment wait times for new patients is an additional barrier to care. Participants felt that accessing primary care is easier for individuals with insurance, and that community-based organizations can connect patients with care at local hospitals and clinics such as Lower Bucks Community Health Center.

CHESTER



Chester County is geographically and demographically diverse, resulting in unique challenges for community members' ability to access primary care. Southern Chester County is home to a large immigrant population and migrant workforce, many of whom do not speak English, are undocumented, or who do not receive insurance through their employer – all of which may discourage community members from seeking care. Community health centers play a crucial role in filling these gaps by offering integrated services and multilingual services and accepting Medicaid. However, hiring providers, particularly bilingual ones, remains a challenge. The availability and accessibility of care is uneven across the county – with some areas in close proximity to medical offices and hospitals and others with little to no providers nearby, often mirroring seriocomic demographics. This has been exacerbated by hospital closures in recent years. Although public transportation is limited and underutilized, services are available, offering routes along main corridors and to and from health system offices and hospitals.

DELAWARE



In Delaware County, access to primary care remains a significant challenge despite insurance coverage, particularly for Medicaid recipients and immigrant populations who struggle to secure timely appointments at community clinics. Due to recent hospital closures in this area, limited healthcare options force many patients to seek care in Philadelphia. Dental care and accessible healthcare facilities present additional barriers, especially for individuals with disabilities, as small practices often lack the necessary equipment to accommodate their specific needs. While resources like Kids Smiles and hospital-affiliated practices help mitigate some gaps of these, improvements to accessibility should be universally addressed.

MONTGOMERY

Montgomery County's Office of Public Health's 2024 Community Health Needs Assessment featured key insights on community members' perceptions on access to care. Community survey summary results showcase disparities in healthcare access among different demographic groups. While most respondents (78.2%) reported having a personal healthcare provider, access varied widely across racial and ethnic backgrounds. Hispanic or Latino respondents were the least likely to have a personal provider, with only 45.8% reporting access, compared to 82.3% of non-Hispanic/Latino respondents. Additionally, healthcare accessibility was relatively high, with 88.6% of respondents stating that they were "always" or "mostly" able to receive medical care when needed. However, younger adults face greater challenges, with those aged 18 to 34 most likely to report difficulty accessing care. Barriers were also higher for refugee and asylum seekers, immigrants, people experiencing homelessness, and single parents.

PHILADELPHIA

Although Philadelphia is home to multiple major health systems and hospitals, community members still experience barriers to primary care – primarily long wait times, inconsistent care based on insurance status, and disparate access based on geographic location – resulting in systemic inefficiencies disproportionately affecting marginalized communities. Due to significant wait times for primary care appointments, more community members are seeking care from emergency departments and urgent cares. Federally Qualified Health Centers serve as crucial safety nets, but their capacity is often stretched thin, limiting timely access to care. Additionally, fear and mistrust of the healthcare system deter some from seeking necessary preventive care, sometimes leading to severe health complications. Community-based organizations, local clinics, and houses of faith are key connection points in Philadelphia – and are often perceived as welcoming and accessible for many community members.

SPOTLIGHT TOPIC

Community-Identified Solutions

Introduction

The following topics represent community-generated solutions shared during the 2022 rCHNA discussions. Recognizing the value of these insights, the Steering Committee sought to understand how these ideas are being implemented today. To do so, we spoke with a broad cross-section of individuals—including leaders from community-based organizations, civil servants, government officials, and other trusted community voices—who offered firsthand reflections on both progress and persistent gaps.

Shared Challenges Across Topics

Across all themes, stakeholders described enduring systemic barriers that prevent meaningful change. These include fragmented systems of care, lack of transportation, language and cultural barriers, community mistrust, and burnout among both professionals and volunteers. Many noted that services exist but remain out of reach due to inaccessible formats, poor communication, and inadequate outreach. Community members frequently shared feelings of frustration from being excluded from decision-making or asked to participate without seeing meaningful follow-through. Even in well-resourced areas, inequities persist when trust is broken, systems don't communicate, or services fail to meet people where they are at.

What's Working Across Topics

Despite these barriers, there is momentum toward progress. What's working is rooted in relationships, trust, and creative local partnerships. From mobile clinics and warm handoffs to faith-based health events and peer-led care navigation, community-driven strategies show promise. Organizations that embed services in trusted places—like churches, libraries, and barbershops—and those that compensate and support local leaders are achieving greater engagement and impact across the region. Transparent communication, culturally aligned outreach, and investments in lived-experience leadership have helped shift systems toward equity and inclusion, even amid resource constraints.

Invitation to Learn More

The following sections represent a deeper look into each topic area. Each section provides detailed insights into community-identified solutions, what's working locally, and actionable steps toward better health and social outcomes across Southeastern Pennsylvania.

Better Integration of Health and Social Services into the Community

Across Southeastern Pennsylvania, community stakeholders, including social service providers, healthcare professionals, and nonprofit leaders, are calling for stronger integration between health systems and community-based social supports. Interviews conducted in Bucks, Montgomery, Chester, Delaware, and Philadelphia Counties revealed common challenges in coordinating care for individuals whose health outcomes are deeply influenced by social factors like transportation, housing, food access, language, and trust.

Despite a shared commitment to improving community health, the region faces systemic barriers which prevent effective collaboration. Chief among these are information silos, fragmented referral systems, inconsistent infrastructure, and persistent inequities in access. These barriers disproportionately impact vulnerable populations, particularly immigrants, people with disabilities, older adults, and those living in underserved or rural areas.

At the same time, promising practices are emerging. Stakeholders highlighted successful food access initiatives, mobile health services, and warm handoff strategies as examples of what's working. These models demonstrate that integration is possible when health systems take a community-centered approach, communicate across sectors, and build long-term relationships with both patients and partners.

Looking ahead, community leaders envision a more connected landscape—one where referral systems are unified, transportation and technology are leveraged for equity, and healthcare institutions are fully engaged as partners in social well-being. While the region's challenges are significant, so too is the willingness among its professionals to collaborate, innovate, and advocate for change.

What follows is a closer look at how these dynamics play out in each county, identifying local challenges, existing strengths and potential solutions as described by those working on the front lines of health and social care.

Challenges and Barriers:

Participants across all counties highlighted persistent and systemic barriers preventing better integration between health and social services. These include fragmented systems, logistical hurdles like transportation, and deep-rooted cultural, structural, and communication issues.

INFORMATION SILOS AND GATEKEEPING

Professionals described an inability to access or share information across organizations, even when services exist. This siloing leads to duplication of efforts, confusion, and missed opportunities for patients.

One Bucks County participant states:

"Really the biggest thing is the information gatekeeping and just not knowing what everybody else does, not knowing what agencies are out there. So I would really love to see some collective resource that we could all communicate through even if it was like the old Yellow Pages - made life a lot easier."

TRANSPORTATION ACCESS

Lack of reliable transportation, especially in rural and suburban areas, was one of the most universally cited barriers to care access.

According to a Chester County participant:

"Transportation is a very big issue that most people from the rural areas find it difficult to transport themselves to location where there is a hospital is a very big challenge."

CULTURAL AND LANGUAGE BARRIERS

Participants explained that interpretation alone is not enough. Without cultural understanding, services can miss their mark entirely.

A Chester County resident explains:

"Not only is the need is for language barrier to be broken, but also cultural barrier. It is two different things to speak one's language, which is great, which is a need, but also understand why culturally this health behavior or this service is not reached out to."

DISCONNECTED REFERRAL AND DATA SYSTEMS

Multiple incompatible referral platforms force clients to repeat their stories and disrupt continuity of care.

Another Chester County participant said:

"Could we all agree to use the same thing? Because if different hospital systems are making referrals out of different systems, and if the county is working out of yet a third system, and then some of the agencies are working out of maybe a fourth system, we don't need people retelling their story over and over. We need people getting help."

BURNOUT AND WORKFORCE CAPACITY

While often implied, the strain on both healthcare and social service workers emerged as a subtle but critical barrier. Multiple participants mentioned overworked staff, high turnover, and limited time for collaboration—even when the will exists.

A community-based organization participant from Delaware County explains:

"I don't know a single person in our profession who truly has bad intentions, but they all have limited time."

MISMATCH BETWEEN SCREENING AND SERVICE AVAILABILITY

Several interviewees described a tension where health systems are now required to screen for social needs but lack meaningful referral options when people screen positive.

One participant from Philadelphia described it this way:

"We screen folks for housing or transportation insecurity… then we have no up-to-date referrals to help people."

THE NEED FOR BIDIRECTIONAL INTEGRATION

While much of the conversation focused on health systems referring into social services, some key informants raised the reverse challenge: CBOs also need more formal pathways to connect clients into healthcare systems.

A participan from Philadelphia shared:

"Typically, we refer patients in healthcare into social services, but we could be doing more to create a full loop."

IMPORTANCE OF TRUST AND CONTINUITY IN RELATIONSHIPS

Trust came up repeatedly, not only as a cultural concern but also in terms of how systems build or break community confidence. Several participants emphasized that short-term pilots or programs that disappear leave communities more skeptical and harder to re-engage.

According to a participant from Chester County:

"It's very hard when a company or agency comes out saying they're doing these wonderful things for the community to trust them... because it's been their experience that they're not going to be there that long."

What's Working Well

While challenges remain, participants pointed to several bright spots in integration efforts. Effective areas include food access programs, mobile and street medicine services, and personalized approaches to client handoffs and care coordination.

FOOD ACCESS AS AN EFFECTIVE ENTRY POINT

Food access, especially those tied to health systems, was widely viewed as successful and replicable models.

A member of a Philadelphia CBO said:

"Food and nutrition is actually one of the areas where health systems are doing a pretty good job. Not all of them, not all the time, but many health systems in the region have either developed their own food pantries or they have referrals to food pantries. They're connected to Philabundance and MANNA and other organizations, and I think food is an area where we're doing better."

MOBILE AND COMMUNITY-BASED SERVICES

Mobile units and outreach programs (e.g., mammograms, dental vans, street medicine) increase access by meeting people where they are.

One Montgomery County participant explains:

"Over in Pottstown, they do street medicine now. And a lot more mobile units like their community health and dental or the mobile mammogram and things like that where they're really getting the doctors out to either other sites in the community. And I think that that's been really successful in that area and I'm not sure if any of that occurs in this part of the county."

WARM HANDOFFS AND RELATIONAL REFERRALS

Building trust through person-centered care and warm handoffs was seen as more successful than transactional referrals.

According to a Chester County participant:

"It really doesn't make a difference. If you hand that person a number and the person still can't access the service. It's still a problem. So, it has to be more involvement in just making sure that that person actually was able to get into that service if in fact that's what's supposed to meet their needs,"

Suggested Actions and Solutions

Participants offered tangible strategies for improving system integration. Suggestions focused on improving communication infrastructure, embedding services in communities, utilizing technology for independence, and institutionalizing long-term support roles.

Multiple stakeholders advocated for routine cross-sector meetings and infrastructure for sharing updates and connecting services.

- **"There needs to be a group of people, whatever they're called, kind of a team that meets regularly. Some frequency about kind of, I guess representatives that know what's happening in the community can take it back and are just educated about, oh, you're doing a program on this. Okay. That's great. We're going to get the word out."** – Delaware County

Embedding hospital outreach within churches, senior centers, and trusted spaces can build visibility and credibility.

- **"Go to a church. After the church service, do an education. You got a captivated crowd. You got them right where you want them. Bring some food, call the day. I think things like that. More of that stuff needs to happen. We really wanna reach into the community."** – Chester County

In-home technology was seen as a cost-effective tool to prevent unnecessary institutionalization and support independent living.

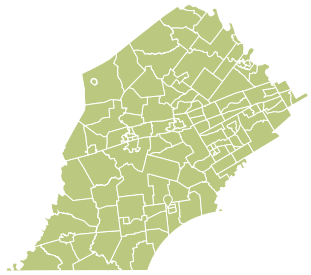
- **"We have about five people who are using in-home medication dispensers, and they would not be able to stay housed if they didn't have those in-home -- it's high-tech. When they're supposed to take medication, they press this button on this machine, the medication drops into a cup, and then they take it. If they don't press the button and they don't pick the medication off the tray, our nurses get a message on their phone and can call them and help them deal with it or go to the apartment."** – Philadelphia County

County-Specific Perspectives

BUCKS

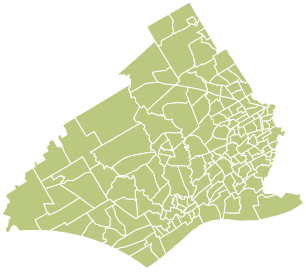
In Bucks County, one of the most pressing challenges is widespread information gatekeeping and lack of cross-agency awareness. Despite being a resource-rich area, participants noted that agencies often do not know what services others provide, leading to missed opportunities for collaboration and fragmented care. Newer staff entering the field expressed frustration at the inability to connect freely with other organizations—even within the same building—due to administrative restrictions and a lack of centralized communication tools. Another major issue is that clients are typically connected to only one agency, even when they have multiple, intersecting needs, which leads to frustration and disengagement. Additionally, clients are often not empowered to make independent decisions, especially when many providers are involved. Yet, there is strong enthusiasm among professionals in the county to bridge these gaps. Some described Bucks County as offering "more services than anywhere" they had worked before, suggesting that the infrastructure exists, but better communication and coordinated referral tools (such as a county-wide directory or Yellow Pages-style system) are essential. Participants also recommended county-wide training focused on fostering client independence and clarifying eligibility across programs as practical solutions to reduce client attrition.

CHESTER



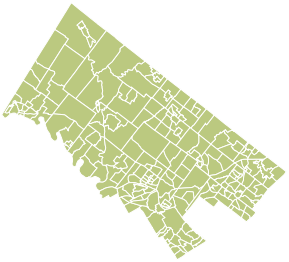
Chester County's integration challenges are defined by geographic and jurisdictional fragmentation. Participants from Southern Chester County noted that while services may technically exist, transportation and awareness remain substantial barriers. Compounding this is the fact that many communities in Chester span multiple county lines, meaning access to services changes depending on where a resident lives, even for people with the same condition or need. A major systems-level challenge is the lack of unified referral infrastructure. Hospitals, counties, and nonprofit agencies all use different platforms, forcing clients to retell their stories repeatedly and often leading to service gaps. Language and cultural barriers were also highlighted, particularly among the county's growing Spanish-speaking population. Nevertheless, Chester County benefits from engaged coalitions like Communities That Care (CTCs) and a strong recognition among local providers of the importance of warm handoffs and trauma-informed communication. Solutions proposed included hospital participation in local coalition efforts, co-locating social service staff in hospital spaces, and institutionalizing long-term navigators to help patients stay connected to services. Participants also stressed the importance of consistent community presence, noting that short-term or underfunded programs erode trust over time.

DELAWARE



In Delaware County, the major barriers to integration stem from organizations being territorial, privatized health systems, and inconsistent access to programs based on residency. Interviewees expressed frustration with large hospital systems whose leadership operates outside the region, noting a disconnect between decision-makers and community needs. Additionally, community-based organizations (CBOs) and churches often limit their programming to internal groups, which restricts collaboration and creates inefficiencies. Some township-level programs are also only available to residents of specific municipalities, further fracturing access across the county. Despite these barriers, Delaware County has shown promise with its 211-call system and a strong network of grassroots organizations eager to collaborate. Participants emphasized that regional coordination teams, including representatives from medical, social service, and community sectors, could help break down silos. They also recommended greater hospital investment in local social infrastructure, funding for mental health services, and a place-based strategy that tailors solutions to the diverse sub-regions within the county (e.g., Wayne vs. Upper Darby). The need for hospital systems to see themselves as community health leaders, not just clinical care providers, was a key theme throughout.

MONTGOMERY



Montgomery County stakeholders identified transportation barriers and language access challenges as two of the most significant obstacles to better integration of health and social services. Although telehealth is available, many clients lack devices, internet access, or digital literacy, making remote care inaccessible. Similarly, language services are insufficient for the county's diverse population, with most bilingual capacity limited to Spanish. Interpreter services exist but are inconsistently applied, and some—like LanguageLine—fail to adequately capture patients' concerns. Still, the county has several promising practices in place. Some participants praised the usage of GLOBO, an interpretation service offering over 240 languages, including ASL and video. There was also enthusiasm around existing mobile health initiatives, such as street medicine and dental vans in Pottstown and Norristown, which were seen as successful models of community care. As a solution, participants recommended partnerships with transportation services like Uber Health, investment in volunteer-based ride coordination, and clearer post-discharge transportation planning at hospitals. To better serve multilingual and multicultural populations, stakeholders emphasized expanding interpreter access and improving cultural responsiveness across systems.

PHILADELPHIA

Philadelphia's integration challenges center on mistrust of healthcare institutions, fragmented systems, and institutional bias toward congregate care for people with disabilities. Many residents are hesitant to seek care in large health systems that feel overwhelming or unwelcoming. Community-based organizations reported that health and social services operate in parallel but disconnected silos, which is especially problematic for people with multiple, overlapping social needs. A recurring concern was the "nursing home default" for patients with disabilities—where hospital discharges lead straight to institutional care due to lack of community-based alternatives. Yet Philadelphia was also highlighted as a leader in food access programs, with health systems running food pantries, food-as-medicine programs, and partnerships with organizations like MANNA and Philadabundance. In-home technology, such as automated medication dispensers, was also noted as a promising innovation that enables people to live independently. Interviewees emphasized the need for holistic, long-term approaches to care that treat food, housing, and health as interconnected. They recommended expanding waiver-based home and community care programs, training hospital staff on disability cultural competence, and developing long-term referral systems with built-in feedback loops. Many felt that the success of food integration could serve as a model for other social determinants of health.

Increasing Community Members Capacity to Become Care Navigators

Across Southeastern Pennsylvania, community members and providers articulated a deep commitment to expanding the capacity of individuals—especially those with lived experience—to serve as care navigators.

These individuals often serve as trusted guides through complex systems of health and social care, but their ability to do so effectively is shaped by entrenched challenges, current successes, and creative grassroots solutions.

Challenges and Barriers:

Participants across all counties highlighted persistent and systemic barriers preventing better integration between health and social services. These include fragmented systems, logistical hurdles like transportation, and deep-rooted cultural, structural, and communication issues.

FRAGMENTED SYSTEMS & ACCESS BARRIERS

Participants highlighted the systemic fragmentation in health and social services, where siloed funding streams (e.g., substance use vs. mental health) hinder coordinated care.

A Bucks County participant said:

"We should be able to refer a client in all those directions in one shot and you get to pick one and hope that you get funding for it."

A Montgomery County participant further explained this challenge:

"I'm thinking about community connections through the county and that they are, I guess intended to be that central hub for resources. But again, I feel like, I don't know if everybody knows about them and then I think one of the challenges is how things are just constantly changing. So, keeping up with the change and what services are available, that's just hard. You could make a resource guide and six months from now it's not going to be current. So, I think that's a challenge of that, but maybe more types of —or a really known community connection. This is here for everybody to use."

LANGUAGE & CULTURAL BARRIERS

Language emerged as a recurring theme across counties, with service navigation often falling to children or overburdened staff.

A Bucks County participant shared their experience:

"I think of like capacity and navigators is our family standard coordinators speak all different languages. I don't know, if your guys – healthcare, if they provide many different languages, we have a bunch of Middle Eastern languages like Arabic, Hindi, Russian, Ukraine, Spanish. So not only are coordinators focusing on funded programs through our agency. People come to them asking what does this mean? What's that? It's like they have to spend so much time explaining in different languages and we're not funded for a lot of that time. So, they have to squeeze where they can to help people, but I know that language is -- as much as transportation language is definitely up there with barriers for our staff to advocate for them or steer them in the right direction."

LACK OF AWARENESS AND OUTREACH

Despite longstanding programs, many residents and even providers remain unaware of available services.

A Philadelphia participant shared:

"So, in starting work in the Northeast, one of the first things I did was to get a grasp of the area, even though I live up there as well, was going to civic meetings, trying to — hey, we might start doing work up here. What's going on? Getting feedback from community members, different civic groups. And one thing I noticed is that most people like some of us in the field, we don't communicate outside of what we're doing. So, the community members that are there want to help, they're at a civic meeting. They obviously have some inclination to do something for their community, but they don't have the resources."

One Montgomery County participant summed up their experience with a longstanding community organization:

"We celebrated our 125th year. I can't tell you how many times we were like … 'Never heard of them'. For real."

VOLUNTEER BURNOUT AND AGING WORKFORCE

Participants described burnout among care navigators and an over-reliance on a small group of aging volunteers.

A participant from Philadelphia shared:

"And I think the biggest thing with the burnout - just in some of community organizations that I have volunteered in and been a part, we ask the same people, we don't go outside of our usual. And there's so many other individuals out in the community that may be open to supporting and volunteering, but they just don't know, and no one's asking."

One Chester County participant further highlighted the challenges with volunteer burnout and engagement:

"It's really challenging to get someone that's going to commit to that on a weekly basis, on a long-term sustainable basis. I think a lot of times we see, like, volunteer pushes and volunteer initiatives that last, you know, months, and then it sort of phases out and fizzles out."

DIGITAL LITERACY & TECHNOLOGY ACCESS

Many participants, especially those working with older adults, flagged digital navigation as a growing barrier. As healthcare systems increasingly rely on patient portals and online systems (e.g., MyChart), some community members struggle to access or understand digital tools essential for care.

A participant from Chester County expressed:

"There needs to be some training…how to navigate on your computer is all the MyCharts and MySpaces that the hospitals have. Everyone can't navigate those things."

To mitigate this barrier, a participant from Philadelphia offered this solution:

"That sort of preparedness is something we can focus on…we can make trainings virtual and on-demand and asynchronous, so we can reach more people."

CRISIS-LEVEL ENTRANCES TO CARE

Participants shared that people often access care only when in crisis, and frontline staff or community members are left trying to interpret needs that are not clearly articulated. This leads to miscommunication, inadequate care, or even criminalization.

A Delaware County participant shared:

"Because this is an issue, it can cause the consumer…to act a certain way, which then triggers them to possibly have somebody called on them…they want services… but there's not someone there on-site that knows a little bit of what's happening."

What's Working Well

What's working to support community members as care navigators' centers on trust, relationships, and culturally rooted approaches. Faith-based organizations, libraries, and grassroots spaces are stepping in as reliable access points where people feel safe seeking help. Community-led efforts—like informal mental health support, Narcan training at civic meetings, or barbers trained to identify and refer clients for care—demonstrate that navigation doesn't have to be clinical to be effective. These approaches are grounded in everyday environments and speak to the lived realities of the communities they serve.

Collaboration is also a key success factor. Interagency gatherings like Kensington's "huddles" create space for problem-solving and sharing resources across sectors. In parallel, organizations that uplift peer leaders with lived experience—like community health workers or caregivers—build deeper trust and reach. Simple efforts like tabling at local events or resource fairs also go a long way in boosting visibility and awareness. Together, these practices highlight that when communities are engaged authentically and given the right tools, they can lead the way in navigating care systems that often feel overwhelming or inaccessible.

TRUSTED COMMUNITY ANCHORS

Faith-based organizations, libraries, and grassroots groups have built strong trust within their communities.

A participant from Chester County said:

"When we needed, at the library, a new lactation room, a Facebook group of moms volunteered to furnish a whole room, plus one year of free diapers and wipes to other moms at the local library, just because I presented this under a community effort that had a name, a space, trust built."

INFORMAL MODELS OF SUPPORT

Programs such as the "Friendship Bench" and Narcan trainings at civic meetings showed the value of low-barrier, community-grounded interventions.

A participant from Chester County expressed:

"It was called Friendship Bench. And it started, I believe, in Africa, and is just coming into the United States. But they had community grandmothers sitting on a bench where people could come and they train these grandmothers in mental health services and things like that. And people could come and sit with the grandmother, and tell them their problems, tell them their issues, have a sort of therapy in this safe space with this grandmother."

A participant from Philadelphia County said:

"So, what ended up happening, inadvertently, is that I was going there to fish for information for a program that we're doing, but what ended up happening is I ended up doing impromptu Narcan trainings and filling in people on different social services in different areas depending on where they live at."

INTERAGENCY COLLABORATION AND LEARNING HUBS

Interagency collaboration and community-based learning hubs emerged as powerful mechanisms for strengthening care navigation, particularly in communities where needs are complex, and traditional systems often fall short. In both formal and informal spaces, participants described how bringing multiple organizations together fosters real-time problem-solving, relationship-building, and shared accountability.

Together, these examples illustrate how collaborative ecosystems, whether in clinical settings or barbershops, build stronger, more responsive networks for care navigation by valuing shared learning, trust, and community-rooted knowledge.

A participant from Philadelphia County said:

"It's just a bunch of people that meet up, and anything happens down there because in that area, you just got to figure it out. So, you're going to come across some of the craziest cases and some of the craziest things to try to figure out. And if you're willing to do the job, you can get into some crazy stuff that you're figuring out, which you bring it there, and you put it on the table like, 'Hey, I don't know what to do. I got this crazy case that's just a mess.' And there's always people there willing to at least brainstorm with you."

A participant from Chester County said:

"We partnered with community care, behavioral health, and provided our hair training where we trained barbers and hairstylists in Black communities to understand mental health diagnosis and referrals for mental health treatment… it was a great process, a great experience for the barbers and stylists."

PEER-LED AND LIVED-EXPERIENCE APPROACHES

The importance of navigators with lived experience—not formal education—was raised repeatedly, especially in communities where trust in formal systems is low. Community Health Workers (CHWs) with shared backgrounds can connect more effectively.

A member from Philadelphia County said:

"There are many, many robust, well-run CHW programs…We can have CHWs train other healthcare workers…I think it's actually been a very straightforward, successful system for places that have invested in it."

LEVERAGING RESOURCE TABLES AND PUBLIC EVENTS

Resource tabling at community events emerged as a valuable, simple mechanism to increase visibility and awareness of services. These efforts help address the challenge of outreach without requiring deep infrastructure.

A paricipant from Montgomery County said:

"We do resource tabling and people come up like, 'Oh wow, I never knew this.' How long have you been around?' '50 years.'"

Suggested Actions and Solutions

Across counties, participants emphasized that increasing community capacity for care navigation requires **intentional investment, inclusive recruitment, and structural support**. Solutions center on **training and compensating individuals with lived experience**, ensuring that those most connected to the community are also empowered to lead. Organizations are working to **standardize care navigation protocols** across sites to ensure consistency, while also developing **virtual and on-demand training** to make learning more accessible.

To prevent volunteer burnout and ensure sustainability, participants advocated for **expanding the volunteer pool**—especially by **engaging youth and young adults** through schools, service requirements, and internships. There is also strong support for **intergenerational mentorship**, pairing experienced older adults with younger volunteers to build mutual learning and long-term capacity. Finally, many called for **compensating volunteers through stipends, gift cards, or workforce development opportunities**, recognizing that the economic realities of many potential navigators must be addressed to make service accessible for all.

There is a strong consensus that organizations must provide funding, training, and recognition for navigators.

- **"There are many, many robust, well run CHW programs within health systems. And really, all it takes is the, you know, desire to fund the position and provide the training, and that training can really come now from the distributed network of CHWs that already exist within the city. So we can have CHWs train. Other healthcare workers, you know, provide their perspectives and things like that. But I think it's actually been a very straightforward, successful system for places that have invested in it."**
- **"There is a woman in the Coatesville community that does a caregiver…she used to care for her husband with Parkinson, and so she does a survey just about like what their experiences with caregiving, and she didn't even know that she could have been reimbursed for the caregiving that she was providing…There is an opportunity for that sort of transition."**

Several participants emphasized the need to intentionally include high school and college students, tapping their lived experiences and leadership potential

- **"Have we gone in and had conversations in the high schools and talked about some of the great work that's being done in their very own community and backyard and the gaps of that volunteer need with all of this work that's being done. and we may be surprised how many? We may say yes."**
- **"So, learning those pieces of because if they're not asked and they're not put in situations where they have the opportunity they may not know where to go to look to ask, or they just, you know, they're in their own world."**

Bridging youth with older adults who have decades of experience can both preserve knowledge and create continuity.

- **"The older generation has a wealth of knowledge. We need to partner the older ones with the younger ones. The younger ones are now willing and able because they're going to get credit for it. The older ones usually love to spread information, love to share knowledge."**
- **"I was just thinking this morning about going to vote, and it was like everyone who was working the polls was an older Black woman from my neighborhood. There was no like that was the only demographic, you know, there were like 10 women there doing it."**

Several interviewees spoke explicitly about economic hardship is a major deterrent to volunteering. Stipends, flexible schedules, and structured programs can mitigate this and increase equity in participation.

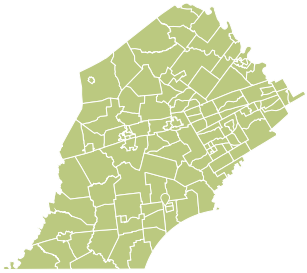
- **"There's like an economic barrier that we don't always think about — that like volunteering does tend to fall to older people because they're no longer, you know, working full time, or they're not trying to do like three gig economy jobs, you know, in between doing whatever else. So, I think any financial support we can give to people, the more the better. And I think that's probably like one of the major ways of doing it. So, in projects that we're working on where we're trying to engage younger people to be a part of it, we're trying to pay like monthly stipends for the hours that they volunteer for us to cover things like what it takes to volunteer."**

County-Specific Perspectives

BUCKS

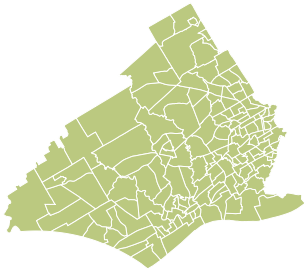
Bucks County faces pronounced challenges related to siloed services, especially for individuals with co-occurring mental health and substance use issues. Providers feel powerless when funding streams dictate care options, regardless of client need. Despite resource availability, navigation remains difficult without centralized, updated directories. Nonetheless, staff are deeply dedicated and eager to refer clients, if only the tools existed.

CHESTER



Chester County has demonstrated innovation through local adaptation of global models like the Friendship Bench and grassroots mobilization at libraries. Participants emphasized the importance of placing care navigation in comforting, familiar community settings. There is a strong local willingness to volunteer when efforts are framed as collaborative, named, and intentional.

DELAWARE



Despite abundant services, accessibility remains a major barrier in Delaware County, complicated by staffing shortages and lack of responsiveness from agencies. Language and cultural mistrust—especially among Latino and Asian communities—compound the problem. However, existing interpreter services and a commitment to outreach offer a foundation to build on.

MONTGOMERY

Montgomery County benefits from longstanding institutions and community clinics, including faith-based vaccine distribution and nutrition services. However, many residents remain unaware of available resources due to limited marketing and constant service changes. The "Community Connections" hub has potential but needs greater visibility and integration.

PHILADELPHIA

Philadelphia stands out for its informal, embedded outreach strategies. Civic meetings, Narcan trainings, and Kensington's "huddles" serve as organic sites of engagement and information sharing. Participants emphasized the need for systems to better support community volunteers, financially and structurally, to avoid burnout and improve continuity.

Integrating Preventative Treatment, Care, and Education in the Community

Across Southeastern Pennsylvania, community stakeholders emphasized the urgency of shifting from reactive to proactive approaches to health.

The conversations revealed persistent challenges in reaching marginalized populations with preventative care, while also highlighting community-driven innovations and solutions. Participants underscored that trust, access, and culturally appropriate outreach are pivotal in successfully delivering health education and preventative services.

Challenges and Barriers:

Community leaders described persistent structural, cultural, and logistical barriers to accessing preventative care. These included transportation, cultural stigma, lack of language-appropriate resources, health system complexity, and socioeconomic conditions.

TRANSPORTATION AND ACCESS ISSUES

Transportation barriers were one of the most commonly cited logistical challenges across multiple counties. Stakeholders noted that even when preventative services exist, unreliable or unavailable transportation renders them inaccessible. These issues not only deter initial appointments but also negatively impact future health-seeking behavior.

Two Philadelphia participants explained:

"If people can't get to where they need to go to get the preventative care or to access something, then [it] doesn't matter that it exists because they can't get there. Or if they can get there, say there is a program that schedules rides for them, maybe a paratransit type program or motive care or something, but those rides are consistently late or no shows or just unreliable, then that's pointless too."

"Transportation not only to get to your preventative care, but then transportation access, the healthiest food that you need to then prevent chronic disease and illnesses. That is a huge barrier."

CULTURAL BARRIERS AND STIGMA

Providers discussed how cultural trauma, and norms prevent many immigrant women from seeking mental health care. Shame, secrecy, and fear of judgment or exposure in their own communities are significant deterrents. These issues often remain invisible to mainstream providers who may lack nuanced cultural understanding.

A Bucks County participant told us:

"They've been raped and it's not something you talk about, you don't get help with. They don't want to be labeled as a victim with needing mental health help… being able to talk about — through counseling, what they went through because they don't want their — maybe their husbands don't know what happened or their friends, they just don't want people to know… it is definitely a barrier for clients to even consider going for help."

A Montgomery County participant shared:

"Nobody thinks they have any problems and they hesitant going to doctor and talk about their problems. They just want to hide all this thing till it really explodes."

SOCIOECONOMIC STRESS AND CRISIS LIVING

A theme across counties, particularly Bucks, was that generational poverty leaves people in constant crisis mode. Preventative care falls by the wayside because people lack the bandwidth to prioritize anything beyond immediate survival needs like food and shelter.

Another Bucks County participant said:

"What happens is when real crisis strikes… that's when we see folks come through and say, hey, what's available?… So, I think that a lot of the barriers that exist in preventative care is we're not getting in front of the folks because we don't know where they are until they're in crisis."

LACK OF HEALTH LITERACY

Despite available services, participants shared that many residents—especially in Chester—lack foundational understanding about why preventative care matters. This "education gap" prevents community members from engaging in health services until a crisis occurs.

A Chester County participant explained:

"To this day, 2024, regardless if the resources out there, if it's accessible, the concept still today is not there. Why would I want to do a preventative effort? And I think that is a huge, huge gap to fill simply by health literacy and health education of the why."

LANGUAGE ACCESSIBILITY

Language access was flagged as a key barrier. Resources, even when available, are often only in English, which makes independent learning or navigation of services nearly impossible for clients with limited proficiency.

A Philadelphia participant said:

"We don't have, not much to give them, flyer or brochure. We just like, search our own, you know, like, online… No. It's a lot of English."

A Delaware County participant said:

"Not everyone is computer literate, knows how to fill it out. It may not be offered in other languages, and the language is not probably usually reader friendly."

COMMUNITY MISTRUST AND HISTORICAL DISCONNECTION

Across counties, there's a thread of longstanding mistrust in institutions—particularly healthcare systems—rooted in cultural disconnection, lack of representation, or perceived elitism. While this overlaps with "challenges," it deserves its own framing because it is more than a logistical or awareness gap—it's a relational and historical one.

A Chester County participant explained:

"I think you still have to have people who look like me in order for me to want to hear what they have to say."

MENTAL HEALTH AS BOTH A BARRIER AND AN UNMET NEED

Mental health came up repeatedly—not just as a standalone need, but as a barrier to engaging in any kind of preventative care. This includes stigma, depression-related inaction, and post-pandemic trauma, especially among youth.

Two Montgomery County participants shared:

"Mental health... post-pandemic, the teenagers, oh Lord. Everything they've had to go through... prevention for mental health would be really important."

"There's not enough providers, and the providers that are there, the waitlists are crazy."

INFORMATION OVERLOAD OR FRAGMENTATION

Several stakeholders—particularly in Delaware and Philadelphia—spoke about the difficulty of navigating too many disconnected systems, where information is either overwhelming, inaccessible, or not presented in ways that encourage uptake.

"I'm inundated with information... And since that takes up 90% of my energy, I don't have an opportunity many times to see what's going on in other communities and see what other people are doing throughout Delaware County."

What's Working Well

Innovative programs and local partnerships were highlighted, especially when rooted in trusted community institutions or tailored to specific populations. Examples include mobile health clinics, faith-based outreach, and home visits from insurers.

COMMUNITY-BASED EDUCATION AND MOBILE CARE

Mobile health clinics and pop-up services were praised as accessible, effective methods of reaching underserved populations. By removing the burden of travel and integrating care into community spaces, these models filled a crucial service gap.

A Montgomery County participant told us:

"What I've seen in Pottstown with the mobile clinic... that seems to be really hitting a population that was not getting any treatment before. It's not preventative, but it's treatment that is working there."

IN-HOME CHECKUPS BY INSURERS

Health insurers were commended for offering in-home health assessments. These check-ins not only improve convenience but also serve as reminders and motivators for patients to complete outstanding screenings and care.

Another Montgomery County participant told us:

"Once a year, [health insurance company] sends a nurse at home. Even though I have my physical once a year, they still want to come. 'Til you let them come, they keep on calling you... So the nurse comes and she takes your blood pressure and what not and asks questions about you had your mammogram and colonoscopy and all that... That reminds you that this one you haven't done it, so you have to get it done."

RESOURCE SHARING AMONG TRUSTED ORGANIZATIONS

Trust in organizations like SEAMAAC was high among community members. When healthcare systems partner with known and respected community organizations, especially those embedded in ethnic or immigrant communities, people are more likely to engage.

A Philadelphia participant told us:

"I think like, if you give to SEAMAAC, I think SEAMAAC will be a good to share information to client community. Because mostly all the community, when they need help, they come to see me."

FAITH-BASED HEALTH EVENTS

Faith institutions were seen as a powerful, though underutilized, vehicle for health outreach. By hosting wellness events and clinics, they bring health information into familiar and trusted spaces. Still, participation remains an issue.

A Montgomery County participant explained:

"This temple, they take care of not only religious, but they have a lot of health clinics. They have yoga clinics, they have a dentist coming and diabetic specialist comes and give lectures and all. But the participation is again a problem."

Suggested Actions and Solutions

Participants proposed clear strategies to strengthen community health education and prevention, such as improving outreach through schools, tailoring messaging through community champions, and integrating culturally relevant communication in familiar settings.

Plain language and representation matter. Participants suggested using relatable, culturally aligned messaging delivered by trusted messengers—not necessarily health professionals—to improve community engagement in prevention education.

- **"I look at those lists all the time, and I think they could be nice, but they don't look like they would be the language or whatever that I want to hear. Right? And then I have to go back to you still have to have people who look like me in order for me to want to hear what they have to say."**

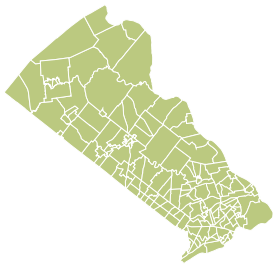
Participants emphasized early intervention through schools and pediatricians as essential to long-term prevention efforts. Children's health habits start early, and so must educational messaging.

- **"How can we better educate our children on eating healthy foods versus eating Takis and Doritos all the time… So how can we do that with the schools, with the hospitals, with the PCPs?"**

Rebranding health education as social, fun, and interactive can help reduce stigma and draw broader audiences. Events like cooking demos or "family fun nights" were named as ways to slip prevention into appealing formats.	• **"So they're not admitting maybe that things could be done differently, because it's not even wrong. It's just that you could do it better. Like nutrition, to have cooking classes, not necessarily a lecture on diabetes, but to be like, let's make these fun snacks and to get people in that way."** • **"There are 70 kids that come to a library story time three times a week. So, think outside the box, go to public spaces like a public library, do health literacy in public libraries."**
A recurring request was for a centralized, user-friendly tool that filters resources based on need and eligibility. A digital or county-specific "one-stop shop" could significantly reduce access barriers and information gaps.	• **"I am by no means IT inclined, but one of my bigger goals is to have a resource... where you can go in and enter certain criteria like... age address, and maybe insurance and that's it, and it populates the list of resources based on that criteria... there's not really like we've talked about a couple of times like a one-stop shop where we can search for things specific."**
Advocacy is needed to shift funding, eligibility, and systemic rules—especially around housing, language access, and documentation. Some interviewees, especially in Philadelphia, touched on policy-level solutions (e.g., adjusting area median income (AMI" guidelines for housing aid) and the importance of systemic change to meet prevention goals—not just programs or messaging.	• **"There's actually legislation that — I'm in a coalition called the Philadelphia Coalition for Affordable Communities, and we're trying to get legislations passed to have the city council allocate 50% of all housing funds that come in, whether it be state, local, or federal, to people who make $32,000 or less, a family of four to the appropriate AMI associated with Philadelphia."**

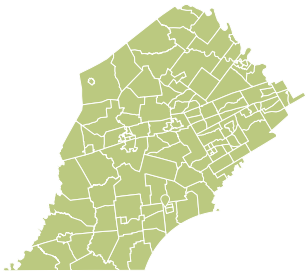
County-Specific Perspectives

BUCKS



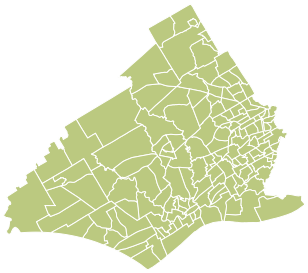
Bucks County is grappling with major cultural and awareness gaps in reaching non-traditional settings for prevention education, such as daycares. Barriers like stigma, generational poverty, and cultural trauma inhibit access to mental health and substance use support. However, success in engaging unlikely partners (e.g., daycare centers) and suggestions for a centralized, digital resource hub point to creative, community-rooted solutions.

CHESTER



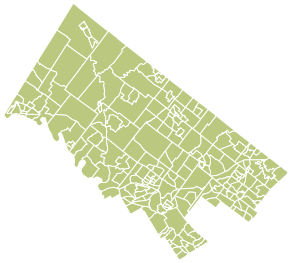
In Chester County, a persistent lack of health literacy underpins many prevention gaps. Community leaders emphasized the need for plain-language messaging, culturally aligned education, and child-focused wellness. Trust and relatability—especially from people who "look like me" and settings outside the clinical space—are vital. Participants called for stronger partnerships between health systems and grassroots organizations to shift public perception of prevention.

DELAWARE



Delaware County stakeholders identified systemic reactivity as a root issue—services only activate once a person is in crisis. Key barriers include language, literacy, and lack of culturally competent outreach. Although there's general awareness of available resources, they're inconsistently used. Solutions focus on proactive outreach, community forums, and multilingual communication to make people feel seen and heard.

MONTGOMERY



Montgomery County highlighted challenges in parental engagement, mental health waitlists, and the undervaluing of adult preventative care. Still, residents recognize the value of mobile care, insurer-initiated check-ins, and informal wellness events through faith institutions. Suggestions included making prevention fun and accessible—such as incorporating education into family-friendly events and hands-on activities.

PHILADELPHIA

Philadelphia's challenges are deeply structural—transportation, housing instability, and the mismatch between available resources and those most in need. Community voices underscored the importance of location-based and trusted messengers, such as CDCs and SEAMAAC. Solutions include partnering with community development entities, tailoring funding models to match actual neighborhood AMIs, and sustaining lessons learned from COVID-era outreach.

Involving Community in Solutions and Implementation

Across Southeastern Pennsylvania, community leaders and health stakeholders emphasized the importance of meaningfully involving residents in designing and implementing health solutions. While there is widespread recognition of the value of lived experience and community voice, many structural barriers—such as staffing shortages, inaccessible formats, and lack of feedback loops—limit meaningful engagement.

At the same time, there are powerful examples of grassroots initiatives, community-driven events, and collaborative task forces that demonstrate what works when institutions partner with residents authentically. Participants offered concrete ideas to advance equity, inclusion, and sustainability through more intentional power-sharing, clear communication, and strategic collaboration.

Challenges and Barriers:

Participants identified a wide range of challenges that undermine authentic community involvement in health solution development. These include systemic issues like transportation and staffing shortages, as well as less visible barriers such as community burnout, fear of not being heard, and inaccessible or overly academic messaging. Power imbalances—where decisions are made without true representation—further weaken trust. Even when community input is gathered, it often goes unacknowledged, leaving residents feeling unheard and excluded. These barriers combine to create a landscape where participation is limited not by disinterest, but by fatigue, frustration, and lack of structural support.

LACK OF TRANSPORTATION AND ACCESSIBILITY

Many communities, particularly older adults, people with disabilities, and those in rural or underserved urban neighborhoods—struggle to access services or participate in forums due to inadequate transportation.

Although Philadelphia has a relatively robust public transit system, gaps in access and connection exit.

A Bucks County participant shared:

"It is hard to eradicate social isolation if you can't get anywhere because there is no public transportation or the transportation that we do have is very limited or very rigid in the timing."

One Philadelphia County participant highlighted:

"Transportation is a problem. And it's not always easy as you would think to get the managed care entity or the hospital to coordinate transportation to and from appointments."

UNDERSTAFFING AND WORKFORCE BARRIERS

Social service organizations are severely understaffed, creating burnout and limiting capacity to innovate or collaborate meaningfully.

A Bucks County participant shared:

"Every social service division is short-staffed… When you're asking people to think beyond their agency, there's a barrier to that as well."

A Delaware County participant echoed this sentiment:

"We're just absolutely overwhelmed with just doing what we do. And trying to do that while doing the work becomes very, very, very challenging."

COMMUNITY BURNOUT AND LACK OF TRUST

Repeated community engagement efforts without follow-through have led to fatigue and skepticism about their potential for sustained impact.

A Chester County participant described this challenge:

"We especially heard at the most recent one in mid-October that the community is, like, happy to provide feedback on health services, and happy to be a part of and sitting at the table of the creation of some of those solutions. But that they do, especially in minority communities like Coatesville, feel really burnt out and sort of left out of the outcome of those conversations and the solutions."

A Philadelphia participant reiterated:

"A lot of people that I know, they say they usually don't come out to community involvements because of lack of knowledge and sometimes still confidence. A lot of them feel like we're going to put them down or we're just generally not going to listen to them."

OVER-SURVEYING WITHOUT FEEDBACK

Surveys are common, but rarely followed by communication or action, reducing credibility. Participants expressed the need to talk to people, not automated systems or surveys.

A Bucks County participant shared:

"So, I think it's not just doing the survey and asking the questions. It's what you do with the information you get and sometimes what you get, you think oh, dear Lord that's huge we can't possibly tackle that right now, or whatever. So, it can be a bit deflating, but it's what we do with that and how we partner and pull other people into the information we get."

A Delaware County participant saidt:

So, when people can see, the people say, 'Hey, I'm a person, and I have this cell phone number, and you can call me. And when you contact us, there will be no automatic service.' They're more inclined to say, yes, I need a person, not a computer, not a survey. I need to speak to a person."

LACK OF FOLLOW-UP AND ACCOUNTABILITY

There is a strong desire for institutions to close the loop when soliciting feedback. Community members expressed that input is often collected but not shared back, leaving people feeling used or ignored. Transparent communication about what is being done with feedback—even when the answer is "not yet"—builds trust.

A Chester County participant described a recent feedback and follow-up experience:

"And so, we've tried to be really intentional about, like, following up with folks and making sure that you know, even from our October event, we got a lot of really good feedback that sort of left us with, like, okay. So, there's things that we have to do like, run down this to do list of, you know, a hundred things that the community wants and it's just not timely or realistic. But being honest with that with the community and saying like, 'Listen, we know that you keep saying that you want this ER reopened in the Brandywine Hospital, and we are hearing you, and we are going to continue to advocate for that.'"

MESSAGING AND INFORMATION ACCESSIBILITY

Reports and communications from health systems are often too complex, academic, or culturally inaccessible. Participants called for more plain language, visual, and multilingual communication, including for those with disabilities. Accessibility isn't just about translation—it's about equity in comprehension and usability.

One Philadelphia participant shared:

"Particularly, we work closely with the deaf and hard of hearing community, and a lot of folks in the community want to be more involved in making decisions or a group like this. But not having ASL offered is a problem for them, obviously. And ASL is not the same as English, so closed captions aren't going to cut it. So, I think not only offering multiple languages, but if it's not able to be offered because of funding, and we all know how that works especially with nonprofits, then offering it as an accommodation that people need to request by a certain date. At least it's being offered as something that they can request,"

What's Working Well

Despite numerous obstacles, participants across counties shared examples of initiatives that are making a difference. What's working includes community-led programming grounded in lived experience, cross-sector partnerships, and culturally responsive events that blend fun with wellness. Programs that provide personal outreach, meet residents where they are, and offer tangible supports like food or childcare have seen stronger participation. Transparent, honest communication about limits and next steps also helps build trust—even when resources are constrained. These successes point to the importance of centering the community not just in message but in method, structure, and leadership.

COMMUNITY-LED AND LIVED EXPERIENCE-DRIVEN INITIATIVES

Groups led by community members with lived experience—such as addiction support volunteers and grassroots wellness efforts—show high commitment and trust.

A Bucks County participant said:

"This group of volunteers... had not had a call in a year and they still showed up to the meeting."

A member from Chester County added:

"The individual that was leading those conversations with the support group was someone with lived experience."

CREATIVE LOCAL EVENTS AND HOLISTIC APPROACHES

Multi-sector events like "Family Fun Help Day" and integration of clinical with non-clinical services (e.g., air fryers and healthy cooking) are drawing engagement.

A Bucks County participant said:

"Different hospitals come out, local farmers bring free vegetables... That is one way we try to increase people's participation

A member from Chester County added:

They gave them an air fryer and said here are healthy recipes you can make. It really worked for the senior population."

COMMUNITY FORUMS AND TRANSPARENT COMMUNICATION

When feedback loops are closed and participation is made accessible (childcare, food, multiple formats), community voices emerge more powerfully.

A Chester County member said:

"We offered childcare. We offered dinner. We offered it after work hours... The direct personal invitation is so powerful."

A Philadelphia County member added:

"We did a lot of listening sessions to find out what people thought the top issues were before setting the topic areas."

Suggested Actions and Solutions

To move forward, participants offered thoughtful, actionable strategies to strengthen community participation in health initiatives. These include forming diverse task forces, co-designing programming with residents, simplifying data and reporting formats, and closing the loop after feedback is collected. Many called for better pathways to hire and train individuals from the community, as well as stronger partnerships with educational institutions to address workforce gaps. By reducing the burden of engagement and redistributing decision-making power, institutions can transform participation from symbolic to strategic—laying the groundwork for more equitable, effective health outcomes.

Task forces that include representatives from various organizations and directly from the community can foster shared goals and planning.

- **"Some kind of task force and the task force would set up forums like this and have different platforms, not just in person and throughout different parts of the community, so that transportation or travel isn't necessarily a barrier. Virtual or even phone conversation, something accessible. So multiple options to contribute to your voice."**

Solutions include integrating social service pathways in higher education, paid internships, and relaxing unrealistic educational expectations.

- **"So maybe we need to work better with universities and create more of a channel directly promoting – 'Hey, come join healthcare.' Look, there's 9 million jobs you can choose from, and letting people know what the options are. I know when I graduated college with my psych degree. I had no idea what I qualify for or what I could do and I didn't know there were that many agencies available in different directions I could go in."**

Tapping into corporate giving, local businesses, and simplifying messaging around impact (storytelling) can unlock new sources of financial support.

- **"But here you go, you need money. Right? So we need to tap into these resources that have money, these for-profit companies, the banks, the communities, the credit unions, whatever it is out there. And I have learned through my work on different boards and different local communities agencies and groups, that there is a lot of businesses out there that want to give back to the community, and want to give back financially so that you can do more. And I'm like, let's tap into them some more to support us in all of these causes and to get the hospital to connect to and just build this bridge, just build this ladder of support, interconnecting."**

Community members emphasized that true involvement means having a seat at the table—not being asked to contribute midway or just for optics. This includes hiring from the community, involving lived experience in leadership roles, and ensuring residents are not just consulted, but co-designing solutions.

- **"I'd say invite them in to hear their stories. It's one thing for us to tell their stories, but it's another thing for the actual person going through the situations to tell their stories, to tell how they feel, to share their experience, because we can speak for them, but it's better if they would speak for themselves. So inviting them in and hearing their voice, I think, would establish some a little bit more compassion as well because there's a story, but then there's a person behind the story as well."**

Engagement efforts often end at data collection. Community members expressed frustration with the lack of updates on outcomes from forums and surveys—leading to feelings of being "used" and disillusioned about impact.

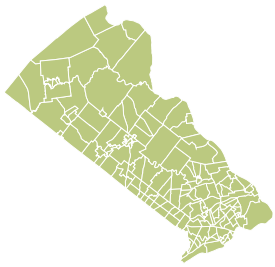
- **"It's so easy for us to to gather information, to come up with feedback and to keep folks updated via like a newsletter or a blog post. And the community is not engaging with our email newsletters, and so as much as we can. you know, through personal relationships. And that extra work of like, yeah, we had people attending the event, and we're gonna call every one of them back and say, like, 'Just wanted to touch base and see, you know, if you had anything else to say.' And here's what we've been working on, and here's what you know. Here's what we think and believe for the next what the next steps are gonna look like as much as we can directly communicate with them and keep inviting them back to events and organizing and being present at existing community events like not necessarily hosting something new, but going to things like 1st Friday, or football games, or whatever it might be, and just continuing to be a presence. I think, helps, even if we're not providing them like a really thorough update on like significant progress. They're still happy to know that we are still engaged with the community still available. To answer questions or give updates as as they become available."**

Communities want to understand the data that informs decisions and be part of interpreting it. But often, data is used to justify decisions already made. When shared meaningfully, it becomes a tool for partnership.

- **"I think the hospitals and the managed care entities can do a better job at sharing data with the community. For example, there might be certain sections of the city where the national average of diabetes is this, but the national average of diabetes in this neighborhood is this. What do you think we can do about it? The community should know, this is happening in our community or there's cancer rates or whatever it is. I just don't feel like they share data in a way that could engage people."**
- **"Data doesn't tell the whole story... But when you're talking to individuals groups, you can get these little nuggets of information that can that may be able to pivot everything and create something that is more suited to what your mutual goals are. So, we're working on it. So, stay tuned 2025, 2026, there's a lot coming."**

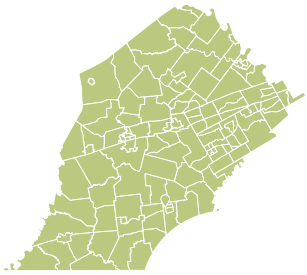
County-Specific Perspectives

BUCKS



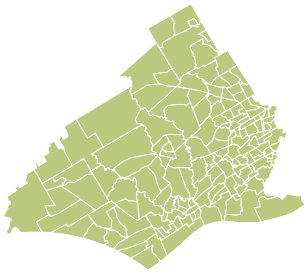
Bucks County faces significant challenges around post-COVID social isolation, particularly among elderly populations and those disconnected from child-centered events. Despite that, dedicated volunteers and creative event models like Family Fun Days offer bright spots. Staffing shortages and systemic workforce barriers remain a key concern, with emphasis on changing education-to-career pipelines.

CHESTER



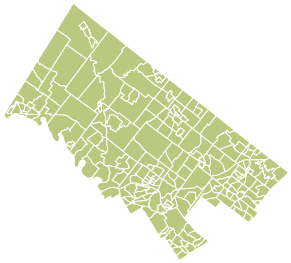
Chester is resource-rich but challenged by coordination and engagement fatigue. Local stakeholders emphasize the need for collective prioritization, intentionality, and transparency. Innovative mobile wellness units and hyper-local support groups show promise. Transparent communication around limitations and real timelines has built trust even amid resource constraints.

DELAWARE



Funding scarcity and organizational siloing dominate Delaware's landscape. Despite high motivation, limited staff capacity hinders outreach and coordination. Community members voiced the need for direct contact, outreach beyond mail/surveys, and cross-sector volunteerism to avoid duplication of efforts.

MONTGOMERY



Montgomery participants emphasized infrastructure solutions—like accessible forums and collaborative task forces. Community members proposed concrete mechanisms like shared committees and multi-modal participation strategies (virtual, in-person, phone) to deepen inclusion.

PHILADELPHIA

Philadelphia's challenges include transportation barriers, trauma and engagement fatigue, and linguistic or cultural disconnects. However, initiatives like pre-pilot studies and community-driven design efforts (e.g., Well City Challenge) offer strong models. Success depends on closing feedback loops and reframing data and reports in community-accessible language and formats.

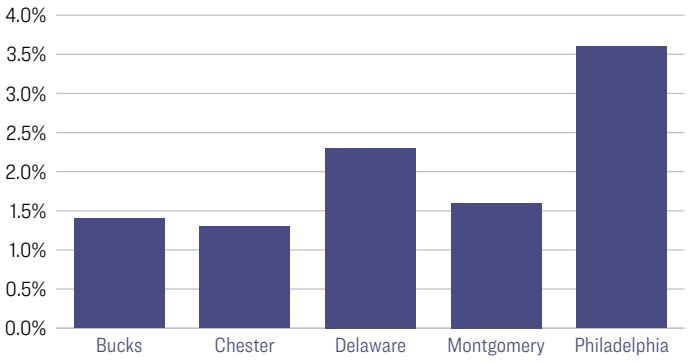
FOCUS AREAS AND COMMUNITIES

This section features primary and secondary data focused on health needs associated with conditions requiring specialized care (cancer, people with disabilities, vision), as well as communities whose needs have historically been less understood or adequately addressed (older adults and youth).

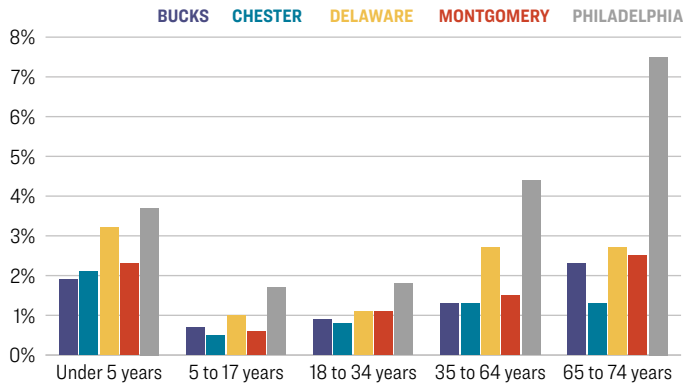
Vision Care

The following discussion explores the needs and opportunities for addressing vision health in Philadelphia, with a focus on Wills Eye Hospital as a specialized facility for treating patients with vision impairments and ocular pathologies. Three focus groups were conducted with individuals receiving preventive and ongoing eye care, representing a diverse range of populations – from middle-class, college-educated professionals to those with low or no income and varying levels of insurance coverage.

Percent of Total Population with Vision Difficulty



Vision Difficulty, by Age



A dedicated section on vision care is new to the 2025 Community Health Needs Assessment (CHNA), reflecting a growing recognition of eye health as a critical component of overall well-being and equity. Quantitative and qualitative data are provided below.

Relevant insights were drawn from broader community and town hall discussions held in Bucks, Delaware, and Philadelphia counties, highlighting concerns specific to older adults, immigrants, and individuals with disabilities. These forums illuminated deep-seated disparities in access to vision care among older adults, immigrants, and people with disabilities, with vision concerns often cited as a top unmet need. Participants highlighted structural gaps in screening, treatment availability, and specialist access, particularly for low-income and uninsured residents. Across the region, individuals face similar themes—delays in care, lack of awareness of existing resources, affordability challenges, and limited culturally competent services. These challenges are intensified for those managing chronic conditions, vision loss, or navigating care as non-English speakers.

Across all groups, participants discussed key issues related to vision health, including access and barriers, impact of cost and insurance on care, provider interactions and trust, knowledge and resources, and potential solutions.

ACCESS & BARRIERS TO VISION CARES

Questions about access and barriers to vision care yielded most responses, with participants sharing their experiences of seeking services in their community and the challenges they encountered.

Many participants experience inconsistent care, long wait times, and systemic barriers when accessing vision services. Some report varying treatment quality depending on the provider, while others express frustration with rushed appointments in government facilities. Free clinics are seen as unreliable, and some patients avoid seeking help until their condition becomes severe.

> **"I go to the same place all the time, and even though I get different clinicians, or whatever it is, you get treated differently each time. It all depends on who it is."**
>
> **"I go to a government facility, and there'd be so many veterans...they just realized brush it through and everything."**
>
> **"I have those glasses, and I can't really see out of them that well, I barely I hardly ever use them. So now I still got to wait another year before I can get glasses again."**
>
> **"I go to the free clinic. A lot of people, when they go to these clinics...they're not getting service or treatment like at other doctor's office or other clinics...and they don't care until something happened to them with a point where they're going blind, or they develop cancer or something like this."**

Long appointment wait times raise concerns about the consequences of delayed care. Additionally, challenges with medical record-sharing between different facilities create inefficiencies, while changes in insurance coverage disrupt continuity of care.

> **"Looking at my son's condition. and then having to wait that long to meet...you don't know what might happen between now and then for a kid of that age. We wish that would have been like immediate, but they said, that's the earliest that they could arrange."**
>
> **"You have to book pretty far out in advance to get appointments, and they are very busy when they're there. But they're pretty good about...moving people through my experience like efficient."**
>
> **"There's not always great communication between like the different parts of hospital. So, the retinal office doesn't like to share the records with the primary eye office, even though they're all part of the same institution... It's just a lot of having to repeat things and ask for things to be faxed overnight."**
>
> **"One issue I had was that my insurance changed last year, and so the doctor that I went to was no longer covered, so then I switched."**

People with disabilities face significant barriers in accessing necessary services, including fitness facilities, vision care, and educational resources. Specialized healthcare and support services are also limited, with long wait times for therapists and difficulty finding Braille instructors.

"I tried three years to bring about a state-of-the-art fitness center for people with disabilities. And I got turned away...I came with my little stuff...the equipment had visual, had sound, braille and on and on. I wanted people with disability to be able to come to a fitness center that didn't look therapeutic."

"I was proud of the lady that just left for even attending and having that visual impaired disability and just caring, just showing up and her needs was met here because everybody was so attentive. So, I definitely want to see more services and things for people with disabilities, all disabilities."

"Access is hard... with my visual impairment, I'm having trouble finding... somebody to teach me braille."

While telehealth has advantages, participants express concerns about the effectiveness of remote diagnostics for conditions requiring direct examination. Accessibility also remains a challenge for individuals with disabilities, as many websites are not designed to accommodate assistive technologies, making it difficult for blind or visually impaired individuals to navigate telehealth platforms independently.

"Yeah, they are like, show me your eye. Do you see it? No, I'm in your chest, it's okay. Put the camera in your ear, let me examine you. How are you gonna do that?"

"It has its advantages...I've done the teleconferencing with the doctor and everything, but I feel better if I'm one on one with the physician...so, that way when it comes time for them to examine if they want for my lungs, eye and everything, you can't do it tele [health]."

"I have an older friend who is blind, and so, in addition to not being exactly tech-savvy, the way that websites are designed is not always the most accessible...I found in helping her that so many websites are just not built in a way that is conducive to software's, which are extraordinarily helpful for people with different disabilities."

EXPERIENCE WITH MANAGING VISION HEALTH

The initial conversation focused on personal experiences with vision issues, how individuals manage their conditions, and the support or challenges they encounter. Participants shared frustrations with healthcare coverage, difficulty accessing necessary treatments, and concerns about long-term vision health.

Some participants seek clarity on vision insurance coverage as they struggle to maintain prescription glasses, while others are curious about potential treatments for severe dry eyes.

"...at the time I got my glasses I had medical coverage, now and I don't. And my glasses chipped, and they told me that I would have to bring in another pair of paper for it to be included under insurance."

"There's only one eye I can partially see a little bit out of my right eye...it's been since I was a young young girl, so, but I've never been able to do anything about it."

"...I have bad dry eyes, and I want to try that transplant that you can get. And you don't have to worry about wearing glasses anymore."

Significant vision challenges, including fluctuating eyesight, sometimes leave participants unable to perform daily activities safely. Some worry that medical treatments could worsen their condition rather than improve it, while others express concerns as newly relocated parents navigating care.

"...with me some days I can get up, and everything is blur, and I can't see nothing, so I just lay in a bed all day, and then other days, if I'm in the house, I don't want to be using any knives or anything like that to that nature, because if my eyes are blurry I end up cutting myself, and I end up in the ER and I ain't trying to be there either."

"...I have no sight in my left eye and some vision in the right...when the weather changes and the time fall back it's dark so I really can't see."

"...you have people sitting in the emergency room with two eyes. They said I came in with one eye and then now my other eye is bothering. So, what it is, is they're treating symptoms, making them worse, and then curing them back so you can't really get where you need to be to get better. So, I'm afraid of that."

"But then lately it appears my 1st born could have a vision issue...I'm new in the in the neighborhood."

More participants share their experiences with prolonged vision issues, including macular degeneration, high myopia, and retinal concerns, requiring routine checkups, treatments, and specialist visits. Some follow long-term treatment plans to prevent further vision deterioration, while others undergo annual monitoring due to family histories of eye conditions.

"About 14 years ago I was diagnosed with macular degeneration which was stable, and I was referred to...my retina specialist, and I've been seeing him now for the last 14 years. Otherwise...seeing the ophthalmologist every couple of years."

"I see a retinal specialist...mostly just yearly monitoring retinal, primary sort of eye doctor and keeping watch for things that, like I have a family history of like cataracts and macular degeneration."

"I need annual vision care. I'm nearsighted...I get checked every year for general eye health and then check and make sure that my retina is okay, because my eyeball is long."

IMPACT OF COST AND INSURANCE

Financial burdens, insurance limitations, and systemic challenges tied to economic and community factors significantly restrict participants' ability to obtain necessary vision care.

Partial insurance coverage makes it difficult to purchase and maintain consistent prescription glasses. High cost is an even bigger concern for those without medical insurance.

> ""And right now I do have insurance, but...it only pays for a certain amount, and then you have to come up with the rest of the money."
>
> "...with all the stuff that I need for my glasses it's gonna cost run me like $500, and I didn't got no job, and I sure ain't got no money to pay for. And that's why I don't get them."
>
> "My vision fluctuates and it's hard for me to stay with one pair of glasses...now that I don't have no medical, the other doctor wants to charge $150 just for the prescription."

Many feel that vision centers prioritize payment over patient needs, while free clinics do not offer vision services, making it difficult to access eye exams and prescriptions.

> "Sometimes when I go, I get this experts look at me. Then somebody else looks at me, and then somebody else...they're like, okay, we're only paying for this amount of money so this is what you get..."
>
> "...they don't have free eye service at the free clinic, either. They have everything else, but they don't have that."
>
> "Some of them don't even take your insurance, so you can't go close to your home, which would be much better."
>
> "Or if you don't have a good insurance, they're not going to take you."
>
> "I shouldn't pay to have my eyes examined because I have a pre-existing condition which I've had since I was 7 years old."

Systemic factors such as location, race, immigration status, socio-economic background, and age shape access to vision care. Financial and racial dynamics are perceived to influence service availability. Immigrants often forgo treatment due to cost or legal concerns. Many delay care, hoping Medicare will cover costs, while older adults report gaps in coverage for essential services.

> "Is it...something to do with, my opinion, race, and the community? You know whether you live high up on a hill, or you live low on a hill, it has that plays a part of it..."
>
> "Well, it depends on the socio-economic status, because I met a lot of people that are coming with sickness from our countries to work here. For example, one guy hit his leg crossing the border. He had an accident, he couldn't see by one eye, but he was like, I just need to make money, don't take me to the hospital. And I'm like, you cannot work like that."
>
> "I have an issue with my eyes. But I know for my glasses. It's like $500 top. And maybe once I turn 65, the insurance will pay for it, but I don't know."
>
> "Senior citizens don't have dental. Or vision or hearing..."

VISION CARE INTERACTIONS

Trust in medical providers is a consistent theme across many conversations detailed in this report. To assess its impact on patients' willingness to follow recommendations, participants were asked whether they trust the information from their vision care providers and feel involved in their care decisions.

Clear communication about treatment, costs, and insurance is key to having trust in medical professionals. While most participants trust their doctors, financial constraints limit their options, and some feel taken advantage of due to their income. There is a wider appreciation for doctors who are transparent and informative, particularly those who take time to explain conditions and treatments. However, long waiting times, unexpected charges, and perceived unequal treatment cause frustration. Despite challenges, participants generally feel comfortable with their care and value having knowledgeable specialists.

"I trust him because he is saying similar to what the other doctors were saying before I got the insurance I have now. But it's still a situation where if you can't afford it, you just can't afford it."

"I don't believe that he's doing things just for the money. He'll tell you the truth... but like I say, it's too much money for me to be able to afford."

"I don't really know these doctors...because I get a different one every time...but as far as deciding my care yes, I do decide how I want to be, how I want to the session to go like..."

"They give me all kinds of information...and I felt like I was sort of part of the team..."

"I just started with this new office, and they gained my trust really quickly, because the way they treated me and answered all my questions..."

"...they billed me one time for something that I did that I thought was like I said that extra care thing...I didn't pay it because they didn't tell me they were going to bill me for it."

"I have to go get my eyes checked because I'm a diabetic... But I don't wanna go...at 8 and get out at 12 because I don't know what this doctor is doing...if you have no income, they assume that you don't have anything to do."

KNOWLEDGE OF VISION HEALTH

To assess the general understanding of eye health, participants were asked about the importance of regular eye exams, their contribution to overall health, awareness of common eye conditions (such as glaucoma, diabetic retinopathy, age-related macular degeneration, and cataracts), and their ability to prevent or manage these issues.

Several participants emphasized the importance of eye exams, particularly for those with serious eye or vision problems. Generally, participants are aware of conditions like glaucoma, cataracts, and macular degeneration, and feel comfortable with their understanding of eye conditions and the information provided during regular screenings and exams.

"I would say, if you have a serious eye problem or you have a serious sight problem, you should go to the doctor at least once or twice."

"I think, it's important to get eye exams because your eyes, your vision does change."

"So, I do know what glaucoma is...I don't have cataracts, because every time I go, what they say to me is that you know you're this close to like maybe a cataract. But I'm not there yet."

"I also feel comfortable kind of my understanding of those issues we do regularly talk about."

"Yeah, I feel confident in understanding eye conditions. Doctor tells me what potentially could happen and how it could get treated and all that."

There's an acknowledgment that aging, environmental factors like air pollution, and lifestyle habits like smoking can affect eyesight.

"Yeah, okay. I know there are two, first the age related, which is almost obvious..."

"I do believe that the older you get different things happen to your eyesight and the environment and the air pollution. And all these drugs, people are smoking. It is killing everybody, and they don't realize it."

While there's comfort in the information provided by doctors, several participants express uncertainty about preventing eye conditions, recognizing that only doctors can provide guidance. Some question if treatments are more profit-driven than focused on curing conditions.

"The other part of that question is, do you feel you have the knowledge to prevent or deal with those issues...how would we know that like we're not doctors...that's why we go to the eye doctor to find those things out."

"...I'm afraid of those ones. I don't know much how to avoid those first two [diseases]..."

"I don't think I have the power to prevent anything, because it's all based on the doctors and what they prescribe, unless I find a natural cure. Because it seemed like it's more money and not curing people than it is curing people."

SUPPORT AND RESOURCES FOR VISION HEALTH

Many community members are unaware of available free vision care resources. Participants suggest better outreach through flyers, emails, and doctor's offices. Some feel resources are selectively shared, making word-of-mouth crucial. However, past disappointments make community engagement difficult.

"Nothing I know of around the neighborhood yet."

"I've never used any community resources and haven't heard about too much. I think I might have seen a study, or a program advertised in an office once..."

"...if there are free services, then people in the community should be getting some kind of correspondence, saying that it's free, so people can know."

"They can hand out flyers. And they can email you when they have these resources."

"...that information should be in your doctor's office as well."

"...they rarely share certain things with certain people, because they want certain people to benefit from it, and not everybody."

"...a lot of times people in the community been burnt so many times. They don't come out."

Accessibility challenges, including restroom shortages and lack of braille instruction, also deter participation. While some do not need community programs due to good insurance, others stress the need for structured programs and hands-on assistive device training.

"...when I go out farther in the suburbs for help, there is more help like they have Porta potties when they do inner city...there's no way to go to the bathroom. So, a lot of times when they had these things for senior citizens, elderly, and other people they don't attend..."

"I need someone to teach me braille and it's urgent for me. I cannot find that resource anywhere...the library, I get free stuff from them...and I'm feeling on it and all I can read is bumpety bump bump because I don't know what I'm doing."

"...I think they're important...I haven't had to use them...with the privilege I have of having such good insurance."

"...when you use those [assistive] devices, you still need something to feel like, okay, this button here and that button there..."

IMPACT OF VISION CARE ON DAILY LIFE

Vision issues cause anxiety, uncertainty, and fear for parents and older adults, as it relates to children and adults with mobility issues. Specialized resources, such as high-powered magnifiers, prove to be invaluable for tasks like reading, while regular vision care and updated prescriptions remain essential for maintaining independence and quality of life.

> **"...I'm now in a situation like, what's the problem with my son's vision, or I as I'm waiting anticipating, is it that he can't see me as I look like? Maybe he can't explain that this is the way things look like. Maybe he has always seen things like that, and thinking that's the correct way they appear...I keep asking, can you see what I'm seeing like? Can you read there...can you see the color?"**

> **"I'm always afraid of falling. I have mobility issues and visual impairment. So, the pavement, our communities need to be very aware of holes and what do you call them, potholes and the sidewalk cracked and things like that."**

> **"...when my retina specialist referred me to this low vision place in Media, [I] ended up with a extremely high-powered magnifying glass, which I have found extremely useful and obviously reading is an issue for me."**

> **"It's...necessary for me to wear glasses to do pretty much anything. So, you know, definitely been important for me to have regular vision care and get updated prescriptions."**

AWARENESS AND UNDERSTANDING OF TREATMENT OPTIONS

Clear and comprehensive information is essential for individuals managing vision conditions. While some participants report receiving clear explanations and ongoing care, others experience uncertainty due to a lack of available treatment options or unclear next steps.

> **"Meanwhile the only source is what the doctors will say, otherwise I don't have another option..."**
>
> **"...throughout the years that I was being treated before the vision started to deteriorate. I was very reassured...they would explain everything that was going on, and then, once my vision started to slow down...they were very helpful in explaining what was going on, and how at that point there was no treatment..."**
>
> **"I feel like. I also definitely had time. good explanations of treatment options, for it was nice."**
>
> **"Yeah, I understand my treatment options well because I don't think they're that complicated. But they are explained to me well, also."**

ACCESS TO SPECIALIZED VISION CARE

Participants share mixed experiences with accessing specialized vision care. While communication and navigation are generally easy, challenges include the lack of a patient portal and difficulty scheduling appointments due to provider availability.

> **"It's very easy to talk to people...my only complaint about them is they don't have a portal, but they do have a very active phone number."**
>
> **"The ophthalmologist I see...he's gotten so busy he's it's hard to make an appointment."**
>
> **"I've had no problems at all... I have nothing but praise for my ability to navigate the system with them."**
>
> **"I really haven't had issues with my ability to access the specialized [care]."**

Suggested Actions and Solutions

Access to quality eye care is essential for overall well-being, yet many individuals face barriers to vision health services. Raising public awareness about eye health, improving accessibility to care, and ensuring support for visually impaired individuals can help address some of these challenges. By utilizing media and public outreach, reinstating school vision screenings, enhancing pedestrian safety, and advocating for healthcare reforms, hospitals can work with communities toward better eye health for all.

Educate the public about eye health through newspapers, radio, television, social media, and mobile clinics targeting places where people gather. Make public service announcements to raise awareness about specific eye conditions and the importance of regular eye exams.

- "Street corners where people gather crowds just make some noise about the eye issues and stuff. I mean it would be more direct to people, and getting close to where people stay..."
- "...you know those are things that you don't necessarily are going to know you have until you've been diagnosed. So, I don't know if they could do more public service announcements on that."

Improve access to vision care by minimizing wait times and better continuity of care. Expand vision tests in schools to make eye care more accessible for children.

- "...try to maintain decent access and not have super long wait lists to get in."
- "...I remember being a child, having my eyes checked by the school nurse...there's some merit to that, because it's hard to take time off sometimes, and your children has to come first of course, but life gets in the way sometimes."

Collaborate with relevant agencies to enhance safety and accessibility for visually impaired, disabled, and older adults, fostering confidence and social engagement.

- "On the crosswalk business, they say it pauses and then it goes, you see a person walking, but there's no verbal cue for any older person [or visually impaired] and it's very difficult."
- "And the other thing is better lighting at night because I'm visually impaired due to glaucoma..."
- "If they make things a little comfortable for the senior or disabled person's environment and community, they can feel a lot more confident in going out and socialize. I love to socialize and... if they just make it comfortable so we can be confident, I think we'll be out more."

Advocate for healthcare reform to improve consistent access preventing disruptions due to insurance changes.

- "...healthcare reform or access to universal healthcare because I had to switch doctors due to health insurance changing, and I would have stayed with the same doctor that I was with if I didn't have to."

Access to comprehensive vision care is not just a matter of convenience, it is a matter of public health, equity, and dignity. The findings across Southeastern Pennsylvania, especially in the voices of those managing vision impairment alongside socioeconomic hardship, reflect a deeply fragmented system in which cost, insurance status, provider availability, and physical accessibility routinely disrupt care. Participants' stories reveal how the consequences of these systemic issues ripple through daily life, affecting everything from independence and employment to emotional well-being and trust in healthcare institutions.

Addressing these disparities requires a multi-layered approach. Solutions must go beyond service provision to include systemic reforms: better insurance coverage for vision services, increased funding for community-based resources, renewed investment in early detection through school and public health screenings, and consistent outreach that makes care visible and welcoming, especially to communities historically excluded from quality eye care. Vision health, as described by participants, is integral to quality of life and long-term health outcomes.

Community Health Needs

All quantitative and qualitative inputs were organized into 12 community health needs that were categorized across three domains:

HEALTH ISSUES

Physical and behavioral health issues significantly impacting the overall health and well-being of the region

- Chronic Disease Prevention and Management
- Healthy Aging
- Substance Use and Related Disorders

ACCESS AND QUALITY OF HEALTHCARE AND HEALTH RESOURCES

Availability, accessibility, and quality of healthcare systems and other resources to address issues that impact health in communities across the region

- Access to Care (Primary and Specialty)
- Culturally and Linguistically Appropriate Services
- Food Access
- Healthcare and Health Resources Navigation (Including Transportation)
- Mental Health Access
- Racism and Discrimination in Health Care
- Trust and Communication

COMMUNITY FACTORS

Social and economic drivers of health as well as environmental and structural factors that influence opportunity and daily life

- Housing
- Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.)

An additional list represents youth specific priorities:

- Substance use and related disorders
- Youth mental health
- Access to Physical Activity
- Lack of Resources/ Knowledge of Resources
- Access to Good Schools
- Activities for Youth
- Bullying
- Gun violence

Participating institutions' ratings of the community health needs were aggregated and are listed below in order of priority: Potential solutions for each of the community health needs, based on all qualitative data collection and evidence interventions, are also included.

PRIORITY

1 Trust and Communication

KEY FINDINGS:

- National surveys indicate declining patient trust in healthcare institutions, often due to provider burnout, high turnover, disparities in treatment, and financial barriers, which disproportionately affect uninsured and minoritized communities. Community conversations reinforced this issue in the region.
- **Challenges in Provider-Patient Communication:** Patients feel rushed during short appointments and unheard by providers, leading to concerns about potential medical errors, particularly with conflicting prescriptions.
- **Emergency Room (ER) Communication Gaps:** ER staff have the most pronounced communication issues, which are closely linked to long wait times and patient frustration.
- **Administrative & Customer Service Concerns:** Poor front-desk interactions, including last-minute appointment cancellations and unprofessional behavior, contribute to negative patient experiences and decreased trust.

POTENTIAL SOLUTIONS:

- Desire for **more empathetic, respectful, and culturally responsive care** and support staff.
- Suggestions included **more social workers** in hospitals and **improved communication** about healthcare changes.
- **Transparent, Timely Communication:** Ensure benefit notices and appointment information are received on time, not after due dates and provide regular updates on healthcare changes and medication protocols.
- **Accountability Mechanisms** for Healthcare and Social Service Staff to provide consequences when institutions or workers drop the ball on paperwork or communication.
- A dream solution expressed by multiple participants was a system where **everyone receives the same quality of care, regardless of insurance status**.
- Implement **team-based care**, including patient navigators, care coordinators, and longer appointments for complex cases.
- Expand and improve **training of healthcare providers in active listening, shared decision-making, and cultural competency** for all healthcare staff.
- Implement **standardized communication tools** and patient status boards to enhance transparency.
- Require **front-desk staff to complete standardized training** in customer service, de-escalation, and empathy-based communication.
- **Expand appointment availability, reduce financial barriers** for uninsured patients, and **improve transparency** in billing and treatment options.

PRIORITY

2 Racism and Discrimination in Health Care

KEY FINDINGS:

- People of color, immigrants, people with disabilities, people with mental illness, people with substance addiction, LGBTQ+ individuals, and other minority groups continue to **experience discrimination and institutional barriers to health care**.
- Insufficient health care staff from diverse and representative backgrounds play a major role in this issue – people do not see themselves reflected in the healthcare workforce; can lead to not "feeling seen."
- **Intersecting identities** lead to exponential impacts on discrimination and racism, and subsequent trauma.
- The **political climate** in the United States contributes to feelings of vulnerability within marginalized communities.

POTENTIAL SOLUTIONS:

- **Cultural Competency and Anti-Bias Training for Providers:** Participants called for healthcare professionals to update their knowledge and attitudes beyond outdated textbooks.
- **Bilingual and Multilingual Staff and Services:** Strong calls for in-person translation services and recruitment of bilingual providers. Languages mentioned: Spanish, Arabic, French, several African languages.
- **More Representation in Healthcare Staffing:** Participants suggested that providers should reflect the communities they serve — racially, culturally, and linguistically.
- **Trauma-Informed, Non-Stigmatizing Behavioral Health Care:** Address the way patients with substance use or mental health needs are often denied full treatment, especially pain management.
- **Systemic Reform for Equity in Access:** Recognize and address structural racism — such as how funding, communication, and service offerings exclude or deprioritize certain communities.
- Expand and improve **training of healthcare providers around anti-racism**, structural racism, implicit bias, and trauma-informed care.
- Increasing number of people of color in healthcare leadership positions.
- Ensure diversity, equity, and inclusion efforts and plans at healthcare institutions include explicit focus on racism and discrimination.
- **Create and fund ongoing forums for community leaders** to work with health system partners to address issues of racism and discrimination in health care.
- Targeted, specialized services to meet culturally specific needs.

PRIORITY

3 Chronic Disease Prevention and Management

KEY FINDINGS:

- **Community gyms and recreation spaces that are well maintained and free/affordable**, were recognized as desirable neighborhood resources, along with safe neighborhoods, and support disease prevention & management.
- **Limited access to healthy food options and limited food education** were noted as some of the greatest barriers to maintaining health and preventing or improving health conditions.
- Some participants shared about knowledge of and experiences with **Long COVID**, while a significant number were unfamiliar with the condition. Millions of adults in the U.S. have been affected by Long COVID. Participants are still generally concerned about acute COVID-19 infection.
- **People with disabilities, who are not all older adults, face barriers to disease prevention and management** due to accessibility issues and require greater advocacy.

POTENTIAL SOLUTIONS:

- Increase **access to local fitness centers** and programs that accept health insurance.
- Promote **community gardens and green spaces for physical activity** and healthy eating.
- Provide consistent access to **nutritional education** for both children and adults.
- Offer more accessible **chronic disease screenings and follow-up care**, especially for older adults.
- Ensure health centers and providers are open during evenings/weekends to improve access.
- **Engage trusted community leader**s to spread key messages (for example, promoting cancer screening).
- Expand successful innovations from the pandemic, such as **virtual and mobile wellness programs**.
- Bring screenings and health education to **faith-based institutions** or where people are.
- Provide screening, referrals, and **"warm hand-offs"** to community-based health and social services.
- Offer support and services to people with Long COVID, providing education on this condition as well.

PRIORITY

4 Access to Care (Primary and Specialty)

KEY FINDINGS:

- Prevailing barriers in accessing care include: **inadequate health insurance coverage** (insurance not accepted, high out-of-pocket costs, no dental coverage), **limited transportation/accessibility of offices/hospitals** (primarily an issue in non-urban settings and amongst older adults), **extended wait times** for appointments (prompting use of ER and urgent care more often), **closures of local hospitals**, and specialists not covered by insurance or not available for appointments/too far.
- In addition to hospital closures, **pharmacy closures** present challenges related to obtaining prescriptions, resulting in increased utilization of prescription deliveries.
- Some pandemic-era changes to access have persisted, including more **pervasive telehealth services, increased interaction with health portals, and virtual health-related programming.**

POTENTIAL SOLUTIONS:

- **Extend clinic hours** to evenings and weekends.
- **Reduce wait times** for appointments, especially for urgent needs.
- **Simplify the referral** and authorization process, which often delays care.
- Provide local **urgent care and dental options**, especially in rural or underserved areas.
- Address **insurance instability** (frequent changes to accepted plans or providers).
- Establish comprehensive health centers addressing physical and mental health, as well as dental care. Provide low-cost or free care options.
- **Expand services** in areas which have experienced closures.
- **Embed social workers** and patient navigators in primary care practices; continue utilization of community health workers (particularly focusing on sharing of community resources and health information)
- Provide **on-site language interpreters** and health education materials in diverse languages.
- Increase racial, ethnic, language diversity of staff and providers to better reflect communities served; offer increased training related to culturally appropriate care.

PRIORITY

5 Healthcare and Health Resources Navigation

KEY FINDINGS:

- Community members' **lack of awareness of resources** is reflective of both community needs and a lack of knowledge.
- The perception of a lack of resources where some might exist is indicative of a need to **improve information dissemination** and methods of accessing that information. Participants frequently felt compelled to share resources and experiences with one another, when needs and complaints arose about health services among the focus group members.
- **Navigating insurance policies**, coverages, web platforms, related resources and healthcare costs prove challenging – especially for older adults who feel less confident with technology use and the transition to Medicare.
- **Mentorship for medical decision-making**, particularly for older adults who live alone, can promote social support, advocacy, and safety.

POTENTIAL SOLUTIONS:

- **Expand non-emergency medical transportation options**, particularly for older adults and rural residents.
- Provide **help navigating insurance plans, applications, and renewals** (e.g., in-person or phone-based support).
- Create **centralized, updated lists of services** and locations (e.g., food vouchers, clinics).
- Provide **tech support** or training for those who struggle with using healthcare portals or telehealth.
- Increase public awareness of **community resource directories** that local health systems have invested in and support community members with using them.
- Increase the capacity of healthcare staff to assist community members with navigation by regular education on available resources.
- Grow the numbers of professionals serving as community resource or **healthcare navigators**.
- Create permanent **social service hubs** that serve as "one-stop-shops" for commonly needed resources.
- Expand low-cost transportation options.

PRIORITY

6 Mental Health Access

KEY FINDINGS:

- Community members shared the quantity and availability of **mental health providers are insufficient to meet ever increasing needs** (particularly post-pandemic).
- Additionally, health **insurance coverage for mental health services and providers is inadequate**.
- **Stigma** around this topic was cited as a barrier – especially in ethnic minority communities.
- The **intersection of mental illness, substance use, and/or homelessness** was recurring concern.
- The general population expressed significant concerns related to **youth mental health** – which is reflected in the youth prioritization.
- **Mental health needs for older adults** focus on grief support and opportunities for community-based social engagement.

POTENTIAL SOLUTIONS:

- Increase the number of **behavioral health providers**, especially in rural areas. Increased behavioral health workforce diversity (e.g., language, racial, and ethnic).
- **Reduce wait times** and eliminate long delays between referrals and services.
- Normalize seeking help by reducing cultural stigma around mental health through community education.
- Offer **telehealth mental health options** for those without transportation.
- Provide **trauma-informed mental health** support tailored to children, youth, and families.
- Improved **care coordination** in integrated care model.
- Co-located prevention and behavioral health services in community settings (**"one stop shop"**).
- Increased training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence.
- Increased individuals with lived experience in the behavioral health workforce.

PRIORITY

7 Substance Use and Related Disorders

Key Findings:

- Community members shared concerns about substance use in their communities, co-occurring mental illness, the potential implications on youth, and the association with poor neighborhood safety.
- **Drug overdose** rates continue to be high due to opioid epidemic.
- **Community-based services** to treat substance use are perceived as **insufficient in number** by some, and/or are not well-known by others.
- **Prevention and education measures** can serve as protective factors against misuse and abuse; questions arose regarding the usefulness and impact of policing related to substance use.

POTENTIAL SOLUTIONS:

- **Expand community-based rehabilitation programs** as alternatives to incarceration.
- Provide **trauma-informed care** and education during health visits, especially for youth.
- Increase provider training to **eliminate bias toward individuals with histories of substance use**.
- Offer drug education at the provider level (not just in schools) with resources for both youth and families.
- **Reduce stigma** through culturally competent and empathetic behavioral health care.
- Sustain and expand prevention programs, ranging from school-based educational programs to community **drug take-back programs**.
- Expand **Narcan training and distribution**.
- Increase **medical outreach and care for individuals living with homelessness and substance use disorders**.
- Encourage use of **Certified Recovery Specialists and Certified Peer Specialists** in warm handoffs for drug overdose and other behavioral health issues.
- Enhanced utilization of **medication-assisted treatment initiatives**, in coordination with behavioral therapies and social support.

PRIORITY

8 Healthy Aging

KEY FINDINGS:

- Community members raised concerns about older adult **isolation, impacting mental health, food access, and healthcare interactions**. Senior centers and community services were frequently mentioned.
- **Transportation barriers** contribute to food insecurity and limited community engagement. Free ride programs often involve long waits, indirect routes, and lengthy travel.
- **Limited digital literacy** and unfamiliarity with technology restrict older adults' access to healthcare and social services.
- **Medicare transitions are often confusing**, causing missed benefits.

POTENTIAL SOLUTIONS:

- **Improve transportation services** for older adults to attend appointments, social events, and access groceries.
- Provide free or subsidized **exercise classes** (e.g., Tai Chi) to support mobility and wellness.
- Increase **availability of nutritious food** through filtered senior food distribution programs.
- Establish or **re-open senior centers** and day programs for social engagement and resource access.
- Offer help with documentation and paperwork (e.g., birth certificates, benefits forms).
- Create anonymous and accessible **reporting systems for elder abuse** or neglect.
- Expanding **services to help older adults age in place**, including affordable home health care, home repairs, food delivery, and utility assistance.
- Increase access to **safe, affordable housing**, including subsidized options.
- Train community health workers to support vulnerable older adults aging in place.
- Create **more opportunities for social interaction** at home and in community spaces.
- Develop **intergenerational programs for socialization** and technology assistance.
- Improve methods of communicating available resources and benefits to increase awareness and utilization.

PRIORITY

9 Culturally and Linguistically Appropriate Services

KEY FINDINGS:

- **Language barriers** are the greatest contributing factor to healthcare access issues for immigrants and ASL speakers. Language issues lead to misunderstandings between patients and healthcare providers or can dissuade patients from attending appointments altogether.
- Provision of high-quality **language services** (oral interpretation and written translation) is critical for providing equitable care to these communities; inquiring of patients at the time of appointment-setting about interpreter needs is ideal.
- Beyond language access, **cultural and religious norms** influence individual beliefs about health; stigma can make seeking help objectionable, particularly mental health services.
- **Fear and not having health insurance discourage** undocumented individuals from seeking medical help.

POTENTIAL SOLUTIONS:

- **Hire bilingual/multilingual providers and translators** (languages mentioned: Spanish, Arabic, French, African dialects).
- Provide **in-person interpreters**, especially during complex or urgent health interactions.
- Ensure all **signage, forms, and digital tools are translated into key community languages**.
- Train providers in culturally responsive care that respects beliefs and traditions of immigrant communities.
- Increase racial, ethnic, and language diversity of staff/**providers to better reflect communities** served.
- Develop organizational language access plans with protocols for identifying and responding to language needs.
- Explore development of **formalized programs to train and credential bilingual staff** (employed for other roles) to serve as medical interpreters.
- Provide on-site language interpreters and health education materials in diverse languages.
- Develop strong **partnerships with community organizations** serving diverse communities that involves providing financial support.

PRIORITY

10 Food Access

KEY FINDINGS:

- Maintaining diets consisting of **fresh produce and healthy foods is consistently difficult** and cost prohibitive. Cheaper fast food and corner store options are also more convenient, readily accessible, and more prevalent – particularly in urban neighborhoods. Likewise, large grocery stores may require transportation to access them.
- A **lack of food literacy** and longevity of poor dietary habits over time also contribute to food choices.
- Local food banks/pantries serve as an indispensable community resource. When available, community gardens offer neighborhoods opportunities to grow their own food in the company of neighbors.
- Older adults have enjoyed **meal delivery services**, as a part of their benefits.
- Immigrants and ethnic minorities face challenges with finding **foods that are culturally relevant** to them.

POTENTIAL SOLUTIONS:

- Maintain and **expand community gardens**, fresh food access, and local markets.
- Offer **nutritional education** for both children and parents.
- Increase **oversight of food stamp benefit security** (e.g., prevent theft and fraud).
- Improve **quality of food provided at pantries** or senior meal programs – not just quantity.
- Ensure more **equitable access to food assistance programs/resources** in region by collecting data.
- Before patients are discharged from the hospital, providing **"warm handoffs" to connect them with community health and social service organizations that address hunger and other needs**.
- Increase collaboration and resource-sharing between hospitals and community groups working on healthy and culturally relevant food access.
- Increase **outreach to raise awareness** and utilization of food assistance programs.
- Provide services that distribute food directly to people where they live.

PRIORITY

11 Housing

KEY FINDINGS:

- Homelessness was indicated to be a concern at 17% of the qualitative community meetings. The overall health of homeless individuals was also of concern to community members, feeling as though **resources were not readily available and that homeless individuals** contributed to sentiments around neighborhoods being unsafe.
- A growing lack of **affordable housing** has led to a year's **long waiting list for subsidized housing**, as well as evictions, and individuals sleeping in places not meant for human dwelling (e.g., cars, outdoors). This phenomenon is pervasive across counties, but particularly in Philadelphia.
- Housing for certain sub-groups, such as **older adults and veterans**, was also noted as priorities

POTENTIAL SOLUTIONS:

- Invest in **affordable housing and shelters**, especially for people experiencing homelessness or with substance use challenges.
- **Improve transitional housing** and reentry programs to prevent homelessness post-incarceration.
- Ensure **stable housing for vulnerable groups** to support health management (e.g., medication, food access).
- Increase investments by hospitals, managed care organizations, and others in **supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness**.
- Explore strategies that aggregate funds to **support rental assistance** or develop an equitable acquisition fund to preserve and create affordable housing.
- Expand **programs supporting habitability** and raising awareness of resources for **housing repair assistance**.
- Increase **Rapid Re-housing Programs**.
- Invest in respite housing for individuals in urgent need of **transitional housing**.

PRIORITY

12 Neighborhood Conditions

KEY FINDINGS:

- Availability of **greens spaces**, dog parks, libraries, and health centers (with parks, walking trails, gyms, pools) contribute significantly to positive perceptions about neighborhood conditions; named as desired neighborhood features.
- Lack of overall neighborhood safety, caused by criminal activity, **community violence**, or **road conditions**, are risk factors for poor mental health and limited physical activity outside.
- **Uncollected trash** build-up and littered streets negatively impact neighborhood morale and contribute to air pollution that can prevent some from opening their windows.
- Community events were praised as opportunities to foster neighborly connections and cohesion.
- **Local pride** from residents who have lived in the area for several decades, particularly in Philadelphia County, contribute to vested interests in improvement, and informed perspectives on neighborhood history and nature of changes.

POTENTIAL SOLUTIONS:

- Increase **investment in neighborhood clean-up efforts** (e.g., trash removal, illegal dumping).
- Expand **tree canopy and green spaces** to reduce heat and support walkability.
- Maintain and **rebuild parks and rec centers** to offer both safety and engagement for youth.
- **Improve sidewalks and streets** for better mobility and pedestrian safety.
- Recognize the mental health impacts of environmental stressors like blight and noise.
- Support **neighborhood remediation** and clean-up activities.
- Collaborate with local advocates engaged in campaigns to improve air quality, especially in areas that have increased exposure to emissions.
- Invest in **infrastructure improvements** to support active transit near hospitals.
- **Improve vacant lots by developing gardens** and spaces for socialization and physical activity.
- Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.

PRIORITY

1 Youth Mental Health

KEY FINDINGS:

- **Youth and adult community members recognize mental health as the primary health** concern in the region.
- Youth mental health was prioritized at 12 of 15 youth meetings.
- Top issues included: **limited access** to mental health services, **lack of coping skill** resources, harmful effects of **social media**, and widespread feelings of **loneliness**.
- Addressing youth mental health in Southeastern Pennsylvania requires a multifaceted approach, including early intervention, increased access to care, community support, and targeted programs within educational settings.
- **High Prevalence of Mental Health Issues:** In 2022, approximately 12.88% of Pennsylvania youth (around 117,000 individuals) experienced a major depressive episode. Alarmingly, nearly 60% of these youths did not receive any mental health treatment.
- **Impact of the COVID-19 Pandemic:** The pandemic exacerbated mental health challenges among teens. A 2022 survey revealed that 37% of responding teens reported poor mental health during the pandemic, and 44% felt persistently sad or hopeless. This suggests that upwards of 35,000 teens in Philadelphia may require mental health support.
- **Suicidal Ideation Among High School Students:** The 2021 Youth Risk Behavior Survey indicated that 22% of high school students nationwide seriously considered attempting suicide in the past year, with 10% having attempted suicide. These figures underscore the critical need for accessible mental health resources for youth.

POTENTIAL SOLUTIONS:

- **Integrate mental and behavioral health services into primary care and school settings:** Normalize mental health care and reduce stigma by embedding services where youth already go. Participants urged that schools have accessible mental health resources in schools beyond just overwhelmed counselors.
- **Embed trauma-informed and healing-centered care into all services and programming:** Recognize the impact of trauma and promote resilience in all youth-facing programs.
- **Increase education and awareness of youth mental health services for families and caregivers:** Equip trusted adults to recognize warning signs and access timely care. Participants recommended Parent/community education on youth mental health, potentially offered at school events like back-to-school nights. They also suggested mandated parenting education/training to better equip caregivers.
- **Support extracurricular and peer-group activities to enhance social engagement:** Reduce loneliness by fostering safe and inclusive environments for connection.
- **Collaborative Care Model:** Proven approach where primary care teams include behavioral health professionals to improve youth mental health outcomes.
- **Trauma-Informed Schools Model:** Builds supportive learning environments by training staff and embedding school-wide trauma practices. Programs like the Philadelphia school-based mental health initiative, supported by the Independence Blue Cross Foundation and Children's Hospital of Philadelphia (CHOP), have been implemented to train school staff in screening and referring students at risk of mental health issues. This approach aims to create a comprehensive support system within schools.
- **Mental Health First Aid Training:** Prepares educators and youth leaders to identify, understand, and respond to mental health crises.
- **Peer Support Programs (e.g., Youth MOVE National):** Promote youth leadership and mutual support for mental health advocacy. Participants advocated for peer-led support spaces in schools like "Relationships First" circles where trained student leaders facilitate discussions.
- **Community Resources for Youth:** Organizations such as The Lincoln Center for Family and Youth offer services including school-based mental health counseling and alternative education programs to support youth mental health in the greater Philadelphia area.
- **Community-Based Support Centers:** Community Evening Resource Centers (CERC) in Philadelphia provide free, safe spaces and activities for children and teens aged 10 to 17, offering structured activities, homework assistance, and opportunities to build friendships. Youth encouraged reducing stigma through community awareness and generational conversations.
- **Early emotional support:** Participants advocated for incorporating social-emotional learning (SEL) from a younger age, not just in high school.

PRIORITY

2 Lack of Resources/ Knowledge of Resources

KEY FINDINGS:

- 30% of youth meetings prioritized **help with navigating health resources**.
- Youth reported difficulty accessing services due to **lack of awareness, system fragmentation, and limited transportation**.
- Many felt they lacked trusted adults or safe reporting pathways.
- **Complex Healthcare Systems:** The intricacies of the healthcare system can be overwhelming for youth, making it difficult to identify appropriate services and navigate insurance processes.
- **Stigma and Fear of Judgment:** Concerns about stigma, particularly regarding mental health services, deter youth from seeking help due to fear of being judged or misunderstood.
- **Transportation Barriers:** Limited transportation options can prevent youth from accessing health facilities, especially in underserved areas.
- **Financial Constraints:** Even with insurance, out-of-pocket costs and uncertainties about coverage can discourage youth from pursuing necessary health services.
- **Limited School-Based Support:** While schools are pivotal in health education, not all institutions have adequate resources or programs to guide students toward appropriate health services.
- **Cultural and Linguistic Barriers:** Diverse populations may face challenges due to language differences and cultural misunderstandings within the healthcare system.
- **Digital Divide:** Not all youth have reliable internet access or digital literacy, hindering their ability to find and utilize online health resources.
- **Fragmented Services:** The lack of coordination among various health services can make it difficult for youth to receive comprehensive care.

POTENTIAL SOLUTIONS:

- **Engage healthcare providers and care coordinators:** Help youth navigate complex systems through warm handoffs and follow-up.
- **Partner with schools to enhance health education and resource sharing:** Ensure youth know what services are available and how to access them.
- **Community Health Worker (CHW) Models:** Train CHWs to support youth and families in navigating care and building trust.
- **School-Based Health Centers (SBHCs):** One-stop access points for physical and mental health care, especially in underserved areas.
- **Trusted Messenger Programs:** Utilize culturally and age-relevant community members to relay information more effectively.
- **Community Initiatives:** Organizations like CORA Services have launched programs such as the Family Navigation Center to assist families in accessing and navigating health services effectively. Participants also encouraged community events (e.g., Healthy Kids Day) that attract families with incentives (bounce houses, food) while sharing resources.
- **More community-based outreach** instead of just web-based referrals.
- **Increase transportation access** or bringing services closer to communities (e.g., having more rec centers or clinics locally).
- **Youth-friendly formats** like social media campaigns to spread resource awareness.
- **Cultural and language access:** Hiring bilingual staff and making materials culturally relevant.

PRIORITY

3 Substance Use and Related Disorders

KEY FINDINGS:

- Identified in 9 of 15 youth meetings as a major concern.
- Key concerns: **binge drinking**, increased **marijuana** and **vape** use, and **trauma due to drug exposure**.
- Youth reported a need for better navigation of behavioral and treatment services.
- In 2022 according to the National Center for Drug Abuse Statistics (NCDAS), approximately 7.22% of Pennsylvania adolescents aged 12 to 17 reported **using drugs in the past month**, with marijuana being the most commonly used substance. In the same study, 9.19% of Pennsylvania teens reported **using alcohol** in the last month, slightly higher than the national average for this age group.
- **Youth experiencing depressive symptoms are significantly more likely to engage in substance use** compared to their peers with a more positive outlook.

POTENTIAL SOLUTIONS:

- **Youth-focused recovery spaces:** Suggestion of AA-style meetings for adolescents.
- **Safe reporting systems** where youth can help others (e.g., call for overdose support) without fear of punishment.
- **Integrated recovery and workforce development programs:** Pairing mental health support with skill-building and community service.
- **CIT (Counselor-in-Training) programs** and volunteer work for youth as alternatives to substance use and ways to build confidence and responsibility.
- **Develop and expand substance use prevention and education programs:** Deliver age-appropriate, evidence-based curricula in schools and communities.
- **Promote prescription drug take-back initiatives:** Reduce misuse by encouraging safe disposal of medications.
- **Botvin LifeSkills Training:** Proven curriculum that builds personal and social skills to prevent substance use.
- **SBIRT (Screening, Brief Intervention, and Referral to Treatment):** Early intervention tool used in schools and health centers.
- **Communities That Care (CTC):** Data-driven framework engaging local stakeholders to reduce youth risk behaviors through tailored strategies.
- **Treatment and Recovery Programs:** Organizations such as the Anti-Drug & Alcohol Crusaders, Inc. (ADAC) provide substance misuse prevention and intervention services targeting youth and families in Philadelphia.

PRIORITY

4 Bullying

KEY FINDINGS:

- Youth cited **bullying**—especially **cyberbullying**—as a major issue impacting mental health.
- **Discrimination**, **harassment**, and **social media toxicity** were recurring themes.
- Among students aged 12–18 who reported being bullied during the 2021–2022 school year, 21.6% experienced cyberbullying, with a **higher incidence among females** (27.7%) compared to males (14.1%).
- The 2023 Pennsylvania Youth Survey (PAYS) highlighted a **strong correlation between being bullied and experiencing depression or suicidal behaviors** among youth in Philadelphia County.

POTENTIAL SOLUTIONS:

- **Social media etiquette education** starting at young ages to combat online bullying.
- **Safe spaces in schools** to talk about feelings, led by peers or trained youth facilitators.
- **Early interventions** to prevent verbal and cyberbullying from escalating.
- **Support for immigrant and bilingual children** facing bullying due to language barriers.
- **Build conflict resolution skills and outlets for emotional expression:** Empower youth to manage emotions and resolve issues constructively.
- **Provide digital citizenship education:** Teach responsible online behavior and how to respond to cyberbullying.
- **Co-create psychologically safe environments:** Ensure schools and programs promote inclusion, equity, and support.
- **Olweus Bullying Prevention Program:** Evidence-based schoolwide program shown to reduce bullying.
- **Second Step SEL Program:** Social-emotional learning curriculum that builds empathy, emotion regulation, and decision-making.
- **Restorative Practices in Schools:** Shifts discipline from punitive to healing by fostering accountability and connection.
- **Support for LGBTQ+ Students:** The National School Climate Survey by GLSEN reports on the experiences of LGBTQ+ youth in schools, highlighting the need for supportive environments to reduce bullying and harassment.

PRIORITY

5 Gun Violence

KEY FINDINGS:

- Youth recognize gun violence as a top concern, **driven by poverty and easy access to firearms**.
- **Immigrant and LGBTQ+ youth face additional risks**, including IPV and sex trafficking.
- Youth report trauma and **limited access to supports** for healing.
- In 2022, firearms were the **leading cause of death among children and teens aged 1 to 17** in Pennsylvania.
- Studies indicate that **Black youths and those residing in urban communities have higher rates of witnessing gun violence** (21.4%) and hearing gunshots in public (51.6%) compared to their non-Black and non-urban counterparts.
- Stories from local youth highlight the profound personal impact of gun violence, **emphasizing the need for community support and policy change to create safer environments**.

POTENTIAL SOLUTIONS:

- **Reallocation of city funding:** Instead of heavy spending in one area, directing more toward youth mental health and education.
- **Safe community spaces** where youth can express fears and ideas (e.g., community art like the "community plate" activity).
- **Community involvement and cleanup events** to reclaim and uplift neighborhoods.
- **Critical feedback on ineffective policing** and calls for greater investment in actual youth-centered prevention and safety measures.
- **Expand violence prevention and youth recreation programs:** Offer safe spaces and constructive alternatives to violence.
- **Integrate social and mental health supports:** Provide trauma-informed care in schools, clinics, and community programs.
- **Advocate for stronger gun safety and economic policies:** Address root causes like poverty, firearm access, and structural inequality.
- **Cure Violence Model:** Treats violence like a contagious disease, using credible messengers to interrupt cycles.
- **Trauma Recovery Centers (TRCs):** Holistic support for youth who experience or witness violence.
- **Youth Empowerment Solutions (YES):** Engages youth in civic action and community transformation.
- **City Initiatives:** In November 2024, Philadelphia's Office of Public Safety launched the Group Violence Intervention Juvenile (GVIJ) program, targeting individuals aged 12 to 17 who are at high risk of involvement in gun violence, aiming to foster positive outcomes and well-being.

PRIORITY

6 Access to Physical Activity

KEY FINDINGS:

- **Youth associate health with movement** and requested more opportunities for physical activity.
- **Limited access to safe green spaces, parks, and recreation** infrastructure in many neighborhoods.
- 13% reported parks or activity spaces are rarely or never available.
- Regular physical activity **enhances cardiorespiratory fitness, supports healthy bone and muscle development, aids in weight management, and reduces symptoms of anxiety and depression among youth**.
- The **pandemic led to a decline in physical activity** levels among children and adolescents, emphasizing the need for renewed efforts to promote active lifestyles.
- Challenges such as **financial constraints, safety concerns, and limited access to facilities can hinder youth participation** in physical activities. Addressing these barriers is essential to ensure equitable access for all communities.
- The American Public Health Association advocates for **enhancing physical activity opportunities in out-of-school programs and increasing accessibility to reduce disparities** and promote health equity among youth.

POTENTIAL SOLUTIONS:

- **Community gardens and step challenges** tied to school programs.
- **Block parties and community clean-ups** that include physical activity components.
- **Rec centers and gym access** where youth feel welcome and included.
- **Peer involvement at gyms** and modeling healthy physical routines in neighborhood spaces.
- **Teach behavioral strategies for physical activity:** Encourage small, daily changes to increase movement.
- **Invest in active infrastructure:** Expand sidewalks, bike lanes, and parks for safe and equitable access.
- **Foster social networks that promote movement:** Peer-led activities and group fitness can improve consistency and motivation.
- **Safe Routes to School (SRTS):** Enhances walkability and biking through community design and education.
- **Play Streets:** Temporarily convert streets into pop-up play zones in under-resourced neighborhoods.
- **SPARK PE:** Research-based program improving fitness and academic performance through quality physical education.

PRIORITY

7 Activities for Youth

KEY FINDINGS:

- 11 of 15 meetings highlighted a need for more extracurricular options.
- Though 92% of youth participate in some activity, **accessibility—particularly in underserved areas—is a major barrier**.
- Programs like **summer camps, leadership clubs, and STEM activities** were top priorities.
- **Promotes Mental and Emotional Health:** Regular engagement in structured activities like sports, arts, music, and mentorship helps reduce stress, anxiety, and depression. It gives youth a positive outlet and builds emotional resilience.
- **Prevents Risky Behaviors:** Youth with access to after-school and community programs are significantly less likely to engage in substance use, violence, or other high-risk behaviors. These programs offer supervision, structure, and positive role models.
- **Builds Life Skills and Confidence:** Participation in group activities teaches teamwork, leadership, time management, and responsibility—skills that are vital for success in school and life.
- **Provides Safe Spaces:** Especially in neighborhoods impacted by gun violence or under-resourced schools, community centers and rec programs can be sanctuaries where youth feel physically and emotionally safe.
- **Supports Academic Success and Future Opportunity:** Programs that blend academics, mentoring, and enrichment activities help close opportunity gaps, support college and career readiness, and connect youth with pathways to higher education and employment.

POTENTIAL SOLUTIONS:

- **Volunteer and leadership opportunities** like CIT programs, community cleanups, or school clubs.
- **Skills-based training with incentives** (e.g., small stipends or "training pay") even before official working age.
- **Reviving youth programs** (e.g., Girl Scouts, Boy Scouts) and emphasizing mentorship.
- **Creative expression projects** like community plates or mural work to connect youth to their environment and voice.
- **Offer activities that foster connection and purpose:** Design programs that build belonging and life skills.
- **Partner with community orgs to expand access:** Leverage existing networks to offer free or low-cost options.
- **Support youth leadership and intergenerational initiatives:** Promote mentorship and civic engagement across age groups.
- **Positive Youth Development (PYD):** Strengths-based approach helping youth thrive emotionally, socially, and academically.
- **21st Century Community Learning Centers:** Federally funded programs offering afterschool and summer learning.
- **Youth Mentoring Programs:** Build trusted, supportive relationships through structured mentor models.
- **Out-of-School Time (OST) Programs:** Philadelphia offers OST programs for young people in grades pre-K through 12, supporting working families and promoting children's academic, social, and personal development. Activities include arts, sports, and academic enrichment.

PRIORITY

8 Access to Good Schools

KEY FINDINGS:

- Youth emphasized disparities in school quality across counties.
- Needs include **improved mental health support, updated teaching methods, and equitable funding**.
- Desired school traits include **diversity, inclusion, quality educators**, and **modern facilities**.
- Students in the School District of Philadelphia have **demonstrated varied academic performance**. In the 2021-2022 school year, approximately 34% of third- to eighth-grade students met reading standards, a 2% decrease from 2018-2019. Math proficiency was at 17%, down 5% from the same period.
- Access to high-quality schools directly affects a young person's ability to learn, graduate, pursue higher education or vocational training, and secure stable employment. **Education is one of the most powerful tools for breaking cycles of poverty and inequity.**
- When students fall behind in reading and math—as is happening post-pandemic—they are more likely to struggle academically in later years, drop out of school, or face limited job prospects. **Early gaps often widen over time without intervention.**
- Schools are not just for academics—they **provide mental health support, meals, social-emotional learning, and connection to services**. Quality schools help meet the basic needs of youth and families, especially in under-resourced communities.
- Communities with strong public schools often have **lower crime rates and greater social cohesion**. Good schools attract families, increase civic engagement, and help neighborhoods thrive.

POTENTIAL SOLUTIONS:

- **Support for bilingual learners** and anti-bullying efforts to ensure comfort in school environments.
- **Creating welcoming and identity-affirming clubs** for students of all backgrounds.
- **Better sexual health and emotional learning programs** that students feel engaged in.
- **Training for teachers and school staff** to be culturally competent and approachable.
- **Advocate for fair funding and staffing:** Reduce disparities by directing resources to underserved schools.
- **Provide interdisciplinary mental health teams in schools:** Normalize mental wellness as part of academic success.
- **Support mentoring, counseling, and career readiness programs:** Prepare students holistically for life after graduation.
- **Community Schools Model:** Integrates academics with health, social services, and community engagement.
- **Multi-Tiered System of Supports (MTSS):** Data-informed framework addressing academic and behavioral needs at varying intensities.
- **School-Based Mental Health Services:** Aligns with pediatric guidance to offer accessible care within the school setting.

Resources

LOCAL HEALTH RESOURCES AND SERVICES

Many health resources and services are available to address the needs of SEPA communities. A list of organizations serving Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties was developed based on those included in the 2019 rCHNA report, as well as community organizations identified by Steering Committee members as partners. Organizations were coded into categories based on types of services provided, and contact information was verified in April 2022 for all included organizations. Descriptions of the categories are below, and a searchable list of organizations with contact information, organized by category and county, is included in the online Appendix.

CATEGORY	DESCRIPTION
Behavioral Health Services	• Services, including treatment, to address mental health or substance use issues
Benefits & Financial Assistance	• Assistance with enrollment in public benefits or provision of emergency cash assistance
Disability Services	• Services for individuals with disabilities
Food	• Food pantries or cupboards, as well as assistance with Supplemental Nutrition Assistance Program (SNAP) benefits
Housing/Shelter	• Assistance with emergency shelter, rental payment, or support services for individuals experiencing homelessness
Income Support, Education, & Employment	• Support for tax assistance, adult education, and employment
Material Goods	• Material goods including clothing, diapers, furniture
Senior Services	• Services for seniors
Substance Use Disorder Services	• Treatment for substance use disorders
Utilities	• Assistance with utility payment
Veterans Services	• Services for veterans

REFERENCES AND DATA SOURCES

The participating hospitals and health systems would like to acknowledge the following organizations for access to data and reports to inform the rCHNA.

ORGANIZATION/SOURCE	DESCRIPTION
Academy Health	• Building Trust and Mutual Respect to Improve Health Care
American Board of Internal Medicine (ABIM) Foundation	• Building Trust Initiative
Centers for Disease Control and Prevention	• Behavioral Risk Factor Surveillance System Data (PLACES) • CDC/ATSDR Social Vulnerability Index • WONDER • Youth Risk Behavior Surveillance System Data
County Health Rankings & Roadmaps	• Health Data by Location • What Works for Health
Feeding America	• Map the Meal Gap
HealthShare Exchange	• Emergency Department High-Utilizers • Gun-related Emergency Department Utilization
Institute for Health Care Improvement	• Organizational Trustworthiness in Health Care
Montgomery County Office of Public Health	• 2024 Community Health Assessment
National Center for Health Statistics	• NCHA Data Query System
National Equity Atlas	• Income Inequality
Pennsylvania Department of Health	• Vital Statistics (Birth, Cancer, and Death Records)
Pennsylvania Office of the Attorney General	• Pennsylvania Uniform Crime Reporting System
Pennsylvania Health Care Cost Containment Council	• Hospital Inpatient Discharge Data
Philadelphia Communities Conquering Cancer	• Listening Session Summaries
Philadelphia Department of Public Health	• Syndromic Surveillance Data
Pennsylvania Commission on Crime and Delinquency, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Education	• Pennsylvania Youth Survey Data
U.S. Census Bureau	• American Community Survey 5-Year Data Decennial Census
Walker Data	• Tidycensus

Notes

Vital records data were supplied by the Bureau of Health Statistics and Research, Pennsylvania Department of Health, Harrisburg, Pennsylvania. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions.

Data for selected indicators is provided by HealthShare Exchange (HSX), the Delaware Valley's health information organization, based on data contributed from its healthcare provider members.

The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency responsible for addressing the problems of escalating health costs, ensuring the quality of health care, and increasing access to health care for all citizens regardless of ability to pay. PHC4 has provided data to the Philadelphia Department of Public Health in an effort to further PHC4's mission of educating the public and containing health care costs in Pennsylvania. PHC4, its agents and staff have made no representation, guarantee, or warranty, express or implied, that the data—financial, patient, payer and physician specific information—provided to this entity, are error free, or that the use of data will avoid differences of opinion or interpretation. This analysis was not prepared by PHC4. This analysis was done by the Philadelphia Department of Public Health. PHC4, its agents and staff bear no responsibility or liability for the results of this analysis, which are solely the opinion of this entity.

ONLINE APPENDIX

An online appendix of resources used to inform and produce this CHNA is available at: RCHNA-SEPA.org