SOUTHEASTERN PENNSYLVANIA

# COMMUNITY
# HEALTH NEEDS
## ASSESSMENT

# 2022

## EXECUTIVE SUMMARY

Identifying and addressing unmet health needs of local communities is 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. 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.

Recognizing that hospitals and health systems often mutually serve the same communities, a group of local hospitals and health systems have again collaborated on a Southeastern Pennsylvania (SEPA) Regional CHNA (rCHNA), with specific focus on Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This continued collaboration enables continuity of approach, while also providing opportunities to expand and improve upon the last assessment process. Participants recognize that the CHNA is an important part of how health systems, multi-sector partners, and communities work together to achieve meaningful and positive community change. In addition to the shared learning, increased efficiencies, and reduced community burden offered by the collaborative approach, participants have derived particular benefit from mutual support in the face of the COVID-19 pandemic and its cascading impacts. In response to the crises of the past several years, the 2022 rCHNA is explicitly grounded in an approach that seeks to advance health equity and authentic community engagement.

## Partnering Health Systems and Hospitals

### Children's Hospital of Philadelphia
- Children's Hospital of Philadelphia
- Middleman Family Pavilion at CHOP, King of Prussia

### Doylestown Health: Doylestown Hospital

### Grand View Health: Grand View Hospital

### Jefferson Health
- Einstein Medical Center Elkins Park
- Einstein Medical Center Montgomery
- Einstein Medical Center Philadelphia
- Jefferson Abington Hospital
- Jefferson Bucks Hospital
- Jefferson Frankford Hospital
- Jefferson Hospital for Neuroscience
- Jefferson Lansdale Hospital
- Jefferson Methodist Hospital
- Jefferson Torresdale Hospital
- Magee Rehabilitation Hospital
- MossRehab
- 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

### Redeemer Health: Holy Redeemer Hospital
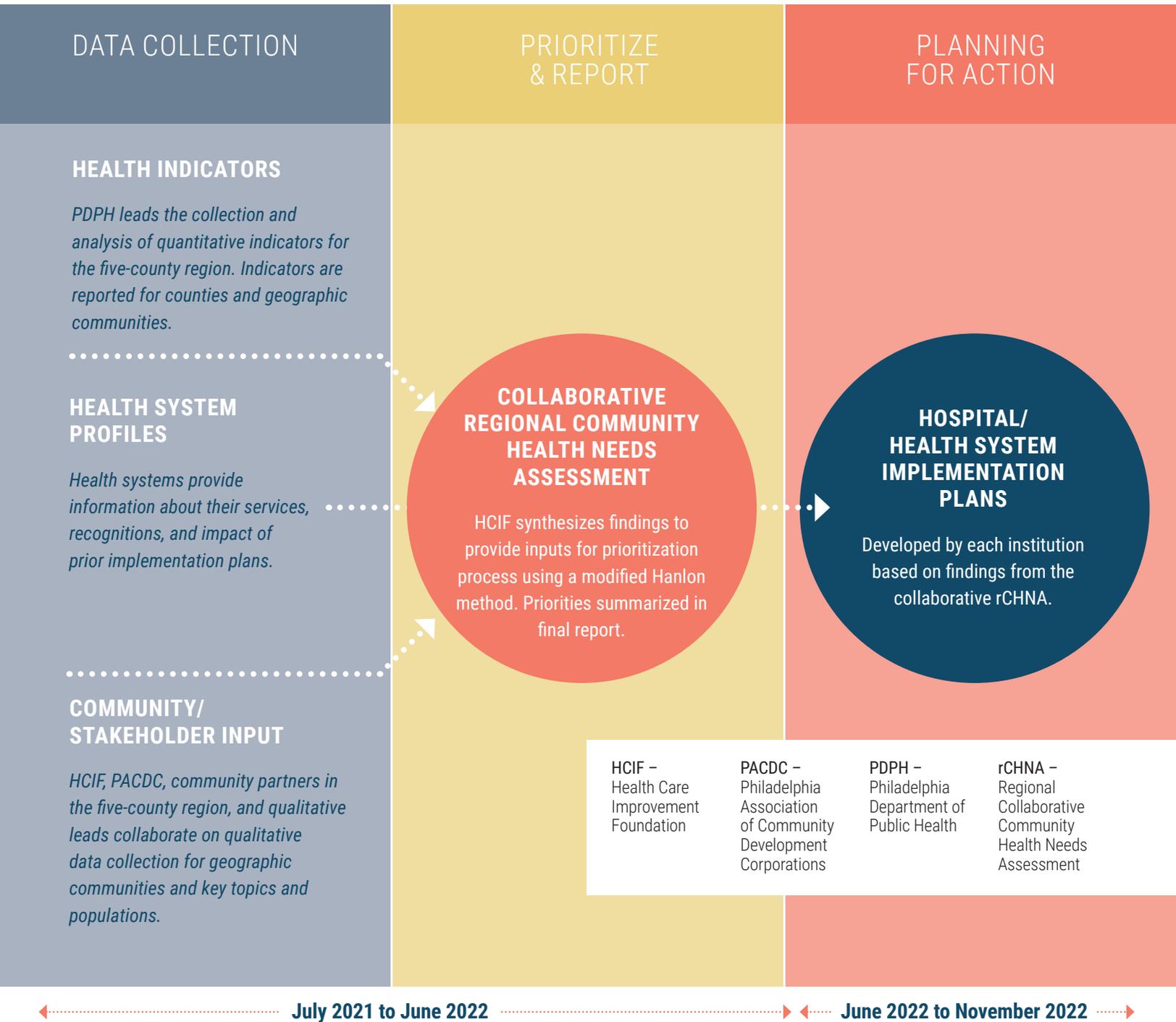
### Temple University Health System
- Fox Chase Cancer Center
- Temple University Hospital
- Temple University Hospital – Episcopal Campus
- Temple University Hospital – Jeanes Campus
- Temple University Hospital – Northeastern Campus

### Trinity Health Mid-Atlantic
- Mercy Catholic Medical Center, Mercy Fitzgerald Hospital Campus
- Nazareth Hospital
- St. Mary Medical Center and St. Mary Rehabilitation Hospital

# 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, hospitals/health systems produce implementation plans to respond to unmet health needs. These plans may involve further collaboration or coordination to address shared priorities.

## DATA COLLECTION

### HEALTH INDICATORS

*PDPH leads the collection and analysis of quantitative indicators for the five-county region. Indicators are reported for counties and geographic communities.*

### HEALTH SYSTEM PROFILES

*Health systems provide information about their services, recognitions, and impact of prior implementation plans.*

### COMMUNITY/ STAKEHOLDER INPUT

*HCIF, PACDC, community partners in the five-county region, and qualitative leads collaborate on qualitative data collection for geographic communities and key topics and populations.*

## PRIORITIZE & REPORT

**COLLABORATIVE REGIONAL COMMUNITY HEALTH NEEDS ASSESSMENT**

HCIF synthesizes findings to provide inputs for prioritization process using a modified Hanlon method. Priorities summarized in final report.

## PLANNING FOR ACTION

**HOSPITAL/ HEALTH SYSTEM IMPLEMENTATION PLANS**

Developed by each institution based on findings from the collaborative rCHNA.

HCIF –
Health Care Improvement Foundation

PACDC –
Philadelphia Association of Community Development Corporations

PDPH –
Philadelphia Department of Public Health

rCHNA –
Regional Collaborative Community Health Needs Assessment

**July 2021 to June 2022**

**June 2022 to November 2022**

## EXECUTIVE SUMMARY

In partnership with the Steering Committee of representatives from the partnering hospitals and health systems, the project team—composed of staff from Health Care Improvement Foundation (HCIF), Philadelphia Department of Public Health (PDPH), and Philadelphia Association of Community Development Corporations (PACDC)—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 the participating hospitals and health systems to develop implementation plans outlining how they will address these needs individually and in collaboration with other partners.

Quantitative data were acquired from local, state, and federal sources and focused on indicators that were uniformly available at the ZIP code level across the region. The PDPH team, which included experts in epidemiological and geospatial analyses, compiled, analyzed, and aggregated over 60 health indicators encompassing data on community demographic characteristics, COVID-19, chronic disease and health behaviors, infant and child health, behavioral health, injuries, access to care, and social and economic conditions.

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

- 26 virtual focus group-style "community conversations" held to gather input from residents of geographic communities across all five counties.

- 21 virtual focus group discussions centered on "spotlight" topics conducted with community organization and local government agency representatives. Topics covered included behavioral health, chronic disease, food insecurity, housing and homelessness, older adults and care, racism and discrimination in health care, substance use, and violence.

Two experts in qualitative data collection and analysis engaged as Qualitative Lead consultants facilitated all of these discussions, analyzed the qualitative data, and summarized key findings.

In addition, 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 either specific to different type of facilities within participating health systems (i.e., cancer centers, rehabilitation facilities) or reflected gaps in the 2019 rCHNA:

- Cancer
- Disability
- Immigrant, refugee, and heritage communities
- Youth voice

Finally, secondary data in the form of reports and summaries from other community engagement efforts were also incorporated into the report.

All data were synthesized by HCIF staff and a list of 12 community health priorities was presented to the Steering Committee. Using a modified Hanlon ranking method, each participating hospital and health system rated the priorities. An average rating was calculated, and the community health priorities were organized in priority order based on:

- Size of health problem
- Importance to community
- Capacity of hospitals/health systems to address
- Alignment with mission and strategic direction
- Availability of existing collaborative efforts

Potential solutions for each of the community health priorities, based on findings from the qualitative data collection, were also included.

# COMMUNITY HEALTH NEEDS

| COMMUNITY HEALTH NEEDS | KEY FINDINGS | POTENTIAL SOLUTIONS |
|---|---|---|
| **1.**<br><br>**MENTAL HEALTH CONDITIONS** | • Youth and adult community members and community partners prioritize mental health as their top health need.<br><br>• Significant mental health needs across the region are indicated by high rates of depression among youth and adults, frequent mental distress, and suicide mortality and suicide attempts/ideation among youth.<br><br>• Trends exacerbated by social isolation, stress, and fear experienced due to the COVID-19 pandemic.<br><br>• Pandemic-related trauma particularly compounded for those communities also contending with trauma associated with high levels of poverty, community violence, and racism.<br><br>• Populations particularly affected include youth, older adults, immigrant communities, LGBTQ+ communities, those experiencing homelessness and housing insecurity.<br><br>• There continues to be a significant lack of community-based, integrated mental health treatment options and a particular dearth of resources for youth with mental health needs and their families. | • Improve care coordination as part of an integrated care model.<br><br>• Increase awareness of behavioral health resources and services.<br><br>• Increase access to safe, structured afterschool activities for youth available on weekends and in the evening.<br><br>• Create spaces for openly discussing mental health for youth to normalize/ destigmatize mental health issues.<br><br>• Co-locate prevention and behavioral health services in community settings ("one stop shop") where families live, work, learn, and socialize.<br><br>• Increase access to support groups to address mental health and substance use.<br><br>• Increase training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence/sensitivity.<br><br>• Increase behavioral health workforce capacity and diversity (e.g., language, racial, and ethnic).<br><br>• Increase individuals with lived experience in the behavioral health workforce.<br><br>• Provide programming to prevent "burn-out" among behavioral health staff.<br><br>• Support efforts to increase funding to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment. |

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|---|---|---|
| **2.**<br>**ACCESS TO CARE (PRIMARY AND SPECIALTY)** | • Supply of primary care providers across the region compares favorably to national data and trends with uninsured rates are improving regionally, but challenges remain with increasing provider acceptance of new patients with Medicaid coverage.<br><br>• Barriers to access to primary care for communities are due to lack of providers in neighborhoods, issues of affordability, and language/cultural barriers.<br><br>• Above issues exacerbated with specialty care, with added challenges posed by even more limited availability of appointments, high cost, and lack of care coordination/linkage with primary care.<br><br>• Impacts of COVID-19 pandemic include increased enrollment in Medicaid, longer wait times for appointments (especially for specialty care), and gaps in access to preventive services. | • Provide education and information about Medicaid (e.g., eligibility, coverage) and assist with enrollment.<br><br>• Create high quality free or low-cost health care options to serve those who may be uninsured or underinsured.<br><br>• Establish comprehensive health centers that would address not only physical health, but also mental health and dental care.<br><br>• Bring more health and social services directly to underserved communities through health clinics in schools or mobile medical clinics.<br><br>• Embed social workers in primary care practices, such as family medicine, pediatrics, and OB/GYN offices.<br><br>• Train all levels of hospital staff and other healthcare providers on delivering "non-biased, culturally appropriate, trauma-informed care."<br><br>• Provide on-site language interpreters and health education materials in diverse languages.<br><br>• Increase racial, ethnic, and language diversity of staff and providers to better reflect the communities they serve.<br><br>• Increase transportation assistance, including adding options for those not eligible for certain benefits.<br><br>• Expand appointment availability and hours in low access areas.<br><br>• Address barriers to telehealth (e.g., related to internet or device access or digital literacy). |

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| **3.**<br>**CHRONIC DISEASE PREVENTION AND MANAGEMENT** | • Conditions like heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute majority of top 5 leading causes of death for all counties.<br><br>• Rate of premature cardiovascular deaths significantly higher in Philadelphia County.<br><br>• Cancer mortality rates highest in Delaware and Philadelphia Counties.<br><br>• Hypertension-related hospitalization rates highest in Bucks, Delaware, and Philadelphia Counties.<br><br>• Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, which disproportionately affects communities of color.<br><br>• COVID-19 pandemic has negatively impacted chronic disease prevention and management. Notably, there have been delays in seeking care, as found in qualitative reports and indicated by lower health care utilization in 2020 as compared to previous years. | • Better inform, educate, and engage the public regarding chronic disease prevention and management.<br><br>• Engage trusted community leaders to help spread important messages (for example, promoting cancer screening).<br><br>• Expand successful innovations from the pandemic, such as virtual wellness programs.<br><br>• Bring screenings and health education to faith-based institutions or where people shop, recreate, or work.<br><br>• Integrate mental health services into overall care management for people with chronic diseases.<br><br>• Before patients leave a hospital or clinic, provide screening, referrals, and "warm hand-offs" to community-based health and social services, as well as resources that assist with lifestyle changes for people managing chronic conditions.<br><br>• Increase networking and collaboration among community organizations and health system partners to improve resource sharing and coordination of services. |

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| **4.**<br>**SUBSTANCE USE AND RELATED DISORDERS** | • Substance use disorders often co-occur with mental health conditions.<br><br>• Substance use is associated with community violence and homelessness.<br><br>• Drug overdose rates continue to be high due to the opioid epidemic. The drug overdose rates in Bucks, Delaware, and Philadelphia Counties exceed the overall Pennsylvania rate. It is the leading cause of death for young adults.<br><br>• The opioid epidemic is associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS).<br><br>• Use of other substances, especially during the COVID-19 pandemic, was of pressing concern to community members and partners. Binge drinking among adults and youth, as well as cigarette, marijuana, and vape use among youth, were raised as increasingly prevalent. High rates of marijuana vaping among youth in the four suburban counties. | • Sustain and expand prevention programs, ranging from school-based educational programs to community drug take-back programs.<br><br>• Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs.<br><br>• Broaden and intensify efforts to reduce vaping among youth.<br><br>• Expand Narcan training and distribution.<br><br>• Increase medical outreach and care for individuals living with homelessness and substance use disorders.<br><br>• Encourage use of Certified Recovery Specialists and Certified Peer Specialists in warm handoffs for drug overdose and other behavioral health issues.<br><br>• Develop texting support services that address underlying issues of substance use, provided by trained peers or qualified therapists to individual clients.<br><br>• Streamline system navigation for providers and the population at large to facilitate access to outpatient services after discharge from inpatient facilities. |
| **5.**<br>**HEALTHCARE AND HEALTH RESOURCES NAVIGATION** | • Community members and partners widely viewed navigating healthcare services and other health resources as a challenge due to general lack of awareness, fragmented systems, and resource constraints.<br><br>• Healthcare providers, particularly in the primary and acute care setting, can play an integral role in linking patients directly to health resources or to community health workers or care coordinators.<br><br>• Navigation includes information as well as transportation. Lack of accessible, affordable transportation options was raised in a large majority (70%) of qualitative meetings, with the need spanning urban and suburban counties. | • Increase public awareness of community resource directories that local health systems have invested in and support community members with using them.<br><br>• Increase the capacity of healthcare staff to assist community members with navigation by regular education on available resources.<br><br>• Grow the numbers of professionals serving as community resource or healthcare navigators.<br><br>• Create permanent social service hubs that serve as "one-stop-shops" for commonly needed resources.<br><br>• Expand low-cost transportation options. |

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| **6.**<br>**RACISM AND DISCRIMINATION IN HEALTH CARE** | • Racism recognized as ongoing public health crisis in need of urgent, collective attention.<br><br>• Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are examples of inequities stemming from structural racism.<br><br>• Representatives of communities of color shared their mistrust of healthcare providers and institutions arising from seeing such disparities and personally experiencing discriminatory treatment in health care settings.<br><br>• Such experiences can lead to forgoing of needed care, resulting in increased morbidity and mortality.<br><br>• Anti-Asian hate crimes increased during the COVID-19 pandemic. Fear of violence among Asian older adults has led to reluctance in leaving their homes, resulting in increased social isolation and adversely affecting mental and physical health. | • Train and hire people with lived experience to work in communities that have been historically marginalized.<br><br>• Increase hospital investment in grassroots community organizations that are working to address social determinants of health and related needs.<br><br>• Expand and improve the training of healthcare providers around anti-racism, structural racism, implicit bias, diversity awareness, cultural competence, and trauma-informed care.<br><br>• Increase the number of people of color in healthcare leadership positions.<br><br>• Ensure diversity, equity, and inclusion efforts and plans within healthcare institutions include an explicit focus on racism and discrimination, with focus on policies, care practices, and ongoing measurement.<br><br>• Create and fund ongoing forums for community leaders to work with health system partners to address issues of racism and discrimination in health care. |
| **7.**<br>**FOOD ACCESS** | • Issues of food access focus primarily on food security. Many community members experience challenges obtaining sufficient food of any kind, as well as issues with accessing healthy food more specifically.<br><br>• Financial challenges brought on by the COVID-19 pandemic has led to an increase in rates of food insecurity across all counties and sharply rising demand for emergency food assistance. Nearly a quarter of Philadelphia households are receiving Supplemental Nutrition Assistance Program (SNAP) benefits.<br><br>• Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities. | • Ensure more equitable access to food assistance programs and resources throughout the region by collecting data.<br><br>• Before patients are discharged from the hospital, provide "warm handoffs" to connect them with community health and social service organizations that address hunger and other needs.<br><br>• Increase collaboration and resource-sharing between hospitals and community groups working on healthy food access.<br><br>• Increase outreach to raise awareness and utilization of food assistance programs.<br><br>• Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food.<br><br>• Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources. |

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| **8.** <br> **CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES** | • About 12 percent of the population across the 5 counties were not born in the U.S. As much as 45 percent of residents of some geographic communities report speaking English less than very well. <br><br> • The need for culturally concordant providers and resources to address language barriers was raised in over 50 percent of qualitative meetings. <br><br> • Provision of high quality language services (oral interpretation and written translation) is critical for providing equitable care to these communities. <br><br> • Beyond language access, cultural and religious norms influence individual beliefs about health. Providers and systems equipped to engage patients about these beliefs and integrate them into care is needed. | • Increase the racial, ethnic, and language diversity of staff and providers to better reflect the communities they serve. <br><br> • Develop organizational language access plans that outline protocols for identifying and responding to language needs. <br><br> • Explore the development of formalized programs to train and credential bilingual staff (employed for other roles) to serve as medical interpreters. <br><br> • Provide on-site language interpreters and health education materials in diverse languages. <br><br> • Develop strong partnerships with community organizations serving diverse communities that involves providing financial support. <br><br> • Train all levels of hospital staff and other healthcare providers on delivering "non-biased, culturally appropriate, trauma-informed care." |
| **9.** <br> **COMMUNITY VIOLENCE** | • Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties. <br><br> • In 2020, Philadelphia lost 447 people to gun violence, the most gun-related homicides in 30 years. It is the leading cause of death for Black men ages 15-43 and Hispanic/Latino men ages 15-31. <br><br> • Community violence driven by community disadvantage disproportionately impacts N, NW, and SW communities in Philadelphia. <br><br> • Trauma associated with exposure to gun violence is widely felt in communities, especially among youth. Significant challenges exist with accessing necessary mental health supports to address negative impacts of such exposure. <br><br> • Women, youth from immigrant communities, and LGBTQ+ communities are at higher risk of interpersonal violence, including intimate partner violence (IPV), sexual assault, and sex trafficking. Reports of increased risk of IPV associated with COVID-19 stay-at-home orders have been shared by local advocates. <br><br> • Negative social media engagement, including cyberbullying, among youth can be a source of community violence. | • Increase awareness and availability of youth programs to prevent violence, including educational programs, sports, and other recreational activities. <br><br> • Integrate social and mental health services into existing youth activities. Also provide training for individuals who are trusted by and work with youth (e.g., teaching artists, coaches, teachers, parents) in addressing trauma and other violence-related issues. <br><br> • Build youth capacity for healthy conflict resolution and create positive outlets for arguments or anger. <br><br> • Create more safe spaces for people to talk about the violence they experience. <br><br> • Train all levels of hospital staff and other healthcare providers on delivering "non-biased, culturally appropriate, trauma-informed care." <br><br> • Increase advocacy for policies to prevent or reduce violence, including initiatives to address poverty and other social determinants that contribute to violence. <br><br> • Partner with community-based organizations to build on each other's strengths and increase funding opportunities. |

# COMMUNITY HEALTH NEEDS

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| **10.**<br>**HOUSING** | • Safe, stable housing is critical for physical and mental health and well-being. Lack of stable housing is associated with 27.3 fewer years of life expectancy.<br><br>• Health issues associated with housing instability include behavioral health issues (mental distress, depression, developmental delays in children, falls among older adults) and medical conditions such as asthma and lead poisoning. Households may forgo needed health care due to financial strain.<br><br>• In 2018, 40 percent of Philadelphia households were cost-burdened (when a household spends 30 percent or more of its income on housing costs, including rent, mortgage payments, utilities, insurance, and property taxes). This figure is expected to be higher as a result of the COVID-19 pandemic.<br><br>• Poor housing conditions like old lead paint, asbestos, infestations, lack of running water or HVAC, and damaged infrastructure disproportionately impact communities with low incomes.<br><br>• Lack of affordable housing is a major driver of homelessness.<br><br>• People experiencing homelessness are at increased risk of mental health and substance use disorders and experiencing discrimination and bias in healthcare settings.<br><br>• Homelessness experienced by youth and older adults are of particular concern for local advocates. | • Drive solutions that prevent homelessness, including advocating for livable wages, more affordable housing, and services that support aging in place.<br><br>• Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.<br><br>• Increase investments by hospitals, managed care organizations, and others in supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness.<br><br>• Explore strategies that aggregate funds to support rental assistance.<br><br>• Explore development of an equitable acquisition fund to preserve and create affordable housing.<br><br>• Expand programs that support habitability and raise awareness of available resources for housing repair assistance.<br><br>• Evaluate existing hospital housing programs for potential expansion, including those that provide home repairs and remediation for high risk youth (e.g., with asthma) and older adults.<br><br>• Train and encourage health care providers to conduct regular housing insecurity assessments for patients and make referrals as appropriate. Train health professionals and social service providers to use a trauma-informed approach when caring for individuals experiencing homelessness or housing insecurity.<br><br>• Increase Rapid Re-housing Programs.<br><br>• Invest in respite housing for individuals in urgent need of transitional housing. |

# COMMUNITY HEALTH NEEDS

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| **11.**<br>**SOCIOECONOMIC DISADVANTAGE (E.G., POVERTY, UNEMPLOYMENT)** | • Individuals living at or near poverty levels have higher rates of adverse health behaviors and outcomes; poverty resulting from structural racism is the underlying determinant for many racial/ethnic health disparities.<br><br>• Inadequate education, limited opportunities, and unemployment are key drivers of poverty.<br><br>• Poverty among children and adults tends to cluster in communities; these communities collectively experience trauma and toxic stress, lower life expectancy, limited access to healthcare and health resources, and greater exposure to unhealthy living environments.<br><br>• Poverty rates are nearly 4 times higher in Philadelphia compared to suburban counties overall, but pockets of high poverty clusters are seen in suburban counties. | • Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs.<br><br>• Partner with local community-based organizations who provide public benefits enrollment assistance to ensure that residents receive all the benefits (e.g., SNAP, Earned Income Tax Credit) for which they are eligible.<br><br>• Collaborate with community colleges and universities to develop and expand programs focused on skills training and development to increase access to family-sustaining careers.<br><br>• Train and employ returning citizens.<br><br>• Advocate for improvements to the disability system to ensure that people with disabilities are able to work without losing attendant care services.<br><br>• Provide workforce development/pipeline programs with schools.<br><br>• Increase access to Science, Technology, Engineering, Arts, and Mathematics (STEAM) education for youth. |
| **12.**<br>**NEIGHBORHOOD CONDITIONS (E.G., BLIGHT, GREENSPACE, AIR/WATER QUALITY, ETC.)** | • Greater neighborhood blight (e.g., abandoned homes, vacant lots, trash) is more likely in high poverty areas and is associated with increased community violence.<br><br>• Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards.<br><br>• Access to outdoor greenspaces and recreation areas like parks and trails are lower in these neighborhoods. The negative impact of such lack of spaces on mental and physical health was shared by community members.<br><br>• Communities expressed concerns about air pollution and climate change, particularly in S Philadelphia, Delaware County, and flood-prone SW Philadelphia.<br><br>• Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity, and further racial segregation. | • Support neighborhood remediation and clean-up activities.<br><br>• Collaborate with local advocates engaged in campaigns to improve air quality, especially in areas that have increased exposure to emissions.<br><br>• Invest in infrastructure improvements to support active transit near hospitals.<br><br>• Improve vacant lots by developing gardens and spaces for socialization and physical activity.<br><br>• Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation. |

# INTRODUCTION

Identifying and addressing unmet health needs of local communities is 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 certain health needs as significant 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 Philadelphia Department of Public Health (PDPH) and the Health Care Improvement Foundation (HCIF) convened an effort to collaboratively develop a regional Community Health Needs Assessment (rCHNA) for four counties of the Southeastern PA (SEPA) region in 2019. This effort represented the first joint CHNA in the region, providing a foundation for future collaboration on both needs assessment and implementation planning to better serve shared SEPA communities.

Once again, local institutions have collaborated on the 2022 rCHNA, enabling continuity of approach, while also providing opportunities to expand and improve upon the last assessment process. Participants recognize that the CHNA is an important part of how health systems, multi-sector partners, and communities work together to achieve meaningful and positive community change. In addition to the shared learning, increased efficiencies, and reduced community burden offered by the collaborative approach, participants have derived particular benefit from mutual support in the face of the COVID-19 pandemic and its cascading impacts. In response to the crises of the past several years, the 2022 rCHNA is explicitly grounded in an approach that seeks to advance health equity and authentic community engagement.

While the basic structure and format of the report are retained from the 2019 effort, the ways in which the 2022 rCHNA departs from the previous process is largely due to a significant increase in size and scope. With the inclusion of additional hospitals and health systems in 2022, the current report not only adds Delaware County to the included service area, but also features full coverage of all ZIP codes in the five-county SEPA region. This has led to the re-defining of geographic communities, as well as increases in the number and types of quantitative and qualitative data in response to the requests of the expanded participant group. Given such differences, as well as the unique impacts of the COVID-19 pandemic on data collection efforts, it is important to note that comparability with the 2019 rCHNA report (especially as related to quantitative data) is limited.