

FOCUS AREAS AND COMMUNITIES

This section features primary and secondary data focused on health needs associated with particular conditions requiring specialized care (cancer and disability), as well as communities whose needs have historically been less understood or adequately addressed (immigrant, refugee, and heritage communities; youth; and LGBTQ+ communities).

CANCER

Cancer is one of the leading causes of death in southeastern Pennsylvania (SEPA).

County-level data for several cancer-related quantitative indicators previously presented in the geographic community profile tables are shown below for ease of reference:

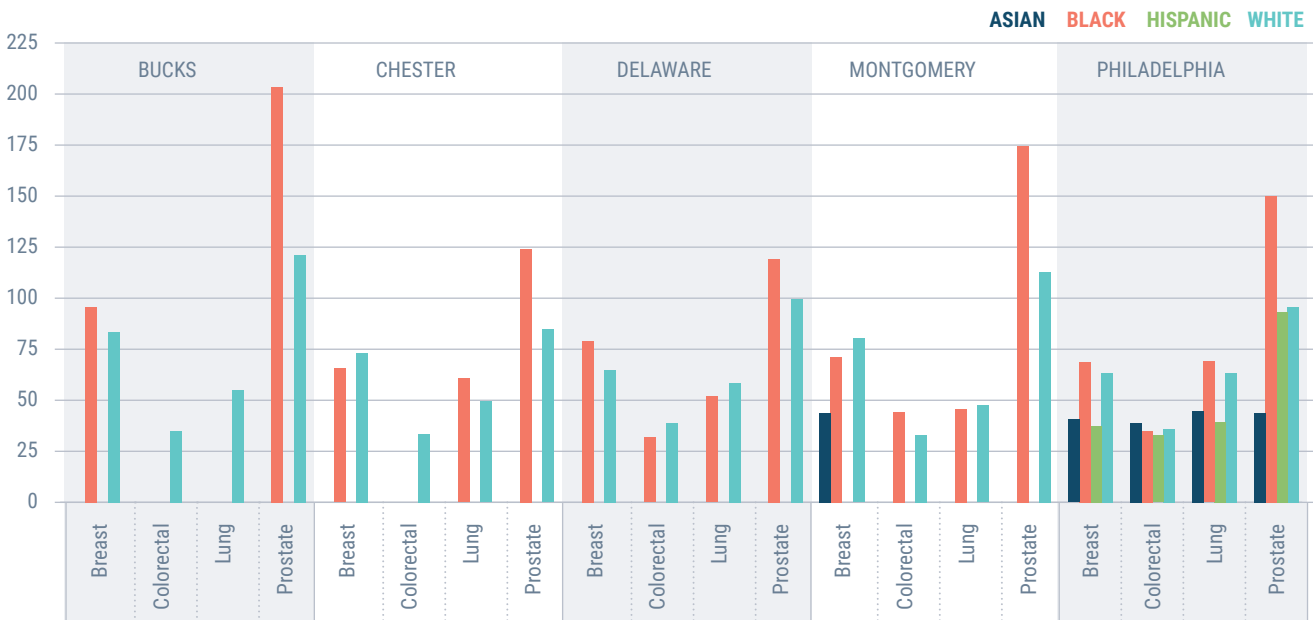
	Bucks	Chester	Delaware	Montgomery	Philadelphia
Major cancer incidence rate (per 100,000)*	308.7	242.9	262.9	286.1	242.5
Major cancer mortality rate (per 100,000)*	91.4	72.8	88.9	85.2	80.3
Colorectal cancer screening**	68.6%	69.5%	65.1%	71.3%	63.5%
Mammography screening**	76.6%	77.6%	77.4%	77.4%	78.3%

* Prostate, breast, lung, colorectal cancers; crude rate per 100,000; 2019 Vital Statistics (PA Department of Health)

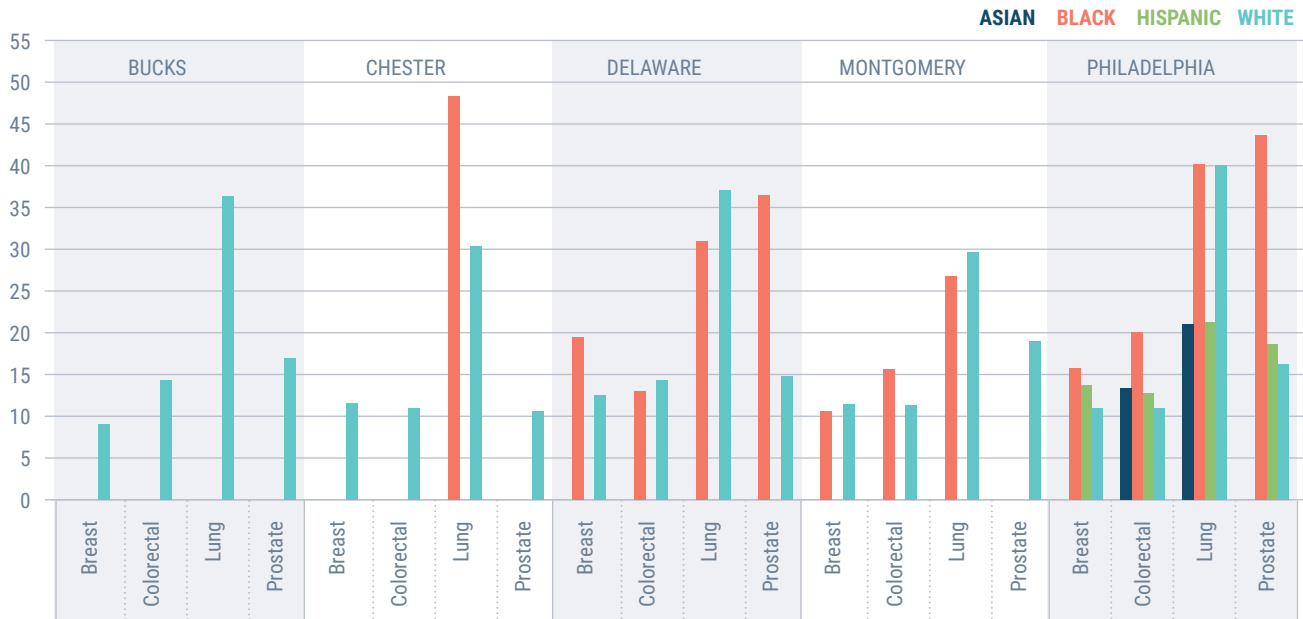
** 2018 Behavioral Risk Factor Surveillance System

Age-adjusted incidence and mortality rates by race for the four most common cancers in each of the five counties, according to 2018 data from the Pennsylvania Cancer Registry on the [Cancer Statistics Dashboard](#), are presented below:

Age-Adjusted Major Cancer Incidence by Race, 2018



Age-Adjusted Major Cancer Mortality by Race, 2018



NOTE: No bar indicates estimate that is unreliable due to low numbers.

These data show not only the extent of cancer’s impact on SEPA communities, but also the variation and scope of racial/ethnic disparities in each of the five counties.

In addition to quantitative data, qualitative data about community needs related to cancer were collected through focus group discussions on spotlight topics, including chronic disease, with representatives of community organizations and government agencies serving each of the counties (see Spotlight Topics section for more details). Key insights related to cancer from those discussions include:

- **Lack of information and stigma surrounding chronic diseases can lead to fear and avoidance of getting screened or seeking treatment.** *“One of the things that I saw was fear, fear of getting that diagnosis, and kind of putting your head in the sand,”* said a participant who managed a cancer screening program. *“There seems to be a ‘Don’t ask, don’t tell, don’t know, and I’ll be okay’ kind of mentality.”*
- **Stress management and social support are important to optimize care.** *“General stress management is a huge barrier, not only through it, but even after treatment,”* said a participant who works with people in cancer recovery. *“One of the things we also hear is sort of once everything stops, so treatment is done, surgery’s done, okay, your doctor’s like ‘You’re good, I’ll see you in three months,’ or whatever. It’s like ‘Holy moly, what just happened?’ It’s like post-traumatic, ‘Now what do I do?’”* Some patients also experience “scanxiety” after treatment for cancer—that is, fear and anxiety before follow-up visits to check for cancer recurrence. After a diagnosis of cancer, *“Number one is just feeling they have the support in their life, whether it comes from friends or family, or just support of others that understand what they’re going through.”*
- With care delayed for some patients due to the COVID-19 pandemic, several participants said **cancer and other conditions are more often diagnosed in later, more advanced stages.** *“The fear of going for those screenings during COVID. A lot of people that typically got yearly colonoscopies or blood work or whatever they’re like, ‘No, we’re going to wait.’ And then things exacerbated in that time, so a lot of people are being diagnosed later, in more advanced stages.”*
- **Staffing shortages at hospitals, coupled with staff redeployment to pandemic-related care, are further challenges.** Another participant who works at a health clinic added: *“We are currently in major catch-up mode when it comes to the cancer screenings, and then availability of getting folks in ... can be months waiting.”*

- **With many people working remotely during the pandemic, fewer workplace wellness programs that offer screening and education are being offered.** *“With the emphasis on the pandemic, there may be a lack of awareness even in workplaces about doing screening as part of work and offering it as part of work. Think about that: a lot of people are working remotely, and that’s where these things used to be in the office, or that people could gather to a bus [providing mobile health services] that is on office property, the access to that is reduced because of people working remotely.”*
- **Environmental exposures.** Indoor and outdoor pollutants were mentioned as risk factors for asthma, cancer, and other chronic diseases by several participants in Philadelphia and Delaware Counties. A Delaware County participant said: *“In the southern part of the county, where we’ve got a huge industrial corridor, we have a lot of anecdotal evidence of high rates of cancer, asthma, lung conditions, and we’re even seeing things like children with chronic nosebleeds, and that shouldn’t be happening. ... So people are facing chronic illness, but physicians are not necessarily aware of the environmental hazards in the community.”*
- **The need to integrate mental health services into overall care management for people with chronic diseases.** *“Mental health is an aspect of everything. If somebody is diagnosed with cancer, they’re going to have some depression, some anger, so mental health comes into everything. So, [we need] to have like an umbrella of mental health that goes across the board.”*

A final important source of qualitative data to inform the rCHNA process were collected by three cancer centers affiliated with participating health systems:

- Abramson Cancer Center (ACC) at University of Pennsylvania (Penn Medicine)
- Fox Chase Cancer Center (FCCC) (Temple Health)
- Sidney Kimmel Cancer Center (SKMC) (Jefferson Health)

Representatives from each of these cancer centers conducted focus group discussions with community advisory board (CAB) members January – February 2022, based on a standardized discussion guide developed jointly. There was a great deal of agreement across all discussions, with common points that resonate with items raised by the spotlight topic discussion groups above. Full summaries of each of the discussions developed by each team are presented below.

ABRAMSON CANCER CENTER AT UNIVERSITY OF PENNSYLVANIA

To solicit feedback about cancer awareness, concerns, and ideas for addressing cancer control, the Community Outreach and Engagement (COE) program of the Abramson Cancer Center (ACC) convened two meetings of its Community Advisory Board (CAB). There were 19 attendees at the two meetings at ACC. The meetings were held on Zoom, audio recorded, and the recordings were transcribed. The COE lead team created summaries of the meeting along with selected verbatim quotations, and combined both summaries from both meetings into this summary.

In your community (or in the community you serve): Is cancer seen as a health concern?

- It is seen as a concern because it is so **prevalent**. It comes up even in general community discussions about health. *“So many people have family members, if not themselves, who have cancer or have died of cancer or are being treated for cancer. So it’s definitely seen as a health concern in the community.”*
- There are a lot of **misunderstandings about cancer**, especially related to family history, the different types, the role of the environment, treatment options, and the variety of prognoses/outcomes (i.e., people think there is nothing that can be done if someone is diagnosed with cancer).
 - *“Our people in the community don’t think there’s any connection between the environment and cancer... that’s an area which we really have to start educating a lotta communities about the connection.”*
 - *“There’s... sometimes a fear about what happens if I do end up with a diagnosis, what will happen then?”*

Do people in your community talk about cancer? If so, what do you typically hear about? If not, why not?

- People often **do not know their family history** or if they know someone in their family had cancer, they often do not know what kind of cancer their family member had. This can sometimes be because medical professionals do not share with patients where the cancer started after it has metastasized.
 - *“I use my cousin as an example. She died before 50 from colon cancer but did not know that there was a family history because nobody in the family shared it. And so she kept being misdiagnosed for something like bronchitis. By the time it was staged, it was end stage.”*
 - *“The health system does not do a good job, especially for brown and black people, to explain what was the original point of origin. It’s kinda like they have – it’s all over... Where did it start? And oftentimes family members never even get that information in order to share with family if they so choose to do so.”*
- **Diverging opinions regarding cancer’s stigma:** on the one hand, some saw cancer as having less stigma than other diseases/illnesses (COVID/AIDS), but for others, it is harder to talk about cancer than sex/sexuality.
- People are most likely to talk about cancer if it **affects someone close to them**, but it is not top of mind otherwise. *“The people in the community talk about cancer. Not, till they get it and/or somebody close has it because for many people, it’s associated – without the education about cancer, it’s associated with fatality, and who wants to talk about that?”*
- **Groups where there is general conversation about health** are usually more comfortable talking about cancer. It also might **be easier to talk about cancer when it’s discussed alongside other health concerns** rather than on its own. *“Where there is strong advocacy, strong support groups, where you have a lotta survivors, there is a lot of conversation. ... Until it hits home, it may not come up as a general conversation.”*
- When there is discussion about cancer, the **mental health aspect is often neglected**, which it shouldn’t be. *“It was tougher for me to learn how to be a cancer survivor than when I was actually in treatment. I would notice these cycles of anxiety around my appointments, and the weeks leading up, I was just – I would experience things that I never experienced in my entire life with respect to anxiety and just irritability and fear.”*

Are there cultural nuances about cancer in your community that should be noted? Are there cultural beliefs or behaviors among your community that make cancer prevention and access to cancer care more challenging?

- Sometimes **religion** plays a role (e.g., “Can’t do anything about it. This is His will”).
- There are potentially **cultural factors** that affect misinformation about cancer and screening and other preventive measures, which could have many long-term negative consequences. For example, cultural ideas about sex prevent people from getting their children the HPV vaccine.
- Other **perceptions in different cultural groups** related to treatment include:
 - There is a myth in the Black community that when someone with cancer has surgery, the cancer spreads throughout the body.
 - When someone must go to the hospital, it is seen as a death sentence—there is not much knowledge around treatment and how people could get better. People do not understand the difference between a comprehensive cancer center and a community hospital.
- **Trusted messengers (especially survivors)** are an important factor to consider when addressing cultural factors.
 - Speakers’ bureaus would be a great asset to Philadelphia, as only one cancer center currently has one. The speaker could be a physician, health educator, or nurse, depending on the audience.
 - Highlighting survivors’ stories and good outcomes of treatment could help: *“Highlight survivor stories, highlight good outcomes in there, and I mean, I think a lotta this is educational, and a lot of it is you’re dealing with folks, they don’t wanna talk about – they got enough stuff going on, they don’t wanna talk about more bad news.”*
 - Messages need to be tailored to the group/community, and trusted messengers are key. Organizations can come in and fill this role, too, in some cases. It is especially effective when they have a health and wellness committee/group within the organization.

- Having **resources in both Spanish and English** is important, as well as making sure the materials are written at a level most people can access/understand: *“...we have bilingual staff that can have those conversations, but I think about people walking into other establishments that may not get that in their native language, in a way that they can relate to.”*

Do you think there is good/adequate awareness or knowledge of cancer? Do people seem aware of particular cancers, and if so, which ones? Which cancers do you believe there should be better awareness of?

- Many people do not know about the different kinds of cancer and just see it as one thing. There are varying **degrees of knowledge** related to different types of cancer. For example, there is not enough awareness of blood cancers, lung cancer, or connection between HPV and head/neck cancer. While there is agreement that there is strong awareness of breast cancer, opinions differ about prostate cancer wherein some think there is a lot of awareness and others do not. There is also a lack of knowledge about the **different degrees of cancer** (precision medicine can help with this).
- It takes a **great deal of effort to have sustained interest** in the topic. It can also feel overwhelming to think about and look out for the signs of all possible cancers.
- The **patient-provider relationship** is key, and providers need to not dismiss the concerns that patients bring to them: *“you’ll have people going in really trying to advocate for themselves, and you have a healthcare provider that isn’t listening...A savvy person may walk out that door and into another healthcare provider door, and sometimes they won’t walk into any healthcare provider, period.”*
- Communities that need special attention include the **LGBTQ community and people who are pregnant**.
- **Advertising for specific cancer treatments can be confusing** for people. *“The pharmaceuticals have new commercials on TV about various different medications for cancer. If you’ve seen that come out, there’s a slew of ‘em out there now, and folks are confused.”*

Do you think people in your community know about cancer screening? Do you think some cancer screenings are more well-known than others?

- There is more awareness of breast cancer screening and colorectal cancer screening, less awareness of lung cancer screening. *“There are certainly some others like lung cancer screenings still a lotta people are not aware of. We need to do a better job with that one.”*
- Many people don't become proactive about being screened until they know someone personally with cancer.
- It would be great to piggyback off of COVID testing/screening to get more people screened for cancer.
- There has been some success in a drive-by Flu-FIT campaign at Abramson.

If someone wanted to know more about cancer, where do you think they would go? What health information (cancer information) do you think they would trust the most?

- **People in their circles** (family nurse, friends and family, someone close to them, people from their church)
- **Someone who looks like them** is more trusted than someone of another race: *“I've heard directly from survivors and the ambassadors that they want to talk to people that look like them.”*
- **People generally trust their doctors and team**, including navigators or social workers at cancer centers: *“...we've done surveys of our community members, and they all say they wanna hear about trials from their doctors.”*
- At the same time, people do not always trust that the healthcare system is supporting them, in part because of the huge costs: *“...I know we still have high copays for a lotta different things, but a lotta people don't necessarily feel like the health system is there for them.”*
- People may seek out information from the **internet or organizations like the American Cancer Society**.
- For older adults, **partnering with a group like the Philadelphia Corporation for Aging** would be a good idea.
- It is important to **consider the whole person** when educating them about cancer. **Funding** is necessary to take ideas and put them into action.

What could we do better to get the word out to your community about the importance of cancer screening? Where would we place/put them? Who should our collaborators be? What would those messages sound like?

- **Neighborhood, local, ethnic newspapers/magazines.** These are the magazines in their neighborhoods, stores, businesses, and they read them regularly. *“They read the Philadelphia Tribune. They read the Philadelphia Sun. They read the Westside Weekly. They read the Leader.”*
- Young people get cancer too, so **social media** is an important outlet for that age group (Instagram, Facebook, Twitter, TikTok), especially with greater use due to the pandemic and not being able to get outside.
- Other important sources include the sometimes overlooked outlet of the **radio, leaders at trusted community organizations, and documents** like infographics with QR codes to websites for further information. A specific resource suggested was a **one-pager** that lists the cancers you can screen for, the age at which you are supposed to be screened, and a phone number for someone within Penn who can help a patient schedule the screening.
- **Variety in messaging** is important—things are not one-size-fits-all. People need to hear that cancer can be treated and you can be a survivor—people do not hear that message often.
- Having **health care in unexpected places** was suggested. Bringing it to where people are, like libraries, churches, mosques, synagogues, supermarkets, parking lots, buses, laundromats, donut shops, and food pantry lines. This ensures that they do not have to worry about transportation or babysitting.

How could we make it easier or more likely that people in your community would be screened for cancer? What are the biggest barriers they face in getting cancer screenings?

- It is important to remember the **social determinants of health**. Some people are just trying to survive, so cancer screening is not top of mind. There are barriers, like the cost of prep for colorectal cancer screening and getting to/from the screening, even when people get signed up/scheduled to be screened.
 - *“Well, if you have a car or you have someone that can drop you off and pick you back up who has the luxury to take off work, who can pay for the parking, all of those things, that they didn't have to come on a bus, there are so many things that we don't consider when we're talking about communities who every day are trying to just figure out how to survive.”*

– “We don’t think about the fact that I could go to the CVS and purchase the stuff for the prep, but everybody doesn’t have the resources to go and plop down \$20 to \$25 to buy the Miralax, the Dulcolax, the – what is that, the Gatorade and those kinda things.”

- **Self-advocacy** is important, too, including empowering people to get a second opinion if they want.

FOX CHASE CANCER CENTER

Fox Chase Cancer Center (FCCC) conducted a focus group with five members of their Community Advisory Board (CAB). For all questions, participants were asked to answer as a voice for the community they serve. The participants are representatives of the following community organizations with whom FCCC closely partners:

- A Hug Saved My Life
- Bethel Deliverance International Church
- FCCC Patient and Family Advisory
- Sista’s Daughters Inc.
- Delaware Valley Community Health (FQHC)

Awareness and Knowledge of Cancer

Cancer is seen as a health concern in all the communities represented in the group. Specific concerns include: **access to treatment and screenings, high rates of diagnosis and death, and fear of screenings and cancer itself**. There is also a concern about **late-stage diagnosis of cancer** which is occurring more as cancer screenings and doctor’s visits have decreased since the start of the pandemic.

Several members stated that many community members **do not talk about cancer and find it taboo** to even discuss their own experiences with cancer. This crosses generations, where many in older and younger generations have been taught not to talk about cancer. Several participants said this was mainly among the African American community. As one participant explained: “*Even my generation, because they were raised by that generation of quietness and so we are trying to break that cycle, but still no one’s talking about it, and if they talk about it it’s in a whisper.*”

Another participant explained that while **breast cancer and others such as thyroid cancer are typically discussed, there are others that are more taboo, such as gynecological cancer**. This is a topic that no one talks about. There are also **superstitions among many cultures**, including the Russian population she works with, that if you talk about cancer you will bring it in to your life. There are also beliefs among many in the community that they will not get cancer and therefore do not need to get screened. As one participant stated: “*Why do I want to do these things to my body, you know I’m not going to get cancer, it’s not going to happen to me.*” This participant also mentioned that from a male perspective, many men think they are invincible and do not need screening.

Participants stated that there is a lot of knowledge about breast cancer, but there are other cancer types that people are not as familiar, such as kidney cancer. Consistent with the point above, gynecological cancers are often not discussed, and many women feel they may be too old to have these types of cancers.

Cancer Screening

There is both a **lack of knowledge about cancer screening and a fear of the screening** and possible resultant cancer diagnosis among the community. Individuals may also be more likely to receive common cancer screenings, such as breast and prostate cancer, but may be more reluctant to obtain colon cancer screening. Skin cancer screening also seems to be underperformed.

The group felt that there needs to be **more information among general practitioners about the importance of screening**. There are some who do not prescribe it among adults they consider to be too old for screening.

One barrier for screening is **distrust of the medical community**. This is also a large barrier for research as well. **Wait times** in medical offices are another barrier. Additionally, a barrier for members of the **LGBTQ+ community is worry about if the healthcare facility will be an affirming healthcare location** (will they be gendered correctly, is there access to appropriate restrooms, etc.?)

Methods for decreasing screening barriers include any screening tests that can be **conducted at home**, such as the at home colorectal cancer tests. Similarly, a **mobile screening** unit to bring screening to the community can reduce barriers for some populations. However, others, such as those that live in senior housing communities, may not like this option because they don’t want everyone that lives in their building to know when they obtain a screening.

Several suggestions were made for **how to increase awareness of screening**:

- **Working with providers to make sure they recommend screening** to all adults of an appropriate age.
- Outreach can also be conducted at **social clubs**.
- Providing reading material is also a useful tool. *“Provide information to take home that is presented in a certain way and would engage them from the standpoint of saying yes here is the stage of life this pertains to you, and you know, things are not over, in that sense, meaning you’re not past the risk of cancer.”*

Personal testimonials are also important: *“The best message also is testimonial and word of mouth in the faith based community, because they are going to believe testimony of those that have partaken of your services.”* It is also important that the people that go into the community to tell them about their screening options are relatable and *“look like the community I’m talking to.”*

It was also suggested that when conducting community outreach events, **focus should be on wellness, not sickness or medical issues**. For example, perhaps instead of calling events health fairs, calling them a wellness fair or community day, in order to bring in more people. Using educational tools, such as the inflatable colon, are also great learning options.

Health Information Resources

Participants were asked where they thought members of their community would go for cancer information. Several participants stated that people in the community talk to their **friends and family** for information. This includes individuals such as **adult children that are physicians or cancer survivors that might be a friend or acquaintance** who are willing to have a conversation about their experience.

Common websites that community members utilize are the American Cancer Society and National Cancer Institute’s websites. Additionally, NCI-Designated Cancer Centers are useful resources.

SIDNEY KIMMEL CANCER CENTER

Representatives from the following organizations participated in the discussion: African Family Health Organization (AFAHO), American Cancer Society, Bucks County Health Improvement Partnership, Chamber of Commerce for Greater Montgomery County, Chinatown Clinic, For Pete’s Sake Foundation, Hepatitis B Foundation, Philadelphia Chamber of Commerce, Philadelphia Corporation for Aging, Philadelphia Department of Public Health, and SEAMAAC.

Cancer is a concern in the community but not always discussed or acted on:

- *“I believe there is a concern as there is awareness about it, however, too often people are not doing the wellness preventative steps.”*
- *“It is a concern, but I don’t hear people talk about it until they or someone they know is diagnosed with cancer.”*

Discussions about cancer include a focus on:

- **Diagnosis.** *“A lot of what I hear is around people being diagnosed with cancer. From a prevention standpoint, it is common to hear people talk about what habits to avoid that may cause cancer such as smoking.”* *“There is no general discussion about the importance or availability of screenings. Most discussion is around positive diagnoses.”*
- **Role of traditional medicine.** *“I hear people say that if you take this medicine, you know, this certain traditional medicine, you will be cured of cancer. So sometimes there are these rumors that go around. Eat this certain food and it’ll take your cancer away or keep you from getting cancer.”*

The community does NOT talk about cancer openly, because:

- **Fear. Cancer is like the death penalty.** *“I think one of the challenges is that people still see cancer as being fatal. It’s not seen as a chronic disease where prevention, early screening really can make a difference.”* *“...a lot of fear around a diagnosis, and that cancer means death is kind of how it’s simply thought about in the community.”*
- **Cultural beliefs such as if it is not talked about, it will not happen:** *“...because in many cultures it’s like foretelling, right? You don’t want to talk about it because you may make it happen. This was something that came up in the African immigrant communities, and also the Pacific Islander communities, that some things that are too scary, that are related to death particularly, they just don’t want to hear.”*
- **Stigma also plays a role:** *“I also think that is where some of the misperceptions are. That cancer is hereditary, and that often stigmatizes the families who have cancer diagnoses, which further limits discussion - people often don’t want their community to know if they have cancer. I think it can be overwhelming, too – so many different cancers, so many different messages!”*
- **Gender differences** around willingness to talk about cancer, with men seen as being less willing to engage.

Cultural nuances about cancer include:

- **Fatalism.** *"...because they don't think of screening traditionally as something that they do, and because you know, there's a lot of other cultural issues. Like fatalism, and like other things that fate, why would I bother?"*
- **Taboo.** *"To some Chinese or Asians, there's a taboo, you know? Something's wrong with you when you have cancer. Something you have done. Not necessarily it's a natural cause or something happened."*
- Undocumented immigrants without **health insurance** are concerned about a positive diagnosis and cost of care: *"A lot of our clients are undocumented, and a cancer diagnosis and screenings are often avoided, because if I test positive or if I have a positive screening, it's overwhelming too, like how am I supposed to pay for this? And can I get care? I'm not sure if I'm allowed to get care because I'm undocumented."*
- **Other barriers to screenings:**
 - *"People are resistant to getting screened, because ignorance is bliss, and it's not a problem if I don't know."*
 - *"Many of our clients live in the moment and so they don't think much about prevention. Some are afraid of getting screenings or just don't want to take off work."* (representative of immigrant serving organization)
 - Cervical cancer is an issue for women in some communities (for example, African immigrant communities) because clients are not comfortable with pelvic exams.

Many are aware of cancer, but there are varying degrees of knowledge, especially related to different types of cancer, and the knowledge is not always accurate:

- **Greater awareness of breast cancer, especially among women, and some awareness of lung, cervical, colon, and liver cancer.** But not much knowledge of other forms of cancer. *"In the African immigrant community, people are mainly aware of breast, cervical, and liver cancer. But some steps are being taken to raise awareness around other kind of cancers as well through our health programs."*
- **Greater awareness of breast cancer screening**, but less information on lung cancer screening or prostate cancer screening. *"Lung cancer screening and eligibility needs to be made more clear, especially with the high death rates seen nationally (not sure what it looks like locally)."*

- **Prevention:** *"I think is greater awareness that cancer kind of runs in the family. ...There's really very little information around prevention, what you can do to minimize your risk."*
- **Accuracy:**
 - *"I also think there is a difference between awareness and knowledge. Many are aware, but the knowledge is not always accurate - there are many misperceptions."*
 - *"In the local focus groups we have done in the AA and AI communities, they mention breast, lung, colon cancer. In the Chinese communities, they also are aware of liver cancer (many know someone who has had liver cancer), but there are many misperceptions about it. In the AI communities locally, we have heard that people confuse liver cancer with cirrhosis and hepatitis."*

When it comes to cancer, the messenger matters:

- **Trusted messengers** include:
 - Community-based organizations: *"So we have found that we are the trusted party, also because we can accommodate languages and people who are not literate and just from a practical standpoint. We're able to communicate and reach people. And so it feels like a lot of the burden has fallen on community organizations for this kind of general public health messaging. Which, to a point, makes sense. And if we have a relationship with people, then that's fine."* *"With regard to our clients, they come first to their cultural health navigator because of their trust, then we send them to health centers."*
 - American Cancer Society website: *"When my family members were diagnosed we utilized ACS resources"*
 - *"Community and religious leaders. A lot of the time, the messenger is more important than the message."*
- **Places where people are thinking about their health** would be a good promotion site, such as health clinics. *"But so many of my clients that go to the health center, and you know, I don't, I'm not familiar really what kind of care they would get at a health center. Are they getting information in their own languages about screenings? ...just places where they're thinking about their health would be a good place."* *"Our patients at the clinic would most likely come to our physicians at the clinic to get the information."*

Messages about Cancer

- Make sure information is offered in **languages that communities speak**.
- **Change the narrative of cancer as a chronic disease.** *"It's not seen as a chronic disease where prevention, early screening really can make a difference. So I think once we do a better job changing that narrative, you'll have more people being proactive..."*
- **Focus on preventative care** including healthy lifestyles to minimize the risk of cancer: *"Another area of messaging that gets neglected is like preventative care. ...the conversation around cancer is really restricted to like what happens when you have a diagnosis, and when you're already sick. ...connecting diet, nutrition, exercise, regular screenings, dental care. You know, these little day-to-day choices, there's not really a clear line drawn between those decisions and avoiding a cancer diagnosis."*
- **Marketing that explains how to prevent or live with cancer:** *"...there's so much messaging from pharmaceutical companies about the medications that treat all these different forms of cancer, which then plays into this society factor of fear, where there isn't the PSA's explaining about how do you prevent it or how do you live with cancer... So if we could flip the communication or marketing trend to be more educational, PSA format...why can't we do that for cancers, you know? Make it trendy and make it stick with people. That lasts a long time."*
- **Imagining the impact of cancer:** *"In the past whenever I did some workshops on screenings, I noticed that I had a better effect when I focused on people imagining what would happen to their lives if they did get cancer."*
- **Engage men around screening:** *"...agree that men's engagement around managing personal health seems to lag behind women's engagement. More dialogue and comfort discussing prostate cancer would be welcome."*
- **Consider the context** of people's lives: *"It is also important to consider how the messaging of prevention in ways that are reaching the audience if they are too busy working and making ends meet day to day."*
- It is also important to include information on the **availability of treatment and resources**.

Suggestions for Cancer Screening

- Addressing lack of time and transportation as barriers through **flexible hours and increased accessibility**:
 - *"(Senior) caregivers who are caring for someone who may be homebound or have some difficulties at home oftentimes don't have the time to get these screenings. So, maybe find flexible timing and outreach efforts that these caregivers can take some time to get these screenings that would be helpful."*
 - *"People's time is a barrier. Making it easier to get screened. Offering screening where people frequently visit, such as community organizations and at work."*
 - *"Continue to partner with specific communities, bring the screening to where the people are presently: businesses/companies, churches, schools, etc."*
- An example of a successful intervention is the **screening bus:**
 - *We loved the screening bus. We loved it. It was a huge hit. It was great, because it was coming to where the community was. People know where our office is, they feel comfortable here. Our case managers were able to vouch for the bus, and we were there in person to explain everything. It was convenient and really efficient and effective. We loved, loved, loved the bus. More busses, please."*
 - *"We have the bus come to the Wyss Wellness Center and that is great!"*
- **Providing support at every step:**
 - *"...if you look at the whole picture, there are challenges at every step, right? Individual, personal, systemic. I think bringing the screenings to where people are is really important, and knowing that your community may have access issues, transportation issues, issues with, you know, flexible work hours. I also think linkage to care is something that I think people are concerned that they're going to be diagnosed with something that they won't be able to follow up on."*
 - *"Most of our people are undocumented...they would need assurance to get the appropriate and free cost treatment after diagnosis."*

DISABILITY

According to the [Centers for Disease Control and Prevention](#), “a disability is any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities and interact with the world around them.”

One in four adults (61 million) in the U.S. live with some type of disability. In 2019, approximately 13 percent of residents of the five-county southeastern Pennsylvania (SEPA) region were living with a disability. People with disabilities have a wide range of diverse needs that may require particular forms of health and social support, but understanding of their population-level needs is limited due to underrepresentation in population-based surveys or qualitative studies and a lack of targeted data collection efforts.

Survey Development & Administration

A survey was developed to assess the health needs of people living with disabilities in the SEPA region (see online Appendix). The questions were adapted from a survey developed by Magee Rehabilitation Hospital for their 2019 community health needs assessment. The questions addressed respondents’ disability, general health status, health care access, health behaviors, non-medical needs, employment status, use of technology and assistive devices, community participation and resource needs, and demographic characteristics. A committee composed of representatives from Bryn Mawr Rehab Hospital, Good Shepherd Penn Partners, Magee Rehabilitation Hospital, MossRehab, and St. Mary Rehabilitation Hospital reviewed and approved the final survey.

The survey was fielded as an online survey October – November 2021. The link to the survey was distributed to a list of contacts generated by committee members, which included partner organizations, community programs, and support groups across the region. Committee members also sent links to their own networks of current and former patients. All who completed the survey and provided an email address were entered in a gift card drawing.

Frequency analysis was conducted on 341 unique submissions. Where appropriate, free response items were coded for key themes by the project team. Frequencies for multiple choice and coded free response items are reported below. For items that were “check all that apply,” percentages may add up to greater than 100 percent.

Survey Results

Respondent Characteristics

The table below summarizes the demographic characteristics of respondents. Respondents who are over 40, white, or had earned bachelor or graduate degrees made up a majority of the sample. Given this sample profile, it is important to note that the findings may not generalize to the larger community of adults with disabilities when interpreting survey results.

		N	%
Gender	Female	163	47.8
	Male	173	50.7
	Other	3	0.9
	Blank	2	0.6
Age	<18	1	0.3
	18-39	33	9.7
	40-59	111	32.6
	60-70	102	29.9
	>70	92	27.0
	Blank	2	0.6
Race	American-Indian/Alaskan Native	3	0.9
	Asian	8	2.3
	Black/African-American	66	19.4
	Native Hawaiian/Pacific Islander	0	0
	White	256	75.1
	Some other race	4	1.2
	Blank	8	2.3
Ethnicity	Hispanic, Latinx, or of Spanish origin	9	2.6
	Not of Hispanic, Latinx, or of Spanish origin	324	95.0
	Blank	8	2.3
Education	Less than high school degree	7	2.1
	High school degree or equivalent	56	16.4
	Some college	57	16.7
	Associate degree	31	9.1
	Bachelor degree	77	22.6
	Graduate degree	111	32.6
	Blank	2	0.6

Additionally:

- Over half of respondents reported being **married or living with a partner**.
- Almost half of the sample are **retired (48%), 29 percent are not currently working, and 11 percent are working full-time**. For those not currently working, the most frequently cited barriers included physical or functional limitations, potential loss of benefits, and needing support on the job.
- **About 77 percent are residents of the five-county SEPA region (Bucks: 11%, Chester: 5%, Delaware: 7%, Montgomery: 12%, Philadelphia: 41%),** with an additional 2 percent from other parts of Pennsylvania. The remainder are largely from New Jersey, New York, Delaware, and Maryland.

Disabilities and Limitations

- Most respondents **(79%) reported their disability as permanent**.
- While **78 percent described their disability or limitation as physical**, 30 percent described it as cognitive and 27 percent as characterized by chronic pain.
- Approximately half of respondents **(49%) reported having their disability or condition for over five years**.
- A large majority **(78%) indicated that their mobility is impacted** by their condition. **Forty-one percent reported impacts on self-care** and 32 percent on remembering and/or concentrating.
- Of those respondents who indicated that they **require personal assistance for life activities (57% of the total sample)**, 67 percent indicated that unpaid family and friends provide this care.
- **22 percent of the sample reported needing help for certain activities but not being able to get it**. These included daily activities such as self-care, mobility-related or physical activity, social interactions, and therapy or other health care.

Current Health

- Most prevalent **health conditions** were as follows:
 - **46 percent of respondents reported falling** within the past 12 months.
 - **42 percent had been diagnosed with high blood pressure or hypertension**.
 - **25 percent reported being diagnosed with a mental health condition**. Of these respondents, 70 percent indicated that they are currently receiving treatment for it.
- **A majority of the sample reported good (41%) or very good health (22%)**. An additional 26 percent reported fair health.

Accessing Health Services

- When asked about health services that had been utilized in the past 12 months, the most frequently selected options were **primary care (82%) and dental care (43%)**. Roughly one-third of respondents reported using emergency care (36%) and nearly a quarter used psychological and/or counseling services (21%).
- Of the 30 percent of respondents who indicated that they could not get the medical care that they needed in the past 12 months, the most frequently selected barriers were: **concern about COVID-19 exposure at the health care setting, inability to get an appointment, and inability to find a provider who understood their condition**.
- A large majority **(81%) reported that they have used telehealth services** in the past 12 months, and a majority of these respondents found **services beneficial (74%)**.
 - Those who had not used telehealth services indicated that they either did not have a need for such services or preferred in-person care.
 - While many found the services **convenient** (especially for particular types of appointments), others expressed **preference for in-person appointments or cited challenges related to technology and limitations of what could be done virtually**.

Disability-Related Resources

- **24 percent of respondents reported needing special equipment or assistive device(s)**, with factors such as cost, insurance-related issues, and lack of knowledge posing barriers to acquisition. Needed equipment included:
 - Lifts, chairs, or other mechanized assists (11%)
 - Ramp for their home (11%)
 - Railings, bars, or other non-mechanized assists (9%)
 - Motorized wheelchair, cart, or scooter (8%).
- About a third (**29%**) reported that they currently participate in **support groups**, with an additional 21 percent indicating that they are not currently participating but would be interested. A variety of resources were not widely used, but some respondents indicated interest in using:
 - Complementary therapy (33%)
 - Adaptive sports programs (22%)
 - Support for caregivers (relief support or respite) (22%)
 - Transportation support (21%)
 - Peer mentors (19%).

Non-Medical Needs

- With respect to housing, the biggest challenges were related to home access and safety:
 - **About a quarter of respondents (26%) with a physical disability indicated that they cannot enter or leave their home without assistance from someone else.**
 - **One in five indicated that their current housing does not meet their needs.** Most commonly shared issues included those related to accessibility, safety, need for repairs, and cost.
- **Fourteen percent of respondents shared that their primary means of transportation does not meet their current needs.** Most cited reasons included cost, need for assistance or equipment, and lack of reliability or convenience of transportation mode.

- **A small, but consistent, subset of the sample expressed significant financial needs:**
 - Eleven percent reported that there was a time in the last 12 months when they were **not able to pay mortgage, rent, or utility bills.**
 - Approximately 12 percent **experienced food insecurity.**
 - Eleven percent needed the **services of an attorney but were not being able to afford one.** Most common legal needs pertained to planning documents (e.g., will, power of attorney), public benefits (e.g., SSI/SSDI), and domestic relations (e.g., divorce, custody).

Lifestyle

- While 36 percent of respondents shared that they exercise at least 30 minutes three or more days per week, **27 percent indicated that they never participate in such activity.** Most frequent barriers to physical activity were: lack of knowledge of exercises appropriate for their condition, lack of interest, and not having the physical capability to participate in exercise.
- **A majority of respondents (71%) reported eating at least one serving of fruits and vegetables in a typical day.**
- **Substance use was not prevalent in the sample:** 93 percent indicated that they do not currently use tobacco, and 87 percent stated that they do not feel that drug or alcohol use impacts their daily life.
- The survey asked about **typical social interactions and activities:**
 - A majority of respondents indicated that they **socialize with close friends, relatives, or neighbors (82%) and feel there are people they are close to (88%).**
 - **Over a third (36%) indicated that they do not feel that their daily life is full of things that are interesting to them.**

IMMIGRANT, REFUGEE, AND HERITAGE COMMUNITIES

The five-county southeastern Pennsylvania (SEPA) region is home to a diverse mix of communities representing a wide range of racial and ethnic backgrounds. These communities consist of foreign-born immigrants and refugees, as well as those native-born to the U.S. with cultural and heritage ties to diasporic communities.

A critical point to underscore about such communities is their heterogeneity in terms of demographic makeup, experiences, and needs. Not only is this section premised on the understanding that no community is a monolith, there is recognition that, under the scope of the current assessment, the ability to fully represent the breadth of the diversity in the region is limited. Insights from primary and secondary data presented in this section therefore seek to illuminate experiences of a subset of communities in the region. Inclusion is based on availability of recent local data for these communities. In addition to using publicly available secondary information on specific communities, support and funding were provided to organizations across the region with both the interest and capacity to collect primary data about health needs from the communities they serve or share relevant secondary data. Data collected from surveys, focus groups, and case management intake records are presented below.

Background

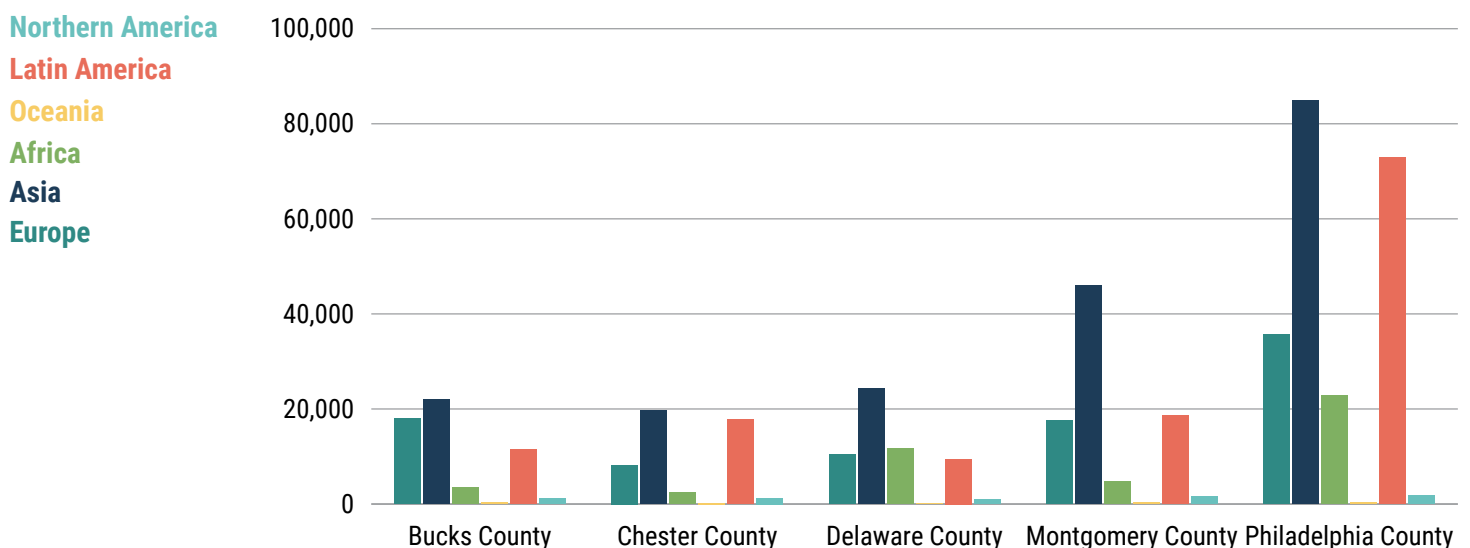
According to 2019 data, approximately 12 percent of residents in the region are foreign-born, with county-level estimates as below:

Foreign-Born Residents

Bucks	Chester	Delaware	Montgomery	Philadelphia
9.7%	9.8%	10.3%	10.7%	14.1%

As shown in the graph below, based on 2018 5-year estimates, places of birth for foreign-born residents varied across SEPA five counties. Those born in Asian or Latin American countries made up a significant share of the foreign-born population in each of the five counties. Also of note is the large share of foreign-born residents in Bucks County hailing from European countries, as well as those born in African countries in Delaware County.

Foreign-Born Population Place of Birth by Country, 2018

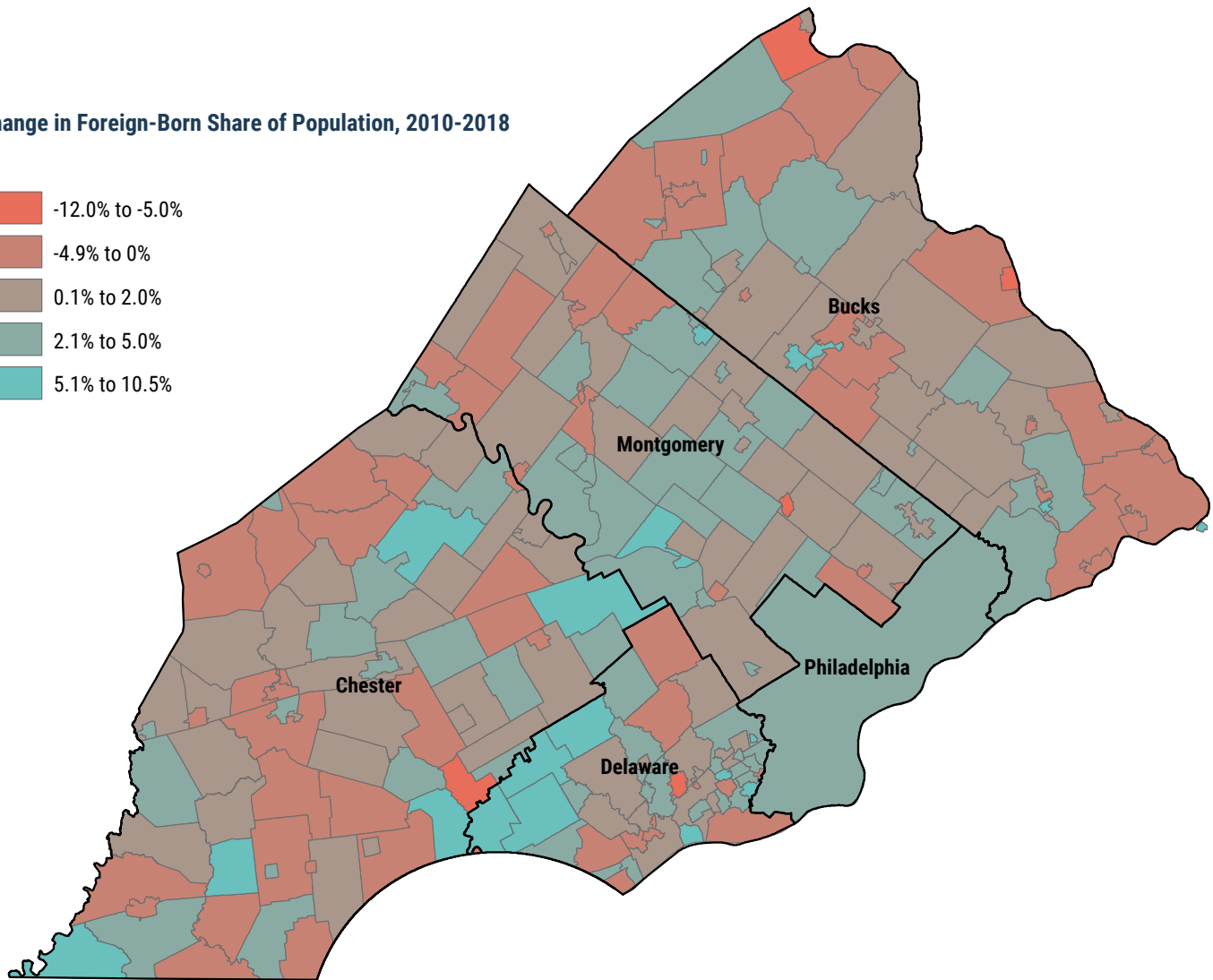
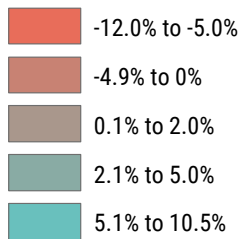


Source: ACS 5-Year Estimates (2014-2018)

During that same period, municipalities with the greatest number of foreign-born residents were Philadelphia (218,489 or 13.9% of the population), Upper Darby Township in Delaware County (16,988 or 20.5% of the population), and Bensalem Township in Bucks County (11,454 or 19.0% of the population). The map below, adapted from [this report](#) developed by the Delaware Valley Regional Planning Commission, illustrates the changes in foreign-born share of the population by municipality between 2010 and 2018.

Relative to the native population in SEPA counties, foreign-born residents were more likely to have a higher median age, lower rates of homeownership, and bifurcation in educational attainment (i.e., higher rates of those with less than a high school education, as well as those with graduate degrees). Foreign-born residents were more likely to be self-employed and overrepresented in industries such as Services, Natural Resources/Construction/Maintenance, and Production/Transportation/Material Moving.

Change in Foreign-Born Share of Population, 2010-2018



Source: U.S. Census ACS 5-year Estimates (2006–2010, 2014–2018)

General Health Needs

The rCHNA qualitative data collection (see summaries of community conversations, spotlight discussions, and data collected for focus areas and communities) revealed consistent themes of barriers to health faced by local immigrant and refugee communities. These include:

Language and cultural barriers.

Many foreign-born residents are English language learners (ELL) with varying levels of English proficiency. Discussion participants raised the need for language services encompassing qualified interpreters and widely available translated materials to ensure equitable access to health care and other services for ELL. This need is particularly acute for certain types of health care (for example, treatment for mental health conditions), where having high quality interpretation or a language concordant provider is critical for optimal effectiveness. The need for providers and health care systems to provide culturally responsive care that takes into account cultural norms and is grounded in cultural humility was underscored, as was the value of community members seeing and working with providers who “look like them.”

Anxiety and safety concerns

- The political and societal climate of the past several years have contributed to an atmosphere of anxiety and fear among some communities, particularly among those who fear deportation and family separation, that adversely affects health. For example, the recent discourse on public charge deterred many, including those who were eligible, from applying for public benefits or programs that provide necessities, such as health care and food, due to fears that the application process will divulge information to federal immigration officials about who they are and where they are living. (A recent [survey](#) conducted by the Pennsylvania Immigrant and Citizenship Coalition found that these fears were shared by youth, with two-thirds of respondents expressing that they do not feel safe in school and a third sharing specific concerns related to U.S. Immigration and Customs Enforcement presence in schools.)
- Anti-Asian violence during the pandemic has led to fear among Asian elders that prevent them from leaving their homes, resulting in social isolation and delayed access to care and other services or resources that support health. This exacerbates issues arising from the need to manage multiple chronic conditions, low health literacy, and difficulties navigating complex health care systems.

Impacts of the COVID-19 pandemic on economic stability.

Diverse immigrant communities were disproportionately affected by stay-at-home orders that shut down businesses and resulted in widespread job losses for the large proportion of immigrants working in retail, service, and hospitality industries. The financial hardships and economic instability have hit these communities hard, leading to increased rates of food insecurity, housing instability, anxiety, and depression.

Refugee Communities

Though not specifically discussed during the qualitative data collection, it is important to note the specific needs of refugees, especially in light of recent world events that have led to the arrival of Afghan and Ukrainian refugees to the region. While data specific to these communities have yet to be fully available, those seeking asylum often arrive with significant medical conditions including injuries from war, infectious diseases, and unmanaged chronic health conditions. Refugees also experience emotional trauma resulting from war, displacement, and loss of loved ones, and are frequently diagnosed with posttraumatic stress disorder (PTSD) and other mental health conditions.

Data from January 2020 to December 2021 collected by [Nationalities Service Center](#) (NSC) provide a snapshot of recent arrivals to the region. As one of three refugee resettlement agencies in the area, NSC case managers conduct an intake needs assessment for any client enrolling in programs such as medical case management; legal support; services for survivors of human trafficking, torture, domestic violence and other crimes; and employment readiness assistance.

Among the 446 clients interviewed for intake, 51.1 percent were male, 48.0 percent female, and 0.9 percent endorsed other gender identities. The median age was 35 years, with the largest share of the group (64.1%) ages 25 to 44 years. Clients' countries of origin were diverse, with particularly significant representation of African and South Asian countries.

Countries, Nations and Territories

(most frequent in **bold**)

Methodology Note: Data capture of clients' country, nation, and/or territory of origin was retrieved from client immigration documentation, or via client self report.

	Count	Percent
Africa 29 Countries, Nations and Territories: Algeria, Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Congo (Democratic Republic of), Congo (Republic of the) , Cote d'Ivoire, Egypt, Equatorial Guinea, Eritrea, Ghana, Guinea, Kenya, Liberia , Mali, Mauritania, Morocco, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Sudan , Togo, Uganda, Zimbabwe	116	26.0%
South Asia 3 Countries, Nations and Territories: Bangladesh, India, Pakistan	78	17.5%
Central America 5 Countries, Nations and Territories: Costa Rica, El Salvador, Guatemala , Honduras, Nicaragua	57	12.8%
Middle East 8 Countries, Nations and Territories: Afghanistan , Iran, Iraq, Jordan, Palestine, Syria , Turkey, Yemen	51	11.4%
North America 2 Countries, Nations and Territories: Mexico , U.S.	39	8.7%
Europe 4 Countries, Nations and Territories: Czech Republic, Poland, Russia, Ukraine	32	7.2%
Caribbean 6 Countries, Nations and Territories: The Bahamas, Cuba, Dominican Republic, Haiti , Jamaica , Trinidad & Tobago	30	6.7%
South America 9 Countries, Nations and Territories: Argentina, Belize, Brazil, Chile, Colombia, Ecuador, Guyana, Peru, Venezuela	23	5.2%
Southeast Asia 3 Countries, Nations and Territories: Myanmar (Burma), Malaysia, Thailand	10	2.2%
Asia 3 Countries, Nations and Territories: China, Kazakhstan, Philippines	7	1.6%
Other or Unknown 1 Countries, Nations and Territories: Papua New Guinea	3	0.7%

Clients' health-related needs were assessed in the following domains:

- **Food access.** 23.5 percent expressed either not having enough food for the week or being unsure. Regardless of this response, a large majority (72.0%) indicated using multiple sources to obtain the food they ate, including some form of assistance. This assistance was most frequently in the form of SNAP/ food stamps, friends or family members, or food banks or other resources.
- **Health conditions.** Slightly over a third (34.8%) of clients had an urgent medical condition.
- **Health care access.** Half of clients did not have health insurance (with half of those due to not being currently eligible), and 43.7 percent did not have a regular doctor or clinic they visited. A third expressed needing help with accessing dental care and 21.5 percent help with accessing vision care.

Based on feedback gathered on health education materials, NSC also identified needs for information about how to access language interpretation services, dental care, and Medicaid among their client population.

African and Caribbean Communities

As indicated by data in the overview and refugee discussions in this section, African and Caribbean communities are a large and growing segment of the immigrant population in the region. This is consistent with a larger [national trend](#) of immigrants from African and Caribbean nations comprising a larger share of the Black population in the U.S., as the current population of 4.6 million Black immigrants is projected to double to 9.5 million by 2060. One in five Black people in the U.S. are either immigrants or children of immigrants. Between 2010 and 2019, Philadelphia saw a 121 percent increase in the Black immigrant population.

Despite this growth, there is a relative dearth of targeted data collection efforts about these communities in the region. Examining the NSC dataset with a focus only on those clients from African or Caribbean countries of origin (N = 146), there are some indications of higher need relative to other populations served by NSC:

- Nearly 38 percent of clients were either not sure or did not have enough food for the week.
- Approximately 40 percent had an urgent medical condition.

Health care access needs for this group were comparable to the full dataset with all clients.

A [recent survey](#) of COVID-19-related needs among African and Caribbean communities conducted by the [Coalition of African and Caribbean Communities](#) (AFRICOM) identified top needs among respondents as employment, housing, food, and access to the internet. Suggestions for resources to help with these needs included cash assistance, as well as assistance with employment, community resource navigation, supports for youth learning, immigration and legal needs, housing and utility needs, health care and insurance, and food and clothing.

In addition to AFRICOM, nonprofit organizations like [African Cultural Alliance of North America](#) (ACANA), [African Family Health Organization](#) (AFAHO), and [Multicultural Community Family Services](#), play a critical role in supporting these communities. Recognizing this role, the Office of Immigrant Affairs and the Mayor's Commission on African and Caribbean Immigrant Affairs in Philadelphia conducted an [assessment](#) of these nonprofits to better understand their capabilities and needs, as well as identify potential areas of support. Of the 24 organizations who participated in the survey, over half have operating budgets of \$20,000 or less. Consistent with that, high priority areas for support involved assisting with fundraising/development and revenue generation and access to systems of support and capacity-building. This suggests opportunities for local government and health care organizations to ensure the continued growth and financial health of largely grassroots organizations providing essential services to underserved communities.

Asian Communities

Asians represented 6.5 percent of the population in the five-county SEPA region in 2019, with highest concentrations in Philadelphia and Montgomery Counties. As shown above, Asian immigrants account for a large proportion of the foreign-born population in both of these counties. Similar to African and Caribbean immigrant communities, there is limited up-to-date information about the health needs of Asian communities in the region owing to a lack of recent, specific, and systematic data collection efforts. The information presented below draw upon data collected and provided by organizations serving Asian communities in Montgomery and Philadelphia Counties.

The Asian American Coalition for Health and Human Services (AAC) in Montgomery County reflects the diversity of Asian communities in Montgomery and Bucks Counties, with representation from Bangladeshi American, Chinese American, Filipino American, Indian American, Korean American, Nepalese American, Taiwanese American, and Vietnamese American communities. With leadership from the [Philip Jaisohn Memorial Foundation](#) (Jaisohn Center), much of the recent efforts of the AAC have been focused on COVID-19 response, significantly increasing COVID-19 vaccination rates among the communities served by member organizations.

In December 2021, HCIF conducted a 90-minute focus group discussion with 12 members of the AAC to learn about community assets and needs related to health. Questions were adapted from discussion guides developed for other rCHNA qualitative data collection. Key insights from this discussion are described below.

• Community assets

- Across all communities, **social connections** between community members was cited as a source of strength, enabling support for members who may not know each other. For elders in these communities, connections through communities like apartment complexes facilitate sharing of information about resources and events by **word of mouth**. Large church networks providing social service support, availability of daycare for elders, and communication tools like KakaoTalk and WeChat were also raised. **Support within families**, particularly intergenerational family support, was noted as a particularly important form of social connection. One participant raised the downsides of reliance on family support for things like health care access, as waiting for the availability of adult children to accompany elders to healthcare appointments can delay care.
- The value placed on **preventive care and health awareness**—with a focus on harmony between healthy eating, exercise, and medicine—was shared as a particular source of strength for some communities.
- Past successful community engagement efforts around health for Asian American communities across the Delaware Valley (for example, with the American Cancer Society) underscore the importance of **engaging health leaders from Asian communities** (e.g., doctors, priests) who can provide health information in different languages.

• Challenges and barriers to health

- **Mental health and substance use issues** were a prevailing concern among AAC members. Stigma associated with mental health conditions, drug use, and suicide prevents communities from talking about it. The lack of culturally sensitive resources and facilities, as well as mental health care providers who speak community members' languages, pose barriers for seeking treatment for these issues. One participant noted that a belief that prayer can solve mental health issues in strong Christian communities can also be a challenge to seeking care, suggesting a need for particular outreach to spiritual leaders in communities.
- **Language barriers** were top of mind for all communities, with several citing limitations around interpretation due to a lack of face-to-face interpreters. These barriers were noted as being particularly problematic for elders.
- Several members raised the impact of **attitudes towards health and health care** on seeking care. Some communities may perceive no need to seek preventive care if they do not feel ill, especially if they distrust the health care system or feel shame for seeking help. Some may avoid talking about health conditions within the family, leading to family members not having a complete understanding of their family history. Other communities shared the “tunnel vision” that exist among members that prevent them from paying much attention to health, telling themselves to work “work through it.”
- Challenges **accessing specialists**, especially those who are language concordant and not an hour's drive away, were also shared.
- For smaller communities, it can be difficult to get attention and health resources directed at them, leading to a **lack of awareness** of what is available for help.

• Issues specific to youth

- Concerns about the **mental health** of teens were prevalent, especially in light of the COVID-19 pandemic impacts on being able to interact with others and build friendships with peers. The need for therapy in schools, as well as therapy provided by bilingual or Asian therapists who understand teens' cultural contexts and barriers, was noted.
- Several AAC members discussed the **generation gap** between youth and parents. The lack of communication between parents and children, especially around issues like relationships, drugs, alcohol, and sex, may lead to parents not being aware of issues their children may be experiencing until they become serious or reach a stage of crisis.
- **Identity issues** for Asian American youth were also raised, which were connected to academic pressure and high parental expectations, as well as racism and threat of anti-Asian hate crimes.

• Issues specific to elders

- Challenges with **technology and internet access** were noted among elders, posing barriers to telehealth. To address this, some noted successful models of intergenerational teaching to increase digital literacy among older adults.
- Issues with **depression and anxiety** among elders arising from lack of social connection and communication with family members were raised. Most “just accept and not deal with it.”
- Navigating **aging in place and family dynamics** is complex. Elders prefer to live with family, but adult children may find it difficult to care for parents as they age and have more serious needs. These children need respite, but it may be difficult to get an adult sitter to provide support. Elders, for their part, are afraid to be a burden on family members, leading them to try to be as independent as possible and therefore not asking for help when they need it.
- Other issues discussed were **lack of transportation and worsened physical conditions** due to delayed care.

• Ideas for potential solutions

- Seminars with psychologists to talk to parents and kids about mental health
- Youth center to give youth an outlet where they can feel they belong and build their self-confidence
- Directory of health care providers by ethnic community
- Engaging ambassadors within communities to share their stories of resources and benefits—as one member put it, “we trust our own people.”
- Immigrant groups with longer histories in the community sharing information with and supporting newer immigrant communities

Themes related to mental health noted in by AAC member are corroborated by a recent survey conducted by the [Philadelphia Chinatown Development Corporation](#) (PCDC), as part of the [Chinese Immigrant Families Wellness Initiative](#) (CIFWI). The [2020 Wellness Leadership Program Impact Report](#) summarizes survey findings (N = 78), reporting that 46 percent of youth respondents (aged 15 to 23) and 100 percent of parent respondents indicated COVID-19 had an impact on their mental health. The most common adverse experiences among youth were family pressure, racism, poverty, and sexual abuse, while parents identified family pressure, death, unemployment, and illness. The Wellness Leadership Program, one component of CIFWI’s strategies to promote mental health wellness, seeks to “raise mental health awareness, develop leadership skills, and promote healthy communication with family” among high school and college students. The 3-month program led to positive effects among the 2020 cohort of youth participants, including lowered anxiety and increased self-compassion and functional health.

One major source of stress and anxiety for Asian communities are increased incidents of anti-Asian hate during the pandemic. PCDC collected data from 315 respondents in March 2021 to explore this further. According to PCDC’s [Anti-Asian Racism Incident Survey Report](#), one in seven had personally experienced an anti-Asian racism incident, with 39 percent of the incidents taking place in public settings. The most common form of incident was racial slurs/name calling (63%), followed by physical intimidation (34%). Over three quarters of respondents did not report the incident to police or any agency due to language barriers and distrust. Such findings bear further widespread and systematic examination to better understand and respond to the ongoing implications of such racial trauma on mental health for local Asian communities.

The health needs of Southeast Asian immigrant and refugee communities in Philadelphia, as revealed by data provided by [SEAMAAC](#), share commonalities with findings already discussed. SEAMAAC has served South Philadelphia communities for nearly 40 years, supporting as many as 18 distinct linguistic communities with a wide array of programming, including education programs for youth, health and social services, and community development initiatives. During the COVID-19 pandemic, SEAMAAC expanded its programming to encompass robust hunger relief efforts.

The following sources of data collected by SEAMAAC were reviewed and analyzed for this report:

- 1. Focus groups** conducted with Cambodian, Chinese, Burmese, Bhutanese, Laotian, and Vietnamese client groups in 2019 to discuss community health needs to inform the development of services for a new health center.
 - 2. Philadelphia Immigrant and Refugee Experiences (PIRE) survey** of clients (N = 78), many of whom were completing their initial intake for case management services from September – November 2021.
 - 3. Interviews** with SEAMAAC staff about physical health and social determinants of health conducted in December 2021.
- 1. Across all client focus groups**, the following were expressed as common needs related to health and therefore important features for the new health center:
- Providing language services, particularly on-site interpreters
 - Ensuring health care is affordable
 - Minimizing wait times
 - Addressing transportation barriers
 - Providing easily understood health education material in diverse languages
 - Ensuring that staff are welcoming and respectful
 - Providing a wide array of services (including specialties) at one site
 - Offering mental health treatment and education
 - Facilitating the passing down of cultural norms such as respect for elders to youth

2. Survey results include:

- A majority of respondents are female (65.4%) and residents of South Philadelphia (84.6%), with a median age of 47 years. Those identifying as Indonesian, Chinese, or Burmese made up over 65 percent of the respondents.
- A large majority express difficulties with speaking, reading, and writing in English.
- Nearly 60 percent are renters, with about half able to pay rent each month (20.5 percent indicated that they do not pay, perhaps reflecting older adults living with family members). Similar patterns were seen with paying for utilities.
- When paying for required expenses, 19.2 percent express needing help from a government agency or other agency/organization, with an additional 9.0 percent indicating that they do not have enough money and do not have anyone who can help and a further 3.8 percent receiving help from family or friends.
- Approximately 30 percent report feeling unsafe sometimes or all or most of the time in their neighborhoods.
- Nearly half are in poor (15.4%) or fair (26.9%) health.
- A majority are able to do the following themselves or with the help of an adult family member:
 - Make a medical appointment
 - Seek emergency care
 - Use transportation to complete everyday tasks
 - Attend regular and new appointments
- Of the 55 respondents who shared what they were most worried about (responses were coded into categories; since respondents provided multiple answers, percentages add up to more than 100%), most common concerns were related to:
 - Their health (45.5%)
 - Finances (41.8%)
 - COVID-19 pandemic (20.0%)
 - Their family (18.2%)
 - Lack of employment (18.2%)
 - Immigration status (10.9%)
 - Housing (9.1%)

- Of the 47 respondents who shared what they are proud of accomplishing in the U.S., the most frequently cited were:
 - Raising their children, providing them an education, and feeling pride in their accomplishments (36.2%)
 - Being employed (14.9%)
 - Making a life for themselves in the U.S. (10.6%)

3. Staff interviews revealed themes common to other data collection efforts described above:

- **Behavioral health**
 - Across the Southeast Asian communities that SEAMAAC staff support, behavioral/mental health is not considered to be a part of health; health is considered to be purely physical. Many clients express that their intake conversation is the first time anyone has asked about their mental health.
 - Mentioning behavioral/mental health is extremely taboo, and stigma can make it offensive to ask about mental health. The closest thing that clients will acknowledge is stress, which is seen as normal, not a big deal, and something that can be overcome.
 - The connection between behavioral health issues like addiction and physical health is not often understood. Addiction is sometimes understood related to drugs, not gambling or drinking.
- **Priority health needs**
 - Chronic diseases such as diabetes, hypertension, high cholesterol, heart disease
 - Health care access and affordability, medication management, health literacy
 - Addiction (gambling and/or drinking)
 - Elder care
- **Priority social needs**
 - Poverty and its cascading effects such as food and housing insecurity, which contribute to health problems
 - Lack of transportation contributes to loneliness, especially for elders who may be unable to socialize with others other than their family members
 - Depression and loneliness resulting from lack of social contact (e.g., when factory workers whose main source of socializing is through the workplace are unable to work due to illness)

- **Prioritizing of work before health due to lack of safety nets like savings and concerns about job loss**
- **Barriers to addressing health concerns**
 - Lack of language access in healthcare settings, as well as in interactions with landlords and schools
 - Immigration status
 - Lack of transportation and accompaniment
 - Long wait times at health clinics
 - Complexities around accepting public benefits, immigration status, and employment
 - Trauma, which affects ability to plan and prioritize needs
 - Internalized feelings of being undeserving of assistance
 - Discrimination based on language, race, or ethnicity
 - Lack of education for clients about navigating systems AND lack of education for providers around barriers that client face
- **Attitudes and beliefs about preventive care**
 - There is a prevailing lack of urgency around it for many communities, as it is regarded as not necessary or a luxury most are unable to afford.
 - Strategies to increase willingness to seek preventive care include framing in terms of potential negative future financial impacts and impacts on loved ones.
- **Impacts of COVID-19**
 - Widespread loss of family and friends, especially in the first 6 months of the pandemic. Cambodian and Indonesian communities were particularly hard hit.
 - Job loss, ranging from factory jobs to closing down of small businesses; women lost jobs due to daycare and childcare centers closures.
 - Digital divide, compounded with language barriers, made it difficult for parents to help their children with online learning.
 - Disparities in access to federal financial assistance like stimulus checks, resulting in financial hardship that put people's housing at risk.
 - Early reluctance to seek health care has led to even more delays in health care currently, as clients face long waits for appointments (especially for specialists).
- **Needed resources**
 - Safe, affordable, quality housing
 - Decent paying jobs
 - More access to culturally appropriate foods (e.g., halal food markets)
 - Benefits that can be accessed by undocumented clients (including transportation assistance)
 - Employment/work readiness programs (high school and adult)
 - Workshops addressing topics such as nutrition/healthy diet, tenants' rights and responsibilities, and bills (medical, utility)
 - Time! Healthcare providers do not have or give enough time with clients. Sustained changes require investment in every case and a holistic approach that takes into account social determinants of health, education about resources, and a person-in-environment (PIE) approach.

Hispanic/Latino Communities

Hispanic/Latino communities made up 8.9 percent of the population across all five SEPA counties according to 2019 estimates. Chester and Philadelphia counties are home to large Hispanic/Latino communities. An analysis [provides a snapshot](#) of Philadelphia's Hispanic/Latino population, which nearly doubled between 2000 and 2018. A large majority hail from Puerto Rico, followed by residents originally from the Dominican Republic, Mexico, and Central America. One in five are foreign-born. Local Hispanic/Latino populations have contended with significant systemic barriers to employment and housing that have contributed to the highest proportion of residents living in poverty (37.3%) than any other racial/ethnic group in the city. This has driven poorer health outcomes, such as higher rates of chronic disease and mental health conditions than other racial demographic groups. Compounding these issues is an array of barriers to health care access, including language barriers, greater likelihood of lacking health insurance coverage than other groups, and higher unemployment rates that contribute to lower incomes and inability to afford health care. Fears related to immigration status and immigration law enforcement have been exacerbated in recent years, posing further barriers to seeking out health care.

These vulnerabilities have translated to communities that have been disproportionately impacted by the COVID-19 pandemic. A recent [data brief](#) catalogues the toll on Philadelphia Hispanic/Latino communities and the factors contributing to the highest age-adjusted rates of COVID-19 incidence, hospitalization, and mortality, and lowest testing rates of racial/ethnic groups in the city. These factors include greater likelihood of being employed in essential occupations, living in overcrowded conditions that are often multigenerational, and lacking a private vehicle (and consequent reliance on public transit or other means that increase the risk of transmission and reduced access to testing and health care services. The digital divide is particularly acute for this group.

The 2019 rCHNA incorporated insights about health needs for Hispanic/Latino communities collected for the assessment, as well as an assessment focused on the [health needs of communities in North Philadelphia](#) conducted in 2018. The current report provides summaries of primary data collection conducted in partnership with organizations serving Hispanic/Latino communities in Montgomery County.

[ACLAMO](#) is an organization based in Montgomery County that “provides educational programs, social services, and access to health and wellness programs to Latinos and other community members to empower them to fully achieve their life potential.” ACLAMO developed a survey to assess the health and well-being of Spanish-speaking communities in Montgomery County, with some focus on the impacts of the COVID-19 pandemic on these communities. HCIF provided assistance with questions and administered funding to support staff time on this project and provide gift cards to respondents. ACLAMO translated the survey into Spanish and conducted the survey with program participants in Lansdale, Norristown, and Pottstown from January – February 2022. The survey was administered as a structured interview with ACLAMO staff asking questions and recording responses. Frequencies for multiple choice and coded free response items are reported below. For items that were “check all that apply,” percentages may add up to greater than 100 percent.

The 126 responses collected were distributed across the three sites as follows:

County	Count	%
Lansdale	26	21%
Norristown	47	37%
Pottstown	53	42%
TOTAL	126	

Respondent Characteristics

Respondents were primarily female, between the ages of 30 and 49, and Hispanic/Latino/a. A large majority were Central American or Mexican American/Chicano. Most of the sample were married or living with a partner.

		N	%
Gender	Female	115	91%
	Male	8	6%
	Blank	2	2%
Age	20-29	15	12%
	30-39	52	41%
	40-49	42	33%
	≥ 50	17	14%
Race	Hispanic/Latino/a	124	98%
	Indian	1	1%
	White	1	1%
Ethnicity	Central American*	41	33%
	Dominican	5	4%
	Indian	1	1%
	Mexican American/Chicano	58	46%
	Puerto Rican	9	7%
	South American*	9	7%
	Blank	3	2%
Marital Status	Single	24	19%
	Legally married	65	52%
	Living together with a partner	26	21%
	Divorced	5	5%
	Widowed	4	3%
	Blank	2	2%

* If respondents indicated that they were Central or South American, they were asked to name their home country. Most common responses were Honduras, El Salvador, Guatemala, and Ecuador. Other countries represented with only one or two responses included Colombia, Costa Rica, Nicaragua, Peru, and Venezuela.

Household Characteristics

- Ninety-four percent of respondents indicated that they lived with others. Of those, over half (57%) said they lived with two other adults, while 16 percent lived with one other adult and 15 percent with three other adults.
- A majority of the sample had at least three children under the age of 18 at home: one (12%), two (32%), or three (26%).
- In the household, 98 percent of respondents reported being either a parent or grandparent.
- The language most spoken in households was Spanish (90%).

Health Status

- A majority of the sample reported fair (21%) or good (52%) health.
- In terms of diagnosed physical health conditions, responses were as follows:
 - Diabetes: 17% (with an additional 10% not sure)
 - Asthma: 13% (with an additional 7% not sure)
 - Hypertension: 16% (with an additional 6% not sure)
- Eight percent of respondents shared that they had been diagnosed with a mental health condition. Of those 10 respondents, 60 percent were receiving treatment for that condition.

Health Service Use

- Seventy-seven percent of the sample had used health services in the past 12 months. Those respondents indicated using the following health services (in order of frequency):
 - Primary care: 68%
 - Dental care: 58%
 - Emergency or urgent care: 29%
 - Sexual or reproductive health care: 23%
 - Hospital inpatient care: 12%
 - Psychological counseling: 12%
 - Home health care: 7%

- Thirteen percent of respondents shared that there was a time when they needed medical care in the past 12 months but did not get it. The reasons for not receiving this care by these respondents (n=16) were given as follows:
 - Difficulty scheduling an appointment: 81%
 - Difficulty affording medical care: 75%
 - Difficulty communicating with a provider: 69%
 - Not knowing where to go: 44%

Health Status

- Respondents indicated significant impacts of the COVID-19 pandemic on their lives, including childcare center/school closure (84%), work hour reduction (84%), income reduction (81%), and job loss (51%). Twenty-seven percent reported that a family member had to continue working outside the home as an essential worker, and 13 percent shared that they had to move out of their home.
- When asked about other impacts on their lives and health, respondents provided free responses, which were coded for themes. Of the 54 responses given, the most frequently reported negative impacts were related to:
 - General emotional and mental health: 46%
 - Finances and anxiety related to finances: 37%
 - Physical health: 9%
 - Family and friends: 7%

Health Barriers

- Survey participants were asked about potential barriers to health they may experience.
 - The biggest barriers to health expressed were related to finances: 46 percent reported being stressed about employment or money, and 41 percent said they could not afford what they needed to be healthy (with an additional 10 percent indicating that they were not sure). Twenty-nine percent shared that they experience racism and/or discrimination.
 - The sample reported having healthy food available near their homes (93%), feeling safe in their neighborhoods (90%), having the transportation needed to get to the doctor (82%), having reliable internet service (80%), and being able to access health care when they need it (79%).
 - When asked about problems not mentioned, 20 responses were gathered. Most frequently mentioned were lack of resources and help (30%), emotional or mental health issues (25%), physical health issues (20%), challenges with family (20%), and changes to life and routines (5%).
- Of the barriers to health presented, the top priorities for respondents (who selected up to four) were related to (in order of frequency of selection):
 - Availability of healthy food near their homes
 - Employment and money concerns
 - Having transportation to go to the doctor
 - Feeling safe in their neighborhoods
 - Having access to health care when they need it
 - Being able to afford what they need to be healthy

Food Security

- Three questions were asked to assess food security in the last 12 months:
 - Over a quarter of respondents (27%) reported skipping a meal because there was not enough money or resources to get food.
 - Seventeen percent shared that their household had run out of food because of a lack of money or other resources.
 - Five percent indicated that they had gone without eating for a whole day due to lack of money or other resources to get food.
- Sixty-five percent of the sample reported that they had received food from a food pantry or other organization in the past 12 months.

Family Priorities

Respondents selected up to four community services that were the most important for helping to keep them and their families healthy. In order of frequency, the most important services were:

- Housing or housing case management (e.g., tenant/landlord disputes, eviction)
- Immigration services
- Rental or utilities assistance
- Youth programs (afterschool) or childcare

Communication

When asked how they get information about health services and issues in their community, respondents selected up to four options. The most commonly selected option by far was one-on-one peer discussion/word of mouth. Other sources (in order of frequency) were:

- Facebook Live
- School or church
- Video or TV programs or commercials
- Pamphlets/brochures
- Billboards/public transportation advertisements

[Centro Cultural Latinos Unidos](#) (CCLU) supports Latino children, youth, and parents in Pottstown with educational, recreational, legal, and health services. CCLU convened a focus group composed of 13 clients and their children in November 2021. CCLU conducted the focus group in Spanish; the discussion was recorded, transcribed, and translated into English for coding and analysis. Key themes from the discussion include:

- **Lack of information or communication** about health resources, including where to go or what to do to stay healthy.
 - **Lack of health insurance** prevents people from going to see a doctor or going to a clinic *“without being rejected because we don’t have it.”* This lack of insurance also leads to high medical bills: *“I got sick and I had to pay tons of bills, and now they are sending me more. All because I don’t have health insurance. They said, ‘But, you don’t have insurance?’, and they said, ‘Unfortunately, you have to pay. You can pay cash, or you can use your credit card.’ It was harder because I was scared, because I didn’t have that amount...”*
 - Other barriers to health care access include **difficulty getting access to a physician, transportation barriers, and long waits for care** (*“over an hour, even if the pain is killing you”*), which can be due to a variety of causes: *“Well, you need to get a translator, they need to check you have health insurance, what’s covered by the insurance... it’s a long wait. And one is ill.”*
 - Others elaborated on issues with **language access**, including lack of interpreters. In some cases, children are asked to interpret: *“For example, when my son took ill, it was 1 a.m. I explained his symptoms to his doctors, and they said, ‘I didn’t understand you; we are going to refer you to X, it’s the only place with Spanish speakers. I can’t understand what you say.’ They were upset at me.... They would tell my son, who was in pain, ‘You need to translate what your mother said.’ I was angry. How could he translate when the pain was killing him?”*
 - **Inequitable treatment:** *“When we go to the hospital, they don’t treat us as they should.” “They make you wait. If you don’t speak English, they don’t treat you, or they treat you in the hall, while standing.”*
- **Impacts of the COVID-19 pandemic** were felt by adults and youth alike.
 - A participant shared that illness prevented her from working and consequently she didn’t have the money to pay rent, while a youth participant expressed her fear that missing so much school due to illness would mean that she would not be able to pass the eighth grade.
 - Others shared challenges with **access to vaccines:** *“Yes, for the vaccines, you had to wait a while, and they didn’t have many Spanish-speakers for the appointments. They made you phone a line, there, they referred you to another line, and no one could really tell you the time and day of your appointment. So, that took a long time. Then, when you had to go back for a check-up, there was no one there to provide the proper assistance. They didn’t do their job.”*
 - Referencing a clinic that was set up to facilitate vaccine access, one participant shared, *“It helped, but there’s more information needed on the status of the vaccination process, where they need to go, if it’s appropriate or not.”* The need for more accessible, reliable sources of information was widely endorsed: *“Something that would make us feel safer would be having more information. Maybe a fixed hotline we could call to get reliable information.”*
 - Potential solutions include **offering affordable transportation to care, “pro bono” doctors** (those who can treat people without asking for their medical insurance, their social security information: *“They shouldn’t ask where you come from, if you have insurance or not. They just should accept you.”*), and doctors (including specialists) and doctors who are Hispanic or speak Spanish.

YOUTH VOICE

Children and youth represent a population with diverse health needs and unique vulnerabilities that require urgent attention in order to prevent lifelong negative repercussions and maximize the potential for growth and thriving.

Unfortunately, the barriers to well-being for all children and youth in the region are significant, as many families across the five counties [struggle with economic stability to support their children](#), and racial and ethnic inequities related to [education](#) and [health outcomes](#) persist. The negative impacts of the COVID-19 pandemic and response on youth learning and development and a [wide array of issues like housing and health](#) are increasingly being documented

Against this backdrop, to facilitate understanding of health issues specific to children and youth, several types of inputs are represented in the report, including:

- Quantitative data on youth (middle and high school student) behavior related to mental health and substance use presented in the county profiles
- Qualitative information about the needs of children and youth from birth to age 18 gathered in each geographic community conversation and spotlight discussion (see individual summaries throughout the report).

In addition, the Steering Committee sought to hear directly from youth (ages 11-25) to ensure robust inclusion of youth voice in the rCHNA. A subset of participating health systems (Children's Hospital of Philadelphia, Einstein Healthcare Network, Main Line Health, Penn Medicine, and Trinity Health Mid-Atlantic) formed a committee to guide the development of this data collection process, which centered on the engagement of youth-serving organizations and programs based in the five-county region. Specifically, program leads were presented with an opportunity to facilitate discussions with youth participants about youths' perceptions of community assets and barriers to health, health needs specific to youth, and ideas for potential solutions. All organizations received funding to hold these discussions, and youth participants received gift cards for their time.

From an initial list generated by subcommittee members, additional outreach was conducted through existing networks (e.g., Greater Philadelphia Extracurricular Collaborative, Philadelphia Youth Sports Collaborative). Twenty-five organizations were engaged to participate in this data collection, representing youth in Bucks, Chester, Delaware, Montgomery, and Philadelphia counties:

Falcons 215

[After School Activities Partnerships \(ASAP\)](#)

[Black Women in Sport Foundation](#)

[Born With Purpose](#)

[Caring People Alliance](#)

[Children's Hospital of Philadelphia Adolescent Initiative](#)

[Focused Athletics](#)

[Ivy Hill Youth Association](#)

[La Liga del Barrio](#)

[Liberty Youth Athletic Association](#)

[Lutheran Settlement House](#)

[Mercy Neighborhood Ministries](#)

[National Network for Youth / Valley Youth House \(Montgomery County\)](#)

[Open Door Abuse Awareness Prevention](#)

[Parent Power](#)

[Philadelphia Chinatown Development Corporation](#)

[Philadelphia City Rowing](#)

[Philadelphia Robotics Coalition](#)

[Philly Teen VAXX Ambassadors](#)

[Starfinder Foundation](#)

[Sunrise of Philadelphia](#)

[The Common Place](#)

[United Philly Soccer](#)

[University of Pennsylvania Netter Center for Community Partnerships](#)

[Youth Mentoring Partnership](#)

About a third of organizations offer sports programming to youth, in addition to other educational and enrichment support, including mentoring and coaching. Others provide out-of-school-time programs, offering a variety of arts-based, educational/tutoring, and youth leadership development programming.

A total of 354 youth participated in 34 discussions held in November 2021 – February 2022. These discussions were conducted both virtually and in-person, at the discretion of the organization, and facilitated by trusted program leaders and staff. Discussions ranged from 30 to 129 minutes, with an average length of approximately 60 minutes. The age distribution of participants is as shown below:

Age	Count	%
<13	33	9.3%
13-15	170	48.0%
16-18	117	33.1%
19-22	24	6.8%
>22	6	1.7%
Missing	4	1.1%
Total	354	

Geographic representation was as follows:

County	# of groups
Bucks	1
Chester	3
Delaware	2
Montgomery	2
Philadelphia	29

NOTE: The number of groups does not add up to 34, as some groups included representatives from multiple counties.

Within Philadelphia, most groups represented either North or West Philadelphia. Residents of Southwest Philadelphia, Center City (including Chinatown), South Philadelphia, Northeast Philadelphia, and Northwest Philadelphia were also represented across the groups. One group included representatives from South New Jersey as well.

Facilitators were given a discussion guide with six questions and suggested prompts (see online Appendix) and provided additional guidance as requested. Facilitators were supported by note takers and, in some instances, opted to record the discussion to capture specific quotes from participants. Organizations summarized the discussion using a report-back form that was provided to them and, where appropriate, submitted additional materials such as notes or sign-in sheets. Based on the report-back form submissions and additional materials, responses were coded for key themes. Frequency of mention across discussions was calculated as a percentage based on 30 submitted reports (some organizations opted to combine multiple discussions into a single report). Since multiple themes were discussed in each group, percentages total over 100%. The themes, percentages, and, where appropriate, illustrative quotes from the discussions are presented on the following pages.

Community Assets

Youth identified the following as key resources and assets that make their communities healthier:

Theme	%	Description and Examples
Connections/mutual support	47%	Participants cited the importance of cohesive, community bonds/relationships and support networks for health. These connections enable community members to be accountable to one another, as several groups valued being able to “watch out” for and check in on one another. Those “willing to take the journey with you” and who “you can count on” are sources of motivation, inspiration, and “cheerleading.” By confiding in one other and acknowledging shared struggles, these strong networks provide mutual care , and foster a sense of belonging and inclusion .
Community spaces/ organizations	33%	Youth frequently noted the importance of spaces like recreation centers and outdoor greenspace (e.g., parks, running trails) in promoting health. These represent not only a space for physical activity and sports, but as important, safe places for community gathering . Participants also noted the need for spaces for creative exploration and expression , as well as the critical role played by local non-profit organizations, faith-based organizations, and businesses in creating a thriving community.
Shared values/mindset	30%	Youth participants underscored the value of shared values and positive mindset for community health. They repeatedly mentioned values related to diversity, unity, freedom, voice, acceptance, inclusion, respect, and collaboration as essential.
Supports for healthy eating	30%	Quite a few group discussions had a strong emphasis on the need for supports for healthy eating. Though youth noted a few existing supports (e.g., school lunches, grocery stores), they also noted the need for support through the growth of resources like farmers markets and produce trucks .
Health resources	27%	Youth recognized the contributions of facilities like pharmacies (especially in light of the COVID-19 pandemic) and health care professionals (including mental health care providers and dentists) in fostering health. Mental health supports were of particularly interest for participants.
Leaders and role models	27%	Participants cited the crucial role of trusted community leaders and adults in their lives who can serve as positive role models and mentors . These include teachers, coaches, counselors, and community police officers who demonstrate that “they care.”
Community activities	27%	Opportunities to connect as a community through community clean ups, donation drives, and cookouts were mentioned by youth participants as positive influences on community health.
School and extracurricular programs	23%	Participants strongly endorsed the role of school-based and extracurricular programs in supporting health. These programs included sports and other afterschool programs that provide opportunities for building connections between youth, fostering social emotional learning , and enabling creative expression .
Supports for physical activity	17%	Participants discussed the importance of fostering opportunities for physical activity more generally, beyond the mention of specific facilities like recreation centers, gyms, or outdoor spaces.
Clean, safe environments	13%	Several groups noted the need to ensure neighborhood and school environments are clean and safe . Safety encompassed protection from air pollution or mold/asbestos in schools , as well as more generally from physical, emotional, or psychological harm .

Community Needs

Participants were asked to share the biggest challenges and barriers to health in their communities:

Theme	%	Description and Examples	Illustrative Quotes
Violence and safety	67%	A predominant concern for youth was the rampant violence in their communities. This is largely in the form of gun violence , but participants also cited instances of interpersonal violence . Youth mentioned fight in schools, police brutality, and gangs in association with violence. For youth of Asian descent, fear of anti-Asian hate crimes was significant. This threat of violence had cascading impacts on youth, both direct and indirect, resulting in not feeling safe enough to go to parks or work out outside . This fear also has a strong negative impact on mental health through experience of toxic stress .	<p><i>"Gun violence...We all know that we were on track to break the record for the most homicides in a year, and I know that it was a lot of killing going on and I know a lot of people affected by it. And I just wanted to say that's a big problem because...we're losing people and people are losing their lives all over dumb stuff like a simple argument or even things that people shouldn't be doing like drug deals, stuff like that."</i></p> <p><i>"There needs to be better gun control. Like everyone – anybody can handle a gun at this point. There's some crazy people out there that just go straight to the killing and not really any solutions."</i></p> <p><i>"And it makes me even more feel some type of way because I cannot wait to move out of Philly and I grew up here. And things, when I was growing up, wasn't like this at all. They do have violence here and there but nothing like this."</i></p>
Food	50%	Participants were concerned about the lack of access to healthy foods in their communities and food insecurity . Many noted the easy access to cheaper fast food and unhealthy foods in corner stores, with supermarkets being further away and less accessible without a car. Youth were interested in increasing access to fresh produce and <i>"good-tasting, nutritious food that will fuel kids for the day."</i>	<p><i>"A lot of people don't have access to healthy food. And so a change I think should be made is one that promotes access to healthy food. Because food insecurity is not only access to food at all but access to food that is healthy and benefits you rather than harms you."</i></p> <p><i>"I think changes, like really big changes such as Pennsylvania has a P-EBT, like all of those benefits have helped my family at least, because during the pandemic one of my parents actually lost their job. And my other parent was affected significantly, because her job involves like, a more person-to-person thing. And she was unable to do that obviously because the COVID-19, which caused us to be in a weird financial situation, so benefits such as P-EBT and Pennsylvania's support has been really helpful. Those changes, I think, were like some of the biggest ones in my family."</i></p>

<p>Mental health</p>	<p>50%</p>	<p>Mental health is a pressing issue for youth. Participants shared the multiple factors influencing mental health in their communities, including concerns about violence and safety as mentioned above and the impact of COVID-19 pandemic stay-at-home orders. Youth frequently mentioned their experience of stress. For example, some cited generational trauma and toxic stress associated with directly experiencing AND living in communities contending with racism, poverty, violence, or substance use. Others cited the challenges of balancing competing demands of schoolwork and parental expectations. Compounding these factors are issues related to stigma associated with mental health concerns in some communities of color and challenges with accessing mental health supports and treatment (lack of awareness of available resources, not being able to get timely appointments, affordability). There is a sense that youth mental health concerns are not taken seriously by adults in their lives, with some telling themselves that <i>"it's not that bad"</i> and getting the message that they should <i>"keep going, you will be alright, get over it."</i></p>	<p><i>"For physical health, people are a lot more willing to go to doctors and learn about their challenges but with their mental health there is a certain stigma, and they don't want to talk about their issues."</i></p> <p><i>"In the community, trauma builds up. That's why they reflect also the trauma..."</i></p> <p><i>"Even though resources are available for mental health support, there is a stigma, especially in the Asian community where one can go for help and not feel judged. People may not get help because of the stigma."</i></p> <p><i>"The Black community does not think that mental health is a thing."</i></p>
<p>Substance use</p>	<p>33%</p>	<p>Participants shared the impact of substance use in their communities, including drug addiction and overdose and peer pressure related to smoking and alcohol use. For several groups, drugs were mentioned in association with violence in their communities.</p>	<p><i>"I wanna throw in instead of like the strengths, I would say the weakness like drugs especially in Philly like in Kensington areas are horrible."</i></p>
<p>Environment</p>	<p>30%</p>	<p>Youth noted the negative impacts of pollution and lack of trees and greenspace in their communities. Several groups were particularly concerned about the presence of trash in public areas and illegal dumping in their communities.</p>	<p><i>"A challenge that we face is people taking advantage of the community and littering and putting trash everywhere basically."</i></p>

Racism and inequity	27%	<p>Racism and resulting inequities in health, as well as inequity arising from discrimination based on other identities (e.g., gender, sexual orientation, ability, intersectional), were of great concern to youth participants. Disparities in COVID-19 outcomes, differing levels of investment in certain communities, associated socioeconomic disparities, and hate crimes were raised in these discussions.</p>	<p><i>"Within health care, there's a lot of discrimination based on color and sexual orientation, which is crazy, because that affects a person's health. Also one thing for individuals who are part of LGBTQ, doesn't really trust...doesn't receive the right medical care. And within the Black community, 37 percent of Black women don't really trust the health community. So I think that ties into being a part of the Black community and being part of the LGBTQ+ community."</i></p> <p><i>"Looking back to the past few years, as a young person going through taken out of school, no vaccine to begin with, seeing Black people that look like you getting murdered, seeing an uprising on TV and try to focus on academics, trying to work, go to college - going through these things and not enough time to process and trying to push through saying 'it's not that bad.' Then thinking about 'Even with access to vaccines and mental health resources it's still very hard to keep going and go get the vaccine and mental health."</i></p>
Housing/ neighborhoods	23%	<p>Several groups discussed lack of affordable housing in communities, housing insecurity, homelessness, the impact of gentrification, and the lack of sustained investment in neighborhoods. One group discussed the interrelationship between lack of housing and mental health concerns.</p>	<p><i>"Homeless people being out on the street 24/7."</i></p> <p><i>"I'd like to change the gentrification of the neighborhoods."</i></p>
Resource information and navigation	23%	<p>Youth shared challenges related to getting information about available health resources and navigating systems to obtain these resources. They expressed a desire for clear communication and education about these resources. They advised potentially using social media and adopting positive, youth-focused approaches to reach youth with health information and messages.</p>	<p><i>"Maybe more of like advertising things that aren't bad. Like, for example, everywhere I go...we see a lot of posters everywhere but it's all advertising parties and nothing is really advertising like yoga classes or meetings like this that we can actually put our input in. I feel like it's very limited to...this information to who we can extend it to. I'm pretty sure there are parents who would love to join and give their input...Being more vocal about the good things and the little things."</i></p>

<p>COVID-related concerns</p>	<p>17%</p>	<p>The COVID-19 pandemic had and continues to have a significant impact on youth and their communities. The stay-at-home orders associated with the pandemic negatively impacted youth mental and physical health. In addition, the challenges associated with vaccines and masking in schools persist, leading to a great deal of confusion with changing rules and eroding trust in adults.</p>	<p><i>"...the thing is that with the pandemic, especially during like the more harsh periods of the pandemic, I don't think anyone can learn during virtual learning at all. Like the majority of students who are more hands on or like who are definitely more used to in-person learning definitely had a hard time, and now they're having an even harder time adapting to school that's going back in person and it just feels like we're all behind. And it's very easy to feel overwhelmed, especially for those with a lot of responsibilities at home as well."</i></p> <p><i>"My mental health and emotional health were affected because of fear of getting sick and being angry that people would not get vaccinated and might inconvenience them but do good for the community's health."</i></p> <p><i>"I used to not talk to people and now I do because I needed to because of being lonely and I got more comfortable with new people. But now I get highly anxious by the lack of people but also having people around, because I am concerned for my family's health and I am concerned about people's view on the vaccine. I am afraid of saying something if I say I support the vaccine. Will that turn people against me?"</i></p>
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<p>Interpersonal dynamics and communication</p>	<p>23%</p>	<p>Several groups were concerned with negative interpersonal dynamics and communication in their communities. Some cited the detrimental effects of “toxic” attitudes, disrespect, comments that impact body image, and making assumptions. Some of these negative dynamics can play out on social media. Other youth shared that sometimes they experienced language barriers and that there were no spaces to express themselves and foster meaningful, deep connections among community members.</p>	<p><i>“...Most of the issues is basically people not communicating with each other as much as they should be or like not understanding where the other person is coming from in order for them to help...”</i></p> <p><i>“People not being able to understand someone else’s opinion...it’s like when you don’t understand it creates conflicts. It will not be a healthy community.”</i></p> <p><i>“...people don’t want to change what they’ve been doing for periods of time, it’s what they’re used to. So if you have like something new or you want to change what’s going on, it’s like an issue and then it becomes like a big problem. And they tend to go on... people aren’t getting heard, no one’s understanding what others are saying...down to it is people who undermine others and don’t try to listen on other people’s issues.”</i></p>
<p>Transportation</p>	<p>17%</p>	<p>Some participants shared barriers to accessing transportation, even with critical needs like attending school and going to medical appointments. The main issues include lack of available, affordable options.</p>	<p><i>“I would use Transnet [a program by Medicaid] but you need to schedule in advance. If you have something urgent it’s hard to get there. For example, when I was pregnant and going into labor, I called and couldn’t get a ride.”</i></p>
<p>Health care access</p>	<p>17%</p>	<p>Youth brought up challenges with accessibility and affordability of health care. The lack of free clinics, the significant distance needed to be traveled for some facilities (or, put differently, few options close by), low appointment availability, long wait times, lack of insurance, and high costs of deductibles were particularly noted. Related to other needs raised, lack of knowledge of available resources where they can go without parents and are free was shared.</p>	<p><i>“Yeah, like, my dad, he works for himself. He has his own business and he doesn’t have insurance and he got hurt working ‘cause he’s a construction worker and like, he’s been – his back is like really bad and I’m like, ‘Are you going to the doctor?’ ‘No, it’s too much. I’m gonna have to tough it out.’ And I think that’s kind of messed up ‘cause he’s doing all this work and he can’t even – he can’t afford insurance ‘cause he has three daughters, so, it’s just a lot.”</i></p> <p><i>“...so, with difficulty accessing mental health, I think that mental health resources, like I think it’s hard to find providers, and like to pay for it too. I have personal experience with this, like I was trying to find with my mom, but a lot of places are either just like - there wasn’t like enough staff. And some of them just didn’t pick up - they had like a waitlist. So, it was just very hard to find like - to get access to help. So, I think that should be improved.”</i></p> <p><i>“I have been to the emergency a few times and each time it was more than a 2-hour wait.”</i></p>

Youth Needs

The main issues for health for youth (with particular prompts related to health care) were shared as follows:

Theme	%	Description and Examples	Illustrative Quotes
Mental health	60%	<p>Similar to what was expressed related to mental health needs in their communities, youth shared with greater intensity their own experiences with stress, pressure, and burnout. Depression, anxiety, and trauma due to the COVID-19 pandemic and community violence were widely shared across groups. A theme of balancing between school, parental expectations, other responsibilities, and social life was consistent across several groups. Other sources of stress and toxicity include expectations around physical appearance and beauty, often exacerbated by social media. Challenges of not talking about mental health issues due to stigma and accessing mental health resources like therapy (long wait times for appointments, limited number of therapists within insurance networks, difficulty finding information, need for parental consent, lack of affordable options) were also raised by participants.</p>	<p><i>"I said the most important issues when it comes to youth nowadays, was mental health. Although COVID-19 does affect our physical health quite a bit I feel like mental issues right now are more prevalent, because as we're starting to like go back and forth between the COVID restrictions. I feel like...it's a lot easier for everyone, especially the youth, to feel overwhelmed. Especially how like earlier, she talked about how her friend was getting overwhelmed with schoolwork. I feel like the pandemic and the two years of completely virtual school has like really made it hard for us to get used to our pace when it comes to schoolwork, and academics, and extracurriculars now that we're like starting to uplift those restrictions. It's really hard to keep up with everything when you haven't done it at all for like two years, and it's like quite abrupt as well."</i></p> <p><i>"On the subject of mental health, a lot of the times people my age will joke about it... it's become such a...maybe convenient or casual topic that you can't ever really tell when someone's serious about something. Like it's just hard to determine who actually needs help."</i></p> <p><i>"I have heard people call our generation the generation of mental health. Some people in the older generation don't take it as seriously as it's supposed to be. They think that it's just 'oh, you're sad...go to church, go pray, go read the Bible'—it's always the same answer. So I think our biggest issue is mental health as the younger generation."</i></p> <p><i>"How things are portrayed toward youth. I feel like we see a lot of things, pick up on a lot of things that we shouldn't, like body health or people trying to be things that they're not and it'll turn out bad for them...like anorexia or especially with the oversized community. Because I feel like people equal health as in you're not bigger but in all actuality, you can be healthy in any size, and I feel like that targets children more than it should."</i></p> <p><i>"It's not always easy to talk to people, like actually have a conversation about your mental health with everybody because not everybody's gonna care...it's been times where I've actually tried to talk to somebody about my mental health and they just like 'I don't care.' So with that, you shut down and you don't wanna talk to anybody because you feel like you can't talk to anybody."</i></p> <p><i>"Doctors prescribing [psychiatric] medication to kids rather than looking deeper into a situation. In school, teachers suspending kids rather than talking to them."</i></p>

Violence and safety	40%	<p>Like the discussion of violence and safety in their communities, youth brought up the impact of widespread gun violence/ easy access to guns on their feelings of safety. They shared that they want to have safer options for being outside and active. Trauma and concerns that “they will die either by the virus or gun violence” were expressed. Some youth expressed a desire to find out how to respond to racist violence without resorting to violence themselves. Cyberbullying was also raised as another form of violence experienced by youth.</p>	<p><i>“There’s something traumatizing about exiting a train station and seeing someone being carjacked at knifepoint does something to you and having to walk past things like that on your way to school is super problematic.”</i></p> <p><i>“And it’s like, when I was younger, back in like middle school and elementary school days, it was not like that. Like, I could go to a park and it’s a lot of people there. I don’t have to worry about running into a gang or seeing a group of kids with black hoodies on, walking around, messing with people or starting stuff. It’s like, I don’t have to worry about that. I went to the park, played and went home safely. And now, it’s like, ‘cause I walk home, you know, from school but I change my route every single time going home. Like I can take three different routes in walking home to get to my house just so I make sure that I’m not being followed or no one’s coming from behind me. Like, I’m very aware, especially now that I’m further away, like, walking from West Philly to Southwest, I’m just more aware of my surroundings.”</i></p> <p><i>“A while back when I was sitting with some people that I called friends, people started driving up slowly in black cars with tinted windows. I told them we should leave. They were like no its fine. I left. They rolled down the windows and started shooting. Two to three people died at that party. Everyone started running but I had a head start. You can’t even sit at a park anymore.”</i></p>
Health care access	30%	<p>The major points across discussions related to health care access emphasized challenges with getting the right information about available health care resources and how to access them, understanding and navigating confusing systems, and managing insurance (and related cost issues, to be discussed below). Participants raised challenges with not getting navigational support from providers, as well as quality issues stemming potentially from bias/ stereotyping and lack of staffing. The issue of a local hospital closing was also mentioned.</p>	<p><i>“I think that for the Black community, it’s very hard to see a doctor, especially given the...current and past racial discrimination within the medical field. It’s very hard for Black people to say, ‘oh I’m gonna go to the doctor to get a checkup’ or ‘oh I’m gonna go to the doctor because I have X, Y, and Z medical condition.’ ‘I’ll figure it out on my own, I’ll be fine, I’ll use these natural resources’...I’m going to go to a hospital that’s not gonna give me the same care because of my skin color?—absolutely not! Just not being able to see doctors in that position that look like us, it discourages you from going.”</i></p> <p><i>“It’s hard to get myself to get meds.”</i></p>
Social needs	30%	<p>The most commonly cited social needs raised were related to food (access to healthy foods), housing, financial instability, and transportation.</p>	<p><i>“I know a lot of people who...had to hurt other people to make sure their family was ok. So when I think about health in my community, I think like financially, making sure everyone is cool so they don’t have to hurt other people so that their family can eat and can have food for the household...”</i></p>

Substance use	27%	Ready access to drugs, alcohol, cigarettes, and vapes was raised by several groups, leading to problems with addiction. One group raised that use of such substances was a coping mechanism for stress and pressure.	<i>"And I feel like anybody could get vape. It's like so easy. It's not like they need to make the like age limit to where you can smoke or a little bit higher so that people can – no kids can buy it and have more education in schools about that type of stuff. Like nobody knows that vaping is way worse than cigarettes and it's like killing your lungs faster than cigarettes did to the organs, that we all see people dying from lung cancer and having like cold and then burns."</i>
Need: Supportive adults	23%	The need for supportive adults in youths' lives was mentioned several times across groups. The important role of these adults as volunteer mentors, positive and responsible role models, and "trusted people that they can go to in order to discuss things" was emphasized by youth, especially to provide support and a sense of safety for difficult or uncomfortable issues they may be experiencing. Youth shared a sense of feeling "let down" by adults at school due to lack of nurses and medical staff; lack of timely and supportive response from security personnel, teachers, and police to violence and bullying; and a lack of mentorship.	<i>"I would say that something we're missing in our community is responsible role models or good role models for the youth, you know. Because it's easy to go out there and just be out and doing whatever you want to do, but when you go out and all you see, you know, is people doing the wrong thing, you know, it's hard to see people doing the wrong thing and not do it yourself 'cause it's even more difficult to know what you're supposed to be doing..."</i> <i>"Probably like more encouragement for youth to stand up for themselves, and just like encouragement from their parents, encouragement from teachers, because a lot of times when they don't say anything or like they just let it slide by, it's like you're kind of like giving up on a child..."</i> <i>"Counselors mainly just help you get into college, but don't wanna talk about your feelings."</i>
Physical health	20%	In contrast to their responses to questions about community needs, youth did raise a few points about physical health issues experienced by youth. Several pointed out obesity and lack of sleep being prevalent across youth. One group shared the importance of greater awareness of chronic conditions affecting youth and increasing support for such conditions.	<i>"I think physical health is also important. Many of my peers don't sleep much because of too much school work."</i>
Need: Communication/connection	20%	Several groups noted the importance of efforts related to increased and improved communication between peers and with adults. Youth across groups shared challenges with socializing (including experiencing anxiety), communicating with new friends, and feeling lonely and disconnected as a result. The negative impact of communicating through social media was also mentioned.	<i>"And then like just a lot of face-to-face interaction, and also like text each other, I guess, but not as much as right now. But then right now, because of how advanced technology is, there's so many social media apps that you can use to communicate with each other. And also, because of COVID, you kind of like - I see some youth be kind of like lost the way of...just like being able to communicate with others."</i>

<p>Need: Wellness supports for youth</p>	<p>13%</p>	<p>A number of discussions mentioned the need for more general resources for youth mental and physical wellness. These could include informational resources, social or emotional wellness resources, or creation of spaces or activities where they can be free, safe, and have fun.</p>	<p><i>"I think it's habits, like we - like young people...are like learning about stuff they need to do - they can do better to help themselves keep themselves healthy. But...like once you have bad habits over time, and it's really hard to change those."</i></p> <p><i>"I think I'd say especially rec centers. 'cause one thing I know that makes me stressed is my work so I want tutoring but I want affordable tutoring or even free, 'cause in my area everything is so expensive and I don't get that because a majority of minorities can't afford that."</i></p>
<p>Cost of health care</p>	<p>13%</p>	<p>In addition to issues with health care access noted above, several groups discussed the impact of insurance coverage limitations and high costs associated with specialty care and therapy.</p>	<p><i>"I was at the doctors and somebody was just talking about like trying to get on birth control and I overheard the doctor say, 'Well, your insurance doesn't cover this, so, you can't get on it.' And they was like just telling her, like, 'Just keep using condoms.' And stuff like that. And I just feel like, and for females, like, that's just like us having to pay for - pay for pads. Why should we have to pay for something that we can't control our period? So, I just feel like pads should be free and if somebody wants to get on birth control, they need birth control, they should just get it for free."</i></p>
<p>Youth autonomy, decision-making, and voice</p>	<p>10%</p>	<p>The importance of youth voice and autonomy for health-related decision-making was emphasized by a few groups. Instead of telling them what to do, providing relevant information so that they can make informed decisions was preferred by youth.</p>	<p><i>"When you bring to them [elder people] your problems, they're gonna try to tell you things that the way they see it. I'm telling you that I see it this way and you're trying to tell me to see it that way, so we're not going to get like the solution. When I bring to you the problem, you should sit down with me and we should discuss it, like what can we do to solve it. The elder people sometime they think that they know everything and they don't want to listen to us and our own opinion."</i></p>
<p>Sexual health</p>	<p>10%</p>	<p>A few groups raised that issues of sexual health were specific to youth, especially as they are experiencing puberty.</p>	<p><i>"In terms of the female community, with like both mental health and physical health, I think that like better sex education in schools is something that's really important. And sex education that is updated to like our modern perceptions of gender and sexuality. I think that's something that's really important for improving both the mental and physical sexual health of especially teenagers, and especially women and people in the LGBTQ community. Because good education can sort of combat stereotypes which can be very harmful like both mentally and physically to people in those communities."</i></p>

Potential Solutions

Participants contributed ideas for potential solutions for improving health for youth and their communities:

Theme	%	Description and Examples	Illustrative Quotes
Social needs	53%	Youth shared ideas for improving food access (e.g., food delivery/car services to increase accessibility for those particularly in need), building affordable housing and providing more resources to those experiencing homelessness, making transportation options more accessible , and providing workforce development and employment opportunities.	<i>"Housing... definitely housing because there's many buildings that could be rebuilt that's in Philly that aren't used and that could be used for housing. But also equity within housing. Equity in jobs. And education."</i>
Mental health supports	50%	Participants offered many creative ideas for providing mental health supports in the community and in schools. Increased access to mental health professionals (counselors, therapists) in community settings, as well as in schools was raised. Peer advocates and teen mentors supporting mental health were also suggested. Youth had ideas for creating spaces for openly talking about mental health (including as a student-led club), as well as measures schools could adopt (periodic anonymous mental health check ins, mental health periods, mini-breaks, or wellness days, mental health days off, de-stressing equipment like weighted blankets in a room focused on wellness). Other ideas included providing workshops on self-care that offer tools such as meditation, as well as campaigns with messages to raise awareness of the body neutrality movement. Youth viewed these efforts as all serving to normalize and destigmatize mental health issues, with some noting the importance of educating parents. It was also emphasized that mental health supports should be free or low cost to increase accessibility.	<p><i>"I said this before, but just like getting more access to mental health resources. I guess, maybe, like giving schools - having schools have more counselors so that students can talk to them."</i></p> <p><i>"A lot of our youth and even the young adults and adults period have gone through a traumatic experience so just having that trauma-informed care..."</i></p> <p><i>"Certain groups where you can just sit and listen to someone talk. Because a lot of the times people treat their disorders so casually that if you just let them speak they'll go to rambling on and start revealing things that they would have never said if they were actually paying attention. So you should sit and listen to people sometimes...and you never know what they're gonna say, as long as you're just quiet you listen they can talk on and on and you'll actually find something out that you can see if you could help them with."</i></p> <p><i>"I would try to like "casualize" therapy because it seems like therapy is such a taboo. Like everybody's like, oh, if you go to therapy you're crazy or therapy is not for you, you don't need it...I would try to normalize therapy, casualize it, casualize talking about mental health in a positive way... And to make group therapy sessions and things like that and have communication, instead of having like someone says something and it doesn't get heard by someone else, things like that."</i></p>

<p>Safety</p>	<p>43%</p>	<p>Youth noted several strategies to potentially increase safety in play areas and neighborhoods (e.g., cameras, officials and other monitoring of playgrounds). To stop gun violence, participants mentioned gun control to get guns off streets. Others suggested building capacity for healthy conflict resolution and creating positive outlets for arguments or anger. Youth discussed the role of police (increasing numbers, having more officers who “look like me”) and strengthening community policing.</p>	<p><i>“Better gun protection laws...who’s accessing this type of stuff? How they’re getting their hands on it and how can we make it safer for those communities so that people who may not be in the right state having access to this type of stuff, or children getting access to it. What we can do to protect ourselves and others, along with the children in the neighborhood getting access to this type of stuff. Better safety measures.”</i></p> <p><i>“I think definitely fixing up Germantown but not pushing out people that lived in Germantown. But fixing it up to a point that it feels like a stable environment. I don’t want to say more police around Germantown because that wouldn’t help but doing something that would help prevent violence.”</i></p> <p><i>“Our police are a major part of this community and they have a lot to do with the interactions between the community and them and so trying to strengthen those community relations and realize that every single cop that you see is not necessarily a bad cop....Just strengthening community policing would be major for communities in general.”</i></p>
<p>Community activities/facilities</p>	<p>43%</p>	<p>Participants felt that increasing community activities like clean ups and social events, as well as facilities like recreation centers or skating rinks, would improve health in their communities. In particular, they emphasized creating safe spaces for youth, such as community gardens, or events like sports tournaments. Such gathering places could offer health-related programming. One group discussed a one-stop-shop for youth to get services and assistance with navigating complex systems, as well as connect with other youth.</p>	<p><i>“I will like kind of say what you said, like community service. And I feel like our biggest issue may be ...the many homeless people that you see out there, there’s probably like, as I came here today I probably seen like 10 homeless there, I always see every day. And I feel like we as community could do... what is it like donation to give out food and stuff and clothes since there’s also COVID so it’s like obviously, they’re affected by all this COVID and stuff. And like me and my friends during COVID we actually planned out and made food, and then we surprised homeless people, we drove around South Philly or North Philly and stuff, we just gave out food. So, I feel like if our community do that, I feel like we could get more people, more homeless out the streets and stuff.”</i></p> <p><i>“I would say like more recreation centers around the community to like keep kids off the street, stuff like that.”</i></p> <p><i>“I want somewhere where I can feel safe....I want somewhere where everybody’s gonna accept me for who I am and not just look at me for, she has an accent, she’s from that place. I want them to see me for who I am and not from where I’m from or how I’m different. I just want them to see me for me.”</i></p>

<p>School and extracurricular programs</p>	<p>43%</p>	<p>The potential to create and offer more clubs to cultivate hobbies, programs to encourage self-development, classes to build life skills, and sports activities to foster social emotional learning was very appealing to youth participants. They emphasized that it was important that the programs be fun and foster connection with others.</p>	<p><i>"I feel like afterschool programs, like, [name] said, she said, not all kids like school but at least, if they know that they could go to basketball practice once the school day is out, they'll give them a motivation or a reason to come to school and to do their schoolwork and do good so that they can stay on their basketball team."</i></p> <p><i>"A lot more programs and stuff but more specifically free programs because the poverty in Philadelphia is like really high and so a lot of people can't afford a lot of things. And so I would say a lot more free programs that people can join because I've noticed that when youth aren't a part of a program or a job or just like not doing anything with themselves, they more so get in a lot more violence and more drama, gun violence and all that type stuff that they could avoid. But since they're not a part of anything they're more so to be in it. And so if there's more free programs for them to join they have more opportunities to find something that they like to do or something that like interests them or something like makes them happy to do."</i></p> <p><i>"Youth in developmental workshops, getting your own sense of identity, just to know that there are things out there, putting youth on different podcasts, different things like that... to just see what out's there in the world."</i></p>
<p>Supportive adults</p>	<p>33%</p>	<p>As raised in responses to an earlier question, the importance of supportive adults in youths' lives cannot be overstated. Again, participants expressed a strong desire for strong community leaders, community volunteers, positive role models, and mentors to help keep them "safe and off the streets." In addition to "teachers who care" (ideally hired from the community), youth offered an idea for building connections with police in schools, as well as thoughts around providing training to adults working with youth on social emotional learning. In addition, one group discussed educating parents on conversations about race and gender.</p>	<p><i>"I guess like in my school community, like once I talked to one of my counselors, it took me a long time. It was like after I went through a really hard time, I didn't talk to her during that hard time. But then it was like after with college applications, which I'm doing right now. And then I started talking to her about problems that I had in the past, and then she was - it was like really helpful and she really made me feel a lot better. And so, I guess, just like counselors in schools, like in school communities work really well."</i></p> <p><i>"Definitely partnering up with schools and being more vocal about females...about our body parts, menstrual cycles, what can we take including herbal things, that could be brought into health. Having the nurses not be in the nurse office and to come check. 'Cause I'm pretty sure there's a lot of students that I knew I grew up would not just really care about themselves because they were suffering from depression from home and their parents didn't check up on them.... So I feel like...the way that you take care of yourself root from childhood."</i></p>

<p>Health care access and affordability</p>	<p>30%</p>	<p>Consistent with responses to earlier questions, youth shared the need for financial and navigational supports when seeking to access health care. The need for more affordable and accessible health care facilities, such as neighborhood clinics, was emphasized. The qualities of health care providers are also important – increasing representation of people of color and diverse gender identities, as well as hiring/training providers who are committed to providing equitable care, was suggested by participants.</p>	<p><i>“Uniformly having providers accessible especially those who are people of color, and/or Queer.”</i></p>
<p>Support systems and resources</p>	<p>23%</p>	<p>From a general perspective, youth are in need of support systems that are integrated and help them connect to needed resources. Similar to health care, youth need help finding out about available resources for other needs and ultimately connecting with them. This was particularly noted for immigrant communities who may be contending with language barriers and fear/anxiety related to asking for help. Some suggested school-based support systems, while others discussed community-based systems that seek to ensure services provided are widely known, accessible, and effective. Some youth suggested culturally relevant public education and awareness campaigns to spread the word about these systems and resources.</p>	<p><i>“For me, I guess like if I could design my own community, I would put in like a lot of support systems, and just build like a friendly environment where everyone can depend on each other, and just help each other out.”</i></p> <p><i>“The youth don’t want the resources that are provided...the youth need more help. They need people to actually go to them with the resources.”</i></p> <p><i>“Resources on different types of topics. So like family issues, on an individual basis as well relationships, how to form integral, intimate, intentional relationships.... You want to have a joyful road in life. You don’t want to just do anything just for the sake of doing it. I think resources, education, self-development are things that our communities could use.”</i></p>
<p>Environment</p>	<p>20%</p>	<p>Suggestions for improving local environments included community clean ups, planting more trees and more plant life, putting up more murals, providing more garbage cans, and preventing illegal dumping.</p>	<p><i>“I would say... getting together and cleaning yards around the neighborhood because seeing trash every day because it doesn’t bring a good image in your mind.”</i></p> <p><i>“Why do you have to clean up a neighborhood just to kick people out? Why can’t all people be allowed to live in their neighborhood? A clean equitable neighborhood, so that they don’t have to go to a white neighborhood to get good produce.”</i></p>

<p>Community connections and collaboration</p>	<p>17%</p>	<p>Participants discussed the importance of building connections and trust with communities, especially for the medical community. This could be achieved by working with trusted messengers and sustaining initiatives in communities (participants noted programs that end when funding ends). Youth also emphasized the need to build connections and collaboration within communities, being supportive of one another and fostering diversity and equality. By building stronger connections and collaborations, these youth feel that advocacy efforts would be that much more effective.</p>	<p><i>"The problems within our community are here by design. Since they are man-made, man/woman can fix them."</i></p> <p><i>"Have more activities and programs for people of different ages and different ethnicity to join. This can bring people out of their house and educate each other so there's less misunderstanding or miscommunication."</i></p> <p><i>"I would have people from different backgrounds, ethnically, race, etc. People of different ages... basically people who are different from each other... so they can all share their ideas and their beliefs and they can also like come to understandings for each other. Which is something that could help people in the real world, like meeting new people from different places, from different backgrounds, with different histories...it could help people understand those people better. I honestly feel that would make the world a little bit better so there's not so much fighting and disagreement."</i></p> <p><i>"Having that somebody that cares about you, that really want to see you grow, it helps....In the Philadelphia community, we have a lot of violence and you know, and having somebody that constantly asks you 'are you ok? Are you having a good day? If you really like the equipment, how it feels and whatnot?' It really makes me feel like somebody values my opinion and for them to value my opinion says a lot."</i></p>
<p>Physical activity</p>	<p>13%</p>	<p>Youth shared the importance of increasing access to opportunities for physical activity that are safe and ideally outdoors.</p>	<p><i>"I would like to see a recess in the schools. I know high schools may not do that but I really miss recess. Since I graduated from 8th grade I had recess, but 9th, 10th, I did virtual in 11th but that don't count, and now I'm in 12th and still no recess. I really miss recess. I like to go outside, get fresh air, run around. I feel like kids, even older kids like us teenagers, we still need it."</i></p>
<p>Youth voice</p>	<p>13%</p>	<p>Several groups prioritized the need for youth leadership and voice related to health improvement in their communities. They expressed wanting to be taken seriously, taking a "seat at the table," "speaking out," and crossing generational divides by sharing their ideas and working alongside adults to improve health.</p>	<p><i>"Our generation is very defensive...and we also feel like we know it all. But we forget that these people have lived through hard times. And they might actually have some insight in a way to help us better. In the moment you may not see it as it's gonna help me... but as a younger generation I feel like we don't know how to take things with a grain of salt...Open-minded. And this can also go for our older generation, too, to be open-minded to us. But I feel like it's a two-way street. Because I've talked to like a bunch of older people, and I have to say that it's one of the best things that I've done. When you want to get somewhere in life, when you want to do something, you look at those people who are doing what you want to do because at the end of the day, they've done it, they've done it."</i></p> <p><i>"Solutions in the community is giving your youth a voice, not only in their towns but bigger!"</i></p>

Substance use	13%	A number of groups noted the importance of programs to address addiction, including increasing services provided in communities, and reducing access to substances by preventing them from being sold to youth.	<i>"...all those people that are on the streets, there should be facilities like rehabs specifically for them to get back on their feet because they always go to locking them up. But in reality, it's not that you control, it's a mental illness – so we shouldn't be putting people in jail for something that they can't control like addiction."</i>
Social media	13%	Youth acknowledged the power of social media as a major form of communication in their lives. Some suggested harnessing the power to spread important health messages, while others suggested the need to ensure that it isn't being used to spread misinformation . Participants offered the idea of education campaigns to share the impacts of cyberbullying and trolling.	<i>"Social media is like a cup—you know, it depends on what you fill it with. You can fill it with poison, or you can fill it with water, you can fill it with juice. What are you consuming on social media? When you go on Youtube, what are you watching? What are you putting your mind, what are you using your brain for?"</i>

LGBTQ+ COMMUNITIES

One of the goals of [Healthy People 2030](#) is to improve the health, safety, and well-being of lesbian, gay, bisexual, and transgender people.

In recognition of the challenges posed by limited and inconsistent collection of sexual orientation or gender identity information, several Healthy People 2030 objectives are focused on increasing the collection of such information in national surveys, including the Behavioral Risk Factor Surveillance System. Such information is critical for identifying and gaining a more comprehensive understanding of the unique health needs of lesbian, gay, bisexual, transgender, queer/questioning, and other identity (LGBTQ+) communities.

Available data underscore the need for urgency not only in understanding, but action. Targeted data collection efforts amply demonstrate the increased risk of poor physical and mental health outcomes among those identifying as LGBTQ+. These stem from intersecting challenges related to societal stigma, interpersonal and institutional discrimination, heightened threat of violence, and lack of access to culturally-affirming and informed health care. The greater likelihood of risky health behaviors, such as higher rates of substance use, found among members of LGBTQ+ communities must be examined in light of these significant stressors. Inclusive, responsive systems of care are necessary to mitigate these increased risks and establish the conditions for sustained well-being for LGBTQ+ communities.

Since 2015, the Pennsylvania Department of Health (PA DOH) has sought to systematically assess the health needs of LGBTQ communities throughout the Commonwealth with what is now the biannual [Pennsylvania LGBTQ Health Needs Assessment](#). For the 2020 assessment, PA DOH partnered with Bradbury-Sullivan LGBT Community Center and the Research & Evaluation Group at Public Health Management Corporation to administer an online survey to LGBTQ-identified Pennsylvania residents. A total of 6,582 respondents participated in the survey, which was available in English and Spanish. Most respondents identified as gay (34.7%), bisexual or pansexual (29.8%), lesbian (18.3%), or queer (10.4%). One in six identified as non-binary (9.2%), genderqueer (2.7%), genderfluid (2.6%) or another gender (2.0%). Nearly half the sample was between the ages of 25 and 49 years and nearly a third under 25. A large majority (83.8%) identified as white, with the remaining identifying as Black or African American (4.6%), another race (4.5%), multi-racial (4.5%) or Asian (2.0%); seven percent identified as Hispanic or Latinx. The sample was highly educated, with 86 percent having greater than high school levels of educational attainment.

Across the entire sample, key findings demonstrate:

- Interest in incorporating healthy living strategies into their lives among nearly all respondents.
- Widespread experience of respect for their LGBTQ identity by their friends and household members.
- Lack of trust of health care providers, as a quarter of respondents have not disclosed their LGBTQ identity with any of their health care providers and over a third fear seeking health care services because of past or potential negative reactions.
- Significant barriers to health care, with over 40 percent experiencing at least one barrier to health care, such as inaccessibility of LGBTQ-affirming providers (too far away, not covered by their health insurance) or inability to afford costs.
- High prevalence of mental health concerns, as nearly three quarters of the sample experienced a mental health challenge in the past year; of those, less than half received counseling or mental health treatment. In their lifetimes, over half have had thoughts of suicide or self-harm.
- Widespread lifetime experience of discrimination based on LGBTQ status.
- Nearly 40 percent have experienced violence from a family member, partner, or spouse. Nearly a quarter report experiencing violence based on their LGBTQ status, with greater likelihood among respondents of color or those who identify as transgender, non-binary, or genderqueer.
- Financial challenges, with nearly a third experiencing food insecurity and more than one in four reporting that they do not have any money left over at the end of the month.
- About a fifth of the sample reporting experiencing homelessness in their lifetime. Nearly a third of respondents of color, as well as nearly a third of transgender, non-binary, or genderqueer respondents, report experiencing homelessness.

Philadelphia residents comprised 13.6 percent of the sample, while residents of Berks, Bucks, Chester, Delaware, Lancaster, Montgomery, and Schuylkill Counties made up the 21.8 percent of respondents designated as a separate Southeastern Pennsylvania (SEPA) region.

Results specific to these areas include:

	Philadelphia	Southeastern PA	PA BRFSS Comparison
Smoking	25%	26%	17%
Binge drinking	38%	31%	17%
Having at least one primary risk factor for HIV	42%	34%	7%

Highest priorities to address in each area include:

- **Philadelphia:** Depression, alcohol/drug addiction, and loneliness/isolation
- **SEPA:** Depression, suicide, and bullying

From a health care perspective, findings from Philadelphia respondents shed light on gaps in care, as:

- Nearly 22 percent do not have a personal doctor or healthcare provider
- Nearly a quarter have not visited a doctor for a routine checkup in the past 12 months
- Almost a third have experienced a negative reaction from a healthcare provider upon learning their LGBTQ status
- A third do not believe most of their healthcare providers have the medical expertise related to their health needs as an LGBTQ person.

To address the needs revealed by this assessment, the following actions are recommended:

- Support connections to LGBTQ-competent providers;
- Support initiatives that address social determinants of health;
- Identify community-wide mental health supports;
- Support chronic disease prevention;
- Promote tobacco cessation opportunities;
- Encourage health screening discussions and health education;
- Bolster community supports for black, indigenous, and people of color;
- Prioritize the health needs of transgender, non-binary, genderqueer, and individuals born intersex;
- Continue and enhance data collection; and
- Partner with LGBT community-based organizations.

Respondents were asked, **“What is one thing you would like to tell healthcare providers to be more welcoming?”** Here are some of their messages:

If you claim competence, I should not be put in a position of educating you on basic care. If you do not claim competence, at least be prepared for an LGBTQ person to walk through your door.

Don't assume everyone is cisgender.

Be honest with us.

Accept and understand that identity often doesn't change how you need to do your job.

Ask if I'm lonely or depressed.

Train staff on transgender interactions and appropriate usage of pronouns and communication skills. We are a population highly vulnerable to mistreatment by medical staff, and most likely do not trust that we will be treated fairly from person to person, as many assumptions are made by our appearance. It is exhausting.

Just because we don't 'look gay' doesn't mean we are not gay.

Ask everyone their pronouns.

Take 'first, do no harm' seriously. That's not just physical, but also intellectual and emotional.

Please be mindful of body language and facial expressions when someone confides that they are LGBTQ+.

Educate yourself.

I know that 'sex' on the intake form is needed for medical reasons, but it would be great if you could also include 'gender' and 'pronouns' on the forms.

A rainbow flag goes a long way.

Be more welcoming to the trans community.

Source: 2020 Pennsylvania LGBTQ Health Needs Assessment

Findings from the 2019 Youth Risk Behavior Surveillance System provide information about the experiences of youth in Philadelphia (a comparable dataset is not available for other counties in the five-county region). More than 1,200 9th to 12th grade high school students from 25 randomly selected Philadelphia public high schools completed the anonymous, self-administered survey in spring 2019. Nearly a quarter of respondents identified as lesbian, gay, bisexual, or unsure.

Among those students:

- Nearly half seriously considered suicide in the prior 12 months (almost three times the rate of heterosexual students) and were over three times more likely to be treated for a suicide attempt than their heterosexual peers.
- Relative to their heterosexual counterparts, LGB students were more likely to report that their mental health was not good (80.3% vs. 55.6% of heterosexual students) and that they felt sad or hopeless for 2 or more weeks in the past year (64.9% vs. 35.3%).
- Compared to 14.3 percent of heterosexual youth, 33.7 percent of LGB youth report drinking in the past 30 days. Binge drinking is also more prevalent among LGB youth relative to heterosexual peers (13.7% vs. 3.8%).
- LGB youth also experienced being physically forced to have sex, sexual dating or physical dating violence, and electronic bullying at much higher rates than their heterosexual peers.
- Thirty percent of LGB youth report experiencing homelessness.

COMMUNITY HEALTH NEEDS

All quantitative and qualitative inputs were organized into 12 community health needs that were categorized across three domains:

Health Issues <i>Physical and behavioral health issues significantly impacting the overall health and well-being of the region</i>	Access and Quality of Healthcare and Health Resources <i>Availability, accessibility, and quality of healthcare systems and other resources to address issues that impact health in communities across the region</i>	Community Factors <i>Social and economic drivers of health as well as environmental and structural factors that influence opportunity and daily life</i>
<ul style="list-style-type: none"> • Chronic Disease Prevention and Management • Mental Health Conditions • Substance Use and Related Disorders 	<ul style="list-style-type: none"> • Access to Care (Primary and Specialty) • Food Access • Healthcare and Health Resources Navigation (Including Transportation) • Culturally and Linguistically Appropriate Services • Racism and Discrimination in Health Care 	<ul style="list-style-type: none"> • Community Violence • Housing • Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.) • Socioeconomic Disadvantage (e.g., Poverty, Unemployment)

Participating institutions' ratings of the community health needs were aggregated and are listed below in order of priority (please see "Our Collaborative Approach" for details on the prioritization process):

- | | | |
|---|--|---------------------------------------|
| 1. Mental Health Conditions | 5. Healthcare and Health Resources Navigation | 9. Community Violence |
| 2. Access To Care (Primary and Specialty) | 6. Racism and Discrimination in Health Care | 10. Housing |
| 3. Chronic Disease Prevention and Management | 7. Food Access | 11. Socioeconomic Disadvantage |
| 4. Substance Use and Related Disorders | 8. Culturally and Linguistically Appropriate Services | 12. Neighborhood Conditions |

Potential solutions for each of the community health needs, based on all qualitative data collection efforts, are also included.

Mental Health Conditions

- Youth and adult community members and community partners prioritize mental health as their top health need.
- Significant mental health needs across the region are indicated by:
 - High rates of depression among youth and adults (1 in 5 adults report diagnosed depressive disorders, and many more are undiagnosed)
 - Across the 5 counties, 15 percent of residents report frequent mental distress.
 - Suicide mortality and suicide attempts/ideation rates among youth (particularly among those who identify as LGBTQ+) that persist and are likely to show increases when more recent data is made available.
- These concerning trends were exacerbated by the social isolation, stress, and fear experienced due to the COVID-19 pandemic.
- Pandemic-related trauma is particularly compounded for those communities also contending with trauma associated with high levels of poverty, community violence, and racism.
- If left undiagnosed or untreated, there is increased likelihood of serious issues that result in increased health care (especially emergency department) utilization and co-occurring substance use disorders.
- Populations particularly affected include youth, older adults, immigrant communities, LGBTQ+ communities, those experiencing homelessness and housing insecurity.
- 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.

Potential Solutions

- **Improve care coordination as part of an integrated care model** that assesses the whole person, addresses both physical and behavioral health, and coordinates care across hospitals and community-based service providers:
 - Expand warm handoffs between hospitals, emergency departments, primary care practices, community behavioral health service providers and community-based organizations.
 - Develop coordinated Crisis Response Systems available 24/7, 365 days a year.

- **Increase awareness of behavioral health resources and services.** Hospitals can promote internal awareness and community knowledge about behavioral health services and how to access them.
- **Increase access to safe, structured afterschool activities for youth** available on weekends and in the evening.
- **Create spaces for openly discussing mental health for youth** to normalize/destigmatize mental health issues.
- **Co-locate prevention and behavioral health services in community settings (“one stop shop”) where families live, work, learn, and socialize.** For example, in partnership with community-based organizations, provide co-located behavioral health prevention programs, treatment, and other intervention services in schools.
- **Increase access to support groups** to address mental health and substance use.
- **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.**
- **Increase behavioral health workforce capacity and diversity** (e.g., language, racial, and ethnic). Increase number of professionals who represent the racially and culturally diverse populations they serve.
- **Increase individuals with lived experience in the behavioral health workforce.** Peer advocates and teen mentors may be particularly effective sources of support for youth.
- **Provide programming to prevent “burn-out” among behavioral health staff.**
- **Support efforts to increase funding** to ensure that all families and children can access evidence-based mental health screening, diagnosis, and treatment, as advocated by the [American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children’s Hospital Association](#).

Access to Care (Primary and Specialty)

- The 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.
- Barriers to access to primary care for communities are due to:
 - Lack of providers in neighborhoods (especially in NE/SW Philadelphia, rural areas in suburban counties)
 - Affordability (particularly among those who are uninsured, those with lower incomes unable to afford co-payments/deductibles)
 - Language/cultural barriers (notably among immigrant communities and English language learners)
- The above issues are 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.
- Impacts of the COVID-19 pandemic include:
 - Increased enrollment in Medicaid (increases ranging from 11% to 20% in 5 counties, 2020-2021)
 - Longer wait times for appointments, especially for specialty care
 - Gaps in access to preventive services, including immunizations for children/youth, health screenings/diagnostic testing for adults (e.g., chronic diseases, breast/colon/prostate cancer)

Potential Solutions

- **Provide education and information about Medicaid (e.g., eligibility, coverage) and assist with enrollment.**
- **Create high quality free or low-cost health care options** to serve those who may be uninsured or underinsured.
- **Establish comprehensive health centers** that would address not only physical health, but also mental health and dental care. (It is worth noting that though not the highest priority, there was consistent mention of the need for improved access to dental care across different communities, suggesting a potential opportunity to explore improved linkage to dental care providers.)
- **Bring more health and social services directly to underserved communities through health clinics in schools or mobile medical clinics.**
- **Embed social workers in primary care practices, such as family medicine, pediatrics, and OB/GYN offices.** These professionals could help to assess, refer, and enroll individuals and families in other needed health and social services.
- **Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”** Community members expressed the need to ensure that all staff are welcoming and respectful.
- **Provide on-site language interpreters and health education materials in diverse languages.**
- **Increase the racial, ethnic, and language diversity of staff and providers** to better reflect the communities they serve.
- **Increase transportation assistance**, including adding options for those not eligible for certain benefits.
- **Expand appointment availability and hours in low access areas.**
- **Address barriers to telehealth (e.g., related to internet or device access or digital literacy)** and provide necessary support to ensure high quality telehealth experiences.

Chronic Disease Prevention and Management

- Conditions like heart disease, cancer, stroke, and chronic lower respiratory diseases continue to constitute the majority of the top 5 leading causes of death for all counties.
- Notable differences between counties in southeastern Pennsylvania:
 - Rate of premature cardiovascular deaths significantly higher in Philadelphia County
 - Cancer mortality rates highest in Delaware and Philadelphia Counties
 - Hypertension-related hospitalization rates highest in Bucks, Delaware, and Philadelphia Counties
- Across and within 5 counties, disparities in burden of chronic disease correlate with poverty, which disproportionately affects communities of color. In Philadelphia, for example, Hispanic/Latino communities have some of the highest rates of chronic conditions, such as asthma and obesity, and the city's non-Hispanic Black population has disproportionately high rates of chronic conditions such as hypertension and diabetes.
- The 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. The full impacts will be clearer with data from 2021 and beyond.

Potential Solutions

- **Better inform, educate, and engage the public regarding chronic disease prevention and management.** Address limited knowledge about chronic disease screening guidelines and resources through engaging campaigns on varied platforms, including virtual health promotion programming.
- **Engage trusted community leaders to help spread important messages** (for example, promoting cancer screening). Men sharing their stories around personal health and screening may serve as particularly effective examples for other men.
- **Expand successful innovations from the pandemic, such as virtual wellness programs.**
- **Bring screenings and health education to faith-based institutions or where people shop, recreate, or work.** Provide flexible times.
- **Integrate mental health services into overall care management for people with chronic diseases.**
- **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.
- **Increase networking and collaboration among community organizations and health system partners** to improve resource sharing and coordination of services.

Substance Use and Related Disorders

- Substance use disorders often co-occur with mental health conditions.
- Substance use is associated with community violence and homelessness.
- 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.
- The opioid epidemic is associated with increases in other health conditions including HIV, Hepatitis C, and Neonatal Abstinence Syndrome (NAS).
- 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.

Potential Solutions

- **Sustain and expand prevention programs**, ranging from school-based educational programs to community drug take-back programs.
- **Advocate to increase and sustain funding for drug and alcohol prevention programs in schools and other programs.**
- **Expand school-based services** that address students' behavioral health, including drug and alcohol use.
- **Broaden and intensify efforts to reduce vaping among youth.** Collect better data to understand vaping trends among youth and encourage school districts to shift toward policies that provide "*more supportive and restorative disciplinary actions*" for students who are disciplined for vaping, such as referral to cessation programs and other support.
- **Reduce youth access to substances** by preventing their purchase by youth (e.g., drugs purchased on the internet).
- **Expand Narcan training and distribution.** Training more professionals, including police, to provide these services could help lower overdoses.
- **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.
- **Develop texting support services that address underlying issues of substance use**, provided by trained peers or qualified therapists to individual clients.
- **Streamline system navigation for providers and the population at large** to facilitate access to outpatient services after discharge from inpatient facilities.

Healthcare and Health Resources Navigation

- Community members and partners widely viewed navigating healthcare services and other health resources, like enrollment in public benefits and programs, as a challenge due to general lack of awareness, fragmented systems, and resource constraints.
- 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.
- Navigation includes information as well as transportation. Many individuals, especially older adults, face significant challenges securing transportation to healthcare and health resources. Lack of accessible, affordable transportation options was raised in a large majority (70%) of qualitative meetings, with the need spanning urban and suburban counties. Financial and logistical issues associated with travel can be a barrier to accessing healthcare and health resources.

Potential Solutions

- **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** available for those in most need (e.g., older adults, some immigrant communities).

Racism and Discrimination in Health Care

- Racism is recognized as an ongoing public health crisis in need of urgent, collective attention.
- The COVID-19 pandemic has unmasked and amplified longstanding health and economic disparities experienced by communities of color. Higher rates of COVID-19 infection, hospitalization, and mortality experienced by Black communities are further examples of inequities stemming from structural racism.
- 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.
- Such experiences can lead to forgoing of needed care, resulting in increased morbidity and mortality.
- Anti-Asian hate crimes have 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.

Potential Solutions

- **Train and hire people with lived experience, such as community health workers and community peer specialists, to work in communities that have been historically marginalized.**
These workers, who could be embedded in local community organizations, would be paid a fair wage to connect people to care, help them navigate services, and assist as their advocates within the health system.
- **Increase hospital investment in grassroots community organizations that are working to address social determinants of health and related needs.**
- **Expand and improve the training of healthcare providers around anti-racism, structural racism, implicit bias, diversity awareness, cultural competence, and trauma-informed care.**
- **Increase the number of people of color in healthcare leadership positions.**
- **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.**
- **Create and fund ongoing forums for community leaders to work with health system partners to address issues of racism and discrimination in health care.**

Food Access

- Issues of food access focus primarily on food security, defined as having reliable access to a sufficient quantity of affordable, nutritious food. Many community members experience challenges with obtaining sufficient food of any kind, as well as report issues with accessing healthy food more specifically.
- The 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.
- Black and Hispanic/Latino communities are disproportionately impacted by food insecurity, as are older adults and immigrant communities.

Potential Solutions

- **Ensure more equitable access to food assistance programs and resources throughout the region.** Hospitals could partner with local organizations to collect and share data to assess and address food access disparities in different communities. Data collection tools also are needed to measure progress toward food security goals. To ensure equitable access to resources, people from under-resourced communities also need a voice at the table.
- **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.** Ensure that patients are connected to public benefits for which they are eligible.
- **Increase collaboration and resource-sharing between hospitals and community groups that are working to increase healthy food access.**
- **Build the evidence base to document the clinical benefits and cost savings of a nutritionally sound diet to prevent or manage common diseases.**
- **Increase outreach to raise awareness and utilization of food assistance programs.** The sheer number of food resources and agencies in the region requires consistent outreach efforts to help people find and connect to what they need. Such assistance should use a wide range of formats and media to reach diverse audiences.
- **Provide services that distribute food directly to people where they live, especially in neighborhoods with limited or no access to healthy food.** Possible ideas for exploration include food trucks or produce distribution from local community gardens.
- **Increase affordable transportation options for people who cannot drive or get rides to emergency food or other needed resources** for people in rural and urban areas of southeastern Pennsylvania.

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.
- The need for culturally concordant providers and resources to address language barriers was raised in over 50 percent of qualitative meetings.
- Provision of high quality language services (oral interpretation and written translation) is critical for providing equitable care to these communities.
- 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.

Potential Solutions

- **Increase the racial, ethnic, and language diversity of staff and providers** to better reflect the communities they serve.
- **Develop organizational language access plans that outline protocols for identifying and responding to language needs.**
- **Explore the 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.** This could mean sharing funding with community organizations for providing consultative support based on their linguistic or cultural expertise or healthcare navigation support to patients.
- **Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”**

Community Violence

- Violent crime and homicide rates are 8-10 times higher in Philadelphia compared to suburban counties.
- 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.
- Community violence driven by community disadvantage disproportionately impacts N, NW, and SW communities in Philadelphia.
- The trauma associated with exposure to gun violence is widely felt in communities, especially among youth. However, they report experiencing significant challenges in accessing the necessary mental health supports to address the negative impacts of such exposure.
- 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.
- Negative social media engagement, including cyberbullying, among youth can be a source of community violence.

Potential Solutions

- **Increase awareness and availability of youth programs to prevent violence, including educational programs, sports, and other recreational activities.** Communication strategies that encompass youth culture and include youth input are needed, as is more funding.
- **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. Help parents advocate for needed mental health services.
- **Build youth capacity for healthy conflict resolution and create positive outlets for arguments or anger.**
- **Create more safe spaces for people to talk about the violence they experience.**
- **Train all levels of hospital staff and other healthcare providers on delivering “non-biased, culturally appropriate, trauma-informed care.”**
- **Increase accountability and coordinated action in addressing community violence from the city, schools, health systems, higher education, neighborhood civic association groups, and community-based organizations.** As an integral part of these efforts, hospitals can:
 - **Increase advocacy for policies to prevent or reduce violence,** including initiatives to address poverty and other social determinants that contribute to violence.
 - **Partner with community-based organizations to build on each other’s strengths and increase funding opportunities.**

#10 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.
- 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.
- 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.
- Poor housing conditions like old lead paint, asbestos, infestations, lack of running water or HVAC, and damaged infrastructure disproportionately impact communities with low incomes.
- Lack of affordable housing is a major driver of homelessness.
- Although point-in-time counts of individuals experiencing homelessness indicate decreases in overall numbers in all five counties over the past several years, continued focus on addressing homelessness is critical, especially when the moratorium on evictions ends.
- People experiencing homelessness are at increased risk of mental health and substance use disorders and experiencing discrimination and bias in healthcare settings.
- Homelessness experienced by youth and older adults are of particular concern for local advocates.

Potential Solutions

- **Drive solutions that prevent homelessness**, including advocating for livable wages, more affordable housing, and services that support aging in place.
- **Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.**
- **Increase investments by hospitals, managed care organizations, and others in supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness.** These programs, which have been shown to reduce healthcare costs, provide housing and rent subsidies along with wrap-around services to prevent homelessness and re-incarceration.
- **Explore strategies that aggregate funds to support rental assistance.** Encourage health systems and health insurance providers to invest in rental assistance.
- **Explore development of an equitable acquisition fund** to preserve and create affordable housing.
- **Expand programs that support habitability and raise awareness of available resources for housing repair assistance.** Such programs can help older adults age in place.
- **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.
- **Train and encourage health care providers, including primary care physicians, to conduct regular housing insecurity assessments for patients, particularly families, and make referrals as appropriate.** Also train health professionals and social service providers to use a trauma-informed approach when caring for individuals experiencing homelessness or housing insecurity.
- **Increase Rapid Re-housing Programs.** These programs help individuals and families to quickly return to permanent housing, while also building community and landlord relationships to increase affordable housing.
- **Invest in respite housing for individuals in urgent need of transitional housing.**

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.
- Inadequate education, limited opportunities, and unemployment are key drivers of poverty.
- 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.
- 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.

Potential Solutions

- **Screen for socioeconomic disadvantage and establish systems for linkage to community resources to address needs.**
- **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.
- **Collaborate with community colleges and universities to develop and expand programs** focused on skills training and development to increase access to family-sustaining careers.
- **Train and employ returning citizens.**
- **Advocate for improvements to the disability system** to ensure that people with disabilities are able to work without losing attendant care services.
- **Provide workforce development/pipeline programs with schools.**
- **Increase access to Science, Technology, Engineering, Arts, and Mathematics (STEAM) education for youth.**

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. This has a negative impact on physical activity, as youth expressed avoiding going outside to exercise due to fears of violence.
- Lack of maintenance of public spaces, like schools, libraries and recreational facilities create additional health hazards. Communities often brought up community clean ups as important community-building activities.
- 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.
- Communities expressed concerns about air pollution and climate change, particularly in S Philadelphia, Delaware County, and flood-prone SW Philadelphia.
- Rapid gentrification of some historically low-income neighborhoods creates risk of displacement and housing insecurity, and further racial segregation.

Potential Solutions

- **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.**

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	Resource
Bucks County Housing Link	<ul style="list-style-type: none"> Point-in-Time Count Data
Centers for Disease Control and Prevention	<ul style="list-style-type: none"> Behavioral Risk Factor Surveillance System Data (PLACES) CDC/ATSDR Social Vulnerability Index Youth Risk Behavior Surveillance System Data
Chester County Department of Community Development	<ul style="list-style-type: none"> Point-in-Time Count Data
Children First (formerly Public Citizens for Children and Youth)	<ul style="list-style-type: none"> No More Dreams Deferred: Building an Education System that Works for Black and Hispanic Students in the Philadelphia Suburbs (Mar 2021) Underwater: 2019 Regional Reports on Child Well-Being (Mar 2019 – Feb 2020)
City of Philadelphia	<ul style="list-style-type: none"> A Digital Equity Plan for the City of Philadelphia (Jan 2022) Connecting Philadelphia: 2021 Household Internet Assessment Survey (Oct 2021) Language Access Plans Nonprofit Assessment Survey Report for African and Caribbean Immigrant/Refugee-led Organizations (Spring 2021)
Coalition of African & Caribbean Communities (AFRICOM)	<ul style="list-style-type: none"> COVID-19: Needs and Recommendations Among African and Caribbean Immigrants (Mar 2021)

Community Legal Services of Philadelphia (Youth Action Board)	<ul style="list-style-type: none"> How the Pandemic Response Has Failed Young People & What We Need to Thrive (Aug 2021)
Delaware County Council	<ul style="list-style-type: none"> Examination of Health and Public Health Service Delivery in Delaware County, Pennsylvania (Jul 2020)
Delaware Valley Regional Planning Commission	<ul style="list-style-type: none"> Broadband: Understanding the Digital Divide (Oct 2020) Immigration in Greater Philadelphia: FY 2021 Update (Jul 2021)
Drexel University Urban Health Collaborative	<ul style="list-style-type: none"> COVID-19 in Context: Racism, Segregation and Racial Inequities in Philadelphia (Jun 2020) The Impact of COVID-19 in Latino Communities in Philadelphia (Jun 2021)
Feeding America	<ul style="list-style-type: none"> Map the Meal Gap Data
HealthShare Exchange	<ul style="list-style-type: none"> COVID-19-related Emergency Department Utilization Emergency Department Utilization Emergency Department High-Utilizers Gun-related Emergency Department Utilization
HUD Exchange	<ul style="list-style-type: none"> Point-in-Time Count Data (Continuum of Care Programs in Delaware County and Montgomery County)
Pennsylvania Department of Health	<ul style="list-style-type: none"> Pennsylvania 2020 LGBTQ Health Needs Assessment (Jan 2021) Vital Statistics (Birth and Death Records)
Pennsylvania Office of the Attorney General	<ul style="list-style-type: none"> Pennsylvania Uniform Crime Reporting System
Pennsylvania Health Care Cost Containment Council	<ul style="list-style-type: none"> Hospital Inpatient Discharge Data
Philadelphia Chinatown Development Corporation	<ul style="list-style-type: none"> PCDC's Anti-Asian Racism Incident Survey Report (Mar 2021) Wellness Leadership Program 2020 Impact Report (Chinese Immigrant Families Wellness Initiative) (Sep 2021)
Philadelphia Department of Public Health	<ul style="list-style-type: none"> 2020 Health of the City Report (Dec 2020) Growing Up Philly: The Health and Well-being of Philadelphia's Children (Mar 2020)
Philadelphia Office of Homeless Services	<ul style="list-style-type: none"> Point-in-Time Count Data
Pennsylvania Commission on Crime and Delinquency, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Education	<ul style="list-style-type: none"> Pennsylvania Youth Survey Data
U.S. Census Bureau	<ul style="list-style-type: none"> American Community Survey Data

Notes

- Vital statistics data were supplied by the Bureau of Health Statistics and Registries, Pennsylvania Department of Health, Harrisburg, PA. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions.
- 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 this entity 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, payor and physician specific information—provided to this entity, are error free, or that the use of data will avoid difference of opinion or interpretation. This analysis was not prepared by PHC4. This analysis was done by PDPH. 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:

<https://www.phila.gov/documents/regional-community-health-needs-assessment/>