Tower Health Phoenixville Hospital

APPENDICES

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Appendix A - Community Stakeholder Interviews

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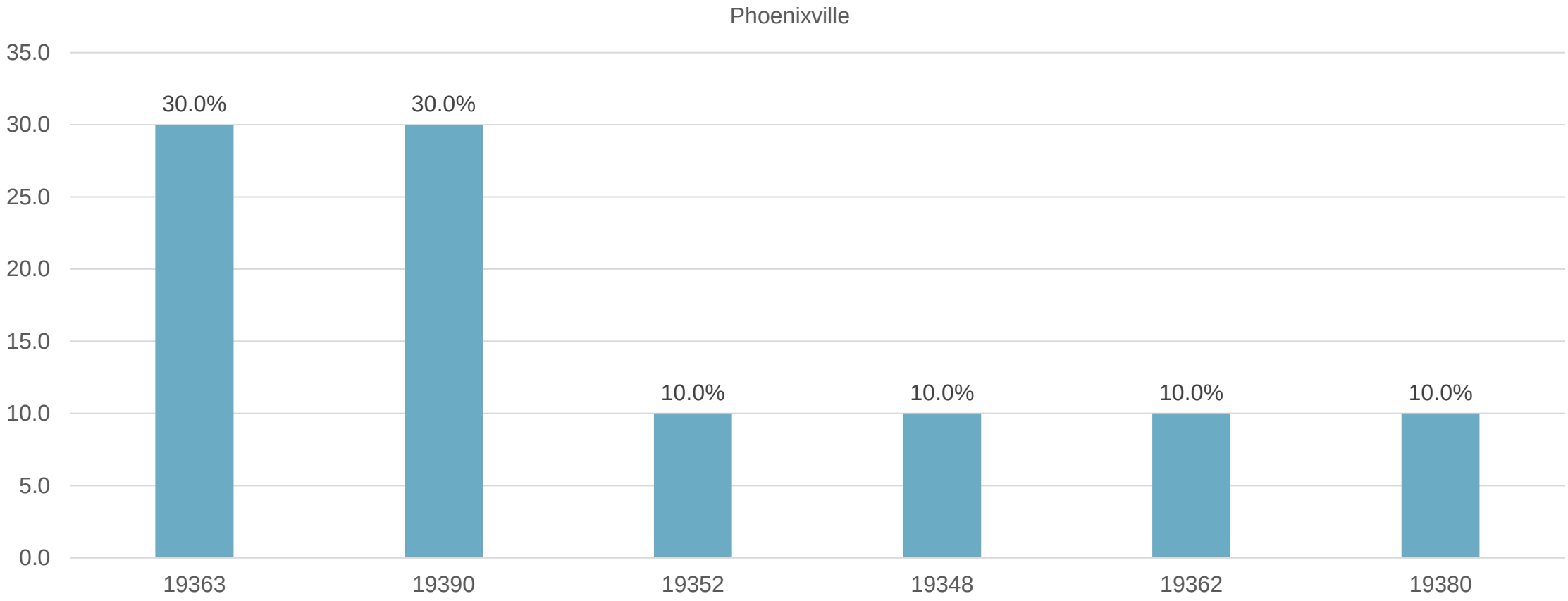
Introduction

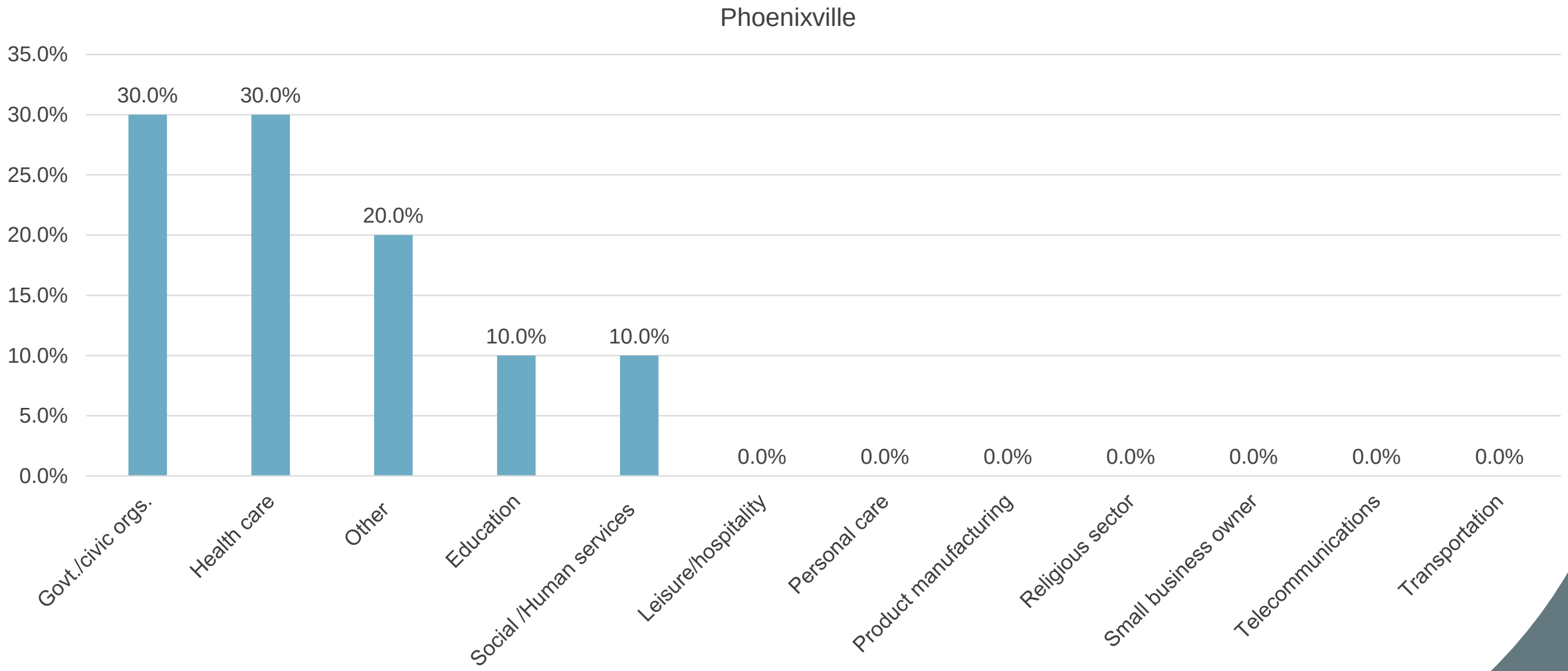
- Tripp Umbach worked closely with representatives from Tower Health to identify community stakeholders. An email was delivered to community stakeholders to introduce Tripp Umbach and define the stakeholders' role in the CHNA process. The email introduced the project and conveyed the importance of the CHNA for the community. Each interview was conducted by a Tripp Umbach consultant and lasted approximately 30 to 45 minutes in duration. Each community stakeholder was asked the same set of questions, as developed by Tripp Umbach and approved by Tower Health representatives. The interviews provided a platform for stakeholders to identify health issues and concerns affecting residents in the service area, as well as ways to address those concerns. A diverse representation of community-based organizations and agencies were among the stakeholders interviewed.
- 10 community stakeholder interviews were conducted beginning in March 2021 within the hospital region. Industry leaders interviewed represented the below businesses:
    1. Alianzas de Phoenixville
    2. Chester County Health Department
    3. Community Health and Dental Clinic
    4. Montgomery County Health Department
    5. Phoenixville Area School District
    6. Phoenixville Borough
    7. Phoenixville Community Health Foundation
    8. Phoenixville Regional Chamber of Commerce
    9. Phoenixville YMCA
    10. The Clinic

ZIP Code Where Work



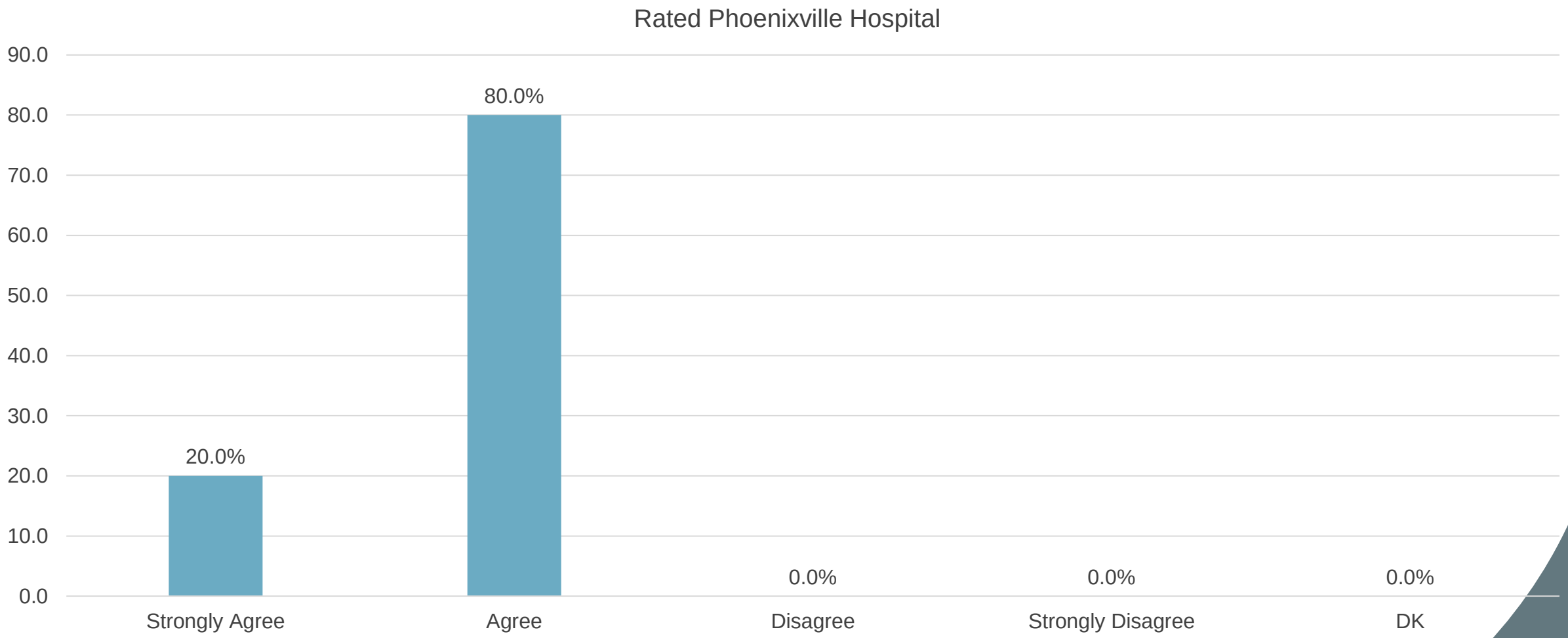
- 90% of community stakeholders interviewed worked in Chester County. (Not shown on graph.)
- 10% of community stakeholder worked in Montgomery County. (Not shown on graph.)

Represented Industry

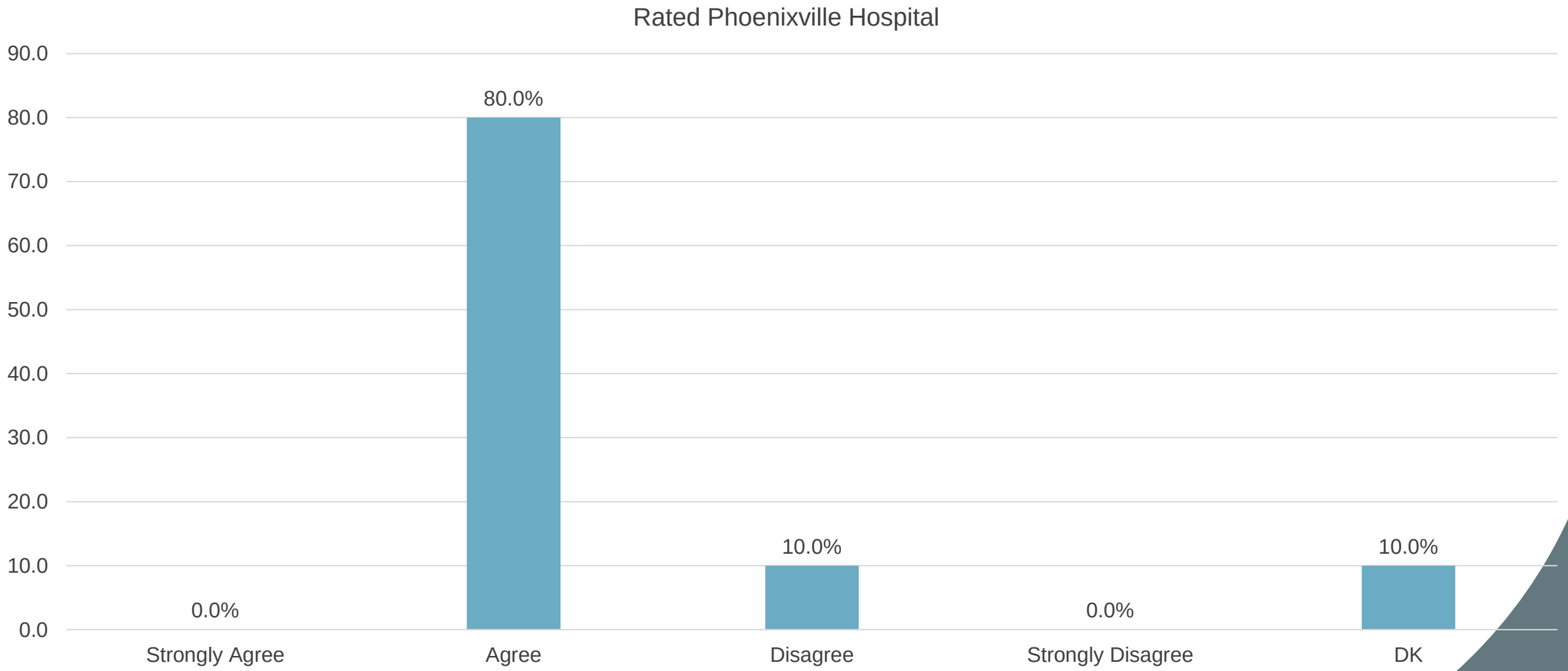


Rate Health and Human Services in Community

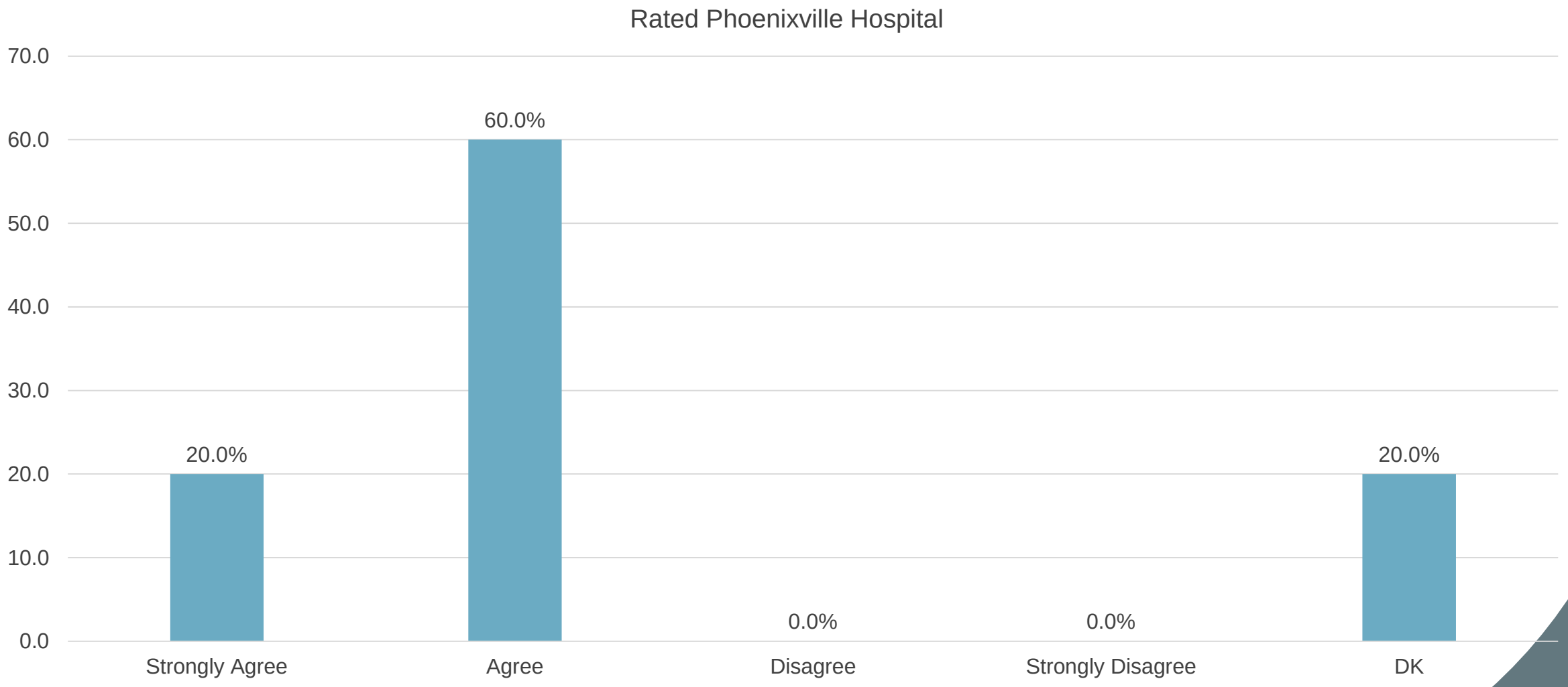
Rate How Hospital Offers High-Quality Health Care for the Community



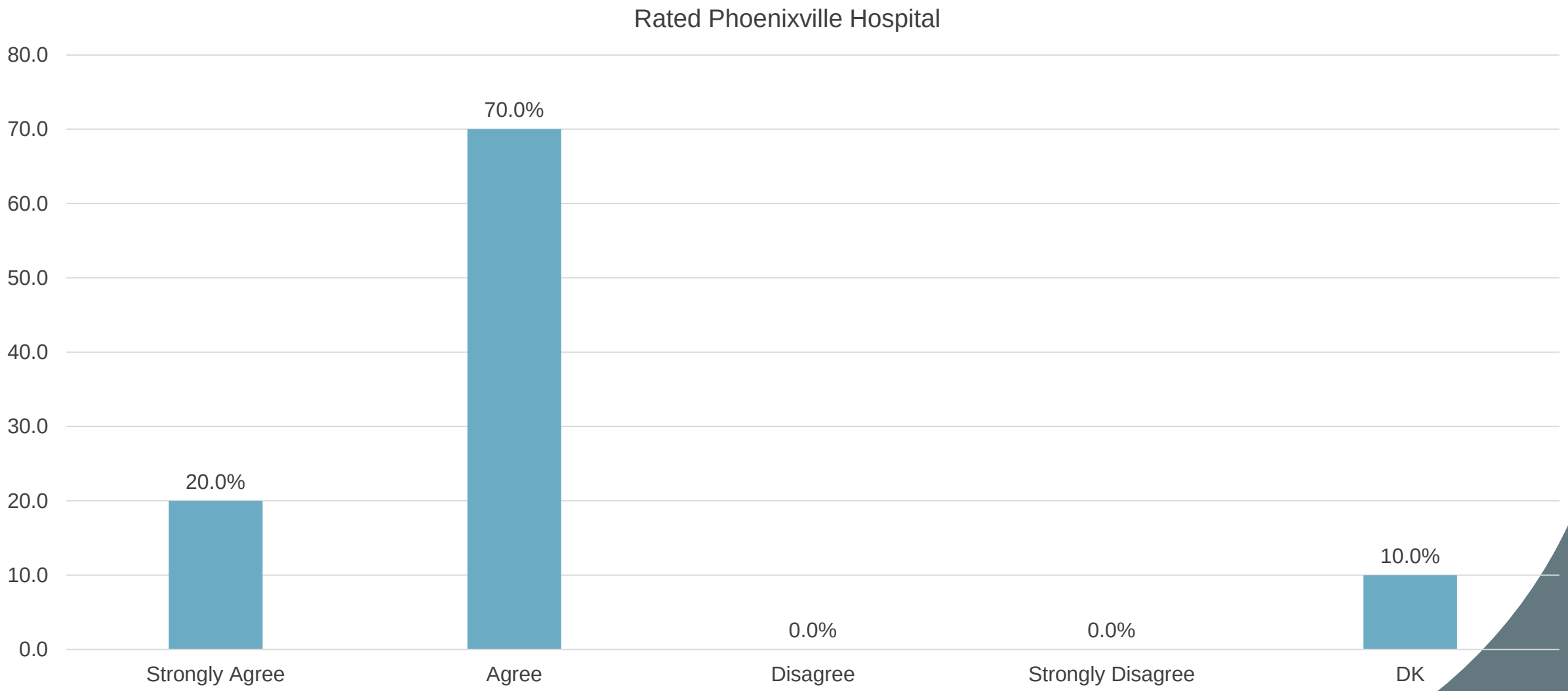
Rate How Hospital Addresses needs of Diverse and Disparate Populations



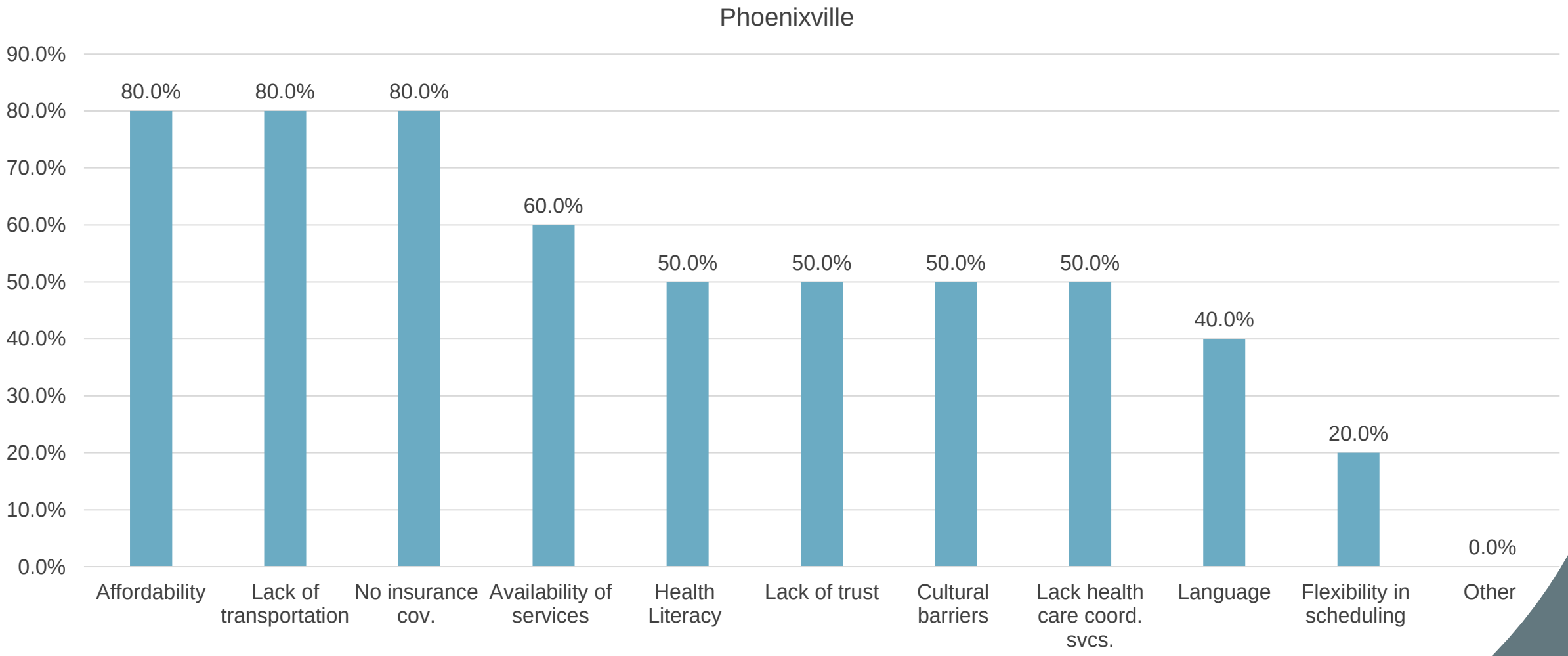
Rate How Hospital Ensures Access to Care Regardless of Race, Gender, Education, and Economic Status



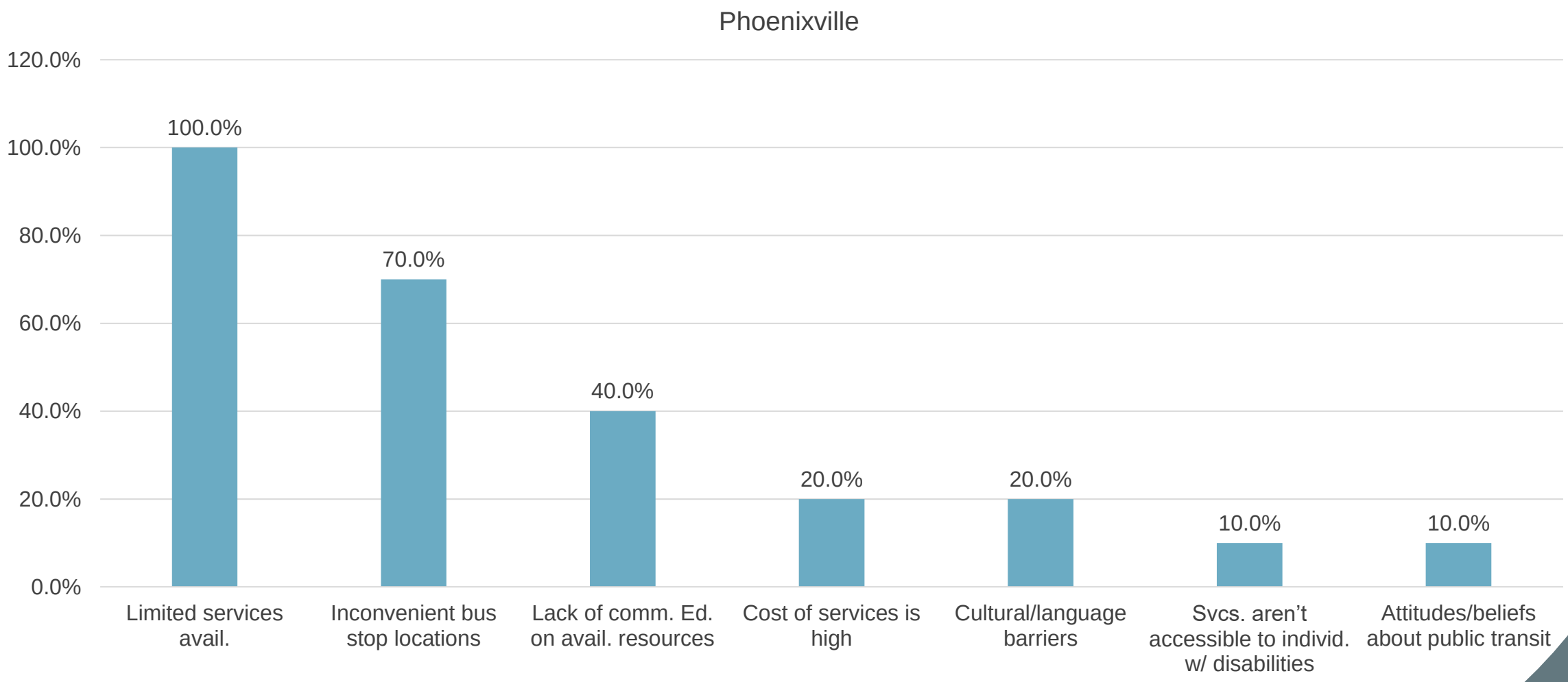
Rate How Hospital Works to Identify and Address Health Inequalities



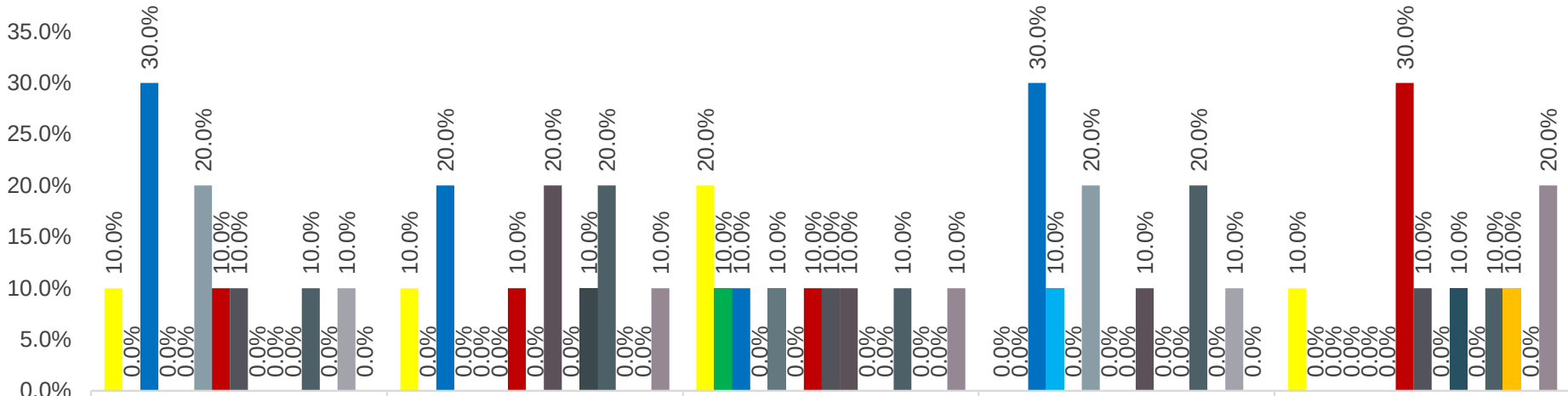
Perceived Barrier(s) for People Not Receiving Care or Services — Check all that apply



Following contributions to the transportation issues in the community — (Top three)

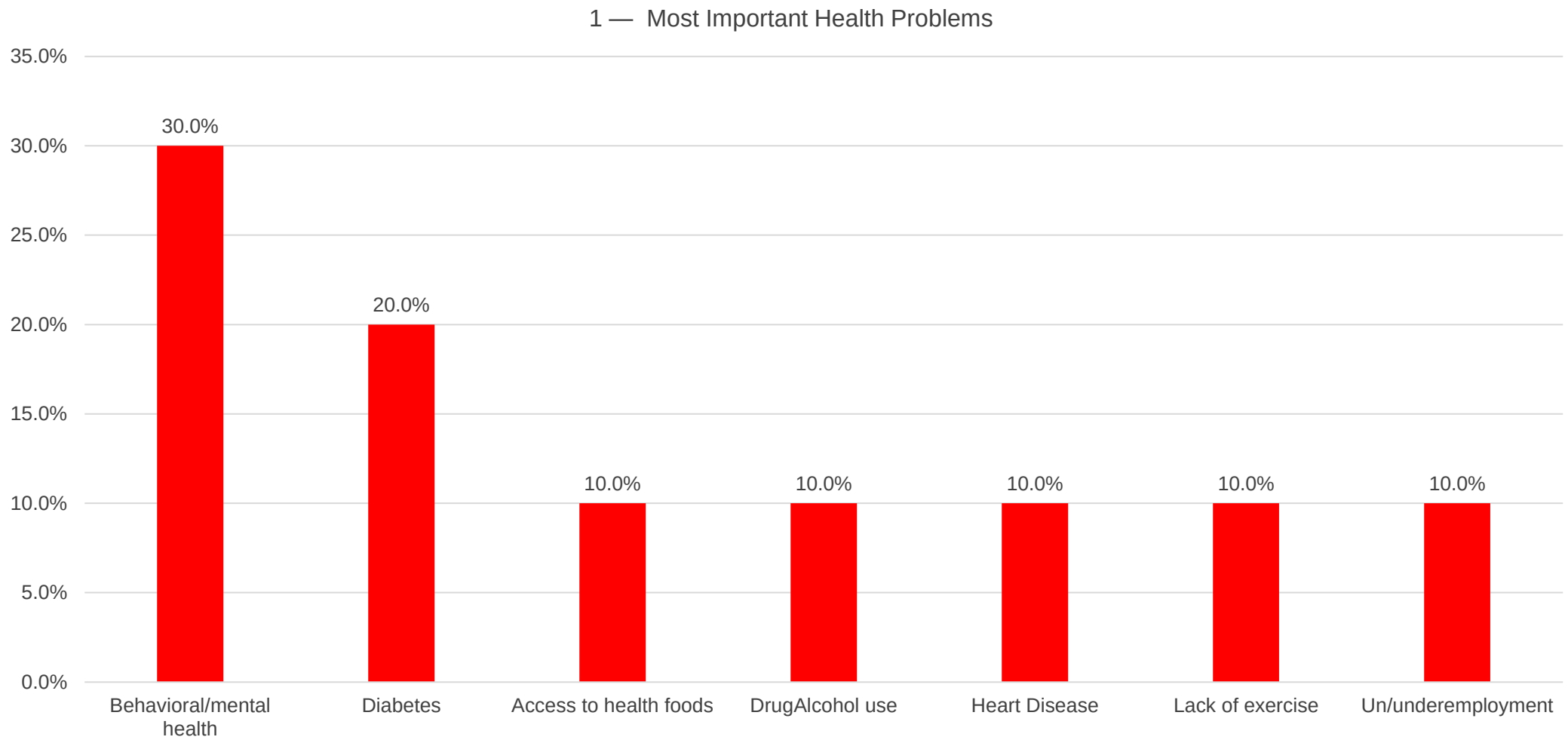


Top 5 persistent “Health Problems” in the community?



	Most Important = 1	2	3	4	5
Access to health foods (i.e., poor diet)	10.0%	10.0%	20.0%	0.0%	10.0%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	0.0%	0.0%	10.0%	0.0%	0.0%
Behavioral/mental health	30.0%	20.0%	10.0%	30.0%	0.0%
Cancers	0.0%	0.0%	0.0%	10.0%	0.0%
Dental health	0.0%	0.0%	10.0%	0.0%	0.0%
Diabetes	20.0%	0.0%	0.0%	20.0%	0.0%
Drug/alcohol use (i.e., substance abuse)	10.0%	10.0%	10.0%	0.0%	30.0%
Heart disease	10.0%	0.0%	10.0%	0.0%	10.0%
High blood pressure	0.0%	20.0%	10.0%	10.0%	0.0%
Homelessness	0.0%	0.0%	0.0%	0.0%	10.0%
Infectious diseases (e.g., hepatitis, TB, etc.)	0.0%	10.0%	0.0%	0.0%	0.0%
Lack of exercise (i.e., overweight/obesity)	10.0%	20.0%	10.0%	20.0%	10.0%
Sexually Transmitted Diseases (STDs)	0.0%	0.0%	0.0%	0.0%	10.0%
Unemployment/underemployment	10.0%	0.0%	0.0%	10.0%	0.0%
Other	0.0%	10.0%	10.0%	0.0%	20.0%

Top 5 persistent “Health Problems” in the community?



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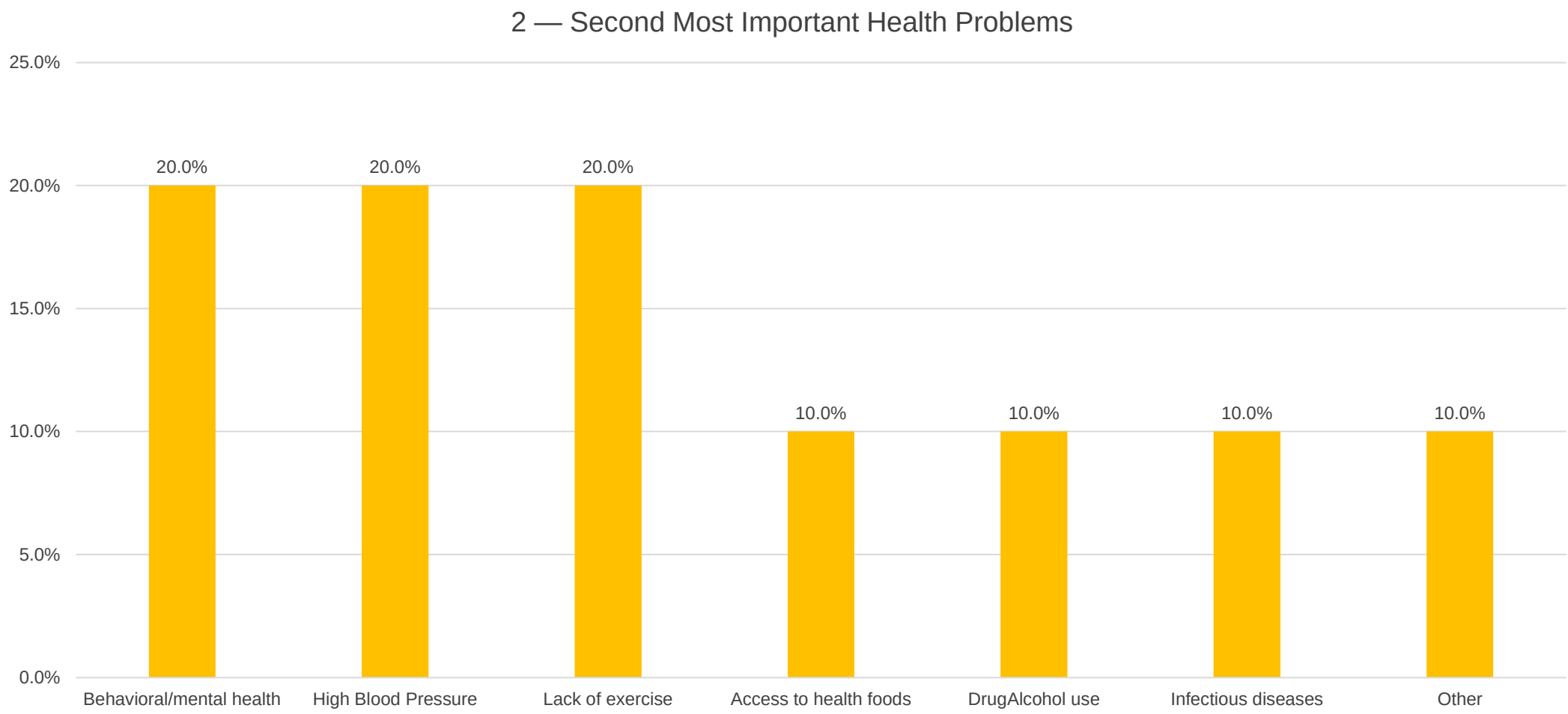
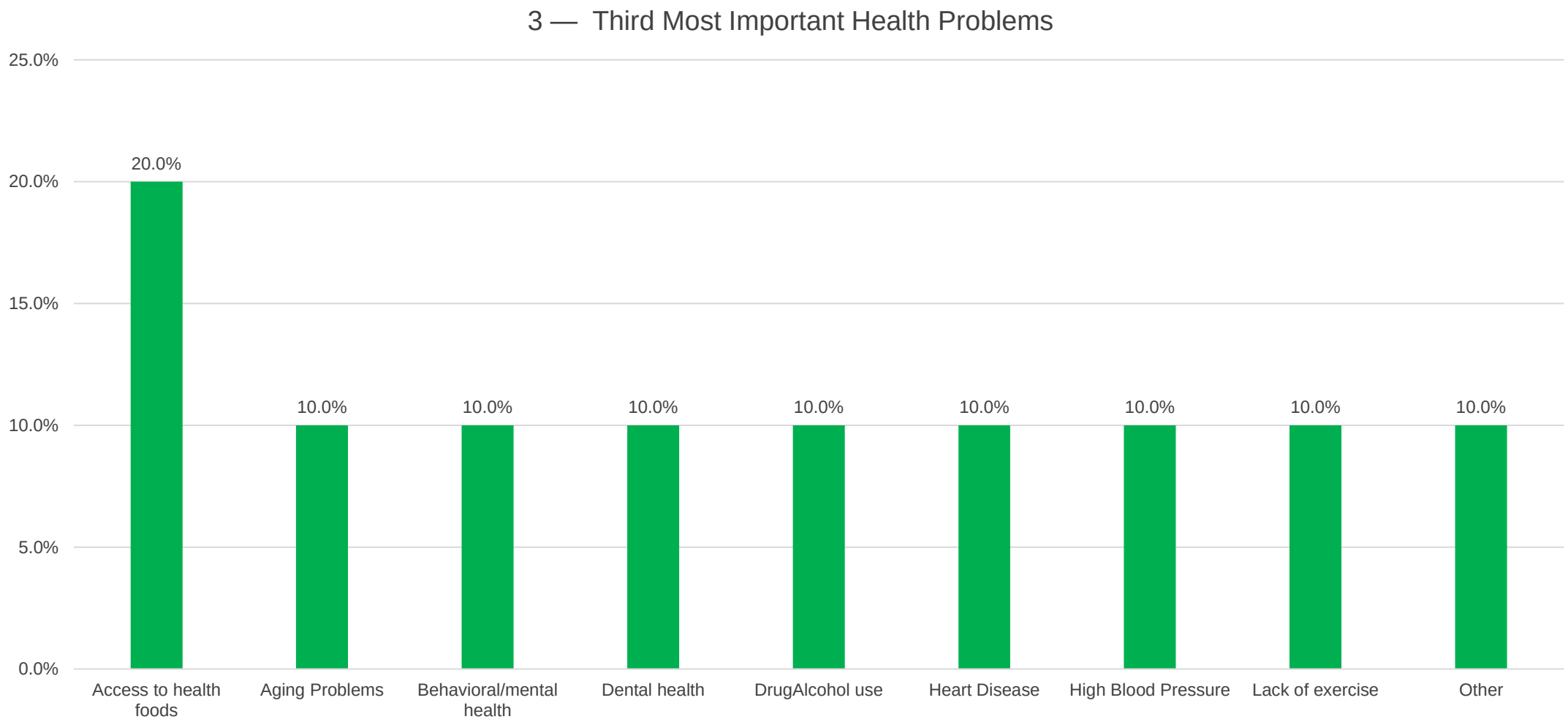
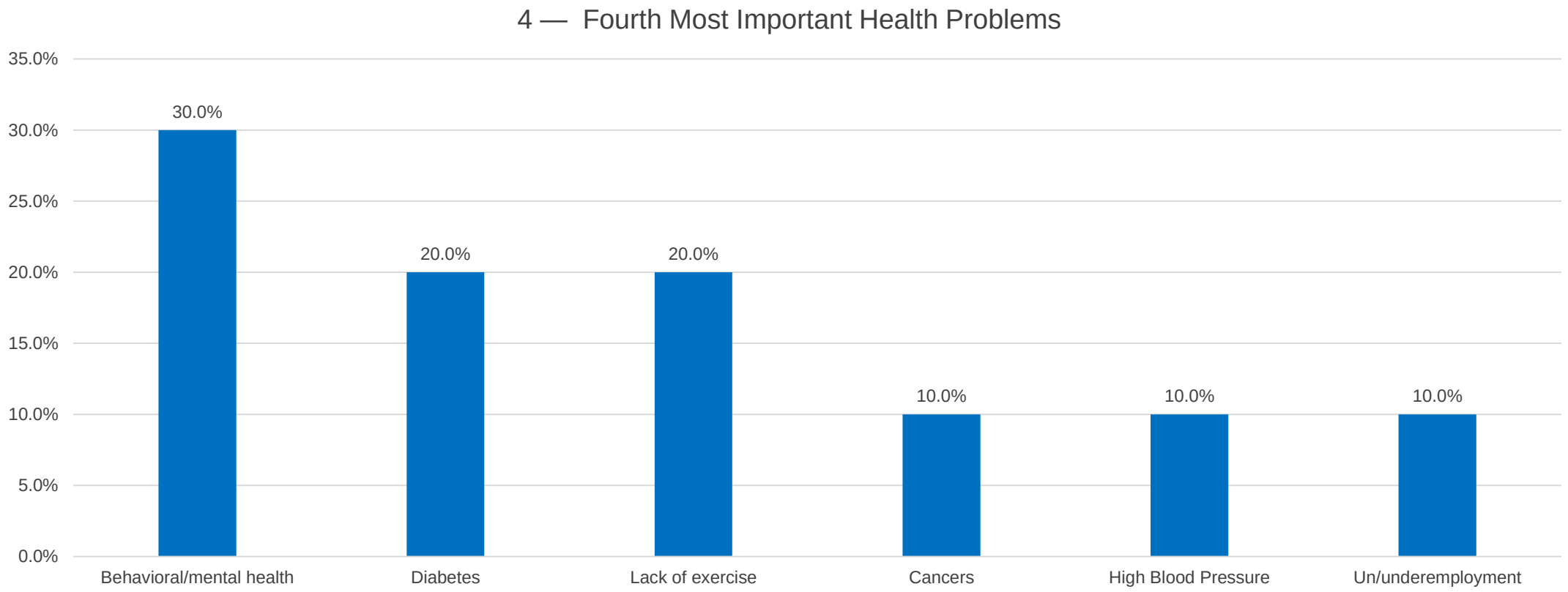


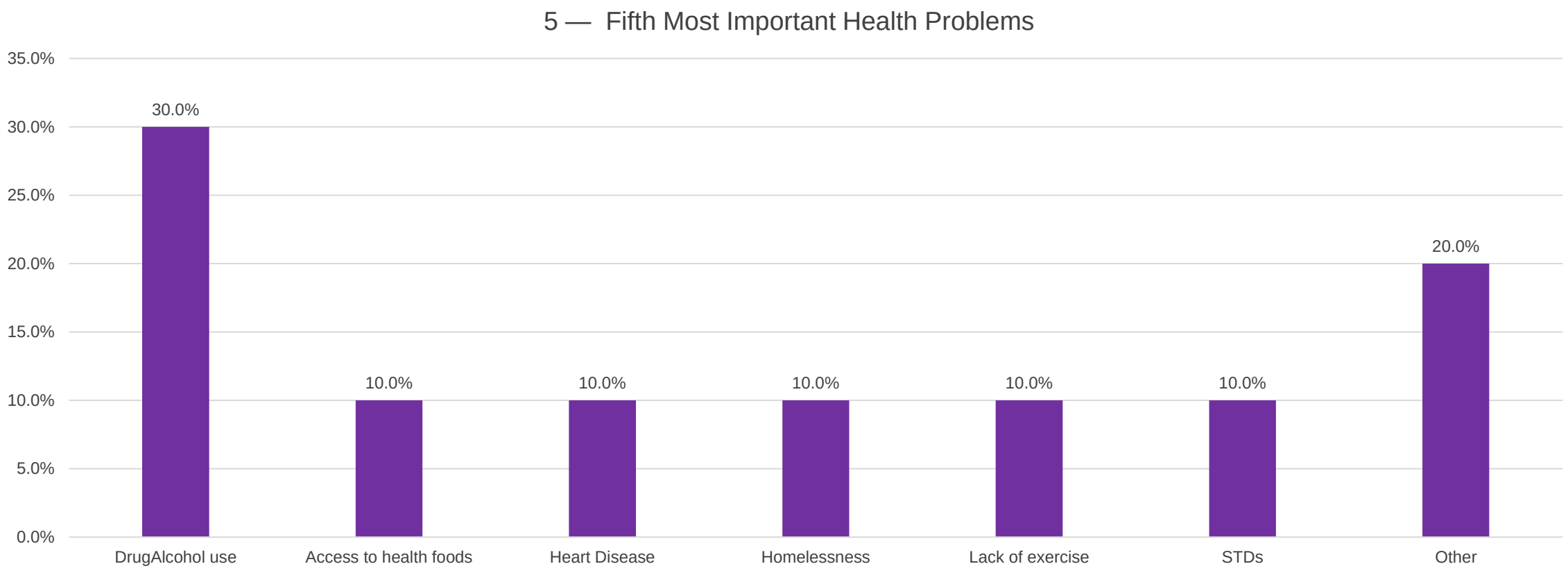
Top 5 persistent “Health Problems” in the community?



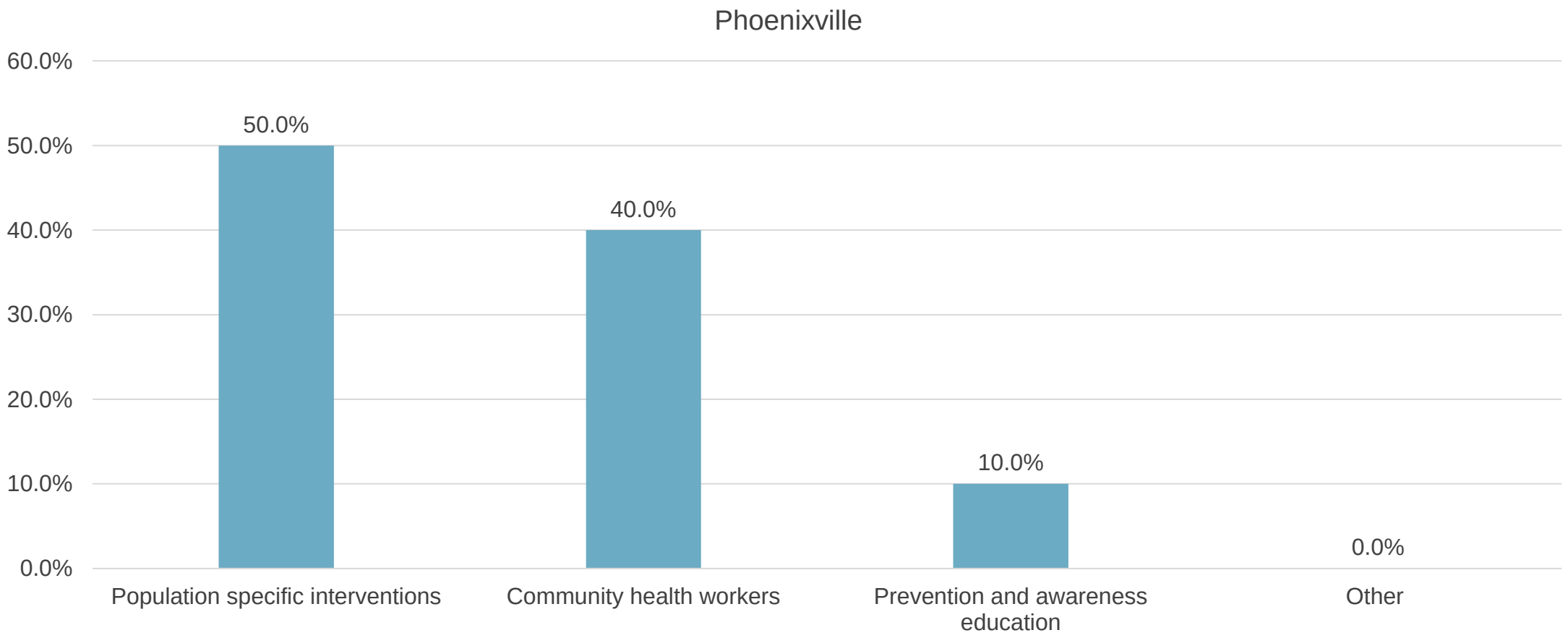
Top 5 persistent “Health Problems” in the community?



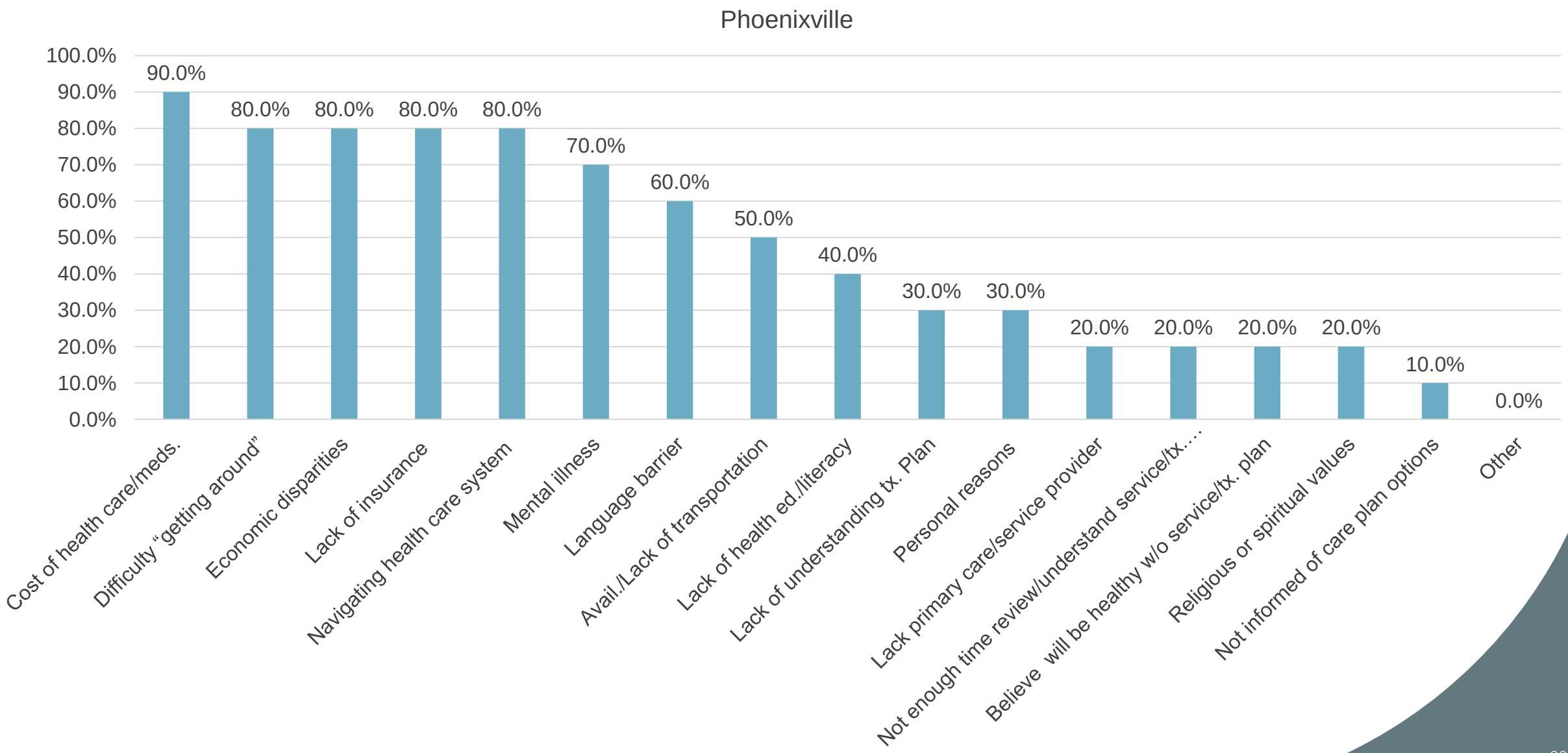
Top 5 persistent “Health Problems” in the community?



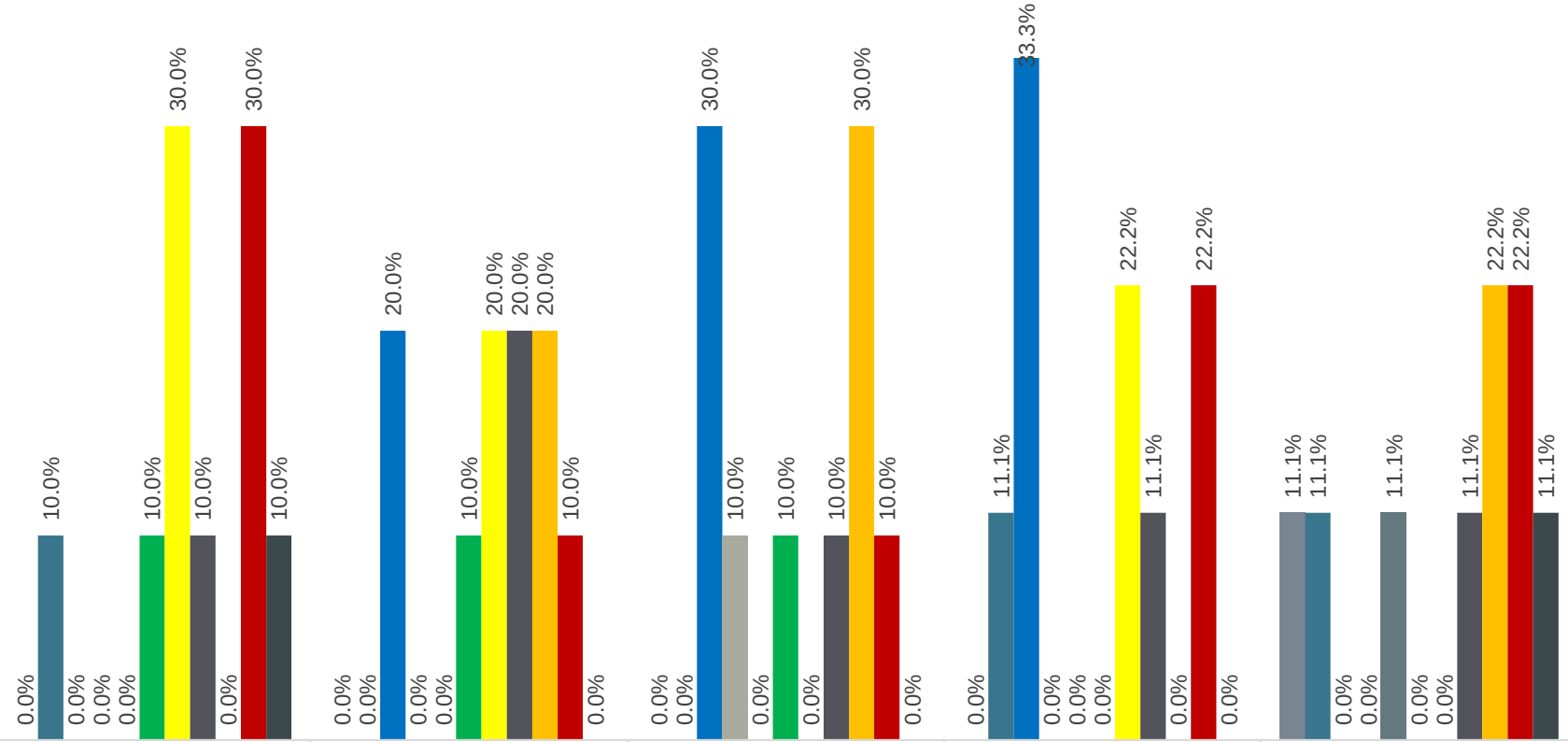
Type II diabetes, pre-diabetes and obesity affects many members of our community. What can we offer the community to achieve and maintain optimal health?



Most significant barriers to improving health and quality of life – Check all that apply

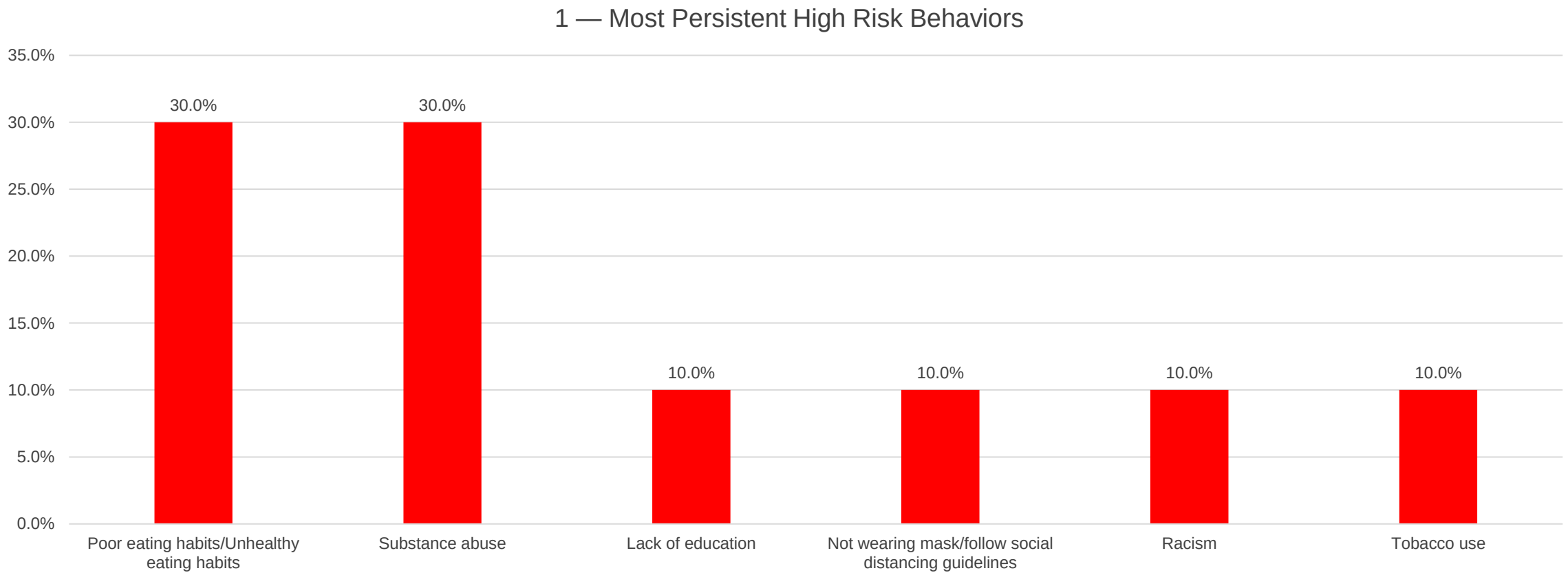


Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



	1 = Most Important	2	3	4	5
Dangerous driving	0.0%	0.0%	0.0%	0.0%	11.1%
Lack of education	10.0%	0.0%	0.0%	11.1%	11.1%
Lack of exercise/inadequate physical activity	0.0%	20.0%	30.0%	33.3%	0.0%
Not getting “shots” to prevent disease	0.0%	0.0%	10.0%	0.0%	0.0%
Unsafe sex/Not using birth control	0.0%	0.0%	0.0%	0.0%	11.1%
Not wearing a mask and following social distancing guidelines	10.0%	10.0%	10.0%	0.0%	0.0%
Poor eating habits/Unhealthy eating habits	30.0%	20.0%	0.0%	22.2%	0.0%
Racism	10.0%	20.0%	10.0%	11.1%	11.1%
Social injustice	0.0%	20.0%	30.0%	0.0%	22.2%
Substance abuse (i.e., alcohol/drug abuse)	30.0%	10.0%	10.0%	22.2%	22.2%
Tobacco use	10.0%	0.0%	0.0%	0.0%	11.1%

Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



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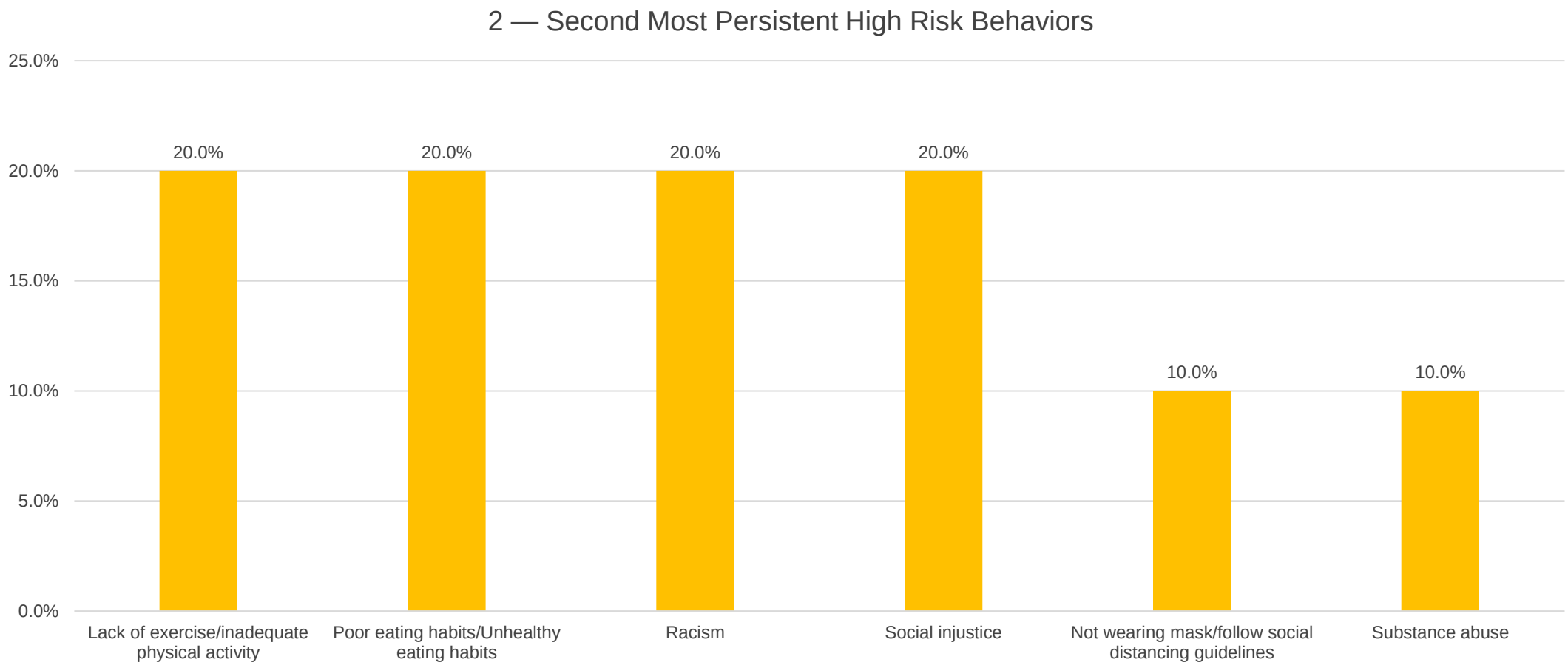

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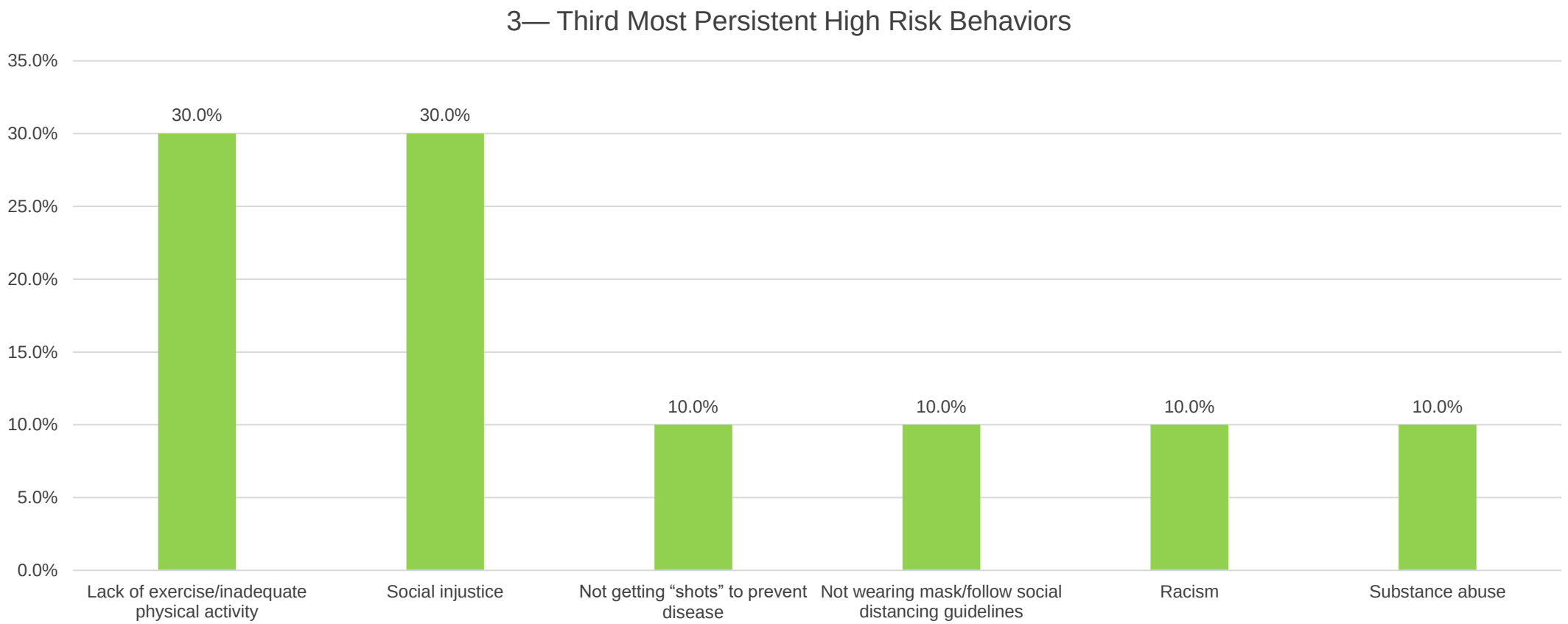

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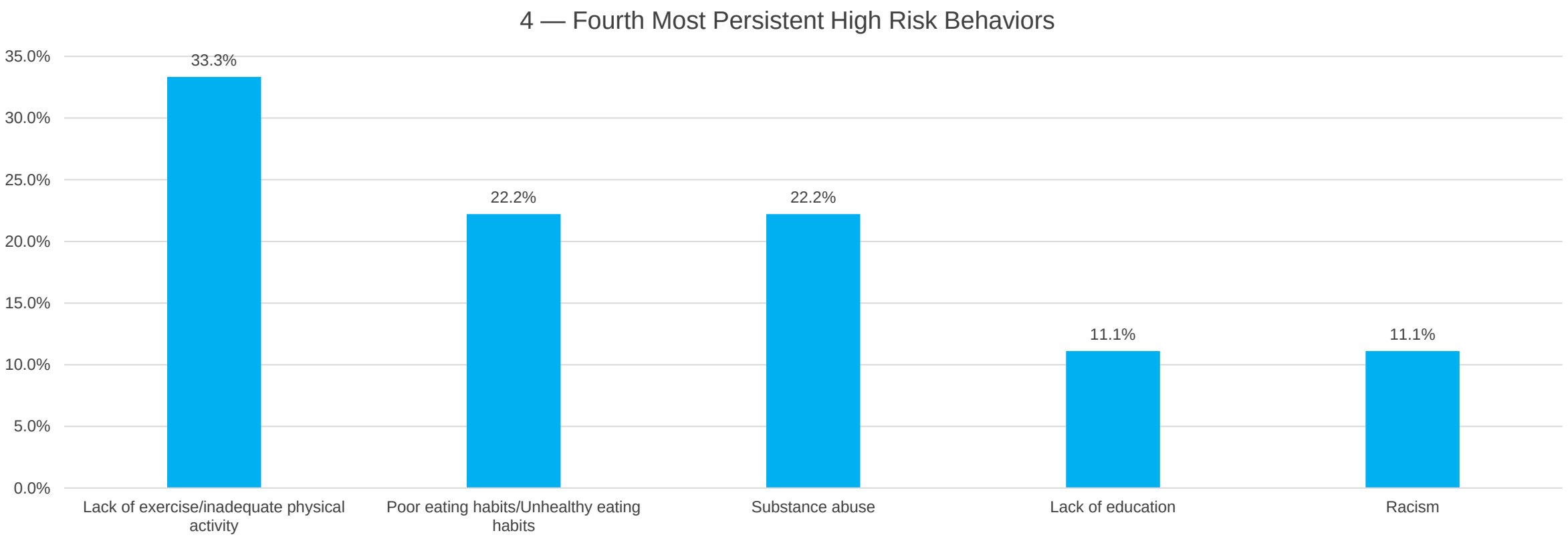

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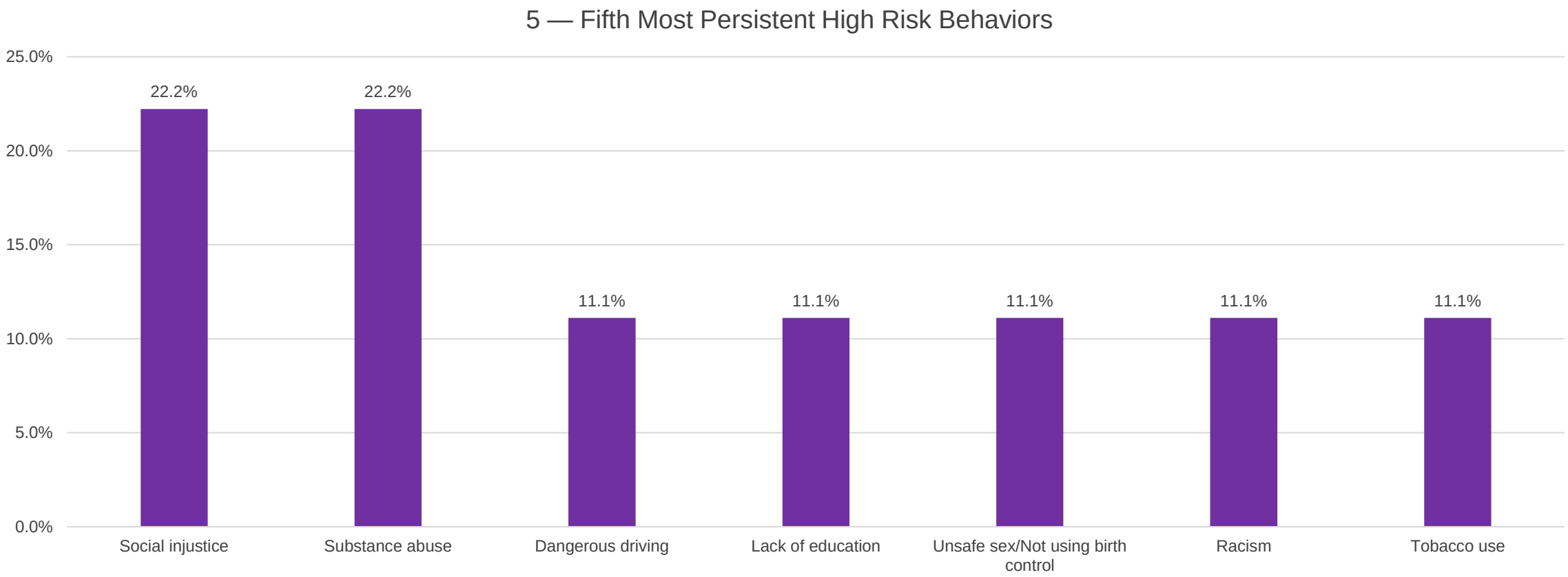
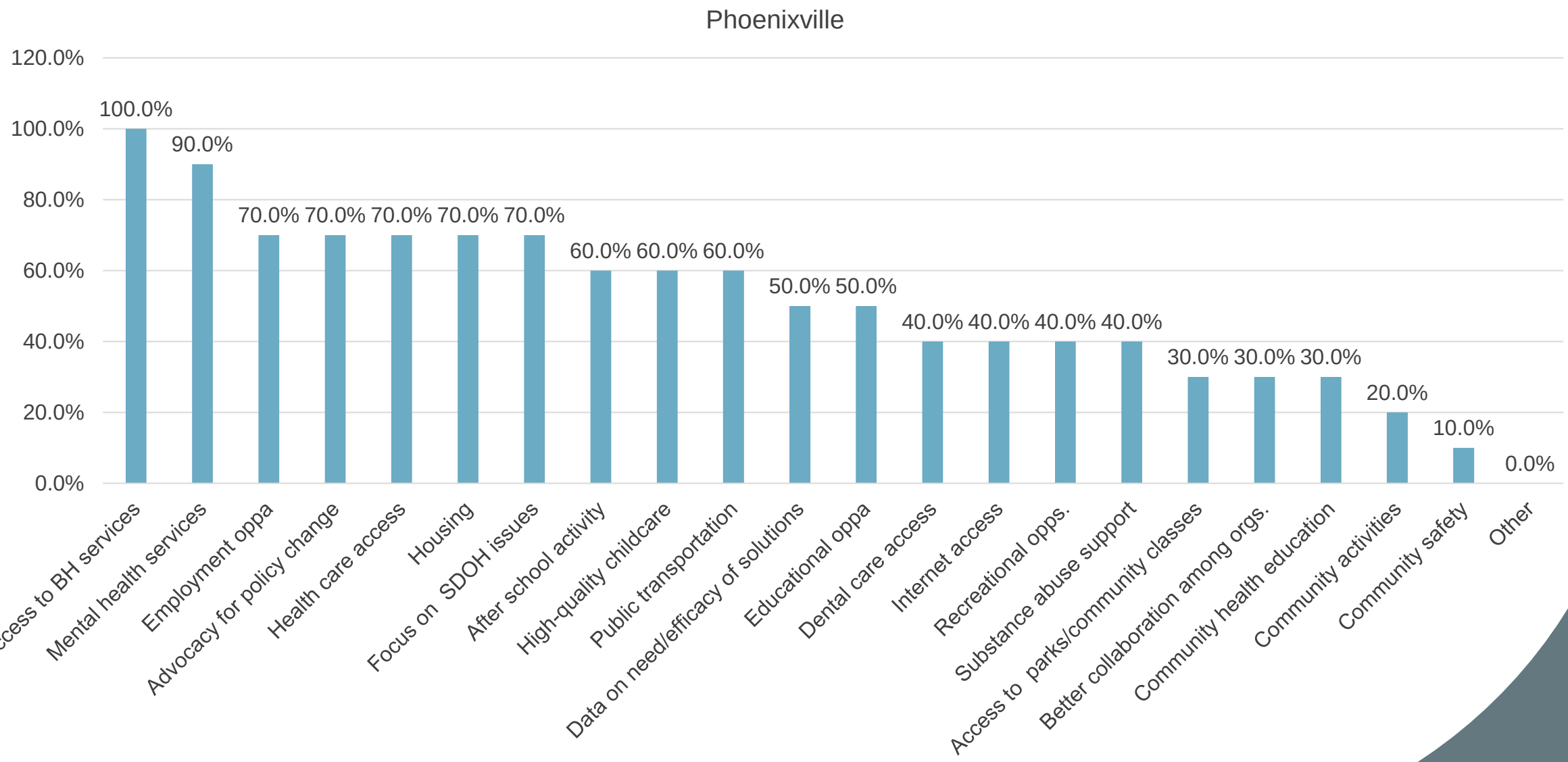
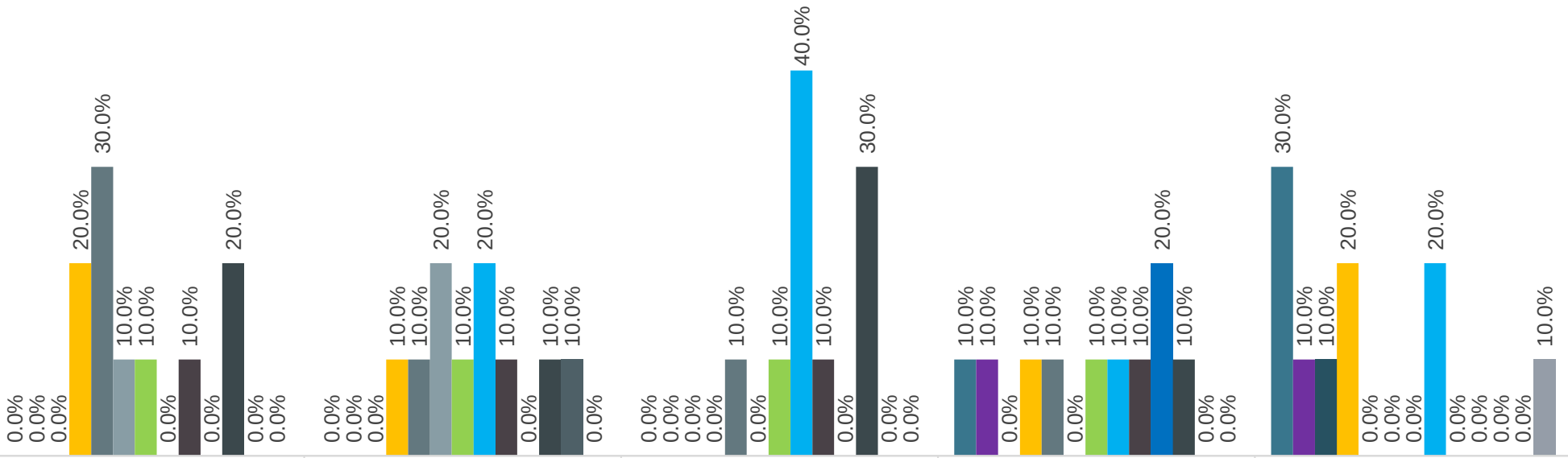


What would improve the quality of life for residents in your community? — Check all that apply



Top 5 populations that are the most vulnerable in the community?



	1 = Most Vulnerable	2	3	4	5
Children/youth	0.0%	0.0%	0.0%	10.0%	30.0%
Chronically ill	0.0%	0.0%	0.0%	10.0%	10.0%
Disabled	0.0%	0.0%	0.0%	0.0%	10.0%
Homeless	20.0%	10.0%	0.0%	10.0%	20.0%
Immigrant/Refugee	30.0%	10.0%	10.0%	10.0%	0.0%
LGBTQ	10.0%	20.0%	0.0%	0.0%	0.0%
Low-income	10.0%	10.0%	10.0%	10.0%	0.0%
Mentally ill	0.0%	20.0%	40.0%	10.0%	20.0%
Minorities	10.0%	10.0%	10.0%	10.0%	0.0%
Older adults	0.0%	0.0%	0.0%	20.0%	0.0%
Uninsured/underinsured	20.0%	10.0%	30.0%	10.0%	0.0%
Women	0.0%	10.0%	0.0%	0.0%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	10.0%

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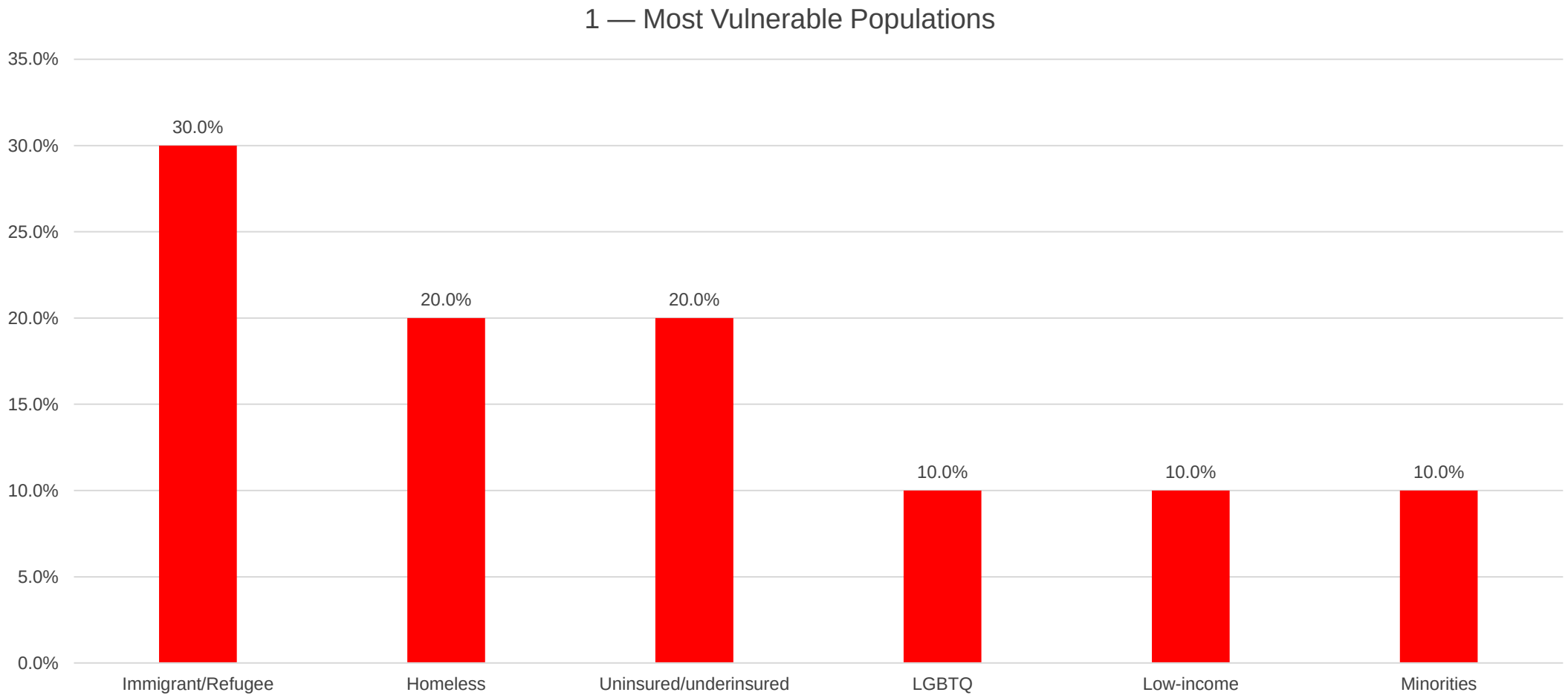

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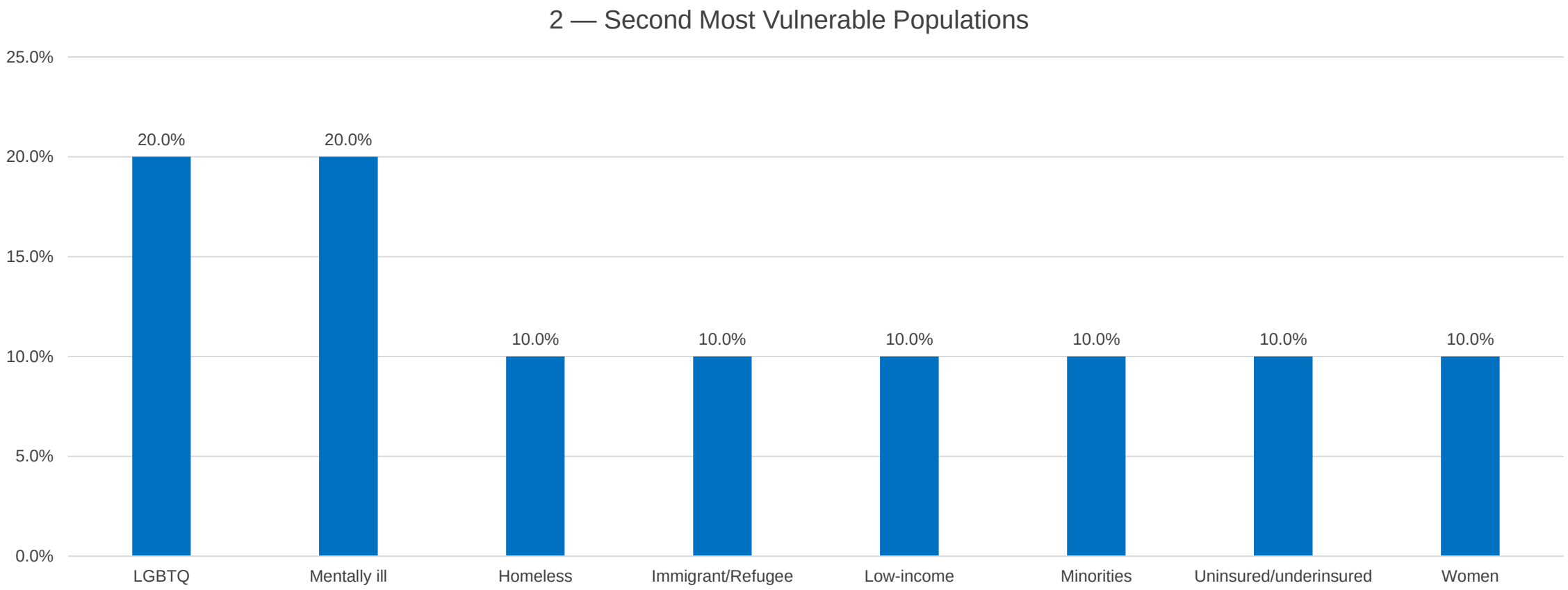

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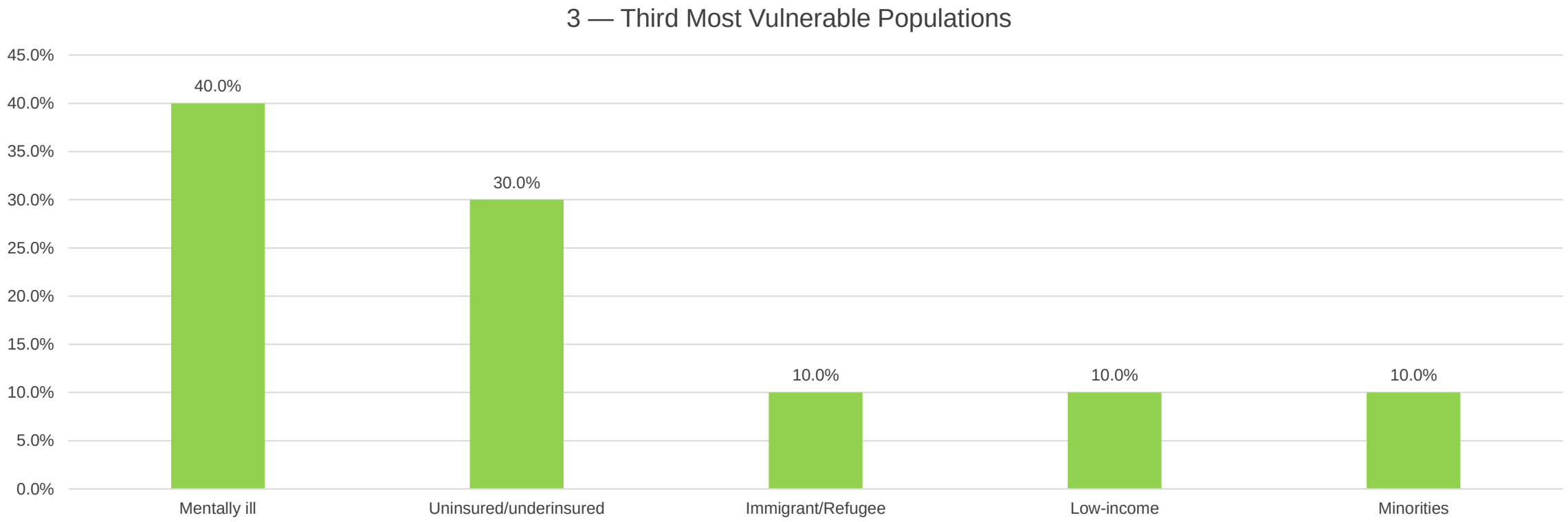

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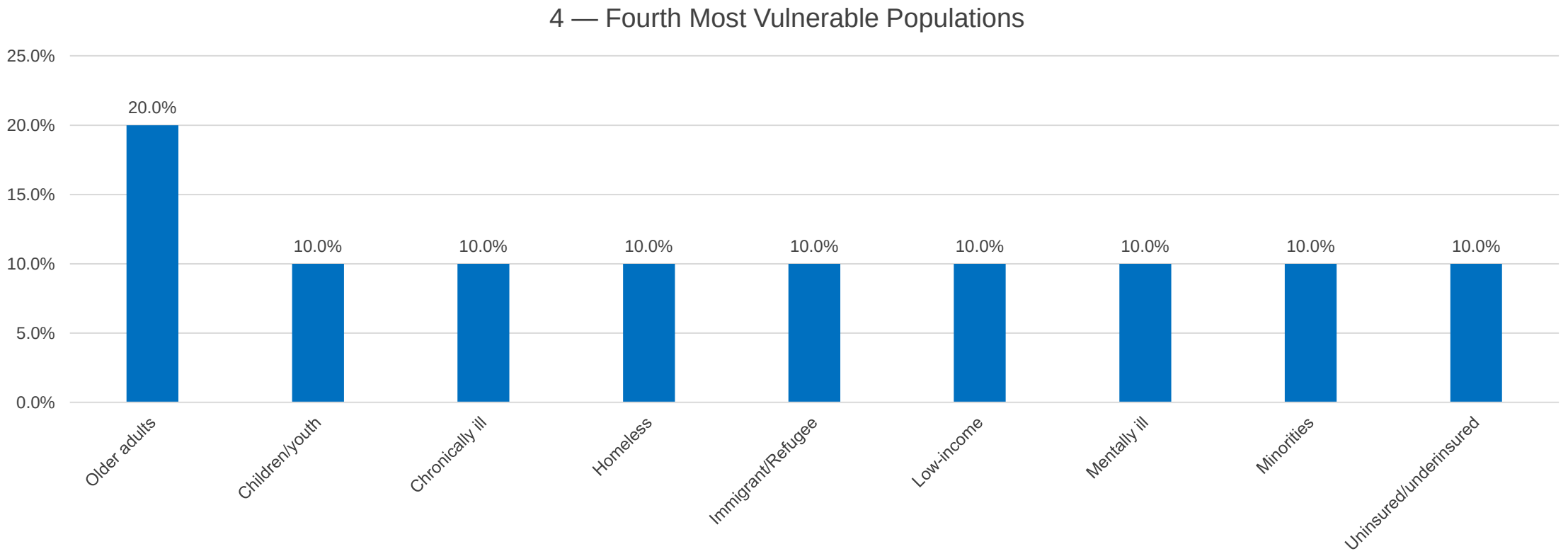

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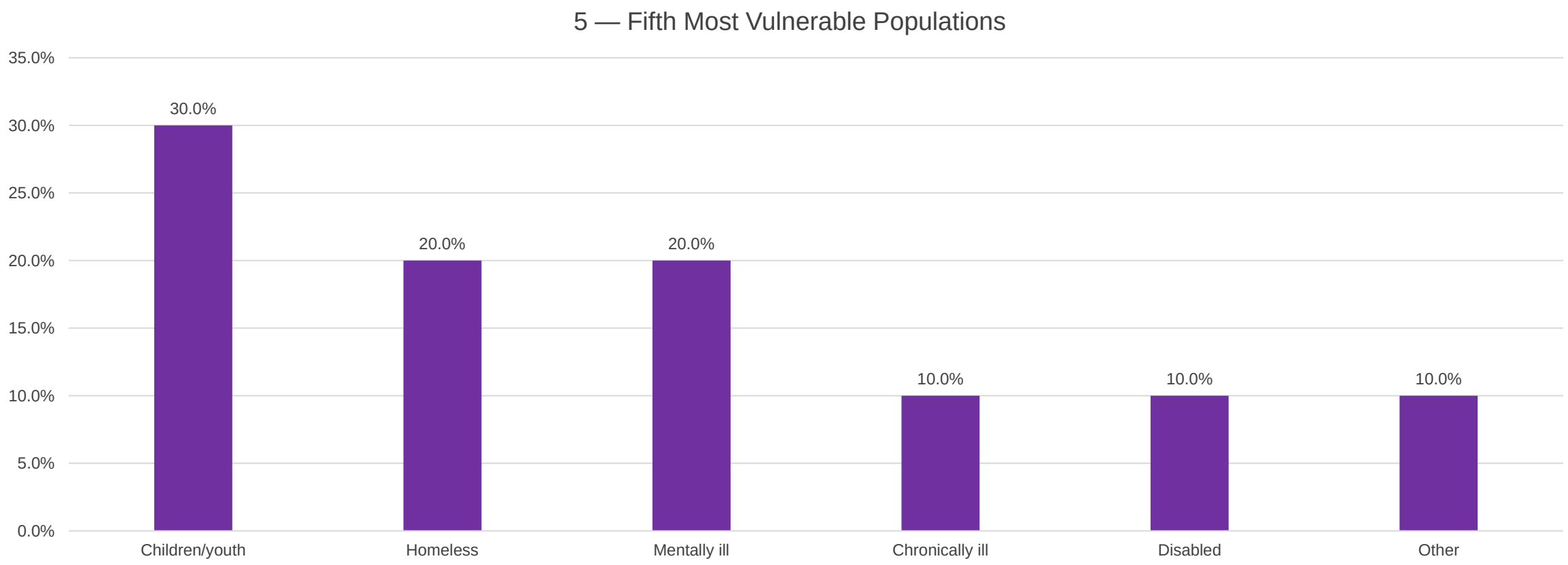
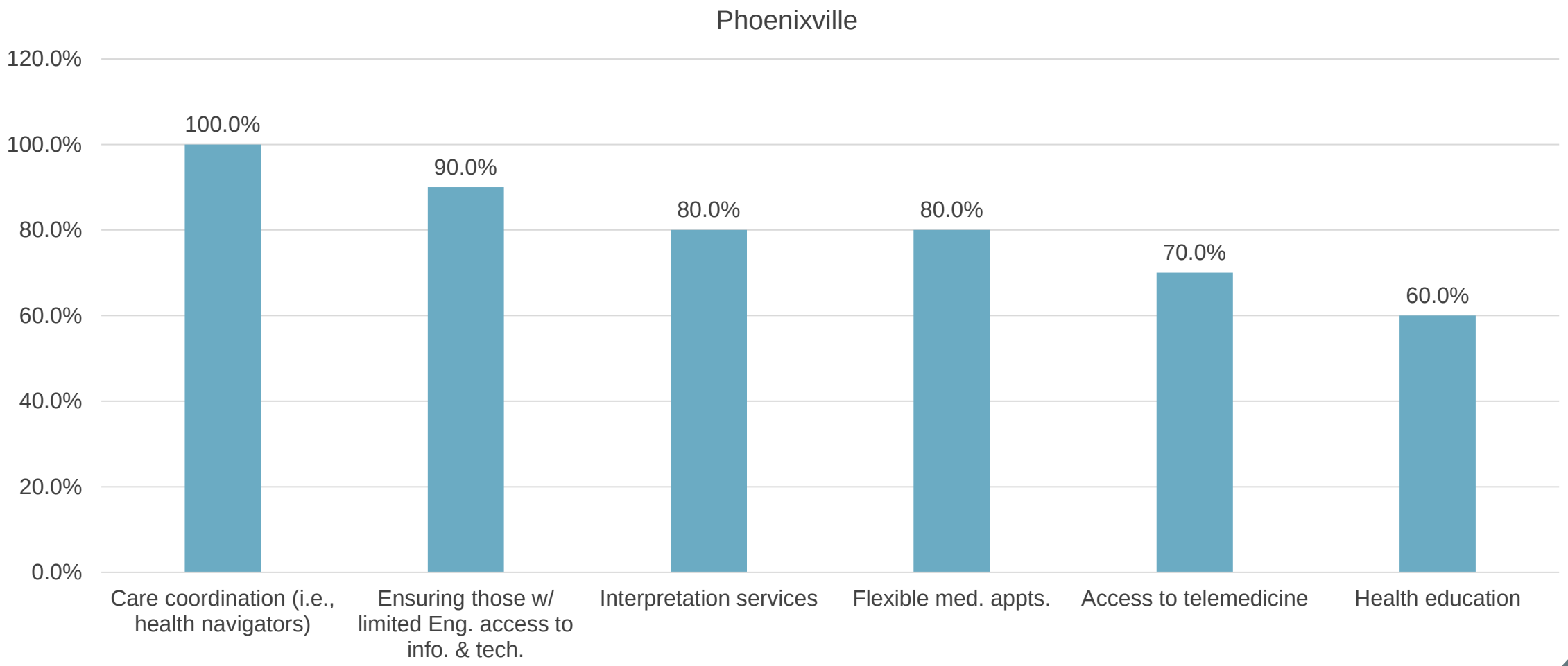
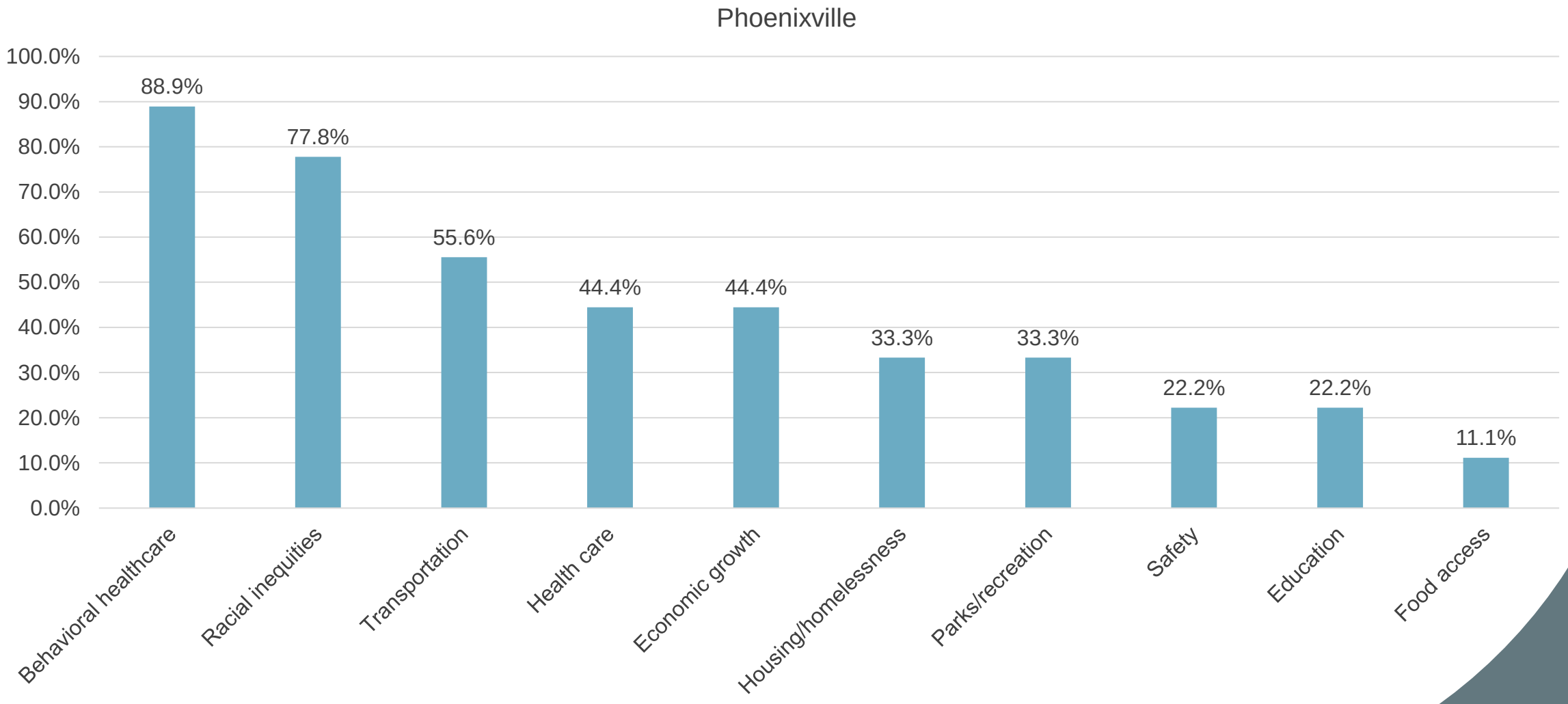


Solutions to help vulnerable populations meet their health needs — (Select all that apply)



What community needs are currently siloed and need further collaboration among non-profits, healthcare, government? (Check all that apply)



How did COVID-19 further impact care, specifically among the underserved and disenfranchised population(s)?

- Created job loss and which impacted access to insurance. Those with no internet access and technology limitations were more impacted. Created transportation issues as some did not want to use public transportation due to pandemic fears.
- Job loss and had to use resources like food and rental assistance. There was a shift in how people prioritized their needs – getting health was not a concern.
- Limited one of the main access points to health care which was schools. School nurses are important in the care they provide but being out of school eliminated that contact. Great impact on child abuse and reporting. No contact with the parents where schools are typically able to link them to needed resources.
- People delayed general preventive care. Underserved populations often did not have the technology to access care.
- For those who already had health inequities, this exasperated it; it made these more apparent.
- With job losses, it impacted access to food and care, vaccine access, and understanding of the process in addition to higher rates of contracting illnesses.
- Immigrants without insurance were mostly impacted as they cannot take time off for appropriate quarantining.
- COVID exacerbated the economic disparities that exist in our community. Lead to loss of housing, less ability to pay, and less preventive care.
- Communication with the underserved was poor. Increased food insecurity and housing. Struggles with the interpretation of government guidelines around staying safe were problematic.
- Created social isolation and reduced access to community and resources.

Did telemedicine and virtual platforms ease access to care? In what way?

- Made it easier to access health care; more pointed conversation and focused; helped in areas of transportation or mobility issues.
- Improved access. Saw improvements in continuing with outreach efforts because we had to continue with it.
- Helped those who had the resources to access; but not for the vulnerable populations. Even if they had the technology, there was no training to use it and it was difficult for many.
- Helped the majority. More appointments were available and it was more convenient, but those with language barriers or technology limitations did not benefit.
- It proved to be more successful than it was believed for certain types of visits.
- Eased transportation challenges and reduced risk exposure.
- Primarily for English speaking but less so for those needing translators. Telehealth greatly benefited those with transportation issues.
- It widened the digital divide among immigrant communities.
- Made it less intimidating to access care and easier. Works well for the first contact and also follow-up care.
- Telemedicine and virtual platforms increased access to care for people who may have difficulty scheduling appointments both in and out of the home.

What actions could your hospital take to better address health disparities?

- Large Latin community/immigrants in the area. Language issues need to be addressed as we have not seen marketing specifically towards the underserved. Unsure how the hospital is viewed in those communities.
- Providing education. Consistency about vaccination and ongoing education. Stick with one campaign so people do not get overloaded with information. With the pandemic, kids are not getting vaccinated.
- Continue to grow the services to provide interpretation amenities off-site in the community. Even if transportation is available people are more comfortable accessing care in their community.
- The hospital does a good job working with non-profits organizations.
- Address root cause; do not lean on just education but partner with others to have an impact.
- Continue providing bridged services with referral to programs that can help improve health.
- Aggressive charity care offerings for patients. Also, follow-up after hospitalization for those without insurance. Support local clinics providing care to the underserved. Provide access to physicians where patients could be referred for care beyond primary care.
- More bilingual, bicultural, culturally competent staff especially in the ER; language line is not enough.
- They should provide clear information on costs and care for the uninsured. Care coordination and warm handoffs with other organizations could improve.
- We need to ensure that we hire staff that is representative of the populations that we serve. We need to ensure that all staff and persons connected to the county use appropriate interpretation and translation services.

Excluding healthcare, what organizations should collaborate to address behavioral health in our community?

- Ann's Heart
- Business community
- CHIMES
- Churches, faith -based
- County Dept of Behavioral Health/Substance Abuse
- Creative Health services
- DAEMION
- Fellowship Health Resources
- Good Samaritans
- Health and human services, social services
- Housing/shelters
- Local government
- Mental health professionals
- Open Hearth
- Orion Community Services
- PACTS (food access)
- Parks and recreation
- Police departments
- Prison system
- Private /non-profit organizations
- Schools
- Social workers
- Spring-Ford Counseling
- Veteran organizations
- YMCA

What do you want the hospital to know that we haven't already asked?

- The clinic and the hospital should work more closely. Hospital is benefitting from The Clinic and the services it provides.
- Financial benefits of collaboration. Lessened the overhead cost of care so we can see more Medicare population. This might benefit the referrals constraints.
- Hospital needs to extend and network more into the communities. As a nonprofit, they should be reaching out more to the community to provide satellite offices, not just those directly around the hospital or to the "resourced" areas but to those in need.
- Good job on collaboration; their work with YMCA on Parkinson's program has been very successful.
- How does the health system leverage existing needs assessments? Phoenixville Hospital does not send updates and progress information. Their sister hospital in the community does that for awareness at a minimum if not for collaboration.
- Consistency is important in programming to reach vulnerable populations.
- Social workers and case managers need to do a better job helping un/underinsured navigate the health care system and educate on what services are available from a follow-up standpoint.
- Hospital is an incredible partner. The community has come together to collaborate with positive outcomes.
- Community organizations including ethnic and faith-based organizations should be active partners with health care facilities.

Are there sufficient health resources in our community? Is there duplication of services?

- Clinic is at capacity; unsure how that will be affected by future decisions; concern that uninsured may not have anywhere to go. Not a concerning extent of duplication.
- There are not sufficient health resources, especially for behavioral health services. Suicide intervention services are sorely lacking.
- Good structure for resources; need better navigation for behavioral health services and there are not enough beds; Duplication not an issue in the community.
- Not sufficient to address inequities; some duplication – some could be consolidated or partner
- Work is being done on duplication; there are sufficient resources but knowledge of them is lacking.
- Hospital could increase resources beyond primary care for under/uninsured. No duplication. Organizations collaborate well.
- Not enough behavioral health for uninsured, in multiple languages & cultural context.
- There are sufficient resources with little duplication.

Public Commentary

1. Do you feel that the assessment you reviewed included input from community members and organizations?

Yes – 80%

No – 0%

Don’t know – 20%

2. Do you feel that the assessment you reviewed excluded any community members or organizations that should have been involved in the assessment?

Yes – 20%

No – 30%

Don’t know – 50%

3. Were there needs in the community related to health that were not present in the CHNA (e.g., physical health, mental health, medical services, dental services, etc.)?

Yes – 10%

No – 70%

Don’t know – 20%

4. Were the implementation strategy directly related to the needs identified in the CHNA?

Yes – 50%

No – 0%

Don’t know – 50%

Public Commentary

How did this CHNA and resulting Implementation plan benefit you and your community? If no, in what way would the implementation plan be beneficial to you and your community?

- Helpful to see information in the report; provides a research document of needs in the community.
- Highlighted areas for improvement and increased collaboration.
- Visibility of the hospital in the community was a benefit. It brought leaders together in the initial phases to have meetings with the hospital. Unsure of any benefits from the implementation. It seemed to fall away with COVID-19.
- More programming specific to the Hispanic population, continued effort toward helping pregnant women, expansion of access to cancer treatment closer to home.
- Collaboration with Tower – Livestrong (cancer patients) and Parkinson's programs.
- We need full implementation on past initiates. Covid halted this and we need to restart the initiates again.

Public Commentary

Please share any additional feedback on the CHNA /Implementation Plan that was not covered already?

- Goals identified were not “stretch goals”; the hospital system kept to obtainable goals which are not necessarily the most beneficial to the community.
- Policing relationships/safety in our communities of color was not covered in the CHNA.
- Once the pandemic passes, re-energize the implementation plan. Lots of important issues were identified but the follow-up needs to happen.
- I hope we can continue with the initiates. We need to add on and not restart it. We need to get back on the course.

Tower Health Phoenixville Hospital

Appendix B – Health Equity Focus Group

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Phoenixville Hospital Health Equity Focus Group

Focus groups were conducted during June 2021 to collect information and capitalize on communication among health and human service providers. The focus groups enabled its participants to explore and clarify insights and perspectives in a manner that maximizes participation and builds on synergy. Designed to collect and synthesize in-depth information on community provider's thoughts and opinions related to health and health equity, the focus group questions directed participants to look at health and health equity through the broadest lens and scope. The health equity focus groups emphasized a two-fold aim:

1. Better understand barriers faced by vulnerable populations
2. Identify action steps to remove barriers to improve health equity

Facilitated focus group interactions expanded a delicate but challenging conversation regarding health equity and enabled community participants to examine changing perceptions, beliefs, and attitudes related to acknowledging contributors to health equity, identifying health disparities, and improving health equity. Through facilitation, an open and candid environment was created, allowing health and human service providers to speak openly and to share perspectives and real stories regarding the impact of health inequities and health disparities of the diverse populations they serve. The health equity focus groups composed of community representatives, clinical, and human service providers were encouraged to uncover and discuss a plethora of complex and compelling barriers, needs of the diverse and disparate populations they serve and to anticipate what actions should be undertaken to address health equity.

Discussion Area of the (7) health equity focus groups:

1. Contributors to health inequity (SDOH contributors to health inequality (i.e., transportation, education, low-income, lack of access to health care, uninsured/underinsured, and mistrust)
2. Impact of racial and social disparities on quality of care
3. Areas having the most impact on people being treated differently (e.g., education, race/ethnicity, income, insurance, not being able to speak English)
4. The magnitude of social and racial inequalities in health in the workplace, education, housing, and government areas
5. Identifying who is accountable for equitable health care
6. Obstacles and barriers to health equity
7. Recommendations to improve health equity
8. Call to action
9. Knowledge facilities need to know related to the community

The discussions among the health equity focus groups unveiled the following "Call to Action" recommendations: health equity and cultural

1. Building a diverse workforce that is reflective of the communities they serve.
2. Continuing to advance cultural competency, language, and translation services.

3. Improve patient engagement and increase awareness/communications of available services and programs both to the community as well as across the hospital.
4. Strengthening communication, partnerships and community engagement.
5. Continue the distribution of health information and reinforce health education.

The objectives of the focus groups were achieved as community participants openly and emphatically expressed care and concern for the disparate and vulnerable populations they serve.

1. Contributors to Health Inequity
Phoenixville
• Telehealth and internet access and applications limited for seniors and minorities • Lack of trust • Overall discrimination of medical community towards residents such as LBTGQ+ groups • Unavailable language services, bilingual staff, and resources • Lack of access among underrepresented groups, working poor, and Medicare patients

2. Impact of Racial and Social Disparities and influence on Quality of Care Received
Phoenixville
• Communicate with different cultures such as LGBTQ+ community • ID risky behaviors and misconceptions of how people access care • Train staff to address discrimination and implicit biases, push for inclusiveness

3. Impact of Patients Being Treated Differently
Phoenixville
• Race/ethnicity - 50% • Income - 20% • Not speaking English - 20% • Insurance coverage - 10% • The racial makeup of a person is a predictor of how care is provided • Need racial representation of providers – there is resistance to seek care otherwise • Need culturally appropriate literature materials • Need racial representation of hospital administrators

4. How Big of a Problem are the Following Areas as Related to Social and Racial inequalities: health, workplace, education, housing, government?
Phoenixville
• Health - 100 % major problem • Education - 100% major problem • Housing - 100% major problem • Govt. - 100% major problem • More prevalence related to racial and social inequalities • Growing support for social justice and inequities – open dialogue on racial inequalities discussions • Break the silos • Need more involvement and listen btr. to community • Housing gentrification is at its worse • Ppl cannot afford housing, COVID made housing situation more difficult • Ageism as a social prejudice as poor seniors are pushed out and treated like minorities • Seniors unable to navigate housing and cannot afford taxes

5. Who Should Be Accountable?

Phoenixville

- Health care - 50%
- Govt. - 40%
- Other - 10%

- Health care is boots on the ground and govt. is not picking up the slack
- More than one answer required, need overall support
- Need pressure on govt. for support
- Insurance/payors are part of the problem; need them to press gov't to address inequity
- Gov't pushes the rules and health care must respond to changes
- Need policy and finances to better serve populations

6. Barriers and Obstacles That Stand In the Way

Phoenixville

- Transportation
- Fear and distrust
- Poor economics and lack of advocacy
- Difficulty in navigating the health care
- Need to give ppl information to make decisions
- Political activism- inform govt. they are not doing their job
- Health systems are powerful economic engines. Use power to make a difference

7. Recommendations to Address Health Inequities

Phoenixville

- Exert voice, political activism and power to effect change and address embedded racism
  Assist ppl who lack coverage, unable to access care, and cannot afford medicine

8. Actions to Improve Health Equity (Call to Action)

Phoenixville

- Provide standardized level of care and protocols for everyone
- Acknowledge services available at TH
- Improve language and translation services
  - Interpreters at night in the ER
  - Improve efficiency of language lines
- Coordinate and connect individuals to wrap-around resources and preventive services

9. What the Hospital Needs to Know About the Community

Phoenixville

- Advocate for ppl and help understand available resources
- Have bilingual staff to explain medical conditions and care
- Remove stigma and fear of deportation in undocumented populations
- Reduce fears, help understand health care, billing process
- Takes several months to receive services ppl need; more difficult since COVID
- Need to do better job of connecting ppl to services
- Underrepresentation of MH providers to serve poor and minority communities
- Provide education and do more on prevention level

Capturing Data / Reduce Rates Among Ethnic Groups/Information and Identifying Interventions

Phoenixville

<u>Identify Interventions</u>

- Mapping and trend analysis looking at specific hospital data
- Understand pockets of issues among struggling and vulnerable populations
- Use data to craft where we are headed and to make own decisions
- Using data to allocate resources and build collaborations
- Review certain ZIP codes to identify needs
- Collaborate and share internal data

Tower Health Phoenixville Hospital

Appendix C – Leadership Focus Group

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Phoenixville Hospital Leadership Focus Group

Focus groups were conducted during June 2021 to collect information and capitalize on communication with the leaders of Tower Health hospitals. The focus groups enabled its participants to explore and clarify insights and perspectives in a manner that maximizes participation and builds on synergy. Designed to collect and synthesize in-depth information on leadership's thoughts and opinions related to health and health equity, the focus group questions directed participants to look at health and health equity through the broadest lens and scope. It is often noted that (1) leadership commitment and involvement are vital to an organization's ability to address complex issues and (2) the beliefs and perspectives of leadership may have the greatest impact on how an organization achieves cultural competency and improves health equity.

The leadership focus groups emphasized a two-fold aim:

1. Better understand barriers faced by vulnerable populations
2. Identify action steps to remove barriers to improve health equity

Facilitated focus group interactions expanded a delicate but challenging conversation regarding health equity and enabled Tower Health leaders to examine changing perceptions, beliefs, and attitudes related to acknowledging contributors to health equity, identifying health disparities, and improving health equity. Through facilitation, an open and candid environment was created, allowing leaders to speak freely and honestly as essential to hear health equity perspectives and real stories regarding health equity and health disparities of the communities. Leadership focus groups composed of administrative, physicians and clinical, leaders were encouraged to uncover and discuss a plethora of complex and compelling barriers, the needs of the diverse and disparate populations they serve and to make recommendations on what actions may be undertaken to address health equity.

Key themes from the (7) leadership focus groups:

1. Contributors to Health Inequity (SDOH Contributors to Health Inequality (i.e., transportation, education, low-income, lack of access to health, uninsured/underinsured, and mistrust/trust factor)
2. Leadership Actions to Provide Equitable Care
3. Using Data to Identify Gaps
4. Use of Clinical Data
5. Staff Training
6. Consistently Providing Training to Staff towards Culturally and Linguistically Appropriate Care
7. Having Health Equity as an Organizational Priority

Key themes from the (7) leadership focus groups unveiled the following recommendations (Call to Action):

- ☐ Develop a plan to achieve health equity

Phoenixville Hospital

- ☐ Importance of continuing to build a more diverse workforce at the leadership and staff levels; reflective of the community served
- ☐ Improve on the level of awareness related to available services and programs both to the community as well as across the health system
- ☐ Strengthening communication and community engagement. Solidify existing partnerships and collaborations. Creation of a community advisory board.
- ☐ Continuing to advance cultural competency, language, and translation services
- ☐ Sharing of information across the system regarding available services and programs as a few hospitals were not aware of the many programs available and active at the system level

The focus groups objectives were achieved as hospital leaders openly and emphatically expressed care and concern for the disparate and vulnerable populations they serve.

1. Contributors to Health Inequity
Phoenixville
• Fear of COVID-19 and unable to navigate telemedicine platform • Low-income, poverty and unemployment • Lack of transportation • Inability to pay for health coverage, high co-pays and deductibles • Lack of access and inadequate services • MH services provided in ER and inpatients • Homelessness • Access to PCPs • Health literacy • Preventive screenings (i.e., mammograms and checkups) • Language barriers • Cultural competency

2. Leadership Actions to Provide Equitable Care
Phoenixville
• Provide access to health care • Conduct system-wide diversity outreach as part of D&I initiative • Provides bilingual materials, signage for hearing impaired, etc. • Need FT interpreters, partner with other organizations • Ensure access to ortho, pharmacy, and prenatal care to undocumented or underinsured women

3. Using Data to Identify Gaps
Phoenixville
• Use demographic data of service areas • Address needs of each subpopulation • Conduct outreach to target specific health issues (i.e., cardio care) • Looks at MH needs, accessing care and treatment • Based on data, apply for grant to secure equipment for those who cannot afford them. Prevents readmissions and tracks outcomes

4. Use of Clinical Data
Phoenixville
• Use data for Latino population and baby program • Use data on smaller scale with nursing programs and partnership with African American church, focusing on diabetes • Look at data to develop new plans • Look at age, readmissions (COVID-19), and payor mix

5. Staff Training
Phoenixville
• Provides diversity training and outreach to staff through online orientation and different D&I topics monthly • D&I Council applied for grant to offer wide scale implicit bias training –working with training organizations • Plans to increase diversity and inclusion of workforce to reflect community • Will work with other groups to help us, will track diversity efforts

6. Consistently Providing Training to Staff towards Culturally and Linguistically Appropriate Care
Phoenixville
• Looks at specific factors and certain populations (LGBTQ+), support groups and partner organizations • Staff participates in health fairs, Latina community • Works with food pantries to promote health and prevention • Partners with YMCA and other community organizations

7. Having Health Equity as an Organizational Priority
Phoenixville
• Provide medical education program to improve access • Provide care where people are located for improved access • Consider Reading's Street Medicine Program to provide free care to the uninsured/homeless • Look at feasibility and financial assistance to provide Ride Help program in Phoenixville

Phoenixville Hospital

Recommendations and Implementation Strategies
Phoenixville
• Use community advisory board to enhance awareness of our services • Provide standardized care, improve health literacy, and measure outcomes • Place PCPs in community to meet needs where people are • Improve diversity of medical staff and workforce to represent the community by race and cultural • Advance cultural competence • Use race and gender data to develop strategies and target chronic diseases • Advance telemedicine in psych, medical, and pediatric areas

Importance of leadership and governance team reflecting the diverse community it serves (Polling Question)
Phoenixville
Very Important - 86% Moderate Importance - 14% • We are owned and served by the community. We need to serve them well • Need improved diversity on leadership group

Does your leadership team reflect its community? (Polling Question)
Phoenixville
Yes - 83% No - 17% • Long-standing committed employees with long history and tenure • Limited openings for representation from the community. • Prefer to mentor, grow our own. Rich benefits, opportunity for education, ID promising individuals to advance into leadership • People lack awareness. We have great clinicians and awards – Phoenixville does not receive recognition like the Penn's and Jefferson's of the world

Tower Health Phoenixville Hospital

Appendix D - Key Informant Survey

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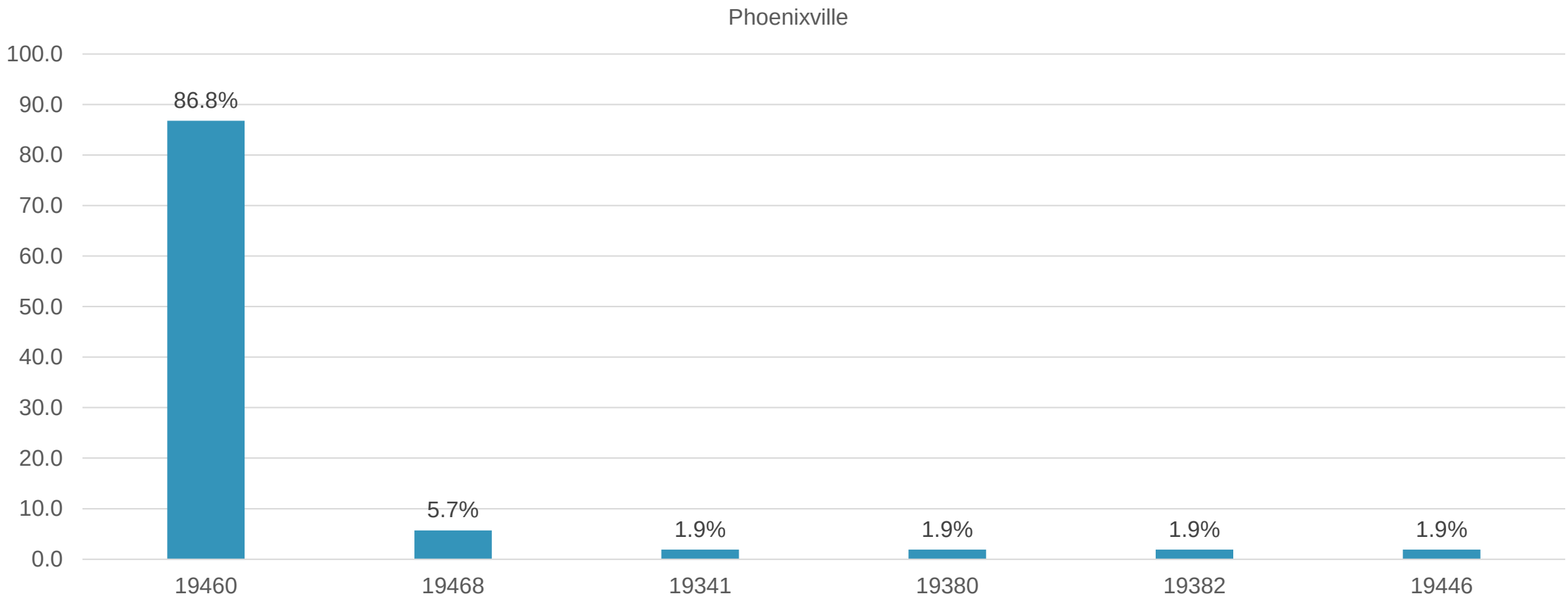
Introduction

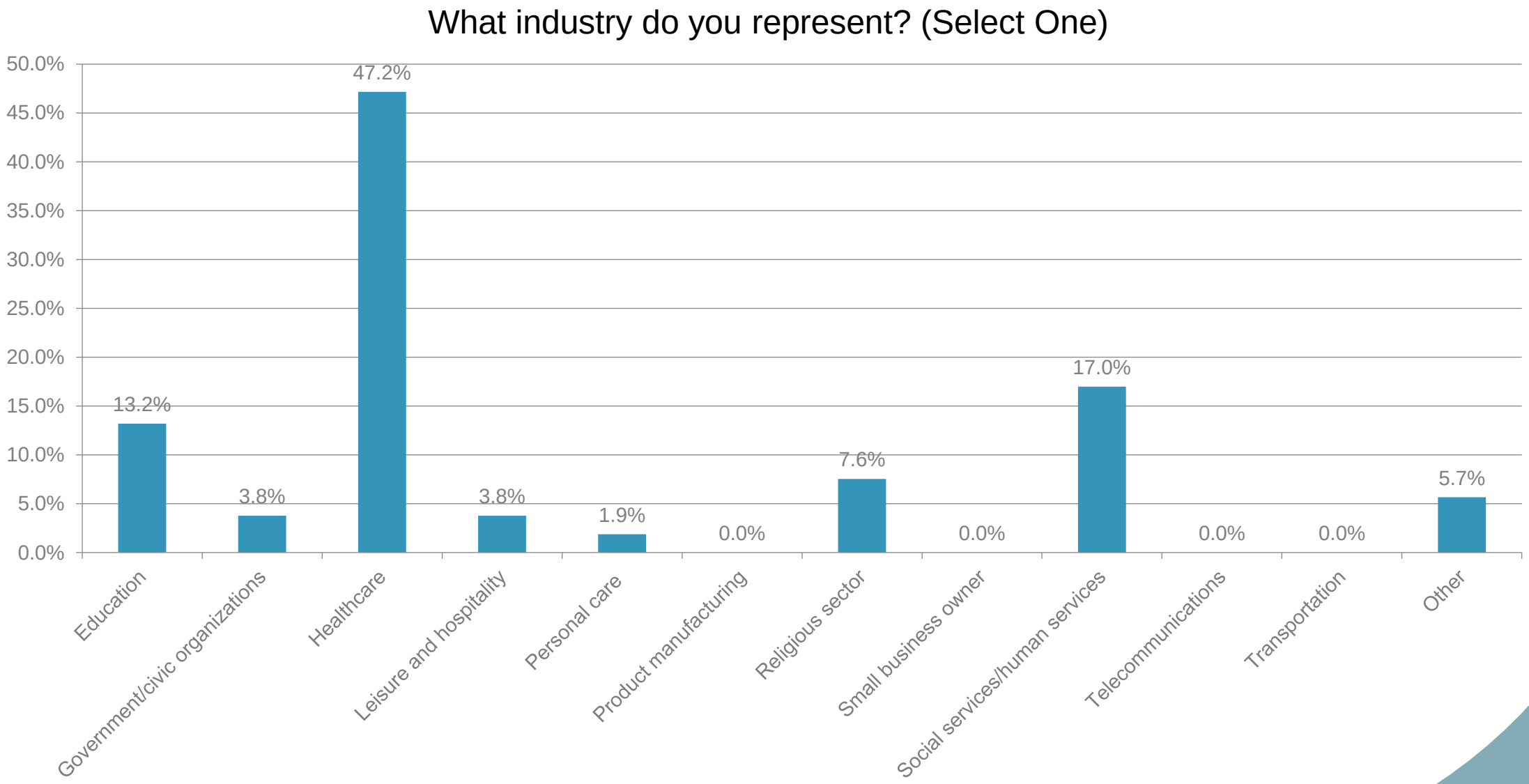
- Tripp Umbach worked closely with representatives from Tower Health to identify key informants in the region. A robust database was created to request survey participation from leaders in the region. An email was sent to key informants by representatives of Phoenixville Hospital to introduce the CHNA process. The email introduced the project and conveyed the importance of the CHNA for Tower Health System and for the community.
- A key informant survey was programmed into Survey Monkey to collect feedback from respective populations.
- The data collection period ran from February 2021 – August 2021.

ZIP Code

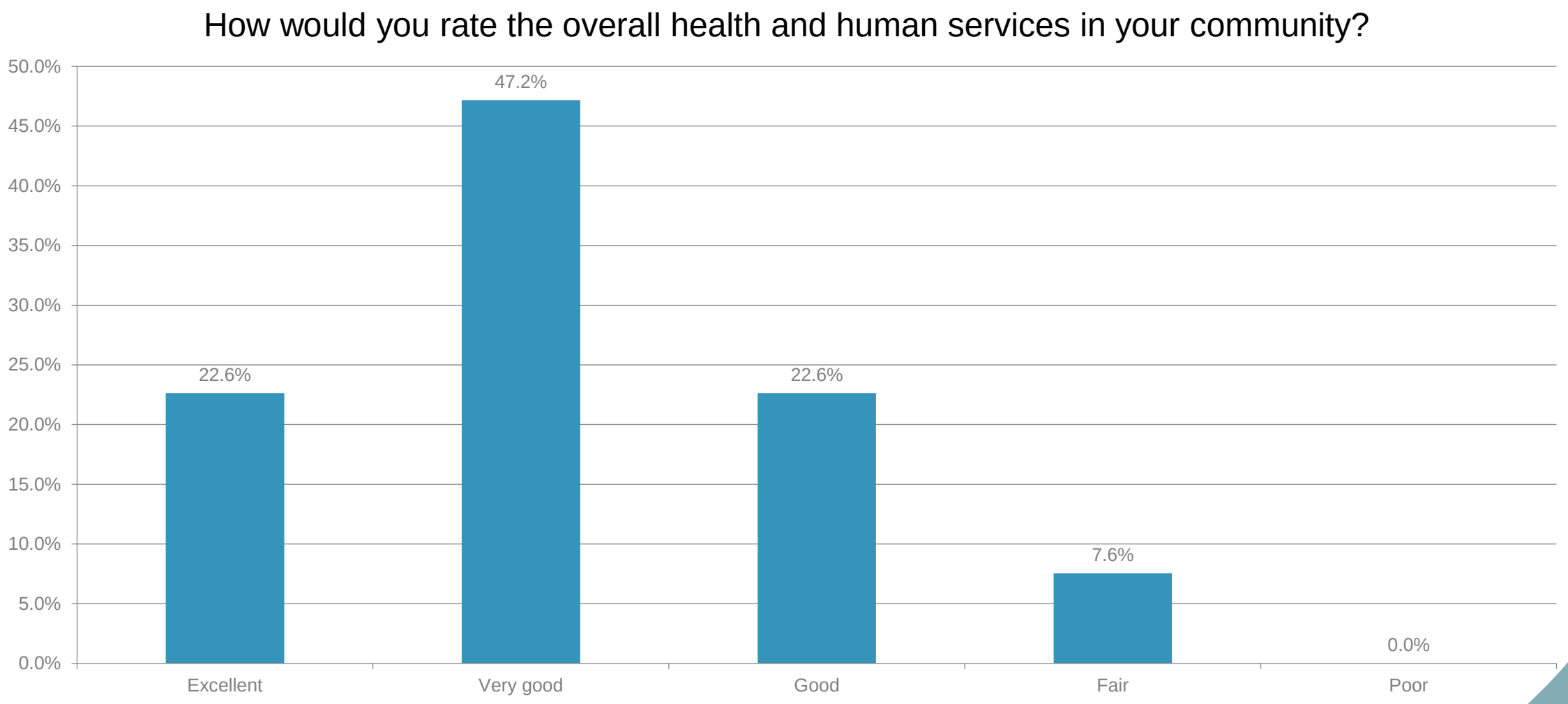


- 94.3% of key informants worked in Chester County and 5.7% worked in Montgomery County.

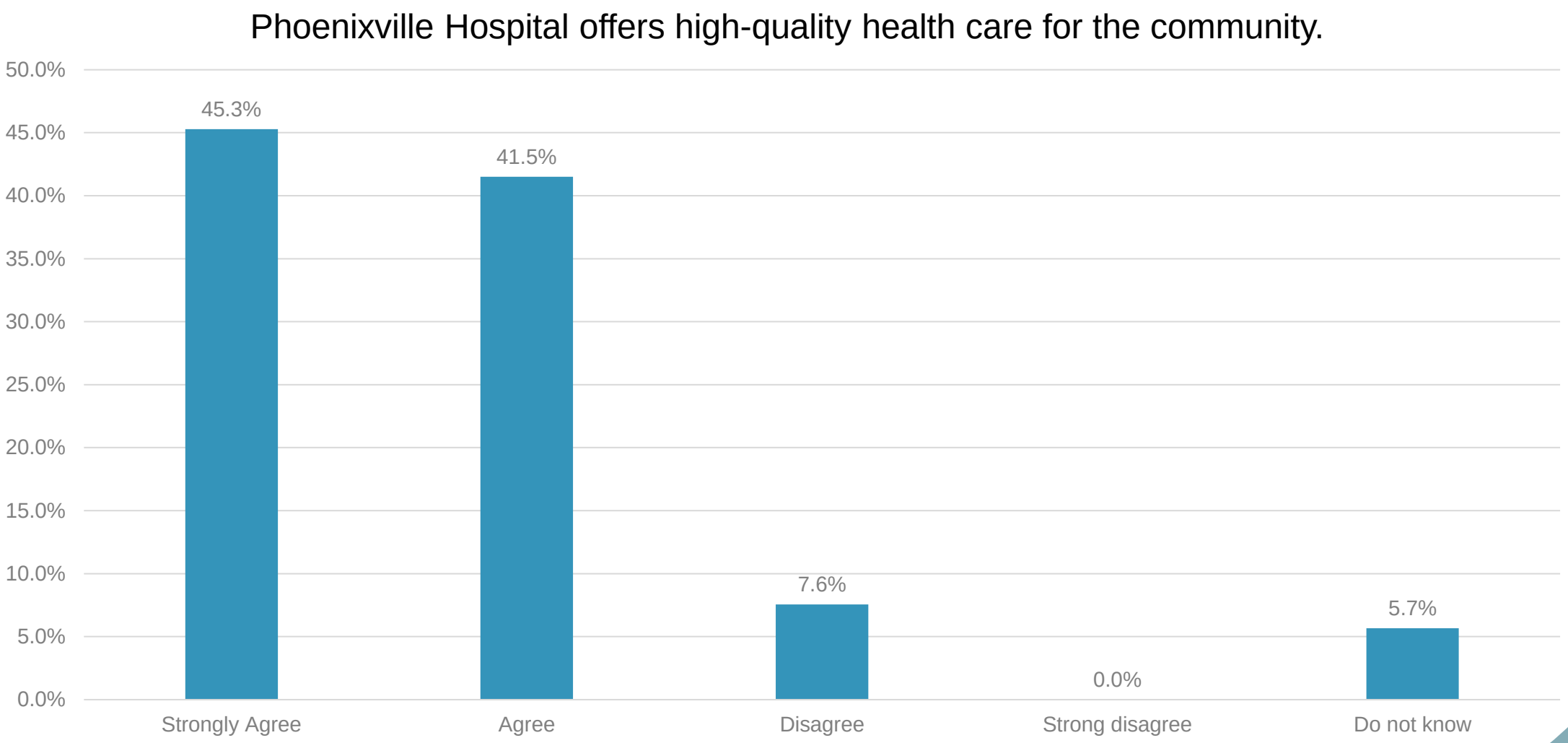
Represented Industry



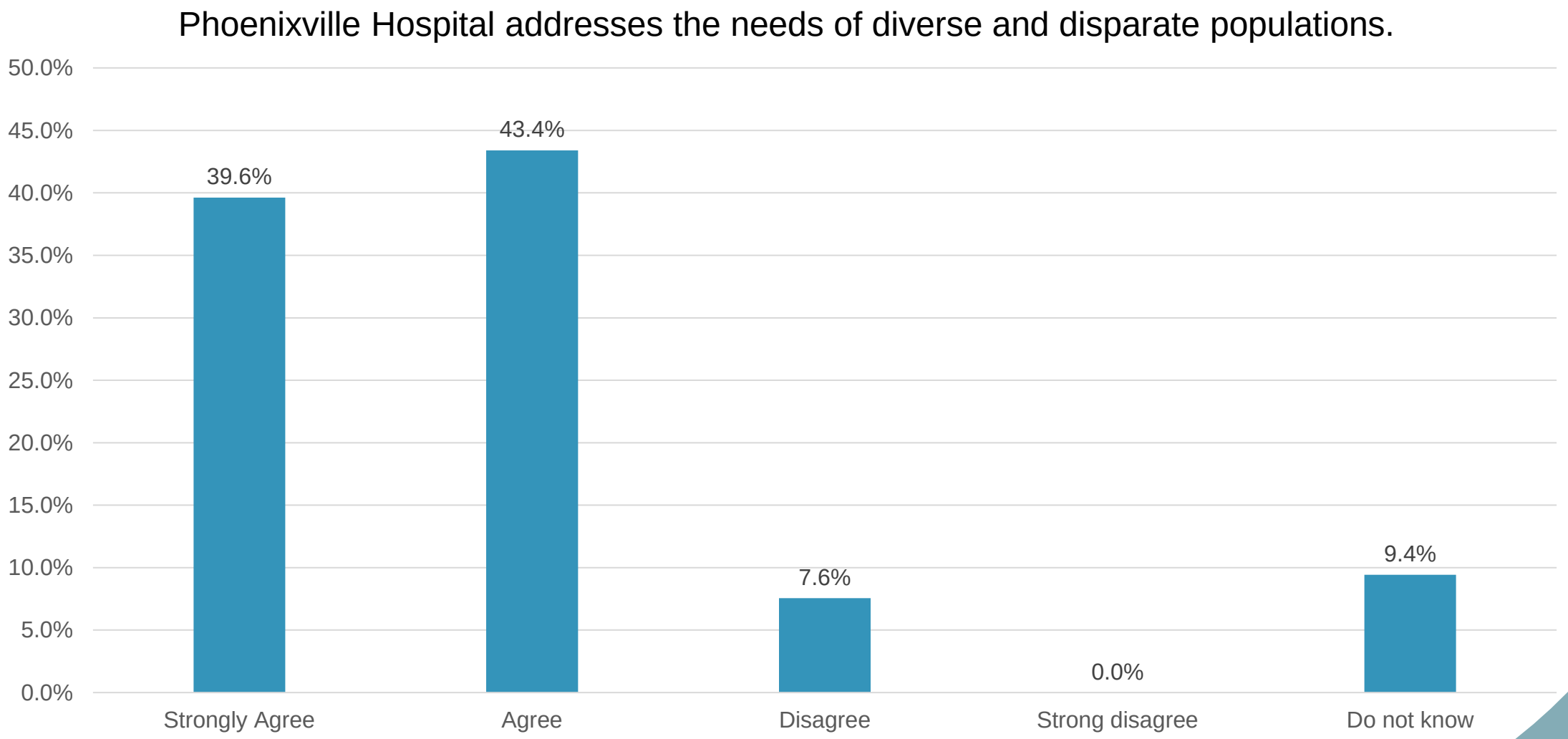
Rate Health and Human Services in Community



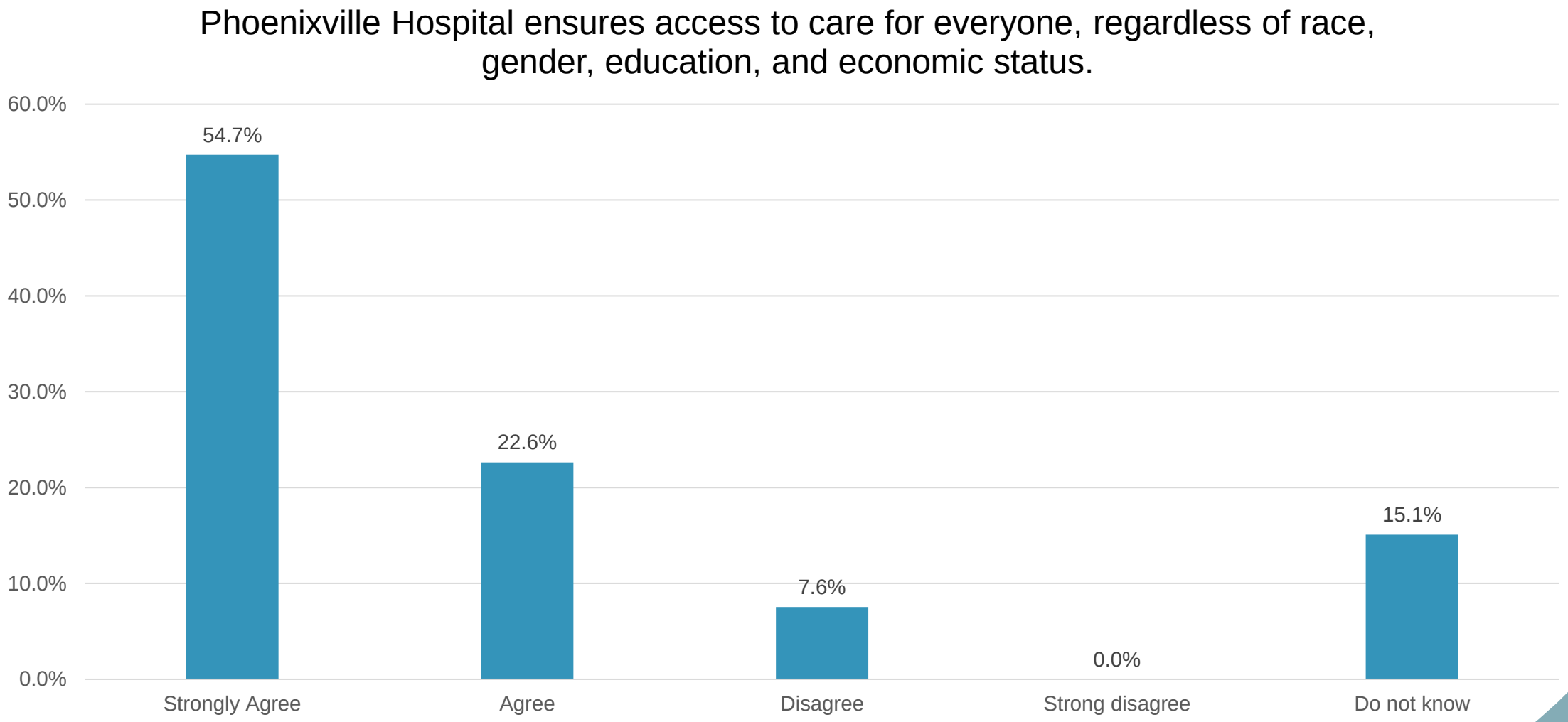
Rate How Hospital Offers High-Quality Health Care for the Community



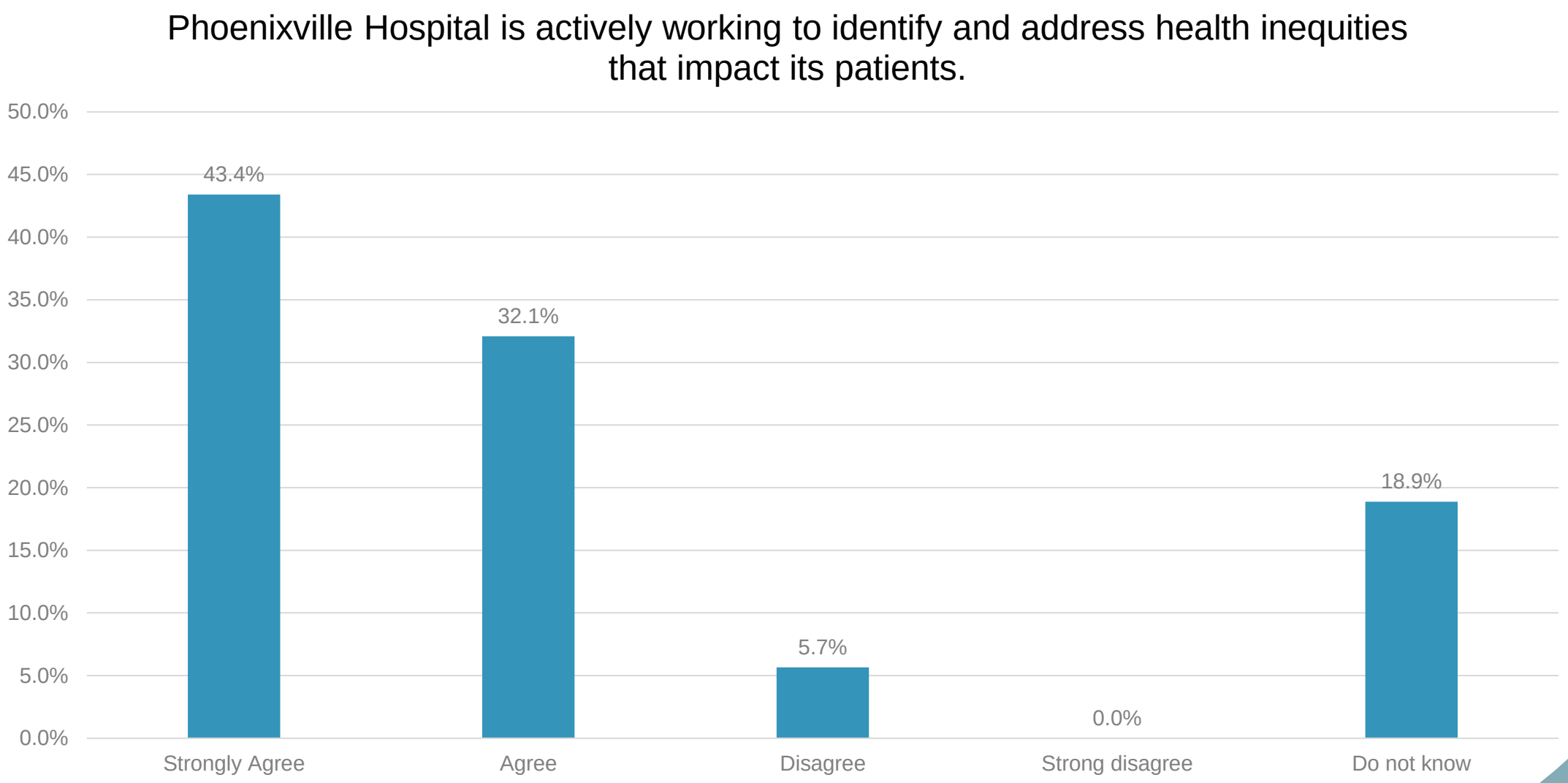
Rate How Hospital Addresses needs of Diverse and Disparate Populations



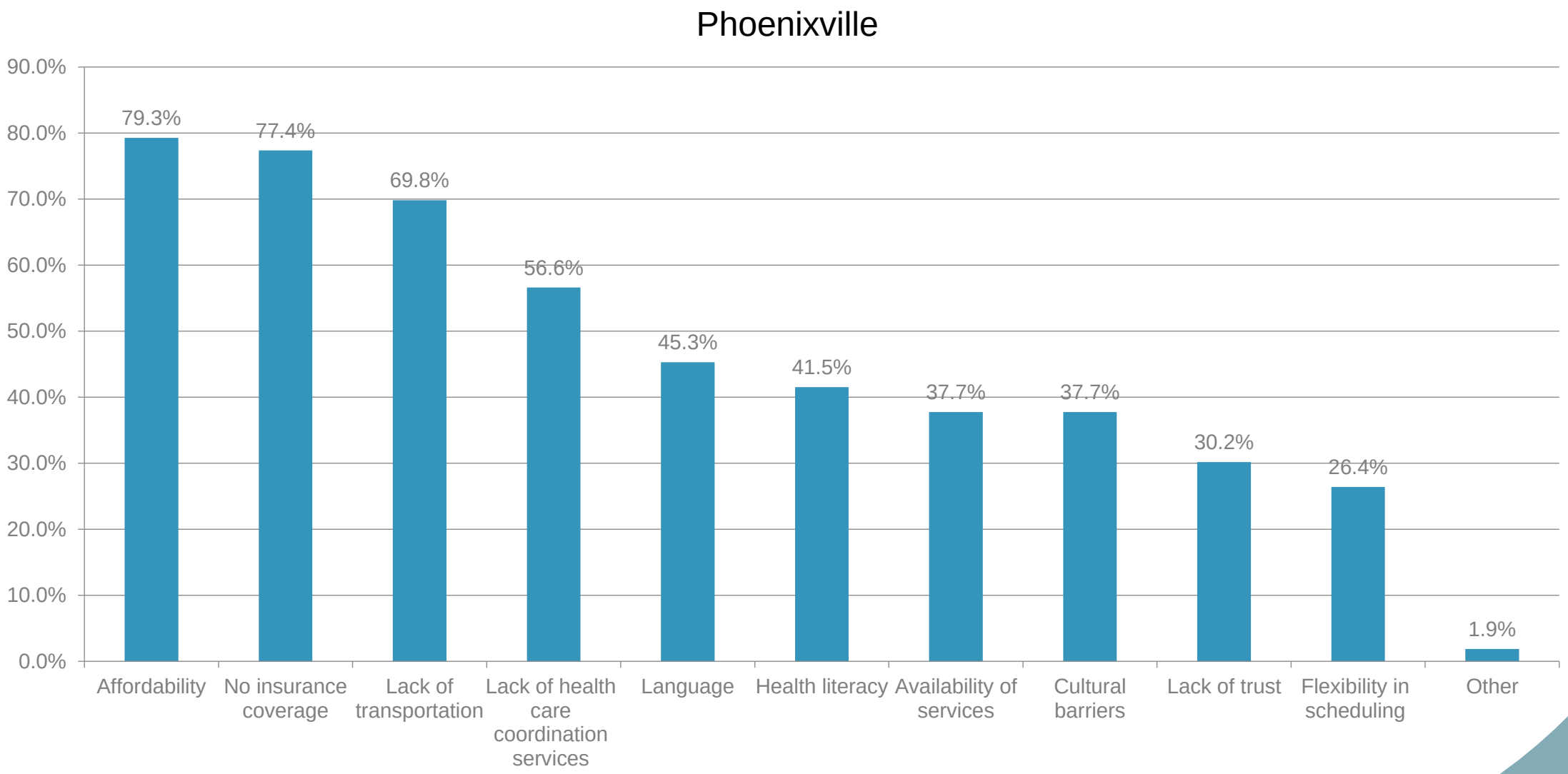
Rate How Hospital Ensures Access to Care Regardless of Race, Gender, Education, and Economic Status



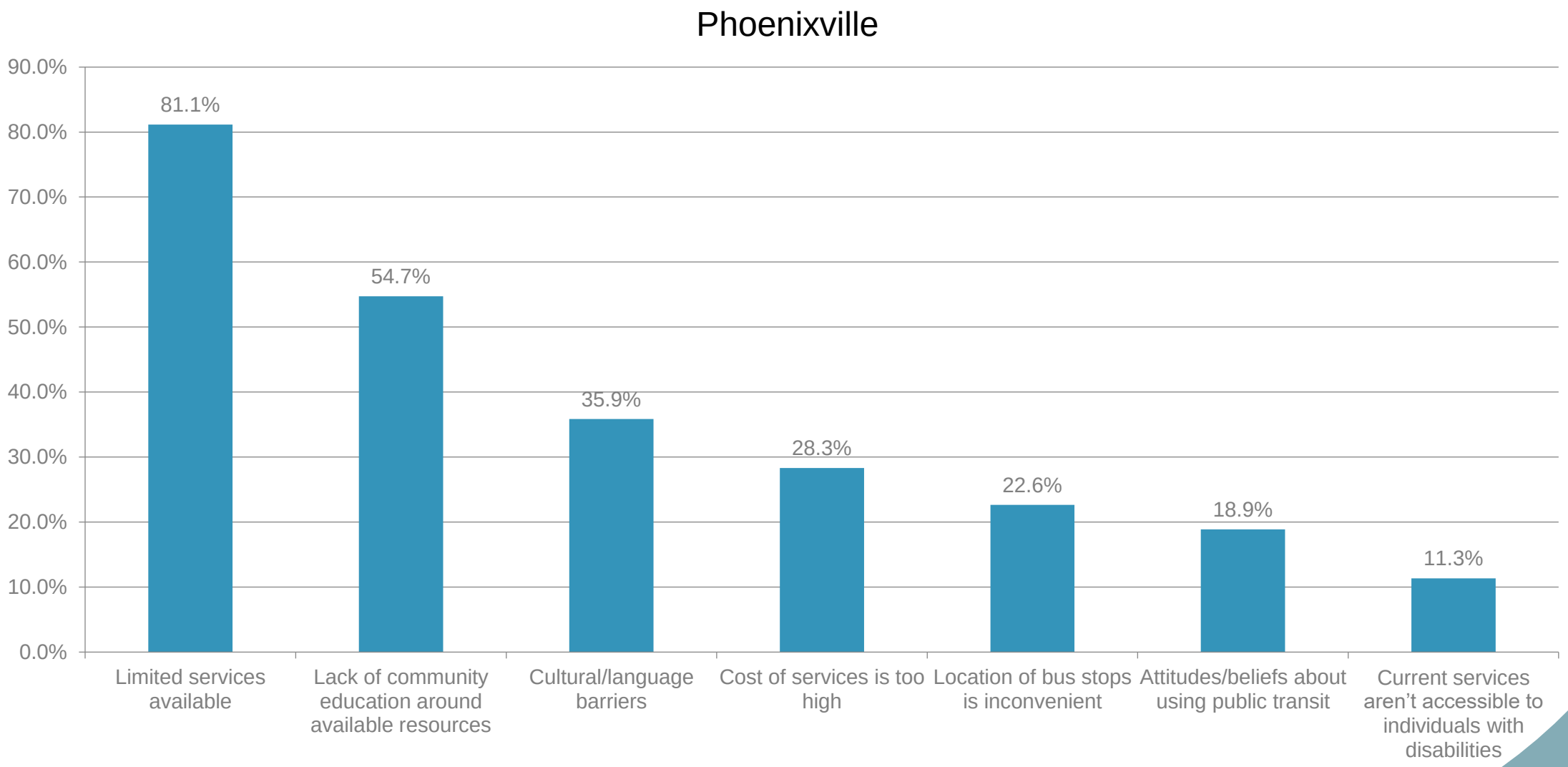
Rate How Hospital Works to Identify and Address Health Inequalities



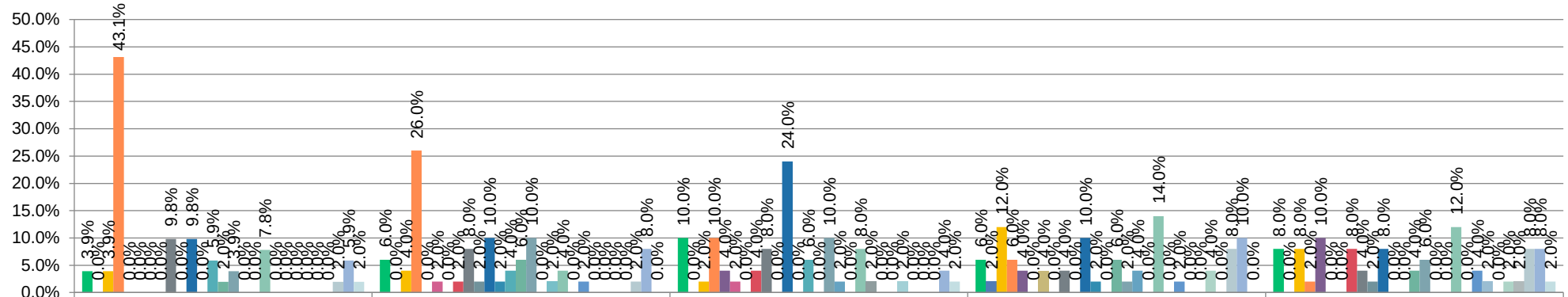
Perceived Barrier(s) for People Not Receiving Care or Services — Check all that apply



Following contributions to the transportation issues in the community — (Top three)

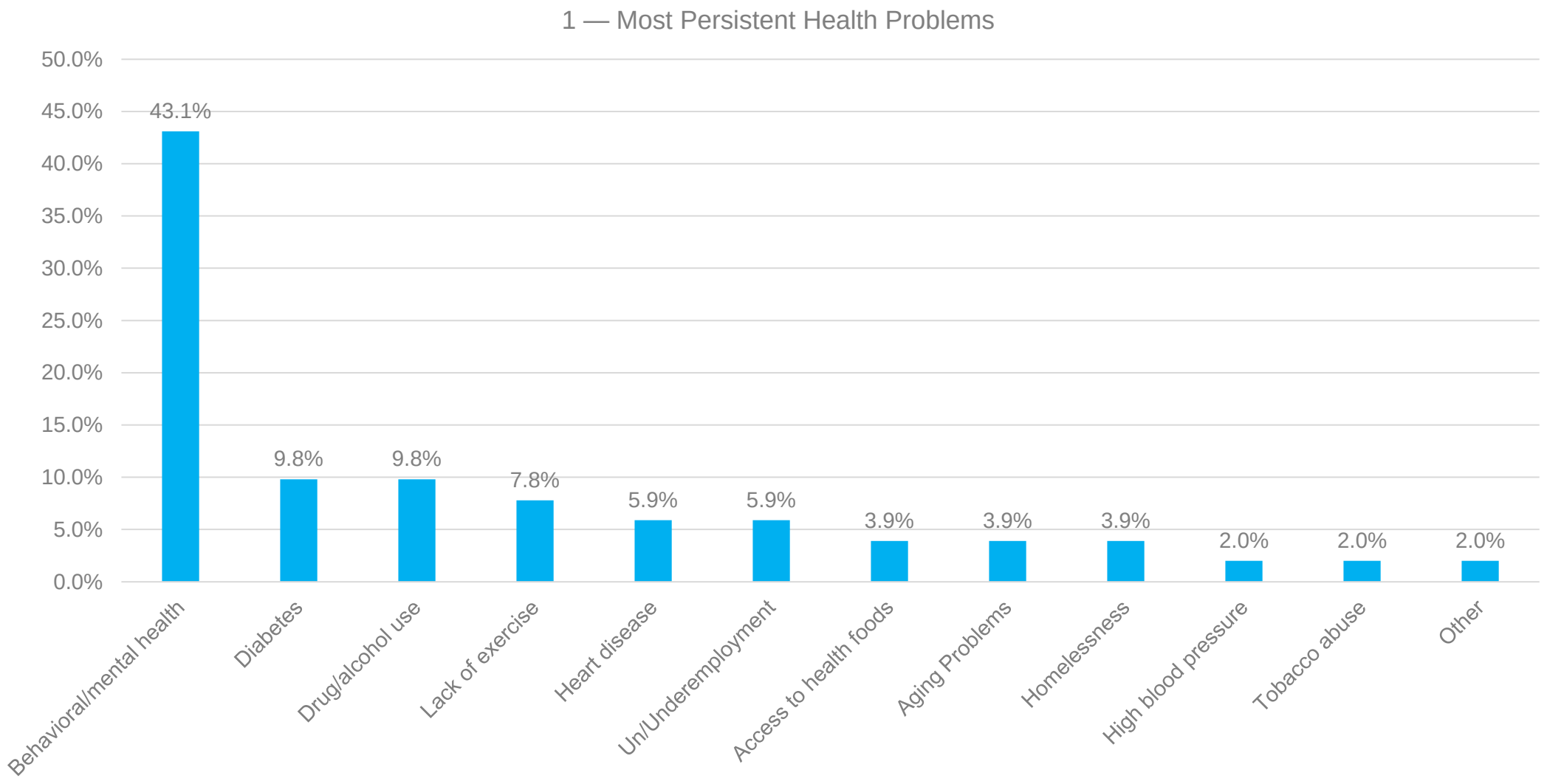


Top 5 persistent “Health Problems” in the community?

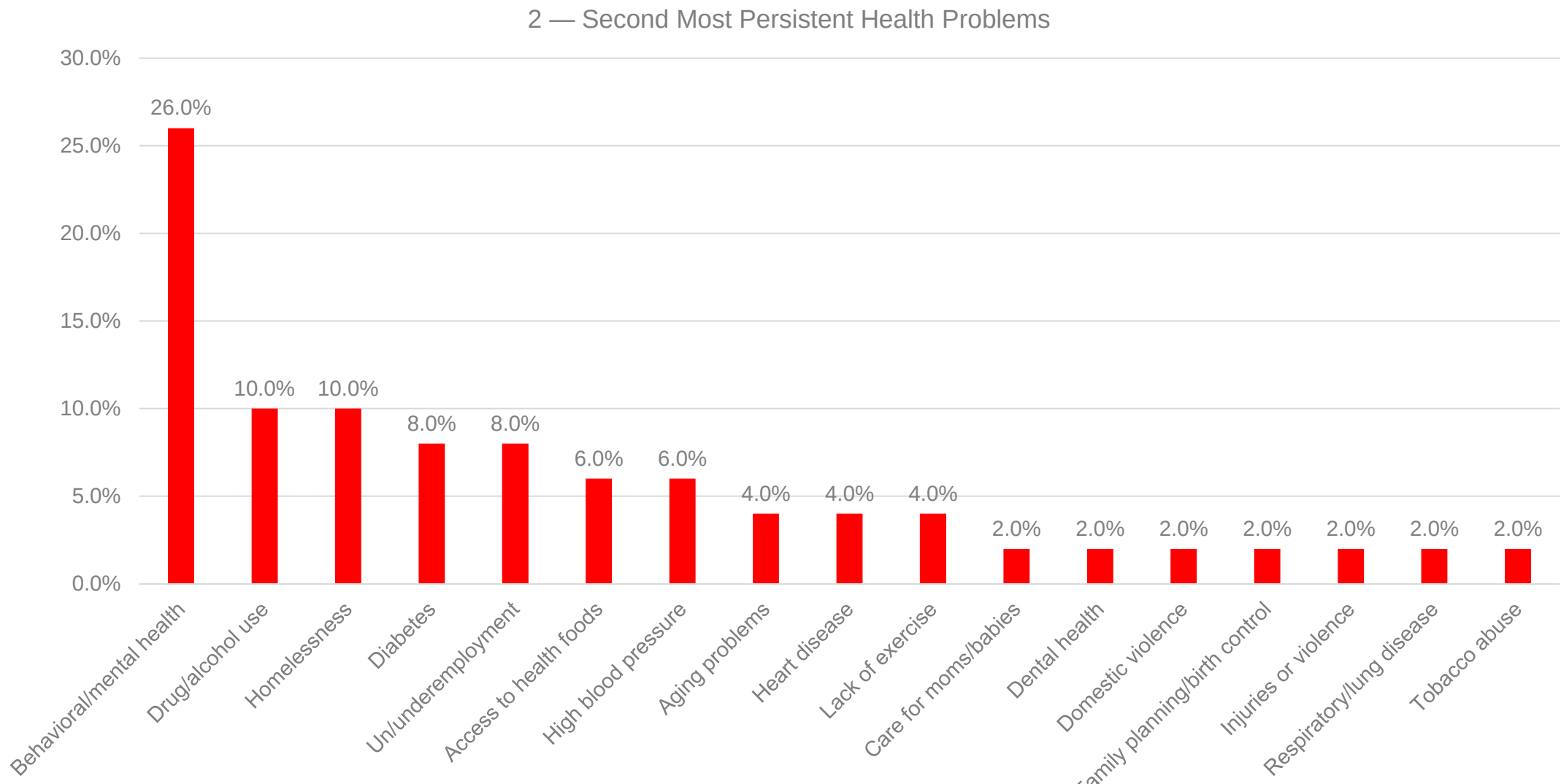


	Most Important = 1	2	3	4	5
Access to health foods (i.e., poor diet)	3.9%	6.0%	10.0%	6.0%	8.0%
Adolescent health	0.0%	0.0%	0.0%	2.0%	0.0%
Aging problems (e.g., arthritis, hearing/vision loss, etc.)	3.9%	4.0%	2.0%	12.0%	8.0%
Behavioral/mental health	43.1%	26.0%	10.0%	6.0%	2.0%
Cancers	0.0%	0.0%	4.0%	4.0%	10.0%
Care for moms/babies	0.0%	2.0%	2.0%	0.0%	0.0%
Child abuse/neglect	0.0%	0.0%	0.0%	4.0%	0.0%
Dental health	0.0%	2.0%	4.0%	0.0%	8.0%
Diabetes	9.8%	8.0%	8.0%	4.0%	4.0%
Domestic violence	0.0%	2.0%	0.0%	0.0%	2.0%
Drug/alcohol use (i.e., substance abuse)	9.8%	10.0%	24.0%	10.0%	8.0%
Family planning/birth control	0.0%	2.0%	0.0%	2.0%	0.0%
Heart disease	5.9%	4.0%	6.0%	0.0%	0.0%
High blood pressure	2.0%	6.0%	0.0%	6.0%	4.0%
Homelessness	3.9%	10.0%	10.0%	2.0%	6.0%
Infectious diseases (e.g., hepatitis, TB, etc.)	0.0%	0.0%	2.0%	4.0%	0.0%
Injuries or violence	0.0%	2.0%	0.0%	0.0%	0.0%
Lack of exercise (i.e., overweight/obesity)	7.8%	4.0%	8.0%	14.0%	12.0%
Maternal/infant health	0.0%	0.0%	2.0%	0.0%	0.0%
Respiratory/lung disease	0.0%	2.0%	0.0%	2.0%	4.0%
Sexually Transmitted Diseases (STDs)	0.0%	0.0%	0.0%	0.0%	2.0%
Stroke	0.0%	0.0%	2.0%	0.0%	0.0%
Suicide	0.0%	0.0%	0.0%	4.0%	2.0%
Teen pregnancy	0.0%	0.0%	0.0%	0.0%	2.0%
Tobacco abuse	2.0%	2.0%	0.0%	8.0%	8.0%
Unemployment/underemployment	5.9%	8.0%	4.0%	10.0%	8.0%
Other	2.0%	0.0%	2.0%	0.0%	2.0%

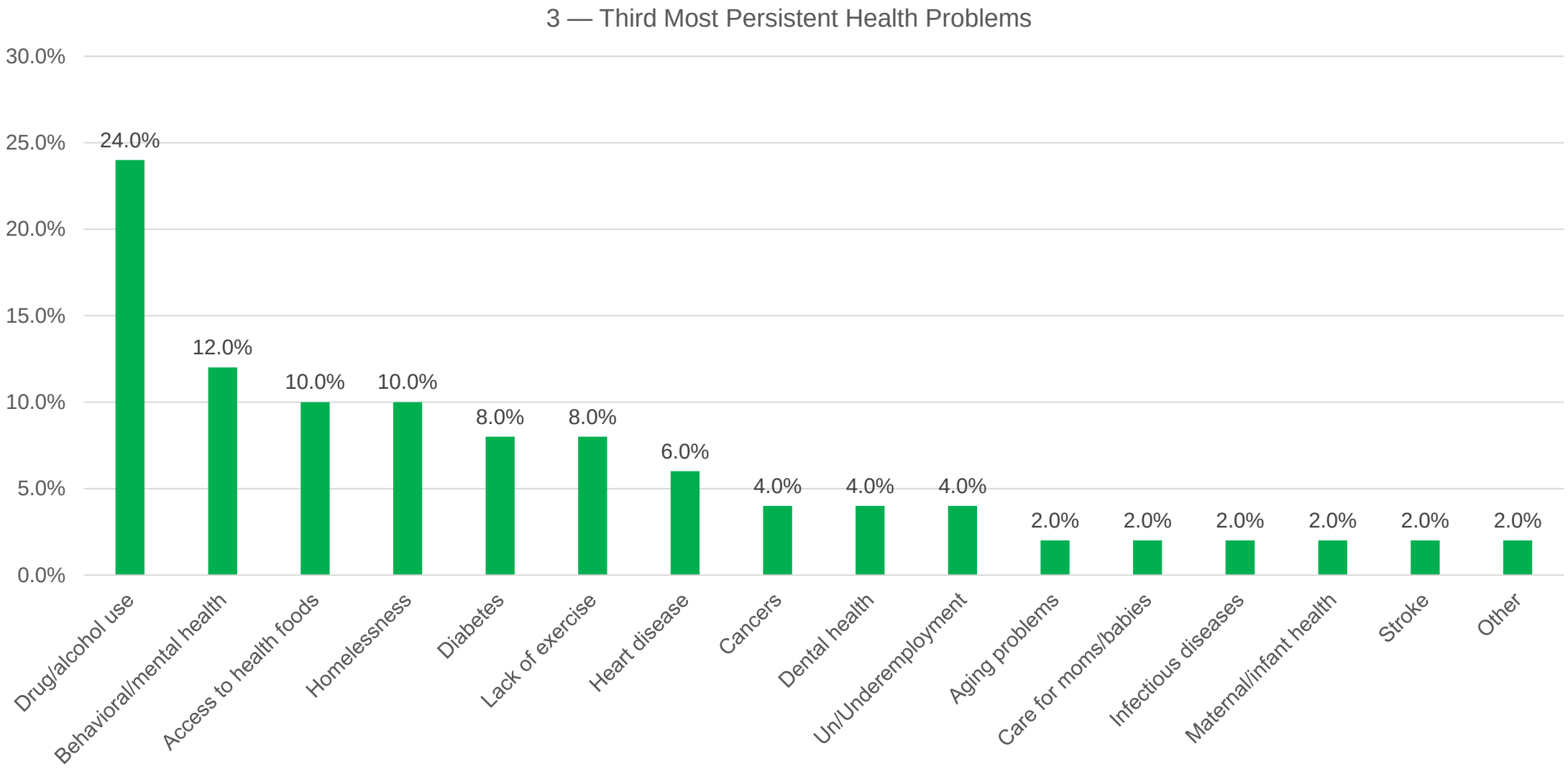
Top 5 persistent “Health Problems” in the community?



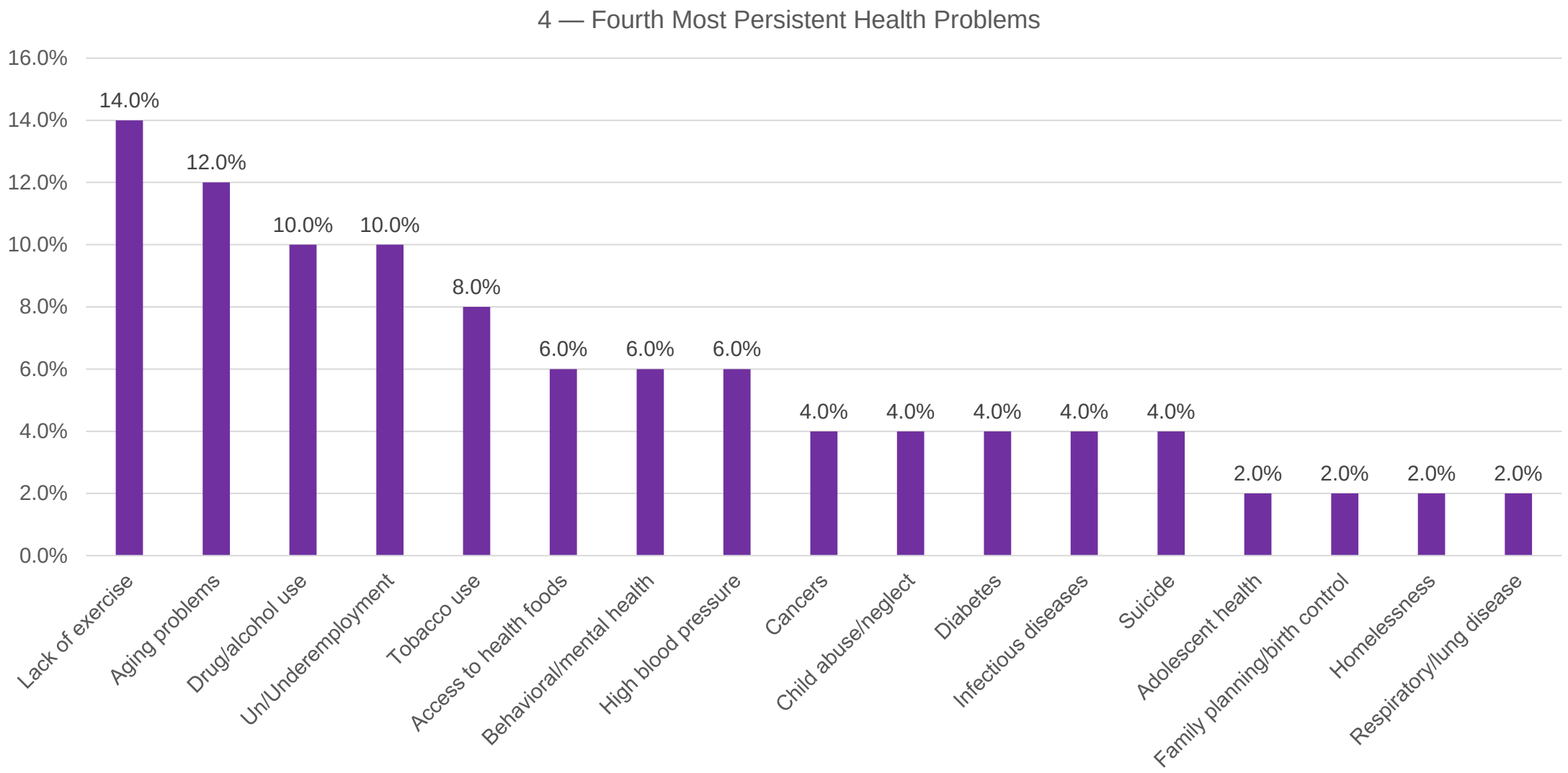
Top 5 persistent “Health Problems” in the community?



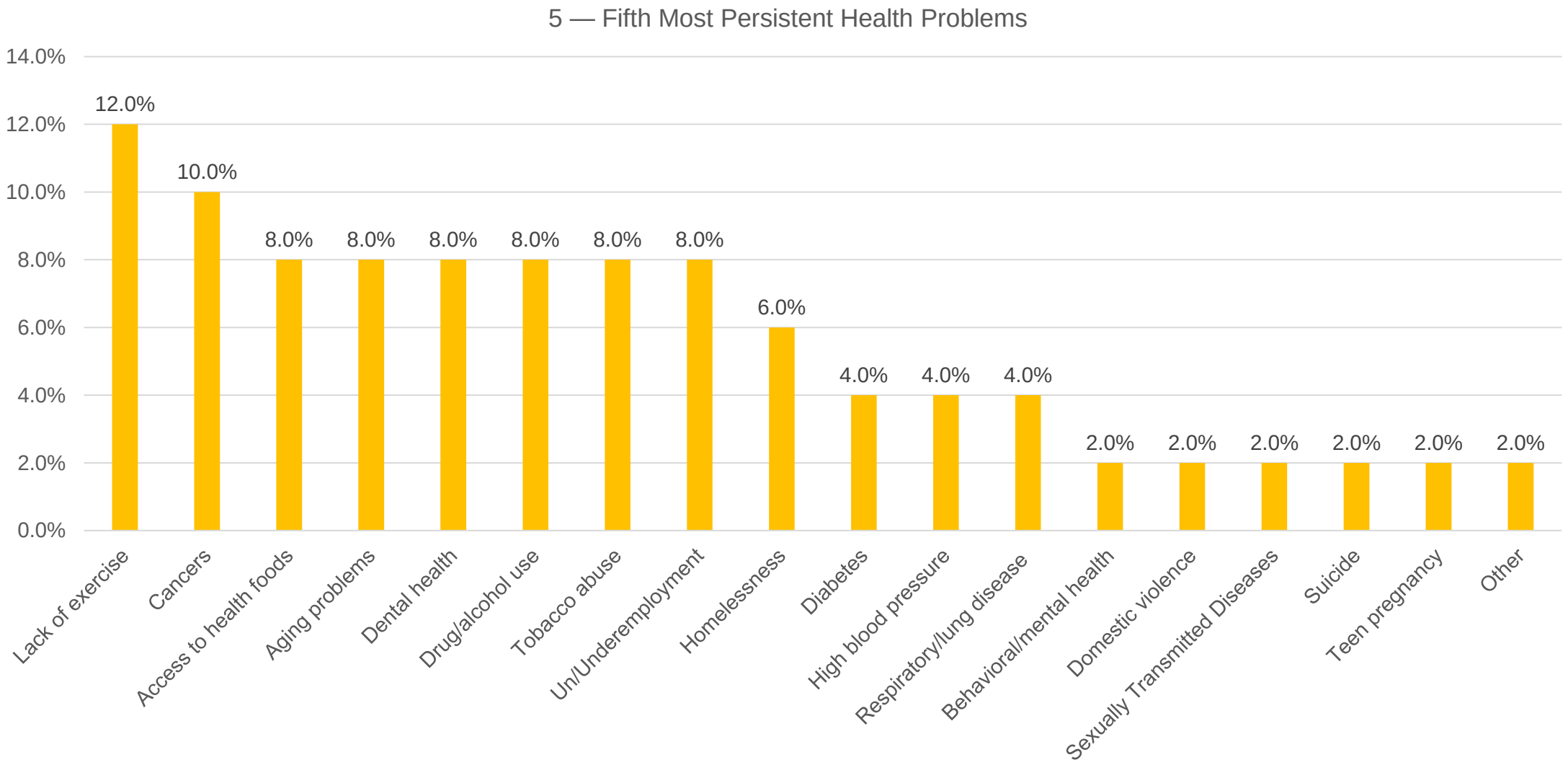
Top 5 persistent “Health Problems” in the community?



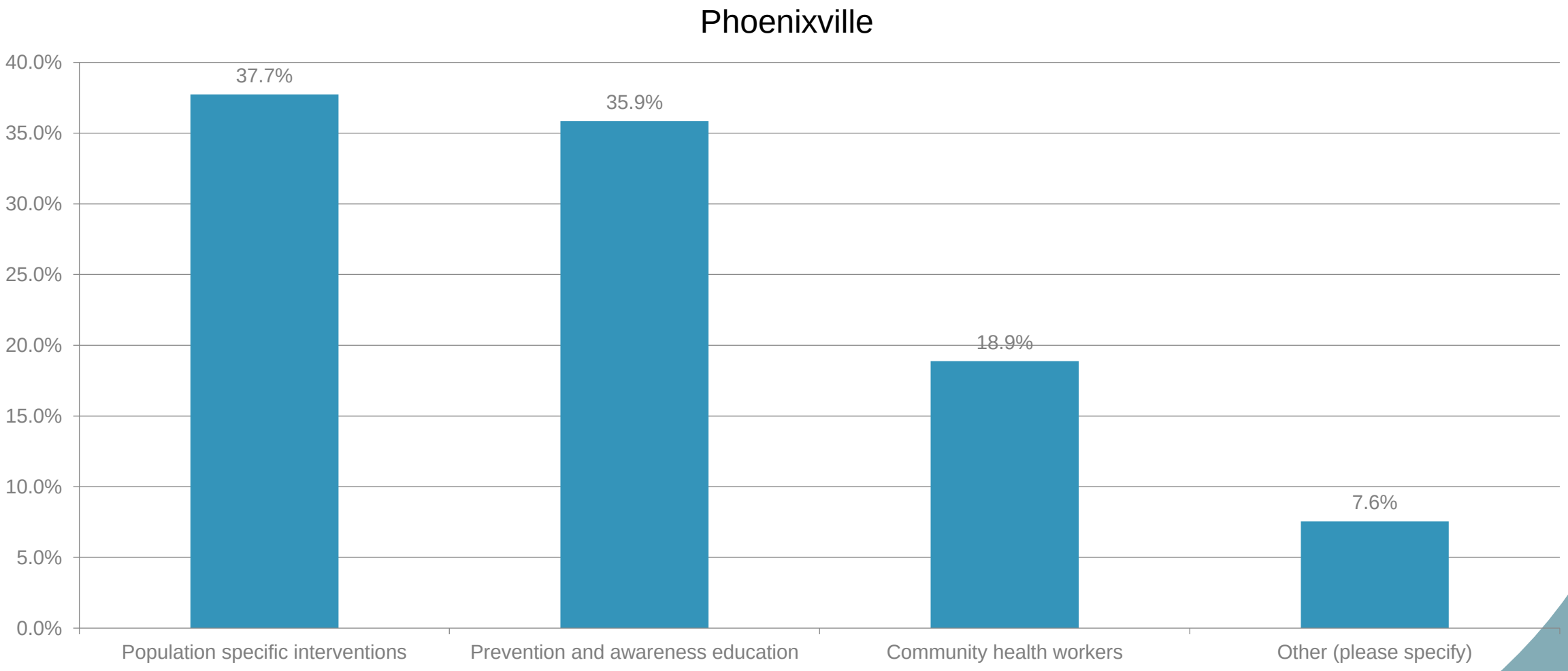
Top 5 persistent “Health Problems” in the community?



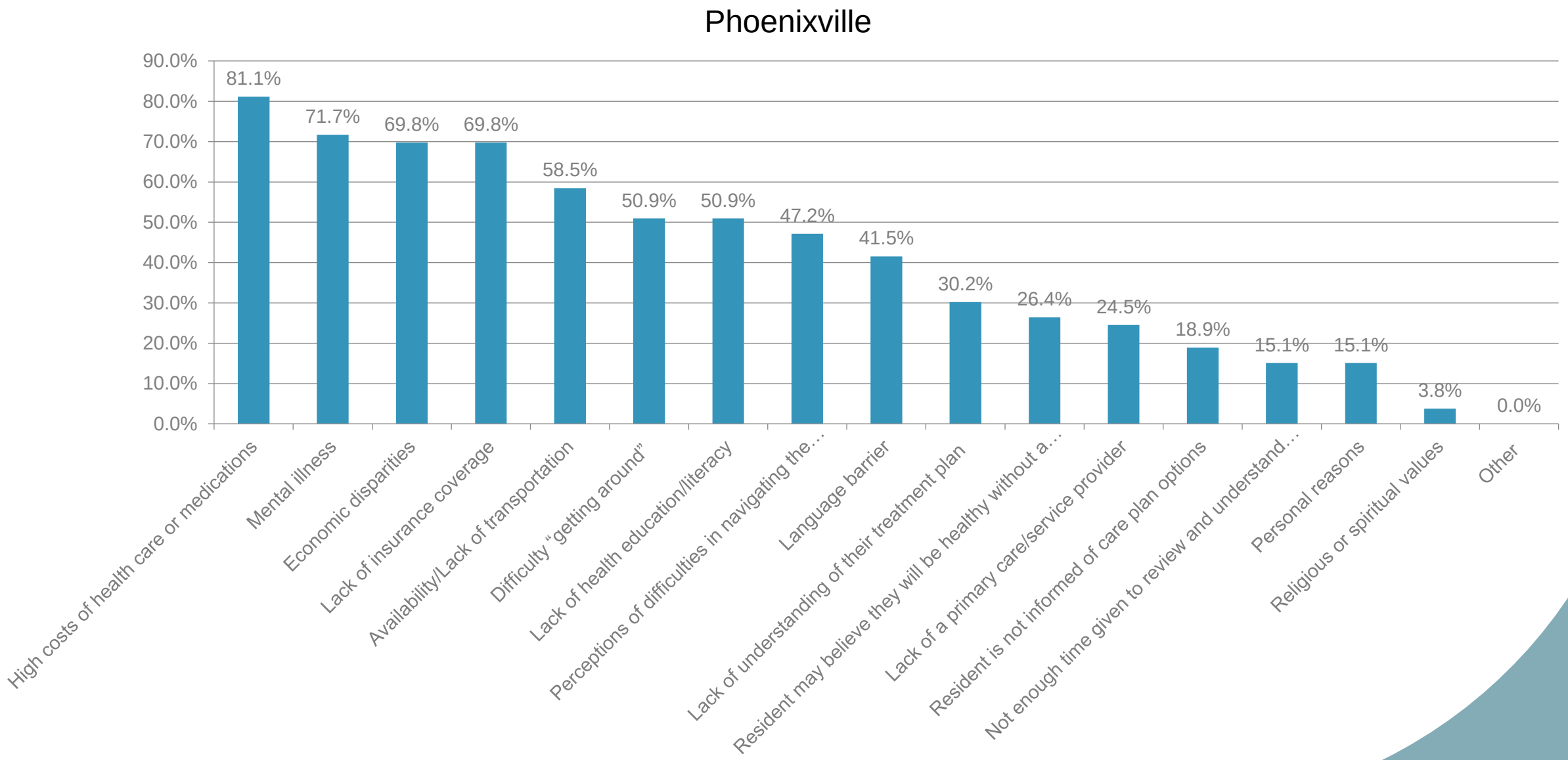
Top 5 persistent “Health Problems” in the community?



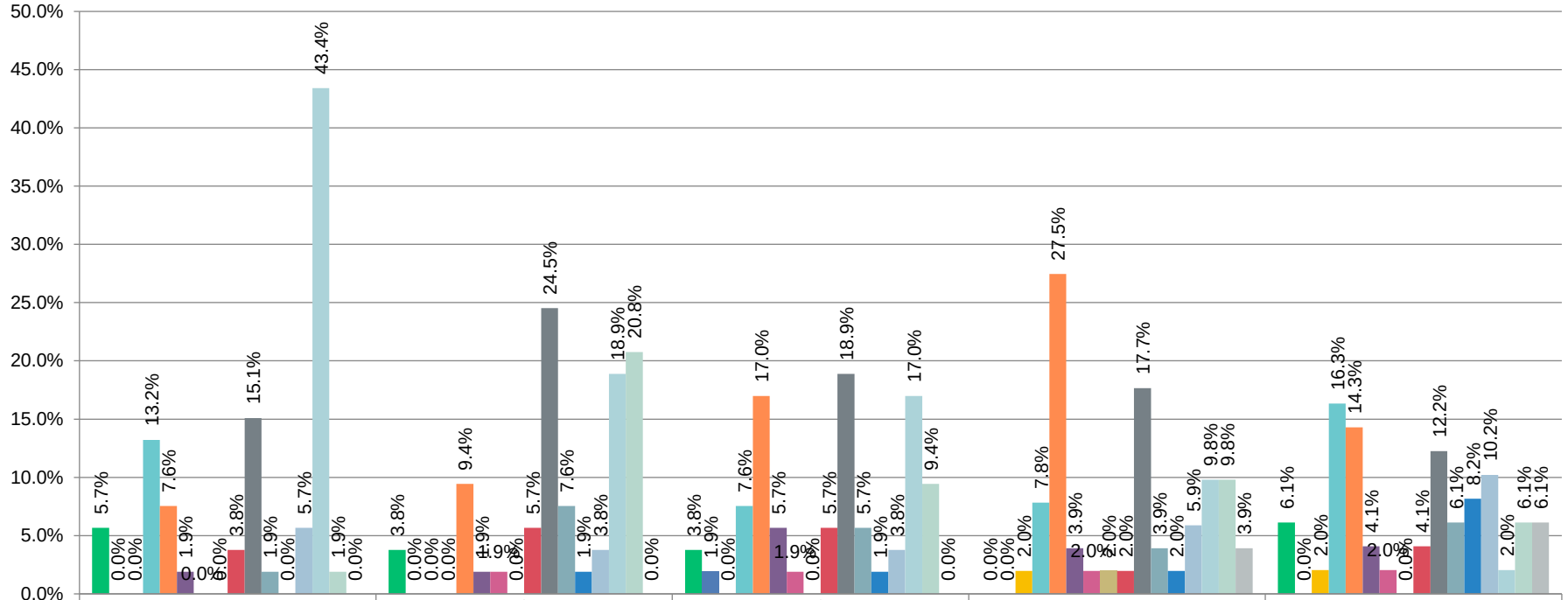
Type II diabetes, pre-diabetes and obesity affects many members of our community. What can we offer the community to achieve and maintain optimal health?



Most significant barriers to improving health and quality of life – Check all that apply

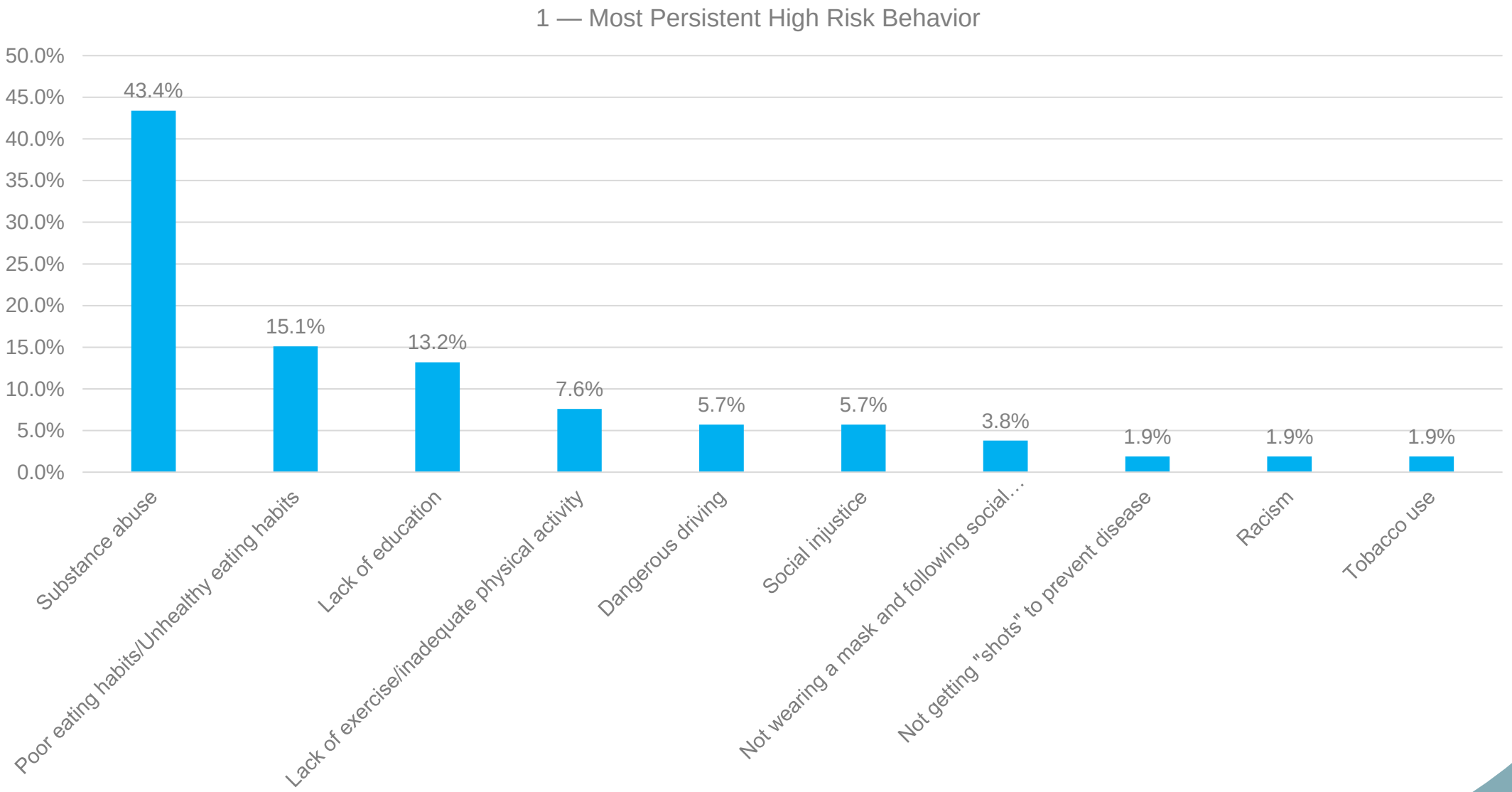


Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important

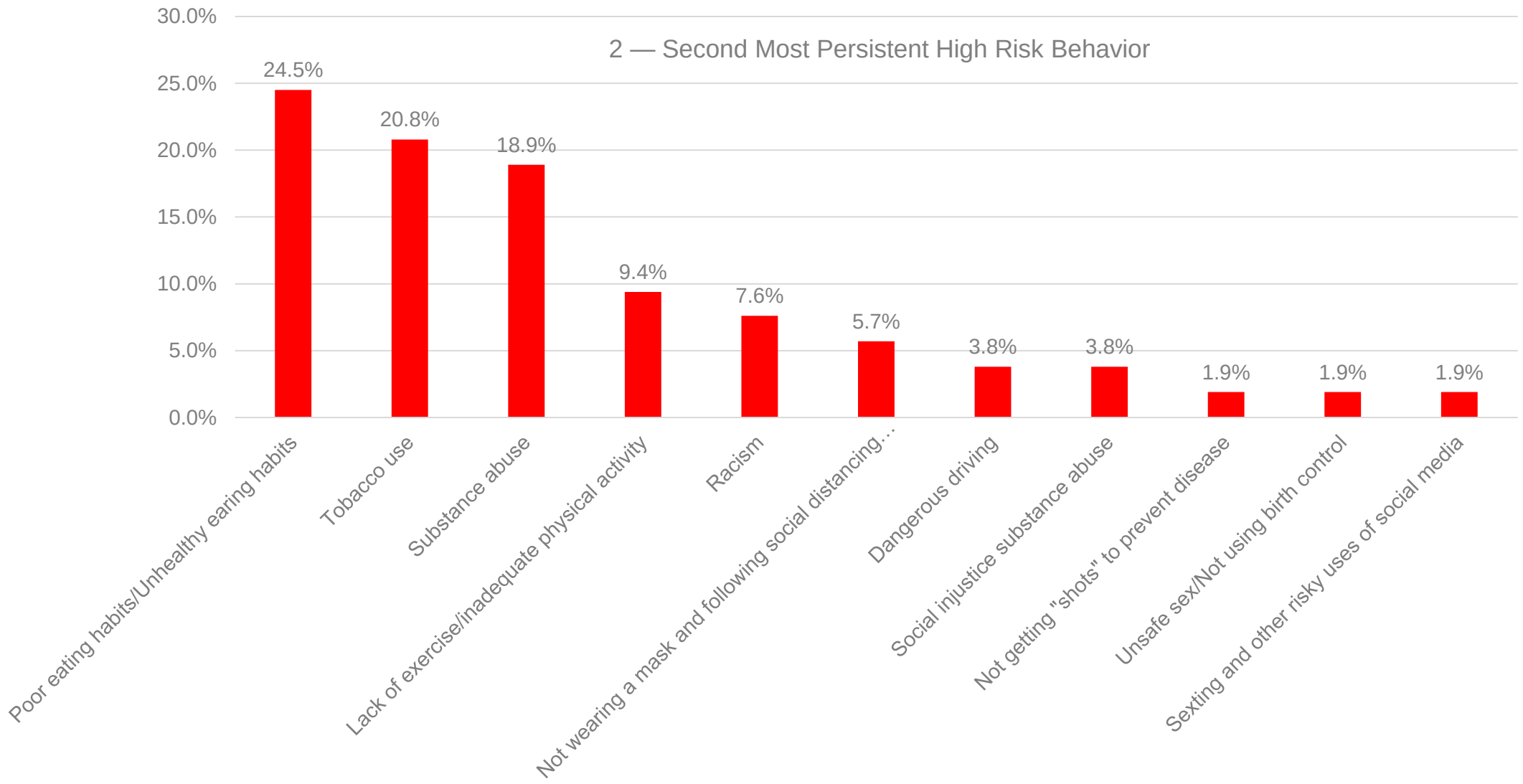


	1 = Most Important	2	3	4	5
Dangerous driving	5.7%	3.8%	3.8%	0.0%	6.1%
Fighting	0.0%	0.0%	1.9%	0.0%	0.0%
Illegal activities like trespassing or vandalism	0.0%	0.0%	0.0%	2.0%	2.0%
Lack of education	13.2%	0.0%	7.6%	7.8%	16.3%
Lack of exercise/inadequate physical activity	7.6%	9.4%	17.0%	27.5%	14.3%
Not getting “shots” to prevent disease	1.9%	1.9%	5.7%	3.9%	4.1%
Unsafe sex/Not using birth control	0.0%	1.9%	1.9%	2.0%	2.0%
Not using seat belts/child safety seats	0.0%	0.0%	0.0%	2.0%	0.0%
Not wearing a mask and following social distancing guidelines	3.8%	5.7%	5.7%	2.0%	4.1%
Poor eating habits/Unhealthy eating habits	15.1%	24.5%	18.9%	17.7%	12.2%
Racism	1.9%	7.6%	5.7%	3.9%	6.1%
Sexting and other risky uses of social media	0.0%	1.9%	1.9%	2.0%	8.2%
Social injustice	5.7%	3.8%	3.8%	5.9%	10.2%
Substance abuse	43.4%	18.9%	17.0%	9.8%	2.0%
Tobacco use	1.9%	20.8%	9.4%	9.8%	6.1%
Other	0.0%	0.0%	0.0%	3.9%	6.1%

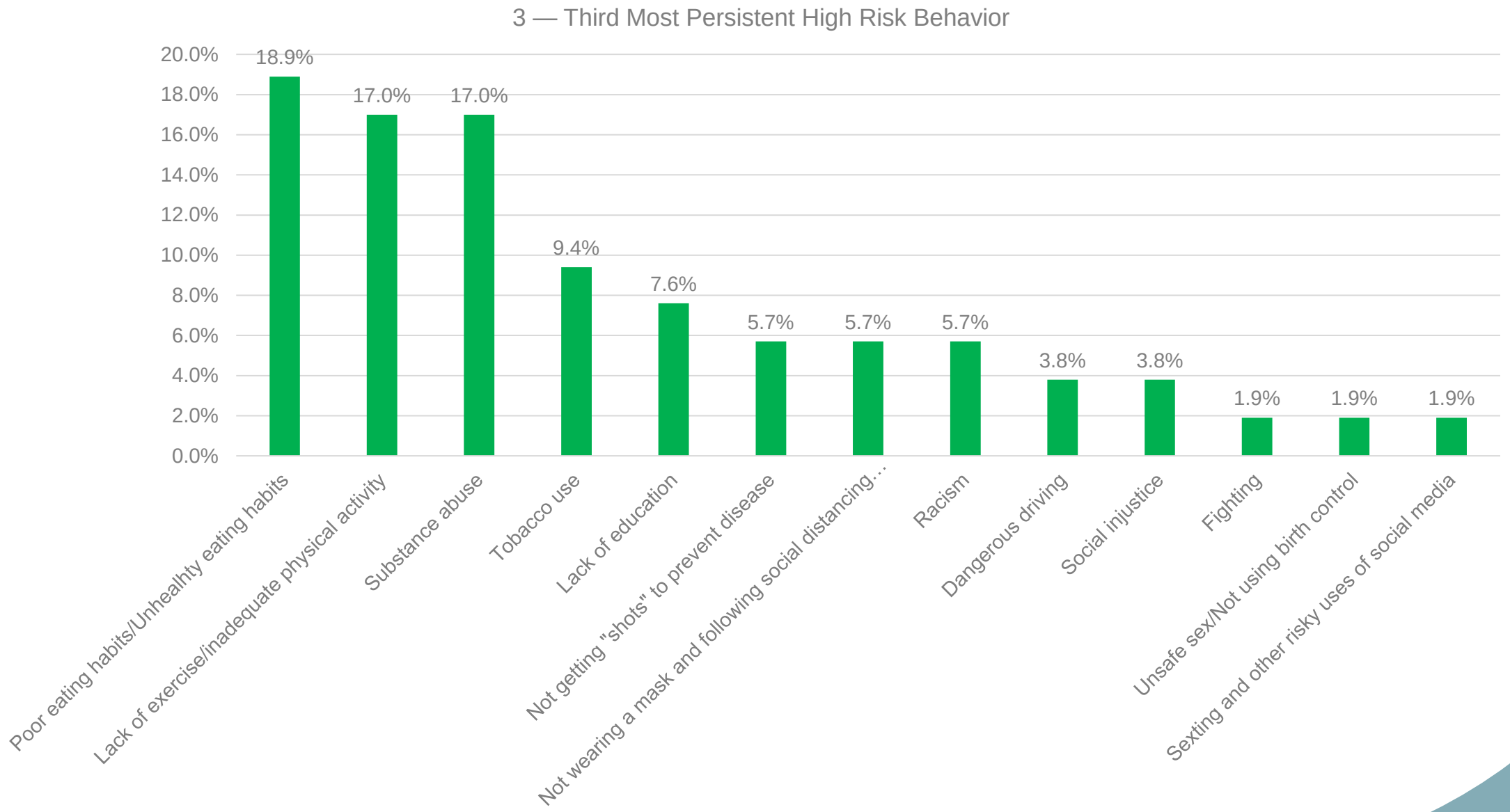
Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



Rank Top 5 Persistent “High Risk Behaviors” in Community — 1=Most Important



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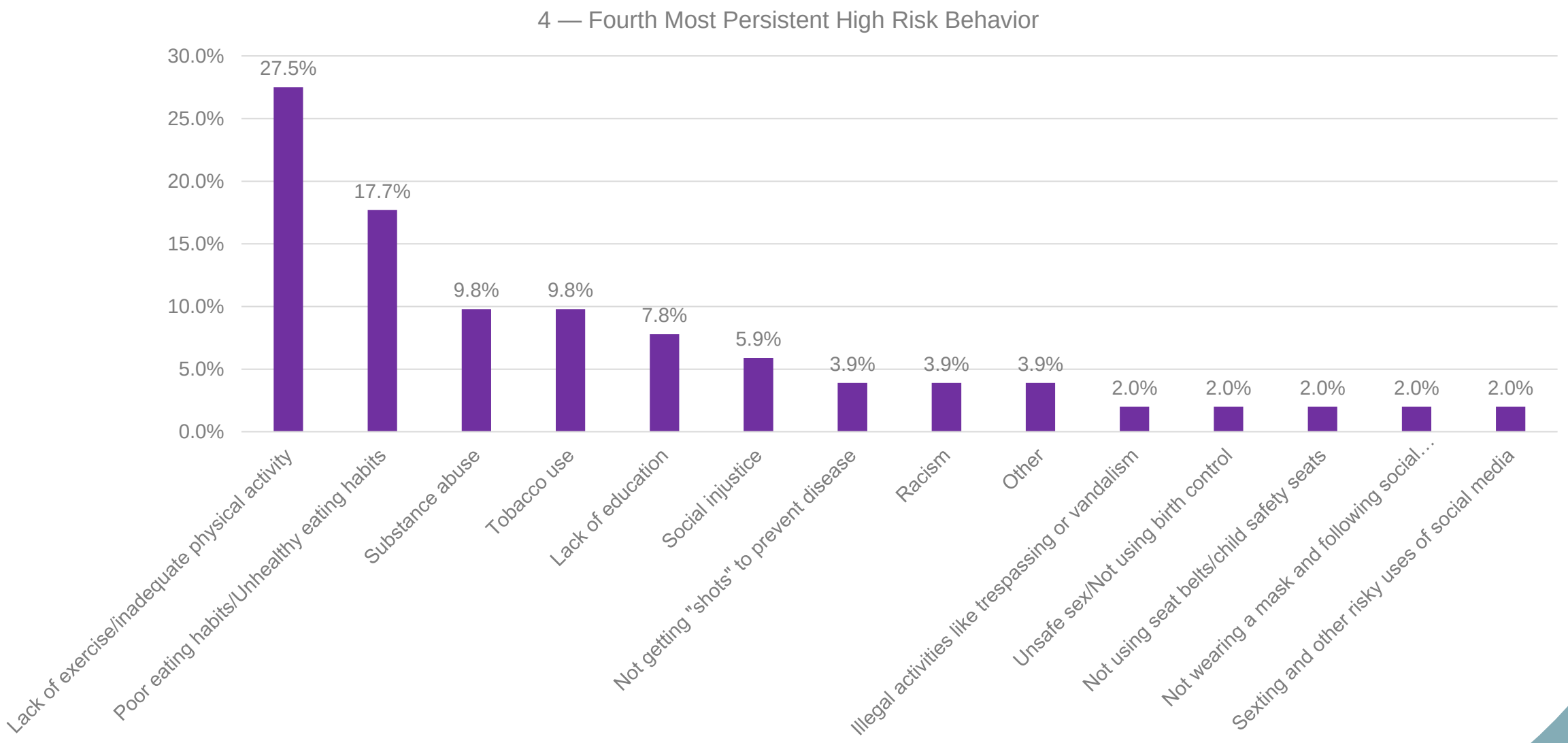

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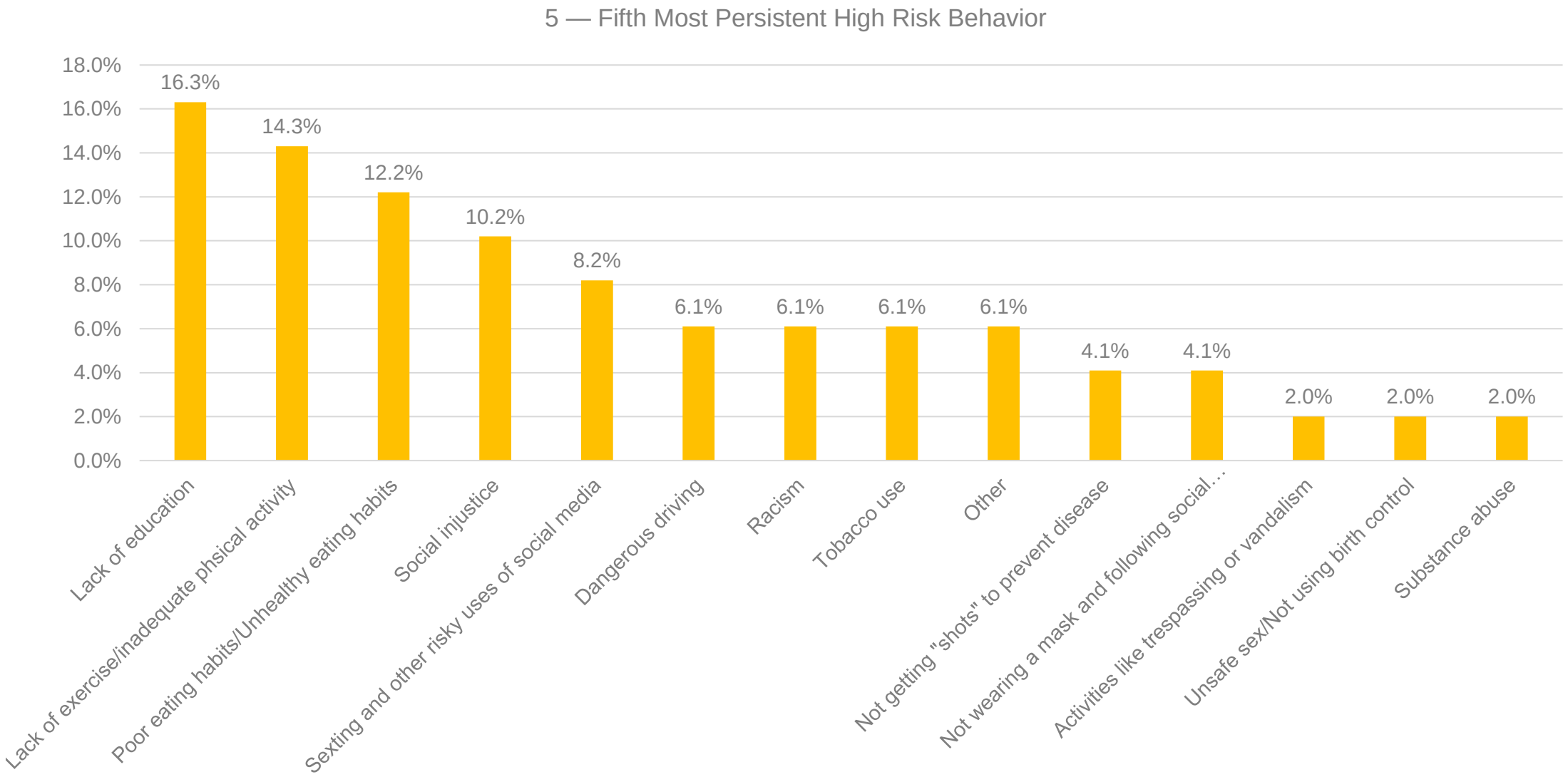
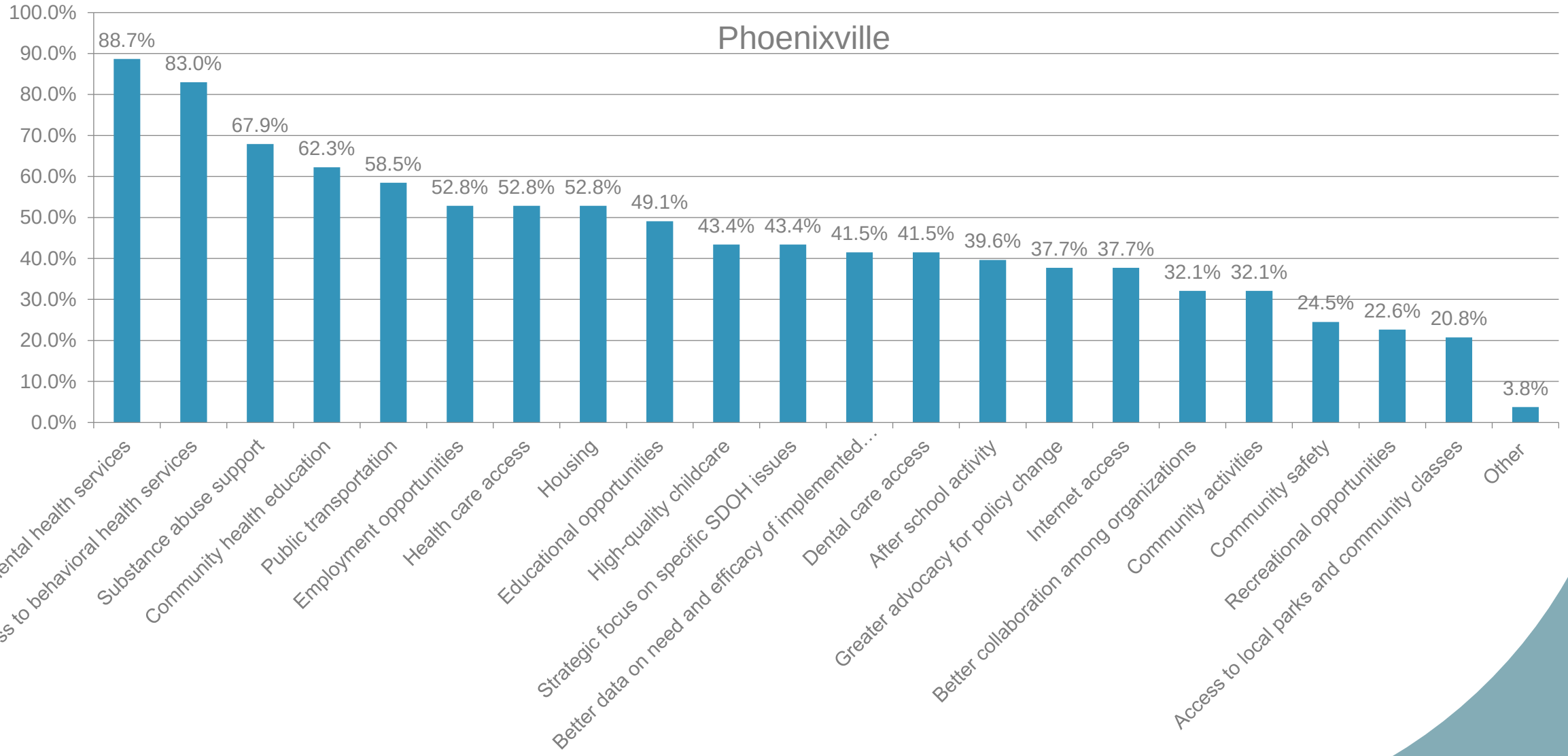
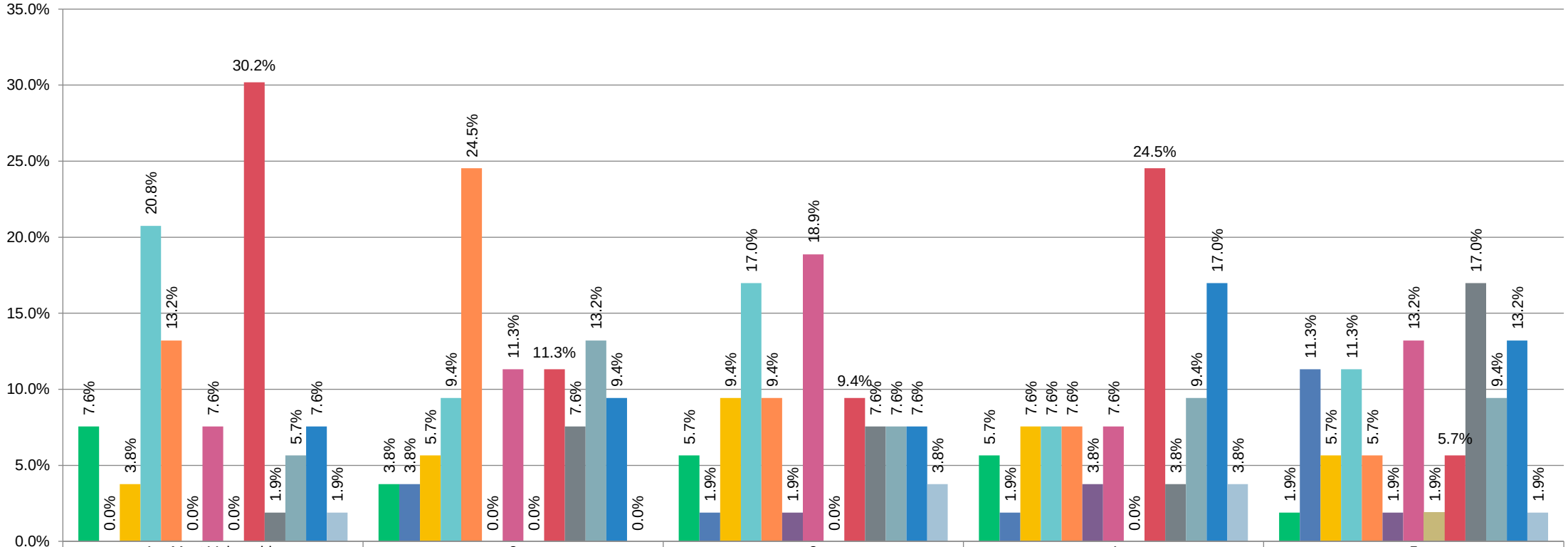


What would improve the quality of life for residents in your community? — Check all that apply



Top 5 populations that are the most vulnerable in the community?



	1 = Most Vulnerable	2	3	4	5
Children/youth	7.6%	3.8%	5.7%	5.7%	1.9%
Chronically ill	0.0%	3.8%	1.9%	1.9%	11.3%
Disabled	3.8%	5.7%	9.4%	7.6%	5.7%
Homeless	20.8%	9.4%	17.0%	7.6%	11.3%
Immigrant/Refugee	13.2%	24.5%	9.4%	7.6%	5.7%
LGBTQ	0.0%	0.0%	1.9%	3.8%	1.9%
Low-income	7.6%	11.3%	18.9%	7.6%	13.2%
Men	0.0%	0.0%	0.0%	0.0%	1.9%
Mentally ill	30.2%	11.3%	9.4%	24.5%	5.7%
Minorities	1.9%	7.6%	7.6%	3.8%	17.0%
Older adults	5.7%	13.2%	7.6%	9.4%	9.4%
Uninsured/underinsured	7.6%	9.4%	7.6%	17.0%	13.2%
Women	1.9%	0.0%	3.8%	3.8%	1.9%

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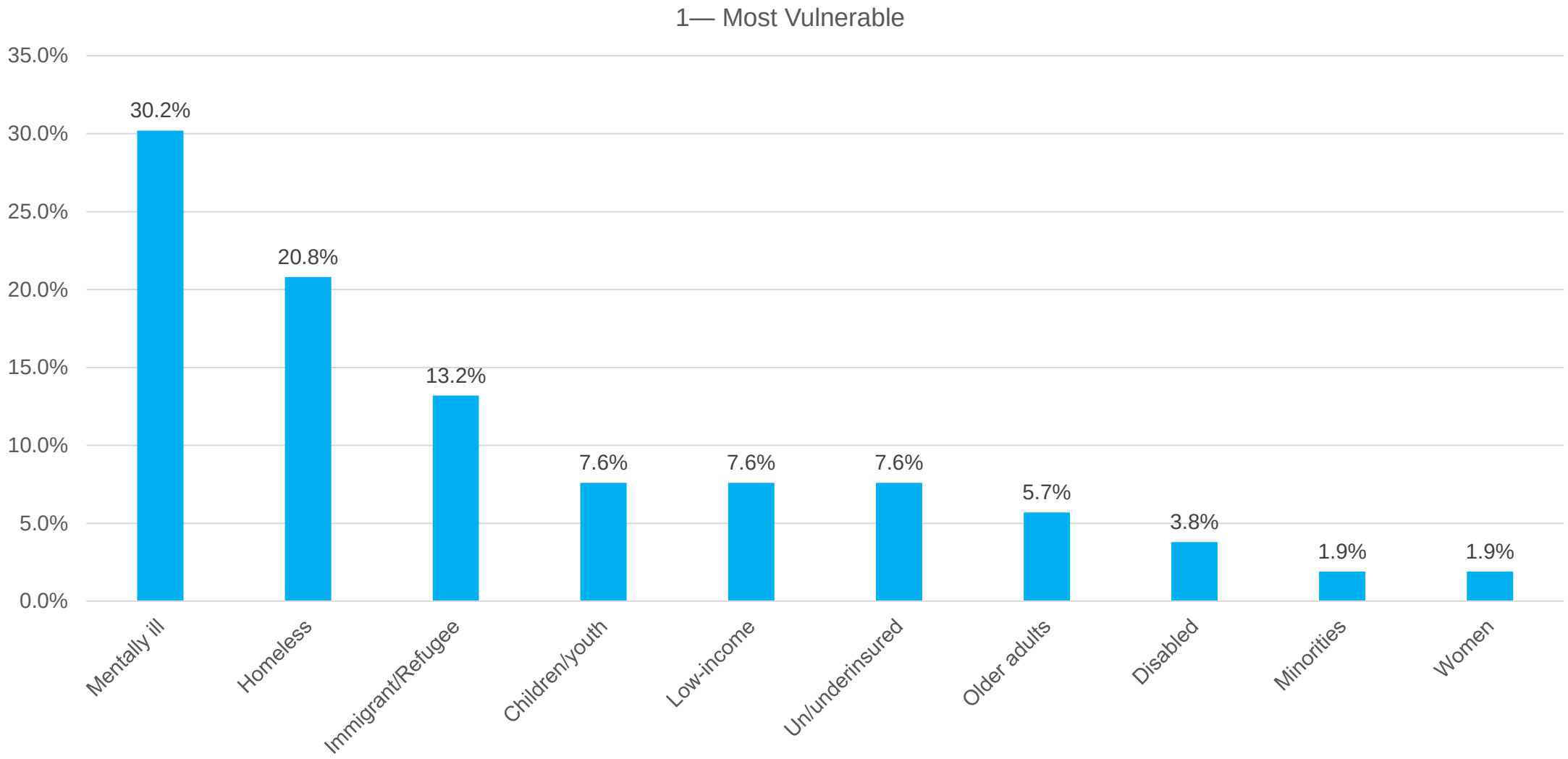

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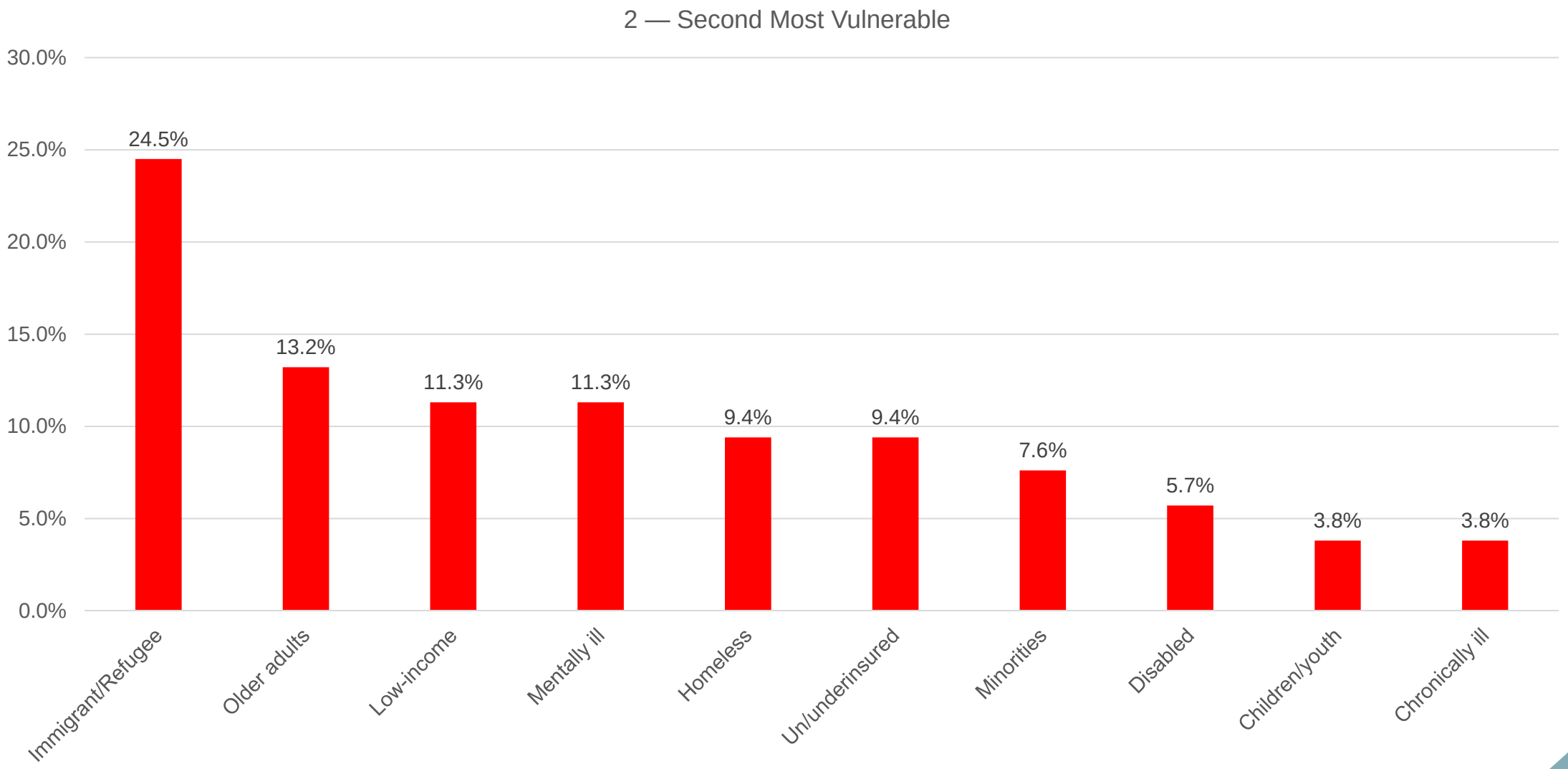

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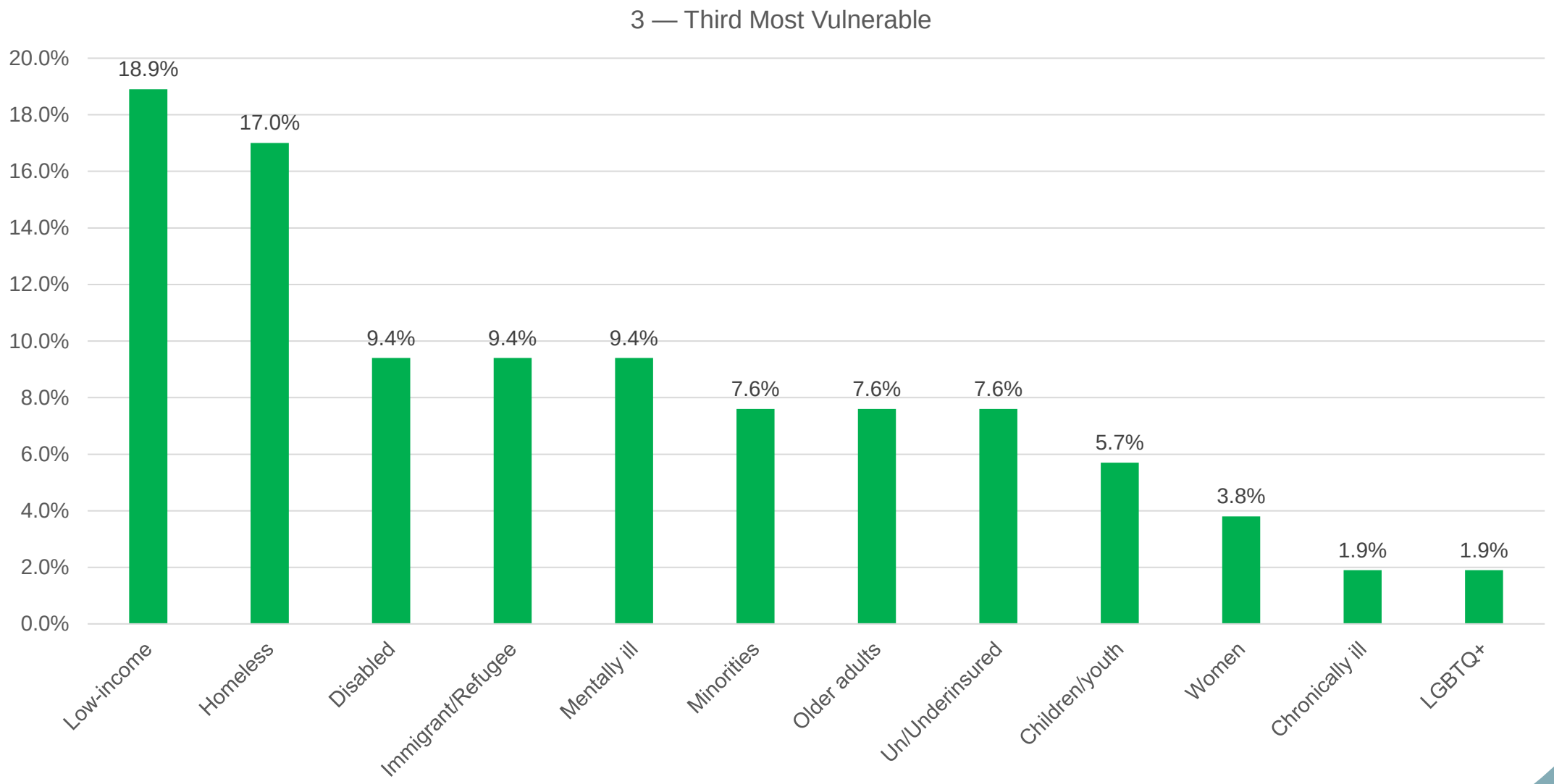

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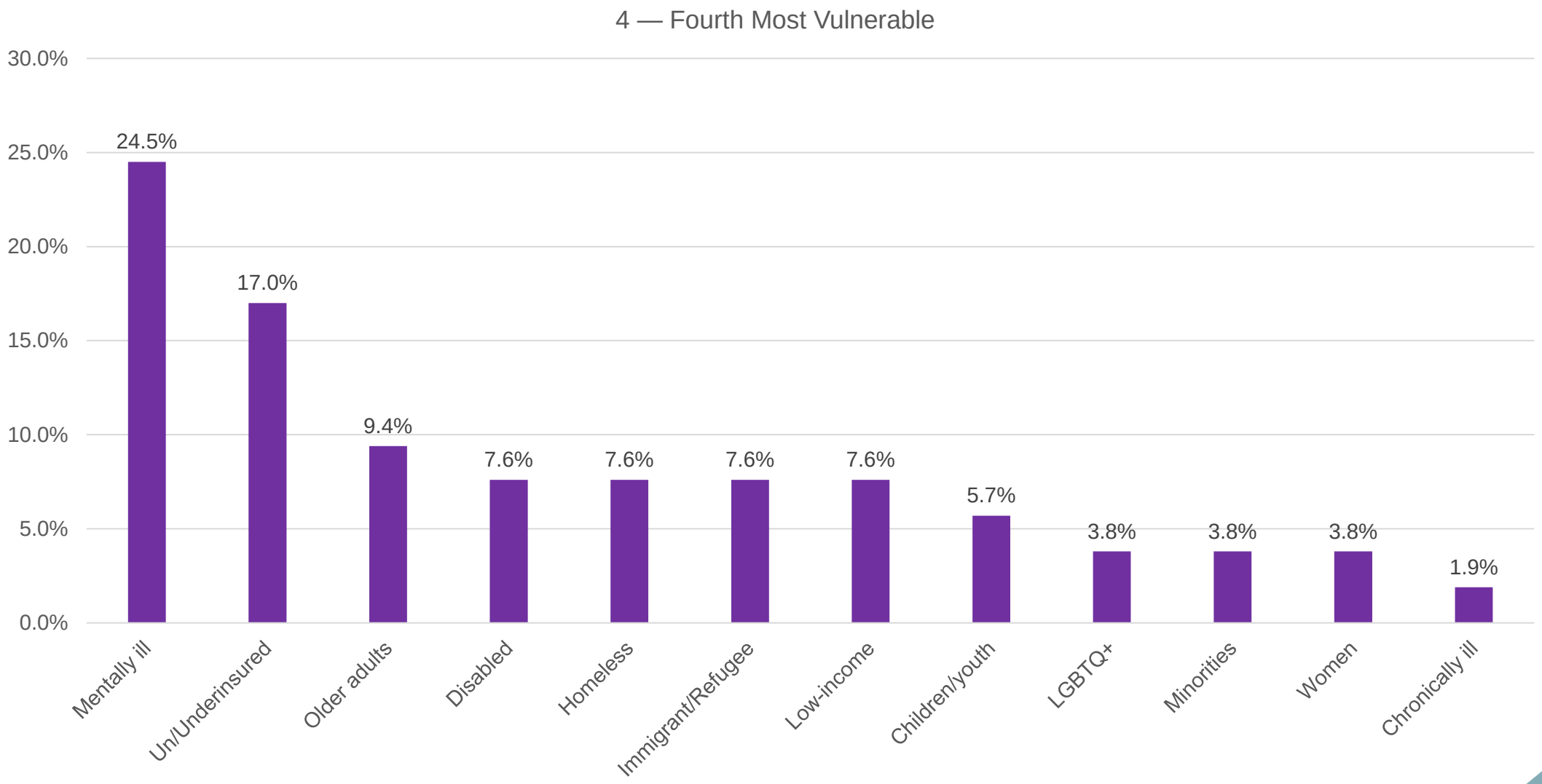

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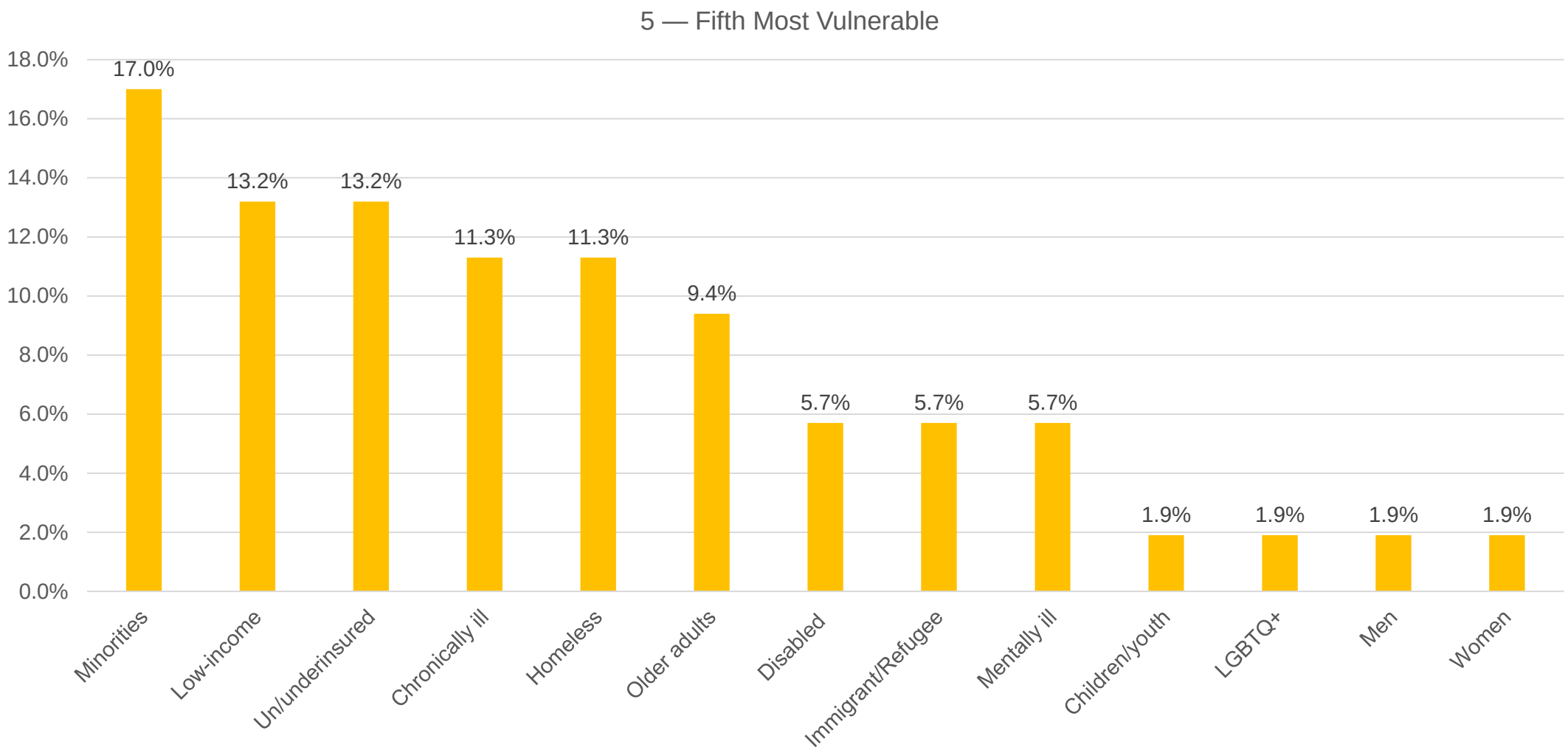
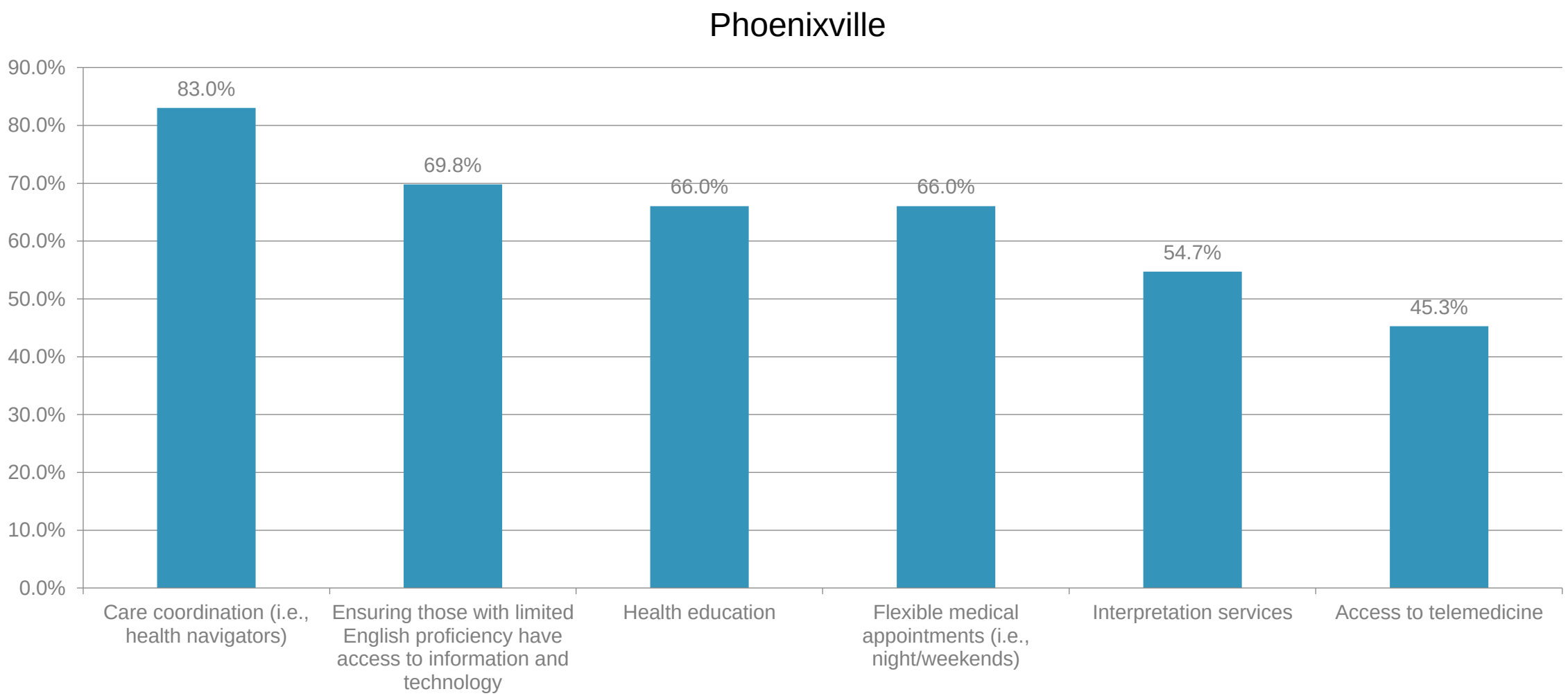
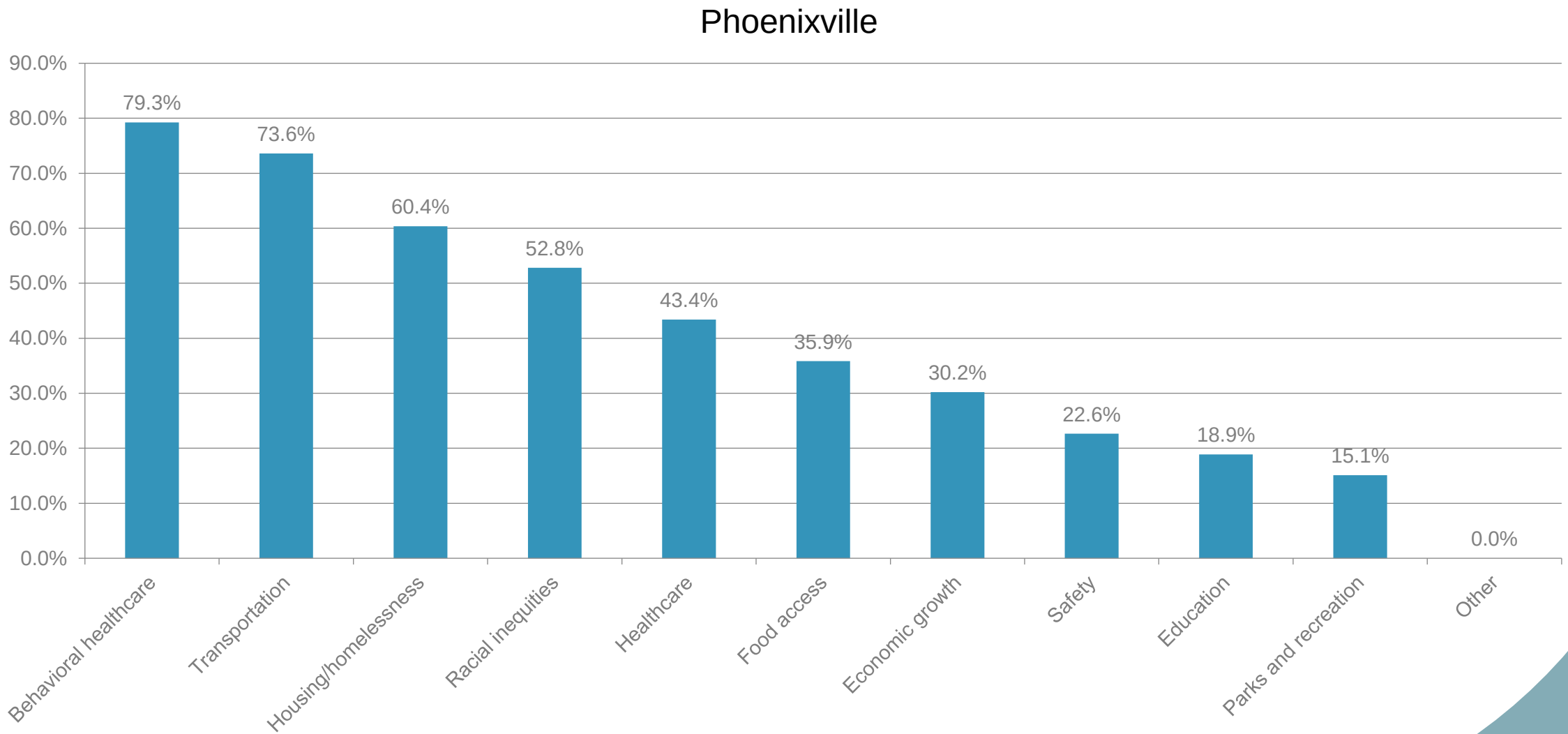


Solutions to help vulnerable populations meet their health needs — (Select all that apply)



What community needs are currently siloed and need further collaboration among non-profits, healthcare, government? (Check all that apply)



How did COVID-19 further impact care, specifically among the underserved and disenfranchised population(s)?

- Created further isolated and the fear of seeking help made them even more vulnerable. Fear, mistrust and confusion.
- Job loss resulted in loss of medical benefits for many, affording food became an issue, lack of technology and knowledge in how to access telemedicine reduced possibility of telemedicine care, lockdowns limited accessibility to services
- Many persons in these populations also had to work during Covid, placing them at high risk for Covid and with fewer resources for childcare, food access, health care.
- Navigation for health care became harder. Chronic disease management was neglected.
- Living together in large groups past COVID spread more quickly
- Main impact was the fear to access care due to COVID concerns. Many may not have access to technology for telemedicine.
- Clinics and other healthcare offices closed for a period of time.
- Shut down services, transportation was disrupted, and food distribution was a problem in some areas
- Overall additional barriers
- Lack of childcare and meals during school closures.
- Created unemployment, domestic violence, child abuse, day care services and health care access.
- Most painfully felt by those experiencing homelessness and among migrant people, those with proper documents and otherwise, they had the least access to resource
- Lost jobs or reduction of hours, increasing rents, mental health and trauma
- Testing is only accessible for children if you have a vehicle. Many of our immigrant students cannot get a covid test for this reason. Vaccines are only going to adults with computer skills/ English skills. Many highly vulnerable people are not getting vaccines.
- Not knowing where or how to deal with mental health
- Locations that homeless individuals would use were along with increased restrictions, jobs were lost, funds for food and housing decreased.
- Virus placed a limit on the number we serve and how we serve them.
- The underserved faced more access issues, they were disproportionately affected by COVID because of living quarters being multiple families in one location

Did telemedicine and virtual platforms ease access to care? In what way?

- It made getting to appointments easier for those who had internet access, those who were tech savvy, if you had computer equipment, Not for low-income or non-English speaking. Very frustration for most people over 70 – population fear getting scammed.
- Provided flexibility, eliminated transportation problems, better flexibility to interaction with medical professionals and get care needed
- Allowed for continuum of care during the pandemic and provided interventions in real time when needed.
- helped in the most basic way of providing at minimum level of healthcare access.
- More availability to reach more patients.
- Virtual healthcare only kept 'tabs' on people. But most vulnerable did not have access. Visits were to be basic and rudimentary.
- Individuals and families were able to access support and services from their homes with little to no barriers.
- Low-income households prioritize their phone and maintained ways to communicate. It expanded care to those that have limited access to transportation and childcare.
- The closure of the library was problematic – additional access limitations.
- MH services lack confidentiality when clients are at home and can be overheard by family members. Medical needs often required being physically seen in person to do a good assessment and observe symptoms.
- Eased access only if the digital divide is also addressed. At-risk populations often have limited internet availability making telemedicine just as inaccessible as in person care.

What actions could your hospital take to better address health disparities?

- Continue community outreach, increase community health services, and community partnerships. Helping agencies such as HCA, Alianzas, Clinic to expand their work
- Point of contact workers going out to educate and encourage better self care and use of technology to bring healthcare information to a wider audience.
- Need for navigators especially for persons with behavioral health issues
- Work to understand the needs of diverse cultures but assure community what hospital offers
- Work with local HCPs and The Clinic to assure uninsured/underinsured persons have access, care coordination/partnerships
- Provide health education and patient comprehension levels
- Hire social/crisis workers to help mental health/drug & alcohol population
- Access to medical supplies/medications (ie. insulin supplies, insulin) post discharge
- Increase supply of health care providers, need for free clinics
- Additional education sessions, screenings in the community; meet them where they are.
- Be more helpful on teaching patients how to use their health portal.
- Expand connections with CBOs to provide services - have more interpreters, social workers, expand community communications
- Increase after-hour appointments for working population
- Provide telemedicine services to shelters or other points of entry for low-income/homeless populations with technology
- Grants to provide internet access for multi-unit housing establishments (computers and education on use)
- Education of leadership and engagement in community
- Treat everyone equally. The hospital can continue to participate with community groups to develop plans to support and improve identified needs.
- Improve health care access, access to fresh healthy food, improve access to care overall, improve access to behavioral healthcare.
- Address the need for transportation. Staff need to be in touch with caregivers.
- Increasing cultural competence training for providers in the local hospital, health insurance and community health workers in the community.
- Be an outspoken advocate for vulnerable populations.
- More access for uninsured children. PHCA is great for dental and vision needs, but each service has its own enrollment process to determine eligibility and that paperwork can be a barrier.
- Have more public informational forums in community spaces that everyone feels welcome.
- How is the hospital seen in the community and why is it not being used? If it is addressed some of health disparities could also addressed
- Provide navigators to help those who don't speak the language, don't understand healthcare coverage, and don't have access to technology
- It sounds trite, but house calls work.
- More mental health agencies.
- Provide financial support, expertise, and personnel to build trust and confidence in the community.
- Cultural diversity education of all staff/doctors, particularly ER

Excluding healthcare, what organizations should collaborate to address behavioral health in our community?

- Businesses
- Civic groups
- Community businesses and non-profits
- Community leaders
- County agencies
- Faith-based groups/religious organizations
- Food banks
- Government agencies
- Health and Human services
- Health Department
- Holcomb Behavioral Health, Maternal and Child Health Consortium with the Bilingual Community Health Workers
- Homeless organizations
- Local counseling services
- Mental health organizations/provider
- Minority coalitions
- Organizations that focus on immigrant populations, low-income people
- Police
- Primary care providers
- Rehabilitation units (in patient and outpatient)
- School Districts
- Senior agencies/centers
- Shelters/half-way houses
- Transportation organizations
- YMCA
- Youth leagues and sports

What do you want the hospital to know that we haven't already asked?

- Continue to outreach and partner
- Address people's cultural and understand their needs
- We appreciate their support and dedication.
- We have a mental health crisis with our pandemic response; more substance abuse accompanied by inadequate resources for this population.
- Phoenixville is one of the best service-coordinated communities around. More open, honest, communication to the community.
- We have many resources and support that provided services during COVID for underserved populations. Those working/essential workers, disabled persons, victims of domestic violence, and those with addictions/mental illness lacked resources and access to care during that time.
- The Phoenixville community already does a good amount of collaboration. Resolve telemedicine or transportations issues.
- There are too many layers between people in need and those who can help them. Complicated scheduling, excessive data collection, multiple visits or separate day testing to address problems, and insurance company vagueness are all barriers to care that could be better controlled.
- Hospital staff is poor at communicating with families. In-home care solutions offered by social work staff are not affordable for the average family. Discharge planning and team meetings should include the family.
- Work with non-profits/agencies to identify high risk individuals who may not have an opportunity to get vaccinated. We should be prioritizing these residents through direct outreach as it would benefit the community overall.
- Informational programs should be held community buildings and/or other social events (back to school BBQ.
- Doing a great job for the Phoenixville community. Thank you to your entire staff for their work to keep people safe and healthy during an insanely difficult year!
- Hard to schedule an outpatient appointment to be timely.
- We want our hospital to be relevant to the community, and to serve as part of the community. We need family physicians, orthopedics, and OB/GYN's.
- Treat all patients the same as if they are paying customers. Everyone deserves care in a respectful way.

Tower Health Phoenixville Hospital

Appendix E - Community Surveys

Phoenixville Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

Introduction

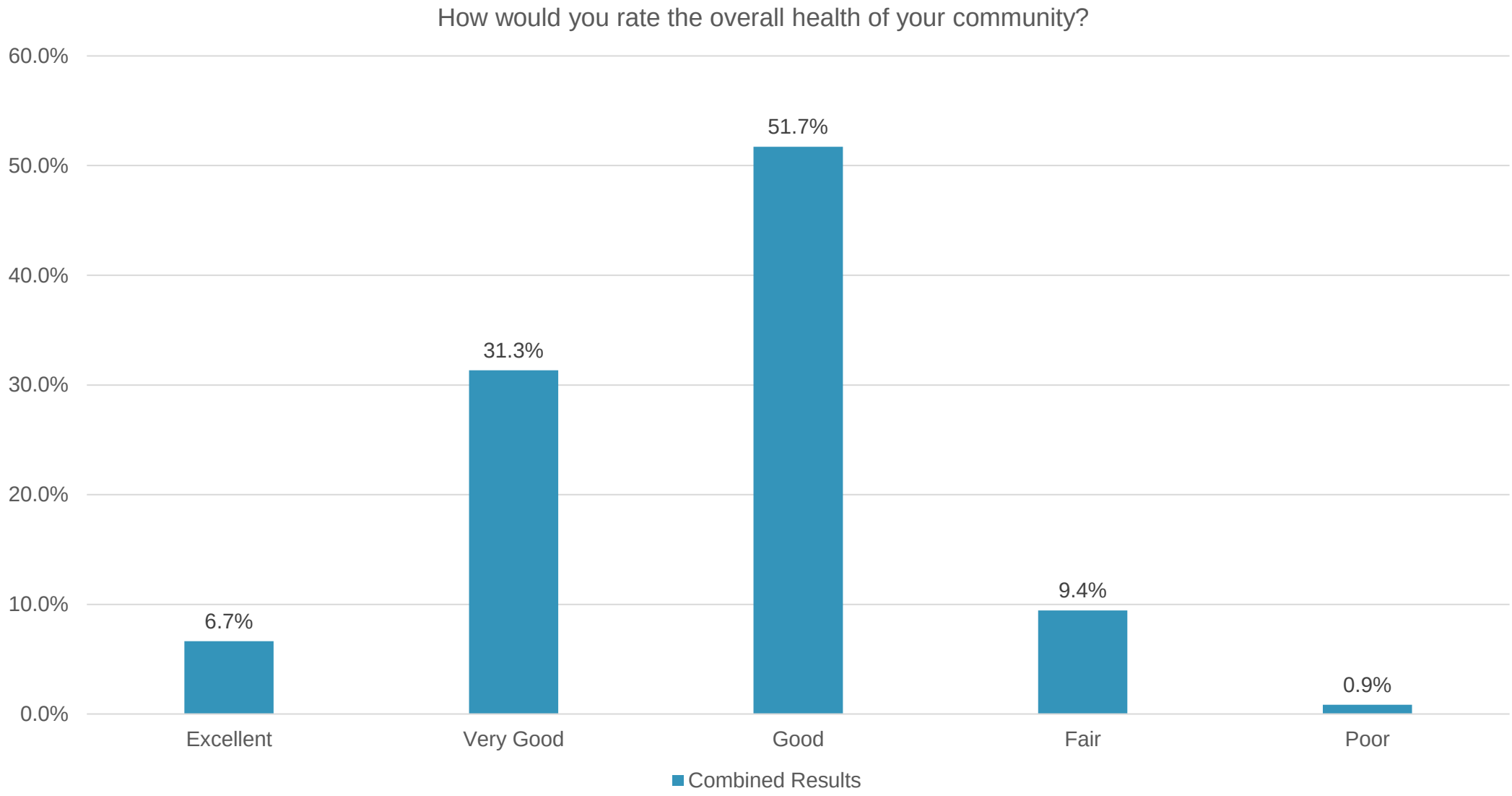
- A community survey was employed to collect input from populations within Tower Health Phoenixville Hospital's service area in order to identify health risk factors and health needs in the community.
- Working with the Tower Health working group the community survey was promoted on social media platforms, newspapers, hospital websites, relationships with community-based organizations, community associations, and clinics. Hundreds of surveys were collected from community residents.

➢ The survey was accessible on Survey Monkey and available in both English and Spanish. In total, 683 surveys were used for analysis. 663 surveys were collected in English and 20 surveys were collected in Spanish.

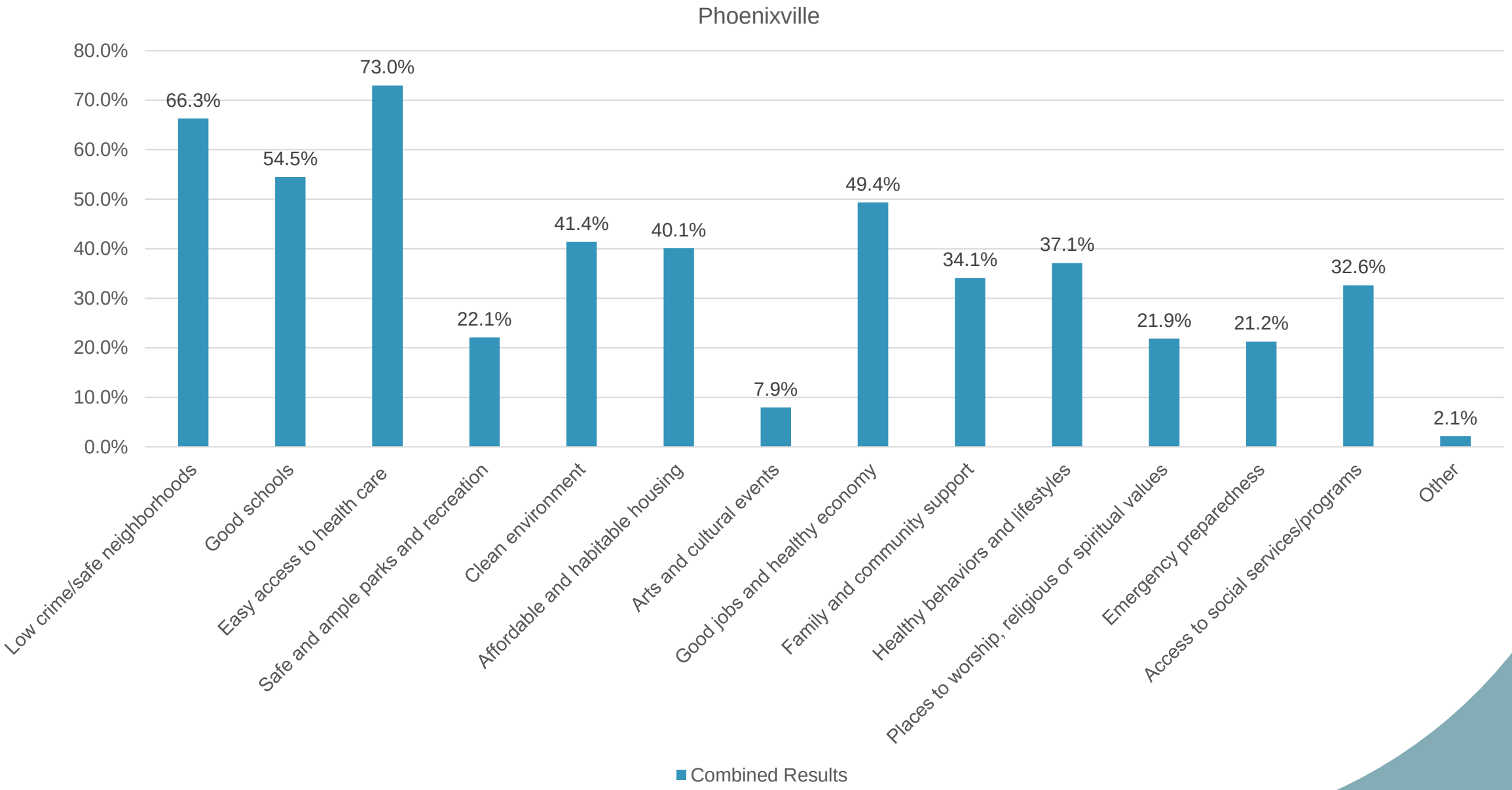
➢ The data collection period ran from July 2021 – September 2021.

Note: "Check all that apply" referenced within the PowerPoint refers to questions where the survey respondents have the ability to select more than one option/choice to the question.

Rate Health and Human Services in Community



What Are the 5 Most Important Factors That Contribute to a “Healthy Community”?



Common Themes
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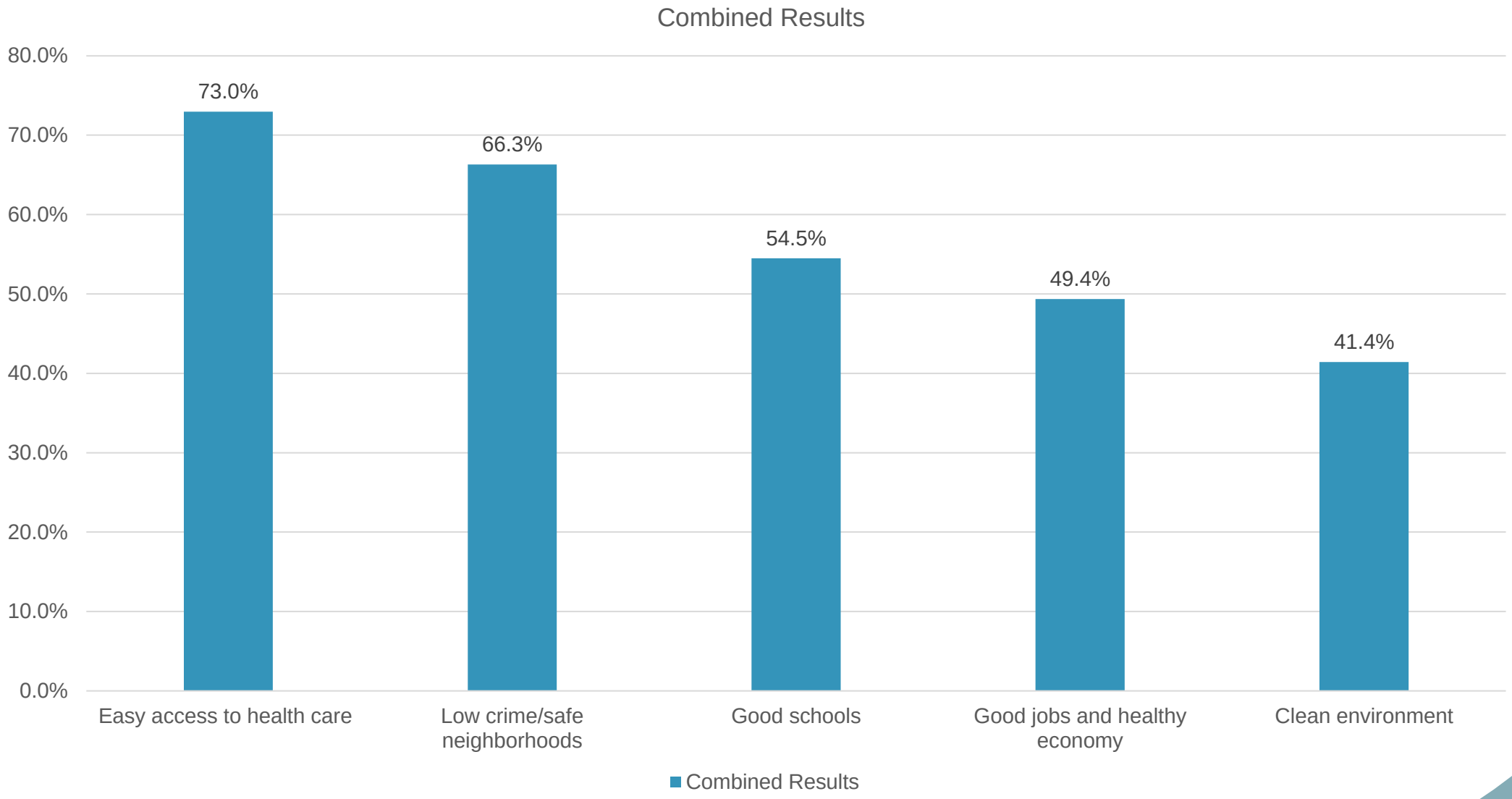
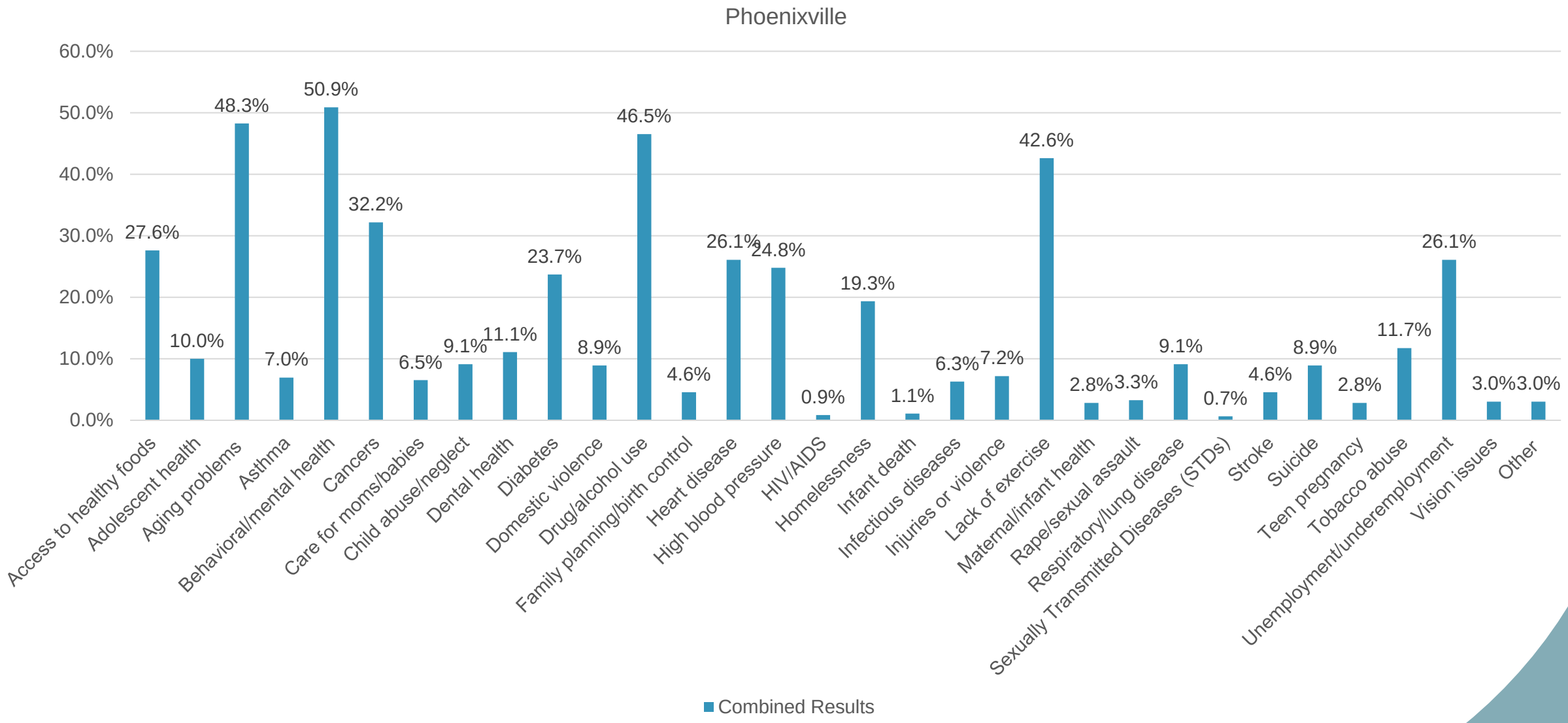


The above chart depicts the top 5 most important factor.

Top 5 persistent “Health Problems” in the community?



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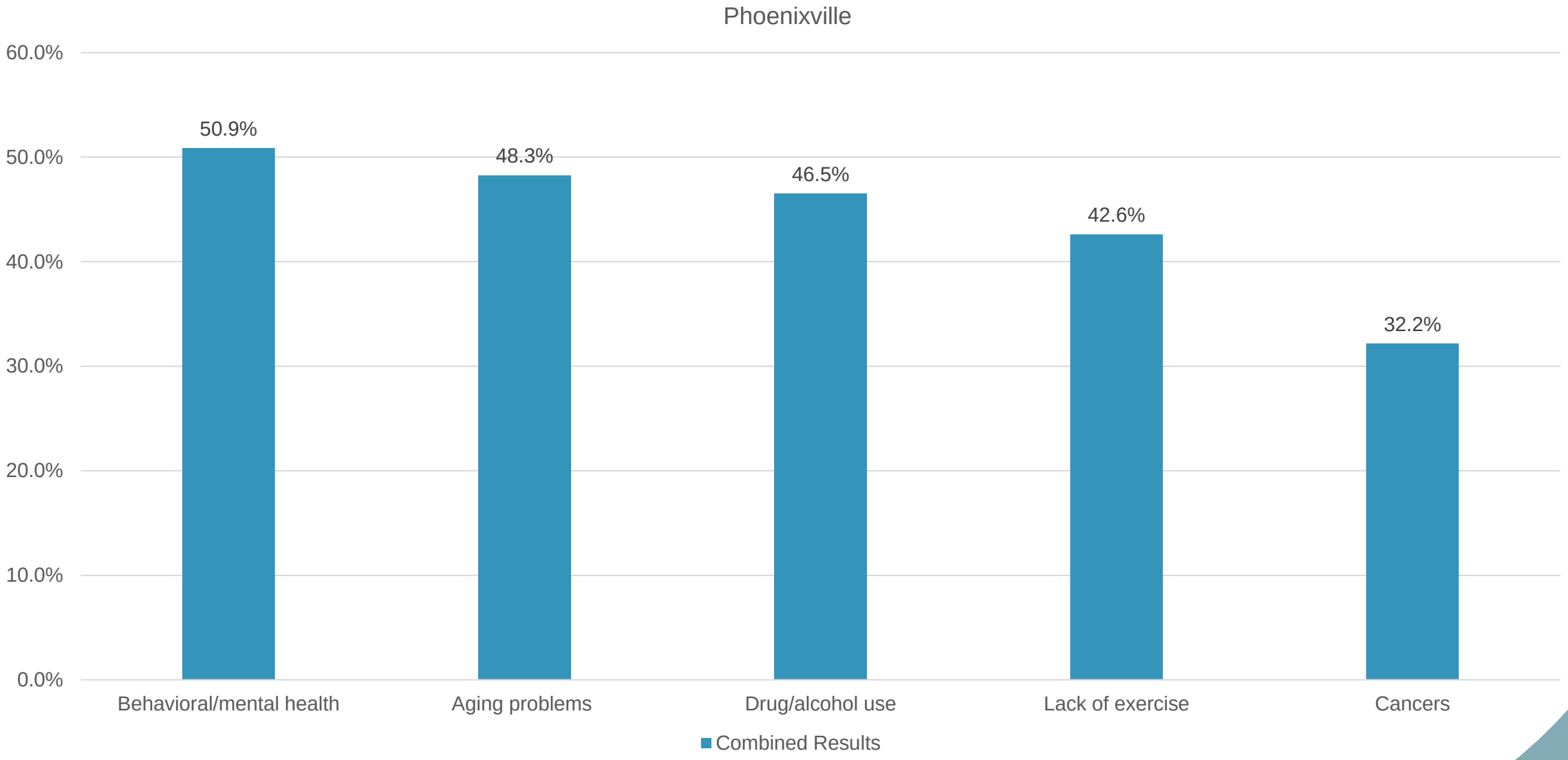
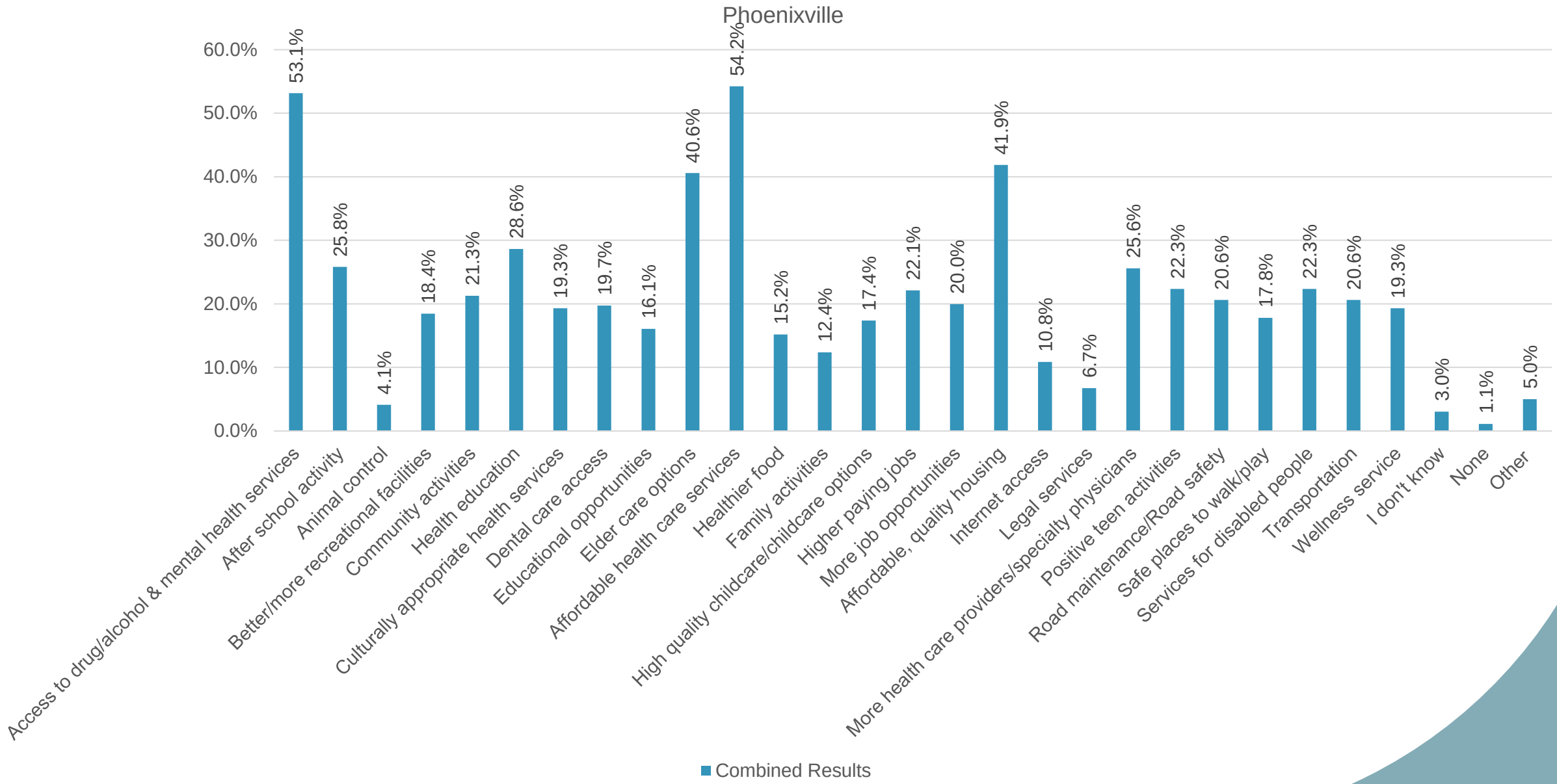


The above chart depicts the top 5 health factors.

What would improve the quality of life for residents in your community? — Check all that apply



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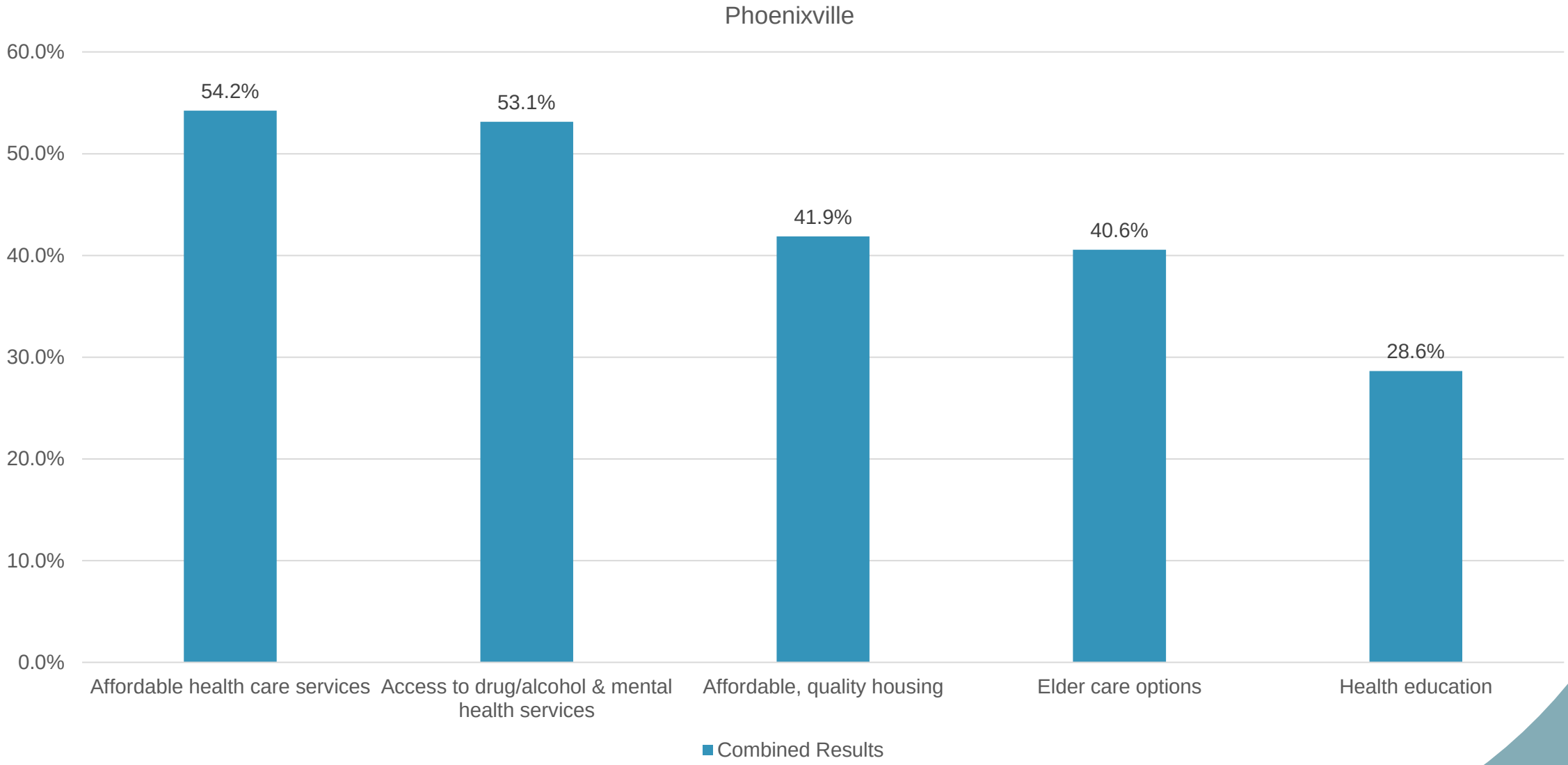
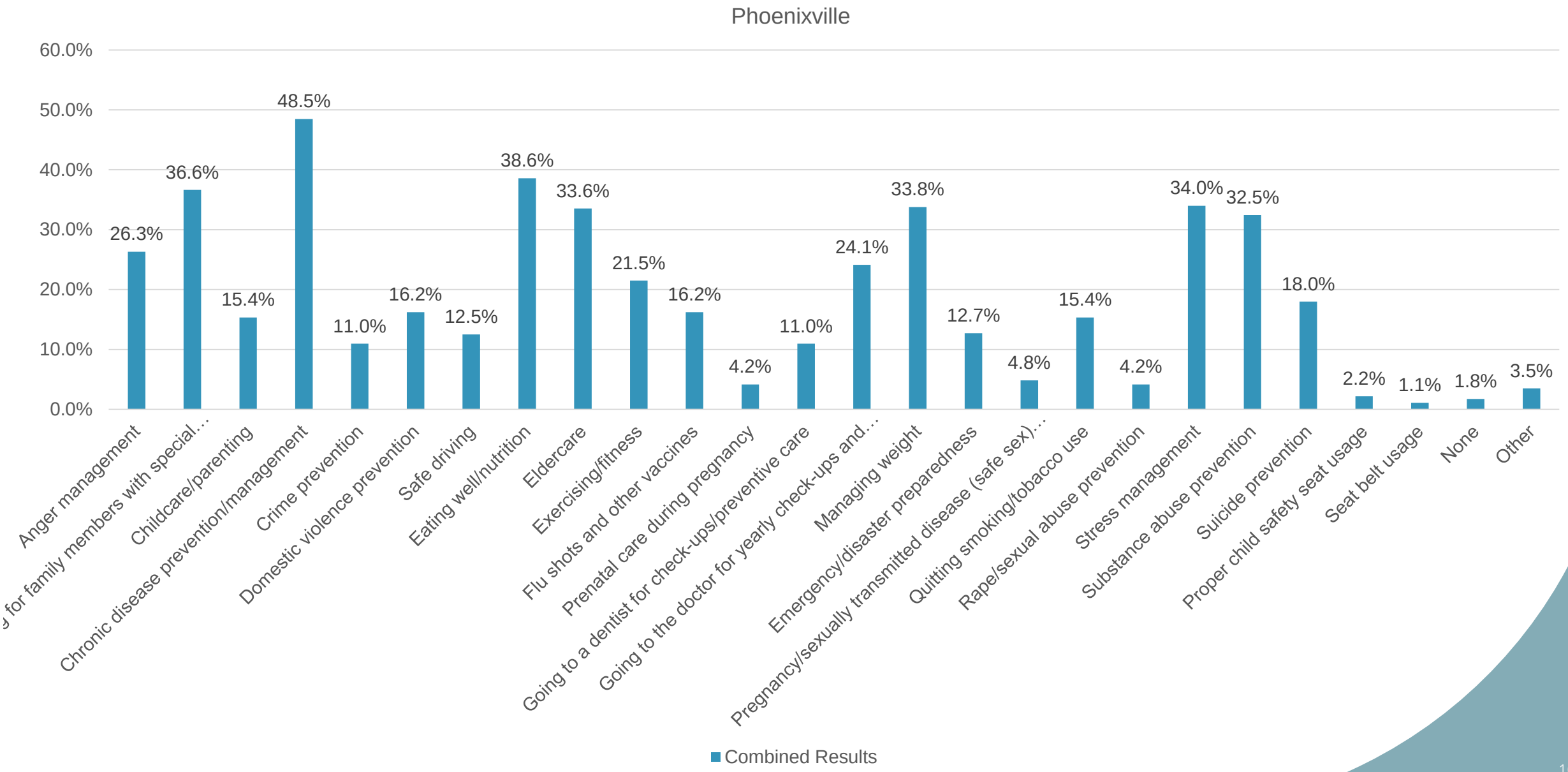


The above chart depicts the top 5 factors that would improve the quality of life for residents.

Select the Top 5 “Health Behaviors” People In Your Community Need More Information About



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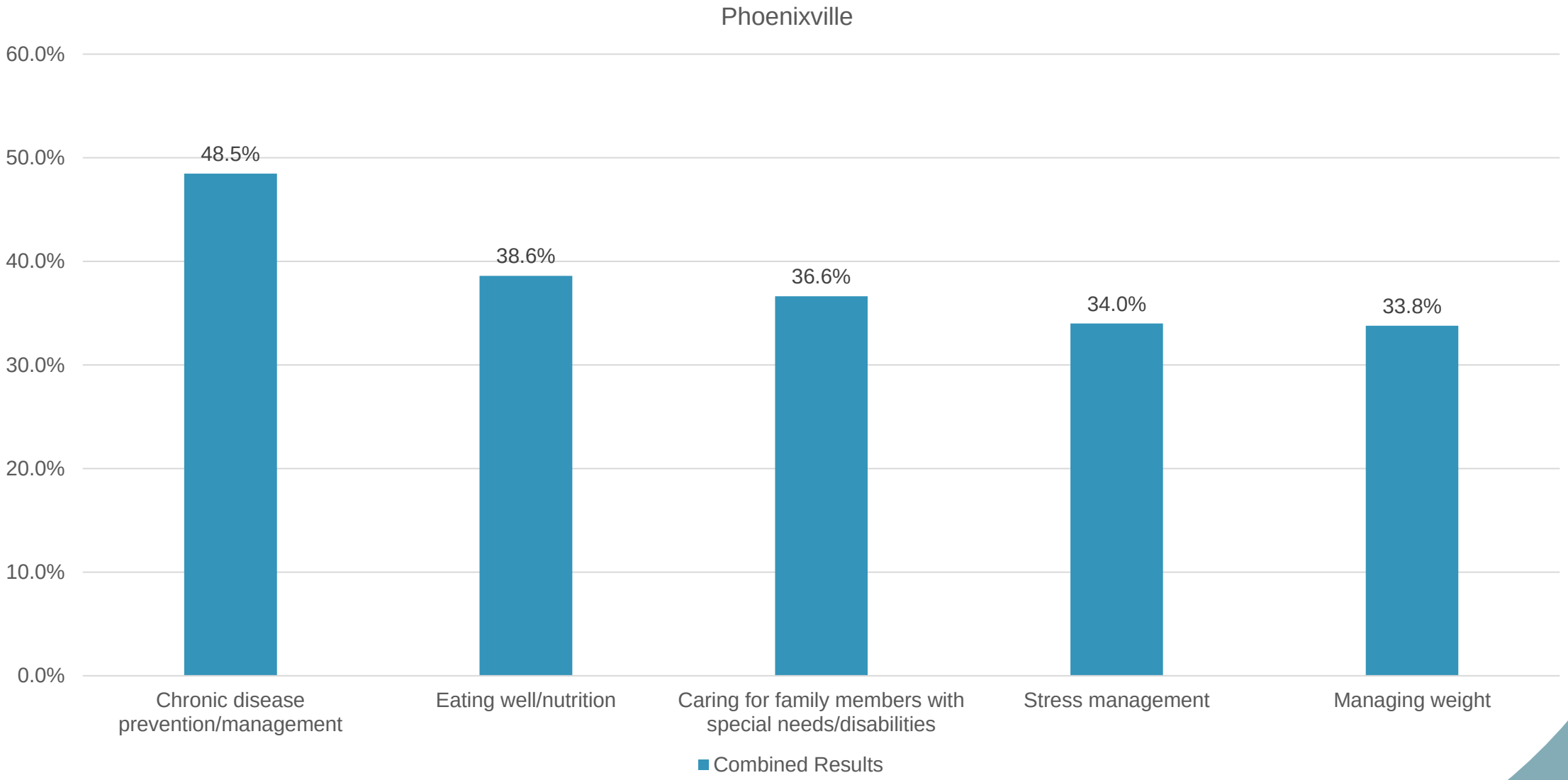
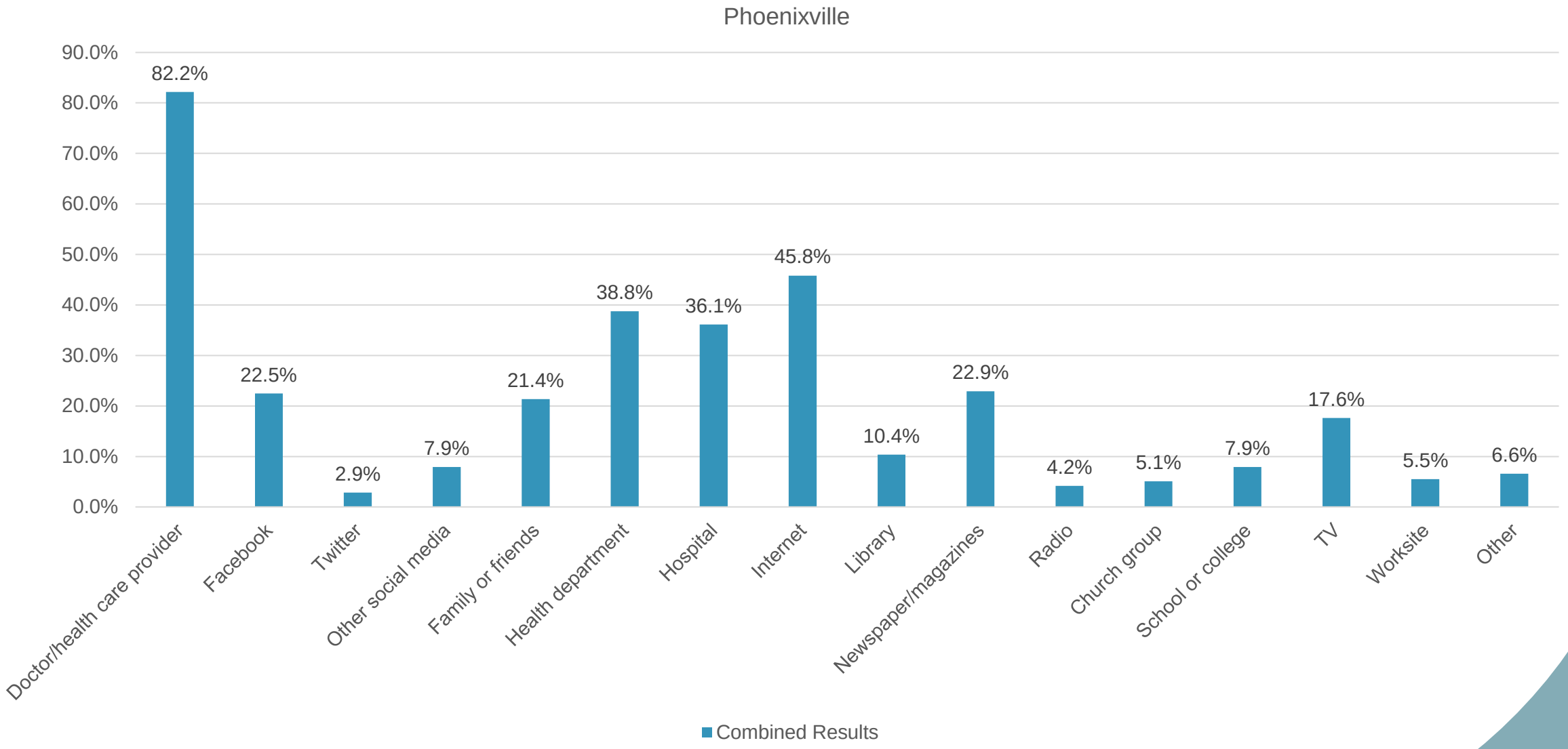
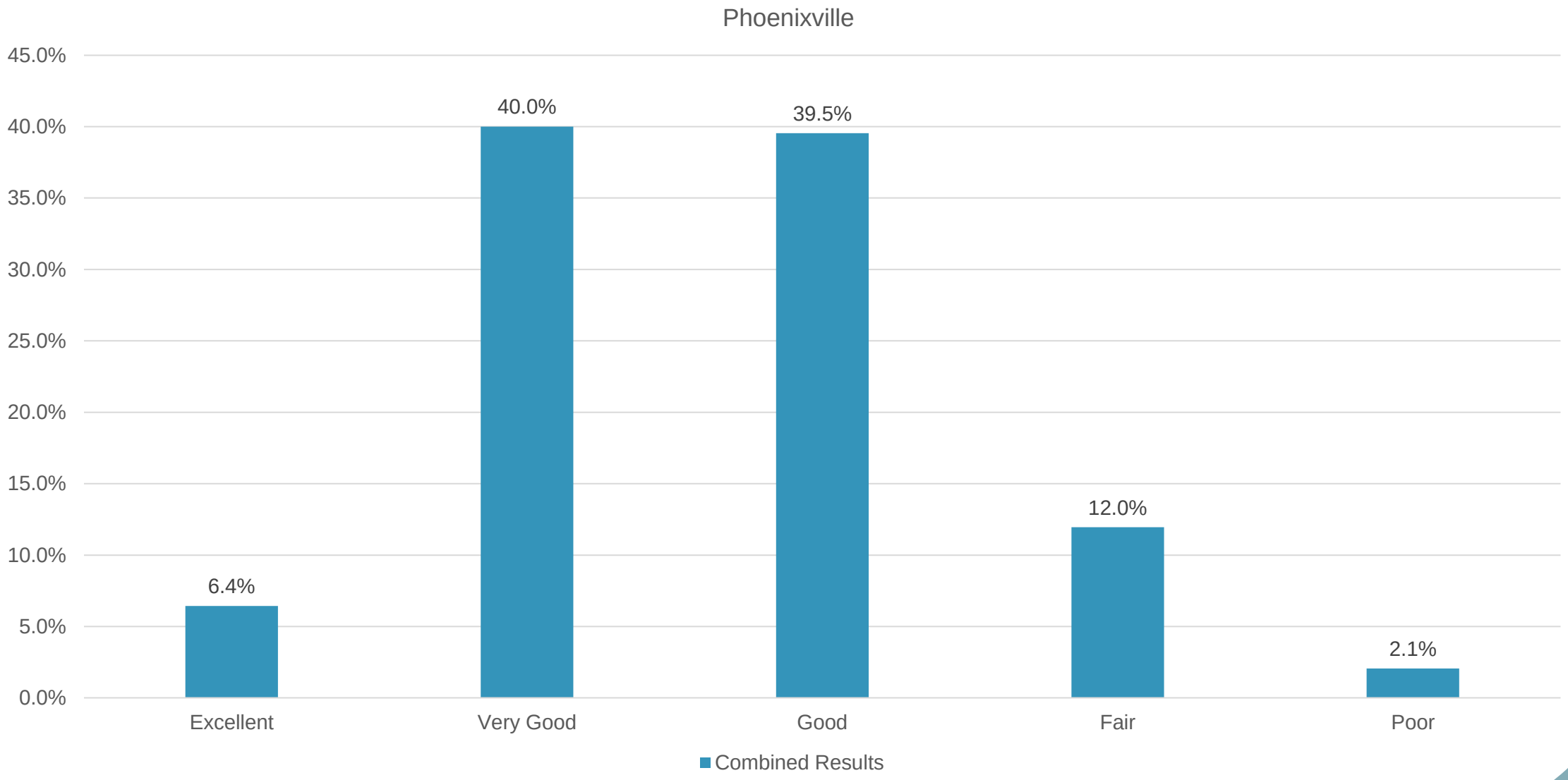


The above chart depicts the top 5 health behaviors people in the community need more information about.

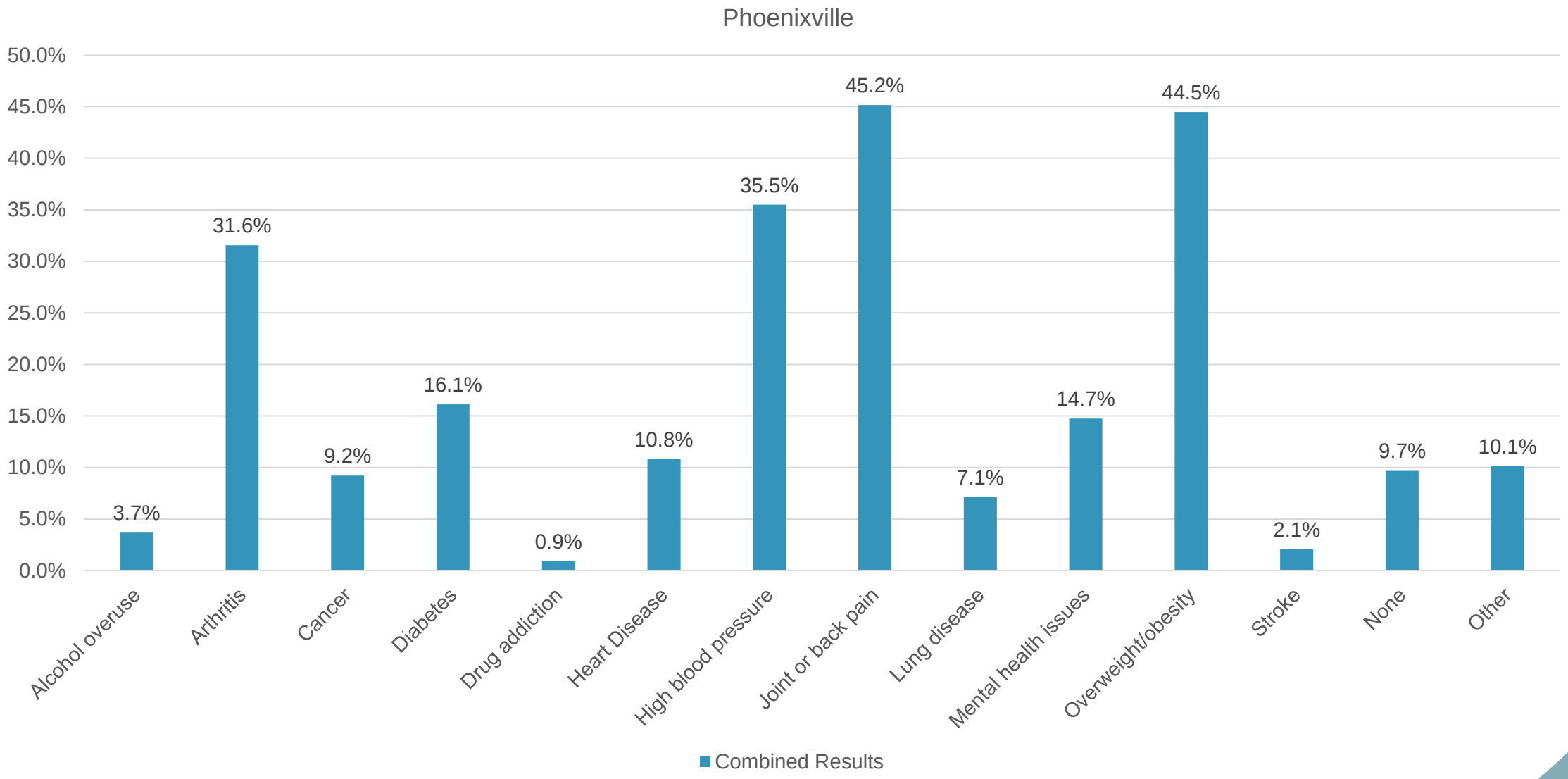
How Would You Like to Receive General Health Education Information (Check all that apply)



How Would You Describe Your Overall Health



Top 3 Health Challenges Currently Faced



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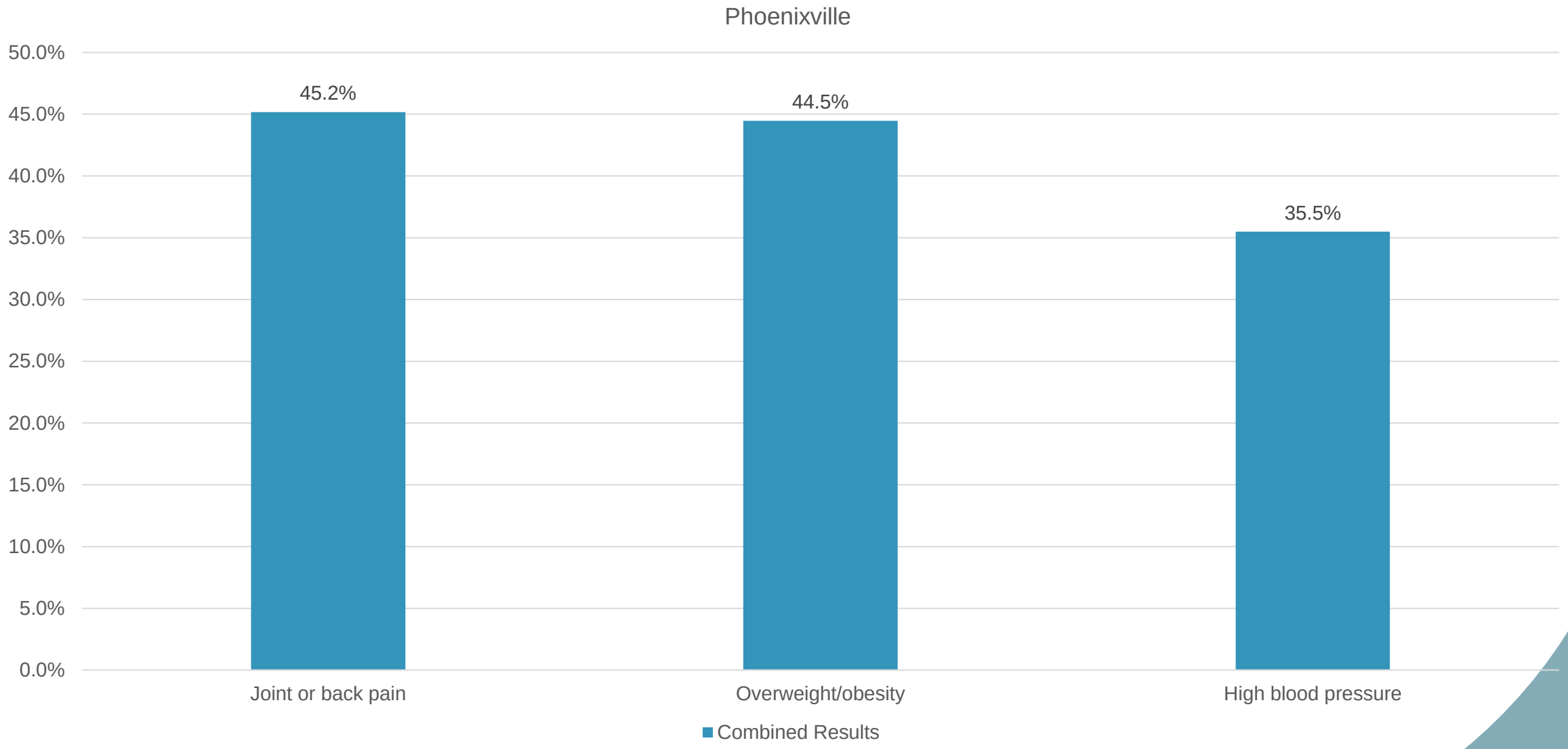
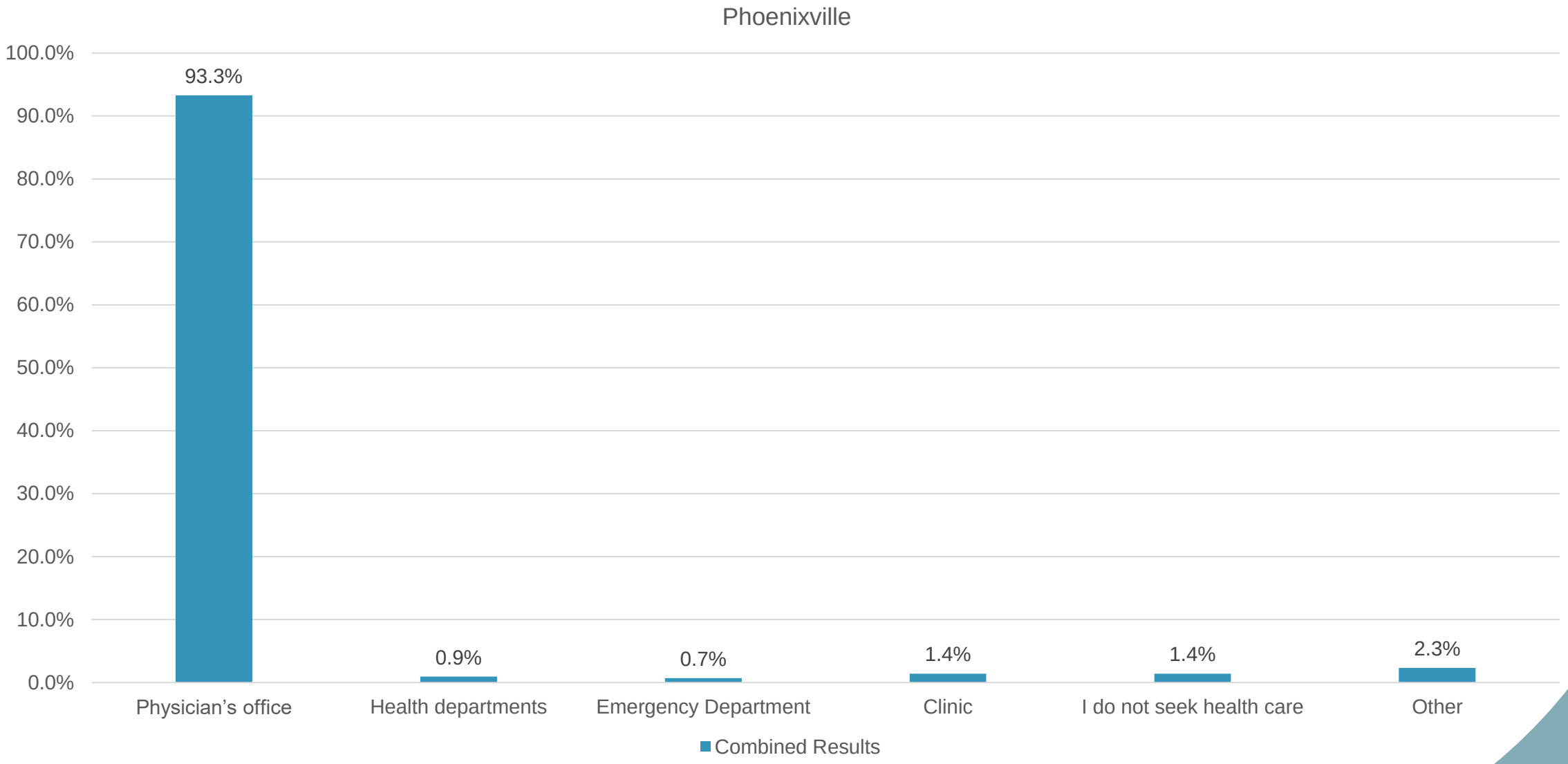
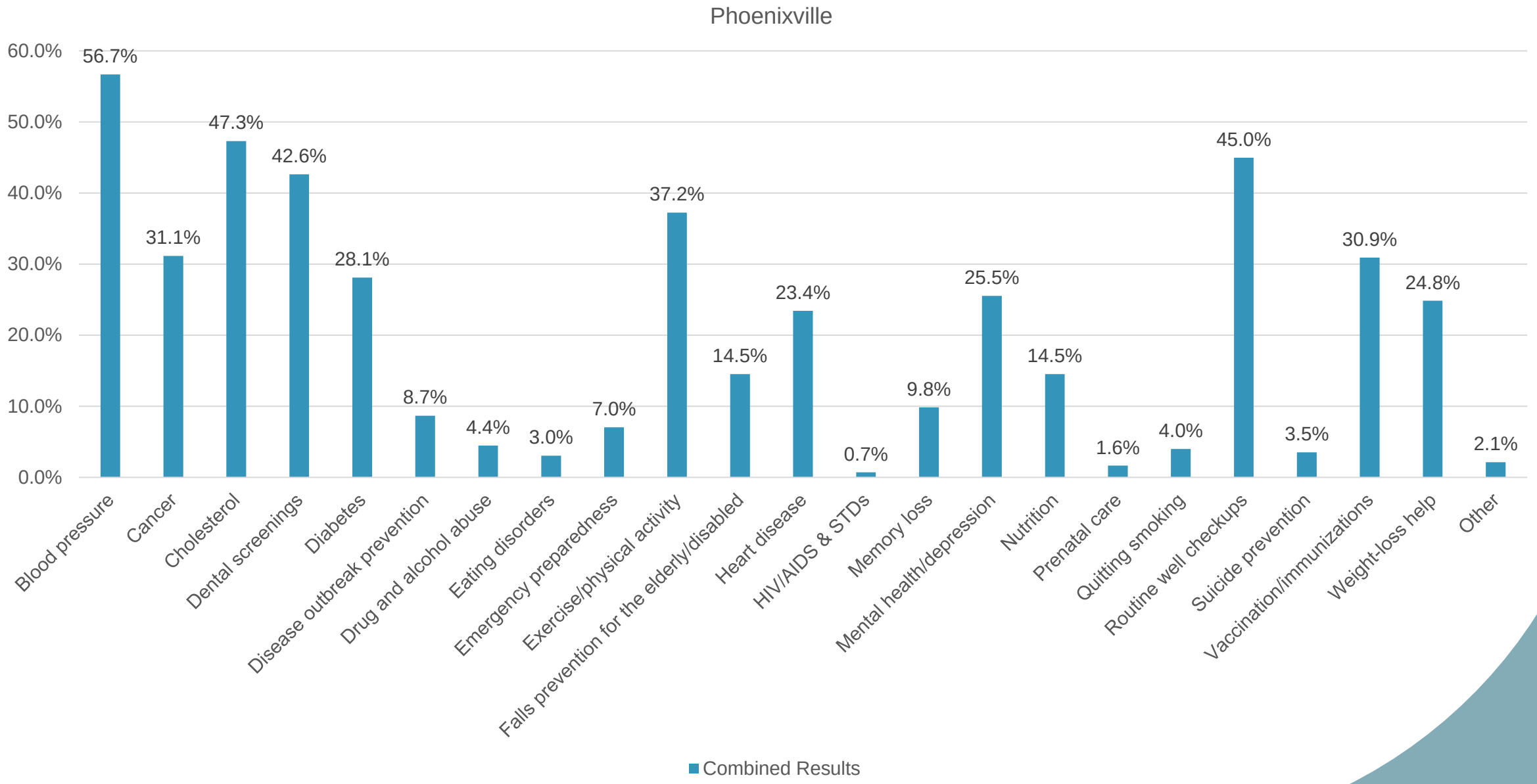


The above chart depicts the top 3 health challenges respondents currently face.

Where Do You Usually Go For Health Care?



What Types of Health Screenings and/or Services are Needed to Keep You and Your Family Healthy?



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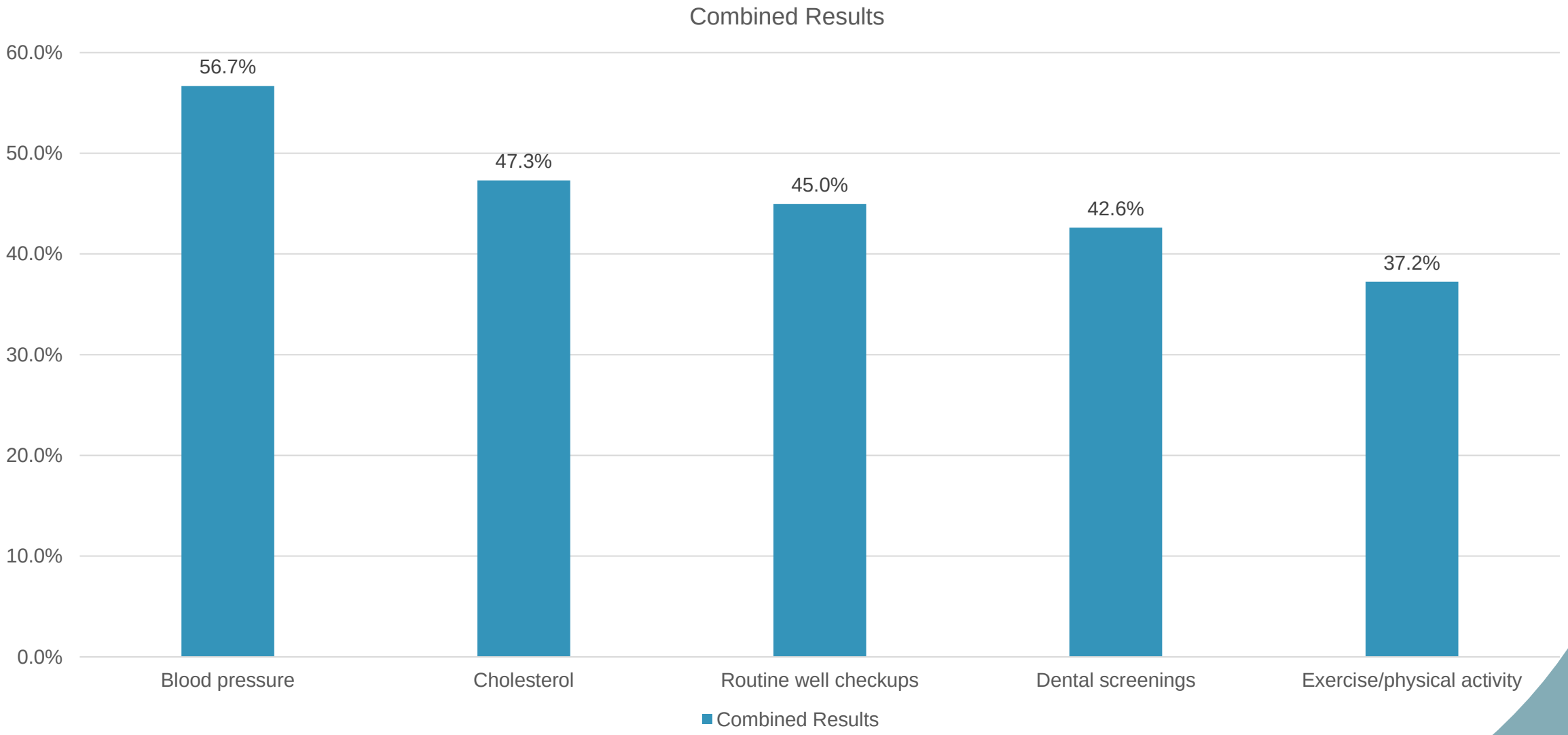
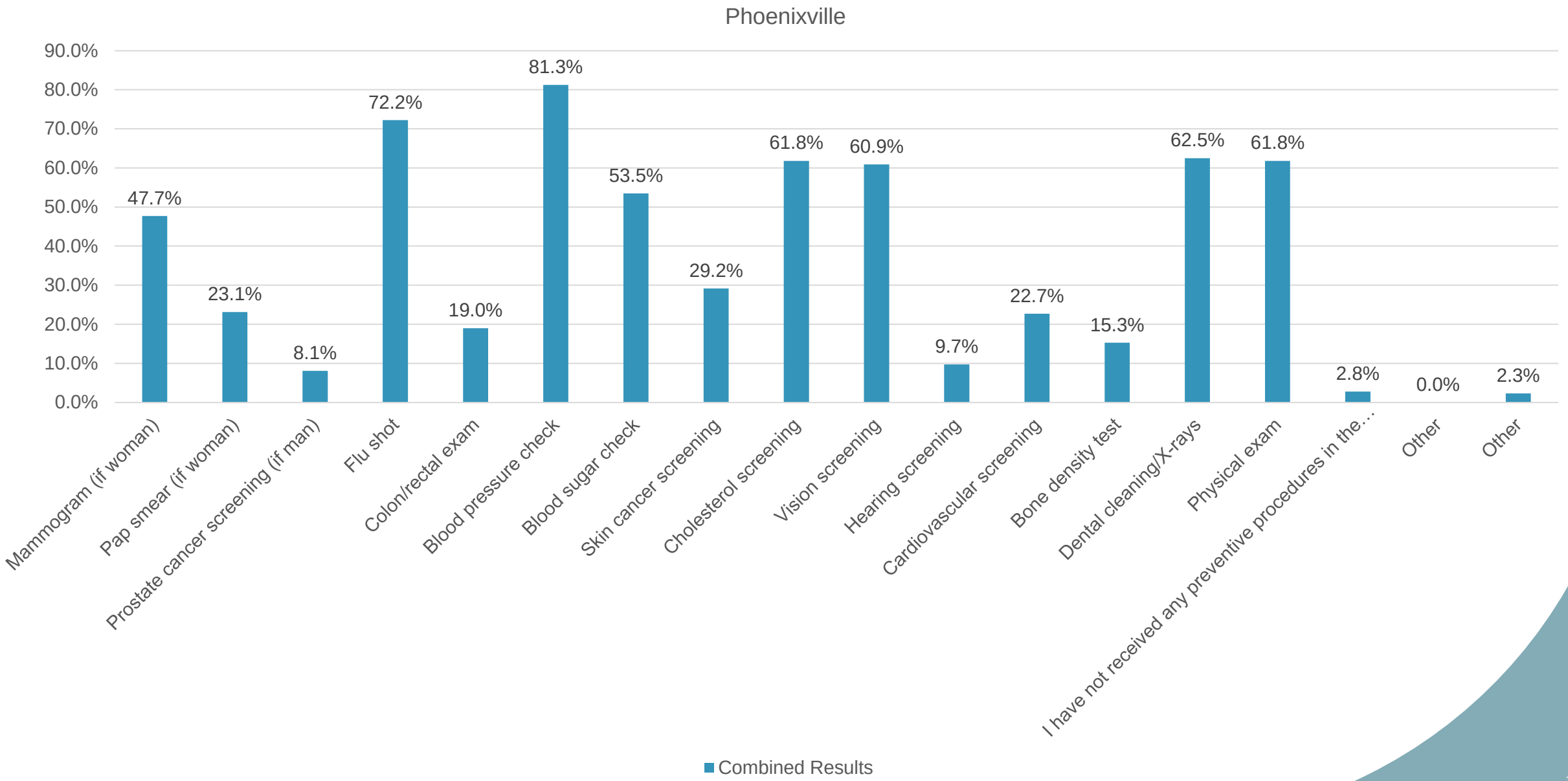


The above chart depicts the top 3 health challenges respondents currently face.

Which of the Following Preventive Procedures Have You Had in the Past 12 Months? (Check all that apply)



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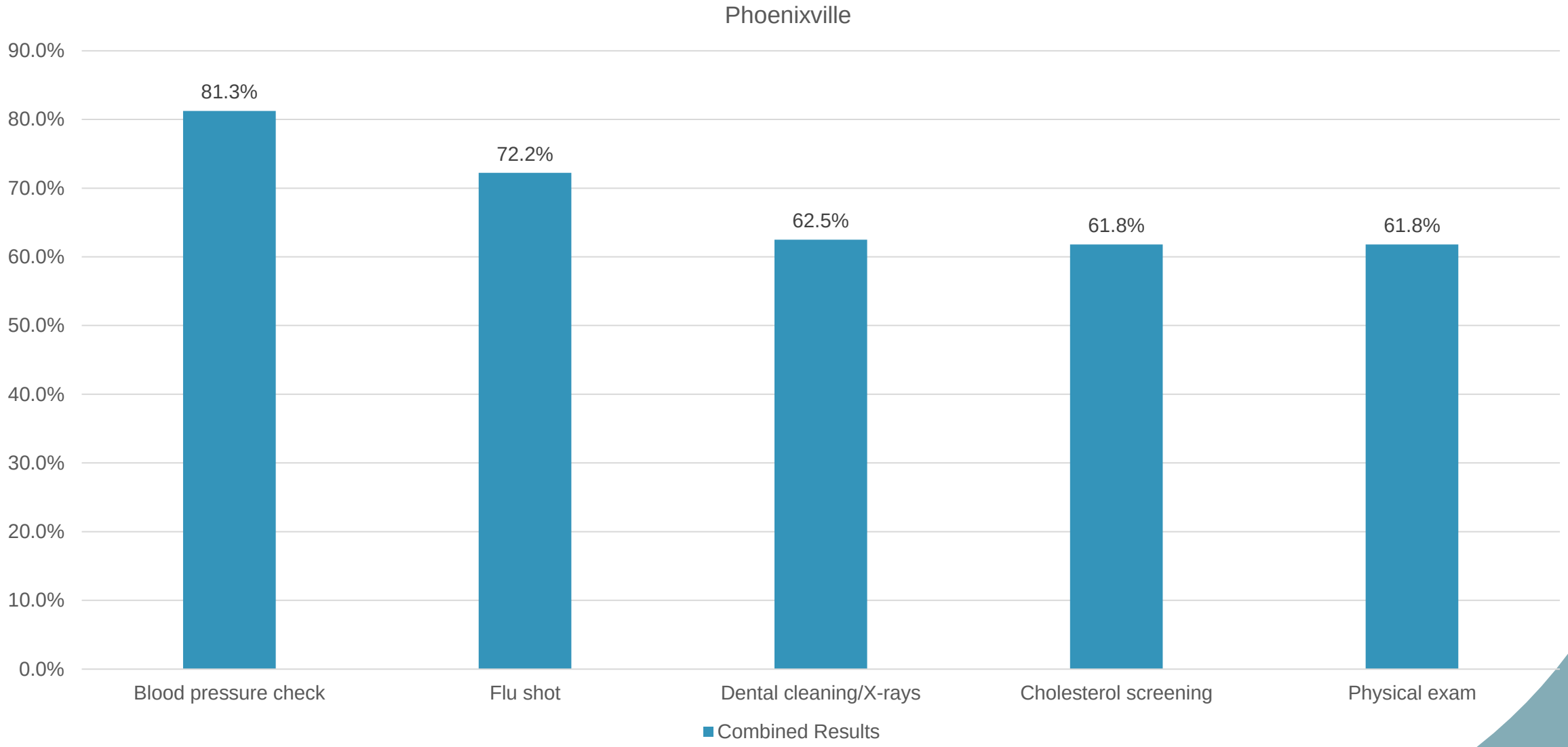
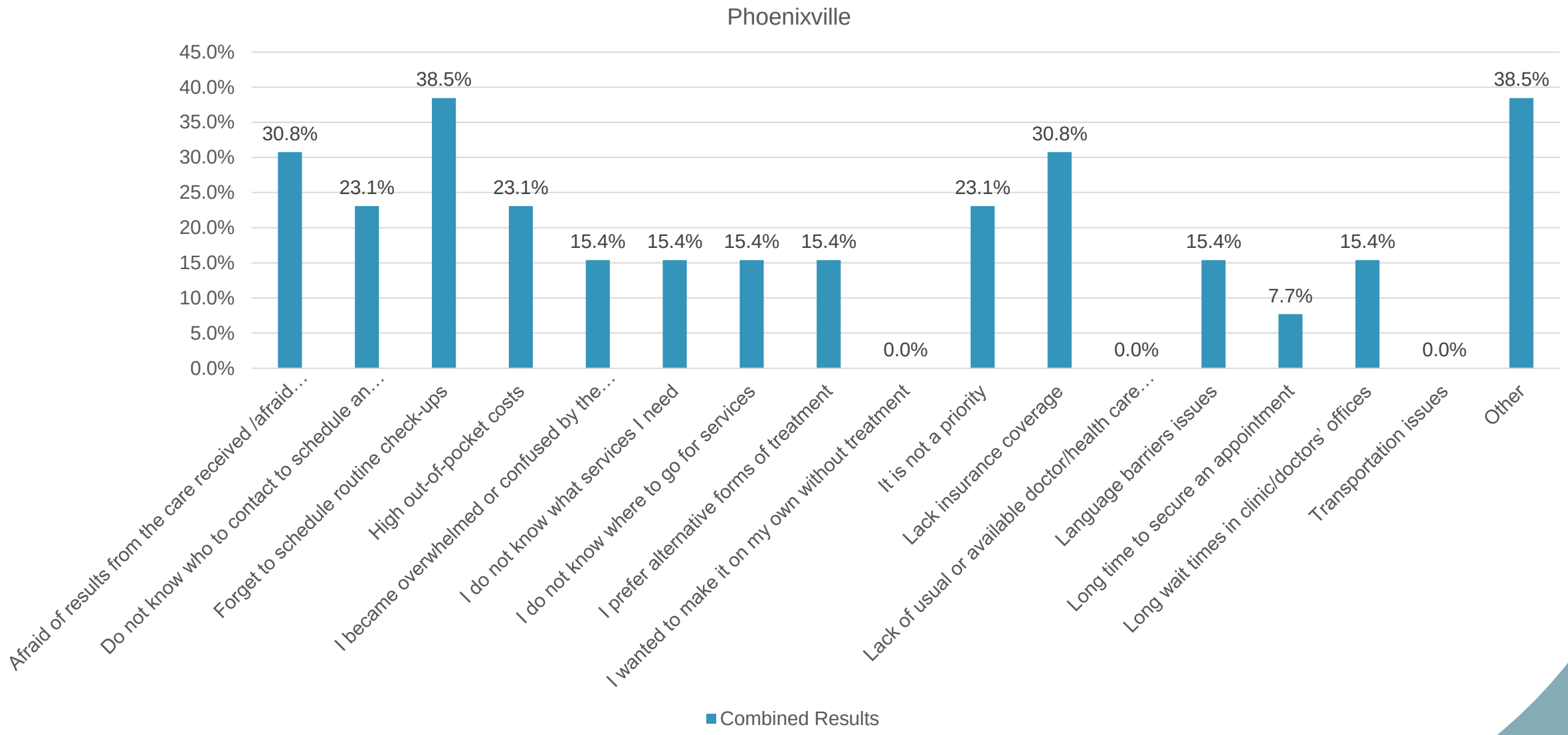
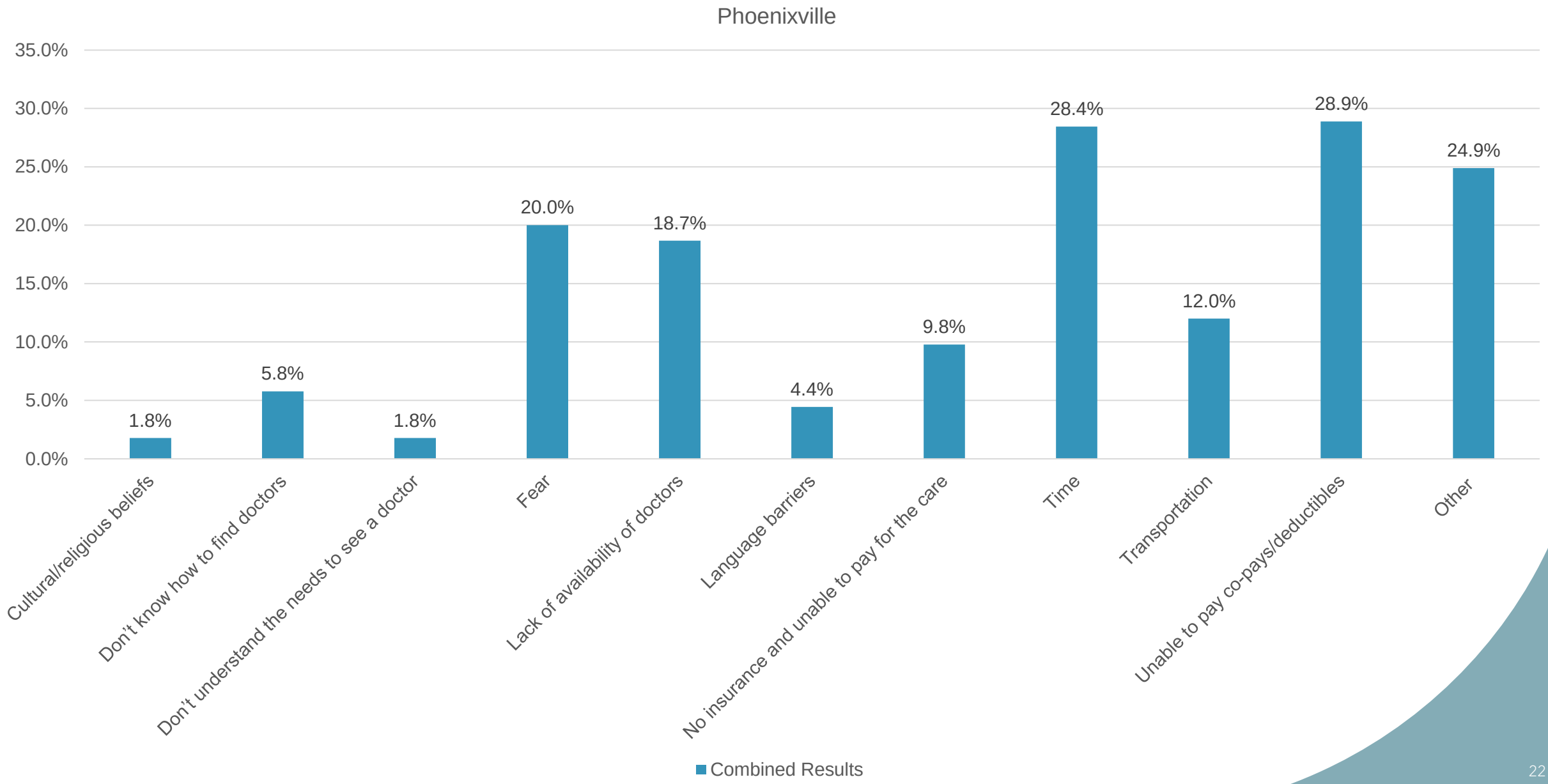


The above chart depicts the top 5 preventive procedures respondents had in the past 12 month.

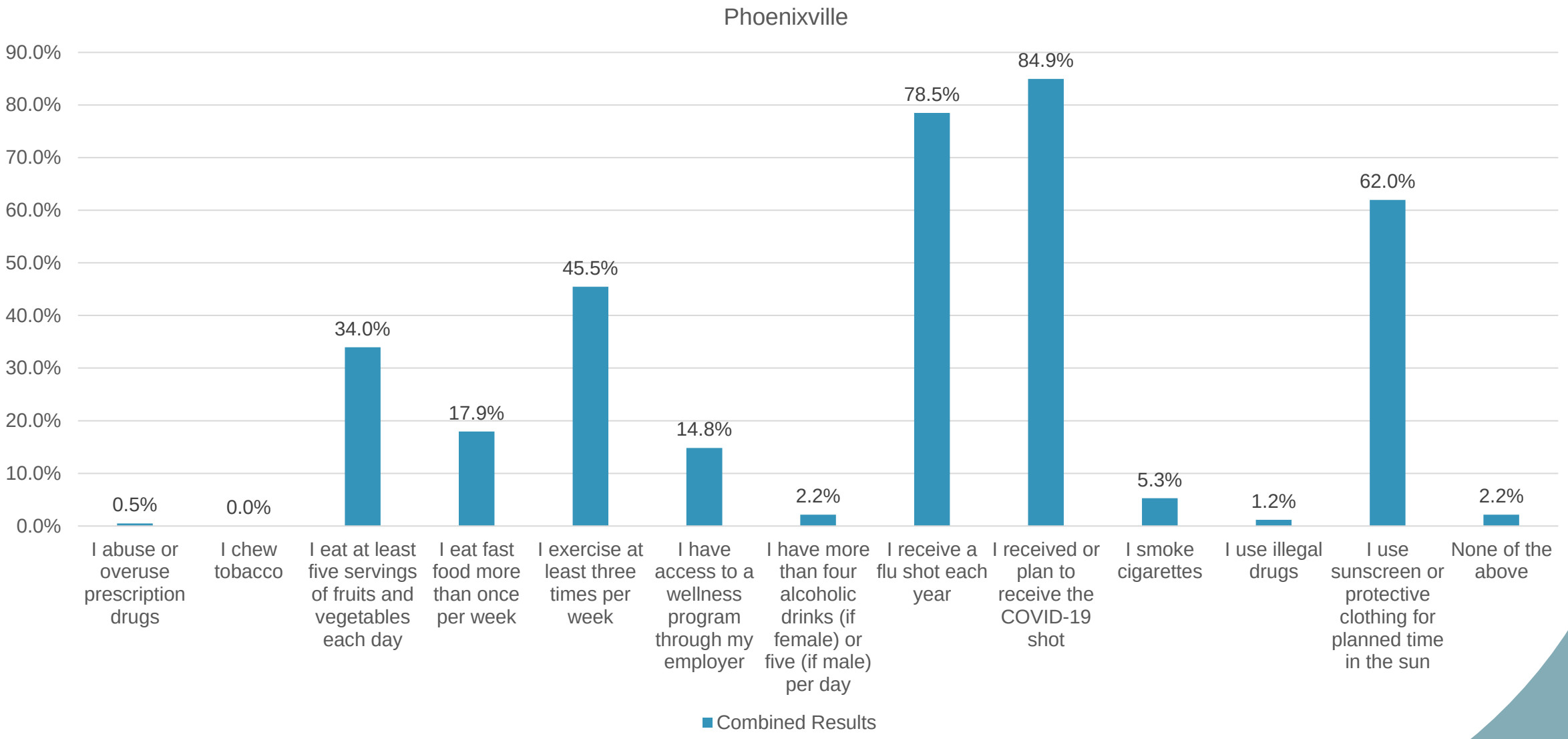
If You Have Not Received Preventive Care Services, Why Not?



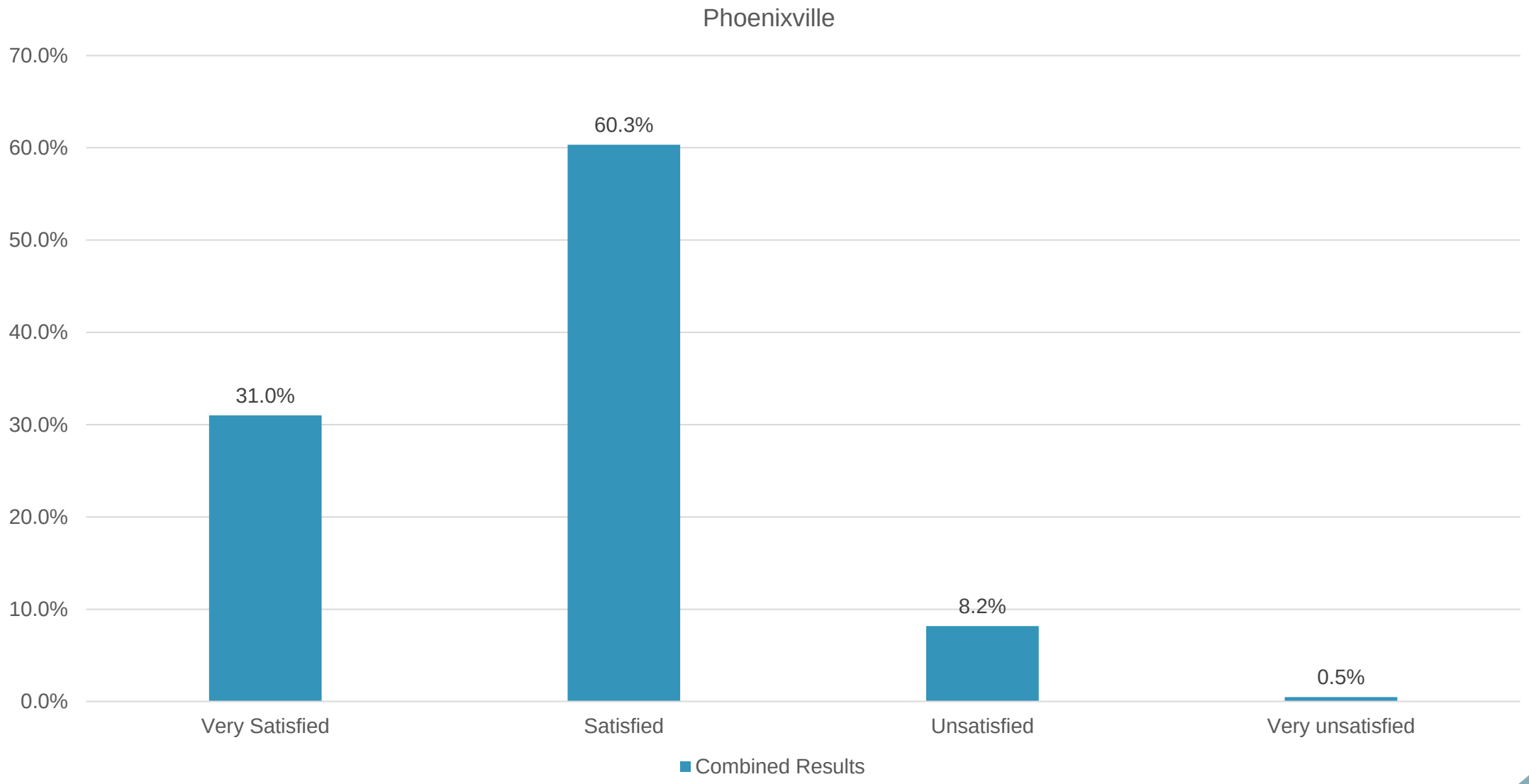
Are There Any Issues That Prevent You From Accessing Care? (Check all that apply)



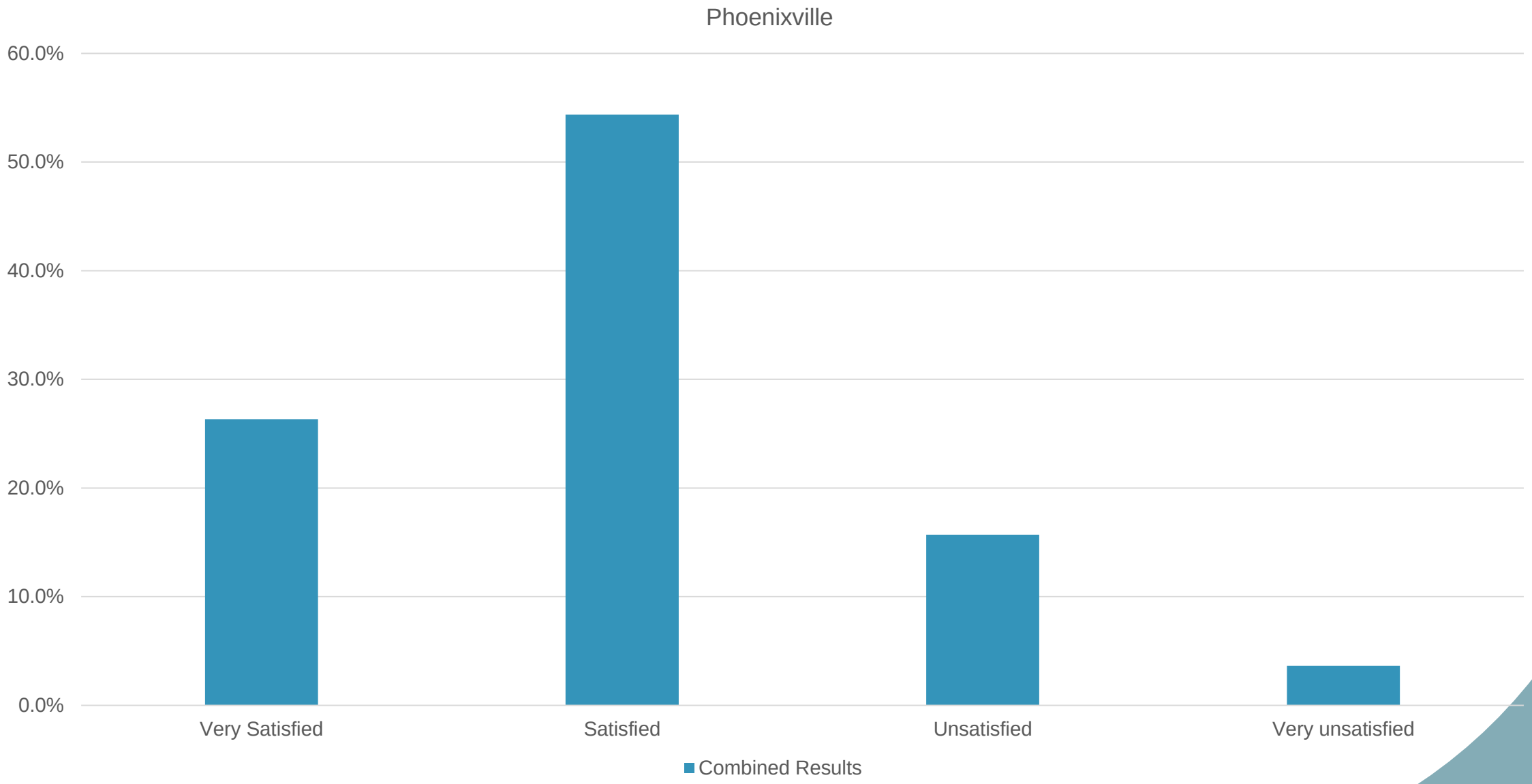
Please Choose All Statements That Apply To You (Check all that apply)



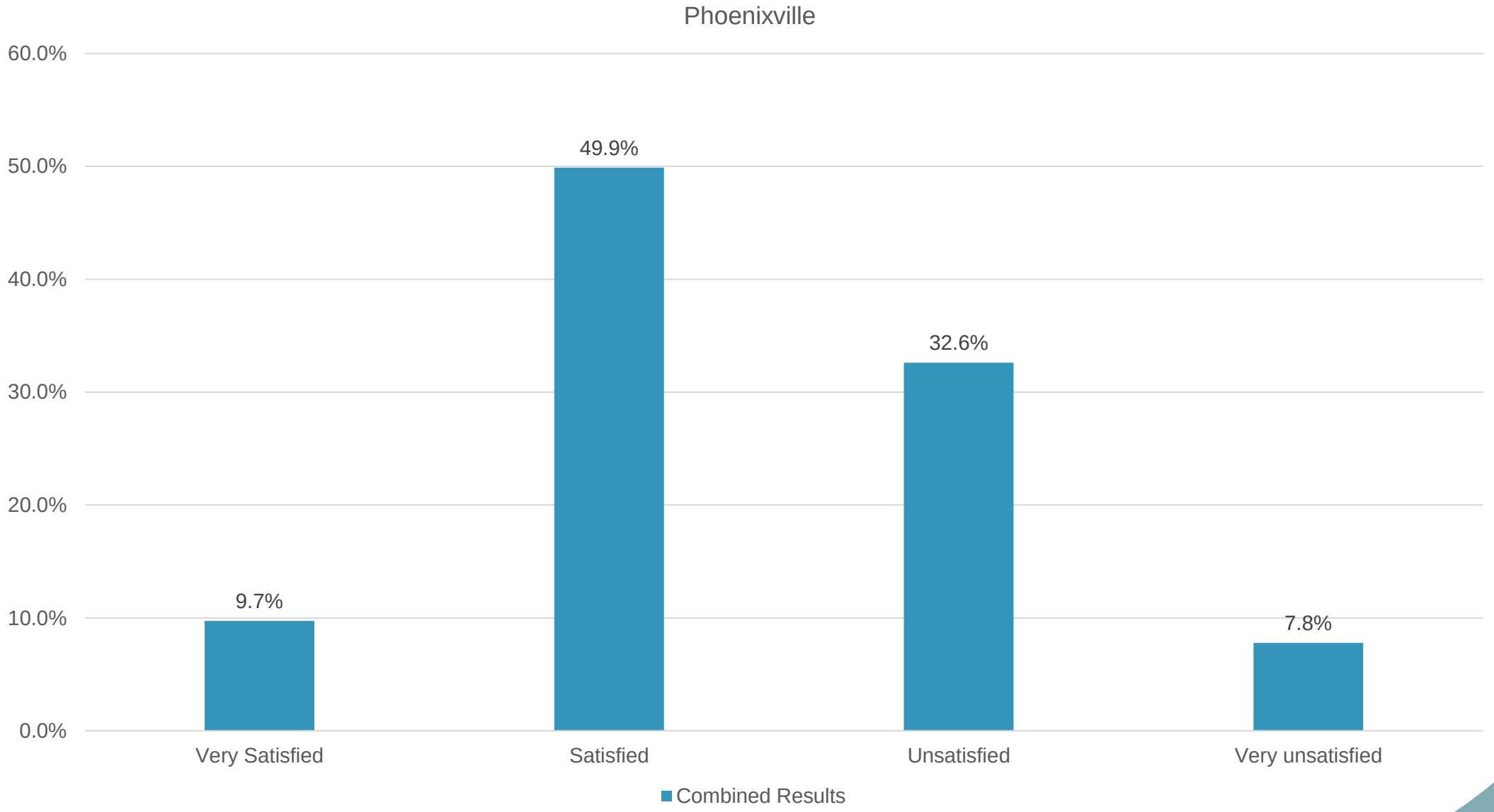
I Am Satisfied With The Quality Of Life In My Community



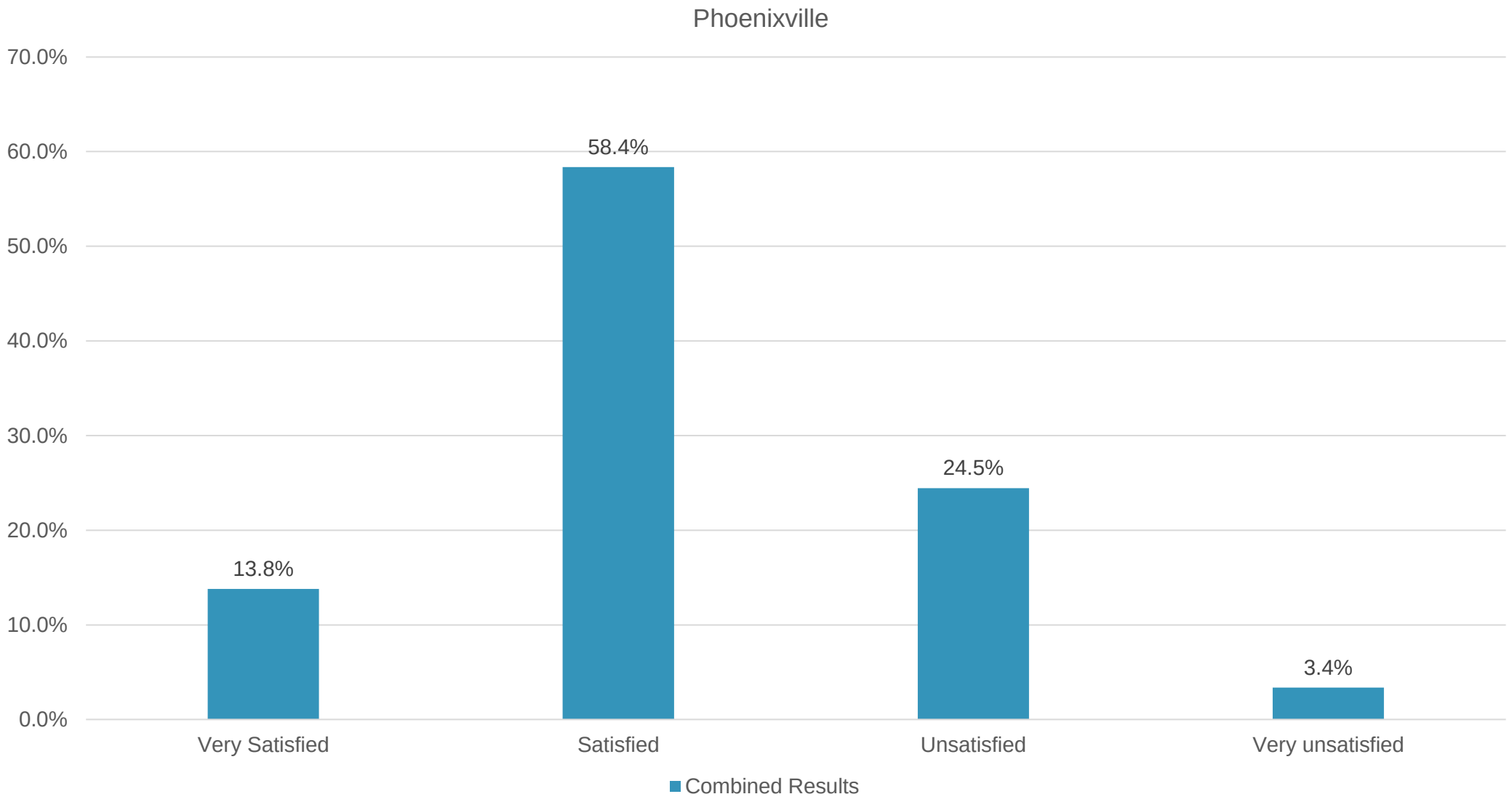
I Am Satisfied With The Health Care System in my Community



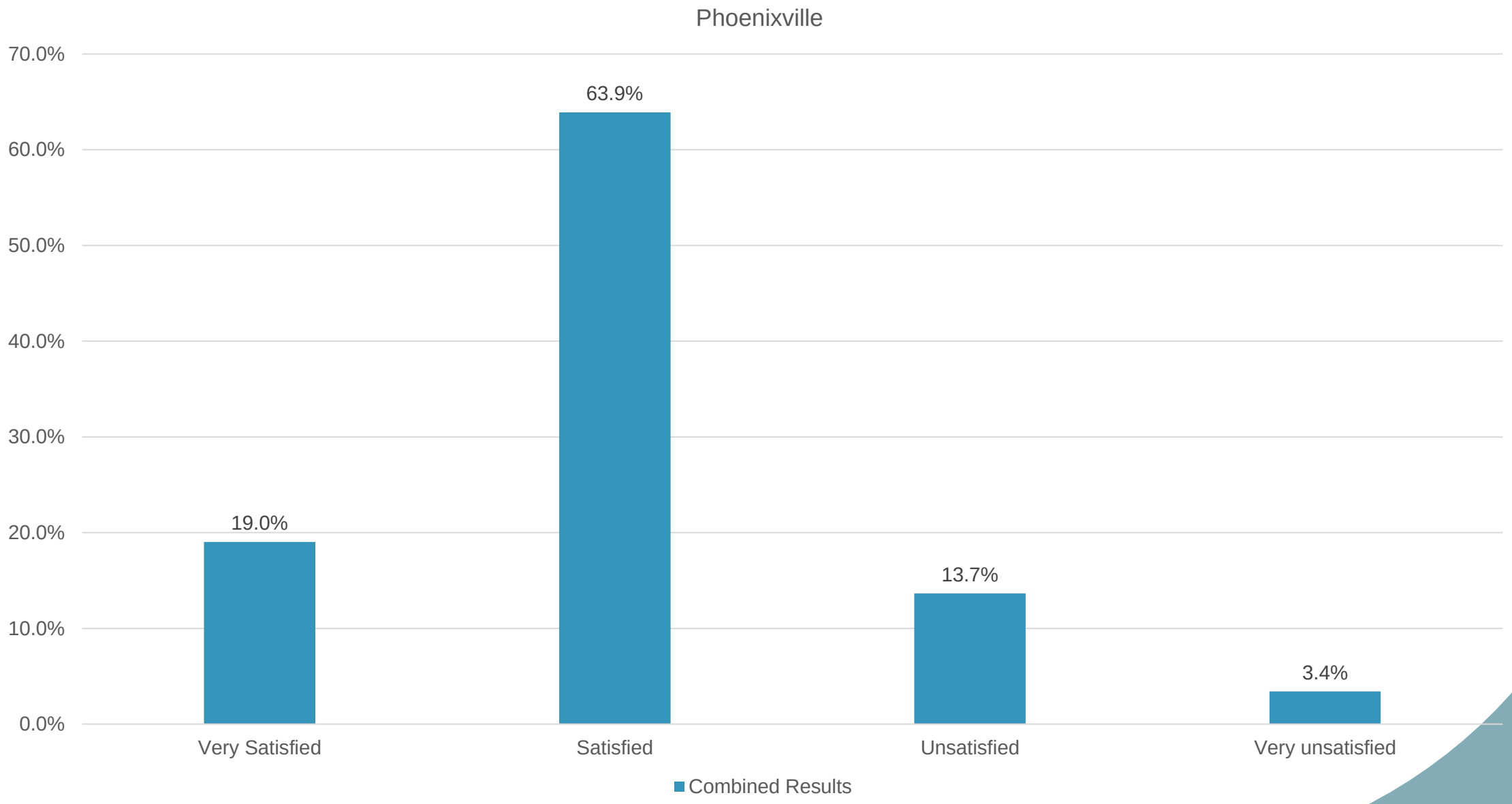
All individuals and groups in my community have the same and equal access to contributing and participating in the community's quality of life.



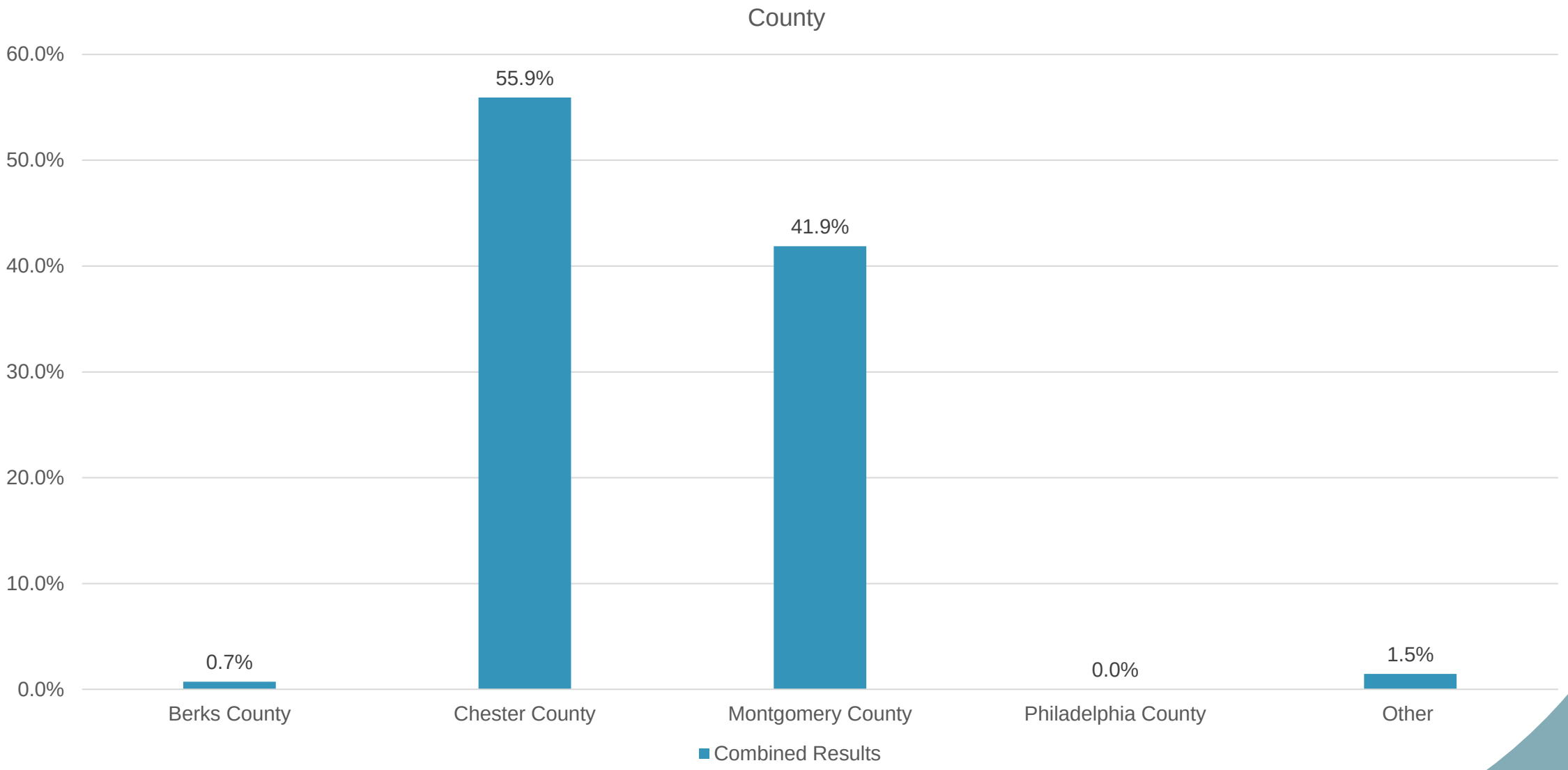
I Am Satisfied with the Amount of Health and Social Services in my Community



I Am Satisfied with the Diversity of my Health Care Providers

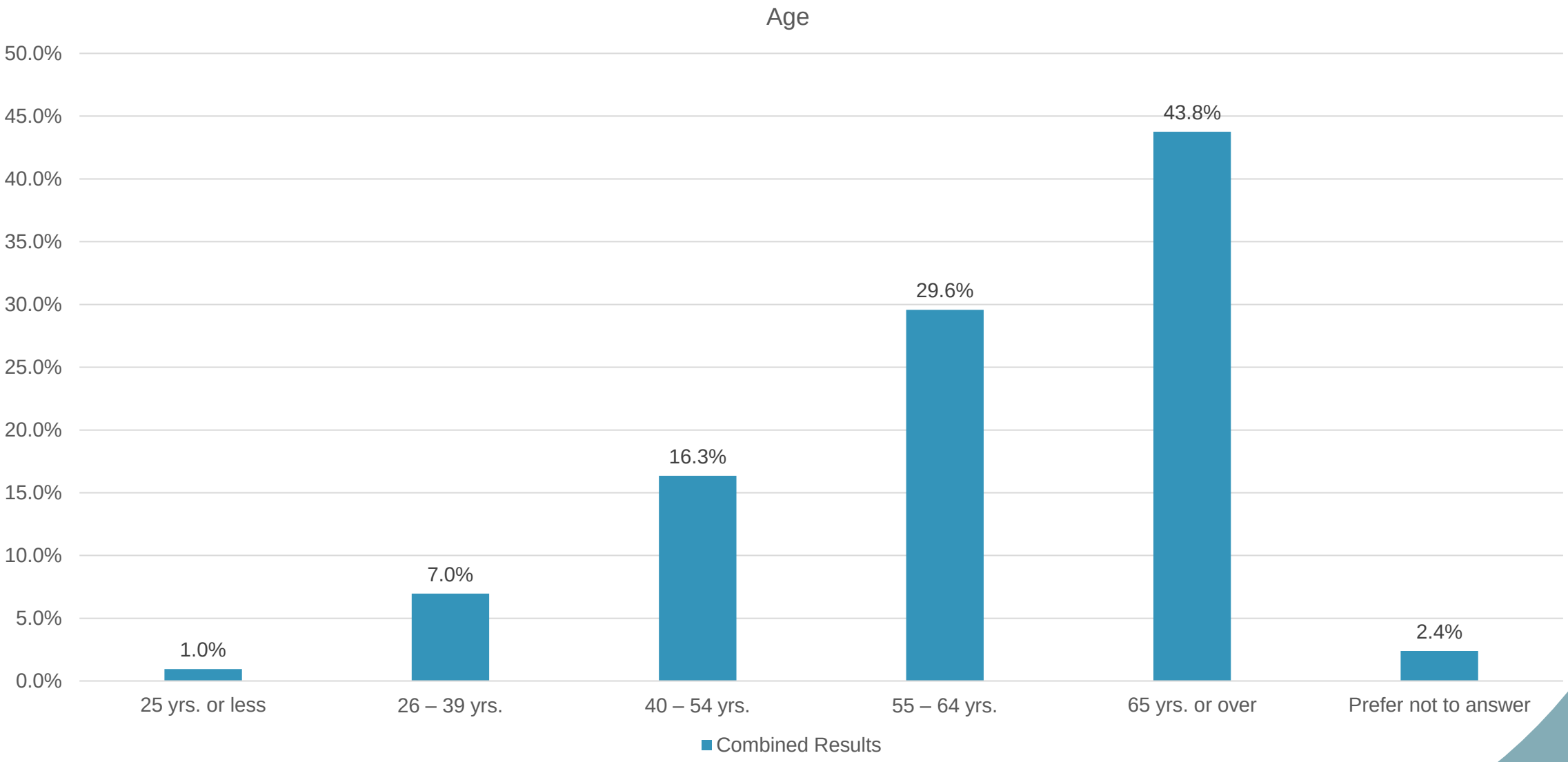


County Where Live

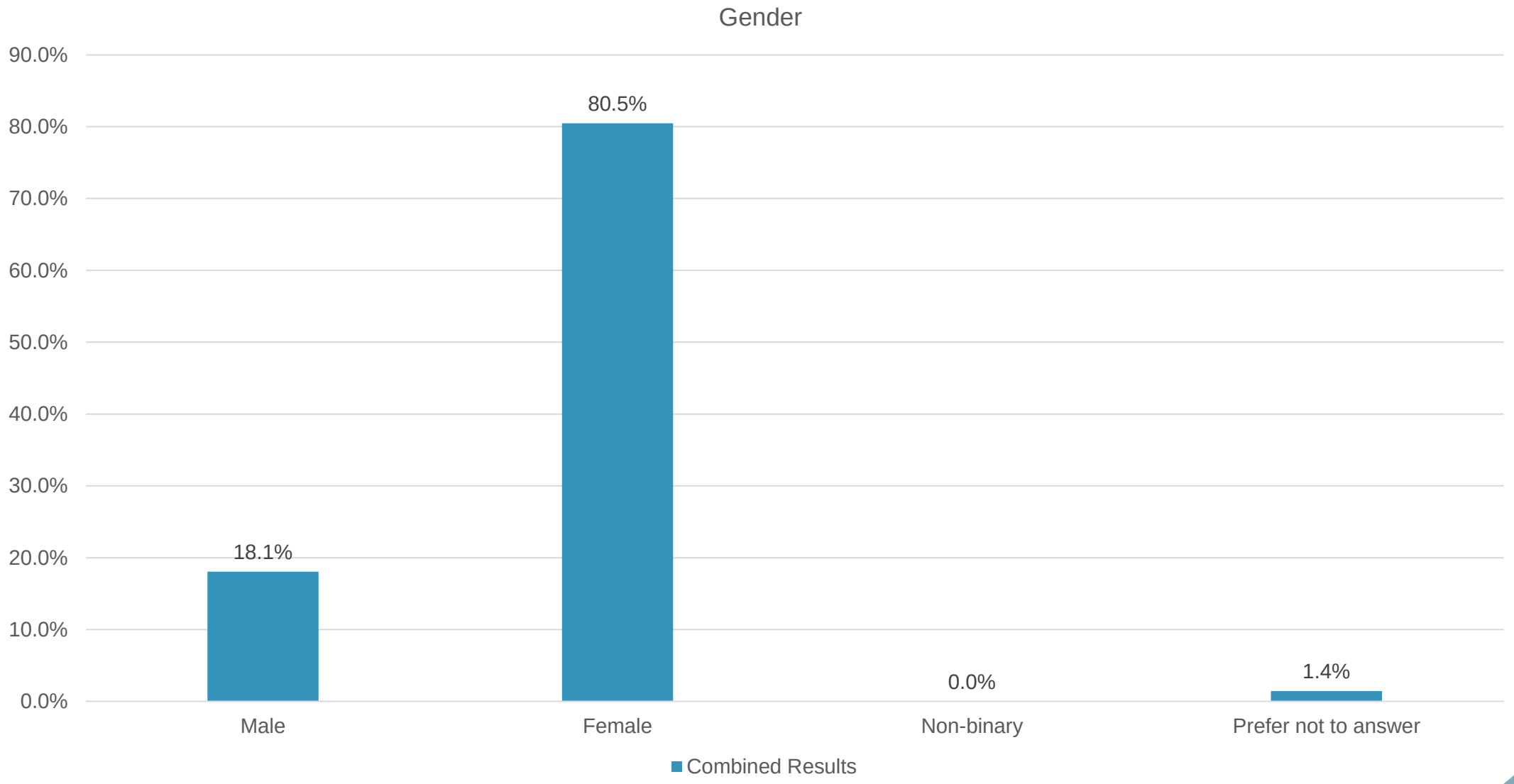


- 55.9% live in Chester County

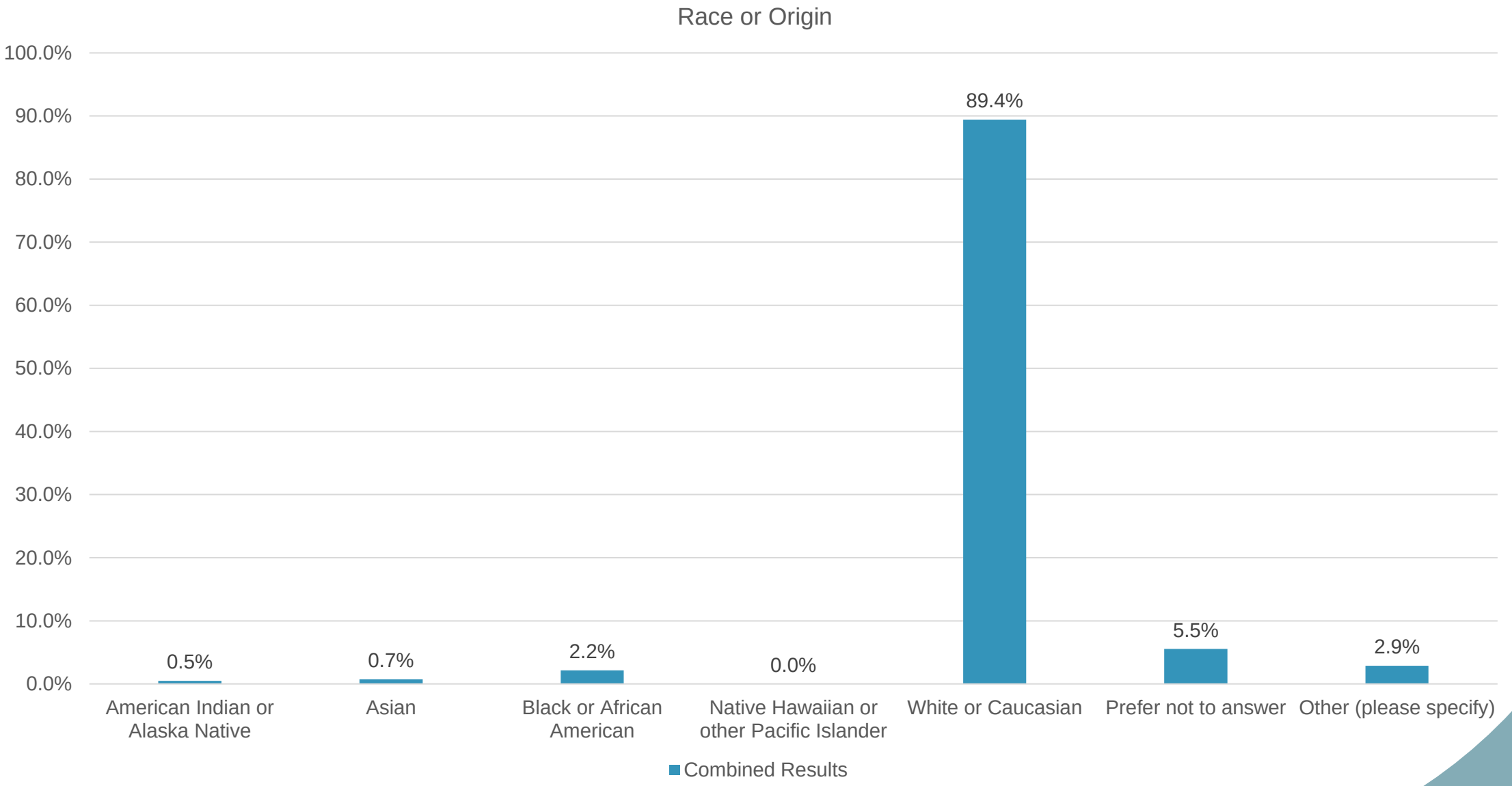
What is Your Age?



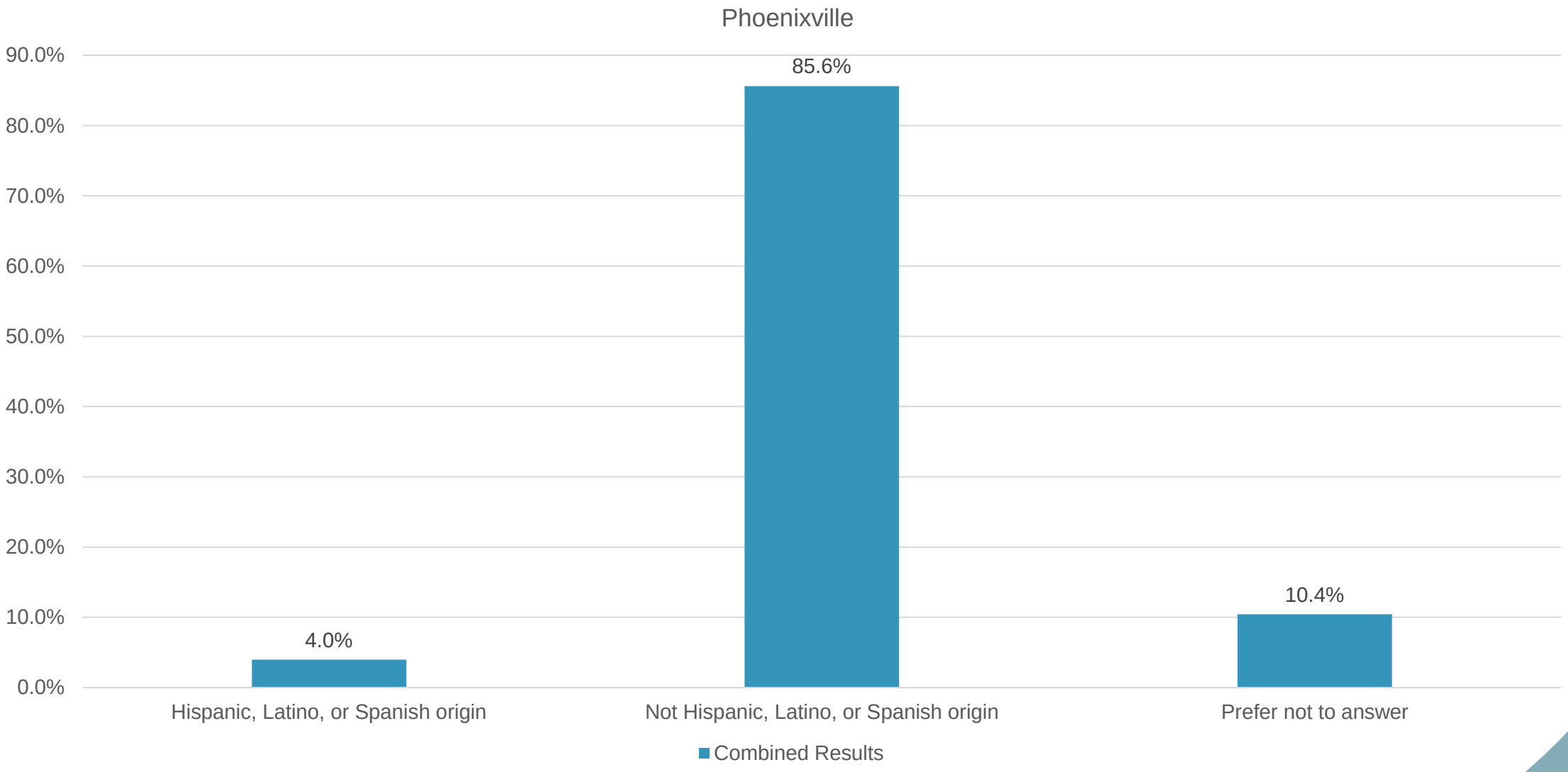
What is Your Gender?



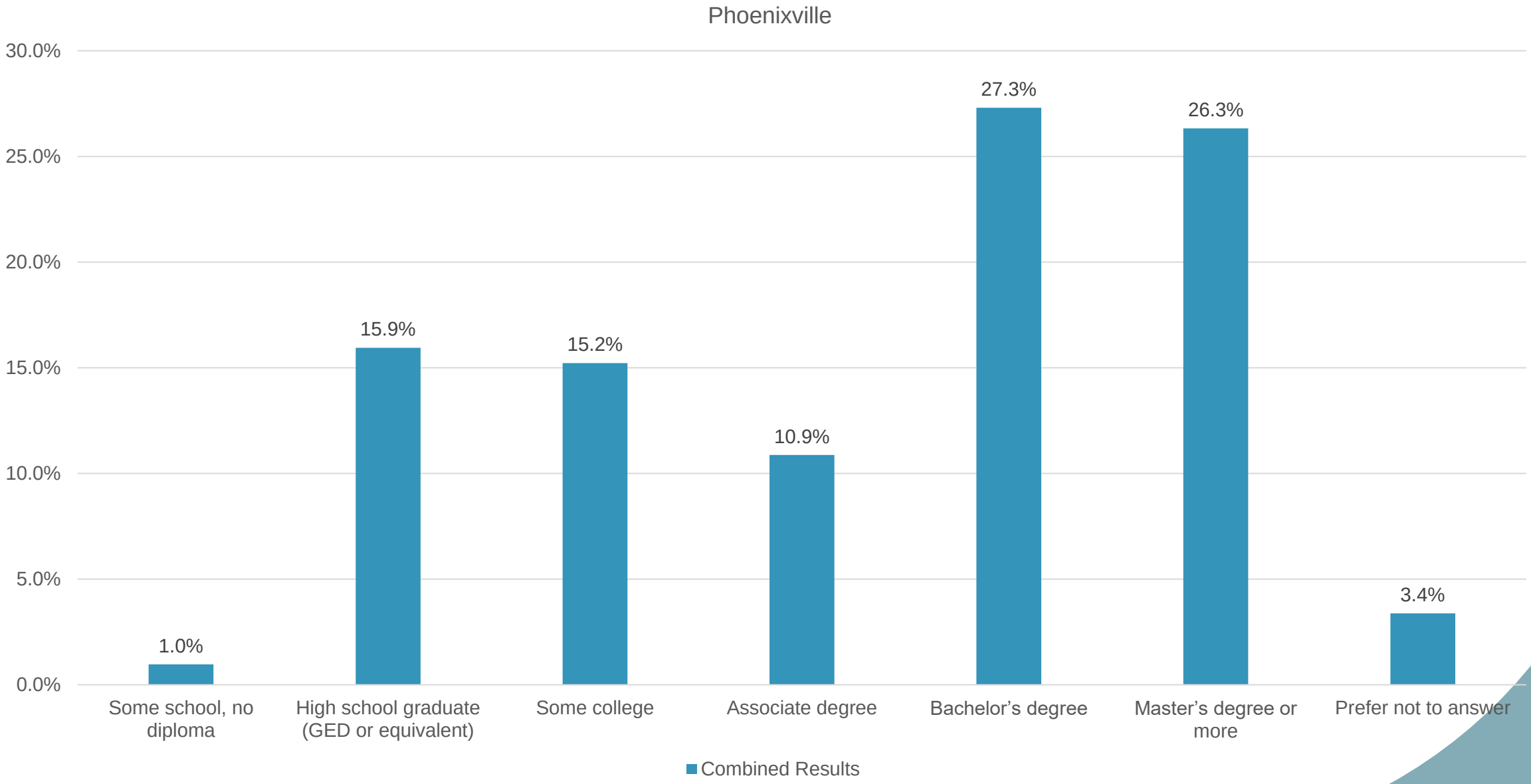
What is Your Race or Origin?



What is Your Ethnicity?



What is Your Highest Level of Education?



What is Your Annual Household Income?