Temple Health

Chestnut Hill Hospital

2025

REGIONAL

Community Health Needs Assessment

FOR SOUTHEASTERN PENNSYLVANIA

Table of Contents

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

Introduction

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

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

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

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

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

Several enhancements distinguish the 2025 rCHNA from previous iterations:

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

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

Chestnut Hill Hospital

Temple Health

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT ADMISSIONS:	EMERGENCY DEPT. VISITS:
148	350	8,058	89,852	45,353

Temple Health—Chestnut Hill Hospital (CHH) is a 148-bed freestanding, licensed acute care community hospital under a not-for-profit company owned and controlled, since January 2023, by an alliance comprising Temple Health (which has 60 percent ownership of CHH), and Redeemer Health and Philadelphia College of Osteopathic Medicine—each with 20 percent ownership. This cooperative relationship strengthens the community hospital while bringing additional expertise, networks and academic support to its employees, physicians and patients.

Serving its community for more than 100 years, CHH has more than 350 board-certified physicians offering inpatient and outpatient services including emergency care, minimally invasive laparoscopic and robotic-assisted surgery, cardiology, gynecology, oncology, pulmonology, orthopedics, primary care practices, two Women's Centers, and an off-site physical therapy center.

Temple Health continues to add new academic-level specialty services to CHH, strengthening access to the world-class care of a university health system in a community setting close to home.

Temple Health

Chestnut Hill Hospital

Advanced cancer care is now available at CHH by Fox Chase Cancer Center specialists focusing on breast cancer, plastic surgery, urology, and access to innovative clinical trials. Specialists from the Fox Chase—Temple Urologic Institute offer comprehensive care for oncologic and non-oncologic conditions including subspecialties like urogynecology and prostate care. CHH is one of the few regional locations offering Aquablation, a minimally invasive treatment for enlarged prostate with fewer side effects. Fox Chase infusion services are also now available at CHH.

Temple Lung Center at CHH offers specialized care to patients with complex conditions such as COPD and Interstitial Lung Disease (ILD) and offers access to cutting-edge clinical trials. The Center's Thoracic Surgery team provides state-of-the-art treatments for common and rare conditions such as lung cancer, and thoracic outlet syndrome. Renowned for treating high-risk and complex cases, the team collaborates closely with Temple's Digestive Disease Center and Fox Chase Cancer Center to offer advanced, personalized cancer treatments.

Temple's Vascular & Endovascular Surgery Program offers advanced, minimally invasive treatments at CHH for vascular disease and specializes in open, hybrid, and endovascular techniques to repair arteries and veins, restoring circulation.

The Temple Neurology Program at CHH provides advanced, personalized care for complex brain, spinal cord, and nervous system disorders. The program is also a Certified Comprehensive Stroke Center, recognized for providing top-tier care from diagnosis to rehabilitation.

Temple's experienced gynecologists at CHH provide comprehensive care to support women's health at every stage of life including well-woman exams, family planning, menopause management, and cancer screenings. The team is skilled in treating various conditions including abnormal pap smears, endometriosis, menstrual disorders, and urinary issues. When surgery is needed, they utilize the latest minimally invasive and robotic techniques for procedures like hysterectomies and fibroid removals.

Temple Ophthalmology at CHH focuses on early diagnosis and treatment and offers services including cataract surgery, glaucoma treatment, and retinal procedures.

Premier Orthopaedics at CHH offers comprehensive care for bone, muscle, and joint conditions. The board-certified specialists treat various issues, including arthritis, extremity injuries, sports medicine, spine disorders, fractures, and ligament or tendon damage.

CHH's Senior Behavioral Health Unit is a 20-bed inpatient facility led by experienced psychiatrists and psychiatric nurse practitioners, and dedicated to older adults requiring short-term care for conditions including depression, psychosis, bipolar disorder, and anxiety.

Impact of Prior Community Health Needs Assessment and Implementation

In CHH's 2022 CHNA, four areas of focus were prioritized based our community's greatest needs:

1. Access to Equitable Care
2. Behavioral Healthcare Access
3. Health Education and Prevention

CHH's Implementation Strategy includes goals and strategies on how to address and solve these key findings from the CHNA. See the complete strategy here: https://www.templehealth.org/locations/chestnut-hill-hospital/about/community-health

Below is a summary of the steps taken since the 2022 CHNA to meet community health needs:

- **Actions to Increase access to equitable care:**
  - We provided patients with free transportation to and from the hospital via UberHealth.
- **Actions to increase behavioral healthcare access:**
  - We developed and filled new position of Nurse Practitioner for our behavioral health team.
  - We trained staff in crisis management.
- **Actions to strengthen health education and prevention:**
  - Outside the hospital walls, we facilitated support groups focused on healthy living.
  - We partnered with local schools to provide health education to students and their caregivers.
  - We strengthened our community outreach efforts through health education and screenings at events in our neighborhoods.
  - We partnered with local nonprofits that address social determinants of health in our community such as Mt. Airy Community Development Corporation, Fact to Face and Meals on Wheels.

Service Area Demographics

ESTIMATED POPULATION

280,048

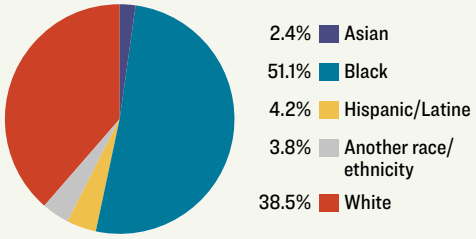
MEDIAN HOUSEHOLD INCOME

$74,876

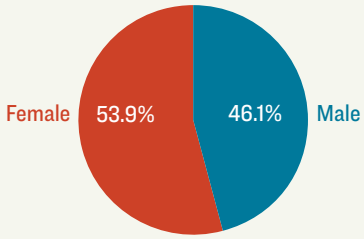
NOT FLUENT IN ENGLISH

0.7%

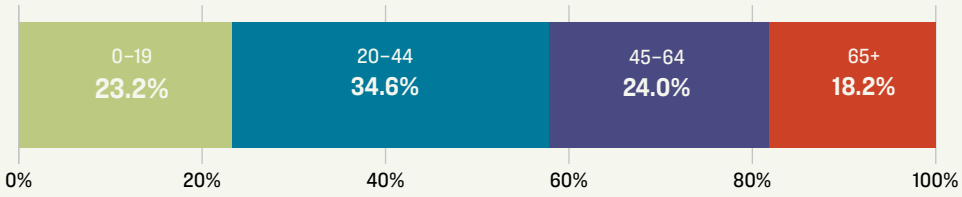
RACIAL COMPOSITION



SEX



AGE DISTRIBUTION



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Chestnut Hill Hospital's primary service area is comprised of 11 zip codes: 19031, 19038, 19118, 19119, 19128, 19138, 19141, 19144, 19150, 19444 and 19462. These are the zip codes from which about 70% of our patients seen on an inpatient and observation basis reside.

Executive Summary

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

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

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

PARTNERING HEALTH SYSTEMS AND HOSPITALS

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

OUR COLLABORATIVE APPROACH

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMUNITY HEALTH PRIORITIES:
General Population

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

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

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

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

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

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

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

COMMUNITY HEALTH PRIORITIES:
Youth

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

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

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

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

Partner Organizations

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

Local Health Departments

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

Community Hubs

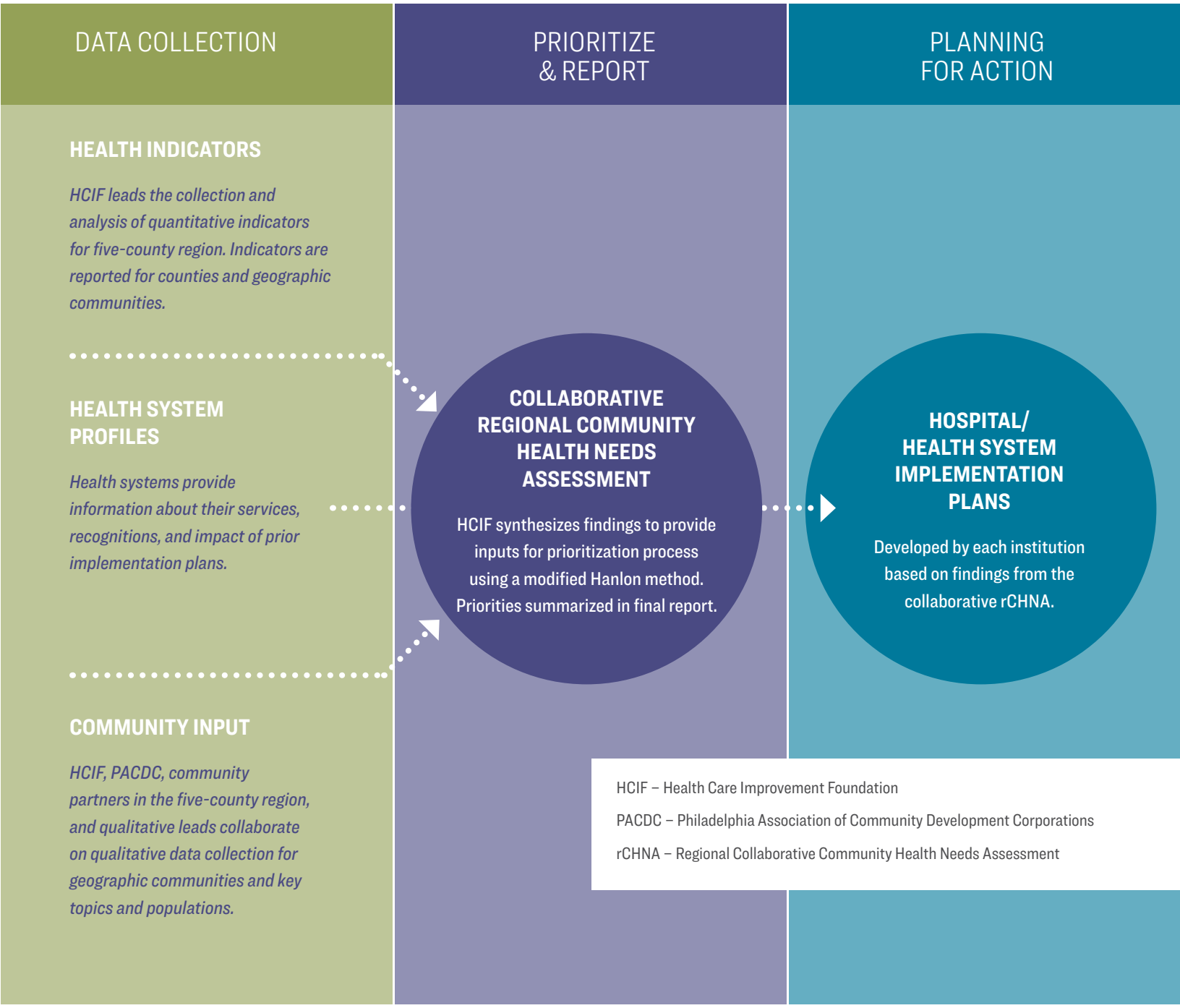
- Bucks County Health Improvement Partnership (BCHIP)
- HealthSpark Foundation
- Philadelphia Association of Community Development Corporations (PACDC)
- SEAMAAC
- The Foundation for Delaware County

Community Conversation Host Sites

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

Our Collaborative Approach

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



HCIF – Health Care Improvement Foundation

PACDC – Philadelphia Association of Community Development Corporations

rCHNA – Regional Collaborative Community Health Needs Assessment

GOVERNANCE

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

Steering Committee Representatives

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

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

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

METHODS: DATA COLLECTION AND ANALYSIS

Health Indicators

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

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

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

Data Collection & Analysis

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

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

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

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

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

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

Community Survey Analysis

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

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

Software

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

Health Indicators

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

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

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

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

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

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

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

+ Data only available for geographic communities in Philadelphia County.

COMMUNITY INPUT

Overview

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

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

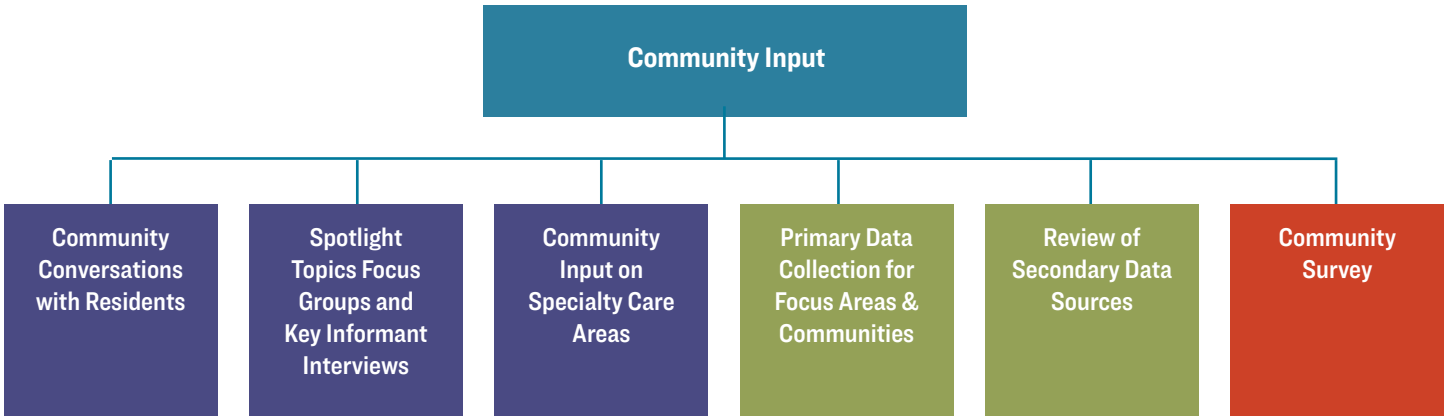
- Primary data collection was undertaken by the project team June 2024 – April 2025. To offer the greatest level of accessibility, both in person and virtual sessions were held in each county.
- Focus group-style, 90-minute "community conversations" were held to gather input from residents of the region.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

SPOTLIGHT TOPICS

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

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

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



QUALITATIVE DATA COLLECTION AND ANALYSIS

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

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

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

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

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

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

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

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

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

DETERMINING AND PRIORITIZING COMMUNITY HEALTH NEEDS

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

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

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

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

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

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

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

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

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

Propriety: Is intervention appropriate and relevant?

Economics: Is there economic feasibility or financial support?

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

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

Legality: Can the intervention be legally implemented?

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

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

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

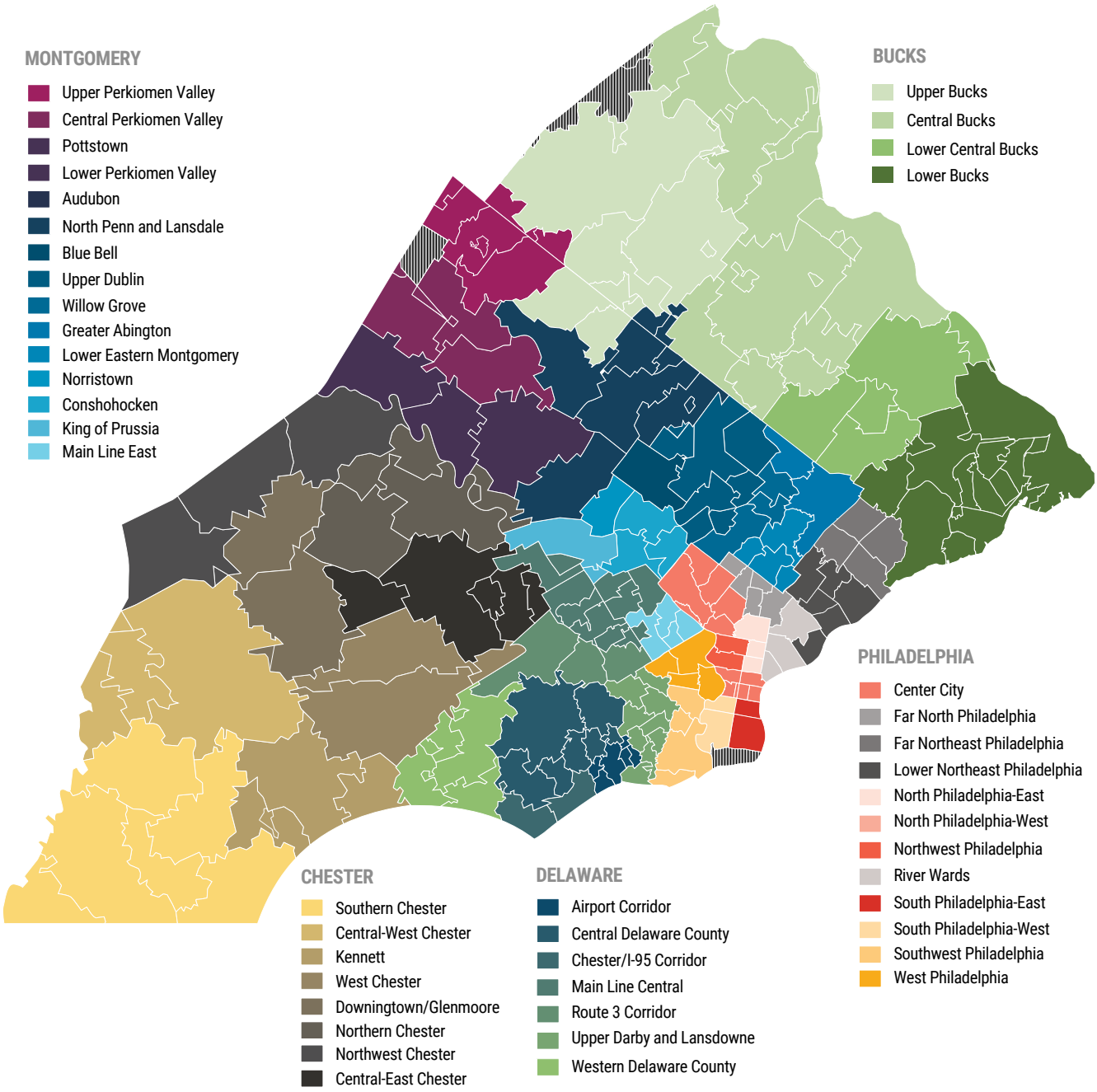
This structured prioritization process ensures that health interventions are both impactful and feasible, ultimately improving health outcomes for the communities served by the regional health system.

FINAL REPORT

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

About the Service Area

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

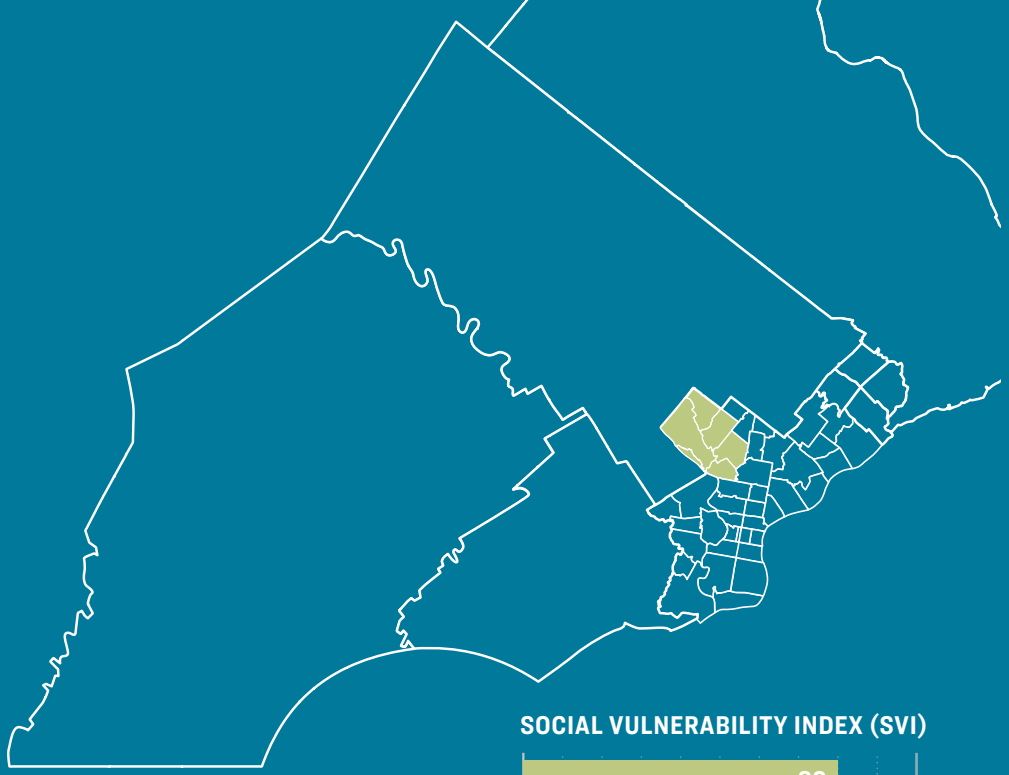


Northwest Philadelphia

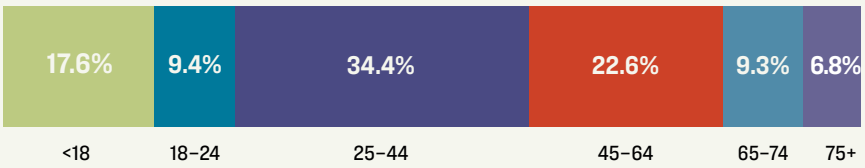
ZIP Codes: 19118, 19119, 19127, 19128, 19129, 19144

This community is served by:

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

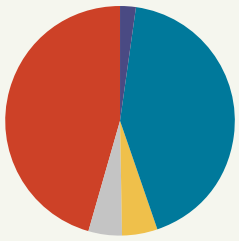


AGE DISTRIBUTION

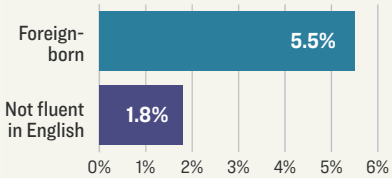


SEX

RACE/ETHNICITY/LANGUAGE



2.4% Asian
42.6% Black
4.8% Hispanic/Latine
4.8% Another race/ethnicity
45.5% White



POPULATION

142,506

MEDIAN HOUSEHOLD INCOME

$74,333

EDUCATIONAL ATTAINMENT

20.5% High school as highest education level

PEOPLE WITH DISABILITIES

18.2%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

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

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

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

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

COMMUNITY SURVEY

Number of Respondents: 103

ADULTS

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

- Diabetes and high blood sugar
- Mental health
- Age-related illnesses

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

- Alcohol use
- Drug use
- Depression

CHILDREN

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

- Intellectual / developmental disabilities
- Injuries
- Mental health

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

- Bullying
- Depression
- Anxiety

COMMUNITY

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

- Good paying jobs
- Affordable housing
- Substance use services

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

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

Far North Philadelphia

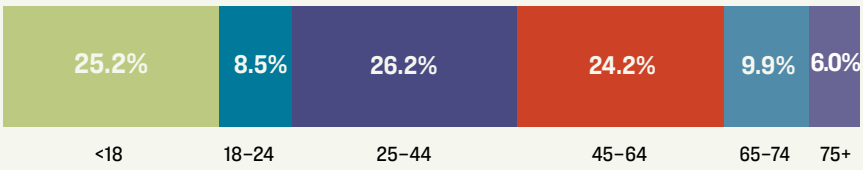
ZIP Codes: 19120, 19126, 19138, 19141, 19150

This community is served by:

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

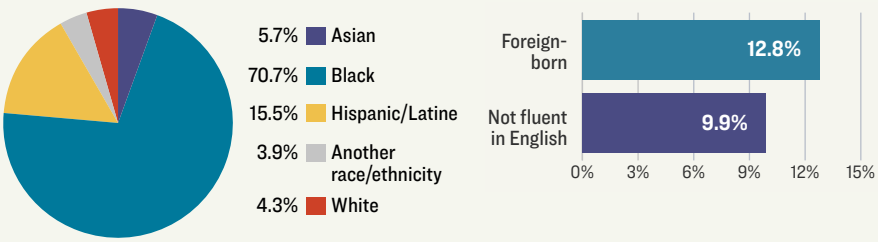
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

178,629

MEDIAN HOUSEHOLD INCOME

$51,294

EDUCATIONAL ATTAINMENT

36.4% High school as highest education level

PEOPLE WITH DISABILITIES

21.8%

LEADING CAUSES OF DEATH – All Ages

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

SUMMARY HEALTH MEASURES

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

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

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

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

COMMUNITY SURVEY

Number of Respondents: 102

ADULTS

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

Diabetes and high blood sugar

Mental health

Age-related illnesses

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

Drug use

Alcohol use

Anxiety

CHILDREN

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

Mental health

Abuse or neglect

Intellectual / developmental disabilities

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

Bullying

Depression

Anxiety

COMMUNITY

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

Affordable housing

Affordable healthy foods

Clean outdoor environment

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

Costs associated with getting healthcare

No health insurance

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

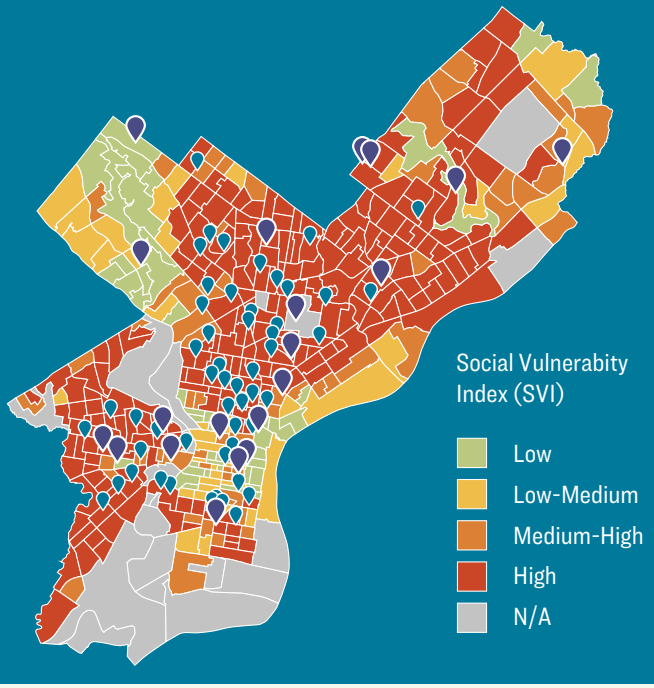
Philadelphia County

SOCIAL VULNERABILITY INDEX (SVI)*

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

HOSPITAL HEALTH CENTER

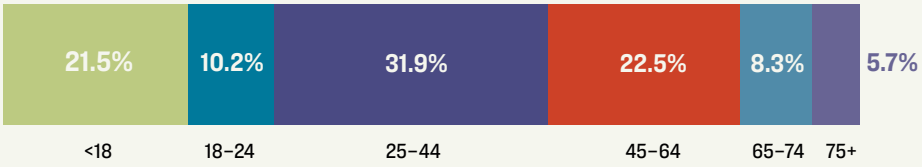
There are 21 hospitals and 23 health centers in Philadelphia County.



Demographics

AGE DISTRIBUTION

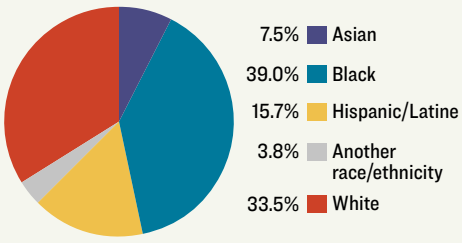
Philadelphia County has an estimated population of 1,582,432 with the largest proportion of residents between the ages of 25 - 44.



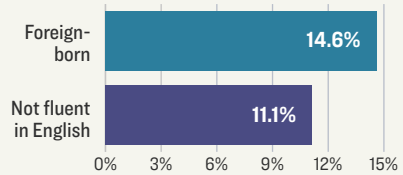
SEX

RACE/ETHNICITY/LANGUAGE

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



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



HOUSEHOLDS

Median Household Income
$57,537

Homeownership
52.0%

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

High School as Highest Education
30.3%

Household Food Insecurity
15.2%

Single Parent Households
48.0%

Same Sex Couples
per 1,000 households
6.0

Commute Greater than 60 minutes
13.3%

Philadelphia County

Health

LEADING CAUSES OF DEATH- All Ages

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

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

13.2%

Depressed/Sad Most Days in the Past 12 Months

46.0%

Binge Drinking

9.6%

Cigarette Smoking

8.0%

Vaping

37.5%

Exposure

Lead Levels in Children (<16 years old)

5.6%

PEOPLE WITH DISABILITIES

Percent of Population

16.8%

Poverty Status in the Past 12 Months

39.0%

Percent who have difficulty with:

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

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

31.3

Violent Crime Rate per 100,000

1,047.3

Gun-related ED Utilization per 100,000

34.7

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

2,111.9

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

Flu Vaccinations (Adult)

47.0%

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

Chlamydia per 100,000

1,082.5

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

Income Inequality

0.44

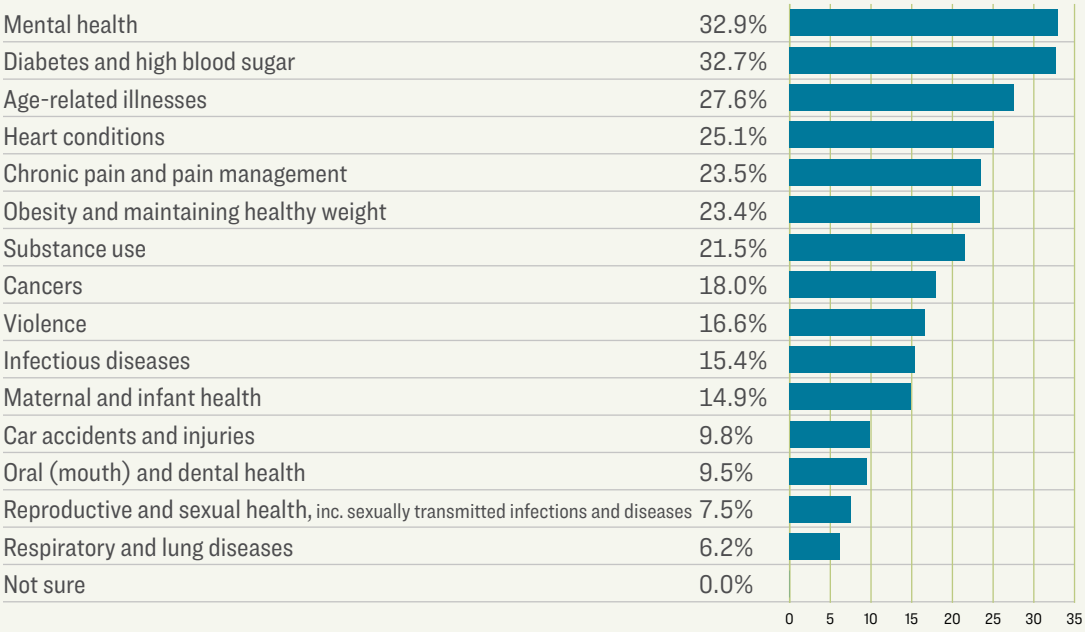
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Philadelphia County

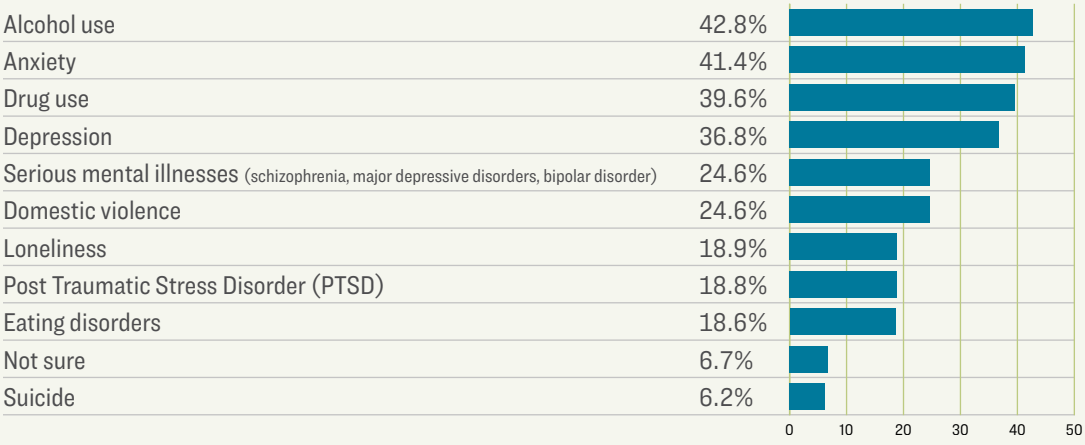
County Survey Results

Number of Respondents: 1,347

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



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

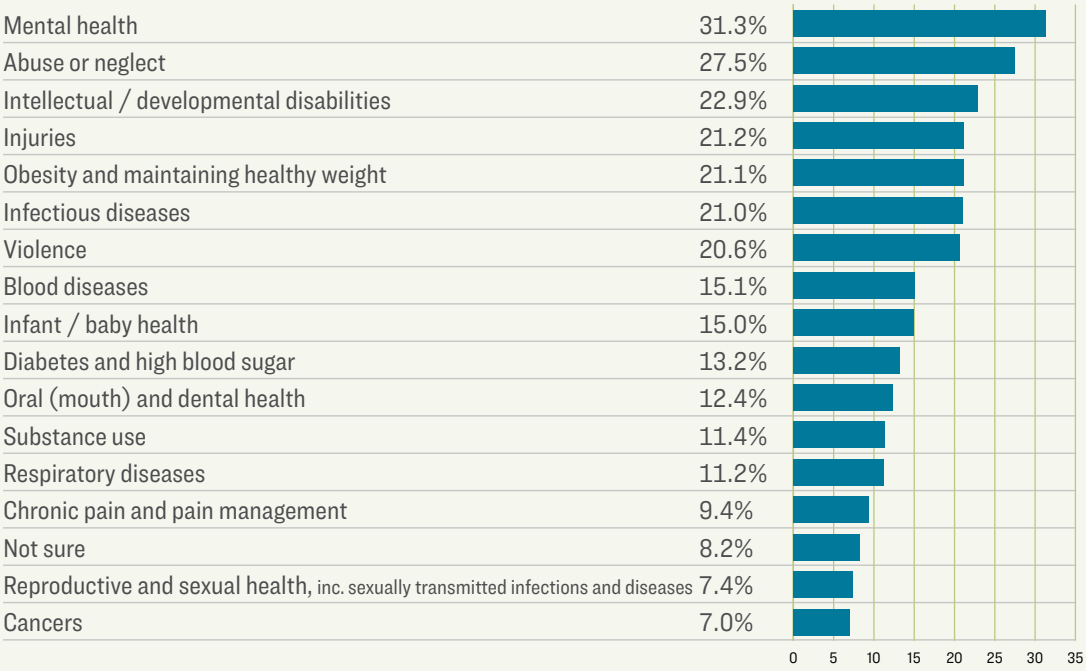


Philadelphia County

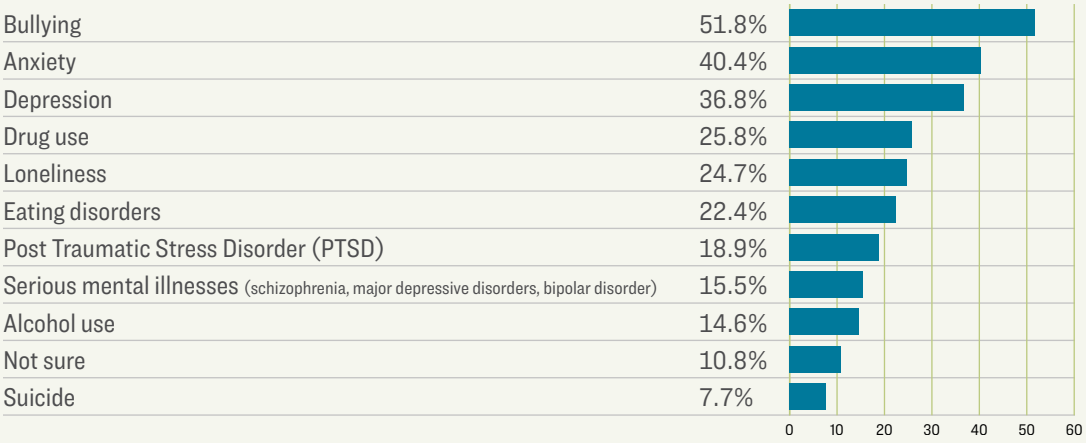
County Survey Results

Number of Respondents: 1,347

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



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

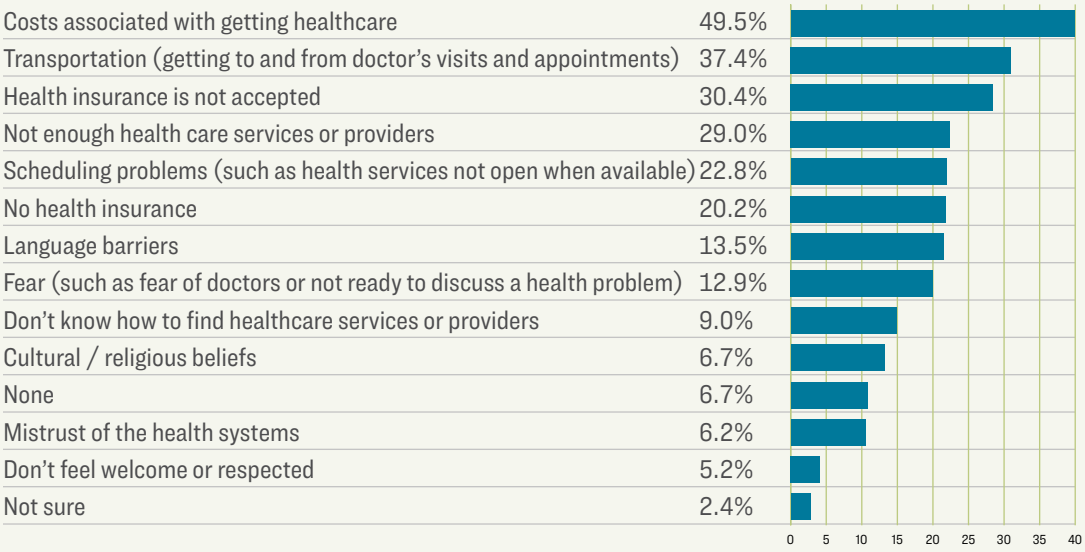


Philadelphia County

County Survey Results

Number of Respondents: 1,347

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



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

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

Conshohocken

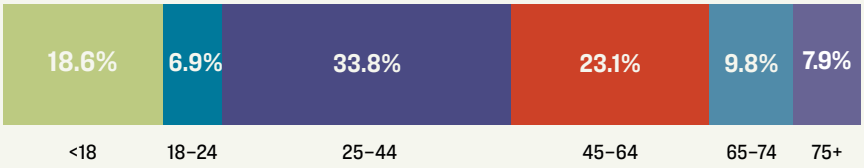
ZIP Codes: 19428, 19444, 19462

This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- Grand View Health
- Main Line Health
- Temple Health - Chestnut Hill Hospital
- Wills Eye Hospital

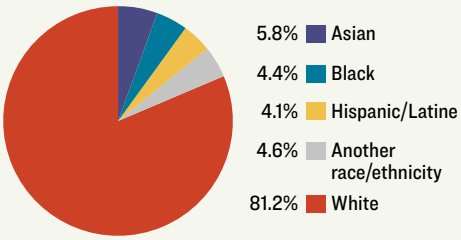
SOCIAL VULNERABILITY INDEX (SVI)

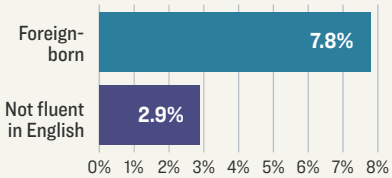
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

47,510

MEDIAN HOUSEHOLD INCOME

$130,282

EDUCATIONAL ATTAINMENT

19.2% High school as highest education level

PEOPLE WITH DISABILITIES

9.9%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Conshohocken	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	981.4	883.5
	Life expectancy: Female (in years)	80.2	80.5
	Life expectancy: Male (in years)	77.0	77.4
	Years of potential life lost before 75	2,434	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.5%	30.2%
	Diabetes prevalence	8.3%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	150.0	152.0
	Hypertension prevalence	28.8%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	46.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	920.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	25.3	32.7
	Major cancer incidence rate (per 100,000)*	225.8	258.4
	Major cancer mortality rate (per 100,000)*	92.9	67.6
	Colorectal cancer screening (adults age 45-75)	71.4%	70.4%
	Mammography screening (women age 50-74)	79.4%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.6	4.2
	Percent low birthweight births out of live births	5.8%	8.3%
	Percent preterm births out of live births	6.2%	9.0%
	Child Opportunity Index**	77.9	67.4
BEHAVIORAL HEALTH	Adult binge drinking	21.1%	19.0%
	Adult smoking	10.5%	11%
	Drug overdose mortality rate (per 100,000)	21.1	21.1
	Opioid-related hospitalization rate (per 100,000)	92.9	180.5
	Substance-related hospitalization rate (per 100,000)	179.4	278.5
	Poor mental health for 14+ days in past 30 days	14%	13.9%
	Suicide mortality rate (per 100,000)	8.4	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,366.0	2,354.0
	Homicide mortality rate (per 100,000)	2.1	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.6%	8.4%
	Children <19 years with public insurance	14.0%	22.2%
	Population without insurance	3.0%	3.8%
	Children <19 years without insurance	3.9%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.0%	6.1%
	Children <18 years in poverty	3.9%	6.5%
	Adults 19-64 years unemployed	4.2%	4.2%
	Householders living alone who are 65+ years	28.0%	27.7%
	Households receiving SNAP benefits	3.9%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.6%	11.4%
	Vacant housing units	4.9%	4.9%
	Single parent households	21.2%	17.1%
	Commute greater than 60 minutes	6.0%	9.0%

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

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

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

COMMUNITY SURVEY

These results reflect responses from the Conshohocken, King of Prussia, and Main Line East communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 35

ADULTS

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

Mental health

Cancer

Heart conditions

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

Depression

Anxiety

Alcohol use

CHILDREN

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

Mental health

Intellectual / developmental disabilities

Obesity and maintaining healthy weight

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

Bullying

Anxiety

Depression

COMMUNITY

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

Affordable housing

Good paying jobs

Mental health services

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

Costs associated with getting healthcare

Not enough health care services or providers

Scheduling problems (such as health services not open when available)

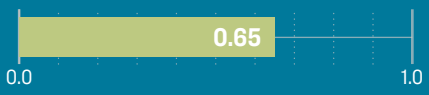
Willow Grove

ZIP Codes: 19001, 19038, 19090

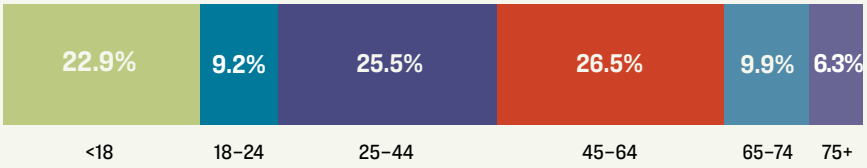
This community is served by:

- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Temple Health - Chestnut Hill Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)

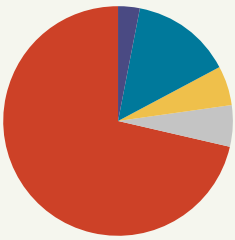


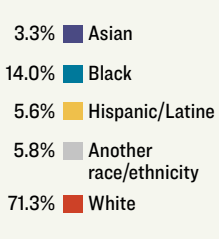
AGE DISTRIBUTION

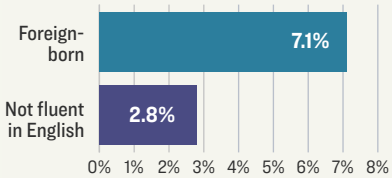


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

69,684

MEDIAN HOUSEHOLD INCOME

$106,645

EDUCATIONAL ATTAINMENT

21.0% High school as highest education level

PEOPLE WITH DISABILITIES

13.5%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Willow Grove	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	905.9	883.5
	Life expectancy: Female (in years)	80.1	80.5
	Life expectancy: Male (in years)	75.6	77.4
	Years of potential life lost before 75	3,930	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.4%	30.2%
	Diabetes prevalence	9.8%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	240.0	152.0
	Hypertension prevalence	31.6%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	44.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	1,048.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	38.4	32.7
	Major cancer incidence rate (per 100,000)*	280.2	258.4
	Major cancer mortality rate (per 100,000)*	68.3	67.6
	Colorectal cancer screening (adults age 45-75)	70.1%	70.4%
	Mammography screening (women age 50-74)	79.2%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	4.0	4.2
	Percent low birthweight births out of live births	8.3%	8.3%
	Percent preterm births out of live births	8.7%	9.0%
	Child Opportunity Index**	70.9	67.4
BEHAVIORAL HEALTH	Adult binge drinking	19.7%	19.0%
	Adult smoking	12.0%	11%
	Drug overdose mortality rate (per 100,000)	29.9	21.1
	Opioid-related hospitalization rate (per 100,000)	241.8	180.5
	Substance-related hospitalization rate (per 100,000)	328.5	278.5
	Poor mental health for 14+ days in past 30 days	15%	13.9%
	Suicide mortality rate (per 100,000)	15.6	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,025.0	2,354.0
	Homicide mortality rate (per 100,000)	2.8	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	8.5%	8.4%
	Children <19 years with public insurance	19.1%	22.2%
	Population without insurance	4.2%	3.8%
	Children <19 years without insurance	2.7%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.8%	6.1%
	Children <18 years in poverty	2.9%	6.5%
	Adults 19-64 years unemployed	4.7%	4.2%
	Householders living alone who are 65+ years	23.4%	27.7%
	Households receiving SNAP benefits	6.9%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.4%	11.4%
	Vacant housing units	4.6%	4.9%
	Single parent households	17.4%	17.1%
	Commute greater than 60 minutes	9.4%	9.0%

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

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

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

COMMUNITY SURVEY

Number of Respondents: 97

ADULTS

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

Mental health

Chronic pain and pain management

Obesity and maintaining healthy weight

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

Anxiety

Depression

Alcohol use

CHILDREN

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

Intellectual / developmental disabilities

Chronic pain and pain management

Mental health

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

Depression

Bullying

Post traumatic stress disorder

COMMUNITY

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

Affordable housing

Services that support people as they age

Substance use services

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

Costs associated with getting healthcare

Not enough health care services or providers

Scheduling problems (such as health services not open when available)

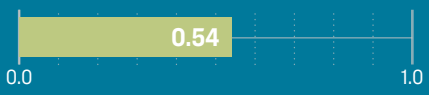
Upper Dublin

ZIP Codes: 19002, 19025, 19031, 19034, 19044, 19075, 19436, 19437, 19477

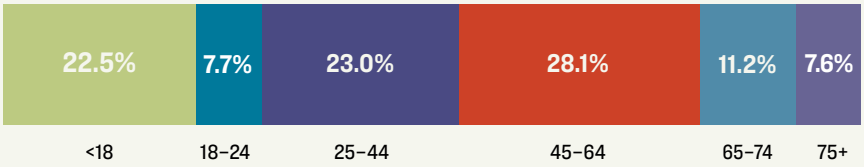
This community is served by:

- Bryn Mawr Rehab Hospital
- Children's Hospital of Philadelphia
- Doylestown Health
- Fox Chase Cancer Center
- Jefferson Abington Hospital
- Jefferson Einstein Montgomery Hospital
- Jefferson Lansdale Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Temple Health - Chestnut Hill Hospital
- Thomas Jefferson University Hospital
- Wills Eye Hospital

SOCIAL VULNERABILITY INDEX (SVI)

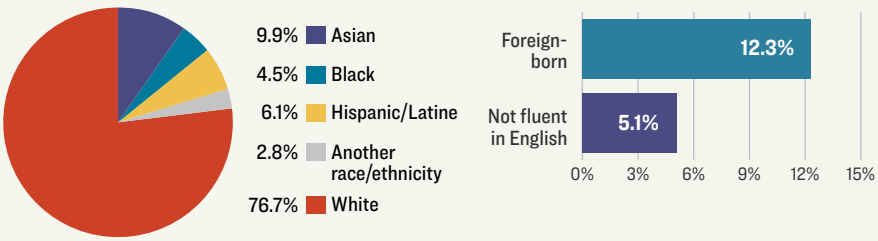


AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

77,430

MEDIAN HOUSEHOLD INCOME

$133,168

EDUCATIONAL ATTAINMENT

17.4% High school as highest education level

PEOPLE WITH DISABILITIES

9.1%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Upper Dublin	Montgomery County
GENERAL	All-cause mortality rate (per 100,000)	949.6	883.5
	Life expectancy: Female (in years)	82.1	80.5
	Life expectancy: Male (in years)	78.6	77.4
	Years of potential life lost before 75	3,018	42,726
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	27.5%	30.2%
	Diabetes prevalence	9.4%	9.7%
	Diabetes-related hospitalization rate (per 100,000)	162.0	152.0
	Hypertension prevalence	32.5%	31.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	38.0	37.0
	Potentially preventable hospitalization rate (per 100,000)	759.0	726.0
	Premature cardiovascular disease mortality rate (per 100,000)	25.9	32.7
	Major cancer incidence rate (per 100,000)*	302.7	258.4
	Major cancer mortality rate (per 100,000)*	67.3	67.6
	Colorectal cancer screening (adults age 45-75)	73.7%	70.4%
	Mammography screening (women age 50-74)	81.0%	79.5%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	1.4	4.2
	Percent low birthweight births out of live births	7.0%	8.3%
	Percent preterm births out of live births	8.6%	9.0%
	Child Opportunity Index**	82.4	67.4
BEHAVIORAL HEALTH	Adult binge drinking	18.0%	19.0%
	Adult smoking	9.2%	11%
	Drug overdose mortality rate (per 100,000)	16.8	21.1
	Opioid-related hospitalization rate (per 100,000)	138.4	180.5
	Substance-related hospitalization rate (per 100,000)	175.9	278.5
	Poor mental health for 14+ days in past 30 days	12%	13.9%
	Suicide mortality rate (per 100,000)	9.1	11.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,138.0	2,354.0
	Homicide mortality rate (per 100,000)	1.3	3.0
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.8%	8.4%
	Children <19 years with public insurance	16.6%	22.2%
	Population without insurance	4.4%	3.8%
	Children <19 years without insurance	4.9%	3.8%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.1%	6.1%
	Children <18 years in poverty	3.4%	6.5%
	Adults 19-64 years unemployed	3.1%	4.2%
	Householders living alone who are 65+ years	24.7%	27.7%
	Households receiving SNAP benefits	5.5%	6.7%
	Households that are housing cost-burdened (% spending >50% of household income)	9.9%	11.4%
	Vacant housing units	4.0%	4.9%
	Single parent households	20.9%	17.1%
	Commute greater than 60 minutes	8.7%	9.0%

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

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

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

COMMUNITY SURVEY

Number of Respondents: 75

ADULTS

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

Diabetes and high blood sugar

Mental health

Heart conditions

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

Depression

Anxiety

Drug use

CHILDREN

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

Mental health

Injuries

Obesity and maintaining healthy weight

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

Bullying

Anxiety

Depression

COMMUNITY

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

Good paying jobs

Affordable housing

Safe neighborhoods

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

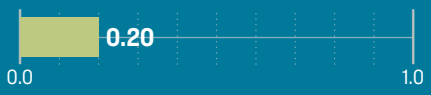
Costs associated with getting healthcare

Don't know how to find healthcare services or providers

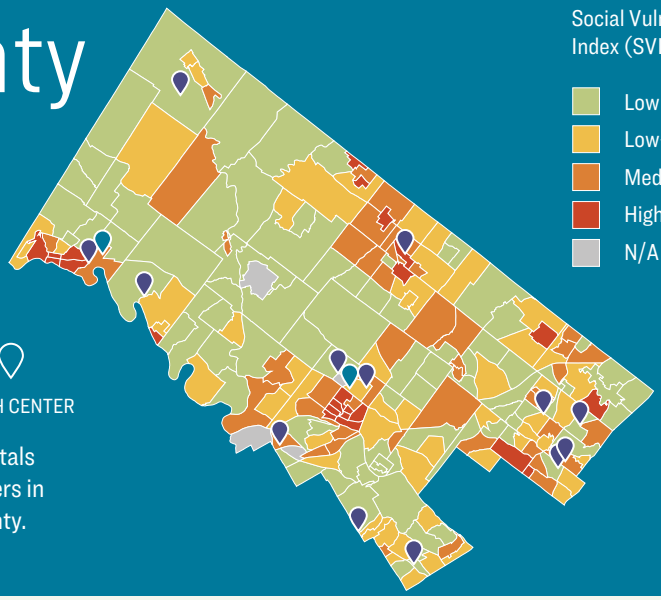
Scheduling problems (such as health services not open when available)

Montgomery County

SOCIAL VULNERABILITY INDEX (SVI)*



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



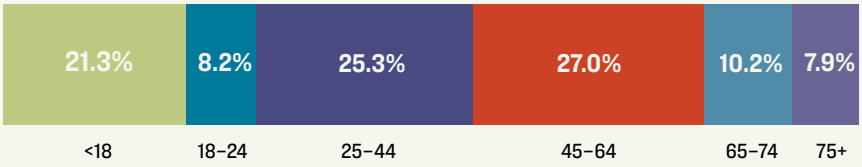
HOSPITAL HEALTH CENTER

There are 13 hospitals and 2 health centers in Montgomery County.

Demographics

AGE DISTRIBUTION

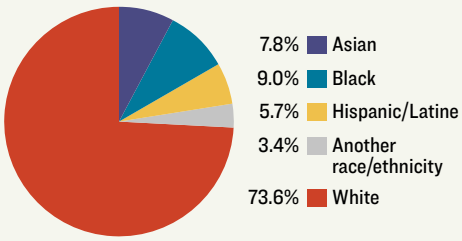
Montgomery County has an estimated population of 861,225 with the largest proportion of residents between the ages of 45 - 64.



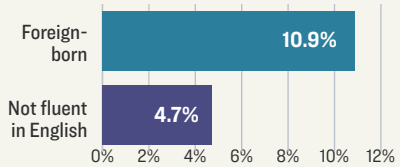
SEX

RACE/ETHNICITY/LANGUAGE

74% of residents are non-Hispanic White. Black residents make the next largest population, comprising 9% of the county's residents.



Nearly 11% of residents are foreign-born and about 5% speak English less than "very well."



HOUSEHOLDS

Median Household Income
$107,441

Homeownership
72%

Severe Housing Cost Burden
% spending >50% of household income
12%

High School as Highest Education
22.6%

Household Food Insecurity
8.6%

Single Parent Households
17.1%

Same Sex Couples
per 1,000 households
3.9

Commute Greater than 60 minutes
9.0%

Montgomery County

Health

LEADING CAUSES OF DEATH – All Ages

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

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

4.6%

Depressed/Sad Most Days in the Past 12 Months

26.4%

Binge Drinking

6.5%

Cigarette Smoking

1.9%

Vaping

9.5%

Exposure

Lead Levels in Children (<16 years old)

2.8%

PEOPLE WITH DISABILITIES

Percent of Population

10.6%

Poverty Status in the Past 12 Months

17.6%

Percent who have difficulty with:

Hearing	2.9%
Vision	1.4%
Cognition	4.1%
Ambulatory	5.3%
Self-care	2.0%
Independent Living	4.1%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

2.2

Violent Crime Rate per 100,000

125.3

Gun-related ED Utilization per 100,000

2.7

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

472.4

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

Flu Vaccinations (Adult)

62.0%

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

Chlamydia per 100,000

233.4

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

Income Inequality

0.47

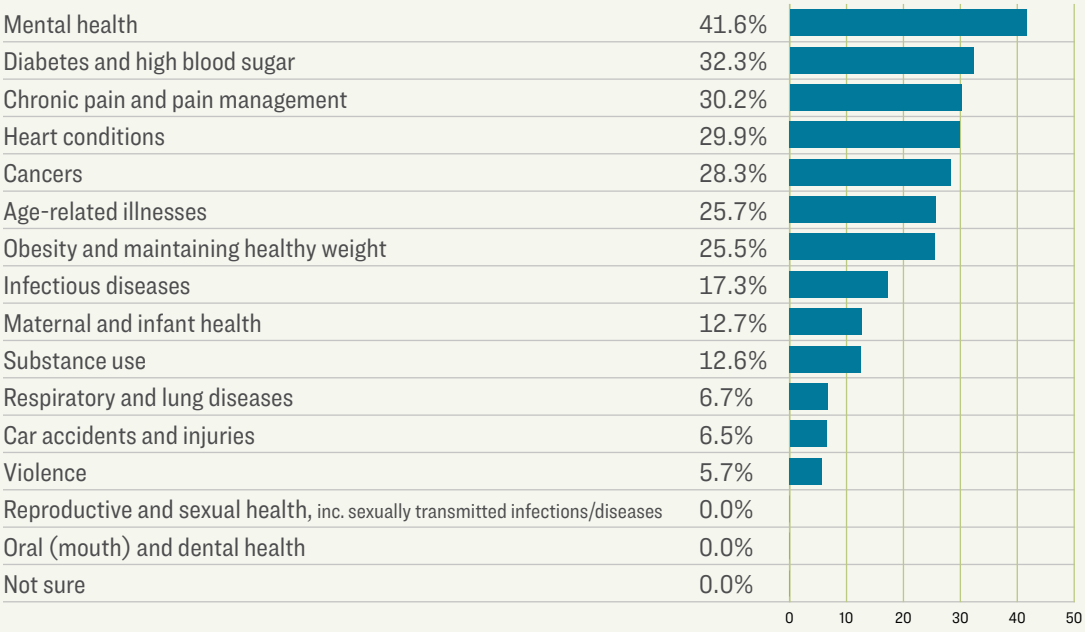
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Montgomery County

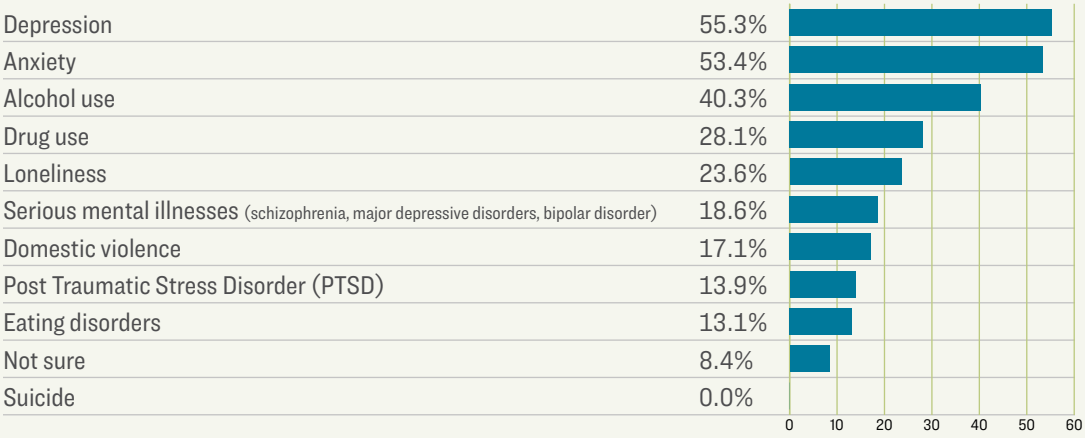
County Survey Results

Number of Respondents: 526

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



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

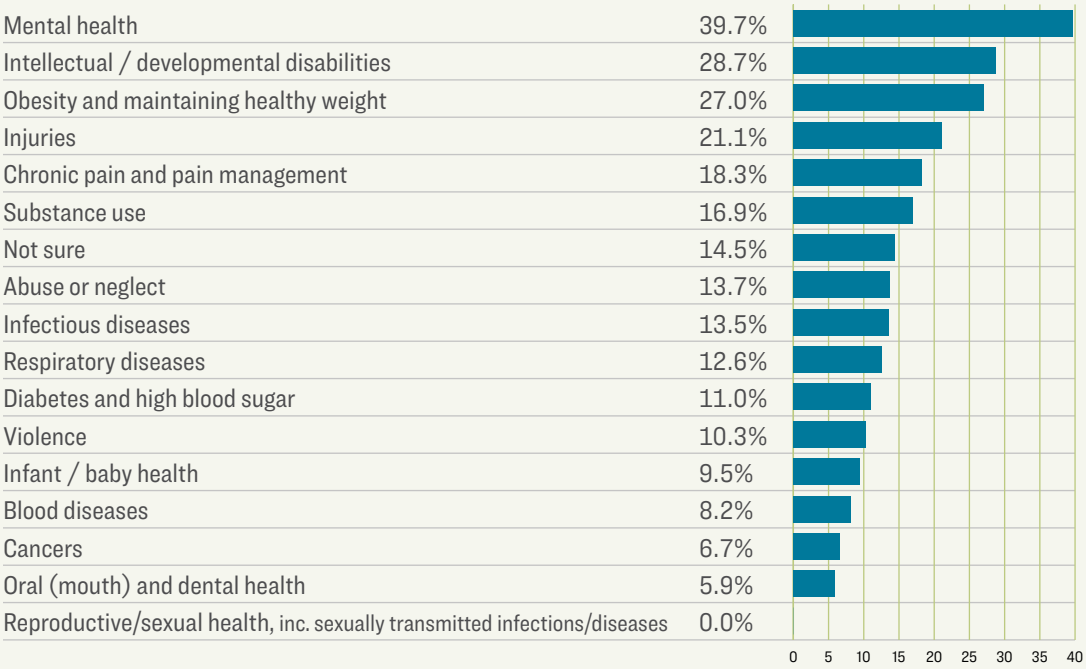


Montgomery County

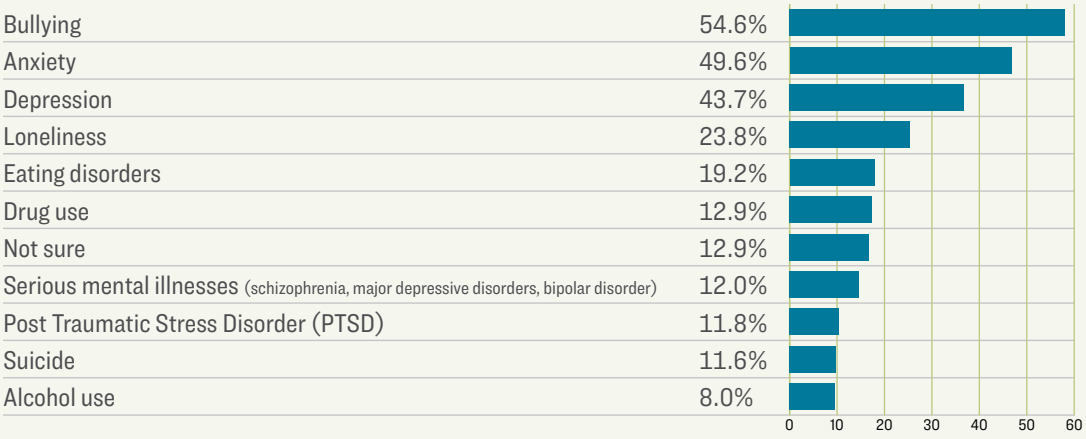
County Survey Results

Number of Respondents: 526

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



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

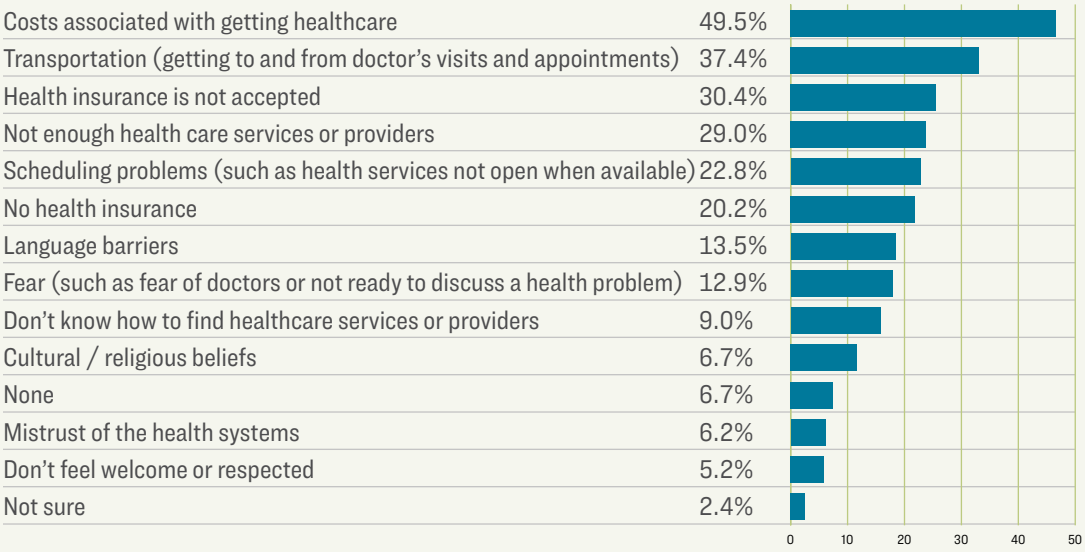


Montgomery County

County Survey Results

Number of Respondents: 526

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



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

	Never Available	Rarely	Sometimes	Often	Always Available	Not Sure
Affordable healthy foods	4.9%	14.1%	31.6%	26.65	20.05	2.95
Affordable housing	7.8%	24.9%	30.4%	17.3%	14.8%	4.8%
Clean outdoor environment	3.0%	6.3%	17.9%	34.8%	35.2%	2.9%
Good paying jobs	6.5%	12.7%	29.9%	30.4%	14.8%	5.7%
Good schools	2.7%	7.8%	17.1%	31.8%	36.3%	4.4%
Health care services	3.4%	7.2%	18.4%	31.8%	37.3%	1.9%
Mental health services	5.5%	14.6%	28.9%	21.5%	15.6%	13.9%
Places to be active such as parks	2.7%	5.3%	12.4%	28.9%	47.7%	3.0%
Safe neighborhood	5.1%	7.6%	28.0%	29.5%	23.8%	6.1%
Services that support people as they age	3.8%	9.3%	24.3%	26.6%	22.2%	13.7%
Substance use services	4.8%	14.3%	23.0%	20.7%	12.4%	24.9%

Philadelphia County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

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

ON GREEN SPACE AND RECREATION

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

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

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

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

FOOD RESOURCES

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

ON FOOD RESOURCES

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

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

A SENSE OF COMMUNITY

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

ON A SENSE OF COMMUNITY

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

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

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

COMMUNITY ASSETS

PUBLIC TRANSPORTATION

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

ON PUBLIC TRANSPORTATION

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

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

COMMUNITY CHALLENGES

LIMITED HEALTHCARE ACCESS

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

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

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

ON LIMITED HEALTHCARE ACCESS

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

"Doctor office is closing too early."

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

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

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

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

COMMUNITY CHALLENGES

BEHAVIORAL HEALTH ISSUES

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

ON BEHAVIORAL HEALTH ISSUES

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

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

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

FOOD DESERTS

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

ON FOOD DESERTS

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

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

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

ENVIRONMENTAL HAZARDS

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

ON ENVIRONMENTAL HAZARDS

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

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

SPECIAL POPULATIONS

CHILDREN AND YOUTH

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

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

ON CHILDREN AND YOUTH

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

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

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

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

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

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

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

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

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

SPECIAL POPULATIONS

OLDER ADULTS

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

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

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

ON OLDER ADULTS

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

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

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

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

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

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

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

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

ADDITIONAL POPULATIONS

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

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

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

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

"

HOMELESSNESS

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

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

FOOD BANKS

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

PWDS

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

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

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

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

"

ACCESS TO CARE

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

ON ACCESS TO CARE

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

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

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

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

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

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

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

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

TRUSTWORTHINESS

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

ON TRUSTWORTHINESS

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

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

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

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

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

COVID-19 PANDEMIC

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

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

ON COVID-19 PANDEMIC

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

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

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

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

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

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

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

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

DIVERSE LANGUAGE PERSPECTIVES

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

Burmese-Speaking Respondents

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

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

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

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

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

Spanish-Speaking Respondents

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

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

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

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

SUGGESTED ACTIONS

Philadelphia County

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

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

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

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

PHILADELPHIA COUNTY
Neighborhood Perspectives

Far North Philadelphia

COMMUNITY ASSETS

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

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

COMMUNITY CHALLENGES

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

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

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

CHILDREN AND YOUTH

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

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

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

OLDER ADULTS

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

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

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

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

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

ADDITIONAL POPULATIONS

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

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

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

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

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

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

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

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

TRUST AND COMMUNICATIONS

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

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

ADDITIONAL CONSIDERATIONS

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

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

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

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

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

SUGGESTED ACTIONS

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

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

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

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

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

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

Montgomery County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

Montgomery County residents appreciated their access to parks and recreational activities, used by residents of all ages.

ON GREEN SPACE AND RECREATION

"...it's just really nice to have a neighborhood where you can just go outside and feel comfortable to just take a breath or go somewhere if you just need a break."

"And then there's parks and stuff where some of my little cousins can go. And then my family loves to do walks in the evening."

"...the senior center that we have, we don't even call it a senior center, but that's what it would be publicly, they have a lot of programming."

"There are walking places. So there are tracks... lots of tracks, even the junior high and high school tracks are being used as well. And I believe there are at least I want to say an upwards to about 6 to 8 pools in the summer, like outdoor pools being utilized."

PUBLIC TRANSPORTATION

Some residents admired the relative accessibility of community resources, based on numerous public transportation options.

ON PUBLIC TRANSPORTATION

"...you got Bucks Smart, you got Transnet, you got SEPTA, and you have your friends and family to get you where you need to go. But nobody has to go a far distance to assist you. That's critical. It's five minutes."

"...transportation. You have free passes for senior citizens for whether it's train or a bus, then they have a very good type of token system for students connecting to school. So, I would say those are definitely advantages."

COMMUNITY ASSETS

SOCIAL ENVIRONMENT

People of multiple faith backgrounds were represented in the community. Residents had opportunities to socialize with one another and took pride in their supportive relationships.

ON SOCIAL ENVIRONMENT

"...and I think that we are also extremely diverse in our community. So, whatever your religion it's here. It doesn't make any difference what it is. And I don't think that every community can offer that. And I think that this is a pocket where you could consider it a treasure because not every community can offer you all those things at the same time: safety, convenience, and all the possibilities of whatever your religion may be."

"...through the years have been able to enjoy socializing here at the library. I don't know that anyone has used that term, but I've been here for many receptions, for book signings, for fundraising activities, for things for children, for older people, middle-aged people."

"Norristown is a very tight knit community. So, like, if something happens, if somebody passes, or if something's going on, we do tend to come together..."

COMMUNITY CHALLENGES

HEALTHCARE ACCESS

Technology integration by healthcare systems served as a barrier for older adults who were not comfortable using it. It could also be a barrier for patients desiring a human experience. Patients faced many barriers and discrimination due to minoritized identities.

"It takes too long to get a doctor's appointment. That is the worst..." Subsequently, emergency room waits lasted up to 24 hours. Poor customer service experiences and a perceived lack of professionalism also served as barriers. High healthcare costs made people "afraid to go into the emergency room. You have to mortgage your house to pay the bill." Delayed service provision then led to advanced health conditions – a greater concern among African Americans. Anxiety about health conditions was also a deterrent for seeking care.

ON HEALTHCARE ACCESS

"...and a common thing, especially, not exclusively, but especially with older people is the digital divide when it comes to the patient portal."

"And I must say this because I'm discriminated against three times. I'm African American, I'm a woman, and I'm a mental patient. Just try to navigate your whole life that way. And what I'm saying, all that discrimination that I had to face all the time, there should be no reason for that."

"I'm saying the hospitals don't do the things that I think are common sensible, not necessarily costly, only because they're so caught up in AI that that's their favorite toy. Oh, we got AI. It does everything. What do we need an 800 number for? I think that's what we're facing."

"...I'm in this dilemma right now [of] finding a good doctor because I'm seeing turnovers in doctors and I had two of my specialists just leave and yeah, just go."

"It's like the attitudes of the people in the different [medical] facilities they act like, I mean, you go in, their attitudes are just so nasty."

"...we experience here working with children, parents who aren't open to having their kids tested for autism and different things like that, because of the challenges [they're] gonna face and them not knowing how to navigate a new life that they weren't expecting."

COMMUNITY CHALLENGES

BEHAVIORAL HEALTH ISSUES

Accessing mental health services presented challenges for respondents and their family members.

ON BEHAVIORAL HEALTH ISSUES

"I was trying to find a therapist. And I ended up finding one through the Jenkintown community page. And I couldn't find anything online and I was desperate. And it was just such a struggle."

"...the resources are not there or they may be there but you don't know how to get to them and that's critical."

"We had a daughter who had mental, drug and alcohol and mental issues and it was very difficult to figure out where in God's name do you go?"

FOOD ACCESS

Residents in Wyncote shared concerns about unhealthy food options within their community, particularly regarding older adults and youth – citing "it's predominantly in certain ethnic areas, lower income areas." Food needs and habits were rooted in culture, and the lack of diverse food options complicated attempts at healthy eating.

ON FOOD ACCESS

"...the 30s to 50s that are always on the run and always eating this ultra processed food. And it is becoming a serious health problem for them. But I don't know how much is going on as an alternative. So, I would just hope that we include that whole issue because following up on what Number One said, from what I gather, doctors are not taught anything about nutrition. And so, it's very hard to have a conversation with your doctor about your eating habits and all that. That's for the nutritionist."

"And someone brought to my attention one day when we go back to the fast food, children can go to a particular well-known store and they can get espressos and cappuccinos and I'm like, are you kidding me? If they're not allowed to get cigarettes and beer, why would you give them this?"

"What I like to see is a good ethnic food supply to the people to stay healthy. What happens especially in the Indian community, their food making is so specific and the expectation of the family is to fulfill those needs. It put strains on a lot of senior citizens because they cannot get a support from the community. And then their food habits are so rigid all their life."

SPECIAL POPULATIONS

CHILDREN AND YOUTH

Social pressures and recent historical events impacting youth were of great concern, particularly since schools appeared to be under-resourced. Youth in some communities did not have direct access to support or sufficient health education. "The information has to be right out in your face." Finding culturally sensitive ways to engage parents was important. There was an expressed need to support young and single parents, to help end cycles of detrimental behaviors.

ON CHILDREN AND YOUTH

"...suicide is very high among the young children. All of a sudden... And the teachers, they have special counselors, extra counselors come in and help them. But in order for a child to open up, you have to really be there every day, not twice a week or once a week or something like that."

"And I understand why it's difficult because parents are working so the hours may not be convenient for them to come in. So, we need to think about, okay, if they can't be here by 5 o'clock and they can then have it after five. Provide some transportation. Provide some food."

"...as a young 20 something, I don't necessarily any solution but I just feel like one thing that's really big for my generation is just burn out and things that have just happened to back to back to back."

"The word of God says my people perish because of lack of knowledge and if they don't know, then people can't get involved. Inner city kids, they need a direct line, they need a resource."

"And also education about their medications because the issues that I have in the school is, a lot of kids are overdosing on medications because their parents are just buying them. They just say they have allergies, they're buying them over the counter antihistamine and if they're not getting no relief, they do not understand that it's every 12 hours or some of it is once a day..."

"So mothers that... lack education or did not know they were pregnant, they continue their... lifestyle. So the chemical imbalances in a lot of our children's brains, that's the issue. So that's why you have depression... because drugs and alcohol affects your brain quickly. That's why when they tell you the very first three months is so precious."

OLDER ADULTS

Recreational activities and meal delivery services for older adults were helpful. "... system is doing a good job with the elderly." Yet there were concerns about this population's isolation, which led to a lack of advocacy, overmedicating, and under-medicating.

ON OLDER ADULTS

"And we have we have programs for people who are relatively healthy, who can line dance and can do various other kinds of exercise programs. They serve lunch at least two days a week. And so, there are a lot of benefits if you can get connected to a senior center..."

"I've seen... the little senior truck that comes in and they'll delivers the dinners in the neighborhood to the seniors."

"What I would like to see when it comes to seniors, a lot of seniors don't have children to look after them to check on them..."

ADDITIONAL POPULATIONS

Concern for veterans was expressed by residents, with their high rates of homelessness, mental illness, and lack of benefits. Their caregivers needed support as well.

Language barriers experienced by immigrants limited their access to care.

People with disabilities face accessibility issues.

The role of religion and faith communities in promoting health was represented significantly among respondents in Montgomery County.

VETERANS

"I have a problem with the veterans thing. What I don't understand why don't the government take care of those people. We pay taxes, those guys go to serve at the time in the service and they come out with different disabilities..."

"So if they are dishonorably discharged, they do not get any benefits. So that's why you see that they are homeless and they have no resources and a lot of them need psychiatric help."

"So we have caretakers taking care of vets with PTSD which need a whole lot of support to them. So it's a horrendous task, it really, really is."

"My son-in-law who's working, he's a Vietnam vet. He did three tours and he's had more people commit suicide than he lost in combat."

PEOPLE WITH DISABILITIES

"So when I think about handicaps, I think about accessibility and I haven't seen a community yet, not one place that really makes accessibility easy."

FAITH AND RELIGION

"...And then the other thing in terms of an asset and I'll just put a shameless [plug], our church, we have a ESL program. It's free. English as a second language. So every Tuesday there, oh, about 100 people from a bunch of different languages that come in and to learn English. So it's free English classes..."

"As a pastor, I really value the work that the chaplains do and the communication that can exist between when patients are there and connecting with their place of worship and so we know who's where and who's in and who's out and have the opportunity to serve them and pray with them. That is invaluable."

"The other thing I found as a doctor, hospitals must be sensitive to-- For example, let's say there's a Islamic patient, they must be respectful of all the different religions. It's no longer just a Christian country. There are Islamic people, the Hindus, the Jewish people. So hospitals must address when they give their menu, for example. They must be respectful of all people."

"I would add health initiatives sponsored by churches in the community like... my church, we are currently holding a diabetes reversal program right now... It's free to the community."

ACCESS TO CARE

Urgent care centers were being used more, as patients had a harder time getting appointments for primary care. Uninsured residents relied on them as well. One respondent noted the barriers presented by pharmacists that were not multilingual. Overall, there was a call for more culturally inclusive health services. Another individual admitted that their own personal lack of motivation limited the positive trajectory of their health. Lastly, the Affordable Care Act improved coverage for residents with pre-existing conditions.

ON ACCESS TO CARE

"The fact that there is urgent care, which there wasn't 20 or 30 years ago is good."

"Well, I actually had to use urgent care because I couldn't get a doctor, right? I went to the hospital, they had me sit there for 12 hours, right? And still didn't do any service..."

"...the need for bilingual and other languages with pharmacies..."

"For example, one of my good friends in Lansdale told me America was created by whites for whites. They do not understand the needs of others. For example, if you get admitted in a big hospital, it's quite intimidating to get into a hospital with all kinds of machines all over you. So hospitals must have in addition to what [respondent] said about chaplains, you must have other staff who are culturally sensitive so that they can communicate."

"Determination, like most people are not motivated enough to keep good health... That's kind of my problem right there."

TRUSTWORTHINESS

One patient shared about reluctantly having an invasive procedure that was not fully successful. A former nurse would periodically advocate for patients – "then when I address the issue, I'm causing a problem. So this happens a lot. I don't trust them." Trust issues developed when residents experienced high turnover with providers, prescriptions that didn't agree with them, a lack of cultural awareness, or being left "in the hands of the interns" after procedures.

ON TRUSTWORTHINESS

"And after he had surgery I would go see him a couple of weeks and after I see him the third time, you know what he said to me? He said to me, I think we're going to need a second surgery. And I said to him, you didn't get it right the first time, you won't do it again, believe it or not. I still have a little problem but it's not near as bad but I'm just telling, I don't have a lot of confidence in doctors. Let me get to it like that. Not at all. I really don't."

"And I said that to the doctor, if you know that this causes a coughing problem which later causes other medical problems in African Americans, why would you prescribe it to me? I'm not taking it."

COVID-19 PANDEMIC

Post-COVID, residents had generally good experiences with the integration of healthcare and technology, including access to health records. Some lamented the requirement of having to see a doctor in-person first, before being eligible for telehealth. Older adults needed technological support.

Most residents still had heightened concerns about COVID-19, while some did not. One respondent was skeptical about the U.S. response to the pandemic, compared to other countries that didn't seem to be affected as gravely. "We have our Western philosophy but there's opportunity perhaps to have more integrated medicine where we can think of some of the Eastern concepts as well." Some unhygienic conditions within health settings were believed to exacerbate contagion. Respondents shared experiences with and knowledge of Long COVID.

ON COVID-19 PANDEMIC

"...I know there are doctors now like you can do virtual visits but the insurance they are scaling back..."

"...it's something that exists because it's like any other thing that's out there. I just don't like [it] to become a factor. You do what you need to do... clean your hands. It's just normal taking care of yourself to me."

"And for me, my long thing with COVID is that I have balance issues and then short-term memories. A lot of times when I'm trying to articulate and say stuff it's just gone."

"I serve 100 patients in one location, so the cost goes down. It's not a healthy situation for all, especially for infectious patients because then you spread and you have infectious community per se which doesn't solve the problem..."

"It's a major concern with myself and my family because in 1993, I was diagnosed with systemic lupus... I have a very, very low immune system."

SUGGESTED ACTIONS

Montgomery County

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

There are Montgomery County neighborhoods with efficient transportation and walkability.

"...what I find about our community is first, there's just endless convenience, okay? That's critical for you no matter what stage of life you're at, whether you're a mother, a grandmother or older, senior citizen so that transportation is available for you..."

Religious institutions provide a variety of services and resources that are open to the community.

"I'm fortunate that -- and I'll say it this way, our church, the senior center that we have, we don't even call it a senior center, but that's what it would be publicly, they have a lot of programming. They also have a social worker that you can talk to and get the resource information. So that's one thing. For those of you who are in that age bracket, our senior center is open to the community. It's not just for our church people. It's for anybody in the community."

The availability of childcare is vital for busy parents.

"One, I'm grateful as someone who is a working parent that there are aftercare pre-care options because school day is not a workday. And then if you add transportation or your commute, it is quite challenging."

Insurance companies with outreach initiatives make a positive impression on residents.

"I see a lot of insurances, health insurance initiatives popping up in communities and hosting health forums and information. So that has become huge in the last several years between emergent cares and your insurances per se setting up things in the community as an outreach of wanting to connect."

The Affordable Care Act has improved healthcare access for Montgomery County residents.

"...that's one thing I would say to Obama that he extended the insurance, health insurance to our kids to the age of [26]."

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

Medical centers can strengthen and diversify the health workforce by incentivizing training for health careers.

"It is very hard to get an appointment. It's a huge barrier. So things like incentivizing people to go into those fields would help because they're not paid well and people don't want to do that for a living when they can do something else. So, when we talk about forgiving student loans or offering scholarships, you have to look at where the areas of need are. And everyone agrees whether you're looking at whatever issue in the world, that mental health is a component. So, I think if the hospitals who have lobbying power could help push incentives for folks to go into that and make a good living or not have to pay for it or some sort of incentive. And then, at the risk of talking too much, I would say we can notice that there's not any men here. And the needs of men and boys fall through the cracks. And I'm not sure what the solution for that is."

Local hospitals can play an active role in gun violence prevention, as a public health issue.

"Let's just talk about gun violence for a second. We haven't really touched on it. And I think that the hospital systems that are in and out of the city and surrounding the city, there is perhaps more they could do from an advocacy. I know it gets tricky because they don't wanna alienate donors and they don't wanna be political. But there's like a stay in your lane, I think. And then there's the doctors that say this is our lane, trauma, pediatricians, ER doctors. They are firsthand seeing these things. It's devastating our communities."

Culturally appropriate treatment interventions should be informed by research with diverse participants.

"I think that is becoming an urgent matter now because as the country diversifies more, then the health care system has to catch up. And that's one of the ways they can catch up is by having diversified clinical trials."

Community liaisons, or community leaders, can serve as brokers of trust between health providers and communities.

"...you can even start out with the block captains in some communities because they're pretty active. Everyone knows the block captain. So if they can penetrate the communities that way, I feel like they would be successful."

SPOTLIGHT TOPIC

Culturally Appropriate Mental Health Care

Access to mental health care that respects a person's culture, language, and background is a growing concern in Southeastern Pennsylvania. The COVID-19 pandemic, hospital closures, and changes in the health care system have made it harder for people to get the help they need. These challenges have especially affected Black, Brown, LGBTQ+, immigrant, disabled, and low-income individuals, who often face more barriers when seeking care.

To better understand these issues, four county-based group discussions and five key informant interviews were held with local leaders who know their communities well. This work builds on the 2022 Regional Community Health Needs Assessment (rCHNA), which explored mental health and substance use across Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. This spotlight focuses on Culturally Appropriate Mental Health Care and shares insights, challenges, and community-driven solutions to improve access across the region.

Challenges and Barriers

Many people in Southeastern Pennsylvania face challenges when trying to get mental health care that respects their culture, language, and background. There are not enough diverse providers who understand the unique needs of different communities, including Black, Brown, LGBTQ+, immigrant, and disabled individuals. Language barriers, high costs, long wait times, and lack of insurance coverage make it even harder to access care. Some people feel judged or misunderstood by their providers, while others are unsure where to go or how to start. Cultural stigma and fear can also stop individuals from seeking help. For many, transportation, limited clinic hours, and hard-to-navigate systems add more stress. These barriers make it difficult for people to get the care they need in a way that makes them feel safe, respectful, and supportive.

LACK OF DIVERSE MENTAL HEALTH PROVIDERS

Many participants shared that their communities do not have enough Black, Brown, LGBTQ+, bilingual, or culturally informed mental health providers.

Individuals noted that they often feel they must explain their culture to their provider, instead of receiving care that already understands and respects their background.

One participant from Chester County said:

"We do not have enough Black and Brown providers, providers who speak languages other than English, providers who are LGBTQ+. And so, there are folks who are finally getting to a space where they're ready to engage in the service, and they have to if they can even communicate with their provider, they then are in a position where they have to educate their provider about their lived experience instead of actually be a service recipient, which is what they're doing. It's an issue that we've heard about. We don't provide clinical services. We are partnering with an organization in the Coatesville area to try to start doing some different things."

Another participant from Chester County mentioned:

"What I hear over and over again is a lack of providers that look like me, that speak the same language as me. And, yeah, I just, I think that that's been a huge issue."

LANGUAGE BARRIERS

Many participants shared that it is hard to find mental health professionals who speak the same language. This can make it difficult to build trust and get the right support.

Some said that interpreters are sometimes used instead of bilingual therapists, but this can be a challenge, especially when talking about sensitive or emotional issues.

While virtual care was seen as helpful, participants noted that it is not always available in multiple languages.

There was also a clear need for mental health materials and referral lists translated into other languages, especially Spanish, to help individuals better understand and use available services.

One participant from Philadelphia County said,

"No. In general, just no. I mean, our behavioral health consultant right now, he has to use a translator. Luckily, he's one of the only ones here that doesn't speak Spanish, so our providers are able to provide that linguistically competent care, but we have had a really hard time finding bilingual providers. And there are still some people that come in with languages that we don't have any providers that speak Haitian Creole or any Asiatic languages. We don't have any, actually, we have one person that speaks Telugu, and that is it. But, yeah, there are definitely gaps in that. And I think interpretation services have gotten super advanced, but we are still using a telephonic interpretation system, which is also a barrier to both mental health care and primary health care. It's just kind of what we're working with now."

COST AND INSURANCE ISSUES

Many participants shared that some mental health providers do not accept insurance due to low reimbursement rates and the amount of paperwork required. This often leaves individuals to pay out of pocket, which many cannot afford.

Even those with insurance may struggle to cover the cost of regular therapy, especially since mental health care often involves weekly or biweekly sessions.

Participants noted that people with hourly jobs, agricultural work, or tip-based incomes often skip care because they cannot afford to miss work or pay for services themselves.

Families with employer-sponsored insurance expressed frustration when they are unable to use their coverage for mental health care.

One participant from Chester County said,

"Cost is a huge issue. So the majority of Chester County residents are -- I know, uninsured and undocumented is another topic, but on this topic, I will say majority of Chester County residents are insured, and the majority have private or commercial insurance. However, a lot of providers in Chester County do not accept insurance because they're not being reimbursed at a rate that is affordable, and the amount of paperwork that is required to complete to get a really low reimbursement rate, they don't accept insurance."

SHORTAGE OF PROVIDERS

Many participants said that a major barrier to mental health care is the shortage of providers. With too few providers and more people seeking care, wait times can be long—sometimes weeks or even months. This is especially hard for individuals who must take time off work to attend appointments.

Some participants shared that people often stop trying to get help because it is so difficult to find care that fits their needs. Even when services are available, there are very few providers who reflect the culture, language, or lived experiences of the communities they serve.

In rural and underserved areas of Southeastern Pennsylvania, the shortage is even worse. Participants also noted a serious lack of bilingual therapists, and many of the trained providers leave for higher-paying jobs in nearby cities.

One participant from Chester County mentioned:

"There aren't any mental health facilities that are counselors that are available. I mean, it's crazy. It's become a specialty field, I guess, and people have to wait a month, two months for care. And, again, it it and then you have to get to the care, because it's not anywhere near where many other clients are. There are barriers all over the place."

One participant from Bucks County said:

"I think we just don't have the providers available. I can't think on the top of my head who I could refer a client to. It's language, yes, but also culturally appropriate services even in the English language. We lack a lot of diversity, I guess, in our service providers and it's a challenge but it's our area where we live."

CULTURAL STIGMA

Some participants shared that in many cultures, mental health is still stigmatized. It is not openly talked about, and people may feel afraid or embarrassed to ask for help.

Others noted that mental health is not always viewed as a real health issue. In some families or communities, it is not taken as seriously as physical health.

Cultural beliefs can also prevent people from seeking care. Some individuals feel that mental health services are not meant for them or their community, which creates a barrier to getting support.

Participants also highlighted that trusted community members, such as church leaders, teachers, or peers, can play a big role in reducing stigma and encouraging people to seek help when needed.

One participant from Philadelphia County said:

"I think one of the biggest issues that we find here is just sort of the cultural acceptance of mental health as a significant issue or something to seek care for."

Another participant from Philadelphia County mentioned:

"But I do think that a barrier to that is just the cultural sort of stigmas and the cultural sort of ideas about mental health and about people that maybe struggle with mental health issues. Again, speaking as somebody who is not Hispanic or Latino, not a person of color, those are the things that I think I've observed in our patient population, and it's really helpful to have culturally competent staff members as well as staff members that are potentially from the same culture, so they're able to kind of sit down and have those conversations. I think it's a deeper issue than just sort of access to mental health care. I think it's more about the acceptance of that care as well. And I don't know if there is an easy or quick fix to that, but that's sort of how we've been navigating it, and navigating that barrier in particular."

One participant from Chester County said:

"I think when we talk about cultural, there is still a hesitation to seek out mental healthcare."

LACK OF TRANSPORTATION AND LOCATION ACCESS

Many participants shared that getting to mental health care is a major barrier. Challenges included limited public transportation, lack of walkable routes, and difficulty accessing offices, especially for people with disabilities.

Mental health services are often far from where people live, particularly in rural or low-income areas. This makes it difficult for those without a car to reach care. Even when public transportation is available, it can take too long, especially for people who work or care for children.

Participants also noted that transportation is a bigger challenge for vulnerable groups, such as older adults, people with disabilities, and those without a driver's license.

To improve access, participants suggested creating one-stop clinics that offer mental, physical, and dental care in a single location. This would make it easier for people with limited transportation to receive the support they need.

One participant from Chester County mentioned:

"I mean, we've had to send people to Philly to get a mental health treatment. It's ridiculous."

One participant from Bucks County said:

"I just think it would be so much more comprehensive for individuals who have transportation issues and other socio-economic needs to have everything centralized and in one location."

LACK OF SUPPORT TO NAVIGATE THE SYSTEM

Many participants shared that the mental health system is confusing and difficult to navigate. People often struggle to find care, understand what services are available, and know how to get started.

Some individuals said they do not have clear referral options or enough information on where to go for help. This can lead to delays or people giving up on seeking care.

Participants suggested the need for system navigators or liaisons, trusted individuals who can guide families and help connect them to the right services.

In addition, insurance adds another layer of difficulty. Checking coverage and finding providers who accept certain plans is challenging, especially for those who are not familiar with how insurance works.

One participant from Bucks County said:

"I'd love to see roles that are specific to just helping people navigate the system, just navigators. In school districts, outside of our area, I know they have parent liaisons or just kind of these point people that can really help people navigate through the system because it's complex. It's so complex."

LACK OF INTEGRATION WITH TRUSTED COMMUNITY SPACES

Participants shared that schools, churches, and community centers are trusted by families but are not always connected to mental health services. These familiar spaces are often underused for outreach and support.

Bringing mental health providers into trusted places can help reduce stigma and make it easier for people to ask for help. When care is offered in locations where people already feel safe, they are more likely to use it.

Stronger partnerships between health systems and local organizations are important. These connections can help build trust and improve access to care, especially in underserved communities.

One participant from Philadelphia County said:

"I've seen success and if you bring providers, mental health providers to trusted sites."

One participant from Chester County said:

"I mean that making sure that the schools have resources to refer out. Maybe making sure that maybe we can go in and do education at the schools because the school is the trusted resource by the parents and by the families. And so, the more they're able to learn about services in the area and then have that as a resource for referral is really important."

UNDERINVESTMENT IN CULTURALLY TAILORED PROGRAMS

Participants shared not enough mental health programs are designed for specific cultural groups. This means many people do not receive care that feels welcoming, relevant, or respectful of their background.

Community-led programs like NAMI's *Sharing Hope* and *Compartiendo Esperanza* were praised for being culturally specific and led by trusted local leaders. However, participants noted that these types of programs are still limited and need to be expanded.

Many culturally tailored programs remain small or in early stages because they lack the funding to grow and reach more people.

Participants also shared that alternative care options—like yoga, acupuncture, and mindfulness—are helpful but often only available to people who can afford to pay out of pocket. These services are rarely covered by insurance, making access limited for lower-income individuals.

Two participants from Chester County mentioned:

"I think when we talk about cultural, there is still a hesitation to seek out mental healthcare. And so having partnerships with really important organizations like NAMI, making sure that places that are trusted community resources, so think about the schools, right?"

"For us, it's just we're still building our capacity to create those relationships so that because we don't know. I'm not a member of those communities. And so ensuring that really building the trust there so that if folks want to use that resource, they're welcome to do so."

Special Populations

Certain groups—including children, youth, older adults, people with disabilities, and those with serious mental illness—face unique vulnerabilities when trying to get culturally appropriate mental health care. Many of them struggle with finding providers who understand their background or can speak their language. Others face problems like stigma, fear of judgment, or not being able to afford care. Some live in areas without nearby services or don't have transportation to get to appointments. These challenges make it harder for special populations to get the right support, which can lead to more serious mental health problems over time.

CHILDREN AND YOUTH

Youth face challenges with provider shortages, cultural stigma, and a lack of school-based referrals.

There's a critical need for youth-focused, trauma-informed care, especially in schools and vulnerable communities.

One participant from Delaware County mentioned:

"Yeah, we we don't have enough therapists out there. And then when you get into -- in Delaware County, I can just use the example of Upper Darby. Upper Darby has over -- just in the high school alone, people who speak over 300 different languages just in the high school. So, then you bridge that out to the larger community of people who are maybe undocumented or whatnot, and they don't speak English, and they're not able to assimilate into the American English speaking therapy or community. As far as therapy, that access is basically going to be a very, very difficult way to navigate."

PEOPLE WITH DISABILITIES

People with disabilities face physical, cultural, and communication barriers to accessing appropriate care.

There's a lack of therapists trained in disability culture and few who know American Sign Language.

Accessibility of transportation, buildings, and therapy platforms remains a major issue.

One participant from Philadelphia County mentioned:

"I think there's definitely issues when it comes to disability culture. We view disability as part of somebody's identity, not a diagnosis. And there's nowhere near enough mental health professionals that understand disability culture. There's also a lack of accessible, physically accessible places for folks with disabilities to go. There's a lack of folks that are mobile. And there's also a lack of folks that know American sign language, which is incredibly difficult to receive services through an interpreter who is learning about the individual's mental health issues. And there's significant gaps, especially on the Medicaid and Medicare side."

IMMIGRANTS AND UNDOCUMENTED INDIVIDUALS

Language barriers, cost, and fear of deportation or system involvement create major access issues.

Many are uninsured or underinsured, and few programs are culturally and linguistically tailored.

There's a deep need for trust-building and culturally sensitive outreach.

One key informant mentioned:

"Well, I would say these folks, the Latino, the undocumented noncitizens, uninsured, they will express -- we go through the intake. Have you ever felt depressed? Do you feel like you have no energy to get out of bed? And that's hard to translate with the interpreter."

PEOPLE WITH SERIOUS MENTAL ILLNESS

People in crisis face limited treatment options after initial contact, resulting in only partial support.

There's a lack of continuity of care beyond initial intervention or suicide prevention efforts.

One participant from Bucks County said:

"You can recognize when somebody is suicidal, take them to crisis. But if they can't get the treatment, then they're still suicidal. We've got half of the equation."

Another participant from Bucks County mentioned:

"We're putting Band-Aids on open giant wounds. All we got is Band-Aids at the moment. But yes, that continuum of care. It's so necessary."

OLDER ADULTS

Older adults often face stigma around discussing mental health and limited access to geriatric psychiatry.

Programs aimed at reducing isolation have shown promise, but access is still limited.

One participant from Philadelphia County said:

"Also, with older adults, we hear that there is certainly stigma around talking about mental health, mental health treatment, etcetera, and that it can be hard. It's difficult to find providers who can support older adults specifically. Geriatric psychiatry, etcetera, it can be difficult to find the right people."

What's Working Well

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

COMMUNITY-LED PROGRAMS AND PEER SUPPORT

Programs like NAMI's *Sharing Hope* and *Compartiendo Esperanza* were praised for being led by trusted community members who share cultural backgrounds with participants.

These programs use storytelling, discussion, and peer leadership to build trust and reduce stigma.

One participant from Philadelphia County mentioned:

"So I think there's opportunities to leverage community-based organizations to do that and also start to put effort behind it where we can show the results. So, I think working together collaboratively is one way to do that."

TRUSTED COMMUNITY PARTNERSHIPS

Bringing services into schools, churches, and local nonprofits was seen as a major strength because people already trust these places. This helps reduce stigma and makes it easier to connect families with care.

CBOs are trusted and serve as key bridges between health systems and hard-to-reach communities. They help reduce barriers by offering advocacy, outreach, and system navigation.

One key informant said:

"Go to a church. After the church service, do an education. You got a capital crowd. You got them right where you want them. Bring some food, call the day. I think things like that. More of that stuff needs to happen. We really wanna reach into the community. Same in the southern part. And, again, we have to make sure we're doing things bilingual. We have to make sure we're reaching everybody."

FREE OR ACCESSIBLE TRAINING FOR PROVIDERS

Free, local training like QPR (Question, Persuade, Refer) suicide prevention and trauma-informed care were appreciated and seen as essential for improving care.

One participant from Bucks County said:

"I'm going to throw in too, how about free training for trauma-informed care. I know there's a wonderful suicide prevention training that was done through the county. Just more of those types of things for providers and I think that's my wish list."

USE OF VIRTUAL MENTAL HEALTH OPTIONS

Telehealth services helped expand access for people who live far from providers or face transportation barriers.

Virtual therapy is especially helpful for hourly workers, young people, and parents who need flexible options.

One participant from Delaware County said:

"Thank goodness that virtual mental health care is a thing, so we're able to accommodate more folks in that way. But if we want bilingual health care to be an issue, we've got to incentivize folks to stay."

Suggested Actions and Solutions

Issues with accessing culturally appropriate mental health care are vast in the Southeastern Pennsylvania region, impacting every county and diverse community populations. To address these challenges, discussion participants offered targeted solutions and highlighted some successful approaches already implemented in their communities. Solutions reflect opportunities for partnership between hospitals and health systems, community organizations, health clinics, and government.

INCREASE DIVERSITY AMONG MENTAL HEALTH PROVIDERS:

Many participants suggested hiring and training more Black, Brown, bilingual, LGBTQ+, and culturally aware mental health providers. This would help clients feel more understood and supported by someone who shares or respects their background.

They also recommended offering incentives—such as higher pay, loan repayment programs, or bonuses for bilingual skills—to help keep diverse providers working in their local communities.

- **"We can't be paying them $40,000 at a base clinician salary when they speak two or three languages. Because if I go to Philadelphia, I'm making $80k. And that's just the reality. And where I think we haven't caught up is really appreciating the need to create that infrastructure and funding for people to stay. Because students will say to me, I want to stay in the county. I want to serve my community, but I also have to pay off loans. And they can do that because bilingual therapists, especially experienced ones, should make more."**

EXPAND COMMUNITY-BASED AND SCHOOL-BASED OUTREACH:

Many participants suggested bringing culturally competent mental health services to trusted community places like schools, churches, and local clinics.

They also recommended partnering with community organizations to help educate families, reduce stigma, and improve access to care.

- **"I've seen success and if you bring providers, mental health providers to trusted sites."**
- **"Community advocates are the ones who are gonna get the message out way more than a provider or a person from one of the health systems. I think you really need to start -- we need to start getting some advocates in the community and empowering them, not just giving them a flyer."**

IMPROVE NAVIGATION AND REFERRAL SUPPORT:

Many participants suggested creating navigator or liaison roles to help people understand and access mental health services, especially for immigrant families and individuals who do not speak English.

They also recommend supporting schools and social service agencies in building stronger and more effective referral pathways.

- **"I want to use my health insurance, I do not wanna pay out of pocket. So, people can't afford to pay out of pocket or people don't want to pay out of pocket or both. And it's a huge issue that we don't have, our behavioral health providers are not being reimbursed at a rate that is appropriate for the care that they are providing, and so they are not taking insurance. And it's that's a big, again, maybe not a cultural, but it's definitely a financial barrier for a lot of people."**

IMPROVE TRANSPORTATION AND ACCESSIBILITY:

Many participants suggested offering transportation to and from appointments or bringing services to places where people already go, like schools or community centers.

They also recommended increasing the use of mobile units and offering more after-hours appointments to improve access.

- **"I just think it would be so much more comprehensive for individuals who have transportation issues and other socio-economic needs to have everything centralized and in one location."**

DEVELOP AND FUND CULTURALLY APPROPRIATE MENTAL HEALTH PROGRAMS:

Participants suggested supporting and expanding mental health programs that are designed for specific racial, ethnic, and language groups.

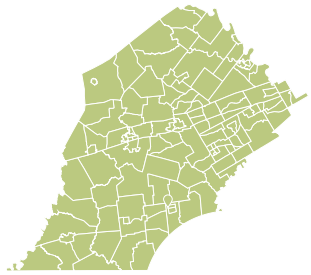
- **"The more partnerships, I guess, hospitals can make, will make it better for in the community also. I mean, it may drive down costs a little bit too, which is good. Again, we need to do it differently. We can't. The hospitals can't. So, they don't have all the answers, and I know that. And I know they don't have all the money. Although they have a lot, they don't have all the money."**

County-Specific Perspectives

BUCKS

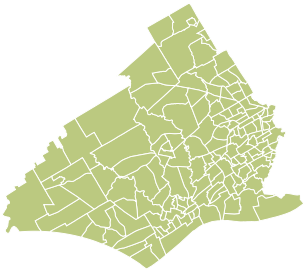
People in Bucks County say there aren't enough mental health providers, especially those who understand different cultures or speak other languages. Transportation and cost are big problems, especially for people with lower incomes. There was also a strong wish for one-stop clinics where people can get mental, physical, and dental care in one place. More training for providers and system navigators was also suggested.

CHESTER



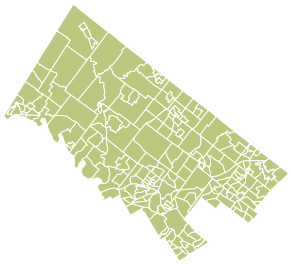
Chester County struggles with a lack of diverse providers, especially for Black, Brown, and immigrant communities. Many residents feel like they must explain their culture to their therapist. Cost is a major issue because many providers don't accept insurance. Community members also pointed out that cultural stigma prevents people from seeking help. Trusted spaces like schools and churches were seen as good places to connect people with care.

DELAWARE



Language barriers are a serious problem in Delaware County, especially in places like Upper Darby where many languages are spoken. There is a lack of bilingual therapists and not enough pay to keep them in the area. Virtual care has helped, but it's not a perfect solution. Transportation, cost, and long wait times also make it hard to get help..

MONTGOMERY



In Montgomery County, people shared that waitlists for mental health care are long and there are very few culturally appropriate options. People want more providers who understand their background and experiences. There is also a need for more support around navigating services and insurance systems.

PHILADELPHIA

Philadelphia faces many of the same issues, too few bilingual providers, long waitlists, and high costs. People with disabilities and older adults have even more trouble finding the right kind of care. Some providers are trying to help by visiting trusted places like churches or health centers. Community-based support and education are seen as important ways to reduce stigma and improve access.

SPOTLIGHT TOPIC

Maternal Health

The Maternal Health Spotlight was created to better understand the challenges, strengths, and opportunities surrounding maternal and child health in our region. To do this, focused conversations were held with a diverse group of stakeholders, including community-based organizations, healthcare providers, support groups, and policy leaders.

Recognizing that the voices of birthing people themselves are often missing from broader conversations, space was made to speak directly with individuals who have lived experience with pregnancy, childbirth, and postpartum care. By listening to both professional and personal perspectives, this spotlight offers a more complete and human-centered picture of maternal health needs and solutions across our communities.

Challenges and Barriers: Access to Care

GEOGRAPHIC DISPARITIES

Participants emphasized the inequitable distribution of birthing facilities in Bucks County. While Middle and Upper Bucks are served by hospitals like Doylestown and St. Luke's, Lower Bucks is limited to a single birthing hospital, requiring many residents to travel outside the county. This disparity results in decreased accessibility for marginalized populations.

A Bucks County participant said:

"Well, for starters, we don't have a lot of birthing hospitals in Bucks County, particularly in lower Bucks. … So Lower Bucks does not have the resources that Upper Bucks has. Now, there are resources across the bridge…, but again, if we're doing a Bucks County needs assessment, there are a resource but not necessarily fully accessible to Bucks County."

TRANSPORTATION AND PHYSICAL ACCESS

In Philadelphia, participants described how a lack of transportation makes even existing resources like food pantries and fresh produce inaccessible. This challenge disproportionately impacts low-income pregnant individuals who are already juggling multiple stressors and responsibilities.

"Yeah. Like, folks, especially people without a car, I know that comes up a lot. Because there are so many food pantries and things and but a lot of people are like, hey, but it's still really hard to get there and pick up my box of food and do all of that. So I think I have heard that specifically from some families I know that have pregnant people in their families, that it's been really hard, and especially for folks who are making just too much so they don't have SNAP benefits, and they're in that pinched place, and they're just trying, they're not eating the healthy fruits and vegetables and things that they know they wanna be eating for their pregnancy."

INSURANCE AND IMMIGRATION STATUS BARRIERS

Participants noted that undocumented and uninsured individuals frequently arrive at health centers during late pregnancy having received no prior prenatal care. This is especially prevalent in Bucks County, where financial, language, and immigration barriers intersect, compounding health inequities for immigrant communities.

"A lot of our clients that we serve are undocumented or uninsured and they tend to come in having had no prenatal care at advanced stages of pregnancy."

LACK OF REPRESENTATION AND CULTURAL COMPETENCY

The absence of racially and culturally representative providers creates a disconnect between pregnant patients and their care teams. This affects trust, communication, and whether individuals feel safe and understood in medical settings.

A Chester County participant told us:

"I didn't see many people that looked like me in the hospital room. I didn't feel when I was in discomfort that I was tended to… especially as a Black woman as well, I have twins, and obviously, I had a high risk pregnancy… I just felt like I wasn't monitored as much as I felt like I needed to be."

QUALITY OF CARE AND PROVIDER BIAS

Participants shared concerns about how healthcare providers treat pregnant individuals experiencing homelessness or substance use disorder. These patients were often treated as if they did not care about their own well-being or that of their baby, leading to feelings of judgment and inadequate care. This stigma erodes trust and discourages engagement with care.

Mothers' concerns during and after labor are sometimes dismissed by clinical staff, even when symptoms suggest complications. This contributes to avoidable maternal deaths and is especially alarming for women of color, who often report not being believed when they express that something feels wrong.

A Bucks County participant said:

"Yeah, treating them like they're less and that they don't care about their babies and social services, it's been not super great there when they're doing removals and everything else. So it just is better at [hospital], they're more sensitive to clients who have mental health and substance use and also treat them with a lot more dignity."

A Chester County participant explained:

"There isn't a lot of advocacy for when women are actually going through the labor and process and they're having issues. They're not really heard, I think. I've heard that several times… someone that I knew that passed away actually at a local hospital from her expressing she wasn't feeling well, literally right after birth. And the nurses were saying, 'Everything is fine. You're reading fine on the monitors. Everything is okay.' But she was, like, physically, she knew her head didn't feel well… ultimately, that night, she passed away."

MENTAL HEALTH AND EMOTIONAL STRESS

Postpartum mental health is often overlooked, with many patients struggling to access appropriate support. Language barriers and lack of warm handoffs to behavioral health providers further alienate patients from needed care.

"There are challenges that come out of being a birthing parent… there is a whole person that is behind that. It has to be support that's just not, 'I'm going to hand you a phone number.' This has to be to a caseworker or a social assistance person… if you just give them a phone number and say, 'Call this number,' they may not answer… they may not trust that that person's going to hear them when they're heard."

What's Working Well

Across counties, participants identified promising practices that support maternal health, including trusted community clinics, culturally responsive programs like CenteringPregnancy, and embedded behavioral health services. These approaches foster trust, promote early engagement in care, and provide meaningful support for diverse and underserved populations.

COMMUNITY-BASED CLINICAL SERVICES

Participants noted that some clinics provide more respectful, culturally sensitive care for undocumented, uninsured, and vulnerable pregnant populations. These institutions were praised for building trust and treating patients with dignity.

"I switched over to a clinic, [Clinic] and that was majorly Spanish speaking population who were undocumented. Probably about 85% of individuals are still majorly Spanish-speaking and undocumented."

SUPPORTIVE PROGRAMMING MODELS

The CenteringPregnancy model was cited as an effective program that blends education, peer support, and clinical care in a group format. Patients appreciated the chance to connect with others and receive anticipatory guidance in a way that felt less intimidating and more empowering.

"CenteringPregnancy program seemed to be very positive. Our patient population really enjoyed it… there's a community part to it as well… it does prompt great discussion between the parents to be able to say, 'Oh, this is how I do it.' And then you're guided by a healthcare professional."

EMBEDDED BEHAVIORAL HEALTH AND NAVIGATION SERVICES

Co-located behavioral health providers and navigators in community health settings made a tangible difference for high-risk populations. These services included proactive outreach, education, blood pressure monitoring, and support before and after pregnancy.

"The navigator was doing follow-ups for appointment reminders, follow-ups after to see how the appointment went… there was a connection to the behavioral health consultant on site to do screening and to do resources… groups throughout the pregnancy… all of those were really critical and important services."

TRUSTED COMMUNITY-BASED ORGANIZATIONS (CBOS)

Organizations like Catholic Social Services and Maternity Care Coalition were described as trusted, nonjudgmental hubs for community members of all backgrounds. Their ability to meet material needs (e.g., diapers, car seats) while offering culturally sensitive support was especially helpful for low-income and immigrant families.

"Catholic Social Services does have many agencies in the area. I just want everyone to know because some people think, oh, they're Catholic. We do service everyone. We do not discriminate against race, gender, religion, any ethnicity. We actually, our population has increased in diversity because of all the immigrants that are coming in."

NAVIGATION SERVICES (EVEN IF UNDERUTILIZED)

While underused, BCHIP's navigation services were identified as a valuable, no-cost option for helping patients access appointments, transportation, and interpretation — especially for reproductive and family planning care.

"BCHIP provides navigation services for people who need help securing family planning. We can provide transportation, we can accompany the person to an appointment, we can help schedule an appointment, we can help with translation services… they are available and underutilized."

DIRECT FINANCIAL SUPPORT PROGRAMS

Participants highlighted programs like the Philly Joy Bank and baby supply closets as practical, immediate support. These efforts reduced stress, helped parents prepare for birth, and allowed them to afford essentials like food, diapers, and car seats.

"Programs like the Philly Joy Bank and stuff like programs that will try to give people money are very helpful, especially when you're trying to do all of those things, like eat healthily and not have to maybe work as many hours or worry about paying rent or bills."

"We have here a baby cupboard, a baby boutique that they can utilize the ladies locker for feminine hygiene products because we know how expensive that is too."

Suggested Actions and Solutions

To address persistent maternal health inequities, participants recommended concrete actions such as expanding cultural competency training, increasing language access, strengthening mental health handoffs, and restoring reproductive care options. These strategies aim to improve care experiences and outcomes by centering dignity, trust, and accessibility.

INCREASE CULTURAL COMPETENCY AND REDUCE STIGMA:

Participants strongly recommended formal training for providers and hospital staff in cultural competence and trauma-informed care, especially for populations facing homelessness, mental illness, or substance use disorders. These trainings were seen as essential to reducing harmful biases.

- **"Training for staff around stigma and meeting the needs of our most vulnerable patients… whether they're someone experiencing substance use disorder or experiencing homelessness while pregnant… meeting the needs of our most vulnerable pregnant patients in a culturally competent way, would be important."**

EXPAND REPRESENTATION AND LANGUAGE ACCESS:

There was consensus that patients feel safer and more heard when providers reflect their community. Hiring bilingual staff and individuals who share cultural or lived experiences with patients improves trust, communication, and engagement.

- **"Having bilingual folks on staff is very, very helpful, and hiring people from the communities with which those systems reside."**
- **"They feel more engaged, they feel more cared for, and the patients feel that they can trust their healthcare provider much more than without having that as an opportunity."**

IMPROVE CONTINUITY AND ACCESSIBILITY OF MENTAL HEALTH CARE:

Rather than simply giving patients a phone number for services, participants stressed the need for case managers or social workers to facilitate the connection to mental health care. This was especially crucial for patients with language barriers or distrust in institutions.

- **"It has to be support that's just not, 'I'm going to hand you a phone number.' This has to be to a caseworker or a social assistance person… they may not answer. They may not take that phone call. They may not trust that that person's going to hear them when they're heard."**

FUND COMMUNITY HEALTH CENTERS AND OUTREACH:

Participants advocated for greater funding to community health centers and programs like CenteringPregnancy. By supporting parents early, before delivery, these programs can proactively address challenges and promote better outcomes.

- **"If there were opportunities within the health systems to be able to fund community health centers or other centers that are caring for those patients prior to them having that birthing experience at one of the hospitals, that would be fantastic… to address challenges, concerns and needs that they may have through that type of a model."**

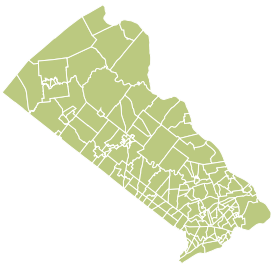
ACKNOWLEDGE AND RESPOND TO RACIAL DISPARITIES IN CARE:

There was strong emphasis on the need to directly acknowledge racial disparities in maternal health care, particularly for Black women. Without confronting these inequities, trust in the healthcare system will remain low and outcomes will continue to reflect systemic racism.

- **"Just the racial disparities around this topic too... there is still a true feeling of concern with their health systems, like trusting their providers, having providers that don't necessarily look like them, who might not take them seriously when they're talking about certain concerns or pains that they're having."**

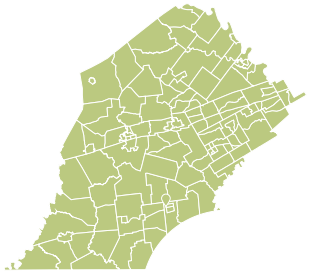
County-Specific Perspectives

BUCKS



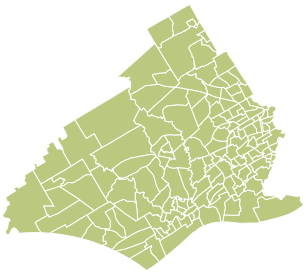
In Bucks County, community providers highlighted stark disparities in maternal care access, particularly in Lower Bucks, where the closure and consolidation of health centers has left many residents without nearby birthing services. Residents described cultural and linguistic barriers to care, especially for Spanish-speaking, Russian-speaking, and undocumented patients. These groups often arrive with little to no prenatal care due to systemic and financial barriers. Some respondents emphasized stigma and discriminatory treatment toward vulnerable populations, including people experiencing homelessness or substance use. Loss of reproductive health services, particularly abortion access, has deepened these inequities. Nonetheless, there are some safety net services in place, such as navigation support for family planning at a local community health center, although these services are underutilized.

CHESTER



Chester County participants underscored a troubling lack of patient advocacy, particularly for Black women and ethnic minorities during labor and postpartum care. A recurring theme was the feeling of not being heard or taken seriously, even when patients presented symptoms that later proved life-threatening. Mental health needs, both for birthing individuals and their partners, were noted as under-addressed, especially among those with limited English proficiency. Despite these challenges, community-based programs like prenatal monitoring initiatives and culturally tailored support groups have made positive impacts for populations such as West African immigrants and Black Americans. Providers stressed the importance of funding culturally relevant group care models and hiring staff reflective of the communities served.

DELAWARE



In Delaware County, participants had limited firsthand insight into local maternal and child health conditions. However, concerns were raised about the need for integrated dental health education during early pregnancy and the complexities of advising patients who are managing mental health conditions with psychotropic medications. The lack of broader commentary suggests a possible gap in awareness or engagement with maternal health initiatives among providers in this area.

MONTGOMERY

Montgomery County has been viewed as a resource-rich area, but disparities still exist, especially for residents in Norristown and other lower-income areas. Community voices emphasized challenges such as the affordability of care, language barriers for immigrant populations, and gaps in mental health services for pregnant and postpartum individuals. Assets include a network of providers committed to cross-sector collaboration and several hospital-based initiatives focused on improving outcomes for birthing individuals. Community stakeholders expressed optimism about current efforts to increase culturally competent care and improve access to maternal health resources, though work remains to ensure equity across the county.

PHILADELPHIA

Philadelphia providers described the need for comprehensive, long-term support from pregnancy through early childhood, particularly for families facing poverty, food insecurity, and limited childcare options. Cardiovascular issues and mental health struggles were recurring concerns, exacerbated by financial strain and lack of trust in the healthcare system. Providers noted that many patients—especially Black women and people with disabilities—experience bias and lack culturally sensitive care. Nonetheless, several programs offering direct financial support, prenatal education, and postnatal resources like baby supplies and mental health check-ins have proven effective. Some participants reported significantly better experiences during subsequent pregnancies, attributing improvements to more responsive providers, expanded community programs, and the integration of digital resources like telehealth and breastfeeding apps.

Community Conversation on Maternal Health

The Maternal Health Community Conversation provided critical insight into the experiences of birthing people across the region, surfacing gaps in education, care, and support throughout the prenatal and postpartum journey. While broader community health conversations often acknowledge maternal health as a key issue, personal stories and lived experiences related to pregnancy, childbirth, and postpartum care are rarely shared in general public forums. Recognizing this gap, we created a dedicated and supportive space for birthing individuals to speak openly about their experiences. This intentional approach allowed us to hear firsthand about the systemic challenges they face—ranging from lack of culturally competent care and disrespectful treatment to unaddressed mental health needs and barriers to postpartum support. These conversations not only shed light on the current state of maternal health in the region but also underscore the urgent need for more compassionate, equitable, and person-centered care systems.

Challenges and Barriers

The community conversations revealed a wide range of concerns and challenges faced by birthing individuals, particularly those from marginalized communities. Participants described feeling under-informed and unsupported throughout their pregnancy journeys, with limited prenatal education and rushed visits that left them unprepared. Many reported experiencing disrespect or bias from healthcare providers—often tied to their race, income level, or cultural preferences—which negatively impacted their sense of safety and trust in the health system. Mental health needs, particularly postpartum depression and anxiety were frequently overlooked or inadequately addressed.

In addition, some mothers shared that they were excluded from essential services simply because they were not teen parents, while others recounted experiences where medical complications were poorly managed or inadequately explained. Gaps in care extended beyond delivery, with some feeling abandoned after NICU discharge or when needing culturally competent, trauma-informed support. Collectively, these narratives reflect a need for more inclusive, informed, and compassionate maternal health systems that center patient voice, lived experience, and holistic care.

LACK OF PRENATAL EDUCATION & SUPPORT

Comprehensive communication and education efforts, especially for new mothers with pregnancy complications, were not always provided.

"I wasn't never really made aware of like the whole journey of pregnancy."

BIAS AND DISRESPECT IN CARE

A lack of support systems and mechanisms for self-advocacy further marginalized mothers with co-morbidities and who were ethnic minorities.

"... if you're poor and uneducated, that's exactly how they treat you at the hospital. Be mindful of where you get your care. When you have money they will treat you better. I work in a hospital, so I know how it goes. It's really unfortunate."

LIMITED ACCESS TO SERVICES FOR OLDER FIRST-TIME MOTHERS

Programs for "new moms" who are not teenagers appeared to be hard to access or were fewer in number.

"...when my sister was fresh out of high school, she was offered those programs to where, as though that you can go to like the [community resource] or the welfare office and sit down and take like a mother, a parenting class, and I wasn't never offered that."

COMPLICATIONS NOT ADEQUATELY MANAGED

Mothers with health issues such as preeclampsia shared they were not properly informed or supported during their pregnancies.

"I had preeclampsia, so I had a lot of check-ups, but this is my 1st child, so I didn't know like other like other ways to kind of go about [it]... I thought I was eating healthy. I didn't actually have a midwife. I think I was like, offered somebody that I could talk to on the phone because it was like right after COVID. So, things were kind of getting back to normal. So for me, I just kind of felt like I didn't know if there were other like other resources for pregnant people who were dealing with like preeclampsia... like they just told me I had high blood pressure and gave me medication. And then I wind up having to have my daughter like at like 33 weeks instead of what they originally planned for, which was like 37, and... I felt like because I didn't have like, I guess, more family support they kind of... I just was going to the appointments, not really getting like or not knowing what questions to ask. I didn't really feel like it was informative. I just kind of felt like I was being told what to do."

LACK OF TRANSPARENCY AND INFORMATION DURING PREGNANCY

Participants shared that important information like fetal size and potential complications were not communicated clearly.

"...my 1st pregnancy was not a good experience either. I had to have an emergency C-section. My baby was too big. They did not tell me how big the baby was during the pregnancy. I could have been careful with my diet..."

LACK OF POST-NICU

Some mothers felt abandoned after NICU care began, without ongoing support or resources.

"I kind of just felt like I didn't really have support after the NICU, because they was just like, 'Oh, well, you know we take care of her. You can come visit.'"

RELIGIOUS AND TRAUMA-INFORMED NEEDS IGNORED

Some participants reported that their religious or trauma-related care preferences were not honored by providers.

"I didn't want a man in the delivery room with me, due to my religion as well as sexual trauma, and I felt as though I was treated differently, because I only wanted women in the room with me."

BIRTH PLANS DISREGARDED

Participants expressed that their choices during delivery were ignored when unexpected changes occurred.

"... so I was transferred. I had to do an emergency transfer from the birthing center to the hospital, and the hospital didn't honor my birthing plan at all. So they just completely disregarded my wishes."

RUSHED AND IMPERSONAL PRENATAL VISITS

Short appointments left patients feeling dismissed and uninformed.

"...prenatal visits are too short. They rush you and do not appear to want to educate you."

UNMET MENTAL HEALTH NEEDS

Post-natal mental health needs were not always met, and limited support led to misunderstandings about one's own mental status.

"I guess I had postpartum, but it wasn't like, I guess, as severe as other women's postpartums can be. It just was like, I just feel like I can't take care of my child, or it was something wrong with me... I couldn't produce milk because I didn't make it to 40 weeks. It was just a lot of different things that wasn't broken down to me or explained to me."

What's Working Well

Participants also reflected on positive experiences and meaningful moments of support that stood out in their experiences. While challenges persist, many birthing people shared stories of improvements such as more responsive providers during subsequent pregnancies, helpful follow-up care, access to financial and material support, and culturally respectful treatment. These experiences underscored the value of person-centered care, consistent communication, and access to practical resources that reduce stress and promote well-being during the perinatal period.

IMPROVED CARE IN SUBSEQUENT PREGNANCIES

Although one participant felt that her initial labor and delivery experience could have been much better, she appreciated her health providers' pivot the second time around to ensure that previous health issues could be deterred.

"...the 1st pregnancy. They didn't take it as serious. It wasn't as serious until, you know. I found out I had preeclampsia towards the end, and they had to do emergency C-section. So, the second time around, they took it really serious. I had constant checkups, constant emails from my doctor, so they and I didn't have a midwife. I had an actual doctor, the 1st time around. I had a midwife."

EXPANDED RESOURCES AND ACCESS OVER TIME

While some participants lamented barriers to resources, others noted improvements over the years through successive experiences with labor and delivery.

"Yeah, maybe it was like a time where there wasn't a lot of things, but I feel like all the things that are offered. Now, I definitely appreciate it."

VARIABILITY IN SERVICES BY LOCATION

Greater knowledge and access may be correlated with specific health centers, and the availability of resources still varies depending on where care is received.

"... I think that there are things you do have to search a little bit. But I think it also depends on where you're actually getting your care. Because, like I said, there's things that I'm like, oh, really like I didn't know that was a service. I didn't know that that we could get that type of help. So it definitely is where you are."

PATIENT FEEDBACK AND HOSPITAL ENGAGEMENT

Some hospitals actively survey patients and seek input about care experiences, which participants felt made a difference.

"... my hospital that I received treatment from. They do a lot of surveying of the patients, asking our input as far as how was our experience? Not only with the provider, but the hospital in general as a whole. And that that helped out a lot actually."

IMPROVED BREASTFEEDING SUPPORT

Participants noted an increase in breastfeeding resources and support over time, including the availability of apps and other tools.

"Breastfeeding support has grown drastically like there's an app called pacify, that helps out... I had my 1st child years and years ago. I didn't receive any assistance, and I ended up quitting breastfeeding."

POSTPARTUM RESOURCE NAVIGATION AND VIRTUAL SUPPORT

Some hospitals provided comprehensive resource connections and scheduled postpartum appointments through video chat, which was appreciated.

"They had people come in after I delivered the baby and gave me lots of resources and sometimes can be a little overwhelming postpartum. But they set up appointments. That I thought that was really good, because appointments were set up just a little video chat like, you don't have to come into the office."

RESPECT FOR BIRTH PLANS AND PREFERENCES

Participants valued being asked about their preferences and supported in expressing their birth plans.

"I was asked several times just like about a birth plan, like, what would you like to do? So that was really helpful. Even was given the option to like, write up something while I was actually there laboring like anything that I wanted. So I thought that was really helpful."

CULTURALLY RESPECTFUL AND TRAUMA-INFORMED CARE

Positive experiences included being treated with respect for cultural and religious preferences, and receiving consistent mental health screening.

"I was lucky with the 2 different hospitals. I had my babies. They respect everything. If my my scarf, they respect that... my doctor was a woman, as my religion... I feel comfortable with a woman with a doctor female doctor... and also my kids' doctor. She's always let me fill a questionnaire every visit, that I'm not depressed... I'm doing well."

PREGNANCY AND INFANT LOSS – LACK OF OPEN DIALOGUE

When it came to the topic of pregnancy or infant loss, a few respondents were able to offer some insight through observations in their communities. But questions around the circumstances of the losses, how to engage in conversation about the topic, and how to offer support were raised.

"Working in the field. I've seen instances of it, but it was all like never a clear reason why, like, you know, was just unexplained pregnancy loss. o I don't have much information on it, and I do think it's one of those things that you don't talk about much. Because it's like, you don't want to talk about that to a pregnant lady. Because who wants to have those thoughts, you know?"

ENVIRONMENTAL, COMMUNITY AND HEALTH-RELATED CONTRIBUTORS TO LOSS

Participants reflected on how weight, comorbidities, nutrition, and domestic violence may contribute to poor pregnancy outcomes.

Broader community-level issues such as violence and drug use were identified as contributing factors to pregnancy loss.

"...one of the girls in my neighborhood, she was pregnant, but she was so overweight and then she has also had some other health issues with which kind of led to her losing her baby. I'm not exactly sure what was her underlying health issues. But I know we were excited one week, and then I seen her 2 weeks later, and she had told me she had lost the baby. And then also other environmental issues like not being able to fully give yourself the nutrition that you need, or maybe people are in domestic violence sit..."

"... unfortunately, I live in a very high crime rate and [there] are lots of drugs. I know a lot of pregnancy loss."

Suggested Actions and Solutions

Participants offered a vision for what a more supportive and equitable maternal health system could look like. Many called for holistic and preventative care approaches that address mental health, physical health, and social needs together. Participants emphasized the importance of early education about pregnancy and complications, culturally sensitive care, and improved communication from providers. There was also a strong call to include men and partners in education efforts, address the emotional and financial toll of infertility, and create more accessible, community-based resources throughout the pregnancy and postpartum journey.

A proactive and **holistic approach to maternal and child health** could help to offset potential health issues and support those who are less experienced in childbirth. Additionally, **limited financial resource**s contributed to undue stress while pregnant.

- **"... a midwife that was like more holistic. That would be like, 'Oh, eat these type of herbs or and this will help bring your high blood pressure,' down so that I didn't have to sit in the hospital for like 3 weeks with trying to figure out if they were going to give me a C-section or not."**
- **"We need more resources for physical and financial help for birthing people. It's a lot of stress on the mother during pregnancy and then having to raise children in this economy... Insurance is a big factor, because I see like a lot of like moms who don't have insurance. And they need different medications or needs during their pregnancy and it's stressful when they can't afford to get it because insurance is so expensive."**
- **"In a perfect world, if during those prenatal visits in the beginning, if every woman could be set up with some type of like therapy or like, ask, you know, if you would like to talk to somebody, even during the pregnancy, because you can become depressed during the pregnancy..."**

Complexities related to infertility were identified and are nuanced, requiring a strategic approach to problem-solving – such as addressing the high costs associated with treatments and the emotional toll that it takes on parents.

- **"I am thankful I did not struggle with infertility, but I would share that I know some people who do struggle with this day by day and due to the cost of going through the fertility treatments they stop trying or they move to their country of origin for help. Due to this matter, there are couples who would like to adopt after trying and cannot due to their immigration status."**
- **"It should automatically be covered through your insurance."**
- **"One of my close friends, same sex marriage, had a good and bad experience with infertility treatments. The process and expense of the treatments to become pregnant was troublesome with one loss but they now have a one-year-old."**

Maternal and child health-related information and support to help people understand and cope with their health and emotions, including opportunities and information-sharing, need to be improved. Men and fathers need support and education as well.

- **"There should be like a lot of people have smartphones now, maybe like a QR code, and it just pop up with like a bunch of resources that's like accessible to the patient."**
- **"I think NICU resources should be, I guess, talked about when they tell you, you have preeclampsia. And this is the opportunity like this could be something that could happen, or when you do hear your baby is in the NICU..."**
- **"I just think people don't... People aren't always honest with their physicians about the things that they know they shouldn't be doing, or the things that you know they may, they may be scared to admit that they do."**
- **"The fact that they want to, you know, push to ban abortion and not also consider other things outside of harming a woman's body. To end a pregnancy or to prevent a pregnancy is a little disturbing. I think they should push more sex conversations to boys, because they ultimately are, you know, the ones that are impregnating the females. So, I think the condom thing, or some type of more education for men on. Why, it's more important to use condoms rather."**
- **"I think that should be something that they talk about with the children. Like, women are getting pregnant and if you guys choose not to go through with the pregnancy, she might be affected by that. And I think that should go for the female and the male to know that the female will go through these certain things. So, maybe they'll think like, dang, maybe we really can't do this or we'll try and protect ourselves a little bit more because she's gonna go through hell in the long run. It might cross a couple of kids' minds before they do certain things. Not like a scare tactic, but I do think it's vital information..."**
- **"I would suggest more education on the possible complications that can occur during pregnancy and what to do to prevent and how to overcome them before they happen. More education on the test they perform when there are complications."**
- **"I feel this is a topic we don't really talk about. I feel the many amounts of birth control aren't spoken about and due to the lack of education, research, and cost many aren't able to have access to this. I also feel women should have some kind of anesthesia for birth control since it can be very painful."**

SPOTLIGHT TOPIC

Older Adults and Aging in Place

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

As one participant shared,

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

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

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

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

Challenges and Barriers:
Access to Healthcare

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

NAVIGATING HEALTHCARE SYSTEMS

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

A participant from Philadelphia stated:

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

Another Philadelphia participant said:

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

A Philadelphia participant added:

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

A participant from Delaware County expressed a similar sentiment:

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

MENTAL ILLNESS

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

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

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

A Chester County participant said:

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

A Philadelphia participant expressed:

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

A participant from Delaware County expressed a similar sentiment:

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

TRANSPORATION CHALLENGES

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

A Bucks County participant shared:

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

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

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

MEDICARE

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

A Chester County participant said:

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

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

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

Aging in Place

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

ACCESSIBILITY

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

A participant from Chester County expressed:

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

A Philadelphia participant agreed, stating:

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

IN-HOME SUPPORTS AND REPAIRS

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

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

A participant from Philadelphia County said:

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

A Delaware County participant added:

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

A Philadelphia County member said:

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

LONELINESS AND ISOLATION

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

A participant from Delaware County said:

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

A Delaware County member added:

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

A Bucks County member said:

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

Resources for Older Adults

ACCESS TO PROGRAMS AND SERVICES

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

A participant from Bucks County said:

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

A Delaware participant stated:

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

Planning

WILLS

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

A Delaware County member said:

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

Another Delaware County member added:

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

A member of Philadelphia County said:

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

What's Working Well

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

SENIOR CENTERS

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

A participant from Delaware County stated:

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

A Philadelphia participant said:

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

FAITH-BASED ORGANIZATIONS

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

A member from Philadelphia County stated:

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

Suggested Actions and Solutions

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

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

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

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

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

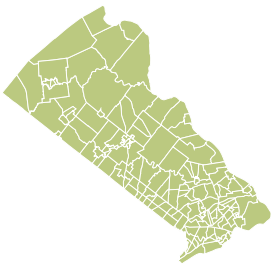
Replicate a "one-stop shop" model for older adult care, where multiple services are integrated into a single location with added support like transportation and comfortable spaces, could enhance convenience and accessibility for older adults in all healthcare practices.

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

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

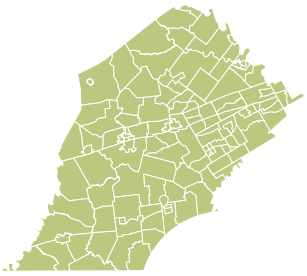
County-Specific Perspectives

BUCKS



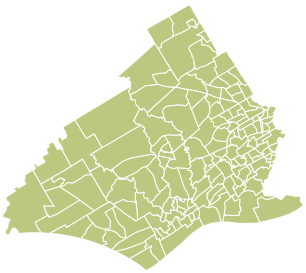
Participants in Bucks County highlighted significant barriers to healthcare access and transportation for older adults, with many emphasizing the financial difficulties that prevent older adults from affording essential medications. Mental health services were a major concern, particularly the stigma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

CHESTER



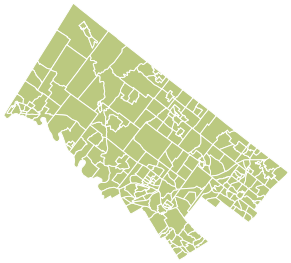
In Chester County, participants stressed the growing need for services that are culturally and linguistically appropriate, reflecting the county's shifting demographics. Digital literacy was a significant barrier, preventing older adults from accessing telehealth and online resources. A common concern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

DELAWARE



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

MONTGOMERY



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

PHILADELPHIA

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

SPOTLIGHT TOPIC

Primary Care Access

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

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

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

Challenges and Barriers:
Scheduling and Availability

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

SIGNIFICANT WAIT TIMES

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

A participant from Philadelphia said:

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

STAFFING SHORTAGES

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

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

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

Delaware County-based participants highlighted:

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

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

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

SCHEDULING

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

A participant from Chester County shared:

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

Use of Emergency Departments and Urgent Care

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

URGENT CARE USE

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

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

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

A participant from Chester County addressed this:

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

One participant from Philadelphia shared:

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

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

MISCONCEPTIONS ABOUT PRIMARY CARE

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

Participants from Chester County discussed the need for community education about the different roles that primary care and urgent/emergency care serve:

"What ends up happening too is there's an education challenge for folks. So, some people, because healthcare is expensive, they just don't go when it could be something that could be solved by seeing your primary care provider before it became an emergency. And then you ended up in the emergency room or urgent care....because folks don't see necessarily their primary care provider as someone to go to before it becomes urgent...That is something that our health systems could help our community to understand, is that the emergency room should not be your first line of defense, it should be used for emergencies and that when you are first experiencing a challenge to go see your primary care provider."

AVOIDANCE IN SEEKING CARE

Community members' negative experiences (bias, discrimination, historical injustices) with certain hospitals and health systems diminished overall trust, leading to avoidance in seeking care with those systems or only using hospital emergency rooms, not primary care.

When describing the closure of a local hospital, a participant from Chester County described community members' reluctancy to seek care:

"...because when they had an emergency, they needed to use the hospital for emergency care...even if they had access to the resources to go to the hospital, because of cultural competency or other comfort levels...but otherwise, they tended not to go to that hospital."

"One of the issues is that many of our lower income and particularly minoritized lower income folks do not feel quite as comfortable going to some of the other hospital options in the county just due to due to issues of again race and cultural competency."

A participant from Delaware County echoed a similar sentiment:

"But what I would say is that it was interesting when the hospital closed, many of our lower income community members, when asked, you know, 'what the negative impact of that hospital closing would have on them', they said 'very little', because they didn't interface with that hospital for a variety of reasons, many of which would be cultural comfort, and so they use the hospital for emergency care."

Accessibility

The inability to physically and logistically access primary care providers was frequently shared as a barrier to care. Issues ranged from the availability and reliability of public transportation, lack of walkability, and the accessibility of offices themselves for people with disabilities.

GREATER DISTANCES

Parts of the region have experienced hospital and office closures, resulting in greater distances to reach care. Additionally, areas with limited or no public transportation, and lower numbers of community members with access to private transportation, face increased barriers to accessing primary care.

A participant from Chester County described:

"Because many of our clients cannot get to the nearest hospital in any direction. And so that becomes a significant limiter. If they have private transportation, it's still a distance, but they can get there at least whenever they need to, I think. Sometimes people forget that there's issues with public transportation, right? One is time, the other one is cost, right? But we usually solve for cost, but you can't solve for time."

ACCESS TO PUBLIC TRANSPORTATION

Proximity to, and reliability and cost of, public transportation impacts accessibility to care across the region, with some counties such as Bucks and Chester experiencing significant challenges. Community-based organizations continue to identify solutions to reduce these barriers.

A participant from a community-based organization in Bucks County described collaborating with SEPTA:

"[SEPTA] can provide you up to 50 SEPTA key cards for free. So that's something we've been using for our clients because we had clients that really wanted to go to Northeast Philadelphia or Philadelphia for care and we'd be like, listen, we can only transport you through Bucks. So that has been really helpful when they can't use BCT or can't use us. We're now giving them SEPTA passes and they can get to and from whether it's for an infusion or whatever they have going on."

LONG ROUTES TO CARE

In some counties although the area lacks comprehensive public transportation, there are services available such as Chesco Connect, Coatesville LINK, and SCCOOT. However, these routes can be long and indirect, depending on where a patient needs to go.

Participants from the Chester County region shared:

"So TMACC, who is the organization that runs the SCCOOT bus and the Chesco Connect, they're working on a new route system. So, I can't speak for them, but there is a new route system where they're trying to combine their long route, which runs from Southern Chester County. It runs from Westchester through Oxford and then back again... for a patient to jump on in Westchester to get something out in Oxford, I think -- I don't remember what the ride time is... but it's a very long route."

PROXIMITY TO PROVIDERS

Community members prefer local, neighborhood primary care options, particularly for those who use public transportation or who have limited physical mobility. In addition to variations in accessibility across the region, proximity to primary care providers varies within the same county, such as Philadelphia, with providers concentrated in specific neighborhoods as op-posed to being dispersed throughout the county.

A participant from Philadelphia described this here:

"There are so many health resources in Center City and places like that but just having things that are more on a neighborhood level is very important and especially people who rely on transportation or can't walk very far to get to where they need to go."

BARRIERS FOR PEOPLE WITH DISABILITIES

In addition to the accessibility of an office's location, the accessibility of an office itself such as the width of hallways and doors or the limitations of medical equipment present significant barriers. This issue is particularly pronounced for people with disabilities and those who are caregivers to people with disabilities.

A participant from Delaware County shared:

"I can tell you that from what I know, my wife uses a wheelchair, and it was incredibly difficult. And we have to use pretty much hospital-based or hospital-affiliated practices because a lot of the smaller practice physicians, they're in small offices."

Additional mentions of specific subpopulations struggling with accessibility are highlighted later in this section of the report.

Fear

In addition to logistical and accessibility barriers, participants across discussions expressed fear as a common deterrent to seeking primary care services. Issues related to fear ranged from not wanting to know "what's wrong", fear of how much care/services will cost, to fear of not having insurance or documentation. Fear may be more prevalent in minoritized communities.

FEAR OF DIAGNOSIS

The fear of not wanting to know what's wrong, and hoping "it goes away," frequently results in significant health situations.

A particularly profound example of the extent to which "fear" impacts care was described by a participant from Delaware County:

"And you know we had a situation where a woman had skin cancer on her leg, and she just ignored it until one day at our after-school program, her leg started to bleed, and she couldn't get it to stop. And you know that she had, she had, like the front of her shin removed...And it was all fear. She knew something was terribly wrong, and when she first knew something was terribly wrong, or something was wrong, you know. That situation would, you know, could have changed, could have been much more minor than go out on disability, you know? Because you couldn't walk, and you had, you know, air oxygen being pumped onto the front of your leg. You know those kinds of situations, and that was the extreme situation. But that is happening in my office, and I think is very prevalent in the African American community."

COSTS

Uncertainty about costs is a common reason to delay care, often resulting in overutilization of emergency departments, or advanced health situations. Subsequent costs may be even more than necessary if care had been sought earlier, when issues arise. The need for clarity and education around costs, insurance coverage, financial support are necessary to reduce delays in care.

A participant from Delaware County described this experience:

"What folks tell me is they're worried about that back-end bill. But then they wait and wait and wait. Like a person who just admitted herself to the emergency room, turns out she just has very, very severe acid reflux. Well, now she has an almost $20,000 bill because she went to the hospital and they did a workup, whereas she could have been seen by a primary care doctor, and I think that that would have alleviated that. But some clarity in what the charges are...I think, would be huge."

Care Coordination

Challenges with care coordination were another common barrier among the discussion participants. This was frequently mentioned in relation to community events, health fairs, and pop-up screenings – specifically confusion regarding what someone should do after a screening or test, where do they go next, and whether that's primary care or a specialist.

LACK OF COORDINATION

Although there is great benefit to community health outreach, without proper care coordination, community members are left without knowing what to do next or may not receive the proper follow up care in a timely manner.

A participant from Philadelphia shared:

"We also are seeing it a lot with specialty care where people go to the like neighborhood health fairs and health screenings and find out that they need a colonoscopy, or, you know, they [have] high blood pressure. So, they really need to go in and see their PCP. And maybe get referred to a cardiologist and all of that. They get these tests, and the health systems go to them and say you need to come see us, and then they say "We're actually not scheduling, because that's a year out.'"

INSURANCE BARRIERS

When community members seek out primary care, they may be using inaccurate or outdated lists of providers who accept their insurance even within the same system or office. Often these are the lists shared through insurance portals, which can cause confusion and delays in care.

A discussion participant from Philadelphia, who also works at an FQHC, shared how this impacts both health centers and patients:

"We're finding out that insurances also sometimes cause barriers because they will list certain primary care doctors. And then if someone tries to come to us for primary care, we're like, 'Well, we're not your primary care doctor.' And they're like, 'Why? I've been going to you for so many years.' It's like, well, they listed someone else, and now there's this whole snafu we have to go through with insurance."

Special Populations: People with Disabilities

LACK OF ACCESSIBLE EQUIPMENT

In addition to barriers related to physically accessing primary care spaces (such as halls and doorways wide enough for wheelchairs), participants shared that at smaller, more local practices, the medical equipment cannot accommodate people with disabilities. This can lead to increased utilization of hospitals or specialty care because those facilities may have more accessible equipment. One participant mentioned that finding accessible dental care is particularly challenging.

Describing this experience, a Delaware County participant shared:

"And the other thing is very difficult to find, because I accompany my wife when she goes for primary care, because a lot of times, even if you can get in and they have wide enough hallways, they do not have medical tables or chairs that somebody using a mobility device can get into... So it leads to a lot more of hospital visits than if there were appropriate facilities to get her into — X-ray machines, MRIs, stuff like that. We wouldn't have to go to the hospital but in a lot of cases, the hospital's the only accessible place."

KNOWLEDGE OF RESOURCES

Compounding the physical barriers faced by people with disabilities are issues related to cultural competency and the need for more providers and care teams to "understand the principles of disability and the independent living philosophy" which are critical to providing compassionate and quality care to this community. Additionally, there needs to be greater education and awareness amongst providers about the resources available to people with disabilities, and the role providers play in securing those resources – such as Medicaid waivers.

A representative from Philadelphia County highlighted:

"We think that community first should be always the option, keeping people in their home, instead of in an institution. I also think there's opportunities to educate the health care systems, including the PCPs on, in particular folks that are enrolled in Medicaid waivers, on what services are available. As an example, I know home modifications were mentioned earlier through the city program, but the Medicaid waivers also cover some of those things. So, if a doctor deems somebody, [it's] a medical necessity for them to be able to continue to stay in their home and live independently, the waivers could cover the cost of a Stairglide or a vertical platform lift or extra lighting in the home. And there's an array of services that are available under these waivers, that the physicians just don't know about, and can help improve and reduce the risk that they're facing today in their own home."

Language and Health Literacy Access Issues

LANGUAGE BARRIERS

Many medical offices and clinics use translation services, such as LanguageLine, but this service is costly, is not always implemented with fidelity, and its usage may be accompanied by discrimination or frustration. These barriers can alienate patients who do not speak English.

A participant from Delaware County shared the following:

"But that said, I have advocated long for the ability to have LanguageLine available. LanguageLine is costly…but the ability to have it as a county-sponsored resource or something like that would go a long [way] — but partnered with that needs to be training on how to use it. So, a lot of places have LanguageLine, but the people are greeted with, 'Oh, you need that?'"

HIRING CHALLENGES

Certain clinics primarily hire bilingual staff in order to best serve their community – which can present challenges in hiring physicians and maintaining enough staff to serve growing needs. Participants also expressed that community members would be more likely to seek out services if they knew the staff was bilingual.

Discussing this dual barrier and opportunity, a participant from Chester County noted the experience at their organization:

"It's very difficult to find primary care providers who are able to work in our setting. It's a community health setting. So, if you're able to accept the position, and then, for us, we also have [to] hire bilingually. So, again, we're going back to that, not about us without us, right? So, hiring from within your community."

LOW LITERACY SUPPORT

Support is needed for individuals with lower literacy levels — in both verbal and written communication/education. The use of infographics was shared as a potential solution.

A participant from Chester County explains:

"It's a health literacy challenge, right? So, if I am not of a high education level, so if I have challenges with literacy, you have to say things very, very simply. You need to use infographics; you need to use 4th to 6th grade language. And it's very difficult for us to do that in the healthcare arena. It's really hard to take these really difficult concepts and make them something that you're not too high of an education level, but you are also not so simple that you're not getting the full concept."

Solutions to Address Primary Care Access Issues

Issues with primary care access are vast in the Southeastern Pennsylvania region, impacting every county and diverse community populations. To address these challenges, discussion participants offered targeted solutions and highlighted some successful approaches already implemented in their communities. Solutions reflect opportunities for partnership between hospitals and health systems, community organizations, health clinics, and government.

IMPROVE TRANSPORTATION OPTIONS:

Encourage partnerships with transit providers to subsidize costs, provider vouchers, include transportation as part of health navigation, or innovate new solutions such as healthcare system-specific shuttles or individual drivers employed by the systems. Additionally, identify if routes need improvement (specifically related to time and distance) and if routes adequately connect community members to health care locations.

- **"Again, pie in the sky, right? If we had all this money in the world, if somehow Chester County could create, and through TMACC or another organization, some type of healthcare shuttle service, 'Uber Health', that kind of a thing, but that the drivers are part of an organization or system, not just, 'I'm Kate. I drive for Uber. I'll go pick up.' Because patients don't always trust that kind of a resource. So, it has to be built in such a way that it's a trusted resource for the patients to utilize in order to access primary care and the hospital systems. If we were able to do that, that would be huge."**
- **"One solution would be to have stronger transportation and have more things covered by insurance or generally just having navigators who at a nonprofit level and all kinds of levels, but just help people to navigate accessibility through transportation to their health provider."**

FOSTER STRONGER RELATIONSHIPS BETWEEN HOSPITALS/ HEALTH SYSTEMS AND COMMUNITY CLINICS:

As noted above, increased usage of emergency departments and urgent care for issues better suited to be addressed by primary care is an ongoing challenge. To address this, participants recommended hospitals and health systems and community clinics and FQHCs work more closely to connect community members with local primary care providers. This could be particularly impactful for those with Medicaid insurance, who may have limited options based on their insurance status. Additionally, community members may be more comfortable seeking care with local, community-based providers – especially those who distrust large systems, speak a language other than English or who have limited transportation options. Shifting usage of emergency departments and urgent cares to primary care will also reduce the burden on emergency departments – both in terms of patient volume and patient needs.

- **"The community health centers could be an opportunity for health systems, to maybe lessen the burdens in their emergency room by making sure that they're partnering with primary care providers like a community health center. Community health centers, if you are an FQHC, which is a federally qualified health center, you're able to accept Medicaid, and there are other primary care providers who do not accept Medicaid. So, if you are a person who is in poverty or you have a chronic health condition and you rely on Medicaid for your insurance, then making sure that the health systems are partnering with providers, like community health centers that are able to accept Medicaid, is really important. It does help, not only the patient, but then helps the health system as well. And that does, I think, increase access at your emergency room because you're preventing and using primary care as a preventative service."**
- **"We see a lot of folks there that don't have, you know, regular PCPs, and that that is a potential target for contacting people who have left, you know, been discharged from the emergency department that we could do work to try to connect them to a primary care provider within the system."**

ENHANCE HEALTH NAVIGATORS & COMMUNITY HEALTH WORKER PROGRAMS:

Participants expressed the value of health navigators and community health workers as successful strategies to foster community engagement, encourage prevention, and support patients' complex needs. These roles should be well-positioned to coordinate screening follow-ups and connection with primary care providers.

- **"More investment in community health worker type programs, especially for at risk populations, to target opportunities to reduce that risk again. Like, the example about you go to a blood pressure monitoring [event] and there should be a follow-up, but the follow-up never occurs. Perfect opportunity where a navigator or community worker can fit in to make sure that there's follow through, and coordination."**

FOCUS ON EQUITY AND ACCESSIBILITY:

Participants offered examples of what's working well for their communities and clients around equity and accessibility – such as community-based clinics and diverse language services. When discussing solutions, participants shared the need to continue offering services and resources (or expanding existing services) in multiple languages, address building layouts and physical accessibility, invest in accessible equipment, train staff in practices and concepts such as trauma-informed care and cultural humility, and hire diverse staff to reflect the local communities.

- **"I think that what is working, in Southwest [Philadelphia] there's a large African, West African population, and there's an organization that has a health clinic and I think that you know that the West African population, you know, is way more comfortable going to that clinic. Even though it's a little rough around the edges, and it's not in a pristine building. And you know that kind of thing, I think that there's more of a trust because they're going to somebody like them than there is to go to a brand [new] facility that, you know, is all pristine, but has a mix or of ethnicities working there."**
- **"Every office has a bilingual staff member, and we have a very, very nice and expensive translation system. So, we have these monitors that will directly talk to them in pretty much any language you can possibly think of."**
- **"So I think with LanguageLine, we always want to pair the training about how and why it's important to use it. But if we are asking small organizations…small practices that are in existing office buildings to adapt, we need to be providing them some ability to do so. There needs to be funds to widen those hallways. I shouldn't be surprised, but I am. And LanguageLine should be available."**
- **"I think in terms of solutions, there are educational resources out there to equip health care professionals to understand the principles of disability and the independent living philosophy and what that means."**

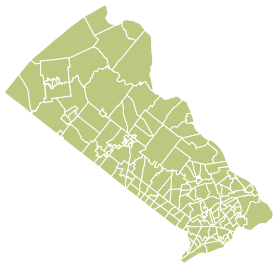
INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS IN THE REGION:

Participants recommended offering incentives or an alternate type of financial funding (either from healthcare systems or federal funding) to encourage medical students and residents to go into the field of primary care, in coordination with education around the benefits of the field itself. With providers retiring across the region, and fewer clinicians moving into primary care, without funding or incentives to close the gaps in providers, primary care access for community members will continue to suffer.

- **"It's hard to afford primary care providers. They're not specialty providers. Their income is maybe a little bit less than some of the specialty folks. So, education and encouraging education of primary care providers would be wonderful. Providing some kind of an incentive for someone to become a primary care provider would be amazing. I don't know that that's something that we would be able to get specifically from the health systems. However, there could be opportunities to encourage healthcare providers to become primary care providers, in some federal funding or partnership funding way of doing things so that we can have more providers from our community to provide care."**

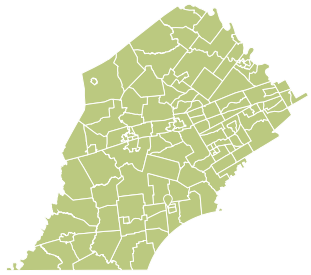
County-Specific Perspectives

BUCKS



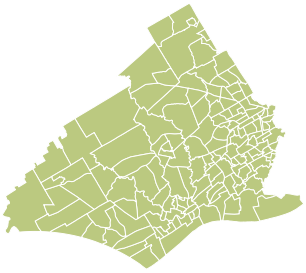
In Bucks County, transportation and logistics to primary care offices and hospitals remains a significant barrier to care – especially when community members seek care in Philadelphia. A partnership between community-based organizations and SEPTA to provide free key cards for clients has proven to be successful and should be expanded to additional organizations. Appointment wait times for new patients is an additional barrier to care. Participants felt that accessing primary care is easier for individuals with insurance, and that community-based organizations can connect patients with care at local hospitals and clinics such as Lower Bucks Community Health Center.

CHESTER



Chester County is geographically and demographically diverse, resulting in unique challenges for community members' ability to access primary care. Southern Chester County is home to a large immigrant population and migrant workforce, many of whom do not speak English, are undocumented, or who do not receive insurance through their employer – all of which may discourage community members from seeking care. Community health centers play a crucial role in filling these gaps by offering integrated services and multilingual services and accepting Medicaid. However, hiring providers, particularly bilingual ones, remains a challenge. The availability and accessibility of care is uneven across the county – with some areas in close proximity to medical offices and hospitals and others with little to no providers nearby, often mirroring seriocomic demographics. This has been exacerbated by hospital closures in recent years. Although public transportation is limited and underutilized, services are available, offering routes along main corridors and to and from health system offices and hospitals.

DELAWARE



In Delaware County, access to primary care remains a significant challenge despite insurance coverage, particularly for Medicaid recipients and immigrant populations who struggle to secure timely appointments at community clinics. Due to recent hospital closures in this area, limited healthcare options force many patients to seek care in Philadelphia. Dental care and accessible healthcare facilities present additional barriers, especially for individuals with disabilities, as small practices often lack the necessary equipment to accommodate their specific needs. While resources like Kids Smiles and hospital-affiliated practices help mitigate some gaps of these, improvements to accessibility should be universally addressed.

MONTGOMERY

Montgomery County's Office of Public Health's 2024 Community Health Needs Assessment featured key insights on community members' perceptions on access to care. Community survey summary results showcase disparities in healthcare access among different demographic groups. While most respondents (78.2%) reported having a personal healthcare provider, access varied widely across racial and ethnic backgrounds. Hispanic or Latino respondents were the least likely to have a personal provider, with only 45.8% reporting access, compared to 82.3% of non-Hispanic/Latino respondents. Additionally, healthcare accessibility was relatively high, with 88.6% of respondents stating that they were "always" or "mostly" able to receive medical care when needed. However, younger adults face greater challenges, with those aged 18 to 34 most likely to report difficulty accessing care. Barriers were also higher for refugee and asylum seekers, immigrants, people experiencing homelessness, and single parents.

PHILADELPHIA

Although Philadelphia is home to multiple major health systems and hospitals, community members still experience barriers to primary care – primarily long wait times, inconsistent care based on insurance status, and disparate access based on geographic location – resulting in systemic inefficiencies disproportionately affecting marginalized communities. Due to significant wait times for primary care appointments, more community members are seeking care from emergency departments and urgent cares. Federally Qualified Health Centers serve as crucial safety nets, but their capacity is often stretched thin, limiting timely access to care. Additionally, fear and mistrust of the healthcare system deter some from seeking necessary preventive care, sometimes leading to severe health complications. Community-based organizations, local clinics, and houses of faith are key connection points in Philadelphia – and are often perceived as welcoming and accessible for many community members.

SPOTLIGHT TOPIC

Community-Identified Solutions

Introduction

The following topics represent community-generated solutions shared during the 2022 rCHNA discussions. Recognizing the value of these insights, the Steering Committee sought to understand how these ideas are being implemented today. To do so, we spoke with a broad cross-section of individuals—including leaders from community-based organizations, civil servants, government officials, and other trusted community voices—who offered firsthand reflections on both progress and persistent gaps.

Shared Challenges Across Topics

Across all themes, stakeholders described enduring systemic barriers that prevent meaningful change. These include fragmented systems of care, lack of transportation, language and cultural barriers, community mistrust, and burnout among both professionals and volunteers. Many noted that services exist but remain out of reach due to inaccessible formats, poor communication, and inadequate outreach. Community members frequently shared feelings of frustration from being excluded from decision-making or asked to participate without seeing meaningful follow-through. Even in well-resourced areas, inequities persist when trust is broken, systems don't communicate, or services fail to meet people where they are at.

What's Working Across Topics

Despite these barriers, there is momentum toward progress. What's working is rooted in relationships, trust, and creative local partnerships. From mobile clinics and warm handoffs to faith-based health events and peer-led care navigation, community-driven strategies show promise. Organizations that embed services in trusted places—like churches, libraries, and barbershops—and those that compensate and support local leaders are achieving greater engagement and impact across the region. Transparent communication, culturally aligned outreach, and investments in lived-experience leadership have helped shift systems toward equity and inclusion, even amid resource constraints.

Invitation to Learn More

The following sections represent a deeper look into each topic area. Each section provides detailed insights into community-identified solutions, what's working locally, and actionable steps toward better health and social outcomes across Southeastern Pennsylvania.

Better Integration of Health and Social Services into the Community

Across Southeastern Pennsylvania, community stakeholders, including social service providers, healthcare professionals, and nonprofit leaders, are calling for stronger integration between health systems and community-based social supports. Interviews conducted in Bucks, Montgomery, Chester, Delaware, and Philadelphia Counties revealed common challenges in coordinating care for individuals whose health outcomes are deeply influenced by social factors like transportation, housing, food access, language, and trust.

Despite a shared commitment to improving community health, the region faces systemic barriers which prevent effective collaboration. Chief among these are information silos, fragmented referral systems, inconsistent infrastructure, and persistent inequities in access. These barriers disproportionately impact vulnerable populations, particularly immigrants, people with disabilities, older adults, and those living in underserved or rural areas.

At the same time, promising practices are emerging. Stakeholders highlighted successful food access initiatives, mobile health services, and warm handoff strategies as examples of what's working. These models demonstrate that integration is possible when health systems take a community-centered approach, communicate across sectors, and build long-term relationships with both patients and partners.

Looking ahead, community leaders envision a more connected landscape—one where referral systems are unified, transportation and technology are leveraged for equity, and healthcare institutions are fully engaged as partners in social well-being. While the region's challenges are significant, so too is the willingness among its professionals to collaborate, innovate, and advocate for change.

What follows is a closer look at how these dynamics play out in each county, identifying local challenges, existing strengths and potential solutions as described by those working on the front lines of health and social care.

Challenges and Barriers:

Participants across all counties highlighted persistent and systemic barriers preventing better integration between health and social services. These include fragmented systems, logistical hurdles like transportation, and deep-rooted cultural, structural, and communication issues.

INFORMATION SILOS AND GATEKEEPING

Professionals described an inability to access or share information across organizations, even when services exist. This siloing leads to duplication of efforts, confusion, and missed opportunities for patients.

One Bucks County participant states:

"Really the biggest thing is the information gatekeeping and just not knowing what everybody else does, not knowing what agencies are out there. So I would really love to see some collective resource that we could all communicate through even if it was like the old Yellow Pages - made life a lot easier."

TRANSPORTATION ACCESS

Lack of reliable transportation, especially in rural and suburban areas, was one of the most universally cited barriers to care access.

According to a Chester County participant:

"Transportation is a very big issue that most people from the rural areas find it difficult to transport themselves to location where there is a hospital is a very big challenge."

CULTURAL AND LANGUAGE BARRIERS

Participants explained that interpretation alone is not enough. Without cultural understanding, services can miss their mark entirely.

A Chester County resident explains:

"Not only is the need is for language barrier to be broken, but also cultural barrier. It is two different things to speak one's language, which is great, which is a need, but also understand why culturally this health behavior or this service is not reached out to."

DISCONNECTED REFERRAL AND DATA SYSTEMS

Multiple incompatible referral platforms force clients to repeat their stories and disrupt continuity of care.

Another Chester County participant said:

"Could we all agree to use the same thing? Because if different hospital systems are making referrals out of different systems, and if the county is working out of yet a third system, and then some of the agencies are working out of maybe a fourth system, we don't need people retelling their story over and over. We need people getting help."

BURNOUT AND WORKFORCE CAPACITY

While often implied, the strain on both healthcare and social service workers emerged as a subtle but critical barrier. Multiple participants mentioned overworked staff, high turnover, and limited time for collaboration—even when the will exists.

A community-based organization participant from Delaware County explains:

"I don't know a single person in our profession who truly has bad intentions, but they all have limited time."

MISMATCH BETWEEN SCREENING AND SERVICE AVAILABILITY

Several interviewees described a tension where health systems are now required to screen for social needs but lack meaningful referral options when people screen positive.

One participant from Philadelphia described it this way:

"We screen folks for housing or transportation insecurity… then we have no up-to-date referrals to help people."

THE NEED FOR BIDIRECTIONAL INTEGRATION

While much of the conversation focused on health systems referring into social services, some key informants raised the reverse challenge: CBOs also need more formal pathways to connect clients into healthcare systems.

A participan from Philadelphia shared:

"Typically, we refer patients in healthcare into social services, but we could be doing more to create a full loop."

IMPORTANCE OF TRUST AND CONTINUITY IN RELATIONSHIPS

Trust came up repeatedly, not only as a cultural concern but also in terms of how systems build or break community confidence. Several participants emphasized that short-term pilots or programs that disappear leave communities more skeptical and harder to re-engage.

According to a participant from Chester County:

"It's very hard when a company or agency comes out saying they're doing these wonderful things for the community to trust them... because it's been their experience that they're not going to be there that long."

What's Working Well

While challenges remain, participants pointed to several bright spots in integration efforts. Effective areas include food access programs, mobile and street medicine services, and personalized approaches to client handoffs and care coordination.

FOOD ACCESS AS AN EFFECTIVE ENTRY POINT

Food access, especially those tied to health systems, was widely viewed as successful and replicable models.

A member of a Philadelphia CBO said:

"Food and nutrition is actually one of the areas where health systems are doing a pretty good job. Not all of them, not all the time, but many health systems in the region have either developed their own food pantries or they have referrals to food pantries. They're connected to Philabundance and MANNA and other organizations, and I think food is an area where we're doing better."

MOBILE AND COMMUNITY-BASED SERVICES

Mobile units and outreach programs (e.g., mammograms, dental vans, street medicine) increase access by meeting people where they are.

One Montgomery County participant explains:

"Over in Pottstown, they do street medicine now. And a lot more mobile units like their community health and dental or the mobile mammogram and things like that where they're really getting the doctors out to either other sites in the community. And I think that that's been really successful in that area and I'm not sure if any of that occurs in this part of the county."

WARM HANDOFFS AND RELATIONAL REFERRALS

Building trust through person-centered care and warm handoffs was seen as more successful than transactional referrals.

According to a Chester County participant:

"It really doesn't make a difference. If you hand that person a number and the person still can't access the service. It's still a problem. So, it has to be more involvement in just making sure that that person actually was able to get into that service if in fact that's what's supposed to meet their needs,"

Suggested Actions and Solutions

Participants offered tangible strategies for improving system integration. Suggestions focused on improving communication infrastructure, embedding services in communities, utilizing technology for independence, and institutionalizing long-term support roles.

Multiple stakeholders advocated for routine cross-sector meetings and infrastructure for sharing updates and connecting services.

- **"There needs to be a group of people, whatever they're called, kind of a team that meets regularly. Some frequency about kind of, I guess representatives that know what's happening in the community can take it back and are just educated about, oh, you're doing a program on this. Okay. That's great. We're going to get the word out."** – Delaware County

Embedding hospital outreach within churches, senior centers, and trusted spaces can build visibility and credibility.

- **"Go to a church. After the church service, do an education. You got a captivated crowd. You got them right where you want them. Bring some food, call the day. I think things like that. More of that stuff needs to happen. We really wanna reach into the community."** – Chester County

In-home technology was seen as a cost-effective tool to prevent unnecessary institutionalization and support independent living.

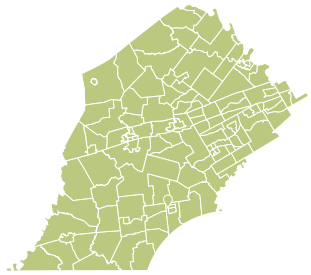
- **"We have about five people who are using in-home medication dispensers, and they would not be able to stay housed if they didn't have those in-home -- it's high-tech. When they're supposed to take medication, they press this button on this machine, the medication drops into a cup, and then they take it. If they don't press the button and they don't pick the medication off the tray, our nurses get a message on their phone and can call them and help them deal with it or go to the apartment."** – Philadelphia County

County-Specific Perspectives

BUCKS

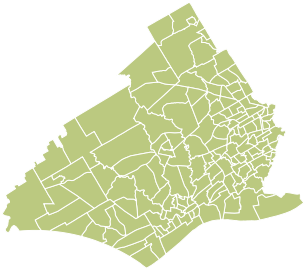
In Bucks County, one of the most pressing challenges is widespread information gatekeeping and lack of cross-agency awareness. Despite being a resource-rich area, participants noted that agencies often do not know what services others provide, leading to missed opportunities for collaboration and fragmented care. Newer staff entering the field expressed frustration at the inability to connect freely with other organizations—even within the same building—due to administrative restrictions and a lack of centralized communication tools. Another major issue is that clients are typically connected to only one agency, even when they have multiple, intersecting needs, which leads to frustration and disengagement. Additionally, clients are often not empowered to make independent decisions, especially when many providers are involved. Yet, there is strong enthusiasm among professionals in the county to bridge these gaps. Some described Bucks County as offering "more services than anywhere" they had worked before, suggesting that the infrastructure exists, but better communication and coordinated referral tools (such as a county-wide directory or Yellow Pages-style system) are essential. Participants also recommended county-wide training focused on fostering client independence and clarifying eligibility across programs as practical solutions to reduce client attrition.

CHESTER



Chester County's integration challenges are defined by geographic and jurisdictional fragmentation. Participants from Southern Chester County noted that while services may technically exist, transportation and awareness remain substantial barriers. Compounding this is the fact that many communities in Chester span multiple county lines, meaning access to services changes depending on where a resident lives, even for people with the same condition or need. A major systems-level challenge is the lack of unified referral infrastructure. Hospitals, counties, and nonprofit agencies all use different platforms, forcing clients to retell their stories repeatedly and often leading to service gaps. Language and cultural barriers were also highlighted, particularly among the county's growing Spanish-speaking population. Nevertheless, Chester County benefits from engaged coalitions like Communities That Care (CTCs) and a strong recognition among local providers of the importance of warm handoffs and trauma-informed communication. Solutions proposed included hospital participation in local coalition efforts, co-locating social service staff in hospital spaces, and institutionalizing long-term navigators to help patients stay connected to services. Participants also stressed the importance of consistent community presence, noting that short-term or underfunded programs erode trust over time.

DELAWARE



In Delaware County, the major barriers to integration stem from organizations being territorial, privatized health systems, and inconsistent access to programs based on residency. Interviewees expressed frustration with large hospital systems whose leadership operates outside the region, noting a disconnect between decision-makers and community needs. Additionally, community-based organizations (CBOs) and churches often limit their programming to internal groups, which restricts collaboration and creates inefficiencies. Some township-level programs are also only available to residents of specific municipalities, further fracturing access across the county. Despite these barriers, Delaware County has shown promise with its 211-call system and a strong network of grassroots organizations eager to collaborate. Participants emphasized that regional coordination teams, including representatives from medical, social service, and community sectors, could help break down silos. They also recommended greater hospital investment in local social infrastructure, funding for mental health services, and a place-based strategy that tailors solutions to the diverse sub-regions within the county (e.g., Wayne vs. Upper Darby). The need for hospital systems to see themselves as community health leaders, not just clinical care providers, was a key theme throughout.

MONTGOMERY

Montgomery County stakeholders identified transportation barriers and language access challenges as two of the most significant obstacles to better integration of health and social services. Although telehealth is available, many clients lack devices, internet access, or digital literacy, making remote care inaccessible. Similarly, language services are insufficient for the county's diverse population, with most bilingual capacity limited to Spanish. Interpreter services exist but are inconsistently applied, and some—like LanguageLine—fail to adequately capture patients' concerns. Still, the county has several promising practices in place. Some participants praised the usage of GLOBO, an interpretation service offering over 240 languages, including ASL and video. There was also enthusiasm around existing mobile health initiatives, such as street medicine and dental vans in Pottstown and Norristown, which were seen as successful models of community care. As a solution, participants recommended partnerships with transportation services like Uber Health, investment in volunteer-based ride coordination, and clearer post-discharge transportation planning at hospitals. To better serve multilingual and multicultural populations, stakeholders emphasized expanding interpreter access and improving cultural responsiveness across systems.

PHILADELPHIA

Philadelphia's integration challenges center on mistrust of healthcare institutions, fragmented systems, and institutional bias toward congregate care for people with disabilities. Many residents are hesitant to seek care in large health systems that feel overwhelming or unwelcoming. Community-based organizations reported that health and social services operate in parallel but disconnected silos, which is especially problematic for people with multiple, overlapping social needs. A recurring concern was the "nursing home default" for patients with disabilities—where hospital discharges lead straight to institutional care due to lack of community-based alternatives. Yet Philadelphia was also highlighted as a leader in food access programs, with health systems running food pantries, food-as-medicine programs, and partnerships with organizations like MANNA and Philadabundance. In-home technology, such as automated medication dispensers, was also noted as a promising innovation that enables people to live independently. Interviewees emphasized the need for holistic, long-term approaches to care that treat food, housing, and health as interconnected. They recommended expanding waiver-based home and community care programs, training hospital staff on disability cultural competence, and developing long-term referral systems with built-in feedback loops. Many felt that the success of food integration could serve as a model for other social determinants of health.

Increasing Community Members Capacity to Become Care Navigators

Across Southeastern Pennsylvania, community members and providers articulated a deep commitment to expanding the capacity of individuals—especially those with lived experience—to serve as care navigators.

These individuals often serve as trusted guides through complex systems of health and social care, but their ability to do so effectively is shaped by entrenched challenges, current successes, and creative grassroots solutions.

Challenges and Barriers:

Participants across all counties highlighted persistent and systemic barriers preventing better integration between health and social services. These include fragmented systems, logistical hurdles like transportation, and deep-rooted cultural, structural, and communication issues.

FRAGMENTED SYSTEMS & ACCESS BARRIERS

Participants highlighted the systemic fragmentation in health and social services, where siloed funding streams (e.g., substance use vs. mental health) hinder coordinated care.

A Bucks County participant said:

"We should be able to refer a client in all those directions in one shot and you get to pick one and hope that you get funding for it."

A Montgomery County participant further explained this challenge:

"I'm thinking about community connections through the county and that they are, I guess intended to be that central hub for resources. But again, I feel like, I don't know if everybody knows about them and then I think one of the challenges is how things are just constantly changing. So, keeping up with the change and what services are available, that's just hard. You could make a resource guide and six months from now it's not going to be current. So, I think that's a challenge of that, but maybe more types of —or a really known community connection. This is here for everybody to use."

LANGUAGE & CULTURAL BARRIERS

Language emerged as a recurring theme across counties, with service navigation often falling to children or overburdened staff.

A Bucks County participant shared their experience:

"I think of like capacity and navigators is our family standard coordinators speak all different languages. I don't know, if your guys – healthcare, if they provide many different languages, we have a bunch of Middle Eastern languages like Arabic, Hindi, Russian, Ukraine, Spanish. So not only are coordinators focusing on funded programs through our agency. People come to them asking what does this mean? What's that? It's like they have to spend so much time explaining in different languages and we're not funded for a lot of that time. So, they have to squeeze where they can to help people, but I know that language is -- as much as transportation language is definitely up there with barriers for our staff to advocate for them or steer them in the right direction."

LACK OF AWARENESS AND OUTREACH

Despite longstanding programs, many residents and even providers remain unaware of available services.

A Philadelphia participant shared:

"So, in starting work in the Northeast, one of the first things I did was to get a grasp of the area, even though I live up there as well, was going to civic meetings, trying to — hey, we might start doing work up here. What's going on? Getting feedback from community members, different civic groups. And one thing I noticed is that most people like some of us in the field, we don't communicate outside of what we're doing. So, the community members that are there want to help, they're at a civic meeting. They obviously have some inclination to do something for their community, but they don't have the resources."

One Montgomery County participant summed up their experience with a longstanding community organization:

"We celebrated our 125th year. I can't tell you how many times we were like … 'Never heard of them'. For real."

VOLUNTEER BURNOUT AND AGING WORKFORCE

Participants described burnout among care navigators and an over-reliance on a small group of aging volunteers.

A participant from Philadelphia shared:

"And I think the biggest thing with the burnout - just in some of community organizations that I have volunteered in and been a part, we ask the same people, we don't go outside of our usual. And there's so many other individuals out in the community that may be open to supporting and volunteering, but they just don't know, and no one's asking."

One Chester County participant further highlighted the challenges with volunteer burnout and engagement:

"It's really challenging to get someone that's going to commit to that on a weekly basis, on a long-term sustainable basis. I think a lot of times we see, like, volunteer pushes and volunteer initiatives that last, you know, months, and then it sort of phases out and fizzles out."

DIGITAL LITERACY & TECHNOLOGY ACCESS

Many participants, especially those working with older adults, flagged digital navigation as a growing barrier. As healthcare systems increasingly rely on patient portals and online systems (e.g., MyChart), some community members struggle to access or understand digital tools essential for care.

A participant from Chester County expressed:

"There needs to be some training…how to navigate on your computer is all the MyCharts and MySpaces that the hospitals have. Everyone can't navigate those things."

To mitigate this barrier, a participant from Philadelphia offered this solution:

"That sort of preparedness is something we can focus on…we can make trainings virtual and on-demand and asynchronous, so we can reach more people."

CRISIS-LEVEL ENTRANCES TO CARE

Participants shared that people often access care only when in crisis, and frontline staff or community members are left trying to interpret needs that are not clearly articulated. This leads to miscommunication, inadequate care, or even criminalization.

A Delaware County participant shared:

"Because this is an issue, it can cause the consumer…to act a certain way, which then triggers them to possibly have somebody called on them…they want services… but there's not someone there on-site that knows a little bit of what's happening."

What's Working Well

What's working to support community members as care navigators' centers on trust, relationships, and culturally rooted approaches. Faith-based organizations, libraries, and grassroots spaces are stepping in as reliable access points where people feel safe seeking help. Community-led efforts—like informal mental health support, Narcan training at civic meetings, or barbers trained to identify and refer clients for care—demonstrate that navigation doesn't have to be clinical to be effective. These approaches are grounded in everyday environments and speak to the lived realities of the communities they serve.

Collaboration is also a key success factor. Interagency gatherings like Kensington's "huddles" create space for problem-solving and sharing resources across sectors. In parallel, organizations that uplift peer leaders with lived experience—like community health workers or caregivers—build deeper trust and reach. Simple efforts like tabling at local events or resource fairs also go a long way in boosting visibility and awareness. Together, these practices highlight that when communities are engaged authentically and given the right tools, they can lead the way in navigating care systems that often feel overwhelming or inaccessible.

TRUSTED COMMUNITY ANCHORS

Faith-based organizations, libraries, and grassroots groups have built strong trust within their communities.

A participant from Chester County said:

"When we needed, at the library, a new lactation room, a Facebook group of moms volunteered to furnish a whole room, plus one year of free diapers and wipes to other moms at the local library, just because I presented this under a community effort that had a name, a space, trust built."

INFORMAL MODELS OF SUPPORT

Programs such as the "Friendship Bench" and Narcan trainings at civic meetings showed the value of low-barrier, community-grounded interventions.

A participant from Chester County expressed:

"It was called Friendship Bench. And it started, I believe, in Africa, and is just coming into the United States. But they had community grandmothers sitting on a bench where people could come and they train these grandmothers in mental health services and things like that. And people could come and sit with the grandmother, and tell them their problems, tell them their issues, have a sort of therapy in this safe space with this grandmother."

A participant from Philadelphia County said:

"So, what ended up happening, inadvertently, is that I was going there to fish for information for a program that we're doing, but what ended up happening is I ended up doing impromptu Narcan trainings and filling in people on different social services in different areas depending on where they live at."

INTERAGENCY COLLABORATION AND LEARNING HUBS

Interagency collaboration and community-based learning hubs emerged as powerful mechanisms for strengthening care navigation, particularly in communities where needs are complex, and traditional systems often fall short. In both formal and informal spaces, participants described how bringing multiple organizations together fosters real-time problem-solving, relationship-building, and shared accountability.

Together, these examples illustrate how collaborative ecosystems, whether in clinical settings or barbershops, build stronger, more responsive networks for care navigation by valuing shared learning, trust, and community-rooted knowledge.

A participant from Philadelphia County said:

"It's just a bunch of people that meet up, and anything happens down there because in that area, you just got to figure it out. So, you're going to come across some of the craziest cases and some of the craziest things to try to figure out. And if you're willing to do the job, you can get into some crazy stuff that you're figuring out, which you bring it there, and you put it on the table like, 'Hey, I don't know what to do. I got this crazy case that's just a mess.' And there's always people there willing to at least brainstorm with you."

A participant from Chester County said:

"We partnered with community care, behavioral health, and provided our hair training where we trained barbers and hairstylists in Black communities to understand mental health diagnosis and referrals for mental health treatment… it was a great process, a great experience for the barbers and stylists."

PEER-LED AND LIVED-EXPERIENCE APPROACHES

The importance of navigators with lived experience—not formal education—was raised repeatedly, especially in communities where trust in formal systems is low. Community Health Workers (CHWs) with shared backgrounds can connect more effectively.

A member from Philadelphia County said:

"There are many, many robust, well-run CHW programs…We can have CHWs train other healthcare workers…I think it's actually been a very straightforward, successful system for places that have invested in it."

LEVERAGING RESOURCE TABLES AND PUBLIC EVENTS

Resource tabling at community events emerged as a valuable, simple mechanism to increase visibility and awareness of services. These efforts help address the challenge of outreach without requiring deep infrastructure.

A paricipant from Montgomery County said:

"We do resource tabling and people come up like, 'Oh wow, I never knew this.' How long have you been around?' '50 years.'"

Suggested Actions and Solutions

Across counties, participants emphasized that increasing community capacity for care navigation requires **intentional investment, inclusive recruitment, and structural support**. Solutions center on **training and compensating individuals with lived experience**, ensuring that those most connected to the community are also empowered to lead. Organizations are working to **standardize care navigation protocols** across sites to ensure consistency, while also developing **virtual and on-demand training** to make learning more accessible.

To prevent volunteer burnout and ensure sustainability, participants advocated for **expanding the volunteer pool**—especially by **engaging youth and young adults** through schools, service requirements, and internships. There is also strong support for **intergenerational mentorship**, pairing experienced older adults with younger volunteers to build mutual learning and long-term capacity. Finally, many called for **compensating volunteers through stipends, gift cards, or workforce development opportunities**, recognizing that the economic realities of many potential navigators must be addressed to make service accessible for all.

There is a strong consensus that organizations must provide funding, training, and recognition for navigators.	• **"There are many, many robust, well run CHW programs within health systems. And really, all it takes is the, you know, desire to fund the position and provide the training, and that training can really come now from the distributed network of CHWs that already exist within the city. So we can have CHWs train. Other healthcare workers, you know, provide their perspectives and things like that. But I think it's actually been a very straightforward, successful system for places that have invested in it."** • **"There is a woman in the Coatesville community that does a caregiver…she used to care for her husband with Parkinson, and so she does a survey just about like what their experiences with caregiving, and she didn't even know that she could have been reimbursed for the caregiving that she was providing…There is an opportunity for that sort of transition."**
Several participants emphasized the need to intentionally include high school and college students, tapping their lived experiences and leadership potential	• **"Have we gone in and had conversations in the high schools and talked about some of the great work that's being done in their very own community and backyard and the gaps of that volunteer need with all of this work that's being done. and we may be surprised how many? We may say yes."** • **"So, learning those pieces of because if they're not asked and they're not put in situations where they have the opportunity they may not know where to go to look to ask, or they just, you know, they're in their own world."**
Bridging youth with older adults who have decades of experience can both preserve knowledge and create continuity.	• **"The older generation has a wealth of knowledge. We need to partner the older ones with the younger ones. The younger ones are now willing and able because they're going to get credit for it. The older ones usually love to spread information, love to share knowledge."** • **"I was just thinking this morning about going to vote, and it was like everyone who was working the polls was an older Black woman from my neighborhood. There was no like that was the only demographic, you know, there were like 10 women there doing it."**

Several interviewees spoke explicitly about economic hardship is a major deterrent to volunteering. Stipends, flexible schedules, and structured programs can mitigate this and increase equity in participation.

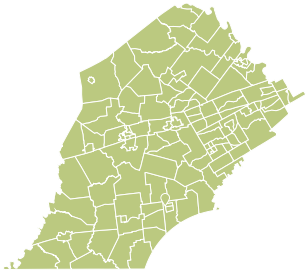
- **"There's like an economic barrier that we don't always think about — that like volunteering does tend to fall to older people because they're no longer, you know, working full time, or they're not trying to do like three gig economy jobs, you know, in between doing whatever else. So, I think any financial support we can give to people, the more the better. And I think that's probably like one of the major ways of doing it. So, in projects that we're working on where we're trying to engage younger people to be a part of it, we're trying to pay like monthly stipends for the hours that they volunteer for us to cover things like what it takes to volunteer."**

County-Specific Perspectives

BUCKS

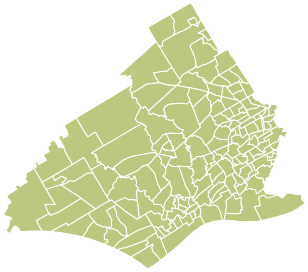
Bucks County faces pronounced challenges related to siloed services, especially for individuals with co-occurring mental health and substance use issues. Providers feel powerless when funding streams dictate care options, regardless of client need. Despite resource availability, navigation remains difficult without centralized, updated directories. Nonetheless, staff are deeply dedicated and eager to refer clients, if only the tools existed.

CHESTER



Chester County has demonstrated innovation through local adaptation of global models like the Friendship Bench and grassroots mobilization at libraries. Participants emphasized the importance of placing care navigation in comforting, familiar community settings. There is a strong local willingness to volunteer when efforts are framed as collaborative, named, and intentional.

DELAWARE



Despite abundant services, accessibility remains a major barrier in Delaware County, complicated by staffing shortages and lack of responsiveness from agencies. Language and cultural mistrust—especially among Latino and Asian communities—compound the problem. However, existing interpreter services and a commitment to outreach offer a foundation to build on.

MONTGOMERY

Montgomery County benefits from longstanding institutions and community clinics, including faith-based vaccine distribution and nutrition services. However, many residents remain unaware of available resources due to limited marketing and constant service changes. The "Community Connections" hub has potential but needs greater visibility and integration.

PHILADELPHIA

Philadelphia stands out for its informal, embedded outreach strategies. Civic meetings, Narcan trainings, and Kensington's "huddles" serve as organic sites of engagement and information sharing. Participants emphasized the need for systems to better support community volunteers, financially and structurally, to avoid burnout and improve continuity.

Integrating Preventative Treatment, Care, and Education in the Community

Across Southeastern Pennsylvania, community stakeholders emphasized the urgency of shifting from reactive to proactive approaches to health.

The conversations revealed persistent challenges in reaching marginalized populations with preventative care, while also highlighting community-driven innovations and solutions. Participants underscored that trust, access, and culturally appropriate outreach are pivotal in successfully delivering health education and preventative services.

Challenges and Barriers:

Community leaders described persistent structural, cultural, and logistical barriers to accessing preventative care. These included transportation, cultural stigma, lack of language-appropriate resources, health system complexity, and socioeconomic conditions.

TRANSPORTATION AND ACCESS ISSUES

Transportation barriers were one of the most commonly cited logistical challenges across multiple counties. Stakeholders noted that even when preventative services exist, unreliable or unavailable transportation renders them inaccessible. These issues not only deter initial appointments but also negatively impact future health-seeking behavior.

Two Philadelphia participants explained:

"If people can't get to where they need to go to get the preventative care or to access something, then [it] doesn't matter that it exists because they can't get there. Or if they can get there, say there is a program that schedules rides for them, maybe a paratransit type program or motive care or something, but those rides are consistently late or no shows or just unreliable, then that's pointless too."

"Transportation not only to get to your preventative care, but then transportation access, the healthiest food that you need to then prevent chronic disease and illnesses. That is a huge barrier."

CULTURAL BARRIERS AND STIGMA

Providers discussed how cultural trauma, and norms prevent many immigrant women from seeking mental health care. Shame, secrecy, and fear of judgment or exposure in their own communities are significant deterrents. These issues often remain invisible to mainstream providers who may lack nuanced cultural understanding.

A Bucks County participant told us:

"They've been raped and it's not something you talk about, you don't get help with. They don't want to be labeled as a victim with needing mental health help… being able to talk about — through counseling, what they went through because they don't want their — maybe their husbands don't know what happened or their friends, they just don't want people to know… it is definitely a barrier for clients to even consider going for help."

A Montgomery County participant shared:

"Nobody thinks they have any problems and they hesitant going to doctor and talk about their problems. They just want to hide all this thing till it really explodes."

SOCIOECONOMIC STRESS AND CRISIS LIVING

A theme across counties, particularly Bucks, was that generational poverty leaves people in constant crisis mode. Preventative care falls by the wayside because people lack the bandwidth to prioritize anything beyond immediate survival needs like food and shelter.

Another Bucks County participant said:

"What happens is when real crisis strikes… that's when we see folks come through and say, hey, what's available?… So, I think that a lot of the barriers that exist in preventative care is we're not getting in front of the folks because we don't know where they are until they're in crisis."

LACK OF HEALTH LITERACY

Despite available services, participants shared that many residents—especially in Chester—lack foundational understanding about why preventative care matters. This "education gap" prevents community members from engaging in health services until a crisis occurs.

A Chester County participant explained:

"To this day, 2024, regardless if the resources out there, if it's accessible, the concept still today is not there. Why would I want to do a preventative effort? And I think that is a huge, huge gap to fill simply by health literacy and health education of the why."

LANGUAGE ACCESSIBILITY

Language access was flagged as a key barrier. Resources, even when available, are often only in English, which makes independent learning or navigation of services nearly impossible for clients with limited proficiency.

A Philadelphia participant said:

"We don't have, not much to give them, flyer or brochure. We just like, search our own, you know, like, online… No. It's a lot of English."

A Delaware County participant said:

"Not everyone is computer literate, knows how to fill it out. It may not be offered in other languages, and the language is not probably usually reader friendly."

COMMUNITY MISTRUST AND HISTORICAL DISCONNECTION

Across counties, there's a thread of longstanding mistrust in institutions—particularly healthcare systems—rooted in cultural disconnection, lack of representation, or perceived elitism. While this overlaps with "challenges," it deserves its own framing because it is more than a logistical or awareness gap—it's a relational and historical one.

A Chester County participant explained:

"I think you still have to have people who look like me in order for me to want to hear what they have to say."

MENTAL HEALTH AS BOTH A BARRIER AND AN UNMET NEED

Mental health came up repeatedly—not just as a standalone need, but as a barrier to engaging in any kind of preventative care. This includes stigma, depression-related inaction, and post-pandemic trauma, especially among youth.

Two Montgomery County participants shared:

"Mental health... post-pandemic, the teenagers, oh Lord. Everything they've had to go through... prevention for mental health would be really important."

"There's not enough providers, and the providers that are there, the waitlists are crazy."

INFORMATION OVERLOAD OR FRAGMENTATION

Several stakeholders—particularly in Delaware and Philadelphia—spoke about the difficulty of navigating too many disconnected systems, where information is either overwhelming, inaccessible, or not presented in ways that encourage uptake.

"I'm inundated with information... And since that takes up 90% of my energy, I don't have an opportunity many times to see what's going on in other communities and see what other people are doing throughout Delaware County."

What's Working Well

Innovative programs and local partnerships were highlighted, especially when rooted in trusted community institutions or tailored to specific populations. Examples include mobile health clinics, faith-based outreach, and home visits from insurers.

COMMUNITY-BASED EDUCATION AND MOBILE CARE

Mobile health clinics and pop-up services were praised as accessible, effective methods of reaching underserved populations. By removing the burden of travel and integrating care into community spaces, these models filled a crucial service gap.

A Montgomery County participant told us:

"What I've seen in Pottstown with the mobile clinic... that seems to be really hitting a population that was not getting any treatment before. It's not preventative, but it's treatment that is working there."

IN-HOME CHECKUPS BY INSURERS

Health insurers were commended for offering in-home health assessments. These check-ins not only improve convenience but also serve as reminders and motivators for patients to complete outstanding screenings and care.

Another Montgomery County participant told us:

"Once a year, [health insurance company] sends a nurse at home. Even though I have my physical once a year, they still want to come. 'Til you let them come, they keep on calling you... So the nurse comes and she takes your blood pressure and what not and asks questions about you had your mammogram and colonoscopy and all that... That reminds you that this one you haven't done it, so you have to get it done."

RESOURCE SHARING AMONG TRUSTED ORGANIZATIONS

Trust in organizations like SEAMAAC was high among community members. When healthcare systems partner with known and respected community organizations, especially those embedded in ethnic or immigrant communities, people are more likely to engage.

A Philadelphia participant told us:

"I think like, if you give to SEAMAAC, I think SEAMAAC will be a good to share information to client community. Because mostly all the community, when they need help, they come to see me."

FAITH-BASED HEALTH EVENTS

Faith institutions were seen as a powerful, though underutilized, vehicle for health outreach. By hosting wellness events and clinics, they bring health information into familiar and trusted spaces. Still, participation remains an issue.

A Montgomery County participant explained:

"This temple, they take care of not only religious, but they have a lot of health clinics. They have yoga clinics, they have a dentist coming and diabetic specialist comes and give lectures and all. But the participation is again a problem."

Suggested Actions and Solutions

Participants proposed clear strategies to strengthen community health education and prevention, such as improving outreach through schools, tailoring messaging through community champions, and integrating culturally relevant communication in familiar settings.

Plain language and representation matter. Participants suggested using relatable, culturally aligned messaging delivered by trusted messengers—not necessarily health professionals—to improve community engagement in prevention education.

- **"I look at those lists all the time, and I think they could be nice, but they don't look like they would be the language or whatever that I want to hear. Right? And then I have to go back to you still have to have people who look like me in order for me to want to hear what they have to say."**

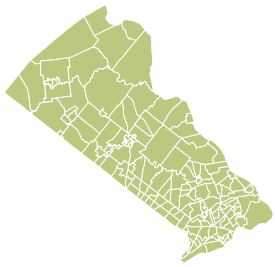
Participants emphasized early intervention through schools and pediatricians as essential to long-term prevention efforts. Children's health habits start early, and so must educational messaging.

- **"How can we better educate our children on eating healthy foods versus eating Takis and Doritos all the time… So how can we do that with the schools, with the hospitals, with the PCPs?"**

Rebranding health education as social, fun, and interactive can help reduce stigma and draw broader audiences. Events like cooking demos or "family fun nights" were named as ways to slip prevention into appealing formats.	• **"So they're not admitting maybe that things could be done differently, because it's not even wrong. It's just that you could do it better. Like nutrition, to have cooking classes, not necessarily a lecture on diabetes, but to be like, let's make these fun snacks and to get people in that way."** • **"There are 70 kids that come to a library story time three times a week. So, think outside the box, go to public spaces like a public library, do health literacy in public libraries."**
A recurring request was for a centralized, user-friendly tool that filters resources based on need and eligibility. A digital or county-specific "one-stop shop" could significantly reduce access barriers and information gaps.	• **"I am by no means IT inclined, but one of my bigger goals is to have a resource... where you can go in and enter certain criteria like... age address, and maybe insurance and that's it, and it populates the list of resources based on that criteria... there's not really like we've talked about a couple of times like a one-stop shop where we can search for things specific."**
Advocacy is needed to shift funding, eligibility, and systemic rules—especially around housing, language access, and documentation. Some interviewees, especially in Philadelphia, touched on policy-level solutions (e.g., adjusting area median income (AMI" guidelines for housing aid) and the importance of systemic change to meet prevention goals—not just programs or messaging.	• **"There's actually legislation that — I'm in a coalition called the Philadelphia Coalition for Affordable Communities, and we're trying to get legislations passed to have the city council allocate 50% of all housing funds that come in, whether it be state, local, or federal, to people who make $32,000 or less, a family of four to the appropriate AMI associated with Philadelphia."**

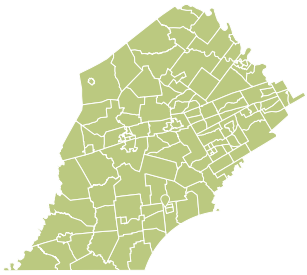
County-Specific Perspectives

BUCKS



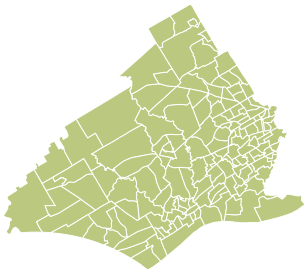
Bucks County is grappling with major cultural and awareness gaps in reaching non-traditional settings for prevention education, such as daycares. Barriers like stigma, generational poverty, and cultural trauma inhibit access to mental health and substance use support. However, success in engaging unlikely partners (e.g., daycare centers) and suggestions for a centralized, digital resource hub point to creative, community-rooted solutions.

CHESTER



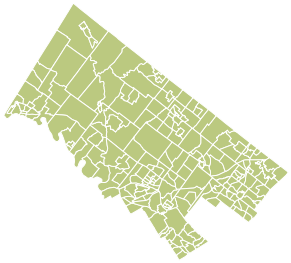
In Chester County, a persistent lack of health literacy underpins many prevention gaps. Community leaders emphasized the need for plain-language messaging, culturally aligned education, and child-focused wellness. Trust and relatability—especially from people who "look like me" and settings outside the clinical space—are vital. Participants called for stronger partnerships between health systems and grassroots organizations to shift public perception of prevention.

DELAWARE



Delaware County stakeholders identified systemic reactivity as a root issue—services only activate once a person is in crisis. Key barriers include language, literacy, and lack of culturally competent outreach. Although there's general awareness of available resources, they're inconsistently used. Solutions focus on proactive outreach, community forums, and multilingual communication to make people feel seen and heard.

MONTGOMERY



Montgomery County highlighted challenges in parental engagement, mental health waitlists, and the undervaluing of adult preventative care. Still, residents recognize the value of mobile care, insurer-initiated check-ins, and informal wellness events through faith institutions. Suggestions included making prevention fun and accessible—such as incorporating education into family-friendly events and hands-on activities.

PHILADELPHIA

Philadelphia's challenges are deeply structural—transportation, housing instability, and the mismatch between available resources and those most in need. Community voices underscored the importance of location-based and trusted messengers, such as CDCs and SEAMAAC. Solutions include partnering with community development entities, tailoring funding models to match actual neighborhood AMIs, and sustaining lessons learned from COVID-era outreach.

Involving Community in Solutions and Implementation

Across Southeastern Pennsylvania, community leaders and health stakeholders emphasized the importance of meaningfully involving residents in designing and implementing health solutions. While there is widespread recognition of the value of lived experience and community voice, many structural barriers—such as staffing shortages, inaccessible formats, and lack of feedback loops—limit meaningful engagement.

At the same time, there are powerful examples of grassroots initiatives, community-driven events, and collaborative task forces that demonstrate what works when institutions partner with residents authentically. Participants offered concrete ideas to advance equity, inclusion, and sustainability through more intentional power-sharing, clear communication, and strategic collaboration.

Challenges and Barriers:

Participants identified a wide range of challenges that undermine authentic community involvement in health solution development. These include systemic issues like transportation and staffing shortages, as well as less visible barriers such as community burnout, fear of not being heard, and inaccessible or overly academic messaging. Power imbalances—where decisions are made without true representation—further weaken trust. Even when community input is gathered, it often goes unacknowledged, leaving residents feeling unheard and excluded. These barriers combine to create a landscape where participation is limited not by disinterest, but by fatigue, frustration, and lack of structural support.

LACK OF TRANSPORTATION AND ACCESSIBILITY

Many communities, particularly older adults, people with disabilities, and those in rural or underserved urban neighborhoods—struggle to access services or participate in forums due to inadequate transportation.

Although Philadelphia has a relatively robust public transit system, gaps in access and connection exit.

A Bucks County participant shared:

"It is hard to eradicate social isolation if you can't get anywhere because there is no public transportation or the transportation that we do have is very limited or very rigid in the timing."

One Philadelphia County participant highlighted:

"Transportation is a problem. And it's not always easy as you would think to get the managed care entity or the hospital to coordinate transportation to and from appointments."

UNDERSTAFFING AND WORKFORCE BARRIERS

Social service organizations are severely understaffed, creating burnout and limiting capacity to innovate or collaborate meaningfully.

A Bucks County participant shared:

"Every social service division is short-staffed… When you're asking people to think beyond their agency, there's a barrier to that as well."

A Delaware County participant echoed this sentiment:

"We're just absolutely overwhelmed with just doing what we do. And trying to do that while doing the work becomes very, very, very challenging."

COMMUNITY BURNOUT AND LACK OF TRUST

Repeated community engagement efforts without follow-through have led to fatigue and skepticism about their potential for sustained impact.

A Chester County participant described this challenge:

"We especially heard at the most recent one in mid-October that the community is, like, happy to provide feedback on health services, and happy to be a part of and sitting at the table of the creation of some of those solutions. But that they do, especially in minority communities like Coatesville, feel really burnt out and sort of left out of the outcome of those conversations and the solutions."

A Philadelphia participant reiterated:

"A lot of people that I know, they say they usually don't come out to community involvements because of lack of knowledge and sometimes still confidence. A lot of them feel like we're going to put them down or we're just generally not going to listen to them."

OVER-SURVEYING WITHOUT FEEDBACK

Surveys are common, but rarely followed by communication or action, reducing credibility. Participants expressed the need to talk to people, not automated systems or surveys.

A Bucks County participant shared:

"So, I think it's not just doing the survey and asking the questions. It's what you do with the information you get and sometimes what you get, you think oh, dear Lord that's huge we can't possibly tackle that right now, or whatever. So, it can be a bit deflating, but it's what we do with that and how we partner and pull other people into the information we get."

A Delaware County participant saidt:

So, when people can see, the people say, 'Hey, I'm a person, and I have this cell phone number, and you can call me. And when you contact us, there will be no automatic service.' They're more inclined to say, yes, I need a person, not a computer, not a survey. I need to speak to a person."

LACK OF FOLLOW-UP AND ACCOUNTABILITY

There is a strong desire for institutions to close the loop when soliciting feedback. Community members expressed that input is often collected but not shared back, leaving people feeling used or ignored. Transparent communication about what is being done with feedback—even when the answer is "not yet"—builds trust.

A Chester County participant described a recent feedback and follow-up experience:

"And so, we've tried to be really intentional about, like, following up with folks and making sure that you know, even from our October event, we got a lot of really good feedback that sort of left us with, like, okay. So, there's things that we have to do like, run down this to do list of, you know, a hundred things that the community wants and it's just not timely or realistic. But being honest with that with the community and saying like, 'Listen, we know that you keep saying that you want this ER reopened in the Brandywine Hospital, and we are hearing you, and we are going to continue to advocate for that.'"

MESSAGING AND INFORMATION ACCESSIBILITY

Reports and communications from health systems are often too complex, academic, or culturally inaccessible. Participants called for more plain language, visual, and multilingual communication, including for those with disabilities. Accessibility isn't just about translation—it's about equity in comprehension and usability.

One Philadelphia participant shared:

"Particularly, we work closely with the deaf and hard of hearing community, and a lot of folks in the community want to be more involved in making decisions or a group like this. But not having ASL offered is a problem for them, obviously. And ASL is not the same as English, so closed captions aren't going to cut it. So, I think not only offering multiple languages, but if it's not able to be offered because of funding, and we all know how that works especially with nonprofits, then offering it as an accommodation that people need to request by a certain date. At least it's being offered as something that they can request,"

What's Working Well

Despite numerous obstacles, participants across counties shared examples of initiatives that are making a difference. What's working includes community-led programming grounded in lived experience, cross-sector partnerships, and culturally responsive events that blend fun with wellness. Programs that provide personal outreach, meet residents where they are, and offer tangible supports like food or childcare have seen stronger participation. Transparent, honest communication about limits and next steps also helps build trust—even when resources are constrained. These successes point to the importance of centering the community not just in message but in method, structure, and leadership.

COMMUNITY-LED AND LIVED EXPERIENCE-DRIVEN INITIATIVES

Groups led by community members with lived experience—such as addiction support volunteers and grassroots wellness efforts—show high commitment and trust.

A Bucks County participant said:

"This group of volunteers... had not had a call in a year and they still showed up to the meeting."

A member from Chester County added:

"The individual that was leading those conversations with the support group was someone with lived experience."

CREATIVE LOCAL EVENTS AND HOLISTIC APPROACHES

Multi-sector events like "Family Fun Help Day" and integration of clinical with non-clinical services (e.g., air fryers and healthy cooking) are drawing engagement.

A Bucks County participant said:

"Different hospitals come out, local farmers bring free vegetables... That is one way we try to increase people's participation

A member from Chester County added:

They gave them an air fryer and said here are healthy recipes you can make. It really worked for the senior population."

COMMUNITY FORUMS AND TRANSPARENT COMMUNICATION

When feedback loops are closed and participation is made accessible (childcare, food, multiple formats), community voices emerge more powerfully.

A Chester County member said:

"We offered childcare. We offered dinner. We offered it after work hours... The direct personal invitation is so powerful."

A Philadelphia County member added:

"We did a lot of listening sessions to find out what people thought the top issues were before setting the topic areas."

Suggested Actions and Solutions

To move forward, participants offered thoughtful, actionable strategies to strengthen community participation in health initiatives. These include forming diverse task forces, co-designing programming with residents, simplifying data and reporting formats, and closing the loop after feedback is collected. Many called for better pathways to hire and train individuals from the community, as well as stronger partnerships with educational institutions to address workforce gaps. By reducing the burden of engagement and redistributing decision-making power, institutions can transform participation from symbolic to strategic—laying the groundwork for more equitable, effective health outcomes.

Task forces that include representatives from various organizations and directly from the community can foster shared goals and planning.

- **"Some kind of task force and the task force would set up forums like this and have different platforms, not just in person and throughout different parts of the community, so that transportation or travel isn't necessarily a barrier. Virtual or even phone conversation, something accessible. So multiple options to contribute to your voice."**

Solutions include integrating social service pathways in higher education, paid internships, and relaxing unrealistic educational expectations.

- **"So maybe we need to work better with universities and create more of a channel directly promoting – 'Hey, come join healthcare.' Look, there's 9 million jobs you can choose from, and letting people know what the options are. I know when I graduated college with my psych degree. I had no idea what I qualify for or what I could do and I didn't know there were that many agencies available in different directions I could go in."**

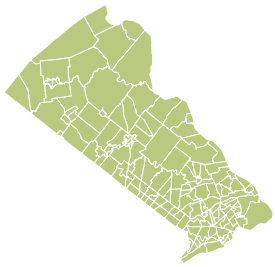
Tapping into corporate giving, local businesses, and simplifying messaging around impact (storytelling) can unlock new sources of financial support.

- **"But here you go, you need money. Right? So we need to tap into these resources that have money, these for-profit companies, the banks, the communities, the credit unions, whatever it is out there. And I have learned through my work on different boards and different local communities agencies and groups, that there is a lot of businesses out there that want to give back to the community, and want to give back financially so that you can do more. And I'm like, let's tap into them some more to support us in all of these causes and to get the hospital to connect to and just build this bridge, just build this ladder of support, interconnecting."**

Community members emphasized that true involvement means having a seat at the table—not being asked to contribute midway or just for optics. This includes hiring from the community, involving lived experience in leadership roles, and ensuring residents are not just consulted, but co-designing solutions.	• **"I'd say invite them in to hear their stories. It's one thing for us to tell their stories, but it's another thing for the actual person going through the situations to tell their stories, to tell how they feel, to share their experience, because we can speak for them, but it's better if they would speak for themselves. So inviting them in and hearing their voice, I think, would establish some a little bit more compassion as well because there's a story, but then there's a person behind the story as well."**
Engagement efforts often end at data collection. Community members expressed frustration with the lack of updates on outcomes from forums and surveys—leading to feelings of being "used" and disillusioned about impact.	• **"It's so easy for us to to gather information, to come up with feedback and to keep folks updated via like a newsletter or a blog post. And the community is not engaging with our email newsletters, and so as much as we can. you know, through personal relationships. And that extra work of like, yeah, we had people attending the event, and we're gonna call every one of them back and say, like, 'Just wanted to touch base and see, you know, if you had anything else to say.' And here's what we've been working on, and here's what you know. Here's what we think and believe for the next what the next steps are gonna look like as much as we can directly communicate with them and keep inviting them back to events and organizing and being present at existing community events like not necessarily hosting something new, but going to things like 1st Friday, or football games, or whatever it might be, and just continuing to be a presence. I think, helps, even if we're not providing them like a really thorough update on like significant progress. They're still happy to know that we are still engaged with the community still available. To answer questions or give updates as as they become available."**
Communities want to understand the data that informs decisions and be part of interpreting it. But often, data is used to justify decisions already made. When shared meaningfully, it becomes a tool for partnership.	• **"I think the hospitals and the managed care entities can do a better job at sharing data with the community. For example, there might be certain sections of the city where the national average of diabetes is this, but the national average of diabetes in this neighborhood is this. What do you think we can do about it? The community should know, this is happening in our community or there's cancer rates or whatever it is. I just don't feel like they share data in a way that could engage people."** • **"Data doesn't tell the whole story... But when you're talking to individuals groups, you can get these little nuggets of information that can that may be able to pivot everything and create something that is more suited to what your mutual goals are. So, we're working on it. So, stay tuned 2025, 2026, there's a lot coming."**

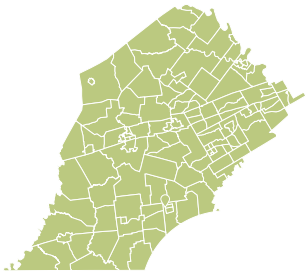
County-Specific Perspectives

BUCKS



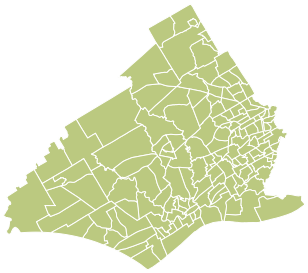
Bucks County faces significant challenges around post-COVID social isolation, particularly among elderly populations and those disconnected from child-centered events. Despite that, dedicated volunteers and creative event models like Family Fun Days offer bright spots. Staffing shortages and systemic workforce barriers remain a key concern, with emphasis on changing education-to-career pipelines.

CHESTER



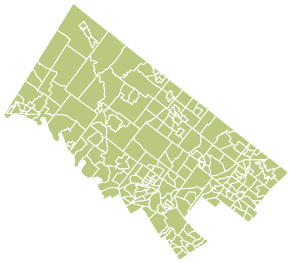
Chester is resource-rich but challenged by coordination and engagement fatigue. Local stakeholders emphasize the need for collective prioritization, intentionality, and transparency. Innovative mobile wellness units and hyper-local support groups show promise. Transparent communication around limitations and real timelines has built trust even amid resource constraints.

DELAWARE



Funding scarcity and organizational siloing dominate Delaware's landscape. Despite high motivation, limited staff capacity hinders outreach and coordination. Community members voiced the need for direct contact, outreach beyond mail/surveys, and cross-sector volunteerism to avoid duplication of efforts.

MONTGOMERY



Montgomery participants emphasized infrastructure solutions—like accessible forums and collaborative task forces. Community members proposed concrete mechanisms like shared committees and multi-modal participation strategies (virtual, in-person, phone) to deepen inclusion.

PHILADELPHIA

Philadelphia's challenges include transportation barriers, trauma and engagement fatigue, and linguistic or cultural disconnects. However, initiatives like pre-pilot studies and community-driven design efforts (e.g., Well City Challenge) offer strong models. Success depends on closing feedback loops and reframing data and reports in community-accessible language and formats.

FOCUS AREAS AND COMMUNITIES

This section features primary and secondary data focused on health needs associated with conditions requiring specialized care (cancer, people with disabilities, vision), as well as communities whose needs have historically been less understood or adequately addressed (older adults and youth).

Cancer

Cancer is one of the leading causes of death in Southeastern Pennsylvania (SEPA), and a concern for local community members, and hospitals and health systems – particularly cancer centers.

To better understand the state of cancer care in this region, key sources of information are presented below – including county-level quantitative data and qualitative findings from public community discussion and cancer care specific conversations held across the region.

A dedicated cancer care focus section was first featured in the 2022 rCHNA to address the specific concerns and needs associated with the topic, as well as to serve as an important data source for participating health systems and in particular, local cancer centers. This section closely mirrors the 2022 report and features new data indicators and additional qualitative inputs.

While the discussion guide used for the public community conversations did not include questions specific to cancer care, the topic did arise organically in multiple instances. These comments have been combined into the "common themes" section below.

A critical source of qualitative data used in this section was gathered by three cancer centers and one hospital affiliated with participating health systems:

- Abramson Cancer Center at University of Pennsylvania (Penn Medicine)
- Fox Chase Cancer Center (Temple Health)
- Jefferson Einstein Montgomery Hospital (Jefferson Health)
- Sidney Kimmel Comprehensive Cancer Center (Jefferson Health)

Lastly, findings from a PCORI grant-funded program — Philadelphia Communities Conquering Cancer, led by Abramson Cancer Center, Fox Chase Cancer Center, and Sidney Kimmel Comprehensive Cancer Center, and community partners across Philadelphia — are included in this section, with consent from participating cancer centers.

Representatives from each of these cancer centers and hospitals conducted focus group discussions with community advisory board (CAB) members in September 2024, using a standardized discussion guide developed jointly, with a focus on building upon the discussions held during the previous rCHNA. Representatives were particularly interested in hearing CAB members' recommendations and strategies for what hospitals can do to improve their experiences across the cancer spectrum (prevention, screening, treatment, survivorship, caregiving, etc.) Discussion guide questions reflected this focus.

The cancer centers facilitated the meetings, which were attended by individuals representing the communities they serve. Some participants were also cancer survivors and shared insights based on lived experience. All sessions were recorded and transcribed for analysis. The HCIF team used the discussion guide to develop a preliminary set of themes, which informed the coding process.

A team of three coders independently applied these pre-developed codes to the transcripts. Intercoder reliability meetings were held to ensure consistency in code application, with particular attention to identifying references to special populations and emergent themes not explicitly captured in the original guide.

There was a great deal of agreement across all discussions – common themes are presented below, followed by the unique insights gathered through individual center/hospital discussions.

Findings

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

QUANTITATIVE DATA

	Bucks	Chester	Delaware	Montgomery	Philadelphia
Major cancer incidence rate (per 100,000)*	323.0	260.2	263.3	258.4	218.9
Major cancer mortality rate (per 100,000)*	82.0	60.8	80.3	67.6	69.4
Cervical cancer rate (per 100,000)	6.4	6.1	6.1	6.6	8.8
Cervical cancer screening (among adults ages 21-65)***	84.3%	85.3%	83.6%	85.0%	80.5%
Colorectal cancer screening (among adults 45-75 years)**	71.2%	70.3%	68.6%	70.4%	66.7%
Mammography screening (among adults 50-74 years)**	78.4%	79.6%	79.3%	79.5%	79.2%

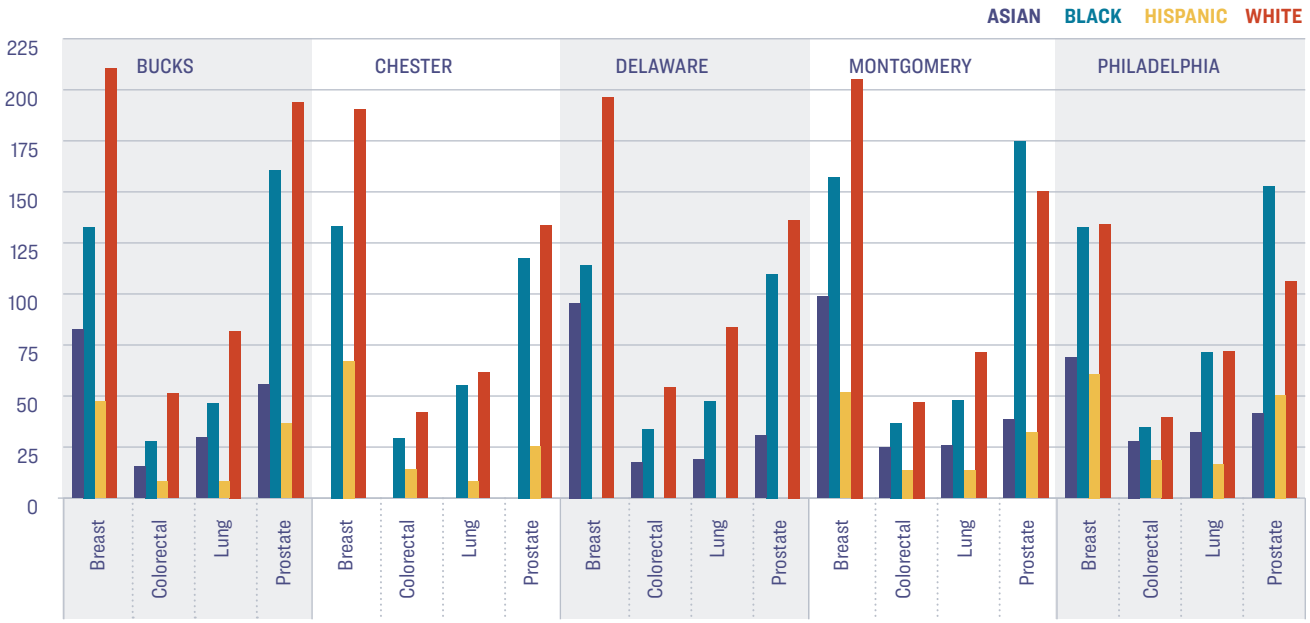
* "Major" cancer defined as: prostate, breast, lung, colorectal cancers; crude rate per 100,000; Vital Statistics, EDDIE (PA Department of Health)

** 2022 Behavioral Risk Factor Surveillance System

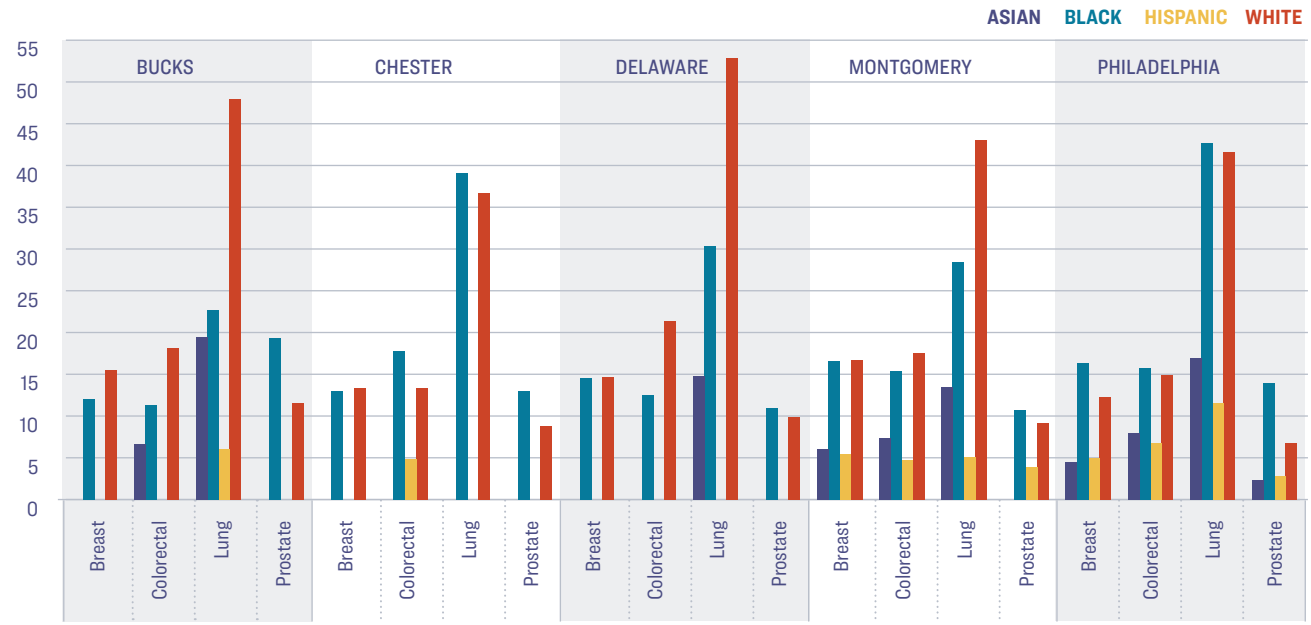
*** CDC PLACES

Age-adjusted incidence and mortality rates by race in each of the five counties, according to data from the Pennsylvania Department of Health's Vital Statistics are presented below:

Age-Adjusted Major Cancer Incidence by Race, 2017-2021



Age-Adjusted Major Cancer Mortality by Race, 2019-2023



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.

Common Themes

Cancer care is a deeply personal and complex journey, shaped by diverse experiences, systemic challenges and barriers, and unique opportunities for improvement. Across conversations and reflections, patients, caregivers, advocates, and community members shared recurring themes which demonstrate the cancer care experience. These themes not only highlight critical areas for improvement but also serve as examples of lived experiences, shedding light on the pressing needs and opportunities within the cancer care continuum for patients and advocates in the Southeastern Pennsylvania region.

EQUITY AND ACCESS TO CARE

Participants shared individual experiences across discussions, highlighting the differences in access and availability of high-quality cancer care – despite living in a region served by multiple hospitals, health systems, and cancer centers. Various geographic disparities, socioeconomic limitations, and systemic inequities create significant barriers to treatment. Patients who live outside of Philadelphia shared their struggles with long travel times to reach specialized care and expressed a desire to receive care closer to home.

"One of the big things is we don't want to go to Philadelphia for treatment. We want to be in our communities where we live and where we have support... I had the experience of losing someone to cancer and part of it was just so onerous for her to leave Chester County and go all the way into Philadelphia for the treatment that she needed."

Regarding socioeconomic barriers and limitations, participants expressed how uncertainty around the cost of care – particularly for those with lower incomes, or who are under- or uninsured, who live on fixed incomes, or who are undocumented – keeps community members from receiving screenings (whether proactively or based on medical guidelines, family history, etc.), seeking out care following positive screenings or diagnoses, and agreeing to undergo treatment. One participant discussed feeling "lucky" because their insurance covered their care, describing their family situation:

"He's taking some unbelievably expensive medications and they've paid for it. So, we're lucky. He actually told one doctor, he said, 'I can tell you right now, if that drug you want me to take is not covered, I'm not going to take it because I want to leave money for my children.' And I said, 'That's not your decision. Whatever it costs, we'll pay for it.' But, fortunately, we were covered. But I can see that that's a major issue for people."

Additionally, the normalization of "office hours" (9am-5pm, no evening or weekend hours), unreliable access to transportation, and long wait times at appointments, present significant barriers for community members with limited ability to take time off from work, those who need childcare, or live in an area with no public transportation options.

"How can we work around the working person? Because we gotta stop assuming people have...they're sitting around doing nothing from 8 to 5, they got money for transportation. We assume a lot of these things in the communities that we>re working with ... we're very far from the truth. With that we do not tend to meet people where they are."

To address these barriers, participants recommended the implementation of new (or expansion of existing) services and resources to reduce the financial and logistical obstacles to care such as telemedicine services, investment in mobile clinics, vouchers for transportation, support with childcare, open more "local" offices, expand office hours, and offer financial navigation assistance.

FEAR

The role of "fear" was consistently shared through each discussion. Its influence in the cancer care continuum manifested as: fear of diagnosis, fear of treatment side effects, fear of financial impacts, and the fear of mortality. For many, the fear attributed to "not wanting to know what's wrong" was the most pervasive. One participant, when discussing low numbers at outreach events, reflected on this specific fear.

"I think for a lot of people, is more, it's like a fear base, right? If I don't get tested, and if I don't do the work to know, then it's not there."

Avoiding screenings can translate to more advanced diagnoses, while fear of the unknowns related to treatment can result in potentially preventable death. Participants shared this specific type of fear can be more pronounced in certain communities and populations – such as older adults and Black/African Americans.

A unique take on the concept of "fear" emerged in connection with the COVID-19 pandemic. Certain communities experienced higher death tolls than others during the pandemic and participants shared that this experience was particularly impactful and that it sparked a sense of proactiveness in community members — taking screenings and overall health more seriously.

"I think it's a willingness, and it I think it comes out of some fear again attributed to what so many people saw with COVID, especially in the communities of color. It hit us really tremendously, and all the stigma around getting the vaccine and and various things. I think it kind of scared people more which can be good even if you're scared, at least you're willing to go get a test done. You're willing to get [a] physical done. You're willing to do something, even if it's out of fear."

Participants – some of whom are survivors themselves – noted the fear of recurrence can linger long after successful treatment, deeply impacting survivors and their families. They shared that although primary treatment may be complete, each subsequent check-up elicits fear and anxiety.

"Survivors are not always okay. Even after being in remission, there's always the fear that when they go for their checkup, it will show up again."

CULTURE AND LANGUAGE

Participants were asked to reflect on how cultural and spiritual beliefs, and language (including literacy) impact their communities' experience with cancer care.

Cultural beliefs about illness and healing influenced community members' willingness to seek care or adhere to recommended treatments. This was particularly pronounced when participants referred to religion and faith, and the belief that faith will heal or cure cancer.

"I am in total agreement with my sister and brother, because in the church there's just such a belief that Jesus can fix it. Yes, Jesus can fix it, but we also need to seek medical attention."

Alternatively, many expressed the importance of the community and social support that faith and religion can provide to those with cancer such meal sharing, support groups, transportation, childcare and caregiver relief. These beliefs and behaviors were often shared in connection with Hispanic and Black/African American communities. Additionally, the reliance on traditional remedies, hesitancy to discuss illness openly, or the avoidance of medical intervention altogether due to historic mistrust in healthcare were shared as well when reflecting on cultural beliefs.

"There's a lot of conspiracies because…we do work with individuals that are…unfortunately, we have really bad history with medical systems. So there are a lot of conspiracies in regarding of especially like cancer diagnosis and cancer treatment."

The lack of language diversity in cancer materials (written and verbal), in discussions with care teams (including support staff), in the instructions and guidance from providers were noted as examples of how language barriers create challenges in accessing care, understanding diagnoses and treatment options, and navigating the complexities of the healthcare system. Although Spanish was the most common language mentioned during conversations, participants noted an increase in diversity in their communities and subsequent language needs – such as languages spoken by "Asian cultures", Spanish dialects (particularly those from Guatemala), French and Creole (common amongst Caribbean cultures). The use of LanguageLine was mentioned as a tool to support diverse language needs. However, participants prefer to see more language diverse staff embedded into offices and care teams to foster greater community representation, in-person communication, and language support as soon as possible.

"We can head it off when they come in a door, so it's good to go out in the community, but once they're in the door, and they come into the facility, we can address that, have protocols in place to to address that."

Beyond diverse languages, participants shared the need for health care providers to acknowledge challenges related to literacy and comprehension, and how it impacts patient-provider communication. This included not understanding certain medical terminology, navigating the shock of a diagnosis, not feeling certain what questions to ask, and the experience of those with cognitive disabilities.

"And you know, I always say to my people, 'Don't leave the room if you don't have a full understanding. And if the conversation is over your head, you can say I need you to explain it to me as if I'm a 2 year old, and I need you to slow it down and and just give it to me, where, in plain language, plain language is language that I understand, however plain it is.'"

Participants indicated that addressing these barriers requires a culturally competent approach, bilingual healthcare providers, educational materials tailored to diverse needs – both language and literacy, and meaningful cooperation between health systems, community-based organizations, and houses of faith.

PREVENTION, SCREENINGS, AND EARLY DETECTION

Despite increasing knowledge about the importance of cancer prevention and screenings as method for early detection, barriers to education and action around these topics persist. Through all conversations, participants shared the value of focusing cancer education and outreach around prevention by discussing annual physicals, nutrition and physical activity, sun protection, etc. Multiple participants referenced interest in these topics from their community members.

"When I brought the cancer prevention person, there's a lot of questions, there's a lot of interest."

Participants also shared that framing cancer screenings as a form of prevention is beneficial to their communities, particularly as a means to destigmatize "the C word."

"You see them wanting to be more preventive. And I like that. I mean, we've been in health field, you've been wanting that for so long…So it kinda, it's like they're still a little, they're scared of that C word, but they're getting past that and saying, 'I'm going to go get care and get checked and do screening.'"

A lack of awareness or confusion around changing guidelines, socioeconomic barriers, and competing priorities were three primary challenges related to screenings shared across discussions. Participants shared that community members expressed confusion and frustration around changing screening guidelines, which can cause distrust in medical institutions and insurance companies.

"Is this just because the insurance companies don't want to pay for it? So, there is kind of always that question, whenever a guideline changes."

This kind of confusion, and resulting mistrust, may cause delays in screenings.

"It was it the cervical cancer screening that's, that went from like one year to 2 years or one year to 3 years. Kind of like, 'Well, maybe I don't need to worry about it then.' Kind of does that lessen the importance of that screening if it, if it now seems to need to be less frequent. So, I think there is kind of just general confusion when the guidelines change."

Socioeconomic constraints included transportation, limited or no paid time off from work, childcare, insurance coverage, finances, etc. Discussion participants connected these constraints to the reality that community members may deprioritize screenings – not necessarily because they are not aware of the importance or the necessity for screenings, but because existing priorities outweigh the future benefits.

"So, when you got all this going on and you're working, you don't have someone to maybe watch your child. You don't have someone to come with you to help you. You don't have money for transportation. It gets to a point where folks may just say that's it. And then what happens is, it progresses, and they end up in the ER."

Participants underscored the critical importance of screenings for early cancer detection.

"You know you've already pushed that cart down the hill. It's a little harder to slow it down."

Screenings for prostate, breast, and skin cancer were said to be the most well-known, while more emphasis should be placed on colon cancer screenings as colonoscopies tend to be particularly sensitive and stigmatized.

When recommending solutions, participants overwhelmingly suggested the continuation of existing community outreach and screening programs (such as mobile vans) – bringing the information and resources to people **"where they're at,"**particularly evenings and weekends. Education and awareness should focus on screenings as prevention, explain screening guidelines – especially when there are changes, and inform community members of how maintaining a healthy lifestyle impacts cancer risk. One innovative approach – **"reverse referrals"** was shared by a participant. Instead of solely relying on patients to schedule their screenings after receiving a referral from their primary care provider, the screening facility is also notified. This way, the facility can proactively reach out to the patient to help facilitate the appointment. This approach could improve follow-through, as some patients may deprioritize referrals or forget to schedule them. By having both the provider and the screening facility engaged in the process, it may increase the likelihood that patients complete their recommended screenings.

INTERPERSONAL COMMUNICATION

Open and honest communication about cancer was highlighted as essential for awareness, early detection, and social support. A common refrain in conversations was the struggle in discussing health histories and diagnoses among family members – whether due to stigma around the topic or the belief that they are "protecting" their family by disclosing what's happening. Many participants shared heartfelt and direct examples of this experience – attending funerals or hearing about deaths without knowing the deceased had cancer.

"I think the thing that really grieves me is that I just went to a home going service on Saturday of a very good friend of mine, who passed away of cancer, and the sad thing that broke my heart is that she never even told her daughter that she had the cancer, and her daughter was devastated."

Understanding one's genetic predisposition to cancer can be lifesaving. Sharing family history allows individuals to take preventive measures, undergo recommended screenings, and make informed healthcare decisions.

"So, if I'm the mother and I have daughters at home, or sisters or mother, beginning to have that conversation as being automatic, of getting hereditary risk assessment for the patient who's the newly diagnosed, but also that that surrounding nucleus."

Many participants felt more community members were becoming comfortable discussing cancer – as one participant put it **"there's less whispering."** Various reasons were theorized to be driving this shift, such as the perception that as more people are diagnosed (or know someone who's been diagnosed) more people are discussing it openly, the success of community health outreach, advances in screening and treatment lead to more survivors discussing their experience, and certain groups feeling more comfortable discussing health in general (i.e. LGBTQ+, women). Participants share that while men may be less comfortable talking about cancer – particularly prostate cancer – they do notice some more openly discussing it, which has a ripple effect on others.

"So, with them being diagnosed, you're seeing more of a discussion. Now, if there's anything of a positive that is coming out of it, they're being more open with their discussion around other men 'cause they tend to be 'No, I'm gonna keep this close to the vest. No one needs to know anything.' So, if they are in certain men's group, whether they're in community groups, fraternities, or the case may be, they're more open to talk about it because it's a sign of being vulnerable. But now they're more open so, and then learning more about it and they're listening to more discussions."

Discussing cancer openly helps reduce stigma, provides emotional support, and fosters a culture where seeking medical advice is normalized. Hospitals can reinforce this through ongoing community outreach, offering support groups for cancer patients and their families, and collaborating with community-based organizations – particularly those whose clients or communities may be less inclined to discuss this topic.

PATIENT-PROVIDER COMMUNICATION

When discussing challenges with patient-provider communication, participants commonly expressed frustration at not feeling seen or heard – either personally or reflecting on community member experiences. A common sentiment was that providers often appear distracted—avoiding eye contact, staring at screens, rushing through appointments, keeping a hand on the doorknob or glancing at the time. Although participants understood the challenges providers face with packed schedules and limited time per patient, this lack of engagement creates an environment where patients feel their concerns are dismissed or not taken seriously. Others described feelings of being pushed **"through the system"** without providers taking the time to truly understand their needs.

Another recurring issue was the absence of diversity among medical professionals. Many patients shared that not seeing providers who **"look like them"** contributed to feelings of judgment or misunderstanding. While some had positive experiences in their care, the lack of representation in professional roles remained a barrier to building trust. In contrast, encountering doctors, nurses, or other healthcare staff from similar backgrounds often helped ease anxieties and foster a sense of connection, particularly during medical crises.

"They are all positive experiences. I'm still alive. But it's rare that at the professional level I'm seeing someone who looks like me. And so that can, that can sometimes make a difference. And when you are showing up in a crisis."

Beyond feeling unheard, some patients struggled to ask questions or voice concerns. Fear, shock, and the overwhelming nature of a diagnosis often left them uncertain about what to ask or how to navigate their care. One participant highlighted how providers may assume they are offering clear guidance, forgetting that for many patients, this is their first encounter with a complex and unfamiliar process.

"So sometimes the physicians, you know, that's their job. They see hundreds of patients all the time. And so, they're on a roll, and they're saying, they're giving good information. But they're forgetting that this person, this is their first go around, and they don't understand that verbiage, and they may not know that next step. And so just taking each case as an individual case and explaining it until they understand it."

Addressing these challenges requires a more community-centered approach to healthcare. Participants emphasized the importance of providers engaging with communities outside of clinical settings. By attending community events, not just as medical professionals, but as active participants, healthcare workers can build relationships and develop a deeper understanding of patient needs. This level of engagement fosters trust and ensures that when a medical issue arises, patients feel more comfortable seeking care.

Equally important is ensuring that patients feel heard during medical visits. Extending appointment times, simplifying medical language, and encouraging patients to advocate for themselves can help bridge the communication gap. One participant stressed the importance of patients asking for explanations in "plain language," ensuring they fully understand their diagnosis and treatment options before leaving the room. Small but meaningful changes in how providers listen, explain, and connect with their patients can lead to a more compassionate and effective healthcare experience.

SURVIVORSHIP AND LIFE BEYOND CANCER

Survivorship is often framed as a celebratory conclusion to the cancer journey, but for many, it is a new chapter filled with its own unique challenges and opportunities. When discussing this topic, participants shared both physical and emotional challenges. Physical effects from treatment, such as fatigue, neuropathy, or issues with fertility, all of which were mentioned in these discussions, can persist long after the disease is in remission. Many of these effects are "invisible" and therefore survivors and their family members take on the role of reminding others how their lives have changed and the lingering physical impacts. Emotionally, participants described how survivors grapple with lingering anxiety, fear of recurrence, and the struggle to reintegrate into their daily lives. Many discussed trying to redefine who they are after cancer.

"People think just because you had that last infusion, now get back to work. You have to do everything. Your life is normal again. Well, it's not. You have side effects. You face fertility issues if you're young. Maybe you're dating. Maybe you've got other issues that are going on that create all these other things. So, I just think that's such a big point that you all say that just because I'm not in active treatment doesn't mean I don't have the cancer, for sure."

Additionally, the loss of the structured support system provided during active treatment can leave survivors feeling isolated. One of the most common themes around this topic focused on the need for survivorship plans – many of whom felt they were provided with limited or no support following their treatment. They identified the need for such plans to feature methods to reduce the risk of recurrence, particularly lifestyle changes (nutrition, physical activity) and to offer resources for social and emotional support (survivor groups, therapy). Some participants noted taking this responsibility on themselves – doing their own research, asking questions of their providers, and seeking out their own support.

"But I think there needs to be more communication about what happens in survivorship because that's not part of the current dialogue. And I'd say as a survivor, what I finally realized is, I was going to be a survivor for the rest of my life. When you're done with those five weeks, you're not done. I'm a cancer survivor, but I'm going to be a cancer survivor until I'm no longer on this earth. And there isn't any conversation about that."

Addressing these challenges requires a long-term, holistic approach that includes survivorship care plans, mental health resources, and community support. Participants also recommended hospitals use storytelling and public awareness campaigns featuring survivors to highlight the opportunities and outcomes which are possible with comprehensive care.

CANCER KNOWLEDGE & AWARENESS

Participants were asked to share their perceptions of cancer knowledge and awareness in their communities and to describe any changes in the past two to three years. Specific cancers, such as breast, skin, prostate, lung, and cervical cancers were among the most recognized within participants' communities. However, awareness of colon cancer, prostate cancer (despite some familiarity), and rare cancers remain lacking.

Several factors influenced community knowledge and awareness about cancer. Concerns were raised about HPV vaccine uptake, with hesitancy growing due to experiences with COVID-19 vaccinations. Many older adults, who are beyond the eligible age for vaccination, struggle to understand the risks associated with HPV-related cancers and what preventive steps they can take.

"They're thinking about 'What do I do? How do I understand this? Why can't I be protected?'"

Additionally, misconceptions around family medical history continue to shape community behaviors. People who believe cancer does not "run in their family" may not take the risk seriously, overlooking the fact that many cancers are not hereditary.

Older adults tended to have greater awareness, often due to personal experiences with cancer over time - having either battled the disease themselves, supported friends and family through treatment, or gained more knowledge through increased exposure to healthcare systems and screenings. Similarly, participants felt women demonstrated a higher level of awareness, particularly regarding breast and skin cancers.

In the digital age, the internet was thought of as the first stop for those seeking cancer-related information.

"The first thing they do is grab their phones, right? And start Googling. And what does the Internet say? What does ChatGPT say?"

However, there is growing concern about the reliability of online sources, particularly as misinformation and conflicting messages are easily spread. While organizations like the American Cancer Society and major cancer research institutions provide trustworthy information, individuals often turn to family, religious leaders, and local community health workers as their most trusted sources. This is especially true in immigrant communities, where information is often shared within close-knit networks.

Building trust remains a central theme in effective cancer awareness and education efforts. Strong relationships within communities foster confidence in the information being shared, particularly when shared by local community health workers, community leaders, survivors, or a faith-based leader. Consistency was cited as a crucial element, with communities needing reliable, comprehensive and culturally meaningful access to resources, screenings, and educational opportunities.

"But people have to understand that this is an ongoing process. It's not a once a year, you know, prostate cancer month, and then after September, I'll see you the year from now. It has to be continuous, continuous, ongoing outreach that build trust, and then out of that I believe that we'll start to see greater levels of participation."

Special Populations

BLACK/AFRICAN AMERICAN

Participants highlighted the influence of religion and faith in this community, which can reinforce beliefs in the power of prayer as a means to heal cancer and downplay the importance of seeking medical care; participants expressed the need for balance with both. Conversely, participants also shared the benefits of social support provided through faith-based communities. They additionally noted reluctancy to seek care due to historical injustices, negative experiences with hospitals/providers. Many participants referred to "fear" as a deterrent to screening, treatment, communication, etc. They expressed wanting to feel respected and welcomed by providers and care teams.

"The fears could just prevent someone from even going in and engaging with a doctor because I was treated this way the last time. So, I'm just going to self-medicate. So, I'm speaking of African American communities."

Participants shared the belief that prevention and early detection saves lives, and that they would like to see more efforts directed toward their communities given the barriers to care, mistrust, and disproportionate rates of cancer in Black/African Americans.

MOTHERS & FAMILIES

The unique challenges faced by mothers and families were mentioned in many conversations, including the barriers to seeking care such as managing competing priorities, obtaining childcare and the importance of including families in discussions related to cancer spectrum – from screening to diagnosis, treatment, and survivorship.

"As somebody who recently had a cancer diagnosis in my family, having the facility or just the departments that are diagnosing or working with families. How easy they are to explain the process and showing their willingness to be able to walk through what the next year or 2 years of chemo may be, for a family is really helpful."

Additionally, the importance of communication among families as it relates to family history was frequently highlighted. Knowing if and how cancer has impacted your family can support early detection in younger family members. This is particularly important with regards to cancers which may be hereditary.

HISPANIC/LATINE

Participants shared common barriers faced by this population – particularly connected to language and culture. These barriers can be heightened depending on the type of cancer, or who's having the experience with cancer.

"I think, for Hispanic population. It's sometimes difficult to speak about. For example, speak about colon cancer or prostate cancer. Particularly among men, this is something related to like the macho culture that sometimes it's difficult to tell a man that they need to follow certain treatments. That implies something. So, it', it's, I think it's something cultural."

The benefits of community outreach and education, as well as the engagement from the community in these events, were mentioned with positive feedback. However, participants shared the need for even more Spanish language education, literature, and overall health care support. This can be especially helpful to ensure community members know their rights when seeking care, any documentation that may be needed (i.e. insurance), and to increase trust overall in local providers.

"I think that something very important among Hispanic and Mexican population is that they don't have insurance, and they tend to believe that if I don't have insurance a medical insurance there's no chance to get those resources that there are in the community."

LGBTQ+

For many in this community who have experience with HIV and AIDS, there are parallel experiences with cancer. The perception is that many people in this community, particularly those who are older, are more open to discussing their health and health care.

"I'm in kind of a specific community of LGBTQ peeps and also older people. So, older people talk about their health more, I've noticed. Here we are. But I think because of the HIV thing, there's more openness to speaking about it. It comes up. Although there are some still, in general, when I tell people that I've had treatment, there's still people [who] think, oh, you didn't lose your hair, or you say the word cancer. I mean, myself. I mean, I didn't even really, I think, admit to myself that it was cancer until halfway through my treatment. It was kind of weird to say that."

Additionally, participants shared that the progress and innovation from HIV and AIDS treatments gives them hope as it relates to cancer research.

MEN

While there is still hesitancy and stigma among men related to cancer, many participants mentioned increased willingness and openness to discussions on the topic in the past 2 to 3 years. This was seen in conjunction with an increase in support groups specific for men and may be connected to an increase in diagnoses, especially related to prostate cancer.

"I know there's been a lot of discussion around education, and men's group with cancer. But the discussion has been pretty much created because of increased diagnosis. And that uptick of men with prostate cancer. And it goes across socioeconomic lines."

Participants emphasized the importance of outreach to men in their own communities – "meeting them where they are at." Examples included barbershops and sporting events. Education should focus on prevention and early detection.

MID-LIFE ADULTS & YOUNG FOR CANCER

There was an overwhelming concern related to the perception that more people are being diagnosed at younger ages, such as 30s and 40s. One participant shared that young people are often dismissed when expressing concerns related to cancer. And because insurance may not cover a biopsy or screening for someone young, diagnoses may be delayed under the assumption that is must be "something else."

"I think this is true for all ages, but particularly for young folks who eventually are diagnosed with cancer. I was dismissed for six months. So, during very active advocacy for myself, told multiple times by multiple providers that I just had a virus and was placated because I was so young and convinced something was wrong. They're like, 'Fine. We'll finally give you a bone marrow biopsy.' And at that point, I had pretty advanced leukemia."

Participants shared the importance of understanding screening guidelines and understanding hereditary considerations for this age group. Those who are younger expressed themselves as finding camaraderie in social media as a means to find social support, share their experience, and to reduce stigma.

"Social media was my opportunity to talk about cancer after I was diagnosed, despite having people in my real life who were impacted and treated at [HEALTH SYSTEM]. I think that as a former 30-year-old, I'm no longer a 30-year-old, but even when I was diagnosed, I was 30, and no one I knew my age had cancer, and actually that turned out to be wrong. One of my friends had been diagnosed, and I met her after she had went through treatment, so I did not know that about her life."

OLDER ADULTS

Overall perception is that older adults have more experience with cancer – both from their own personal experience and with friends and family members. They may also be more aware of screening guidelines based on increased engagement with health care providers.

"There are a lot of grandmothers who have been around the block with this."

Many older adults are also adept at utilizing technology and the internet, which can be both positive and negative in terms of the reliability of the information they're consuming.

"All my seniors are on the Internet now. We're as dangerous as teenagers...they are all, you know, with very, very few exceptions, well into their, you know, eighties and nineties. These people are doing searches."

WOMEN

Participants expressed a belief that women are aware of importance of screenings related to breast and cervical cancer and that they are often more actively engaged in their health care. This can also translate into women encouraging each other to be screened, ask questions, and advocate for themselves.

"I think for me, I've had people that were like, 'I have not done a self-breast exam until I knew that it was possible, until I heard that you were diagnosed with breast cancer.' And so, for me, it's been as much of a personal connection that I can make with people to be like, 'I went through this thing. It was terrible. But it would've been a lot terrible had I not touched my boobs for a few more months before I found it.' And so, for me, it is just like having someone that you know who's just up front and like, 'Yo, you should really do self-exams for that and for other things.' It sucks to be the person that reminds people to touch their boobs, but I would like to do that for them."

Although women seem to be more engaged with their care, many participants shared the belief that it seems as though women are being diagnosed younger and dying from breast cancer. Women experience unique physical and emotional challenges related to breast cancer – specifically when considering, or following, mastectomies and the need for additional support related to this experience.

"Because you have some women that have had a double mastectomy, or something of that nature. You know. They may not want to go through reconstructive surgery. I mean, I don't know. Some, some choose not to do so, and some choose to do so, but there needs to be somebody there that they can really really get to the meat of whatever decision that they're trying to make."

Participating Cancer Center Insights

In addition to the common themes shared across community discussions, each participating cancer center surfaced insights that were uniquely shaped by the populations they serve, their engagement strategies, and the local context in which conversations occurred. These reflections offer valuable nuance, and in some cases, point to emergent needs and opportunities for more tailored responses across the cancer care continuum.

ABRAMSON CANCER CENTER

Abramson Cancer Center hosted one virtual discussion with seven members of their community advisory board members.

At the **Abramson Cancer Center**, participants reflected on an evolving cultural shift in how cancer is discussed—particularly among men. There was a sense that conversations are becoming more open and proactive, with community members, especially those impacted by prostate cancer, beginning to share their experiences and encourage others to seek care. This shift was attributed in part to the impact of the COVID-19 pandemic, which brought health concerns to the forefront and, for some, shifted perspectives around the importance of prevention and screening. The role of storytelling emerged as a powerful force—participants shared that hearing about others' experiences helps reduce stigma and creates opportunities for dialogue in families and communities.

Despite these gains, participants emphasized the need for health systems to do more to demonstrate presence and accountability. Several reflected that hospitals can feel like "occupying forces" rather than trusted partners—particularly when they are visible only during events or outreach efforts, rather than embedded in ongoing community life. To build trust, participants called for more consistent presence and greater investment in the "whole person"—including support with food access, transportation, and other practical needs. Faith and spirituality also featured prominently in these discussions. Some participants noted persistent beliefs in divine healing as a sole path to recovery, which can delay or deter engagement with medical care. Others highlighted promising shifts within the faith community, where partnerships between churches and healthcare institutions are gaining ground. Participants emphasized the importance of continuing to build these bridges and ensuring they are grounded in mutual respect and shared purpose.

FOX CHASE CANCER CENTER

Fox Chase Cancer Center (FCCC) hosted two virtual discussions with 10 members of their Community Advisory Board (CAB).

The conversation hosted by **Fox Chase Cancer Center** reflected strong connections between the center's outreach efforts and community trust. Participants spoke positively about the impact of Community Health Workers and Community Ambassadors, who serve as consistent, credible messengers for cancer education and prevention. There was a notable sense that these efforts are resonating and leading to increased interest in prevention—not only to avoid cancer altogether, but to prevent treatment side effects and recurrence. One area of discussion focused on colorectal cancer screenings—particularly hesitancy around colonoscopies. Participants raised the question of whether alternative screening tools like Cologuard should be more widely promoted to those who are unlikely to undergo more invasive procedures. Environmental health concerns were also shared, with participants pointing to specific buildings in the Frankford area of Philadelphia where they believe occupational exposure (e.g., to asbestos) may be linked to elevated cancer rates. These concerns highlight the importance of incorporating environmental context into cancer education and prevention strategies. While Fox Chase's language access efforts were generally seen as robust, participants underscored the importance of early and ongoing language support as part of routine care—not just during key touchpoints or upon request.

JEFFERSON EINSTEIN MONTGOMERY HOSPITAL

Jefferson Einstein Montgomery Hospital hosted one in-person discussion with 10 community members – representing both caregivers and survivors.

Participants at the **Jefferson Einstein Montgomery Hospital** felt that cancer diagnoses are becoming more common, especially among younger individuals, and there's greater openness in discussing it today than in the past. While social media and Google are often used to gather general information, community members overwhelmingly trust their oncologists and care teams for medical guidance. Faith communities provide crucial emotional and practical support, leading to suggestions that hospitals partner with places of worship for education and outreach. Participants expressed the need for clearer, earlier communication about cancer risks, symptoms, and screening guidelines—especially at routine doctor visits—and emphasized barriers such as language access, transportation, and appointment delays. Low-income communities face even greater challenges due to lack of resources and education. Survivors wanted more support for wellness, like nutrition, exercise, and appearance-related tips (hair, skin, massage), as well as emotional and financial assistance. There was a strong desire for more localized, accessible support groups, mentorship programs, and partnerships between healthcare systems and public organizations to better serve vulnerable populations.

SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER

Sidney Kimmel Comprehensive Cancer Center (SKCCC) hosted two virtual discussions with 29 members of their Patient & Family Advisory Board and their Community Advisory Board.

At the **Sidney Kimmel Comprehensive Cancer Center**, participants reflected a dual reality: an increase in cancer-related outreach—especially within the Hispanic/Latino community—and ongoing challenges rooted in stigma, fear, and mistrust. While outreach was appreciated, participants expressed concern about the inconsistency of engagement efforts, noting that when programs or events are discontinued without explanation, it can reinforce long-standing skepticism of health systems. The importance of sustained, visible presence was a recurring theme. Participants also spoke to the powerful role of representation in shaping awareness and comfort—particularly the value of seeing people "who look like me" in advertisements, on social media, or in public education campaigns. These moments of recognition not only provide information but help reduce feelings of isolation for those undergoing treatment. Conversations also surfaced the reality that for many, cancer occurs in the context of broader life stressors—including caregiving responsibilities, economic hardship, and lack of access to supportive services. These challenges underscore the need to address cancer as a community-wide concern, with tailored responses that reflect the full scope of people's lives.

Solutions and Suggested Actions

BUILD TRUST TROUGH CONSISTENT COMMUNITY PRESENCE

Participants emphasized that trust is built not through one-time outreach but through ongoing, visible engagement. Cancer centers and health systems should be seen as authentic partners in community wellbeing—not just providers of clinical services.

"We've got to give people something they leave with... not just show up and then disappear again."

PARTNER WITH FAITH-BASED COMMUNITIES TO REDUCE STIGMA

Faith leaders and congregations play an influential role in shaping beliefs about illness and healing. Collaborating with them offers a pathway to balance spiritual beliefs with medical advice and to build bridges with harder-to-reach groups.

"So we ministers have finally gotten past this idea... that it's all Jesus and no medicine. Now we partner hand-in-hand with the institutions in our community."

EXPAND AND INTEGRATE COMMUNITY HEALTH WORKERS AND AMBASSADORS

Community Health Workers (CHWs) and Ambassadors are viewed as trusted, credible messengers. Their involvement helps reduce barriers to care and fosters greater understanding and trust.

"So I love the Community Ambassador program... that helps get the word out and educates people. When we show up in the numbers, it goes directly to treatment."

NORMALIZE AND EXPAND SCREENING ALTERNATIVES

Participants suggested offering non-invasive alternatives for cancer screening, especially for procedures with low uptake like colonoscopies. Meeting people where they are—without judgment—can improve screening rates.

"Should we stop fighting that battle? Maybe we need to encourage folks to use a different tool if they're never going to do a colonoscopy."

EMBED LANGUAGE AND LITERACY ACCESS THROUGHOUT CARE

While services like LanguageLine are helpful, participants recommended early, in-person support and expansion into languages beyond Spanish. Literacy needs should also be addressed through plain language and clearer explanations.

"We can head it off when they come in the door... have protocols in place to address it right away."

ADDRESS ENVIRONMENTAL AND OCCUPATIONAL RISK FACTORS

Environmental exposures—like asbestos in older buildings—were flagged as a health concern. Cancer centers should acknowledge and investigate these concerns to ensure they're responding to the full spectrum of community risks.

"Everybody in that building had a different type of cancer. And I think it's from the asbestos... breathing that in every day."

ENSURE CONTINUITY IN PROGRAMS AND OUTREACH

Communities expressed frustration when programs were discontinued without explanation. Maintaining consistency or clearly communicating changes is essential for preserving trust and momentum.

"These are groups that have been disappointed time and time again by healthcare systems."

SUPPORT SURVIVORS BEYOND TREATMENT

Survivors often feel unsupported after treatment ends. Participants called for more structured survivorship planning—covering everything from nutrition to emotional wellbeing—to help navigate life after cancer.

"Just because I'm not in active treatment doesn't mean I don't have cancer. I'm a survivor until I'm no longer on this earth."

Tailor OUTREACH TO SPECIFIC COMMUNITIES

One-size-fits-all outreach is not enough. Participants urged health systems to bring education and services to places where people already feel safe and seen—such as LGBTQ+ centers, barbershops, and community centers.

"If you're in men's groups, fraternities, community groups... they're more open to talk about it. It's a sign of being vulnerable, and now they're listening."

Disability

Disability affects the lives of millions of people in the United States, shaping not only health outcomes but also experiences with care, independence, and community participation. According to the Centers for Disease Control and Prevention (CDC), "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." As of 2025, approximately one in four adults—an estimated 67 million people—live with some form of disability. In the five-county southeastern Pennsylvania (SEPA) region, about 14 percent of residents are currently living with a disability. Understanding the diverse needs, barriers, and strengths of this population is critical to advancing equity and ensuring that services are inclusive, accessible, and empowering. This report draws on both survey and qualitative findings to paint a fuller picture of life with a disability in SEPA—capturing challenges in care access, mental health, daily life, social connection, and the importance of advocacy and community support.

A survey was developed to assess the health needs of people living with disabilities in the SEPA region (see online Appendix for results and a copy of the survey itself). This survey retained core questions included in the 2022 rCHNA disability survey, with the addition of several evidence-based items addressing quality of life, experiences with microaggressions, trust in health care providers, and feelings of isolation. The original questions explored respondents' disabilities, general health status, health care access, health behaviors, non-medical needs, employment status, use of technology and assistive devices, community participation, resource needs, and demographic characteristics.

A committee composed of representatives from Bryn Mawr Rehab Hospital, GSPP Rehabilitation, Jefferson Moss-Magee Rehabilitation - Center City and Jefferson Moss-Magee Rehabilitation - Elkins Park, and St. Mary Rehabilitation Hospital reviewed and approved the final survey instrument. The survey was fielded online in two waves: August–September 2024 and again in April 2025 to support focus group recruitment. The survey link was distributed through committee-generated contact lists, which included partner organizations, community programs, and support groups across the region. Committee members also shared the link through their own networks of current and former patients. All survey participants who provided an email address received a $10 gift card as a thank-you.

Descriptive analysis was conducted on 140 unique submissions. Where appropriate, open-ended responses were coded by the project team to identify key themes. For "check all that apply" questions, percentages may exceed 100 percent due to multiple selections.

In addition to the survey, two focus groups and four individual interviews were conducted to explore topics such as access to care, experiences with clinicians, community assets and barriers, and the isolation and loneliness associated with having a disability.

Human Subjects Protection

The focus group protocol was reviewed and approved by Advarra Institutional Review Board (IRB). All participants provided informed consent, and procedures followed institutional and federal guidelines to ensure the protection of human subjects.

Survey Results

RESPONDENT CHARACTERISTICS

The table at right 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.

Characteristics		N	%
Gender	Man	75	48%
	Woman	75	48%
	Nonbinary	2	1%
	Transgender Man	1	<1%
	Prefer Not to Answer	3	2%
Age	18-24	5	3%
	25-44	31	20%
	45-64	81	52%
	>65	38	24%
	Prefer Not To Answer	1	1%
Race/Ethnicity	American-Indian/Alaskan Native	1	<1%
	Asian	9	5%
	Black/African-American	22	13%
	Hispanic/Latine	7	4%
	Native Hawaiian/Pacific Islander	1	<1%
	White	116	70%
	Some other race	2	1%
	Prefer Not To Answer	5	3%
Education	High school degree or equivalent	18	12%
	Some college	19	12%
	Associate degree	14	9%
	Bachelor degree	46	29%
	Graduate degree	53	34%
	Prefer Not To Answer	6	4%
Sexual Orientation	Straight	134	85%
	Gay or lesbian	10	6%
	Bisexual	6	4%
	Not Sure	2	1%
	Pansexual	1	<1%
	Prefer Not To Answer	6	4%

Additionally:

- Almost half the sample is **currently not working (43%), 24 percent are retired, 16 percent are working full-time and 10 percent are working part-time**. The remaining 7% include students, people who volunteer, care givers and those able to work but unable to find employment. About half of those working part-time do so because earning more puts them at risk for losing disability or attendant care benefits.
- **About 85 percent are residents of the five-county SEPA region (Bucks: 13%, Chester: 7%, Delaware: 9%, Montgomery: 26%, Philadelphia: 30%)**, with an additional 10 percent from other parts of Pennsylvania, collar counties in New Jersey and Delaware. The remainder are largely from outside the Greater Philadelphia region.

Disabilities and Limitations

- Most respondents **(92%) reported their disability as permanent**.
- Using the Center for Disease Control's standardized disability questions:
  - 9% are deaf or have serious difficulty hearing.
  - 12% are blind or have serious difficulty seeing even with glasses.
  - 41% have serious difficulty concentrating, remembering or making decisions because of physical, mental or emotional conditions.
  - 64% have serious difficulty walking or climbing stairs.
  - 44% have difficulty bathing or dressing.
  - 53% have difficulty doing errands alone because of a physical, mental or emotional condition.
- For those reporting more than one health condition or disability:
  - **24%** report **chronic pain**.
  - **19%** report **chronic disease**.
  - **12%** have **trouble speaking**.
  - **11%** report being **neurodivergent** including being on the autism spectrum, having ADHD, dyslexia, dyspraxia or Tourette syndrome.
- More than half of respondents **(68%) reported having their disability or condition for over five years**.
- About a quarter of participants **(26%) indicated that their mobility is impacted** by their condition. **Another 27%** reported difficulty with interactions such as making friends, being around others and communicating with others.
- Of those respondents who indicated that they **require personal assistance for life activities (92% of the total sample)**, 50% indicated that unpaid family and friends provide this care.
- **49% 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:
  - **47% reported falling** within the past 12 months.
  - **17% reported having diabetes or high blood sugar.**
  - **13% reported having been diagnosed with asthma.**
  - **37% had been diagnosed with high blood pressure or hypertension.**
  - **54% reported being diagnosed with a mental health condition.**
- **About half of the sample reported good (35%) or very good health (12%).** An additional 35% 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 (27%) and dental care (18%)**. About 11% of respondents reported using emergency care and about 15% reported use of psychological and/or counseling services.
- Of the almost 60% 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: **participants could not get an appointment, could not find a clinician who understood my condition, have difficulty identifying a doctor or clinic or had too much difficulty getting to the doctor's office or clinic**.
- Almost all participants who indicated they **take medication (98%) were able to regularly get the medication they needed (96%)**.
- Of the nearly 50% of respondents whose insurance status impacted their ability to get care, **the most frequently selected barriers included insurance did not pay for what was needed, could not afford care needed, could not find clinician that accepted insurance**. Of those reporting insurance barriers only **2% indicated they had no insurance at all**.
- About two- thirds of participants **(66%) reported that they have used telehealth services** in the past 12 months, and a majority of these respondents found **services beneficial (96%)**.
  - 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**.
- The majority of participants **(82%) reported using a portal, website or app to see health information, communicate with their health team or make an appointment** in the past 12 months, and a majority of these respondents found **services beneficial (93%)**.
  - Those who had not used telehealth services indicated that they prefer to speak to someone on the phone or had difficulty with digital access.

Disability-Related Resources

- **27% of respondents reported needing special equipment or assistive devices**, 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 (7%)
  - Stair access supports (5%)
  - Railings, bars, or other non-mechanized assists (6%)
  - Vehicle big enough for a wheelchair, cart, or scooter (5%)
- Nearly half **(43%) reported that they currently participate in support groups**, with an additional 22% 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:
  - Transportation support (28%)
  - Peer mentors (19%)
  - Support for caregivers (relief support or respite) (15%)
  - Care navigation (15%)
  - Complementary therapy (8%)
  - Adaptive sports programs (7%)

Non-Medical Needs

- With respect to housing, the biggest challenges were related to **home access and safety**:
  - **About a quarter of respondents (24%) with a physical disability indicated that they cannot enter or leave their home without assistance from someone else.**
  - **Almost 30% 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.
- **Twenty-three 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.
- **More than a quarter of the sample expressed significant financial needs:**
  - Almost 20% reported that there was a time in the last 12 months when they were **not able to pay mortgage, rent, or utility bills**. **Forty-four percent** of participants reported that **housing costs were somewhat or very difficult in the past year**.
  - Approximately **38% experienced food insecurity and 47% were often or sometimes worried about food insecurity**.
  - Twenty-seven percent needed the **services of an attorney but were not being able to afford one**.

Lifestyle

- While 33% of respondents shared that they exercise at least 30 minutes three or more days per week, **28% indicated that they never participate in such activity**. Most frequent barriers to physical activity were: not having the physical capability to participate in exercise, inability to afford a gym membership or no places near their home to exercise and lack of knowledge of exercises appropriate for their condition.
- **A majority of respondents (81%) reported eating at least one serving of fruits and vegetables in a typical day.**
- **Substance use was not prevalent in the sample:** 92% indicated that they do not currently use tobacco; 95% stated that they either do not use or do not feel that drug use impacts their daily life; and 86% stated that they either do not use or do not feel that 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.**

Quality of Life and Connection

- More than **two-thirds of respondents (67%) rank quality of life as 'so-so'**, neither good or bad.
- Despite almost 80% of participants indicating they regularly socialize, more than half of participants experience some form of isolation often or some of time including:
  - **Twenty-two percent of participants feel they often lack companionship** and 32% lack companionship some of the time.
  - **Thirty percent of participants report often feeling left out** and an additional 33% feel left out some of time.
  - **Twenty-eight percent of participants feel isolated from others often** and another 33% feel isolated some of the time.

Experience with Disability Microaggressions

Microaggression	% Applicable	% Impacted
People feel they need to do something to help me because I have a disability.	91%	62%
People express admiration for me or describe me as inspirational simply because I live with a disability.	91%	67%
People express pity for me because I have a disability.	88%	35%
People do not expect me to have a job or volunteer activities because I have a disability.	85%	31%
People offer me unsolicited, unwanted, or unneeded help because I have a disa-bility.	88%	38%
People are unwilling to accept I have a disability because I appear able-bodied.	79%	31%
People minimize my disability or suggest it could be worse.	90%	44%
People act as if accommodations for my disability are unnecessary.	89%	36%

While the survey provided valuable insight into trends in access, resource use, and unmet needs across the SEPA disability community, the lived experiences behind the numbers reveal even deeper truths. To better understand how people with disabilities navigate daily life, interact with health and social systems, and define quality of life, two focus groups and four in-depth interviews were conducted.

These conversations explored issues such as mental health, caregiving, social connection, systemic trust, and self-advocacy—shedding light on the emotional, relational, and structural dimensions of living with a disability. Participants' voices brought richness and nuance to the data, elevating the themes from statistics to stories.

Access to Care

Access to care encompasses a broad range of experiences that shape whether, and how, people with disabilities are able to get the healthcare and support they need. Participants described numerous barriers, from delayed appointments to inaccessible clinic environments. One person shared that post-pandemic delays were widespread: **"There's always a long wait for any doctor nowadays,"** especially for specialists and therapies. Even when appointments happened, the facilities were sometimes unprepared. One participant recalled arriving in respiratory distress only to learn the provider **"didn't have oxygen or anything in his office,"** and he was sent home with no help.

Transportation and logistical hurdles were major subthemes. **"I need rides, I can't drive myself now… that can be really difficult to coordinate,"** one woman explained, describing how unreliable paratransit and agency transport often caused her to miss care altogether. Financial barriers also emerged as key obstacles—especially costs not covered by insurance. One man noted, **"The cost of home care… it's just one of those things that's often not covered,"** leaving people to pay out of pocket for essential support. Others shared stories of navigating confusing insurance denials or delays for treatments they needed.

Communication was another critical piece of access. A participant with a neurological condition explained, **"It's gonna take me a longer time to process what you're saying, and I'm not leaving until I understand."** Without time, clarity, or written instructions, even having an appointment didn't guarantee appropriate care. True access meant being treated as someone who deserved to fully understand and participate in care decisions.

Alongside these barriers, some participants shared moments of supportive, well-designed care. One person compared experiences at two therapy sites: at the hospital, he received attentive, concierge-like service—**"staff met me with a wheelchair and escorted me"**—but not at the same health system's affiliate site. This highlighted how responsive systems can make care accessible, while inattentive ones leave patients struggling.

Participants also emphasized **respect** as a vital part of access. Disrespect or dismissiveness—especially tied to invisible disabilities—eroded the quality of care. **"Sometimes I feel like they assume I can't read or write,"** one woman said, highlighting how stereotyping can undercut a patient's credibility. Others described being talked over or not accommodated in exams, leading to frustration and missed information.

Power in decision-making was closely tied to access. Many participants felt they had to push hard to be heard. **"If I don't question them, who will? It's my health,"** one said. This advocacy was sometimes misunderstood as being "difficult," but participants saw it as necessary to ensure their needs were met. One woman described how she has to educate every new provider about her condition: **"Why don't you all know about aphasia? If I say I have aphasia, I need you to speak slowly."** These acts of advocacy—even switching providers or dictating how a visit should go—were about claiming a rightful voice in their care.

Experiences of **discrimination in care** further complicated access. A wheelchair user described a snowy day when **"they plowed all the snow into the handicap spot,"** leaving her unable to reach her doctor's office. Her complaint was ignored. Others described being denied care or questioned unfairly due to disability-related insurance or visible conditions. These stories revealed how both policy-level and interpersonal discrimination shape whether patients receive equitable treatment.

At the broader systems level, **trust and mistrust** shaped how participants approached access. Many described healthcare and insurance systems as adversarial. **"You look at the [denial] letter… and go, 'Were they even on the same phone call I was on?'"** one participant asked. Still, some found pockets of trust in individual providers who took time and advocated for them.

Transitions from pediatric to adult care added another layer of complexity. **"Moving from the school age, transitioning into adulthood becomes this vast scope of unknown things,"** a mother said, describing how her son lost the coordinated services he relied on. While adult systems often expect individuals to be independent, they frequently fail to provide the necessary guidance to support that independence. Simply turning 18 does not automatically equip young people—or their families—with the tools to navigate complex adult systems. Without intentional transition planning and continued support, families are left feeling overwhelmed and unsure of how to move forward.

Outside of clinical settings, participants also pointed to **broader health-related barriers** in their lives. Unsafe housing, poor public infrastructure, and limited access to food or community services made it hard to stay healthy. **"If you don't have a car to get to the food pantries… obviously the people in need of these supports can't get them,"** one said. These environmental and economic factors directly influenced health and reinforced the need for community-level changes.

Still, many highlighted the value of **community supports** that worked. **"There have been a lot of resources available,"** one person said, referring to local nonprofits and peer groups. Accessible transportation, wellness activities, and advocacy organizations were often described as game-changers. **"There's a lot of peer support out there if you look,"** another noted.

Finally, **health and digital literacy** challenges were cited as modern barriers to care. From navigating telehealth to deciphering insurance forms, many participants felt overwhelmed. One man shared, **"I see now, because everything is connected to the phone… I need a phone."** For others, peer support and self-teaching helped bridge the gap, but they emphasized the need for better tech training and more accessible provider communication.

In sum, participants' stories made clear that access to care is about much more than scheduling appointments—it's about transportation, respect, power, discrimination, trust, and navigating complex systems. Where supports were in place, care felt possible. But too often, the fight for access was exhausting and unjust, underscoring the urgent need for more inclusive, responsive systems.

Solutions for Access to Care

Participants identified several key strategies to improve access to care for people with disabilities. First, they emphasized the need for more **disability-competent providers**—clinicians who understand various conditions, communicate clearly, and are equipped to accommodate different needs. Ongoing provider training in accessibility and respectful care was strongly recommended. Second, **transportation support** emerged as critical. Suggestions included expanding paratransit services, offering travel vouchers, and developing shuttle programs for medical and social needs.

Third, participants advocated for **simplified insurance processes** and stronger care coordination, including patient navigators who can assist with scheduling, referrals, and insurance appeals. Lastly, participants called for **more integrated telehealth and digital access tools**—paired with training and support to ensure that technology enhances rather than hinders access. These practical solutions reflect a desire not only for medical services, but for systems that recognize and respond to the full scope of disability-related barriers.

The Experience of Being Disabled: Emotional, Social, and Support Dimensions

Living with a disability deeply impacts emotional and social well-being, not just physical health. Participants spoke openly about how their mental health was affected by both their conditions and the systems they had to navigate. Many experienced **depression, anxiety, and chronic stress**, often triggered by loss of independence, pain, or the emotional toll of feeling misunderstood or devalued in daily life and healthcare settings. **"I am statutorily blind, and that has also affected my mental health,"** one participant said, explaining how the progressive loss of vision slowly closed off the world she once knew. Others spoke about how physical limitations chipped away at their identity: **"After a while, you get into a funk because you can't do what you used to."** These expressions of grief and frustration were common, especially from those who had recently experienced a major shift in health or ability.

The emotional toll wasn't limited to the disability itself—it was **compounded by negative experiences with healthcare providers, insurance companies, and public systems**. Several participants described being dismissed or misunderstood by doctors, which triggered anxiety and made them dread appointments. Others linked their mental health struggles to systemic barriers like job insecurity or housing instability. One woman noted that the stress of nearly losing her job due to health-related absences **"kept me up at night and worsened my health overall."** These reflections show how navigating a difficult or disrespectful system can intensify mental health issues, creating a cycle that affects both physical and emotional well-being.

Despite these struggles, there were signs of **resilience and growth**. A participant with aphasia described how she used to beat herself up when her speech faltered: **"I used to get so… it would just depress me more."** Over time, she shifted to a more compassionate inner dialogue: **"Now I've learned to be gentler with myself."** Others shared that seeking therapy or joining a support group helped them cope and reconnect with others. For many, mental health care wasn't just helpful—it was transformative. **"I finally felt understood,"** one said about joining a group. Participants also emphasized the need for integrated mental health services, such as being referred to counseling automatically after a diagnosis or trauma. As one person put it, **"Mental health is very important, especially when you have [a disability],"** advocating for it to be treated as an essential part of care, not an afterthought.

Closely tied to mental health was the theme of **isolation and loneliness**. Participants described how social disconnection was both a cause and effect of their health challenges. Many shared that they no longer had strong support networks; illness had chipped away at their social lives. **"I don't work anymore… your communication isn't like it was,"** one woman said, describing how losing the routine and relationships of work left her adrift. Others noted that friends gradually stopped inviting them to events, assuming they couldn't attend. Over time, this erosion of contact created a sense of being forgotten.

Importantly, isolation wasn't always about physical solitude—it often stemmed from **feeling misunderstood or "othered."** One woman explained that having multiple disabilities made people treat her as fundamentally different: **"My long span of having many disabilities… I personally experienced a lot of isolation."** Others shared that even when they were with others, they felt emotionally alone, especially if their communication needs weren't respected. A participant with a speech impairment described the frustration of people trying to finish her sentences: **"They don't understand the frustration when I don't want you to feed the words for me."** These seemingly small moments created a disconnect that added to her loneliness.

Physical barriers played a role too. Several participants said they avoided social outings because of the effort required to get there—transportation challenges, poor infrastructure, or inaccessible buildings. **"Even though I'm grateful for public transportation, it's a challenge… I don't want to socialize sometimes because it's such an ordeal to get out,"** one person shared. Others who had relocated for care or housing reported being surrounded by strangers, unable to build new connections.

Yet again, **peer support emerged as a lifeline**. Whether through Zoom groups, community centers, or faith communities, participants found comfort in shared experience. **"It's nice to hear you're not alone in this… we're part of the world,"** one person said during a focus group session. This moment of recognition—of mutual understanding—served as a powerful antidote to isolation. People described how support groups, even if virtual, helped them feel included and valued. Others took proactive steps to build community, like forming informal networks with neighbors or becoming peer mentors.

Independent living and relationship support emerged as a fragile balance. Participants wanted autonomy but often lacked help with everyday tasks—transportation, housework, companionship. One person reflected, **"God knows I would love to have more help… even to the point of, oh my gosh, having the dude who does my lawn."** Those without a partner or family nearby faced steeper challenges. Pride and shame were emotional barriers to asking for help, particularly among men. Some built informal networks—neighbors, church friends—to fill the gap, showing resilience and creativity in maintaining independence.

Caregiver support and burden was another side of this conversation. Participants deeply valued family caregivers but were also keenly aware of the strain. **"My mom has been amazing, but I feel like it's taken a toll on her,"** one person said. Others were caregivers themselves while managing their own disabilities, leading to compounded stress. Financial strain, lack of respite options, and emotional fatigue were common, and many worried about the future if caregivers became unavailable.

Finally, **advocacy and self-advocacy** stood out as powerful tools for navigating all of these challenges. Participants described filing complaints, organizing support groups, joining hospital advisory boards, and founding nonprofits. **"I am always wearing my advocate hat,"** one participant said, illustrating how advocacy became a way of life—protecting their own rights while improving conditions for others. These acts, large and small, fostered a sense of agency and purpose, even in the face of overwhelming systems.

In sum, the emotional and social dimensions of disability are as significant as the medical ones. Mental health support, connection, autonomy, caregiver balance, and advocacy all shape how people live and thrive with disability—and when those elements are missing, they carry heavy costs.

Solutions for Connection

Solutions for Connection revolves around ideas and initiatives to reduce loneliness and build community among people with disabilities. After many participants shared their struggles with isolation, this theme captured the hopeful turn: what can we do about it? Participants had a chance to brainstorm and endorse various solutions – some they've experienced working, and others they wish to see implemented.

One overwhelmingly supported solution was **increasing the availability of support groups and peer gatherings**. **"I like the idea… more support groups publicly available. I think that's a great idea,"** one participant said, jumping off another's suggestion. There was a consensus that support groups (whether for specific conditions or more general disability social groups) help people connect, share experiences, and feel less alone. Participants discussed how these could be made more accessible – for instance, held in community centers or libraries (public, neutral places), possibly facilitated by a counselor or volunteer, and better advertised so people know about them. **"A lot of people either don't know or don't have access to those groups,"** the participant continued, noting that awareness is key. The idea of doctors or clinics referring patients to local support groups was floated; essentially, integrating social support into the care plan. The group clearly felt that structured settings where disabled individuals can meet each other are invaluable. Several people had personal anecdotes: one mentioned a stroke survivors group that "saved" her from deep depression, another talked about a virtual group for young adults with disabilities that became her friend circle. These examples reinforced the point – **organized peer support** is a lifeline, and expanding it would directly combat loneliness.

Technology as a tool for connection came up as well. Even though earlier there was frustration over technology, here participants noted its positive side. **Zoom gatherings** were cited: **"We do weekly support groups on Zoom… there's lots of folks from anywhere who join in,"** one participant mentioned. This was seen as a great solution for those who can't easily leave home or who live far apart. People can bond online and perhaps occasionally meet in person when possible. Social media groups specific to disability interests were also mentioned (with caveats about sometimes misinformation, but for socializing they can be good). One participant said he found a Facebook group for people with his rare disease and now has friends across the country from it – even traveling to meet one in person. Participants agreed that **digital connection** is a powerful solution, as long as people are comfortable with the technology (looping back to digital literacy and accessibility efforts).

Another major idea was **community events and activities designed to be inclusive**. Participants thought communities should create more opportunities for people with and without disabilities to socialize in a comfortable way. One person suggested a monthly game night or movie night at the local recreation center that specifically welcomes individuals with disabilities (providing needed accommodations but also open to all, to encourage integration). **"I think it was number 3 who threw out… more support groups…,"** another said, building on earlier comments, **"but also maybe like social events – like mixers where people can just hang out."** They imagined things like an adaptive sports day, art classes adapted for various abilities, or disability-friendly festivals. The key is these events would be well-publicized and normalized, not just one-off special occasions. Some noted that organizations do exist that host such events (like Easterseals, Centers for Independent Living, etc.), but they wished for more funding and frequency for these.

Participants also touched on **transportation solutions** as a prerequisite for connection. All the events in the world don't help if people can't get there. So, some suggested expanding shuttle services or volunteer driver programs for those with mobility issues to attend social gatherings. One person said her community started a free shuttle that **"goes to different parts of town that are important."** Such transit options, possibly funded by local government or nonprofits, were seen as enabling solutions for connection.

Interestingly, a participant with significant mobility limitations said that even just **phone calls** make a difference: **"They do have activities here… they've led me down the path of prayer,"** he said about his assisted facility residence, **"and we pray a lot. We also have folks who call to check on us."** This highlighted those simple interventions, like a scheduled call from a volunteer or staff just to chat or say hello, can brighten someone's day and make them feel cared about. Another participant mentioned "friendly visitor" programs where volunteers visit homebound older adults or individuals with disabilities regularly — she thought expanding those programs would be beneficial.

A few participants brought up the idea of **buddy systems or peer mentoring**. For example, pairing someone who's newly disabled with a peer who's been living with disability for a while – not only to provide practical advice but also friendship. One man said when he first became a wheelchair user, an older gentleman who also used a wheelchair took him under his wing through a local program, and that bond was crucial to his adjustment. They remained friends beyond the formal mentoring period. Standardizing such buddy programs (maybe through hospitals or community organizations) was seen as a great way to ensure no one falls through the cracks after a life change.

Advocacy and community education were mentioned as long-term solutions to change attitudes that cause isolation. For instance, teaching school kids about disability inclusion, or having community workshops to "demystify" disabilities, so that the general public is more comfortable interacting with and including people with disabilities. Over time this type of programming and education could reduce the social barriers and make organic connections more likely. While this is more preventative and cultural, the participants did see value in it.

Finally, it was noted that **the conversation we were having right now is part of the solution**. By coming together in this survey/focus group and sharing, they were already lessening isolation. One participant said, **"These conversations… give us an opportunity to differentiate care from quality care… and to be heard."** This comment highlighted the value of creating space for disabled individuals to define what quality care means beyond basic services. Through collective discussion, participants could identify shared priorities, articulate what a meaningful quality of life looks like, and feel a sense of connection and validation by being heard within a supportive group setting.

In conclusion, the **Solutions for Connection** theme was uplifting because it focused on positive action. Participants clearly believe that loneliness is not an inevitable fate – there are concrete steps to be taken. They championed **support groups, inclusive events, better transportation, buddy systems, and leveraging technology** as ways to bring people together. Importantly, those with firsthand experience in some of these solutions vouched for their effectiveness: **"We're not alone, and we're trying to fit in… it helps to hear each other,"** as one said. The collective wish was for these types of programs to be more widespread, consistent, and integrated into community offerings. There was a sense of empowerment: having identified solutions, participants seemed motivated to pursue them or at least to voice that these changes are needed. In a way, this theme tied the narrative together on a hopeful note – yes, there are many challenges, but also many ways to foster connection, and the participants are eager to see those ways expanded.

Intersectionality

Intersectionality in this context refers to how disability intersects with other identities or social factors (such as race, gender, socioeconomic status, incarceration history, etc.) to shape a person's experience. Although fewer participants spoke directly about this theme, those who did provided insightful examples of how their disability experience is compounded by other aspects of who they are.

One participant highlighted the importance of **cultural and linguistic background** in her healthcare. She struggled for years to find mental health providers who could understand her context – a woman of color and an immigrant. Eventually, she succeeded: **"I managed to find some providers from my particular background – so this would be women from minority backgrounds or from immigrant backgrounds."** This made a tremendous difference to her comfort level in care. **"There's a lot that I can tell them that they intuitively understand,"** she explained, **"[I don't have] to explain too much."** In other words, sharing gender and cultural identities with her providers meant she didn't have to constantly translate or justify her experiences; they "got it." Her story shows how **race/ethnicity and gender** intersect with disability in care settings – when these are aligned, the care feels more supportive, and when they're not, patients may feel misunderstood. It was an important reminder that a one-size-fits-all approach in healthcare can leave people from minoritized backgrounds feeling lost or alienated, whereas a provider who shares aspects of their identity can alleviate that burden.

Another powerful example of intersectionality came from participants who had been involved with the **criminal justice system**. One gentleman shared his experience of being incarcerated while managing mental health challenges. **"I was like in [prison] with a bunch of men, and I just didn't socialize that much,"** he admitted. It was only when he **"became a peer support and then the block tutor for the special needs unit"** that he found a sense of community. In helping other inmates with disabilities, he connected deeply: **"I could relate with those guys because I am them."** Here, his identity as a formerly incarcerated person and as someone with a disability converged. He felt "othered" both as a person with a disability in society and as an ex-prisoner, but in that role as peer mentor, those pieces of his identity combined to give him purpose and belonging. After being incarcerated for 20 years, reentering society was extremely challenging for him – he mentioned feeling "empty" coming home to a changed city and struggling with everyday technology, such as self-checkout machines. In addition to dealing with his health and disability, he bore the label of "ex-offender," which carries its own stigma. When two store employees laughed at him for not knowing how to use a self-checkout kiosk and joked, **"old head, you been locked up?"** it illustrated the prejudice he faced. That intersection of **disability and incarceration history** made his transition doubly hard: he had to catch up with societal changes and find people who would accept him. His story emphasizes that for some, disability can't be separated from contexts like incarceration – the two interlock to influence their challenges and needs.

Participants also touched on **mental health stigma and sexual orientation** as intersecting factors. One man described feeling judged in the past when seeking help for depression because some providers – or even friends – would say dismissive things like **"we all get sad, come on."** That lack of understanding was partly due, he felt, to a cultural stigma around mental illness. One participant shared, "I identify with the LGBT community," and reflected on past healthcare experiences where certain questions from providers made him "feel weird." Although he did not specify the questions, it can be inferred that they may have been phrased insensitively or based on assumptions about his sexual orientation, contributing to discomfort and a sense of exclusion in the care setting. **"That was in the past… typically now I don't experience that,"** he noted, implying that healthcare has become more aware of LGBTQ+ concerns over time, but it was clearly an issue he remembered. This shows an intersection of **disability, mental health, and LGBTQ+ identity** – any one of those can invite bias, and together they can complicate finding supportive care. For him, knowing that element of his identity might affect a provider's attitude was an extra worry layered on top of managing her health.

Interestingly, one participant reflected on intersectionality from a position of relative privilege. He introduced himself by acknowledging, **"I have my privilege, you know, as a white male,"** and yet he described a particular kind of fear. Despite his privilege, he said, **"I'm scared of doctors in a way… I don't want to ask for maybe a certain medication, or I don't want to admit… that I'm having a problem."** This reluctance to show vulnerability, which he partly attributed to being a man in our society ("a macho thing"), intersected with his mental health needs.

Fortunately, he found a psychiatrist who was "very open" and supportive, and **"that experience with that particular person has been wonderful."** His perspective is telling: even someone who does not face racial or economic disadvantage still experiences a kind of intersectional barrier – in this case, the societal expectations of masculinity affecting how he engages with healthcare. It underlines that intersectionality isn't only about marginalization; it's about **how all facets of identity interact**. For him, being male made it harder to admit he needed help (due to stigma around men and mental health), and being disabled made that help necessary – a tricky combination he had to navigate.

In summary, the **Intersectionality** theme illuminated that people with disabilities are not monolithic – their other identities significantly shape their experiences. Whether it's finding refuge in a provider who shares your culture, or struggling with societal reintegration after prison, or ensuring a safe space as an LGBTQ+ individual, these additional layers can either buffer or intensify the challenges of living with a disability. Participants' narratives here call for a more nuanced understanding in services: cultural competence in healthcare, support systems for those with disability and a criminal record, sensitivity to gender and sexual orientation in treatment, and acknowledgment that disability intersects with issues of race, class, and beyond. Recognizing these intersections is key to addressing the full person, not just their disability in isolation.

General Population Perspectives

The **general population perspectives** theme captures insights from community members—caregivers, advocates, and concerned residents—who may not identify as disabled but are aware of disability-related issues. These comments emerged from a broader series of community conversations about health and well-being, offering an important outside-looking-in viewpoint that often validated and reinforced the voices of people with disabilities.

Across the board, general population participants expressed empathy and concern, especially for older adults who lose mobility and face financial strain. **"Many people lose their driver's license when they are older,"** one participant said, noting the lack of affordable alternatives: **"They need a person to take care of them, and some people don't have the money to pay for that [help]."** Others pointed to community efforts—like meal delivery services—as examples of what's working but acknowledged that services for medical transport or social needs remain insufficient.

A recurring theme was the **invisibility of the disability community**. One passionate advocate who tried for years to improve a local adaptive fitness center said, **"The disability community to this day, in my opinion, is left out… the voiceless hidden community."** His frustration with bureaucratic inaction showed how even non-disabled allies are aware of systemic neglect—and are sometimes stonewalled when trying to help.

Many echoed the need for **expanded services and inclusion across all ages**. **"People with disabilities are definitely suffering the most… from the youth all the way up to our seniors,"** one person observed. Another shared pride in witnessing inclusive community behavior: when a blind woman attended a local event, **"everybody was so attentive… her needs were met."** That moment stood out as rare and commendable, subtly highlighting that such inclusion is not yet the norm.

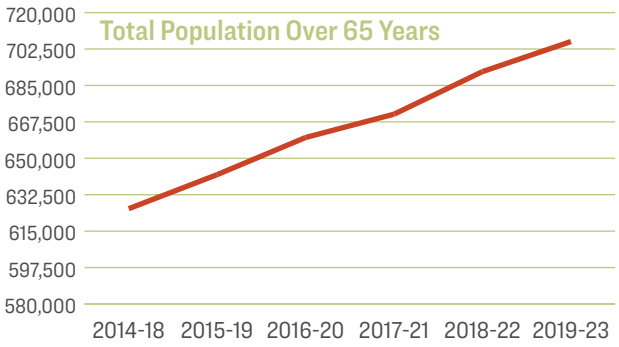
General population voices also revealed awareness of **technical and systemic challenges**—from poorly run paratransit programs to the financial burdens of caregiving. One participant described how unpredictable ride services leave people stranded: **"You never know when your rides are coming… if they're late, they don't even know they're late."**

In sum, general population community members served as powerful allies in these discussions. They saw and echoed many of the barriers described by discussion participants with disabilities—transportation, affordability, social exclusion—and added their own frustrations and hopes. Their perspectives highlight that disability access is not just a personal issue; it's a community one. They called for improved services, infrastructure, and inclusion, expressing solidarity and a willingness to act. Their voices added strength to the overall message: people with disabilities should be seen, heard, and supported—by everyone.

Together, the survey and qualitative data presented above highlight the complex and multifaceted experience of living with a disability in southeastern Pennsylvania. While many participants expressed resilience and described meaningful support systems—ranging from peer groups to trusted providers—there were also clear and persistent barriers: inaccessible services, financial hardship, social isolation, and deep mistrust in institutions. Emotional and mental health impacts were intertwined with structural challenges, and personal stories of exclusion often paralleled broader systemic failures. Yet participants also offered solutions—calls for more inclusive community programming, better caregiver support, integrated mental health care, and expanded opportunities for connection and advocacy. The findings underscore the urgency of addressing disability not just as a clinical condition but as a social and policy issue requiring comprehensive, person-centered strategies. This report aims to inform that work—by ensuring that the voices and needs of people with disabilities are central to planning, policy, and community health initiatives across the region.

Older Adults

As the older adult population continues to grow in size, it is essential to assess their distinct health, social, and economic needs, which differ from those of the general population. This report examines key issues affecting older adults in the community, including health care access and socioeconomic support. Their care needs are often more complex, requiring specialized services and coordinated support systems.



To identify existing challenges and areas for improvement, we used several methods to gather community perspectives. We analyzed community survey results, stratifying responses to compare the differences in priorities among the group aged 65 and older with the general population (18-64). This survey had a total response of 3,146 individuals, with 14% (451) being over 65 years old. We also collected qualitative data through community conversations with older adults at aging organizations, including Brandywine Valley Active Aging, Bethel Deliverance International Church, and Wayne Senior Center. We also gathered perceptions of older adults' health through targeted questions in community conversations with the general public (adults over 18) across the five-county region.

According to the community survey, people 65 and over reported:

Top 5 Barriers	Top 5 Health Problems	Top 5 Mental Health Problems
Costs associated with getting healthcare	Age-related illnesses	Depression
Transportation	Heart conditions	Anxiety
Health insurance is not accepted	Mental health	Alcohol use
No health insurance	Diabetes and high blood sugar	Loneliness
Scheduling problems	Cancers	Drug use

Compared to the general population, the aging population expressed significantly greater concern about health insurance coverage as a barrier, likely related to their dependence on Medicare and supplemental plans. Age-related illnesses and challenges of loneliness and social isolation were also rated as more significant concerns by older adults. They reported lower levels of willingness to discuss their health problems and a diminished sense of feeling welcome or respected in healthcare settings. Finally, the availability of affordable housing has emerged as a particularly prominent challenge for this population.

We will now explore these themes in greater depth through qualitative data collected from in-person community meetings at aging organizations, highlighting the personal experiences and perspectives shared by older adults.

Resources for Older Adults

SENIOR CENTERS & PROGRAMMING

There is a variety of programs available for older adults, emphasizing **education, arts, social engagement**, and overall well-being. Older adults have access to free educational opportunities at local schools and universities. **Arts and cultural programming**, including theater performances and concerts at outdoor venues provide entertainment and enrichment. Senior centers play a vital role in **fostering community** by offering diverse activities such as exercise classes, games, language courses, and arts programs.

"The senior center is really a wonder and one of the things I really like about it, the obvious things are exercise, different exercise classes. But somebody could say, well, they don't need anything beyond that. They don't need the ukuleles, they don't need music, they don't need art. Those things have been so valuable to the center as well as food and the obvious things"

Beyond traditional senior centers, churches and libraries serve as important **social hubs** where older adults can connect with others and access additional resources. While many programs are free or low-cost, affordability remains a concern for some individuals. In addition to recreational and educational programming, senior centers also address public health needs by providing nutritious meals, socialization opportunities, and extended hours during extreme heat, ensuring older adults have safe and comfortable spaces when needed.

AWARENESS & ACCESSIBILITY

Participants expressed concern about a widespread **lack of awareness** among older adults regarding available services, particularly as more essential tasks move online. Many older adults struggle with **technology**, yet accessible training opportunities are limited, making it difficult for them to order groceries, access resources, or navigate digital platforms.

"A lot of people, probably the vast majority of people don't know how to order food from the grocery store and have it delivered to their house."

They also feel left behind due to a **lack of patience and guidance** from service providers. While helpful food access programs exist, such as **meal delivery trucks and community produce distributions**, many older adults remain unaware of these options or how to use them.

"So, there are areas that still need help, and a lot of people don't know that the help exists, so they need to be educated as to what's out there and what's available to them."

Some nonprofits and senior centers have started offering training on ordering groceries online, which could be especially beneficial for those with mobility challenges or health concerns. Additionally, while Social Security benefits vary based on career and earnings, some older adults **struggle to make ends meet** and are ineligible for programs like SNAP benefits. Resources such as free SEPTA passes and discounted farmer's market coupons are available to older adults, but many are **unaware of these benefits**. Without broader outreach and education efforts, many older adults could continue to miss critical resources that could improve their quality of life and support their independence.

HOUSING

Participants highlighted the positive impact of **aging housing developments**, noting that these residences have significantly improved the quality of life for many older adults. These apartments with features like **elevators and accessible transportation options**, such as nearby bus stops, have provided **safer and more convenient living arrangements** for those who may struggle with stairs or other physical barriers in traditional homes. However, some participants shared the challenges of securing affordable housing, pointing out that **income restrictions** often disqualify individuals from low-rent options, leaving them with limited alternatives. In such cases, older adults may need to **rely on family for temporary shelter** while searching for stable housing.

"The lady I'm staying with, so the house is going to be sold. So, I have to get out of the house. Now, I tried to apply for the low rent housing. They said my income is too high. I have to go to my son's house and crowd him up until I find a place to go."

Despite these obstacles, participants acknowledged the availability of various resources that **support independent living, including mobility aids and home modifications**. Some credited state-funded initiatives, such as lottery-funded services, play a key role in making these services more accessible. While gaps remain, participants recognized the progress made in ensuring that older adults have access to the housing and resources necessary for safe and comfortable living.

Access to Care

ADVOCACY & CARE NAVIGATION

Participants expressed concern about older adults who **lack family support** and emphasized the need for community members to step in as advocates. Many struggle to **navigate medical decisions**, often not fully understanding what doctors tell them or what they are signing. Having someone to check on them, help them comprehend their medical care, and ensure they receive appropriate treatment is crucial. Participants also highlighted the risks of both overmedication and undermedication, stressing the importance of **advocates who can monitor prescriptions** and ensure medications are taken correctly. With rising rates of dementia and Alzheimer's, the need for such support is even more urgent. They suggested that individuals or groups could "mentor" an older adult, much like one would mentor a younger person, offering guidance, companionship, and assistance in navigating healthcare decisions.

Participants also expressed frustration with the **complexity of the healthcare system**, particularly when trying to **access primary care**. Some shared experiences of long wait times just to establish a primary care relationship, even when dealing with urgent health concerns.

"It takes too long to get a doctor's appointment... A person has to wait over two months to see a doctor? And then what they do when they tell you that. So, if you have a problem they say, go to the emergency room, which is like triple the cost of seeing a doctor, a regular appointment."

The requirement to see a primary doctor before being **referred to a specialist** was a common challenge, particularly in fields like dermatology, where delays could worsen existing conditions. Others noted that while some individuals had no issues getting a primary doctor, others faced systemic obstacles, such as miscommunications within health networks that prolonged the process.

MEDICARE

Older adults expressed frustration over the **lack of clear education** about Medicare options, particularly as they approach age 65. Many feel that some benefits are confusing or misleading, with key restrictions, such as limited provider networks and required specialist referrals, often not fully disclosed.

"There's a bigger issue here and that is that there is inadequate education as people are nearing the age of 65 to learn from an unbiased source about all options necessary that the government requires for when you sign up for Medicare. What level of care? What kind of prescription drug plan? How do you even analyze any of this? Someone who is nearing the age of 65 needs to know how far in advance to start doing research. If they are unable to do that themselves, then who else is available?"

Navigating the complex system without sufficient guidance is challenging, and while some community volunteers provide assistance, their availability is limited." There is also widespread **confusion about coverage details**, with many older adults unaware of their entitlement to certain benefits, such as annual check-ups, or what aspects of care are covered. Some have even found themselves educating healthcare providers on these issues. While some senior centers offer **monthly counseling sessions** to assist with Medicare decisions, many older adults remain **uninformed about their choices**, leaving them vulnerable to gaps in care and unexpected expenses. Participants emphasized the urgent need for comprehensive, accessible, and unbiased Medicare education to help older adults make informed healthcare decisions.

TELEHEALTH

Participants shared a range of experiences with telehealth, with many praising its convenience and accessibility. Virtual visits were appreciated for allowing easy access to healthcare professionals through portals, enabling patients to track their medical history and communicate with their doctors from the comfort of their homes.

"I think it's nice we can access our lab work, because then I can look up what I don't know. I can look up what I don't understand, and I don't have to ask as many questions. I'm more concise when I ask questions at the doctor's office."

The ability to access lab results and other medical information online was seen as an advantage, empowering patients to review their health data and ask more informed questions during follow-up office visits. Some participants also highlighted the value of telemedicine during the COVID-19 pandemic, particularly for high-risk individuals, as it provided a safer alternative to in-person visits while still ensuring ongoing care.

Despite the benefits, several challenges with telehealth were raised. A major issue for older adults was **difficulty navigating platforms**, which made it harder to engage with healthcare providers.

"The system that we live in now is becoming more computer. So it kind of fans out with our elderly having them, accessibility to understand how that works. So, no one has the patience anymore to sit there and dialect with you. They want you go online, go on your computer. So, my heart now says, how does that affect our older people to make sure that that information and resource that they're being taught that there's a system set up for them to be able to do that."

Participants also shared frustrations about unclear communication from medical offices regarding how to access portals and delays in receiving help. One participant struggled to **access medical records online**, requiring multiple attempts for assistance. Additionally, interpreting medical information online caused stress and confusion, as one participant misinterpreted a lab result, leading to **unnecessary panic**.

"Well, I had the mammogram and all the other testing that you get for your yearly. Well, when it came over my computer, got my trusty phone, I said, oh, wow. I'm in there reading it, I was almost in tears, I thought I was dying. Because I don't know what I seen. It was horrible."

The lack of in-person interaction was another point of contention, with several participants preferring face-to-face consultations for a **more personal experience** and effective symptom assessment. **"Certain specialties and certain problems are more compatible with telemedicine. If it's a cardiology problem, they have got to listen to your heart if there is a problem or there's got to be a visit so an EKG can be done,"** shared one participant, highlighting the limitations of virtual visits for more **hands-on care**. Despite these challenges, there was recognition of the growing importance of telehealth, with many calling for improvements in accessibility, communication, and support to make it more effective for everyone.

TRUSTWORTHINESS

Trust in healthcare providers among older adults varies significantly, with some individuals expressing **strong confidence** in their doctors, hospitals, and specialists, particularly when the **healthcare system is well-established and transparent**.

"Especially when you're ill, you're vulnerable and you need some sense of, I will be okay. They will take care of me. And I've always had it."

However, there are instances where trust is compromised, including skepticism around sharing and privacy of electronic health records, or when treatment recommendations lead to **negative health outcomes**.

Additionally, negative experiences with medical professionals, ranging from doubting quality of care to **poor communication from providers**, can severely affect trust. These experiences often lead to a preference for doctors that are familiar, even if out-of-network, due to past negative experiences. Some participants also voiced frustration over high healthcare costs, particularly for services not covered by insurance, which adds to their **dissatisfaction with the healthcare system**. Expansions of health systems into communities has also raised red flags, with one participant questioning, **"So what I'm going to say is, what is like every health system who goes in community - you have certain ones who target certain geographic areas - what are their responsibility to the community that they are building and that they basically taking over? Like what are they doing as a way how they are helping the community that they keep building in?"** Overall, while many feel confident in their providers, there is an undercurrent of skepticism in the health care system, and the accessibility and affordability of care.

MENTAL HEALTH

Participants highlighted the significant issue of isolation among older adults, particularly those who live alone and **lack access to social activities**.

"Is isolation an issue? Of course. Sure. Most seniors live alone and if they don't have access to outside activities, isolation sets in and then it becomes their norm. It's what they become accustomed to."

Over time, isolation becomes a routine way of life for many, and without regular social connections or support, these individuals can be left vulnerable and **disconnected from essential resources**. Moreover, participants noted that older adults may face communication barriers, such as using outdated technology or having hearing difficulties, making it harder for them to stay connected with others and **seek help when needed**. While some hospitals and police departments have systems in place to check on older adults, many are unaware of or unable to access these services. These proactive efforts, such as volunteer programs and wellness checks, aim to ensure the safety and well-being of older adults, but without broader outreach and education, many individuals remain isolated.

Beyond isolation, participants also emphasized the **stigma** surrounding mental health.

"I think that there's still such a stigma that comes with many mental health issues, even though we've made great strides in trying to accept that overall. But I still think that a lot of people are embarrassed or ashamed to come forward and admit to people that they have these issues."

This stigma can prevent older adults from discussing their mental health needs or accessing necessary care, exacerbating feelings of loneliness and distress. Additionally, the **intersection of mental health and socioeconomic status** presents further challenges.

"There are mental problems. We have so many individuals with mental problems that have nowhere to go. They have nowhere for housing. There are some community housing groups where they stay in. But when [state mental institution] went, they just were distributed wherever, dropped off or whatever."

These sentiments underscore the need for more accessible mental health services, stronger community outreach, and efforts to reduce stigma so that older adults and those with low incomes can receive the care and support they need.

COMMUNITY ASSETS & CHALLENGES

Participants highlighted several community assets that support their well-being. Many residents appreciate the **availability of parks, playgrounds, and walking trails** in their areas, encouraging physical activity.

"I think just having accessibility to green space ties in with being able to shop at local farmer's markets and things like that. That really encourages a healthy lifestyle."

Some noted feelings of safety and a strong sense of community in their neighborhood, with people of all ages, including older adults, participating in walking and running activities. Additionally, local **houses of faith offer programming** that addresses physical, mental, emotional, and financial well-being. The availability of recreational centers was also mentioned as a key asset for both youth and older adults, helping to keep people active and connected to the community.

Many participants raised concerns about **traffic safety**, pedestrian accessibility, and transportation infrastructure. Near-miss incidents and hit-and-run accidents highlight the need for improved crosswalk visibility, clearer pedestrian signals, and additional signage. Participants raised frustration about specific locations throughout their communities, one saying, **"That's a great danger."** Some crosswalks are poorly designed, with obstructions or flooding that force pedestrians into unsafe situations. **Pedestrian safety** is especially critical for older adults and individuals with disabilities, as some signals lack auditory cues, and certain streets need better signage to alert drivers.

Beyond transportation, there are concerns about **access to public services, social support, and healthcare**. Overflowing trash bins, inadequate infrastructure maintenance, and accessibility barriers make it difficult for individuals with mobility challenges to navigate their surroundings. **Food insecurity** is another pressing issue, with disparities in access to fresh, nutritious food affecting lower-income residents. **"The amount of unhealthy food centers that are of course in certain communities. It's predominantly in certain ethnic areas, lower income areas. The type of food services that are provided in those areas are accessible, easy and it's the poorest food for people to eat. We need more fresh foods, more accessibility so people can get to the market, those same places where there's a fried food place or whatever, we need some healthy areas for people to eat."** Social isolation, particularly among older adults, is also a concern, as some lack transportation or awareness of local programs that could provide assistance.

COVID-19

Participants expressed concerns about the resurgence of COVID-19 and the emergence of new variants in Pennsylvania. Some participants were worried about the lack of vaccines and expressed frustration with neighbors who refuse vaccinations, highlighting the risks this poses to vulnerable individuals like older adult family members. Several noted that COVID-19 **exacerbated underlying health conditions**, with some reporting new respiratory issues attributed to long-COVID. Others shared concerns about inconsistent mask-wearing in healthcare settings, advocating for clear guidelines to protect high-risk individuals. Despite these concerns, some participants continued to take precautions, such as wearing masks in public and utilizing social distancing options such as curbside pickup at grocery stores to avoid crowded spaces.

"If I go into any large area like that where there's a lot of people, I'm wearing a mask. I carry a mask all the time. Usually there's one in my pocket."

Telemedicine was seen as a helpful tool, especially during the pandemic, for minimizing exposure to high-risk groups. While some participants expressed reluctance to receive further boosters, others were hopeful for new vaccines to address the latest strains.

Suggested Actions and Solutions

Older adults have proposed several solutions to address health issues, emphasizing the importance of accessible and comprehensive care. Many suggested that health care should be **fully covered** for older adults, as well as prescription medications. Increased awareness about available health benefits, such as the annual check-up under Medicare, was also highlighted as essential. Some participants advocated for more widespread **use of community resources**, such as Meals on Wheels and senior center programs, which proved invaluable during the pandemic.

There was also a strong desire for **better communication and education** about available resources. For example, using **printed newsletters** to inform residents about community health resources could reach those without internet access.

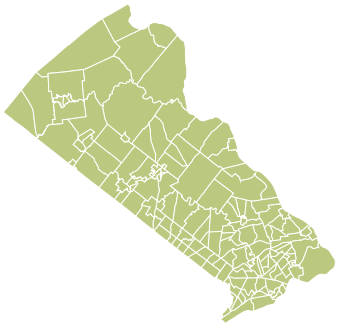
"With our township, they have a newsletter. I get it electronically. I went to the website and signed up for it, but if every resident or household received a paper copy and it contains some community resource phone numbers, that could be a way of reaching people who don't have computers and do read their mail. And I think that some of the health resources, community health resources and ways to reach these agencies or whatever could all be put somewhere in these monthly newsletters."

Participants also suggested **improving access to preventative care and healthy lifestyle education**, with an emphasis on nutrition and exercise. Addressing inefficiencies in emergency rooms, such as long wait times and unclear admission decisions, was another area of concern. Overall, participants emphasized the need for more consistency in healthcare policies, better outreach to older adults, and continued support for health and wellness initiatives.

Next, we examine insights from in-person community meetings held across various counties, where participants of all ages shared their perspectives on the challenges older adults face in accessing healthcare and resources for aging in place.

County-Specific Perspectives

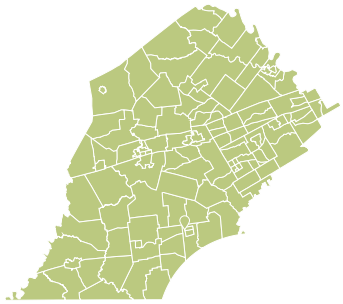
BUCKS



Community members highlighted several key challenges that older adults face, particularly in mobility, financial stability, cultural expectations, and access to care. Transportation emerged as a significant concern, with many older adults losing their ability to drive and relying on limited public transit options or assistance from churches and community organizations. Financial insecurity was another prominent theme, especially among immigrant populations, where individuals who had spent their working years supporting families abroad found themselves with little to no savings and were forced to continue working well past retirement age. Some interviewees noted stark differences in approaches to elder care, comparing systems where older adults often live independently or in nursing homes with those where family members provide care within multi-generational households.

Other barriers included language and technological limitations, which made it difficult for some older adults to access health services, understand medical information, or utilize available resources. Concerns about the quality of care in nursing homes and the financial burdens associated with long-term care were also raised, with some participants describing predatory practices and loss of assets upon entering such facilities. Despite these challenges, community members also pointed to existing support systems, such as senior day programs and local organizations that provide transportation and assistance. However, many stressed the need for better outreach, communication, and culturally competent services to ensure older adults are aware of and can access these resources.

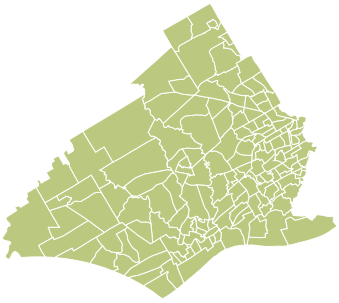
CHESTER



Participants highlighted the significant challenges faced by older adults, especially in terms of isolation, access to healthcare, and community support. The COVID-19 pandemic exacerbated these issues by limiting social interaction and access to essential services. Many older adults struggle with transportation and navigating the fragmented healthcare system, often facing long wait times for specialty care. There is also concern over financial strain, with many older adults unable to afford retirement homes or sufficient in-home care, which adds to their stress. The isolation felt by older adults can also lead to decline of physical and mental health, making it critical to address these needs in a more efficient and accessible way.

Community resources like senior centers and peer support programs are seen as valuable solutions, providing both social interaction and essential services. However, not all older adults take advantage of these resources due to stigma or lack of awareness. Some interviewees suggested creating more opportunities for peer-driven support, such as tech-savvy older adults helping others or teens assisting their peers. Improving the accessibility of services, such as clearer communication about benefits and better transportation options, is essential to support older adults. Overall, fostering a more cohesive community network can help address the complex needs of this population, promoting better health and well-being.

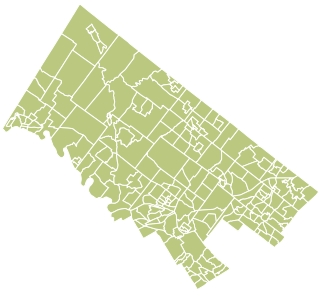
DELAWARE



Participants shared their perspective on resources available for older adults and the challenges they face. Interviewees highlighted the benefits of local services like the YMCA, which has programs that offer free, accessible exercise classes for older adults. However, the costs of gyms and the lack of transportation for some older adults were also concerns. Additionally, some participants emphasized the importance of social interaction for older adults, as it helps combat loneliness. They mentioned community centers offering free classes and the need for more caregiving support, especially for those living alone or with Alzheimer's.

The conversations also touched on the struggles of family caregivers and the challenges of providing home care for elderly parents. Interviewees noted the difficulty of balancing personal needs with caregiving responsibilities, as well as the emotional toll it can take. There was also concern over the lack of support for caregivers and the isolation that many older adults experience. Suggestions included increasing caregiver support groups and community services to help older adults remain engaged and independent. Participants stressed the importance of fostering community connections and providing more accessible resources for both older adults and their caregivers.

MONTGOMERY



Participants highlighted the benefits of senior centers, emphasizing that they provide valuable programs for healthy older adults, such as exercise and line dancing, along with meals served a couple of times a week. Senior centers also collaborate with local senior transportation services, making it easier for people to access the center. They expressed a positive view of senior centers, noting that they offer a supportive environment where older adults can receive care and social interaction. They believe that accepting care can help reduce stress and improve the quality of life for older adults, fostering a sense of community and happiness.

PHILADELPHIA

Participants emphasized the significant challenges older adults face in maintaining financial stability, accessing healthcare, and securing nutritious food. Many older adults live on fixed incomes, making it difficult to afford essential services such as housing, medical care, and groceries. The reduction of emergency SNAP benefits has worsened food insecurity, and complex eligibility requirements, confusing renewal processes, and limited mobility create additional barriers to assistance. Healthcare access is a pressing issue, with long wait times for specialty care, high prescription costs, lack of transportation, and fragmented systems making it harder for older adults to receive adequate care. Additionally, there is an unmet need for in-home support due to workforce shortages and affordability concerns.

Social isolation is another major concern, often exacerbated by mobility issues and the lingering effects of the COVID-19 pandemic, leaving many older adults with few social connections. Though community resources like senior centers, peer support programs, and home-delivered meal services are available, many older adults are unaware of these options or hesitant to use them due to stigma. Participants suggested expanding transportation services, simplifying public assistance applications, and increasing awareness of existing resources. Strengthening community-based programs, such as intergenerational support initiatives, was also seen as a promising solution to improve the well-being of older adults and ensure they receive the support they need.

Youth Voice

The 2025 Regional Community Health Needs Assessment (rCHNA) takes a youth-centered approach to better understand the health needs of young people ages 11 to 26 across Southeastern Pennsylvania. Youth are the experts of their own experiences, and their voices offer important insight into what's working, and what's not in their communities. This report shares their stories, concerns, and ideas to help hospitals, health systems, and community partners create programs that truly meet their needs.

Between August and October 2024, the Health Care Improvement Foundation (HCIF), along with the rCHNA Youth Voice Sub-Committee and local organizations, hosted 15 focus group discussions with 154 youth across five counties: Bucks, Chester, Delaware, Montgomery, and Philadelphia. Led by Dr. Briana Bronstein from Widener University, these conversations gave youth a safe space to reflect on their health, surroundings, and future. A separate community survey also gathered adult perspectives on youth issues.

Youth spoke about the strengths in their communities, like supportive relationships and access to parks and schools. They also shared serious concerns, such as, bullying, gun violence, mental health challenges, and lack of access to food, safe transportation, and equal education. Youth also shared solutions: more mental health support, safer neighborhoods, better schools, and programs that prepare them for success.

This report highlights the priorities, challenges, and ideas youth shared. By centering their voices, it offers a roadmap for building healthier, safer, and more supportive communities.

Methods

The 2025 Regional Community Health Needs Assessment (rCHNA) used a youth-centered approach to gather input from young people ages 11 to 26. The goal was to understand what youth see as the biggest health needs and challenges in their communities.

To do this, the Health Care Improvement Foundation (HCIF), with guidance from the rCHNA Youth Voice Sub-Committee, worked closely with trusted community organizations that serve youth. A total of 154 youth were engaged in this process across five counties in Southeastern Pennsylvania:

- Bucks County: 6 youth
- Chester County: 9 youth
- Delaware County: 10 youth
- Montgomery County: 12 youth
- Philadelphia County: 113 youth

Youth were invited to take part in 15 focus group-style discussions, held both in person and online between August and October 2024. These sessions were led by Dr. Briana Bronstein, Ph.D., from Widener University. Dr. Bronstein is an expert in special education and community-based learning. Each session lasted about 60 minutes, and youth received gift cards for participating. Each community organization that hosted a session also received a donation.

The following community-based organizations helped engage youth and hosted discussion sessions:

- Abington Township Public Library
- Awbury Arboretum
- Congregation Temple Beth 'El
- Esperanza College
- Garage Youth Center
- Greener Partners
- Middletown Free Library
- Netter Center
- Northeast Family YMCA
- Philadelphia Chinatown Development Corporation

Major health systems also supported this effort, including:

- Children's Hospital of Philadelphia (CHOP)
- Doylestown Health
- Jefferson Health
- Main Line Health
- Penn Medicine
- St. Christopher's Hospital for Children

Each session followed a discussion guide developed by the rCHNA Steering Committee. The guide included nine key questions to help youth share their thoughts on community strengths, health concerns, and possible solutions. Dr. Bronstein was supported by note takers, and sessions were recorded to ensure that youth voices were accurately captured.

After the discussions, a thematic analysis was used to look for common ideas and patterns across counties. Special populations were also considered to make sure all voices were included.

In addition to youth focus groups, a general community survey was shared with adults to gather their perspectives on youth health needs. The survey was available in English and seven other languages and was supported by local hospitals and community organizations.

All of this information helped identify the top health priorities in the region. These findings will guide how hospitals and health systems develop plans to address the most important needs, both on their own and in partnership with others.

MENTAL HEALTH

Across all focus group sessions, youth clearly stated that mental health is the most important health issue affecting their lives and communities. Their stories and insights revealed several key mental health challenges:

DEPRESSION, ANXIETY, AND SUICIDE

Many youth shared personal experiences with **depression, anxiety**, and even **suicidal thoughts**. They said that these struggles are often ignored or misunderstood, especially by older generations, teachers, and school staff. Some youth felt like they had no one to turn to and were afraid to ask for help due to **stigma** or fear of being judged.

Youth said more resources like coping skills groups, peer support, and open conversations about mental health would help them feel less alone.

> **ON DEPRESSION, ANXIETY, AND SUICIDE**
>
> **"I feel like depression, because at the same time, most kids, they don't know what depression is. I went through depression, where I was staying in bed, I didn't eat, and I didn't know what was happening until after I got out of it. I thought I was the only person going through what I was going through."**

BULLYING, HARASSMENT, AND ONLINE HARM

Youth across the region shared that bullying, both in person and online, is a major concern in their lives. Many talked about being picked on for how they look, what they wear, or simply for being different. Cyberbullying, in particular, was seen as especially harmful because it can follow students outside of school and into their homes.

Young people reported experiencing body shaming, online harassment, and having personal or inappropriate images shared without their consent. Some young people also said they faced racial discrimination and felt unsupported when they reported these incidents to school leaders. Many described situations where teachers or administrators failed to take action, which made them feel unheard and unsafe.

These experiences were closely tied to youths' mental health. Youth expressed how bullying lowers self-esteem, increases anxiety and depression, and makes school a stressful environment. They also said schools and communities don't always offer enough support or resources to help students cope.

According to the general population survey, **bullying was the most commonly reported mental health-related issue for youth (51.8%)** in the region.

Overall, youth called for stronger accountability, more supportive adults, and better systems in schools to prevent bullying and protect youths' well-being.

ON BULLYING, HARASSMENT, AND ONLINE HARM

"Kids talking to strangers online, or even just like bullying."

"And another thing about harassment, people will do the craziest things to other people and not care about it at all. Especially guys in my school, they're very immature. And they will disrespect people, like other ladies and just think it's okay."

"I think what we want to change in our community is just the amount of people just bullying. Some people do bullying [to] someone for no reason."

COMMUNITY VIOLENCE AND SAFETY

Many youth shared deep concerns about gun violence and safety in their neighborhoods. They talked about feeling unsafe doing everyday things like walking to school, going to the park, or even heading to work. Youth described how the constant threat of violence, especially from guns and gang-related activity, affects both their mental and physical health.

Some youth said they avoid going outside because they're afraid of being caught in a shooting. Others said gun violence has made places like parks and playgrounds unusable, especially for younger kids. A few mentioned that their communities used to feel safe, but violence has increased, and now even quiet neighborhoods are seeing things like drive-by shootings.

Youth expressed that safety and mental health are connected. The fear of violence adds to daily stress, and many feel like adults and systems meant to protect them aren't doing enough. They called for more support, including gun safety education, a stronger presence of trusted adults, and programs to prevent violence before it happens.

ON COMMUNITY VIOLENCE AND SAFETY

"I live in Philadelphia, and it's like parks on every corner. But because of gun violence, kids aren't able to play and do what they wanna do because it's unsafe."

"I've heard so much talk and we keep seeing this on the media about how people are really just worried about school shootings, and parents are scared to send their own kids to school. And kids are scared to be in school, because they're worried that someone will break in and kill them."

"And there's also, you know, the about the gun violence that I can't go more than a month without hearing something that I can't tell was that a fire truck or a gunshot? I'm just gonna choose the ladder, and I'm terrified to get out of my, I never wanna leave my house after sundown. I don't care what reason, if the sun is down, I'm not leaving by myself and there has to be at least two more people with me."

SUBSTANCE USE AND ADDICTION

Young people shared serious concerns about substance use in their communities, especially in schools. They talked about vaping, smoking, underage drinking, and drug use being common and often starting at a young age. Many said these behaviors are used to deal with stress, mental health struggles, or problems at home when other support isn't available. Some youth also said that drugs and alcohol are too easy to access and are becoming too normalized among their peers.

They shared that peer pressure plays a big role. Some feel left out or judged if they don't participate in smoking or drinking. Others mentioned that being surrounded by substance use, especially in social settings or even in their own families, makes it harder to avoid.

Youth believe more needs to be done to educate people about the real harm of addiction. They suggested hearing stories from people who have struggled with addiction might make a bigger impact than just hearing "don't do drugs."

ON SUBSTANCE USE AND ADDICTION

"Alcohol, smoking, the fentanyl issue in Kensington, depression for kids my age."

"Like sometimes people ask for money and they don't ask for food but, and a lot of people stay addicted to the drugs and then end up overdosing."

"I've seen a few people die through the drugs."

"I feel like a lot of vapes are targeted towards young children, because when you think about it, it's like banana, bubble gum, like, all these Fruity Pebbles. I've seen people smoke Fruit Loops or whatever. And so, I feel like those aren't really flavors targeted towards adults. They're targeted towards children…

"And then, also in the media, they portray vaping as something that cool people do."

EATING DISORDERS AND BODY IMAGE

Many youth shared that social media and unrealistic beauty standards can lead to eating disorders and poor body image. They explained that online trends—like extreme dieting, gym culture, and "pretty privilege", create pressure to look a certain way. This pressure can lead young people to skip meals, count calories, or follow unhealthy diets without realizing they may be developing an eating disorder.

Youth also pointed out that platforms like TikTok often promote harmful weight-loss advice. They noticed that some teens even build their identity around harmful behaviors, including disordered eating, because of how these issues are shown in pop culture.

Some youth shared that stress from school, sports, or family life can also affect both mental and physical health.

They said depression and anxiety often go hand-in-hand with eating disorders, and that many young people are struggling with these challenges quietly.

Overall, youth made it clear that body image and eating disorders are serious mental health concerns, and they want more support, education, and awareness around these issues.

ON SUBSTANCE USE AND ADDICTION

"I feel like the Internet and models and everything has this pretty privilege thing, and it says the same as on how people think they should be and how they should look and put a certain way, and because of that it causes young teenagers today to, oh, well, I have to lose 25 pounds by next week, so I only can eat one meal, or without even noticing that they slowly gain an eating disorder from calorie counting, or all juice diets, which the Internet just only ups and promotes, especially Internet things like TikTok."

These conversations show that youth are deeply affected by mental health struggles and want more support, resources, and safe spaces to be heard. Their voices are a powerful call to action for schools, health systems, and community l eaders to respond with care and urgency.

YOUTH HEALTH ISSUES

Youth across the region also shared their concerns about health problems affecting themselves, their families, and their communities. Their input helped highlight several areas of concern:

CHRONIC DISEASES AND UNHEALTHY LIFESTYLES

Many youth said they see serious health problems like diabetes, heart disease, obesity, and cancer happening often in their families and neighborhoods. They linked these issues to unhealthy eating, limited physical activity, and not having access to healthy food or safe places to exercise. Some youth explained that even when they want to be healthy, it's hard to make good choices when they feel unsafe outside or don't have the right resources.

> **ON CHRONIC DISEASES AND UNHEALTHY LIFESTYLES**
>
> **"My family is plagued with diabetes, obesity, and heart problems. I'm like one of the few in my family where I don't really have to deal with any of those problems, but a lot of my family members have died from it too."**

SEXUAL HEALTH AND EDUCATION

Youth also talked about the lack of quality sex education in schools. They said many students do not get enough information about safe sex, relationships, and emotional well-being. As a result, they noticed high rates of teen pregnancy and sexually transmitted diseases (STDs) in their communities. Youth explained that when these topics are ignored in school, misinformation spreads, and young people don't always know how to protect themselves.

> **ON SEXUAL HEALTH AND EDUCATION**
>
> **"Sex education is kind of neglected nowadays. People say that there's more sexual education in schools, but honestly, the kids are not gonna pay attention, especially when they feel like you don't care."**

MENTAL HEALTH, ABUSE, AND DEVELOPMENTAL CHALLENGES

In addition to the focus group conversations, a general population survey showed that the top three health concerns for youth in the region include mental health (31.3%), abuse or neglect (27.5%), and intellectual or developmental disabilities (22.9%). These issues reflect the need for more mental health support, protection from harm, and better access to services for youth with special needs.

These concerns show that youth are not only aware of the health challenges around them, but they are also eager for better education, safer environments, and more support to lead healthier lives. Their voices provide important direction for programs and policies that aim to improve youth health across the region.

YOUTH HEALTH TRENDS

Youth also discussed health trends, both positive and negative, that are becoming more common in their everyday lives.

GROWING AWARENESS AND ACCEPTANCE OF MENTAL HEALTH

Youth shared that mental health is being talked about more openly than in the past. Many said they've seen a positive shift, more people are going to therapy, speaking up about their struggles, and learning how to take care of their emotional well-being. While some stigma still exists, youth feel that mental health is starting to be taken seriously by their peers, families, and schools.

This trend shows hope for stronger support systems and earlier help for those who are struggling.

ON GROWING AWARENESS AND ACCEPTANCE OF MENTAL HEALTH

"I feel like it's about mental health. In some way, it's good that people are talking more about it. That has become more normalized."

"When other people take mental health more seriously, I feel like more people are inclined to speak up."

"people are getting the help they need earlier on, and finding diagnosis that they need or just helping themselves, because some kids that do know what mental health is and realize something's wrong and slowly helping themselves to fix them."

THE IMPACT OF SOCIAL MEDIA ON HEALTH AND WELL-BEING

Youth also talked a lot about the influence of social media. While they acknowledged that it could help people connect and learn, many also shared concerns about cyberbullying, body image pressure, explicit content, and unrealistic standards that harm mental and emotional health. Some mentioned that too much time online can negatively affect relationships and self-esteem.

Youth said they want more education about healthy social media use and more support when online harm happens.

ON THE IMPACT OF SOCIAL MEDIA ON HEALTH AND WELL-BEING

"Social media is such a big thing with our generation."

"Social media has a big influence on the youth. I don't think a lot of youth realize what you post online never goes away. People have seen it, people aren't going to just forget about it. That can cost you your job, that can cost people's lives, and I think it's just really important for the youth and other people just to be educated on social media etiquette."

"Over usage of technology. Now it's a lot more common for relationships to be online, which can obviously harm somebody's mental health or harm relationships internally."

These trends, the normalization of mental health care and the powerful role of social media, are shaping how youth view their health and the world around them. Listening to their insights can help schools, parents, and communities support youth in more effective and meaningful ways.

CHALLENGES AND BARRIERS

Youth shared many serious challenges and barriers in their communities that impact their daily lives and well-being. Through focus group discussions, several key concerns were identified across the region:

LITTERING AND ENVIRONMENTAL ISSUES

Youth across counties voiced frustration about pollution and trash in public places. Many talked about how hard it is to enjoy parks and community spaces because of litter. They saw this as a sign that their neighborhoods are not being cared for properly and said it affects how safe and proud they feel about where they live.

ON LITTERING AND ENVIRONMENTAL ISSUES

"But I also feel like a barrier, I feel like for the community as a whole would be the litter. It's just so absurd. You can't even go outside into a park without seeing piles of trash. And it's like, if it's your community and you're living in it, and you're living in this neighborhood, why wouldn't you want to take care of it?"

"I'm starting to see a lot more trash in the playgrounds, and that's even like the younger generation just not being disrespectful but not respecting the community they live."

ACCESS TO HEALTHY RESOURCES AND HEALTHCARE

Another common challenge was lack of access to basic resources. Youth said it is often hard to find healthy food, get affordable healthcare, or use reliable transportation. These barriers can make it difficult for families to stay healthy and for young people to get the support they need.

ON ACCESS TO HEALTHY RESOURCES AND HEALTHCARE

"Access to resources. Well, definitely access to health in general."

"Probably, like, the prices in, like, grocery stores where, like, people have, like, less access to income, like, their own income."

These challenges show that while youth feel connected to their communities, they also face daily struggles that impact their health, safety, and quality of life. Their voices help guide future efforts to create safer, cleaner, and more supportive environments for all young people in the region.

ACCESS TO CARE ISSUES

Young people shared several concerns about getting the care and support they need. The top issues they mentioned are explained below.

ACCESS TO MENTAL HEALTH RESOURCES

Mental health was the most common concern among youth. Many said it's hard to get the help they need. They shared that behavioral hospitals often provide poor quality care, and there is still a lot of fear and stigma around asking for help. Some youth don't know where to go or feel uncomfortable talking about their problems. Others said the resources available don't feel anonymous or supportive enough.

ON ACCESS TO MENTAL HEALTH RESOURCES

"I'm not sure about, like, statistics and stuff like that, but usually, access to health care and stuff like that, in the younger generation, they're usually savvy in there. They usually are good about going to the doctors and stuff. I would say, mental health and finding resources for mental health is usually a struggle. Or just having a stigma against utilizing resources for mental health, like therapy or meditation or just talking to someone usually get utilized."

"I was going to say there are a bunch of resources at my school, especially for people who are struggling with mental health. There's always safe to say, which we always have, but a lot of kids have realized, as we continue to use these resources that are anonymous, that they're not really anonymous. And there are consequences to using it, and so people have relied on it less, and it just becomes this backward thing where people don't even want to access this resource, because for sure, there are safeguarding issues and legality of not -- that you can't really remain anonymous like that. But now that just makes people want to use it less."

ACCESS TO HEALTHY FOOD AND NUTRITION

Many youth said healthy food is too expensive or hard to find. They talked about how junk food is everywhere, but fruits and vegetables are harder to get, especially in neighborhoods without good grocery stores.

ON ACCESS TO HEALTHY FOOD AND NUTRITION

"Access to fresh healthy foods."

ACCESS TO CARE ISSUES

ACCESS TO TRANSPORTATION AND SERVICES NEARBY

Young people often struggle to get to the services they need because of long distances or unreliable transportation. Some said buses are unsafe or don't run often enough. If services are far away or hard to reach, many youth go without the help they need.

ON ACCESS TO TRANSPORTATION AND SERVICES NEARBY

"I think having a wider access in transportation would be nice."

"I think public transportation is a problem. Going back to the money thing, a car is expensive, the bus isn't always the safest route to go. And in the North-East the buses are not super easy to -- there's like maybe three buses, there's like 84, the 67, and the 20."

OTHER CONCERNS: EASY ACCESS TO DRUGS AND VAPES

While not a care barrier, many youth said it's too easy to get drugs, alcohol, and vapes. This raises safety and health concerns and shows how access can sometimes work in harmful ways.

ON EASY ACCESS TO DRUGS AND VAPES

"Not really related to what anyone else said, but still related to health, I think that I would change how easily kids our age have access to vapes and such, especially in our high schools and even middle schools kids have such easy access to drugs, to vapes, to all these things that are bad for your health. And it's so normalized, and there I feel like not much is being done in schools."

These issues highlight the importance of improving care systems so that all youth can get the help and support they need, when and where they need it.

GOOD SCHOOLS

Youth shared their ideas for improving their schools and communities. Their feedback focused on the need for more useful education, better mental health support, and community-based solutions to keep youth safe and healthy.

MORE RELEVANT AND PRACTICAL EDUCATION

Many youth said that schools should focus more on real-life skills like financial literacy, health education, and career preparation. They feel that while traditional subjects are important, schools don't always teach them how to manage money, take care of their health, or get ready for the workforce.

ON MORE RELEVANT AND PRACTICAL EDUCATION

"And I think-- oh, sorry. Going off of like in the schools of the life someone skills of like, in this generation, a lot of people order food because they were never taught how to cook, they were never taught how to make things. And so, that inevitably you're spending a lot of money and stuff, and. And I think too with the college, -- my school did an okay job, but I feel like they could have done a lot better of, like, okay, you kind of have an idea of where you want to go for school, I mean, not everybody does, and that's okay, but will this job, will you be able to pay back your schooling? Will you be able to pay back those loans with the job that you want to get in the future and stuff like that? And it's like, they don't teach you those life skills of how to think about that stuff or how to get there, how to find those scholarships, how to outreach. They'll send you a link, but then it's like, are you able to answer these questions or this essay, was education enough to teach you how to do all of that stuff on your own and things like that?"

BETTER MENTAL HEALTH AND SOCIAL SUPPORT

Youth also talked about the need for stronger mental health support in schools. While some schools have counselors, many students said they don't feel comfortable using these services or worry about privacy. They want more safe spaces, group support options, and counselors who feel approachable and trustworthy.

ON BETTER MENTAL HEALTH AND SOCIAL SUPPORT

"Also having counselors at school that you can go to at any time. Because know at my old school there wasn't a counselor there."

"I was going to say there are a bunch of resources at my school, especially for people who are struggling with mental health. But a lot of kids have realized they're not really anonymous, and now people don't even want to access t his resource."

These insights show that youth are thinking seriously about their futures and their communities. They want schools and neighborhoods that help them grow, support their mental health, and give them the tools they need to succeed in life.

ACTIVITIES FOR YOUTH

Youth shared how they stay involved and connected in their communities. Many spoke about activities that help them build friendships, feel supported, and give back.

SPORTS AND EXTRACURRICULAR CLUBS

Youth shared that being part of sports teams, dance groups, and school clubs gives them a strong sense of community. These activities provide a safe space to have fun, make friends, and feel included. Whether it's school sports, church-based activities, or after-school programs, youth said these experiences helped them stay active and build lasting social connections.

ON SPORTS AND EXTRACURRICULAR CLUBS

"Having access to local sports teams and community centers makes it easy to stay active and meet new people."

"I'll definitely say, us, the YMCA. I think a lot of the younger community that live in this area access this facility as much as possible and they use it to their advantage. And I think it creates a better life for them."

"Oh, I consider the dance team my community. I feel like it's a safe space, I feel like we have a great time, easy for us to get along and talk about things, that's where my community is at."

COMMUNITY SERVICE AND VOLUNTEERING

Many youth said that volunteering and giving back to their neighborhoods is a big part of their lives. They enjoy helping others and said it brings people together. Volunteering also gives them a sense of purpose and allows them to support communities that may not have many resources.

ON COMMUNITY SERVICE AND VOLUNTEERING

"For me, it'd be the Philadelphia Suns where we do - where we volunteer, we play sports, get to know each other like we're family."

SOCIAL AND CULTURAL IDENTITY GROUPS

Youth talked about how important it is to be part of cultural and identity-based groups, such as Black Student Unions, Asian cultural clubs, or LGBTQ+ support groups. These spaces help them feel seen, supported, and understood. They also provide education and community around shared experiences and identities.

ON SOCIAL AND CULTURAL IDENTITY GROUPS

"Seeing yourself represented in the community and having an entire safe space in the case that it feels really nice to just be able to see yourself and have a place to go if you really want to."

These activities show how youth connect with their communities through sports, service, and cultural identity. They also highlight the need for more safe, inclusive, and accessible spaces where young people can grow, feel supported, and lead positive changes.

YOUTH LEADERSHIP

Many youth shared how they are taking on leadership roles in their schools, communities, and workplaces. These opportunities help them build confidence, gain experience, and prepare for their futures.

VOLUNTEER AND COMMUNITY SERVICE LEADERSHIP

Youth spoke proudly about their involvement in volunteer programs, community service projects, and youth-led outreach efforts. Whether helping at food drives, caring for animals, or starting their own projects, many youth said these hands-on experiences helped them become more responsible and feel more connected to their communities.

ON VOLUNTEER AND COMMUNITY SERVICE LEADERSHIPS

"For my community and my congregation, specifically the youth, I'm in leadership with that. So being able to take the lead, being a guide and help as best as possible. And also creating opportunities for us to give back to the community."

"I feel like there are a lot of opportunities. I think it's also much easier now that we have online. We have the opportunity to go online and just search up volunteering opportunities, like charities we can attend, just all our resources. But I feel like sometimes it's hard to really get into it because of requirements like you have to be in a wait list for a couple of years or -- okay, not a couple, but a year, or you can only attend if you're 18 or older in that sense."

SCHOOL-BASED LEADERSHIP ROLES AND CLUBS

Many youth said they developed leadership skills through school clubs, student government, and academic programs. These roles gave them the chance to speak up, plan activities, and represent their classmates. Clubs like HOSA (Health Occupations Students of America), GSA (Gender and Sexuality Alliance), and others were mentioned as key places for youth leaders.

ON SCHOOL-BASED LEADERSHIP ROLES AND CLUBS

"We volunteer all the time. We're in almost every after school program."

"At my school. We just recently, like in the last few years, we started a GSA club. Gender and sexuality awareness like, yeah, that."

"But to go on the leadership thingy, the HOSA Club is a really big one. I was vice president for a year for it and my friend was also, my friend actually was the president for a year. There are also other leadership roles within that, not just president, vice president, there's treasurer and other roles such as that. But I think that is a stepping stone for something a lot bigger, because it showed me that there are so many different things, so many different opportunities you could take a hold of, not just in the HOSA club, but also through the trips we would take in, state and international."

CAREER DEVELOPMENT AND EARLY WORK EXPERIENCE

Youth also talked about internships, job training programs, and early college experiences that helped them build real-world skills. Through programs like Counselor-in-Training (CIT) at camps, hospital internships, and college credit courses, youth learned responsibility and leadership in work settings.

ON CAREER DEVELOPMENT AND EARLY WORK EXPERIENCE

"For me, it was leadership roles when I did. I was an intern, and I helped kids out, which is hoping them engage and interact, I think in the summer of 2023. So, that was one of the leadership roles I obtained. There's other places and other programs where I was in the leadership role, but that helped me interact more with different age groups, and things like that."

These youth-led experiences, whether in the community, at school, or through job programs, are helping shape the next generation of leaders. Youth shared how important it is to have opportunities to lead, grow, and give back, and they want more support to continue building those skills.

WHAT'S WORKING WELL

Although youth shared many challenges and barriers in their communities, they also talked about what is working well. In conversations held across five counties, young people shared what they believe are the biggest strengths in their communities. They described what makes their communities feel strong, supportive, and positive.

STRONG SENSE OF COMMUNITY AND SUPPORT

Many youth said that the people in their communities are their greatest strength. They shared how neighbors, friends, and even strangers look out for each other. Support systems like mentors, counselors, and social groups help them feel connected and cared for. Youth also said they feel proud of how their communities come together during tough times.

ON STRONG SENSE OF COMMUNITY AND SUPPORT

"I like to see when people like, random strangers be helping other random strangers. I just love it. It warms my heart."

COMMUNITY EVENTS AND INITIATIVES

Youth spoke highly of local events that bring people together, such as block parties, gardening programs, and community cleanups. These activities give people a chance to work together, meet new friends, and build stronger neighborhoods. They also help youth feel like they belong and can make a positive difference.

ON COMMUNITY EVENTS AND INITIATIVES

"Two months ago, we actually had like this block party where we cleaned up our whole block. And honestly, I would say like that's our biggest strength is the fact that we know how to communicate with each other, when we see a problem, we know how to deal with that."

ACCESS TO RESOURCES AND FACILITIES

Young people shared how important it is to have easy access to things like parks, schools, community centers, mental health support, and public transportation. These resources help youth stay active, healthy, and connected to others. Youth also mentioned how small businesses and local programs help make their communities feel close-knit and supportive.

ON ACCESS TO RESOURCES AND FACILITIES

"The access we have out here, like urgent care, all the stuff around here, we've got stores, we've got markets, we've got we've got restaurants, places. So that way there's still produce and resources that you can go around and you don't have to drive, maybe hour or 30 minutes away. Just so you can go to the grocery store or get food, as long as it's just in the area. That's how I like some areas that have all the resources in just one place and not all spread out."

These insights show how youth value connection, community effort, and access to helpful resources. Their voices highlight the strengths that already exist and can be built upon to support healthier, more united communities.

SUGGESTED ACTIONS AND SOLUTIONS

Youth were asked to share ideas on how to improve their schools and neighborhoods. They offered thoughtful, community-focused solutions to help young people feel safer, healthier, and more supported.

INCREASED MENTAL HEALTH AND SUBSTANCE USE SUPPORT

Youth emphasized the urgent need for better access to mental health care and substance use recovery programs. Instead of punishing youth who are struggling, they suggested workshops, group meetings, and community services that provide support and healing. Many believe that early help can prevent bigger problems later on.

ON INCREASED MENTAL HEALTH AND SUBSTANCE USE SUPPORT

"I also think that the way that we shift our resources is a solution. Instead of the city putting millions of dollars to A, let's put some of that money towards youth mental health and youth education."

"To get help just without being penalized maybe"

ENHANCED PUBLIC SAFETY AND GUN VIOLENCE PREVENTION

Many youth shared that they don't always feel safe in their neighborhoods or schools. To improve safety, they suggested having more trained staff on campus, gun safety education programs, and metal detectors in schools. These ideas came from a desire to prevent violence and protect students from harm.

ON ENHANCED PUBLIC SAFETY AND GUN VIOLENCE PREVENTION

"And I think it should be more safety around, so people could be more safe going outside. I need to see police at every corner, you know. Cause I ain't about to be going to my job, and I think I'm about to get my head blown off seconds later. I don't want to feel like that. I need the police to be more active and aware, everyone are surrounded."

"I'd say maybe a stronger enforcement. Maybe more police or something like that."

"I would say, I wanna introduce more gun safety laws to my community and then, education on how to deal with firearms and stuff like that. But definitely more, making it harder for people to get guns."

BETTER ACCESS TO EDUCATION, COMMUNITY PROGRAMS, AND CAREER READINESS

Youth said they want more opportunities to build real-life skills through education, extracurricular programs, and career training. They highlighted the need for community centers, mentorship programs, and resources for underprivileged youth to help them grow and succeed in life.

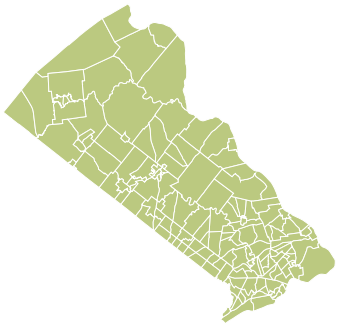
ON BETTER ACCESS TO EDUCATION, COMMUNITY PROGRAMS, AND CAREER READINESS

"And another one was introducing more, like, outreach programs that help young people in inner-cities and stuff like that. Explore job fields and stuff. Like, they get to really see different career paths that they can go into. Something like that."

These youth-led solutions show a strong desire for prevention, education, and support. Youth across the region want to be part of creating safer, more inclusive, and opportunity-filled communities, and they're ready to lead the way.

County-Specific Perspectives

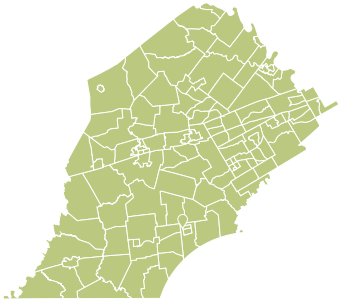
BUCKS



Youth in Bucks County identified two major concerns impacting their health and well-being: substance use and academic and social pressures. Many youth shared that vaping, alcohol, and drug use are common and start as early as middle school. Flavored products were seen as targeting teens, and students felt schools were not doing enough to address the issue. They recommended stronger prevention efforts using real stories and clearer messaging about health risks.

Youth also described feeling overwhelmed by school demands, pressure to succeed, and stress from social media. They called for more mental health support, access to therapy, and programs that help prepare them for life after high school, such as job shadowing and workshops. Despite these challenges, many youth spoke about strong community support, safe neighborhoods, and quality school programs. Their feedback can help shape future programs that better support youth in Bucks County.

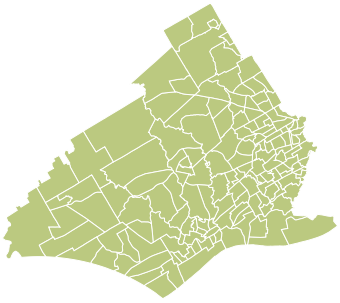
CHESTER



Youth in Chester County identified two key concerns affecting their well-being: mental health and substance use, and the need for stronger community connection and inclusion. Many youth reported high stress, family issues, and peer pressure, leading some to use vaping, alcohol, or drugs as a way to cope. They said they need more trusted adults, better mental health education, and easier access to support services.

Youth also spoke about the importance of feeling accepted and included. Bullying, cyberbullying, and social isolation were common concerns. They want more opportunities to connect through school clubs, volunteering, and community events. Clean, safe spaces and respectful environments were seen as essential to helping youth feel valued and supported.

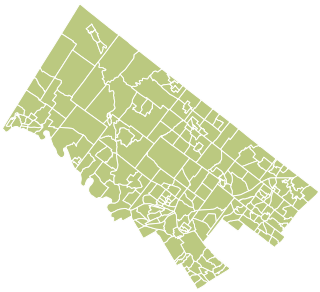
DELAWARE



Youth in Delaware County shared concerns about mental health, school pressure, and inclusion. Many reported feeling overwhelmed and said school counselors and mental health resources often feel unhelpful or hard to access. Youth called for more trusted adults, better mental health education, and services that fe.el real and focused on their needs

Students also described high academic pressure and a lack of understanding from teachers when they struggle. They want more practical classes like financial literacy and more time to rest. While some youth felt supported through clubs and leadership roles, others shared concerns about bullying, peer pressure, and lack of diversity. They asked for safer, more inclusive spaces where all students feel welcomed, respected, and able to lead.

MONTGOMERY



Youth in Montgomery County shared concerns about mental health, school safety, and substance use. Many reported feeling stressed, anxious, or depressed, often without trusted adults to turn to. Bullying, online harassment, and the pressure to support friends added to their struggles. Youth said stigma and a lack of early mental health education make it harder to ask for help

Youth also described feeling unsafe at school due to bullying, threats, and sexual harassment, often worsened by social media. They said schools don't always respond effectively and called for stronger safety measures and accountability. Substance use, especially vaping and marijuana, was another concern, with youth noting increased peer pressure and misleading online messages. They asked for more honest, age-appropriate drug education. Despite these issues, youth recognized the value of supportive clubs and inclusive community programs.

PHILADELPHIA

Youth in Philadelphia County identified mental health, community safety, and limited access to youth opportunities as key concerns impacting their health and well-being. Many youth reported high levels of stress, anxiety, and trauma related to school pressure, bullying, social media, and lack of trusted adults. They also highlighted easy access to vaping, alcohol, and drugs—especially flavored products targeting teens, and called for more youth-friendly mental health services and education.

Safety was another top issue, with youth expressing fear in public spaces due to gun violence and bullying. Many said safety concerns keep them from joining programs or using community resources. Youth also noted a lack of accessible jobs, internships, and support services, particularly for those under 16. They recommended better outreach, use of social media, and stronger community connections to increase access and improve safety and mental health support.

Community Health Needs

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

HEALTH ISSUES

Physical and behavioral health issues significantly impacting the overall health and well-being of the region

- Chronic Disease Prevention and Management
- Healthy Aging
- Substance Use and Related Disorders

ACCESS AND QUALITY OF HEALTHCARE AND HEALTH RESOURCES

Availability, accessibility, and quality of healthcare systems and other resources to address issues that impact health in communities across the region

- Access to Care (Primary and Specialty)
- Culturally and Linguistically Appropriate Services
- Food Access
- Healthcare and Health Resources Navigation (Including Transportation)
- Mental Health Access
- Racism and Discrimination in Health Care
- Trust and Communication

COMMUNITY FACTORS

Social and economic drivers of health as well as environmental and structural factors that influence opportunity and daily life

- Housing
- Neighborhood Conditions (e.g., Blight, Greenspace, Air and Water Quality, etc.)

An additional list represents youth specific priorities:

- Substance use and related disorders
- Youth mental health
- Access to Physical Activity
- Lack of Resources/ Knowledge of Resources
- Access to Good Schools
- Activities for Youth
- Bullying
- Gun violence

Participating institutions' ratings of the community health needs were aggregated and are listed below in order of priority: Potential solutions for each of the community health needs, based on all qualitative data collection and evidence interventions, are also included.

PRIORITY

1 Trust and Communication

KEY FINDINGS:

- National surveys indicate declining patient trust in healthcare institutions, often due to provider burnout, high turnover, disparities in treatment, and financial barriers, which disproportionately affect uninsured and minoritized communities. Community conversations reinforced this issue in the region.
- **Challenges in Provider-Patient Communication:** Patients feel rushed during short appointments and unheard by providers, leading to concerns about potential medical errors, particularly with conflicting prescriptions.
- **Emergency Room (ER) Communication Gaps:** ER staff have the most pronounced communication issues, which are closely linked to long wait times and patient frustration.
- **Administrative & Customer Service Concerns:** Poor front-desk interactions, including last-minute appointment cancellations and unprofessional behavior, contribute to negative patient experiences and decreased trust.

POTENTIAL SOLUTIONS:

- Desire for **more empathetic, respectful, and culturally responsive care** and support staff.
- Suggestions included **more social workers** in hospitals and **improved communication** about healthcare changes.
- **Transparent, Timely Communication:** Ensure benefit notices and appointment information are received on time, not after due dates and provide regular updates on healthcare changes and medication protocols.
- **Accountability Mechanisms** for Healthcare and Social Service Staff to provide consequences when institutions or workers drop the ball on paperwork or communication.
- A dream solution expressed by multiple participants was a system where **everyone receives the same quality of care, regardless of insurance status**.
- Implement **team-based care**, including patient navigators, care coordinators, and longer appointments for complex cases.
- Expand and improve **training of healthcare providers in active listening, shared decision-making, and cultural competency** for all healthcare staff.
- Implement **standardized communication tools** and patient status boards to enhance transparency.
- Require **front-desk staff to complete standardized training** in customer service, de-escalation, and empathy-based communication.
- **Expand appointment availability, reduce financial barriers** for uninsured patients, and **improve transparency** in billing and treatment options.

PRIORITY

2 Racism and Discrimination in Health Care

KEY FINDINGS:

- People of color, immigrants, people with disabilities, people with mental illness, people with substance addiction, LGBTQ+ individuals, and other minority groups continue to **experience discrimination and institutional barriers to health care**.
- Insufficient health care staff from diverse and representative backgrounds play a major role in this issue – people do not see themselves reflected in the healthcare workforce; can lead to not "feeling seen."
- **Intersecting identities** lead to exponential impacts on discrimination and racism, and subsequent trauma.
- The **political climate** in the United States contributes to feelings of vulnerability within marginalized communities.

POTENTIAL SOLUTIONS:

- **Cultural Competency and Anti-Bias Training for Providers:** Participants called for healthcare professionals to update their knowledge and attitudes beyond outdated textbooks.
- **Bilingual and Multilingual Staff and Services:** Strong calls for in-person translation services and recruitment of bilingual providers. Languages mentioned: Spanish, Arabic, French, several African languages.
- **More Representation in Healthcare Staffing:** Participants suggested that providers should reflect the communities they serve — racially, culturally, and linguistically.
- **Trauma-Informed, Non-Stigmatizing Behavioral Health Care:** Address the way patients with substance use or mental health needs are often denied full treatment, especially pain management.
- **Systemic Reform for Equity in Access:** Recognize and address structural racism — such as how funding, communication, and service offerings exclude or deprioritize certain communities.
- Expand and improve **training of healthcare providers around anti-racism**, structural racism, implicit bias, and trauma-informed care.
- Increasing number of people of color in healthcare leadership positions.
- Ensure diversity, equity, and inclusion efforts and plans at healthcare institutions include explicit focus on racism and discrimination.
- **Create and fund ongoing forums for community leaders** to work with health system partners to address issues of racism and discrimination in health care.
- Targeted, specialized services to meet culturally specific needs.

PRIORITY

3 Chronic Disease Prevention and Management

KEY FINDINGS:

- **Community gyms and recreation spaces that are well maintained and free/affordable**, were recognized as desirable neighborhood resources, along with safe neighborhoods, and support disease prevention & management.
- **Limited access to healthy food options and limited food education** were noted as some of the greatest barriers to maintaining health and preventing or improving health conditions.
- Some participants shared about knowledge of and experiences with **Long COVID**, while a significant number were unfamiliar with the condition. Millions of adults in the U.S. have been affected by Long COVID. Participants are still generally concerned about acute COVID-19 infection.
- **People with disabilities, who are not all older adults, face barriers to disease prevention and management** due to accessibility issues and require greater advocacy.

POTENTIAL SOLUTIONS:

- Increase **access to local fitness centers** and programs that accept health insurance.
- Promote **community gardens and green spaces for physical activity** and healthy eating.
- Provide consistent access to **nutritional education** for both children and adults.
- Offer more accessible **chronic disease screenings and follow-up care**, especially for older adults.
- Ensure health centers and providers are open during evenings/weekends to improve access.
- **Engage trusted community leader**s to spread key messages (for example, promoting cancer screening).
- Expand successful innovations from the pandemic, such as **virtual and mobile wellness programs**.
- Bring screenings and health education to **faith-based institutions** or where people are.
- Provide screening, referrals, and **"warm hand-offs"** to community-based health and social services.
- Offer support and services to people with Long COVID, providing education on this condition as well.

PRIORITY

4 Access to Care (Primary and Specialty)

KEY FINDINGS:

- Prevailing barriers in accessing care include: **inadequate health insurance coverage** (insurance not accepted, high out-of-pocket costs, no dental coverage), **limited transportation/accessibility of offices/hospitals** (primarily an issue in non-urban settings and amongst older adults), **extended wait times** for appointments (prompting use of ER and urgent care more often), **closures of local hospitals**, and specialists not covered by insurance or not available for appointments/too far.
- In addition to hospital closures, **pharmacy closures** present challenges related to obtaining prescriptions, resulting in increased utilization of prescription deliveries.
- Some pandemic-era changes to access have persisted, including more **pervasive telehealth services, increased interaction with health portals, and virtual health-related programming.**

POTENTIAL SOLUTIONS:

- **Extend clinic hours** to evenings and weekends.
- **Reduce wait times** for appointments, especially for urgent needs.
- **Simplify the referral** and authorization process, which often delays care.
- Provide local **urgent care and dental options**, especially in rural or underserved areas.
- Address **insurance instability** (frequent changes to accepted plans or providers).
- Establish comprehensive health centers addressing physical and mental health, as well as dental care. Provide low-cost or free care options.
- **Expand services** in areas which have experienced closures.
- **Embed social workers** and patient navigators in primary care practices; continue utilization of community health workers (particularly focusing on sharing of community resources and health information)
- Provide **on-site language interpreters** and health education materials in diverse languages.
- Increase racial, ethnic, language diversity of staff and providers to better reflect communities served; offer increased training related to culturally appropriate care.

PRIORITY

5 Healthcare and Health Resources Navigation

KEY FINDINGS:

- Community members' **lack of awareness of resources** is reflective of both community needs and a lack of knowledge.
- The perception of a lack of resources where some might exist is indicative of a need to **improve information dissemination** and methods of accessing that information. Participants frequently felt compelled to share resources and experiences with one another, when needs and complaints arose about health services among the focus group members.
- **Navigating insurance policies**, coverages, web platforms, related resources and healthcare costs prove challenging – especially for older adults who feel less confident with technology use and the transition to Medicare.
- **Mentorship for medical decision-making**, particularly for older adults who live alone, can promote social support, advocacy, and safety.

POTENTIAL SOLUTIONS:

- **Expand non-emergency medical transportation options**, particularly for older adults and rural residents.
- Provide **help navigating insurance plans, applications, and renewals** (e.g., in-person or phone-based support).
- Create **centralized, updated lists of services** and locations (e.g., food vouchers, clinics).
- Provide **tech support** or training for those who struggle with using healthcare portals or telehealth.
- Increase public awareness of **community resource directories** that local health systems have invested in and support community members with using them.
- Increase the capacity of healthcare staff to assist community members with navigation by regular education on available resources.
- Grow the numbers of professionals serving as community resource or **healthcare navigators**.
- Create permanent **social service hubs** that serve as "one-stop-shops" for commonly needed resources.
- Expand low-cost transportation options.

PRIORITY

6 Mental Health Access

KEY FINDINGS:

- Community members shared the quantity and availability of **mental health providers are insufficient to meet ever increasing needs** (particularly post-pandemic).
- Additionally, health **insurance coverage for mental health services and providers is inadequate**.
- **Stigma** around this topic was cited as a barrier – especially in ethnic minority communities.
- The **intersection of mental illness, substance use, and/or homelessness** was recurring concern.
- The general population expressed significant concerns related to **youth mental health** – which is reflected in the youth prioritization.
- **Mental health needs for older adults** focus on grief support and opportunities for community-based social engagement.

POTENTIAL SOLUTIONS:

- Increase the number of **behavioral health providers**, especially in rural areas. Increased behavioral health workforce diversity (e.g., language, racial, and ethnic).
- **Reduce wait times** and eliminate long delays between referrals and services.
- Normalize seeking help by reducing cultural stigma around mental health through community education.
- Offer **telehealth mental health options** for those without transportation.
- Provide **trauma-informed mental health** support tailored to children, youth, and families.
- Improved **care coordination** in integrated care model.
- Co-located prevention and behavioral health services in community settings (**"one stop shop"**).
- Increased training for healthcare providers, community-based organizations, schools, law enforcement, and others in Mental Health First Aid, trauma-informed care, and cultural competence.
- Increased individuals with lived experience in the behavioral health workforce.

PRIORITY

7 Substance Use and Related Disorders

Key Findings:

- Community members shared concerns about substance use in their communities, co-occurring mental illness, the potential implications on youth, and the association with poor neighborhood safety.
- **Drug overdose** rates continue to be high due to opioid epidemic.
- **Community-based services** to treat substance use are perceived as **insufficient in number** by some, and/or are not well-known by others.
- **Prevention and education measures** can serve as protective factors against misuse and abuse; questions arose regarding the usefulness and impact of policing related to substance use.

POTENTIAL SOLUTIONS:

- **Expand community-based rehabilitation programs** as alternatives to incarceration.
- Provide **trauma-informed care** and education during health visits, especially for youth.
- Increase provider training to **eliminate bias toward individuals with histories of substance use**.
- Offer drug education at the provider level (not just in schools) with resources for both youth and families.
- **Reduce stigma** through culturally competent and empathetic behavioral health care.
- Sustain and expand prevention programs, ranging from school-based educational programs to community **drug take-back programs**.
- Expand **Narcan training and distribution**.
- Increase **medical outreach and care for individuals living with homelessness and substance use disorders**.
- Encourage use of **Certified Recovery Specialists and Certified Peer Specialists** in warm handoffs for drug overdose and other behavioral health issues.
- Enhanced utilization of **medication-assisted treatment initiatives**, in coordination with behavioral therapies and social support.

PRIORITY

8 Healthy Aging

KEY FINDINGS:

- Community members raised concerns about older adult **isolation, impacting mental health, food access, and healthcare interactions**. Senior centers and community services were frequently mentioned.
- **Transportation barriers** contribute to food insecurity and limited community engagement. Free ride programs often involve long waits, indirect routes, and lengthy travel.
- **Limited digital literacy** and unfamiliarity with technology restrict older adults' access to healthcare and social services.
- **Medicare transitions are often confusing**, causing missed benefits.

POTENTIAL SOLUTIONS:

- **Improve transportation services** for older adults to attend appointments, social events, and access groceries.
- Provide free or subsidized **exercise classes** (e.g., Tai Chi) to support mobility and wellness.
- Increase **availability of nutritious food** through filtered senior food distribution programs.
- Establish or **re-open senior centers** and day programs for social engagement and resource access.
- Offer help with documentation and paperwork (e.g., birth certificates, benefits forms).
- Create anonymous and accessible **reporting systems for elder abuse** or neglect.
- Expanding **services to help older adults age in place**, including affordable home health care, home repairs, food delivery, and utility assistance.
- Increase access to **safe, affordable housing**, including subsidized options.
- Train community health workers to support vulnerable older adults aging in place.
- Create **more opportunities for social interaction** at home and in community spaces.
- Develop **intergenerational programs for socialization** and technology assistance.
- Improve methods of communicating available resources and benefits to increase awareness and utilization.

PRIORITY

9 Culturally and Linguistically Appropriate Services

KEY FINDINGS:

- **Language barriers** are the greatest contributing factor to healthcare access issues for immigrants and ASL speakers. Language issues lead to misunderstandings between patients and healthcare providers or can dissuade patients from attending appointments altogether.
- Provision of high-quality **language services** (oral interpretation and written translation) is critical for providing equitable care to these communities; inquiring of patients at the time of appointment-setting about interpreter needs is ideal.
- Beyond language access, **cultural and religious norms** influence individual beliefs about health; stigma can make seeking help objectionable, particularly mental health services.
- **Fear and not having health insurance discourage** undocumented individuals from seeking medical help.

POTENTIAL SOLUTIONS:

- **Hire bilingual/multilingual providers and translators** (languages mentioned: Spanish, Arabic, French, African dialects).
- Provide **in-person interpreters**, especially during complex or urgent health interactions.
- Ensure all **signage, forms, and digital tools are translated into key community languages**.
- Train providers in culturally responsive care that respects beliefs and traditions of immigrant communities.
- Increase racial, ethnic, and language diversity of staff/**providers to better reflect communities** served.
- Develop organizational language access plans with protocols for identifying and responding to language needs.
- Explore development of **formalized programs to train and credential bilingual staff** (employed for other roles) to serve as medical interpreters.
- Provide on-site language interpreters and health education materials in diverse languages.
- Develop strong **partnerships with community organizations** serving diverse communities that involves providing financial support.

PRIORITY

10 Food Access

KEY FINDINGS:

- Maintaining diets consisting of **fresh produce and healthy foods is consistently difficult** and cost prohibitive. Cheaper fast food and corner store options are also more convenient, readily accessible, and more prevalent – particularly in urban neighborhoods. Likewise, large grocery stores may require transportation to access them.
- A **lack of food literacy** and longevity of poor dietary habits over time also contribute to food choices.
- Local food banks/pantries serve as an indispensable community resource. When available, community gardens offer neighborhoods opportunities to grow their own food in the company of neighbors.
- Older adults have enjoyed **meal delivery services**, as a part of their benefits.
- Immigrants and ethnic minorities face challenges with finding **foods that are culturally relevant** to them.

POTENTIAL SOLUTIONS:

- Maintain and **expand community gardens**, fresh food access, and local markets.
- Offer **nutritional education** for both children and parents.
- Increase **oversight of food stamp benefit security** (e.g., prevent theft and fraud).
- Improve **quality of food provided at pantries** or senior meal programs – not just quantity.
- Ensure more **equitable access to food assistance programs/resources** in region by collecting data.
- Before patients are discharged from the hospital, providing **"warm handoffs" to connect them with community health and social service organizations that address hunger and other needs**.
- Increase collaboration and resource-sharing between hospitals and community groups working on healthy and culturally relevant food access.
- Increase **outreach to raise awareness** and utilization of food assistance programs.
- Provide services that distribute food directly to people where they live.

PRIORITY

11 Housing

KEY FINDINGS:

- Homelessness was indicated to be a concern at 17% of the qualitative community meetings. The overall health of homeless individuals was also of concern to community members, feeling as though **resources were not readily available and that homeless individuals** contributed to sentiments around neighborhoods being unsafe.
- A growing lack of **affordable housing** has led to a year's **long waiting list for subsidized housing**, as well as evictions, and individuals sleeping in places not meant for human dwelling (e.g., cars, outdoors). This phenomenon is pervasive across counties, but particularly in Philadelphia.
- Housing for certain sub-groups, such as **older adults and veterans**, was also noted as priorities

POTENTIAL SOLUTIONS:

- Invest in **affordable housing and shelters**, especially for people experiencing homelessness or with substance use challenges.
- **Improve transitional housing** and reentry programs to prevent homelessness post-incarceration.
- Ensure **stable housing for vulnerable groups** to support health management (e.g., medication, food access).
- Increase investments by hospitals, managed care organizations, and others in **supportive housing programs known to be effective in reducing housing insecurity and preventing homelessness**.
- Explore strategies that aggregate funds to **support rental assistance** or develop an equitable acquisition fund to preserve and create affordable housing.
- Expand **programs supporting habitability** and raising awareness of resources for **housing repair assistance**.
- Increase **Rapid Re-housing Programs**.
- Invest in respite housing for individuals in urgent need of **transitional housing**.

PRIORITY

12 Neighborhood Conditions

KEY FINDINGS:

- Availability of **greens spaces**, dog parks, libraries, and health centers (with parks, walking trails, gyms, pools) contribute significantly to positive perceptions about neighborhood conditions; named as desired neighborhood features.
- Lack of overall neighborhood safety, caused by criminal activity, **community violence**, or **road conditions**, are risk factors for poor mental health and limited physical activity outside.
- **Uncollected trash** build-up and littered streets negatively impact neighborhood morale and contribute to air pollution that can prevent some from opening their windows.
- Community events were praised as opportunities to foster neighborly connections and cohesion.
- **Local pride** from residents who have lived in the area for several decades, particularly in Philadelphia County, contribute to vested interests in improvement, and informed perspectives on neighborhood history and nature of changes.

POTENTIAL SOLUTIONS:

- Increase **investment in neighborhood clean-up efforts** (e.g., trash removal, illegal dumping).
- Expand **tree canopy and green spaces** to reduce heat and support walkability.
- Maintain and **rebuild parks and rec centers** to offer both safety and engagement for youth.
- **Improve sidewalks and streets** for better mobility and pedestrian safety.
- Recognize the mental health impacts of environmental stressors like blight and noise.
- Support **neighborhood remediation** and clean-up activities.
- Collaborate with local advocates engaged in campaigns to improve air quality, especially in areas that have increased exposure to emissions.
- Invest in **infrastructure improvements** to support active transit near hospitals.
- **Improve vacant lots by developing gardens** and spaces for socialization and physical activity.
- Advocate for and implement responsible and equitable neighborhood development that avoids displacement and segregation.

Resources

LOCAL HEALTH RESOURCES AND SERVICES

Many health resources and services are available to address the needs of SEPA communities. A list of organizations serving Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties was developed based on those included in the 2019 rCHNA report, as well as community organizations identified by Steering Committee members as partners. Organizations were coded into categories based on types of services provided, and contact information was verified in April 2022 for all included organizations. Descriptions of the categories are below, and a searchable list of organizations with contact information, organized by category and county, is included in the online Appendix.

CATEGORY	DESCRIPTION
Behavioral Health Services	• Services, including treatment, to address mental health or substance use issues
Benefits & Financial Assistance	• Assistance with enrollment in public benefits or provision of emergency cash assistance
Disability Services	• Services for individuals with disabilities
Food	• Food pantries or cupboards, as well as assistance with Supplemental Nutrition Assistance Program (SNAP) benefits
Housing/Shelter	• Assistance with emergency shelter, rental payment, or support services for individuals experiencing homelessness
Income Support, Education, & Employment	• Support for tax assistance, adult education, and employment
Material Goods	• Material goods including clothing, diapers, furniture
Senior Services	• Services for seniors
Substance Use Disorder Services	• Treatment for substance use disorders
Utilities	• Assistance with utility payment
Veterans Services	• Services for veterans

REFERENCES AND DATA SOURCES

The participating hospitals and health systems would like to acknowledge the following organizations for access to data and reports to inform the rCHNA.

ORGANIZATION/SOURCE	DESCRIPTION
Academy Health	• Building Trust and Mutual Respect to Improve Health Care
American Board of Internal Medicine (ABIM) Foundation	• Building Trust Initiative
Centers for Disease Control and Prevention	• Behavioral Risk Factor Surveillance System Data (PLACES) • CDC/ATSDR Social Vulnerability Index • WONDER • Youth Risk Behavior Surveillance System Data
County Health Rankings & Roadmaps	• Health Data by Location • What Works for Health
Feeding America	• Map the Meal Gap
HealthShare Exchange	• Emergency Department High-Utilizers • Gun-related Emergency Department Utilization
Institute for Health Care Improvement	• Organizational Trustworthiness in Health Care
Montgomery County Office of Public Health	• 2024 Community Health Assessment
National Center for Health Statistics	• NCHA Data Query System
National Equity Atlas	• Income Inequality
Pennsylvania Department of Health	• Vital Statistics (Birth, Cancer, and Death Records)
Pennsylvania Office of the Attorney General	• Pennsylvania Uniform Crime Reporting System
Pennsylvania Health Care Cost Containment Council	• Hospital Inpatient Discharge Data
Philadelphia Communities Conquering Cancer	• Listening Session Summaries
Philadelphia Department of Public Health	• Syndromic Surveillance Data
Pennsylvania Commission on Crime and Delinquency, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Education	• Pennsylvania Youth Survey Data
U.S. Census Bureau	• American Community Survey 5-Year Data Decennial Census
Walker Data	• Tidycensus

Notes

Vital records data were supplied by the Bureau of Health Statistics and Research, Pennsylvania Department of Health, Harrisburg, Pennsylvania. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions.

Data for selected indicators is provided by HealthShare Exchange (HSX), the Delaware Valley's health information organization, based on data contributed from its healthcare provider members.

The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency responsible for addressing the problems of escalating health costs, ensuring the quality of health care, and increasing access to health care for all citizens regardless of ability to pay. PHC4 has provided data to the Philadelphia Department of Public Health in an effort to further PHC4's mission of educating the public and containing health care costs in Pennsylvania. PHC4, its agents and staff have made no representation, guarantee, or warranty, express or implied, that the data—financial, patient, payer and physician specific information—provided to this entity, are error free, or that the use of data will avoid differences of opinion or interpretation. This analysis was not prepared by PHC4. This analysis was done by the Philadelphia Department of Public Health. PHC4, its agents and staff bear no responsibility or liability for the results of this analysis, which are solely the opinion of this entity.

ONLINE APPENDIX

An online appendix of resources used to inform and produce this CHNA is available at: RCHNA-SEPA.org