Penn Medicine
Chester County Hospital

2025 REGIONAL Community Health Needs Assessment

FOR SOUTHEASTERN PENNSYLVANIA

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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. **Healthcare and Health Resources Navigation**	• Community members shared concerns about **substance use in their communities, co-occurring mental illness**, the potential **implications on youth**, and the association with **poor neighborhood safety**. • Drug overdose rates continue to be high due to **opioid epidemic**. • **Community-based services** to treat substance use are perceived as **insufficient** in number by some, and/or are not well-known by others. • **Prevention and education measures** can serve **as protective factors** against misuse and abuse; questions arose regarding the usefulness and impact of policing related to substance use.	• Expand community-based rehabilitation programs as alternatives to incarceration. • Provide trauma-informed care and education during health visits, especially for youth. • Increase provider training to eliminate bias toward individuals with histories of substance use. • Offer drug education at the provider level (not just in schools) with resources for both youth and families. • Reduce stigma through culturally competent and empathetic behavioral health care.

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

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

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

COMMUNITY HEALTH PRIORITIES:
Youth

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

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

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

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

Introduction

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

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

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

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

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

Several enhancements distinguish the 2025 rCHNA from previous iterations:

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

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

Chester County Hospital

Penn Medicine

BEDS:	PHYSICIANS:	INPATIENT ADMISSIONS:	OUTPATIENT TESTS & PROCEDURES	EMERGENCY DEPT. VISITS:
329	833	18,063	718,480	64,182

Chester County Hospital is a Penn Medicine hospital dedicated to the health and well-being of the people in Chester County, Pennsylvania, and surrounding areas.

Chester County Hospital is a 329-bed inpatient facility in West Chester. Its outpatient services extend to satellite locations in Exton, West Goshen, New Garden, Jennersville, and Kennett Square. Chartered in 1892 as a 10-bed dispensary, the hospital has served Chester County and its surrounding communities for over 130 years. Chester County Hospital joined the University of Pennsylvania Health System in 2013 as part of its ongoing effort to provide the most progressive services available. In 2020, the hospital completed the most significant expansion in its history. The project welcomed a state-of-the-art procedural platform with 15 operating room suites, a 99-bed patient tower, a new main entrance, and an expanded and renovated Emergency Department.

VISION STATEMENT

To be the leading provider of care in the region and a national model for quality, service excellence, and fiscal stewardship.

OUR VALUES

Chester County Hospital focuses on five foundational values that preserve key aspects of its corporate culture while reinforcing and clarifying expectations for the future. The values are:

Innovation, Collaboration, Accountability, Respect, and Excellence. These are known internally by their acronym, ICARE.

ACCOLADES RECEIVED

Centers for Medicare and Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) has awarded Chester County Hospital a five-star rating- the highest possible score.

Cancer Commendation

In 2023, the Abramson Cancer Center at Chester County Hospital's cancer program was reviewed and reaccredited with commendation by the Commission on Cancer (CoC) of the American College of Surgeons. The National Accreditation Program for Breast Cancers also reaccredited the Breast Health Program.

Magnet Team: Reaccreditation

Chester County Hospital's nursing staff has been recognized by the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program® for its excellence in patient care.

Chester County Hospital Baby-Friendly

Chester County Hospital has received prestigious international recognition as a designated Baby-Friendly birth facility by Baby-Friendly USA.

Diabetes Education Program: Reaccreditation

The Diabetes Self-Management Program achieved accreditation by the Association for Diabetes Care and Education Specialists (ADCES). Accreditation represents a high level of quality and service to the community and the ability to better meet the needs of those affected by diabetes.

National Diabetes Prevention Program (NDPP)

The Center for Disease Control (CDC) has designated Chester County Hospital with Full Plus Recognition for its diabetes prevention program. This designation is reserved for programs that effectively deliver a quality, evidence-based program that meets all the standards for CDC recognition and additional retention thresholds.

Chester County Hospital Recognized for Excellence in Emergency Nursing

Chester County Hospital's emergency department has been selected as a recipient of the Emergency Nurses Association's 2024 Lantern Award for demonstrating excellence in leadership, practice, education, advocacy, and research performance. Only 94 emergency departments across the U.S. were recognized in 2024.

Primary Stroke Center

Chester County Hospital is recognized for its commitment to providing high-quality stroke care. The Joint Commission certified Chester County Hospital as a Primary Stroke Center. The American Heart Association presented Get with The Guidelines® —Stroke GoldPlus award for its proven dedication to ensuring that all stroke patients have access to best practices and life-saving care.

U.S. News & World Report: 2024/2025

Chester County Hospital is ranked #13 in Pennsylvania and #7 in the Philadelphia Metro Area. The hospital is recognized as High-Performing in gastroenterology (GI) and GI surgery, neurology and neurosurgery, pulmonology and lung surgery, heart failure, heart attack, stroke, back surgery, hip replacement, chronic obstructive pulmonary disease (COPD), and pneumonia.

Chester County Hospital Named One of America's 50 Best Hospitals by Healthgrades

Healthgrades recently recognized Chester County Hospital as one of America's 50 Best Hospitals for 2023. This acknowledgment places Chester County Hospital in the top 1% of hospitals nationwide for consistently providing overall clinical excellence across a broad spectrum of conditions and procedures.

Penn Medicine Hospitals Awarded Spring 2024 "A" Hospital Safety Grade

Chester County Hospital was one of six Penn Medicine health system hospitals to receive an "A" grade for Spring 2024. The Leapfrog Hospital Safety Grade is the only hospital ratings program based exclusively on hospital prevention of medical errors and patient harm.

50 Top Cardiovascular Hospitals 2024

Chester County Hospital was named one of the nation's top-performing hospitals by Fortune and IBM Watson Health. The annual "Fortune/IBM 50 Top Cardiovascular Hospitals" study spotlights leading short-term, acute care, non-federal US hospitals that treat a broad spectrum of cardiology patients.

2024 AHA-GWTG Atrial Fibrillation Gold Quality Achievement Award
This award recognizes the hospital's consistency in quality and the provision of the latest evidence-based treatments for AFIB patients.

Accredited in 2023 as a Chest Pain Center with Primary Percutaneous Coronary Intervention
This distinction is awarded to heart and vascular teams focused on the efficient and effective care of acute coronary syndrome (ACS) patients.

The American College of Cardiology NCDR Chest Pain: MI Registry Gold Performance Achievement Award
This award recognizes Chester County Hospital's commitment and success in implementing a higher standard of care for heart attack patients. It signifies that Chester County Hospital has reached an aggressive goal of treating these patients to standard levels of care as outlined by the American College of Cardiology/American Heart Association clinical guidelines and recommendations.

CCH Receives National Recognition for its Commitment to Providing High-Quality Heart Failure Care
This award recognizes CCH's commitment to improving outcomes for patients with heart failure, meaning reduced readmissions and more healthy days at home.

The International Board of Lactation Consultant Examiners® (IBLCE®)
The IBCLC Care Award recognizes hospitals and community-based facilities that demonstrate their commitment to promoting, protecting, and supporting breastfeeding and the lactation consultant profession.

Vizient 2023, Bernard A. Birnbaum Quality Leadership Award, Complex Care Medical Centers - Top Performer
The Bernard A. Birnbaum, MD, Quality Leadership Award recognizes participating healthcare organizations in four cohorts through the Vizient Quality and Accountability Study, which measures performance on the quality of patient care in six domains: safety, mortality, effectiveness, efficiency, patient-centeredness, and equity. The study factors in measures from the Vizient Clinical Data Base and includes performance data from the HCAHPS survey and the CDC's National Healthcare Safety Network.

Press Ganey Human Experience Pinnacle of Excellent Award 2024
This award recognizes clients who have maintained consistently high levels of excellence over three years in patient experience, employee engagement, physician engagement, or clinical quality performance.

Impact of Prior Community Health Needs Assessment and Implementation

The 2022 CHNA and resulting three-year implementation plan identified multiple priorities and actions to address our community's health needs. Highlights of the impact of this plan over the past two years include the following:

Access to Primary and Specialty Care

- Provided care for 13,604 uninsured and underinsured patients in the Chester County Hospital OB/Gyn Clinic.
- Identified 2,974 patients eligible for primary and specialty care in-home visits in collaboration with Penn Medicine at Home providers.
- Provided free screenings, labs, and diagnostic radiology services for underserved populations referred by community partner agencies.

Chronic Disease Prevention and Management

- Facilitated 1,422 chronic disease prevention and management wellness and health education programs for 35,084 participants.
- Hosted 336 chronic disease management support group meetings for 2,170 participants.
- Provided 88 blood pressure and cardiovascular risk screenings for 1,390 participants.

Culturally and Linguistically Appropriate Care

- Provided 14,232 hours of clinical and non-clinical interpretation for a broad range of languages.
- Provided gestational diabetes counseling to 108 Spanish-speaking patients using a bilingual diabetes educator.
- Provided 1,000 Spanish-speaking expectant parents with culturally appropriate printed materials.

Food Access

- Collaborated with the Chester County Food Bank to create an on-site food pantry which provided food for the households of 1,170 OB/Gyn Clinic patients with food insecurity.
- Provided resources and community education programs on food insecurity in collaboration with the Chester County Food Bank.

Healthcare and Health Resources Navigation

- Provided free transportation to 3,364 cancer treatment patients.
- Aided 3,610 patients with transitions in care through Penn Partners in Care nurse care managers in each Penn primary care practice.
- Followed up with 72,640 discharged patients via the Penn Medicine Connects program.

Mental Health Conditions

- Created the Behavioral Health service line to streamline and enhance processes to meet the needs of patients with mental health concerns.
- Provided free suicide prevention training (Mental Health First Aid, Youth Mental Health First Aid, and QPR– Question, Persuade, Refer) for community members and hospital staff.
- Collaborated with community and faith-based organizations (CFBOs) to identify community mental health needs, and provided programs to meet those needs.

Racism and Discrimination in Healthcare

- Promoted staff educational forums aligned with diversity recognition awareness months (e.g., Black History, AAPI, Pride, and Hispanic Heritage).
- Reported on stratified health outcomes metrics (e.g., length of stay, mortality, readmission rates) using Race, Ethnicity, Ancestry, and Language (REAL) data. Reported outcomes to the CCH management team and Community Advisory Board meetings.
- Provided multiple staff training modules on racism, discrimination, diversity, equity, and inclusion.

Substance Use and Related Disorders

- Provided support to 672 patients seen by a Certified Recovery Specialist (CRS) through the Community Outreach & Prevention Education (COPE) program.
- Provided eight community education programs on substance use disorder.
- Provided naloxone nasal spray (Narcan®) upon discharge to patients at risk for an opioid emergency or overdose (1,004 outpatient prescriptions written, 341 prescriptions dispensed by hospital pharmacy).

Service Area Demographics

ESTIMATED POPULATION

439,614

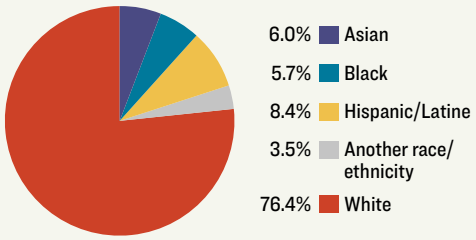
MEDIAN HOUSEHOLD INCOME

$123,608

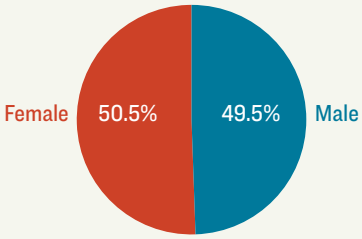
NOT FLUENT IN ENGLISH

2.1%

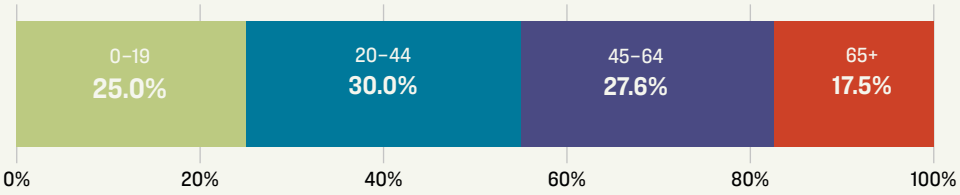
RACIAL COMPOSITION



SEX



AGE DISTRIBUTION



TARGETED SERVICE AREA FOR COMMUNITY HEALTH IMPROVEMENT

Chester County Hospital defines its service area as the ZIP codes that attract the highest market share, as well as those that contribute greater than 4 percent of inpatient volumes or are contiguous to ZIP codes that meet that criteria.

ZIP codes: 19311, 19316, 19317, 19319, 19320, 19330, 19335, 19341, 19342, 19343, 19344, 19348, 19350, 19352, 19355, 19358, 19362, 19363, 19365, 19367, 19372, 19374, 19375, 19380, 19382, 19390, 19425

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

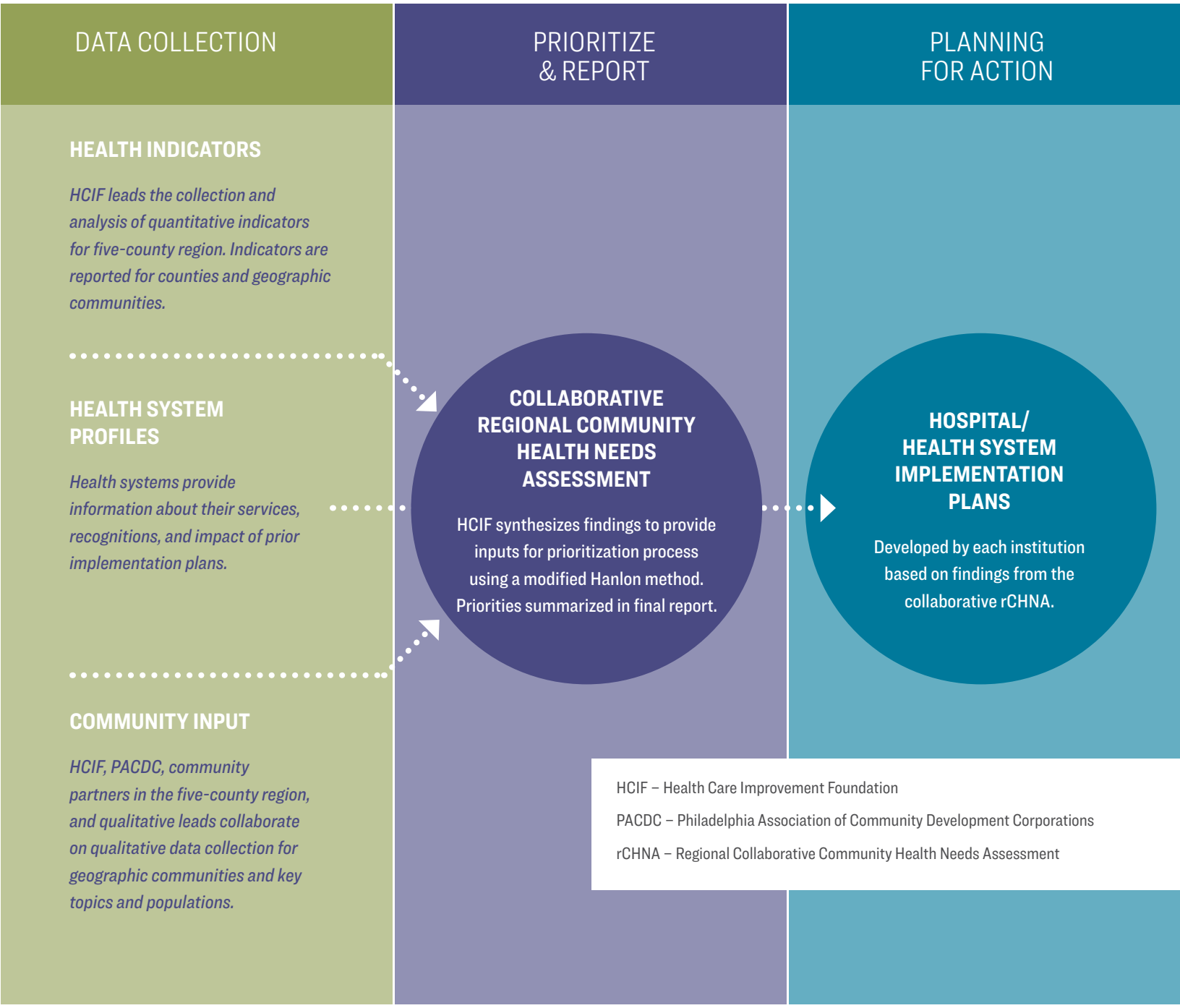
- Bucks County Health Improvement Partnership (BCHIP)
- HealthSpark Foundation
- Philadelphia Association of Community Development Corporations (PACDC)
- SEAMAAC
- The Foundation for Delaware County

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
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)

Indicator	Details	Year(s)	Source
Poverty status	Poverty status of those with a disability in the past 12 months	2022	American Community Survey, Census Bureau (5-yr)
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:

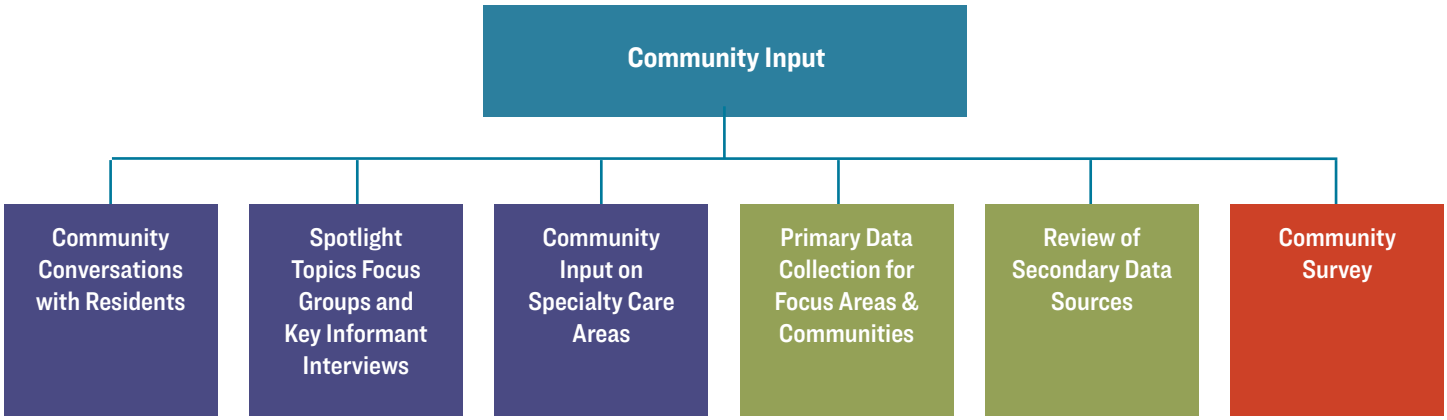
- Primary data collection was undertaken by the project team June 2024 – April 2025. To offer the greatest level of accessibility, both in person and virtual sessions were held in each county.
- Focus group-style, 90-minute "community conversations" were held to gather input from residents of the region. 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.

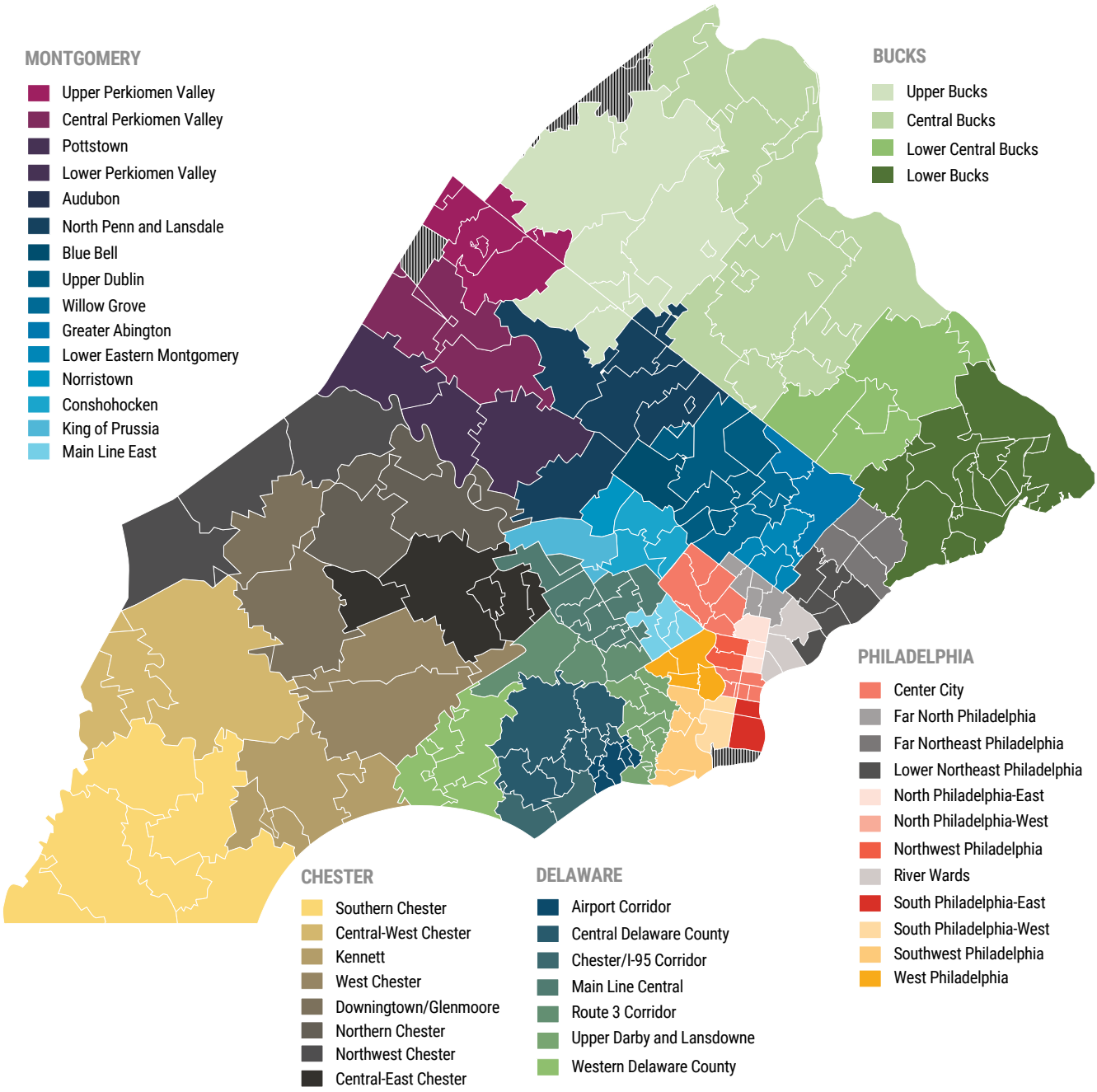
This structured prioritization process ensures that health interventions are both impactful and feasible, ultimately improving health outcomes for the communities served by the regional health system.

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.

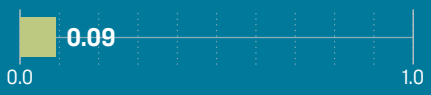
About the Service Area

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.

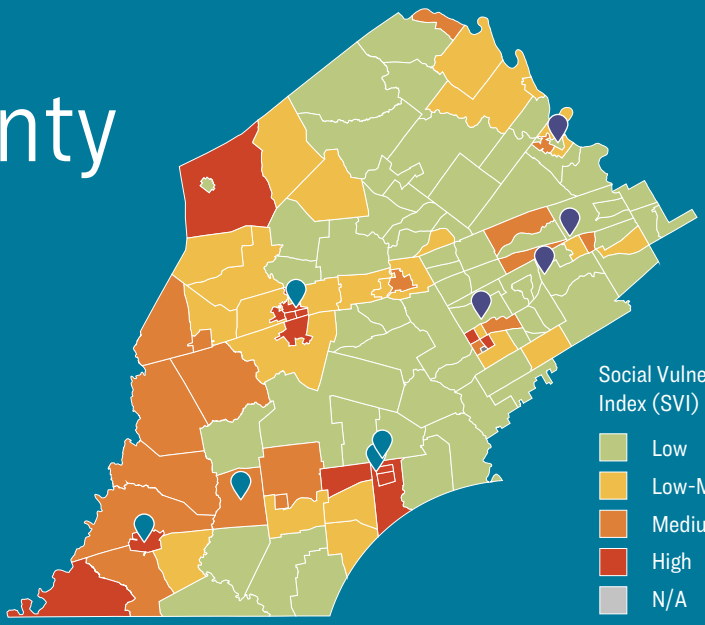


Chester County

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

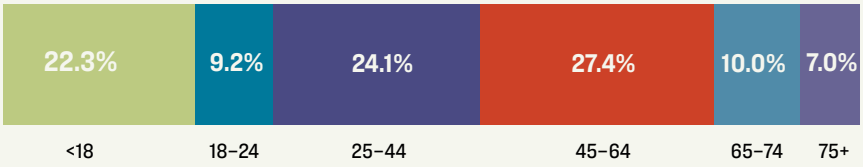
There are 5 hospitals and 4 health centers in Chester County.*

*ChristianaCare - West Grove anticipated opening Summer 2025

Demographics

AGE DISTRIBUTION

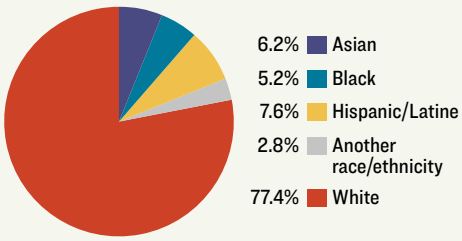
Chester County has an estimated population of 540,896 with the largest proportion of residents between the ages of 45 - 64.



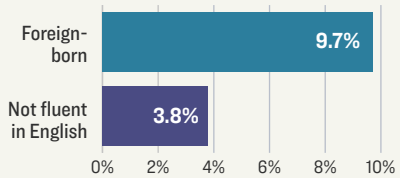
SEX

RACE/ETHNICITY/LANGUAGE

77% of residents are non-Hispanic White. Hispanic/Latine residents make the next largest population, comprising about 7.6% of the county's residents.



Nearly 10% of residents are foreign-born and about 4% speak English less than "very well."



HOUSEHOLDS

Median Household Income
$107,826

Homeownership
75%

Severe Housing Cost Burden
% spending >50% of household income
11%

High School as Highest Education
19.3%

Household Food Insecurity
8.1%

Single Parent Households
18.2%

Same Sex Couples
per 1,000 households
2.8

Commute Greater than 60 minutes
9.2%

Chester County

Health

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases
4. Covid-19
5. Chronic Lower Respiratory Diseases

CHILDREN & YOUTH

Youth Behavior

Ever Attempted Suicide

4.0%

Depressed/Sad Most Days in the Past 12 Months

23.6%

Binge Drinking

8.8%

Cigarette Smoking

2.7%

Vaping

9.2%

Exposure

Lead Levels in Children (<16 years old)

2.3%

PEOPLE WITH DISABILITIES

Percent of Population

9.1%

Poverty Status in the Past 12 Months

16.7%

Percent who have difficulty with:

Hearing	2.6%
Vision	1.3%
Cognition	3.8%
Ambulatory	3.7%
Self-care	1.5%
Independent Living	3.1%

VIOLENCE & SAFETY

Mortality due to gun violence per 100,000

1.9

Violent Crime Rate per 100,000

115.2

Gun-related ED Utilization per 100,000

3.1

COMMUNITY HEALTH STATUS

High ED Utilization per 100,000

377.7

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)

60.0%

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

212.3

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

0.45

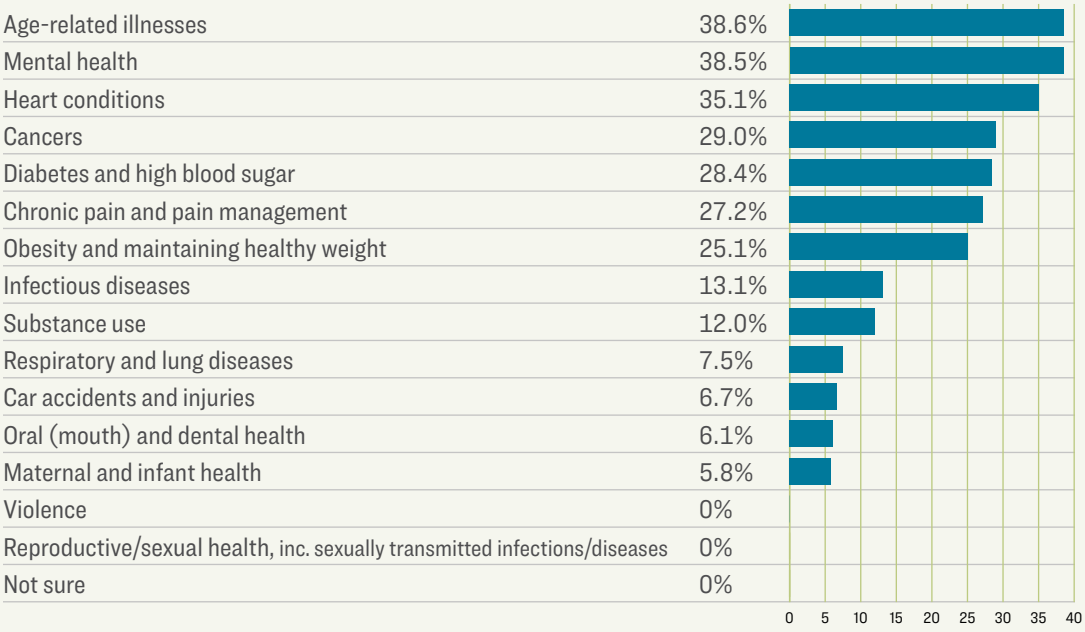
This measure is often used to assess income or wealth distribution within a population. It ranges from 0 to 1, where 0 indicates perfect equality (everyone has the same income) and 1 signifies maximum inequality (one person has all the income while others have none).

Chester County

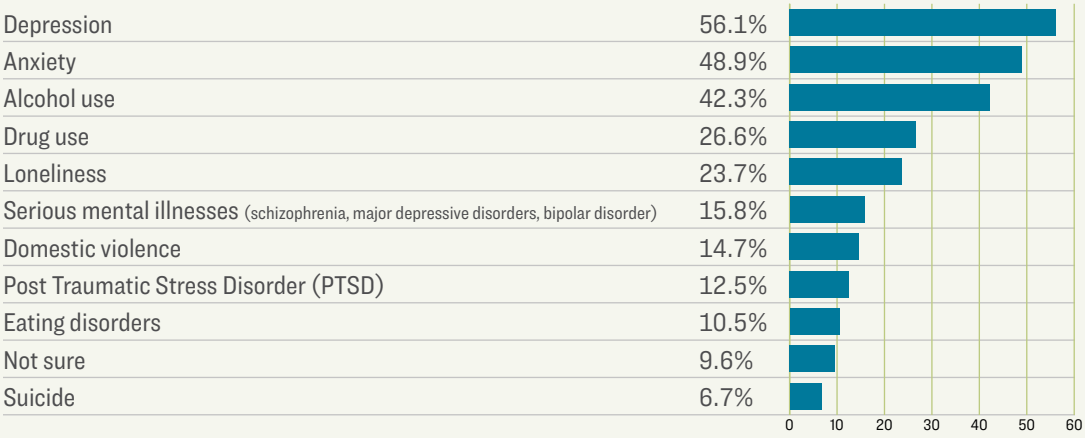
County Survey Results

Number of Respondents: 658

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?



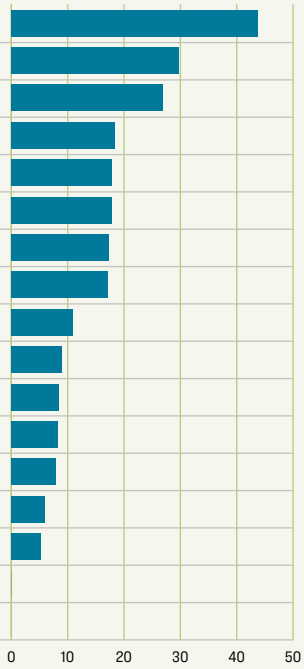
Chester County

County Survey Results

Number of Respondents: 658

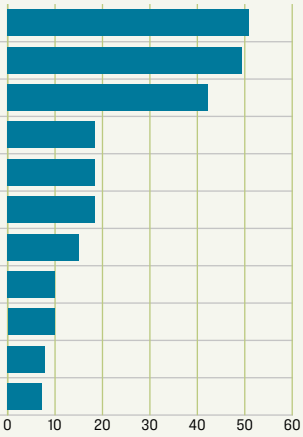
Thinking about your or other CHILDREN in the community where you live, what are the top 3 HEALTH problems?

Mental health	43.8%
Intellectual / developmental disabilities	29.8%
Obesity and maintaining healthy weight	26.9%
Not sure	18.4%
Substance use	17.9%
Injuries	17.9%
Infectious diseases	17.3%
Abuse or neglect	17.2%
Respiratory diseases	10.9%
Violence	9.0%
Chronic pain and pain management	8.5%
Oral (mouth) and dental health	8.2%
Diabetes and high blood sugar	7.9%
Infant / baby health	5.9%
Blood diseases	5.2%
Cancers	0.0%
Reproductive/sexual health, inc. sexually transmitted infections/diseases	0%



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

Bullying	50.9%
Anxiety	49.4%
Depression	42.3%
Loneliness	18.5%
Drug use	18.4%
Not sure	18.4%
Eating disorders	15.1%
Alcohol use	10.0%
Suicide	9.9%
Serious mental illnesses (schizophrenia, major depressive disorders, bipolar disorder)	7.9%
Post Traumatic Stress Disorder (PTSD)	7.3%

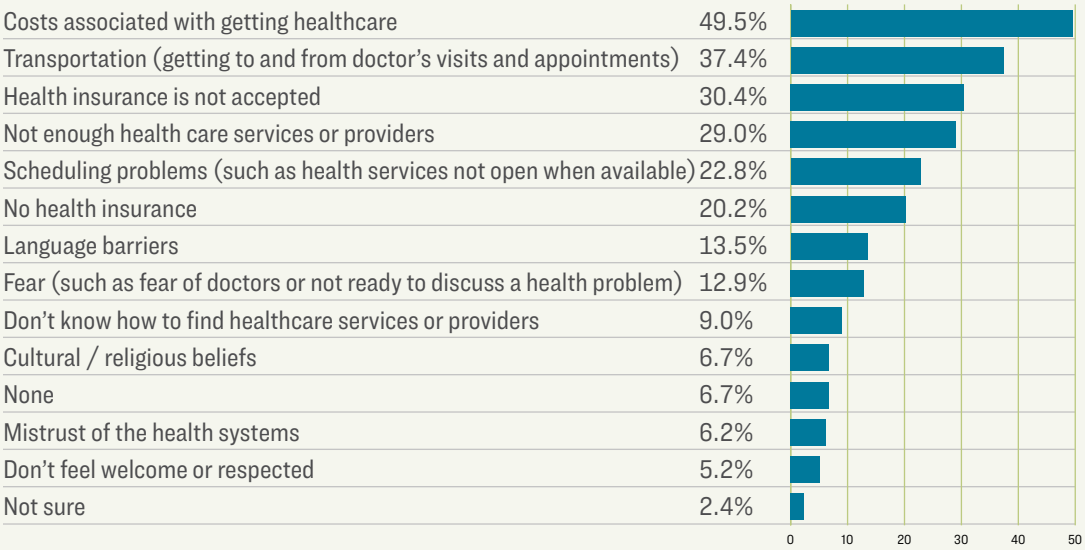


Chester County

County Survey Results

Number of Respondents: 658

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	3.7%	12.9%	33.6%	29.6%	17.0%	3.2%
Affordable housing	10.3%	32.7%	26.9%	15.1%	5.5%	9.6%
Clean outdoor environment	2.1%	4.1%	19.2%	31.3%	40.1%	3.2%
Good paying jobs	2.3%	13.7%	30.1%	30.1%	14.1%	9.7%
Good schools	1.2%	5.6%	14.1%	27.1%	45.0%	7.0%
Health care services	1.8%	6.1%	20.1%	33.4%	36.2%	2.4%
Mental health services	4.6%	16.6%	23.9%	21.9%	12.6%	20.5%
Places to be active such as parks	2.0%	3.7%	15.8%	25.7%	50.2%	2.7%
Safe neighborhood	9.0%	21.4%	25.2%	19.6%	14.6%	10.2%
Services that support people as they age	1.5%	9.9%	26.9%	29.2%	17.2%	15.4%
Substance use services	4.3%	10.6%	22.0%	18.4%	13.5%	31.2%

Chester County

COMMUNITY ASSETS

GREEN SPACE AND RECREATION

Some residents shared that they appreciated having access to parks and walking paths. Opportunities for physical activity contributed to overall positive health experiences.

ON GREEN SPACE & RECREATION

"...there's a lot of group walking and people doing things. It's not just individuals from the house, it's people who together to do some form of activity."

"I'll say the area that I live in which is Kennett Square, Southern Chester County, there are a number of health and fitness facilities and some of them are very affordable and you can take advantage of a number of different health facilities from swimming, physical activity, Pilates, pickleball, everything like that. So it's a good way to maintain a level of health."

"And we have a great department of parks and recs. The borough does music in the park to bring the community together, the township does sporting activities and things."

HEALTHY FOOD RESOURCES

Community members have recognized social and health benefits related to the availability of fresh, local produce. Food banks also provided a variety of options to residents.

ON HEALTHY FOOD RESOURCES

"I live in Chadds Ford for which is close to Kennett Square in Southern Chester County, and we have a lot of local farmers and local produce and there's been some nice sharing of that, especially in the summertime with raised beds and that sort of thing. We're starting a co-op in Kennett Square because we want to be able to have local food all year round and local products. But I feel like there's a commitment to having space for agriculture, which is the food we need."

"The food pantry, serves hundreds of people a distribution and they do that twice a month, once in the daytime, once in the evening..."

COMMUNITY ASSETS

A SENSE OF COMMUNITY

Community members valued relationships with neighbors and the support that they provided for one another.

ON A SENSE OF COMMUNITY

"I live in... a retired community, and walking, conversations and talking about how your day is going and we form bonds and then... when we see somebody that is needy in terms of physically, mentally or anything like that, we rise to the occasion and do what it is we need to do and it's reciprocal. So it's a good feeling and that is good for your spirit, your mind, your health."

"I know every community has some problems, but for the most part, I always feel safe walking."

"I think I can speak, for, like the Hispanic community, I feel like Southern Chester County is really inclusive..."

ENVIRONMENTAL QUALITY

Air and noise pollution improvements were referenced by community members as playing active roles in an enhanced quality of life.

ON ENVIRONMENTAL QUALITY

"I think one thing that may have helped the community health wise is the local steel company... for many years they've had a new system they use it with the electric furnace and they don't produce the pollution."

"We have not had the smell from the treatment plant which is in South Coatesville. And it seemed like every Wednesday you have to feel, it was bad. But it has gotten better because I haven't noticed it in maybe a couple of years now."

"The quiet rural atmosphere, it is calming."

HEALTH RESOURCES

Respondents noted the importance of local health education opportunities, and access to medical specialists.

ON HEALTH RESOURCES

"I think the local hospital community department provides a lot of education around different topics that are great into the community that we tend to spread to the community that there's access in education as well."

"I think we have many high-quality healthcare providers in Chester County. I know we have the cancer center, we have all these specialties that I feel like a lot of communities do not have. I'm grateful for that in the specialist that you can take referrals to, and that we partner with Philadelphia and their resources. So there's that kind of partnership too."

"I was really happy to find how easy it was to find a dentist, a foot doctor, a chiropractor. In this small community, there are many ways to take care of yourself, that are easily accessible."

COMMUNITY CHALLENGES

HEALTHCARE ACCESS

Hospitals were not readily accessible to all residents, which could prove harmful in emergency situations. There were further implications related to where ambulances were allowed to transport patients. There were also no urgent care centers that were close enough. There were concerns about dental neglect, for residents of all ages, and a lack of oral health literacy.

A respondent, and nurse, spoke to the need for patients to be assisted in the navigation of health services, needs, and options. Language barriers could limit access, particularly Portuguese and Eastern European languages.

Lastly, certain hospitals and mental health providers didn't accept Medicaid and it was believed that "they're just trying to find a way to cut those who are most expensive off their list."

ON HEALTHCARE ACCESS

"...we are far from a local hospital, pretty much have to decide. Where I work, we had to call for ambulances and you don't know where to tell people to take them..."

"I mean you look at someone and they have rampant decay and they go to the dentist... some of them have the fear, lack of transportation, lack of funds, if they do have insurance, they really don't have money for the copay."

"It's very hard to find the Medicaid dentist – anywhere. Other than the FQHCs, there's one in Coatesville, one in Pottstown."

"You're talking about technology but not everybody has access to the technology or the knowledge of how to use it."

"I also feel that we really don't have health navigators that help people through the system, and I think hospitals could do so much better with that in helping people see what are the steps they go through... I don't feel like we're navigating through those steps that you have to take to get the treatment and to finish and mental health, all the things that you need when you've been diagnosed with something."

"I drive my son to Philly for his doctor, for someone who knows how to work with people with disabilities, but you know not everybody can do that..."

TRANSPORTATION

Insufficient public transportation made access to health services, grocery stores, and recreation activities difficult for people who didn't live near them. Many areas did not have sidewalks, or the sidewalks were in disrepair.

ON TRANSPORTATION

"So transportation can become a huge issue if you have like an elderly person that needs the power of attorney or needs support, those resources are not available without going out of town."

"So they either live adjacent to them or they've got to drive because public transportation in Chester County is not good."

BEHAVIORAL HEALTH ISSUES

Residents found it difficult to find mental health services. When they did, there tended to be long waits for appointments. There seemed to be a lack of access to information or efficient dissemination of information about local services.

The mental health of residents of all ages was a concern, particularly that of parents who should be emotionally well-equipped in their roles.

ON BEHAVIORAL HEALTH ISSUES

"...we have groups that meet here that finding psychiatric or emotional support is a desert around here."

"...to go back to what she was saying, I think it is also a lack of education, for the fact that people here probably could video chat with a therapist or a psychiatrist or emotional support like that, they just don't know that that's like an option. So I think that's probably something that's worth talking about."

"From reading historically, in the 70s, we opened up psychiatric facilities, said nobody should be in here, they should be out and amongst people and, but we didn't build resources, not like we have resources for other parts, good resources for here down in healthcare."

"We have a shortage of counselors and we have a shortage of psychiatrists. We really do, and then Spanish-speaking or other language ones, we are really short."

"I see that in my work as a police chaplain, you know, I get called out on emergencies and stuff, and there's just no place to put anybody. We just are so short of beds."

HOUSING

High housing costs, and long waiting lists for affordable housing exacerbated the problems of "the poorest of the poor."

ON HOUSING

"...the rents and the lot rents all that's going up, they can't afford it, they can't meet, they get evicted, they're living in their cars. It's a cycle of poverty."

"And especially if they're in the trailer parks, they think their costs aren't going to change, but the trailers need new roofs or the plumbing goes or something catastrophic. I know many of them with space heaters because their regular heating is not working."

"There's even people and I don't know if you've ever heard, but like in my community when I first moved there, with the homelessness and that. There's people living in the tree line of the forest back there, there's tents in the woods."

SPECIAL POPULATIONS

CHILDREN AND YOUTH

Participants were complimentary of the schools in their communities. But "right now, there's disparity. Those that can afford pre-K go, those that can't, don't go."

Concerns raised by community members revolved around parents needing support with childrearing, navigating services for children with disabilities, the mental health of youth, and hungry children. Also, for those "living in poverty, with parents in jail or gone, or raised by grandparents," support was needed.

Different activities and resources, such as youth centers, vacation bible school, and swim lessons were appreciated.

ON CHILDREN AND YOUTH

"I think we have a great public school system. We have locally, we have Honey Brook Elementary Center, multiple preschool options here that serves an underserved area of the community. So we have after school programs, there's people to people that does a youth center right here in the borough."

"Also you have a lot of one household. So these kids are basically raising themselves. So they're not eating healthy and that's a problem and they're the ones that you might find out on the street late at night because nobody's looking after our babies."

"I lived in a area where we had three suicides at the high school level and my grandson went to that school. I saw firsthand what he went through, so I think that that needs to be addressed at a high level because there are so many things and peer pressure is going on with the students, with the kids, the Internet and those types of things and how can they be that be serviced for their needs?"

"...children that have been identified to be at risk for not eating properly over the weekend will get a backpack every Friday when they go home from school. With food that they can prepare themselves..."

OLDER ADULTS

Senior residential communities provided a myriad of resources and activities, that also helped to foster connectedness. Those living alone (mostly women), lacking transportation, and located far from resources were more vulnerable. Limited technology use with this population not only served as a barrier to health services, but also for taking advantage of grocery delivery services through apps. Residents have sought help from the Department of Aging, but responses were delayed.

ON OLDER ADULTS

"[Name] and I live in a 55 community here... where they let us know of all the activities and events that are going on. We have access to the pool, with the membership and a fitness room. So it is nice that there are things to do for the seniors as well."

"I think there's a concern too for support as aging residents of the community get older, because a lot of support services are either in larger cities or they're around hospital settings, neither of which is Honey Brook."

"We don't have a senior center. We used to have Honey Brook Senior Club and everybody just faded away. But we don't have a senior center like Coatesville, and Downingtown and places like that."

"We fund Meals on Wheels, and we are seeing that the number of people that are accessing those services is growing."

"I think it's very lonely for some seniors who are not part of a community..."

ADDITIONAL POPULATIONS

Families with low-income faced issues with childcare, health insurance coverage and other benefits, and maintaining full-time employment.

Members of the Amish community faced unique barriers to health care related to being disengaged with modern technologies, such as motor vehicles and phones. The nature of their work also put them at greater risk for injuries.

Immigrants required culturally and linguistically appropriate services.

Veterans needed assistance with housing, health, and dental services. Residents noted that the VA hospital offered some assistance, but they "fix them up and send them back on the street, on Lincoln Highway." Greater awareness of services was needed.

"

LOW INCOME

"...she has to go do Instacart with a baby with her, in order to make enough to try to pay a rent."

"And they're like, 'Well, you should just get a full time job and you have benefits.' And I'm like, 'I would rather not have the benefits and be able to pay rent and everything else compared to getting health insurance.'"

"I think there's no daycare options for families in need either. We have daycare in the area but it's expensive."

"...what do you do when your kid's sick and daycare sends them home? It says, would it have to be fever-free for 24 hours before they come back?"

AMISH COMMUNITY

"Amish customers have a lot of accidents. I was at a home yesterday and I tried not to cry but their nephew is two and he's in a body brace... They're not going to have a car to put them in there and take them anywhere. They have to walk to find a phone to call for help, somebody has to come and take them to the hospital. Now, the kid's in a hospital, miles and miles away from home, you can't even get there by horse and carriage."

IMMIGRANTS

"There's a huge Spanish-speaking population..."

"A number of years ago for Thanksgiving, people would distribute turkeys. At least in this particular situation, Latinos and turkeys didn't mix. What they wanted was chicken. So now we get chicken, the food banks distributing chicken. So it's kind of understanding the cultural differences and whether you're talking about eating better or whether you're talking about certain diseases, which might be unique to a certain culture..."

VETERANS

"My husband is a veteran and you have to know the inroads. He gets everything he needs. But if you don't know about the program and you don't go to find out, then you suffer. But my husband, he gets what he needs."

"

ACCESS TO CARE

Geographic residence near county borders is sometimes complicated where community members could and could not receive health coverage, inconveniently increasing travel time and prolonging 911 responses. Residents didn't understand why some hospitals remained "decaying" and abandoned when they were needed. Some relied on urgent care centers, which health insurance may not have covered in full.

Waiting for appointments with specialists took months. Respondents expressed the desire for more transparency with health costs and billing. Neighborhood pharmacies were closing. Lastly, people with disabilities who relied on medical transportation services had long wait times for pick up and drop off. Transit services through Medicaid were further complicated when patients needed to travel to different counties.

ON ACCESS TO CARE

"A lot of facilities are like 45 minutes away. I have County insurance and I can't go anywhere in here."

"And there's even been fire trucks that ran medical... ran as an ambulance. There's not enough to go around."

"But I know people who tried to get an appointment with someone in mental health services. It's a long time."

"My son needed physical therapy. So we went and I said, is there cost? No, no, don't worry about it. Health insurance will cover it. Eight appointments later -- You get the bill. We have a $3,500 deductible. We wouldn't have made eight appointments in a row if we knew that."

"I will tell you that the folks in the disability community what they call para transit, they call it Para-stranded."

"We lost a large community pharmacy. They delivered to the elderly."

"I think they could have appointments on the portal... they're trying to get all their clients trained on the portal. And then you can go in for an appointment. Wouldn't it be wonderful just to set up your appointment on the portal..."

TRUSTWORTHINESS

Longevity was a common factor in the patient/provider relationships where trust was present. One respondent explained that trust could be difficult to foster when there were language barriers.

ON TRUSTWORTHINESS

"The only one that I have is my gynecologist and she will go back to talking to me about my grandmother who raised me. And my mother and I's relationship, like she generally takes time and that's the only person that takes time with me."

"Well, yes, again, because I have the same doctors and so forth that I've had for years and years and years and I trust them."

COVID-19 PANDEMIC

For most, post-COVID technology use in healthcare presents convenience and accessibility. There were older individuals who preferred in-person and telephone access. There was a sense that the pandemic's residual impact was a provider shortage.

Persistent concerns about COVID-19 were mixed, as was knowledge of Long COVID. There was a greater concern for older adults and people with disabilities. There were concerns about symptoms and contagion and how they continued to negatively interfere with work and childcare.

ON COVID-19 PANDEMIC

"It makes it more accessible. I don't have to leave work for hours, just 15 minutes."

"They don't know how to do it and they're afraid because they've heard of all the scams and everything. They're afraid to put any personal information online if they did not grow up that way and that's very difficult for the older population."

"People are scared to say that they have it, because of that. Like to not be able to go to work... or working in the daycare."

"I just didn't know what it was called. So my sister-in-law has [Long COVID]. But she has it into where it's like anxiety and stuff."

"...we're in a crisis. We're so far behind, the system is overwhelmed and the only way to get under it is to spend more resources with preventative care."

SUGGESTED ACTIONS

Chester County

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

Telehealth is convenient and facilitates treatment planning.

"...I have access to a portal that I can go into, it's very convenient for me and the portal works so well because all my data is in there and looking at my data, I can make decisions and I can go to my doctors and they can make decisions, we can make decisions together. I can easily access them through that portal, and I just find it amazing because I can do this all from sitting at home and it really works well, especially after you are 65 years old and you're retired..."

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

More can be done to make telehealth services more accessible.

"There's a lot of health care services where someone does not have to be in person or they might not want to be in person, especially if you're talking about mental health or behavioral health issues, they might be much more comfortable doing that in their home. So what is Chester County's digital health component of its health strategy and how is it going to execute that so that the people who really need those services can get those services? There's many, many people in Chester County who have excellent Internet, can afford subscription costs, have devices."

Artificial intelligence can be explored to help remediate language barriers.

"I'm taking an AI course right now just to understand more about AI and there are the same things. People are saying it's dangerous, but there is so many advantages to it too. One of the advantages, by the way, is it can interpret languages so perfectly. I work with the Guatemalans and we could not find an interpreter to speak the languages of the Guatemalans and for healthcare. You can get AI to get the perfect accent and the perfect script that they will totally understand what you're saying and you don't have to hire an interpreter. You've got this wonderful voice coming through that sounds like them."

Long-term support and resources for parents/families is needed.

"So what kind of services are we giving to those parents? How are we finding them? How do we keep track of them after they have babies? Ten years [later], are we checking in on them? Are we giving them resources? Are we empowering to connect with other people in the community to help support them? So many people feel like they just have to do it on their own and they don't, we weren't raised to raise a village. We were raised to be in a village where we were."

Community and faith leaders can be leveraged to meet community health needs across cultures.

"I was going to say there's one positive thing that happens here and it's Pastor [omitted], once a month, they have a meal here. And it's just by their age and there's so many older people that come out and they sit around these tables and they talk. And if more churches could do that, and we have a Baptist church in town. We have a Baptist church and if we can get together with some of those ministers and talk to them, then maybe, they can do a service, a meal..."

Community health navigators and advocates can support patients with accessibility issues, such as older adults living alone, non-English speakers, and people with disabilities.

"In our area, I'd like to see the availability of advocates for all these people that don't know where to go, what to do. And even if we have them, the people have to be aware that we have them, and know how to get the help. So I'd really like to see advocates of filling out forms, just all those things that we take for granted too."

Central-East Chester

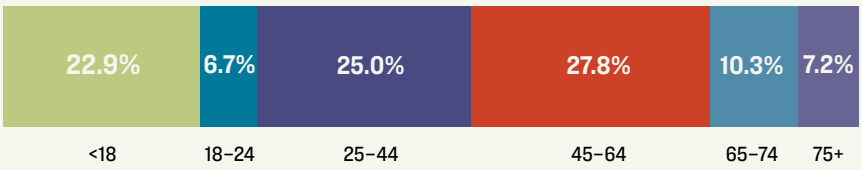
ZIP Codes: 19301, 19312, 19333, 19341, 19345, 19355

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health
- Wills Eye Hospital

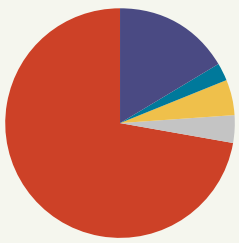
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

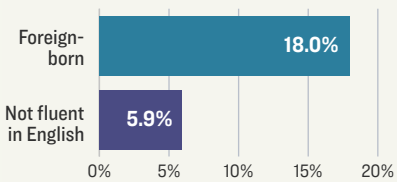


SEX

RACE/ETHNICITY/LANGUAGE



16.6% Asian
2.4% Black
5.1% Hispanic/Latine
3.7% Another race/ethnicity
72.1% White



POPULATION

77,897

MEDIAN HOUSEHOLD INCOME

$155,513

EDUCATIONAL ATTAINMENT

10.3% High school as highest education level

PEOPLE WITH DISABILITIES

8.4%

LEADING CAUSES OF DEATH – All Ages

1 Cancer
2 Heart Disease
3 Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Central-East Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	746.4	763.5
	Life expectancy: Female (in years)	82.7	81.7
	Life expectancy: Male (in years)	79.1	78.5
	Years of potential life lost before 75	2,982	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	26.2%	31.1%
	Diabetes prevalence	8.6%	9.7
	Diabetes-related hospitalization rate (per 100,000)	92.0	112.0
	Hypertension prevalence	27.7%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	36.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	626.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	20.7	23.5
	Major cancer incidence rate (per 100,000)*	279.4	260.2%
	Major cancer mortality rate (per 100,000)*	44.0	60.8
	Colorectal cancer screening (adults age 45-75)	74.1%	70.3%
	Mammography screening (women age 50-74)	81.8%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.6	3.3
	Percent low birthweight births out of live births	7.0%	6.7%
	Percent preterm births out of live births	8.0%	8.3%
	Child Opportunity Index**	92.7	74.1
BEHAVIORAL HEALTH	Adult binge drinking	17.6%	18.6%
	Adult smoking	8.0%	12.6%
	Drug overdose mortality rate (per 100,000)	11.6	20.9
	Opioid-related hospitalization rate (per 100,000)	69.2	111.1
	Substance-related hospitalization rate (per 100,000)	113.6	167.8
	Poor mental health for 14+ days in past 30 days	12.6%	15.1%
	Suicide mortality rate (per 100,000)	11.6	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,868	2,094.0
	Homicide mortality rate (per 100,000)	2.6	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	4.6%	7.6%
	Children <19 years with public insurance	14.9%	20.4%
	Population without insurance	2.9%	4.7%
	Children <19 years without insurance	2.8%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.3%	5.8%
	Children <18 years in poverty	3.5%	6.5%
	Adults 19-64 years unemployed	4.4%	3.7%
	Householders living alone who are 65+ years	22.3%	24.0%
	Households receiving SNAP benefits	3.1%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.4%	10.8%
	Vacant housing units	4.0%	3.9%
	Single parent households	15.2%	14.0%
	Commute greater than 60 minutes	10.8%	9.2%

"--" 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: 58

ADULTS

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

Age-related illnesses

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

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

Substance use

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

Anxiety

Bullying

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

Mental health services

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

Health insurance is not accepted

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

Central-West Chester

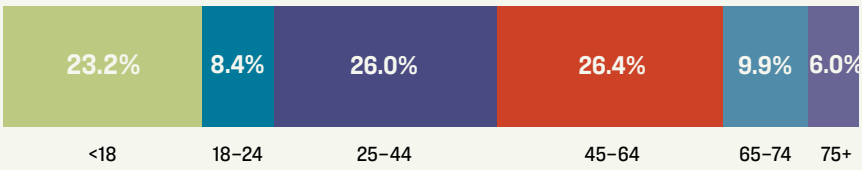
ZIP Codes: 19310, 19320, 19358, 19365, 19367, 19372

This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

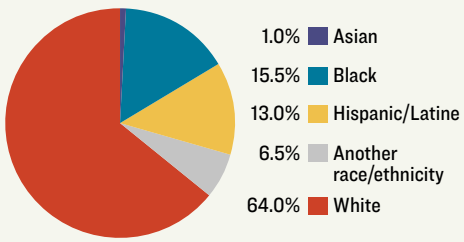
SOCIAL VULNERABILITY INDEX (SVI)

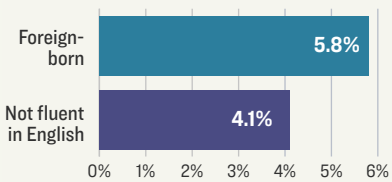
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

68,829

MEDIAN HOUSEHOLD INCOME

$90,115

EDUCATIONAL ATTAINMENT

34.3% High school as highest education level

PEOPLE WITH DISABILITIES

16.6%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Accidents

SUMMARY HEALTH MEASURES

Category	Measure	Central-West Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	969.5	763.5
	Life expectancy: Female (in years)	78.5	81.7
	Life expectancy: Male (in years)	73.9	78.5
	Years of potential life lost before 75	5,009	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	35.0%	31.1%
	Diabetes prevalence	11.1%	9.7
	Diabetes-related hospitalization rate (per 100,000)	327.0	112.0
	Hypertension prevalence	31.7%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	66.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	1,428.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	42.5	23.5
	Major cancer incidence rate (per 100,000)*	310.5	260.2
	Major cancer mortality rate (per 100,000)*	83.5	60.8
	Colorectal cancer screening (adults age 45-75)	68.0%	70.3%
	Mammography screening (women age 50-74)	78.0%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.6	3.3
	Percent low birthweight births out of live births	7.4%	6.7%
	Percent preterm births out of live births	10.3%	8.3%
	Child Opportunity Index**	50.2	74.1
BEHAVIORAL HEALTH	Adult binge drinking	18.5%	18.6%
	Adult smoking	16.3%	12.6%
	Drug overdose mortality rate (per 100,000)	57.1	20.9
	Opioid-related hospitalization rate (per 100,000)	212.4	111.1
	Substance-related hospitalization rate (per 100,000)	339.8	167.8
	Poor mental health for 14+ days in past 30 days	16.5%	15.1%
	Suicide mortality rate (per 100,000)	11.7	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,305	2,094.0
	Homicide mortality rate (per 100,000)	4.40	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	15.9%	7.6%
	Children <19 years with public insurance	38.3%	20.4%
	Population without insurance	6.7%	4.7%
	Children <19 years without insurance	6.4%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	10.6%	5.8%
	Children <18 years in poverty	18.6%	6.5%
	Adults 19-64 years unemployed	4.4%	3.7%
	Householders living alone who are 65+ years	22.1%	24.0%
	Households receiving SNAP benefits	13.6%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	11.5%	10.8%
	Vacant housing units	5.2%	3.9%
	Single parent households	28.4%	14.0%
	Commute greater than 60 minutes	11.0%	9.2%

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COMMUNITY SURVEY

Number of Respondents: 98

ADULTS

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

Mental health

Heart conditions

Diabetes and high blood sugar

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

Depression

Alcohol use

Drug use

CHILDREN

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

Mental health

Abuse or neglect

Intellectual / developmental disabilities

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

Bullying

Anxiety

Depression

COMMUNITY

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

Affordable housing

Affordable healthy foods

Good paying jobs

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

Costs associated with getting healthcare

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

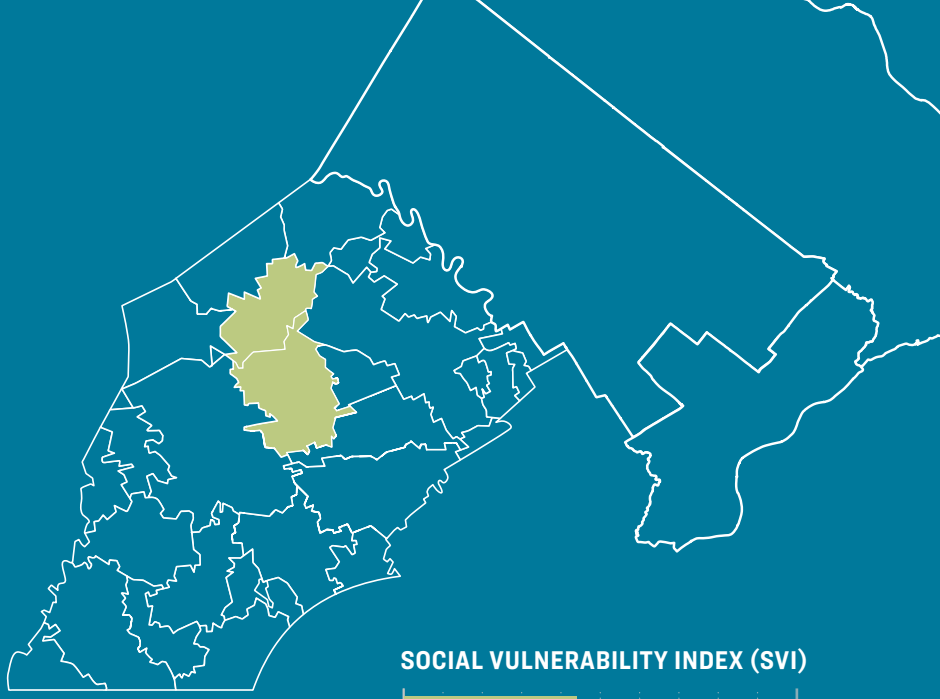
Not enough health care services or providers

Downingtown/ Glenmoore

ZIP Codes: 19335, 19343

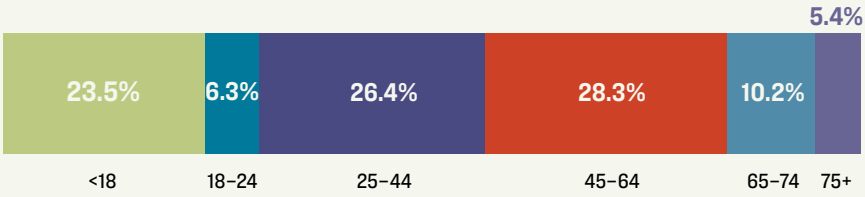
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health
- Wills Eye Hospital



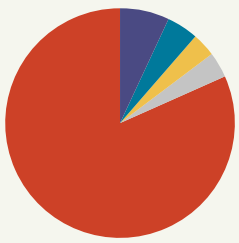
SOCIAL VULNERABILITY INDEX (SVI)

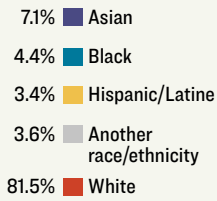
AGE DISTRIBUTION

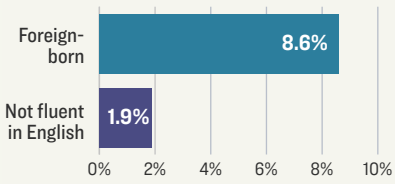


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

61,119

MEDIAN HOUSEHOLD INCOME

$140,197

EDUCATIONAL ATTAINMENT

16.9% High school as highest education level

PEOPLE WITH DISABILITIES

8.2%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

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

Category	Measure	Downingtown/Glenmoore	Chester County
GENERAL	All-cause mortality rate (per 100,000)	561.9	763.5
	Life expectancy: Female (in years)	83.3	81.7
	Life expectancy: Male (in years)	80.9	78.5
	Years of potential life lost before 75	1,649	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.8%	31.1%
	Diabetes prevalence	8.9%	9.7
	Diabetes-related hospitalization rate (per 100,000)	136.0	112.0
	Hypertension prevalence	27.9%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	43.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	760.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	16.8	23.5
	Major cancer incidence rate (per 100,000)*	375.9	260.2
	Major cancer mortality rate (per 100,000)*	32.0	60.8
	Colorectal cancer screening (adults age 45-75)	72.3%	70.3%
	Mammography screening (women age 50-74)	81.3%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	3.3
	Percent low birthweight births out of live births	6.9%	6.7%
	Percent preterm births out of live births	9.3%	8.3%
	Child Opportunity Index**	73.6	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.7%	18.6%
	Adult smoking	10.4%	12.6%
	Drug overdose mortality rate (per 100,000)	10.1	20.9
	Opioid-related hospitalization rate (per 100,000)	119.4	111.1
	Substance-related hospitalization rate (per 100,000)	161.5	167.8
	Poor mental health for 14+ days in past 30 days	13.1%	15.1%
	Suicide mortality rate (per 100,000)	15.1	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,232	2,094.0
	Homicide mortality rate (per 100,000)	1.70	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.8%	7.6%
	Children <19 years with public insurance	16.5%	20.4%
	Population without insurance	2.3%	4.7%
	Children <19 years without insurance	1.8%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	2.9%	5.8%
	Children <18 years in poverty	2.1%	6.5%
	Adults 19-64 years unemployed	3.6%	3.7%
	Householders living alone who are 65+ years	24.5%	24.0%
	Households receiving SNAP benefits	3.7%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	10.1%	10.8%
	Vacant housing units	2.3%	3.9%
	Single parent households	13.9%	14.0%
	Commute greater than 60 minutes	8.3%	9.2%

"--" 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: 72

ADULTS

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

Mental health

Age-related illnesses

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?

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?

Anxiety

Bullying

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

Mental health services

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

Health insurance is not accepted

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

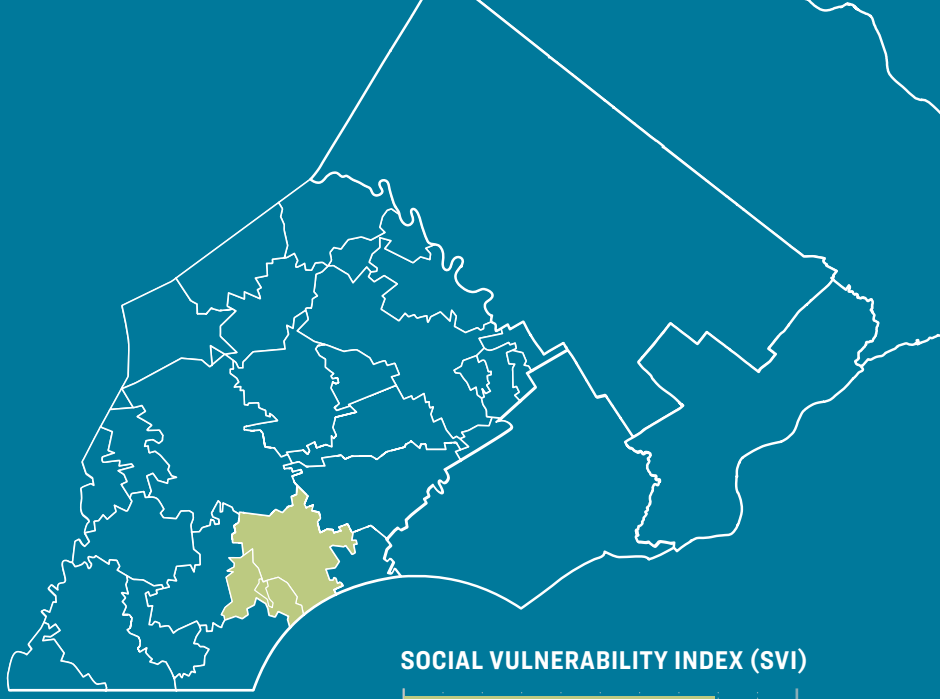
Kennett

ZIP Codes: 19311, 19348, 19374, 19375

This community is served by:

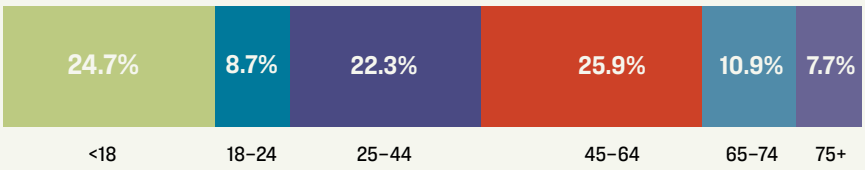
- Bryn Mawr Rehab Hospital
- Chester County Hospital*
- Children's Hospital of Philadelphia
- ChristianaCare - West Grove*
- Main Line Health
- Wills Eye Hospital

* ChristianaCare - West Grove Campus anticipated opening Summer 2025



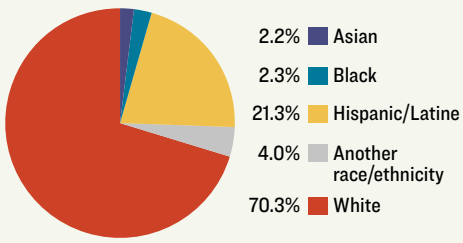
SOCIAL VULNERABILITY INDEX (SVI)

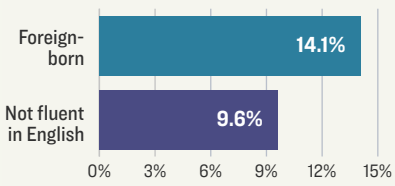
AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE





POPULATION

36,429

MEDIAN HOUSEHOLD INCOME

$124,622

EDUCATIONAL ATTAINMENT

17.5% High school as highest education level

PEOPLE WITH DISABILITIES

10.7%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

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

Category	Measure	Kennett	Chester County
GENERAL	All-cause mortality rate (per 100,000)	702.7	763.5
	Life expectancy: Female (in years)	83.2	81.7
	Life expectancy: Male (in years)	81.7	78.5
	Years of potential life lost before 75	1,258	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.2%	31.1%
	Diabetes prevalence	10.0%	9.7
	Diabetes-related hospitalization rate (per 100,000)	96.0	112.0
	Hypertension prevalence	27.4%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	30.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	590.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	22.3	23.5
	Major cancer incidence rate (per 100,000)*	220.3	260.2
	Major cancer mortality rate (per 100,000)*	47.4	60.8
	Colorectal cancer screening (adults age 45-75)	67.1%	70.3%
	Mammography screening (women age 50-74)	79.5%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	3.3
	Percent low birthweight births out of live births	7.5%	6.7%
	Percent preterm births out of live births	8.5%	8.3%
	Child Opportunity Index**	70.9	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.6%	18.6%
	Adult smoking	12.0%	12.6%
	Drug overdose mortality rate (per 100,000)	8.4	20.9
	Opioid-related hospitalization rate (per 100,000)	36.2	111.1
	Substance-related hospitalization rate (per 100,000)	53.0	167.8
	Poor mental health for 14+ days in past 30 days	13.9%	15.1%
	Suicide mortality rate (per 100,000)	13.9	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,506	2,094.0
	Homicide mortality rate (per 100,000)	8.40	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.2%	7.6%
	Children <19 years with public insurance	23.6%	20.4%
	Population without insurance	7.7%	4.7%
	Children <19 years without insurance	6.0%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	4.1%	5.8%
	Children <18 years in poverty	6.9%	6.5%
	Adults 19-64 years unemployed	3.2%	3.7%
	Householders living alone who are 65+ years	24.7%	24.0%
	Households receiving SNAP benefits	4.5%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	8.2%	10.8%
	Vacant housing units	3.9%	3.9%
	Single parent households	22.2%	14.0%
	Commute greater than 60 minutes	8.2%	9.2%

"--" 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: 45

ADULTS

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

Age-related illnesses

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

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".

Safe neighborhoods

Affordable housing

Affordable healthy foods

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

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

Costs associated with getting healthcare

Not enough health care services or providers

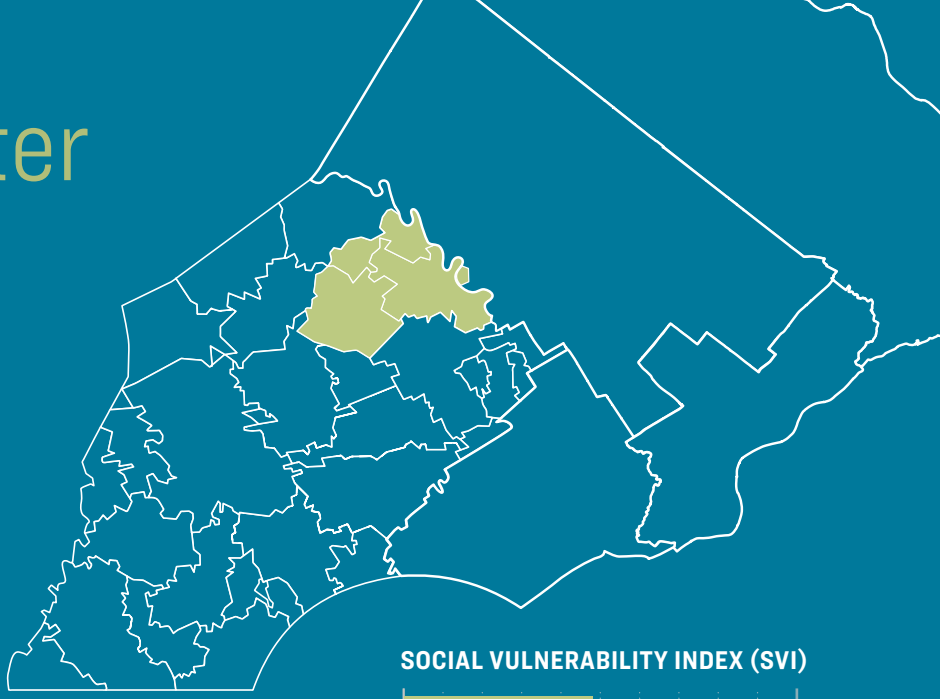
Northern Chester

ZIP Codes: 19425, 19453, 19460, 19475

Note: This community includes one ZIP code (19453) which crosses into Montgomery County.

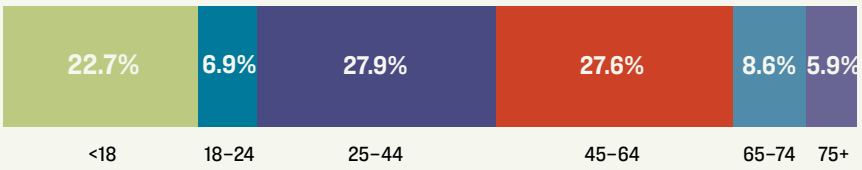
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



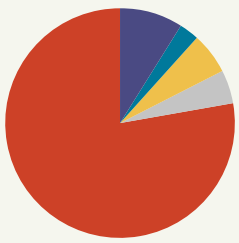
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION

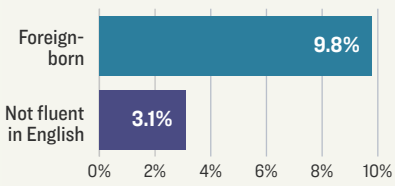


SEX

RACE/ETHNICITY/LANGUAGE



9.0% Asian
2.9% Black
5.7% Hispanic/Latine
4.7% Another race/ethnicity
77.6% White



POPULATION

74,801

MEDIAN HOUSEHOLD INCOME

$131,569

EDUCATIONAL ATTAINMENT

17.1% High school as highest education level

PEOPLE WITH DISABILITIES

10.3%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

Category	Measure	Northern Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	785.0	763.5
	Life expectancy: Female (in years)	79.4	81.7
	Life expectancy: Male (in years)	78.0	78.5
	Years of potential life lost before 75	4,024	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	29.9%	31.1%
	Diabetes prevalence	9.3%	9.7
	Diabetes-related hospitalization rate (per 100,000)	169.0	112.0
	Hypertension prevalence	28.4%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	33.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	943.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	24.3	23.5
	Major cancer incidence rate (per 100,000)*	264.8	260.2%
	Major cancer mortality rate (per 100,000)*	73.0	60.8
	Colorectal cancer screening (adults age 45-75)	72.2%	70.3%
	Mammography screening (women age 50-74)	81.3%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	6.4	3.3
	Percent low birthweight births out of live births	6.5%	6.7%
	Percent preterm births out of live births	7.5%	8.3%
	Child Opportunity Index**	81.7	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.2%	18.6%
	Adult smoking	11.5%	12.6%
	Drug overdose mortality rate (per 100,000)	24.3	20.9
	Opioid-related hospitalization rate (per 100,000)	129.7	111.1
	Substance-related hospitalization rate (per 100,000)	198.6	167.8
	Poor mental health for 14+ days in past 30 days	13.5%	15.1%
	Suicide mortality rate (per 100,000)	10.8	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,628	2,094.0
	Homicide mortality rate (per 100,000)	1.4	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.0%	7.6%
	Children <19 years with public insurance	18.5%	20.4%
	Population without insurance	3.6%	4.7%
	Children <19 years without insurance	2.7%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.3%	5.8%
	Children <18 years in poverty	7.9%	6.5%
	Adults 19-64 years unemployed	2.9%	3.7%
	Householders living alone who are 65+ years	26.8%	24.0%
	Households receiving SNAP benefits	7.0%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	8.3%	10.8%
	Vacant housing units	4.1%	3.9%
	Single parent households	21.7%	14.0%
	Commute greater than 60 minutes	8.4%	9.2%

"--" 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: 37

ADULTS

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

Mental health

Heart conditions

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?

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?

Anxiety

Bullying

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".

Safe neighborhoods

Affordable housing

Public transportation

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

Costs associated with getting healthcare

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

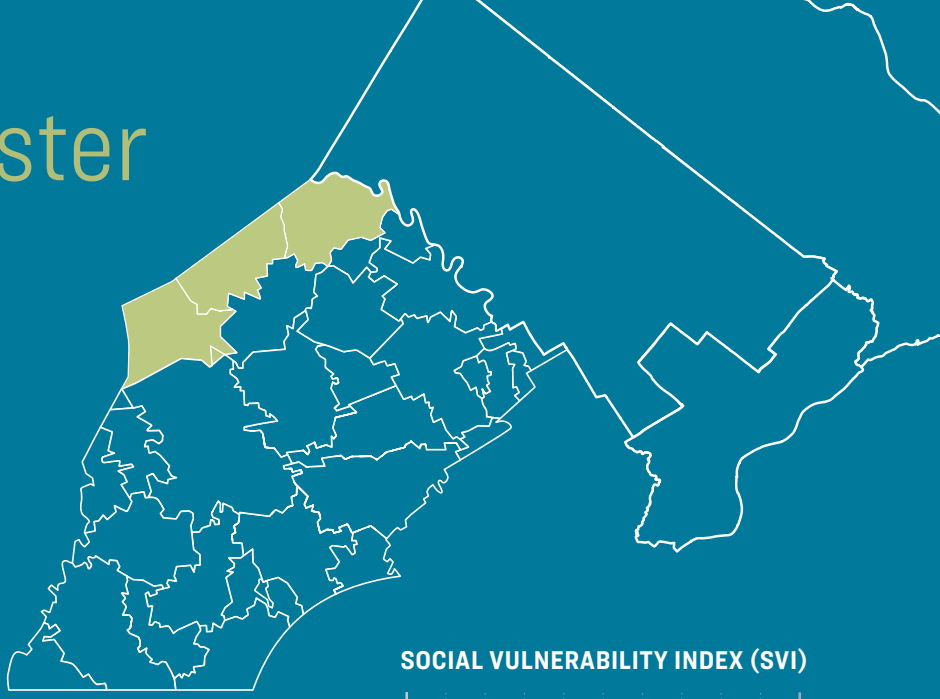
Health insurance is not accepted

Northwest Chester

ZIP Codes: 19316, 19344, 19465, 19520

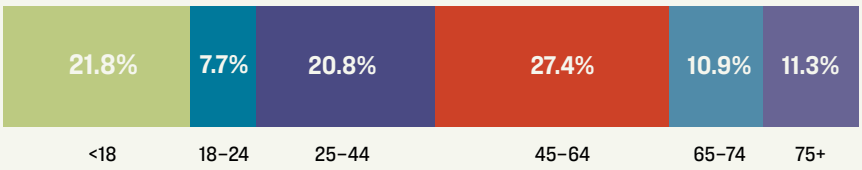
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Main Line Health
- Wills Eye Hospital



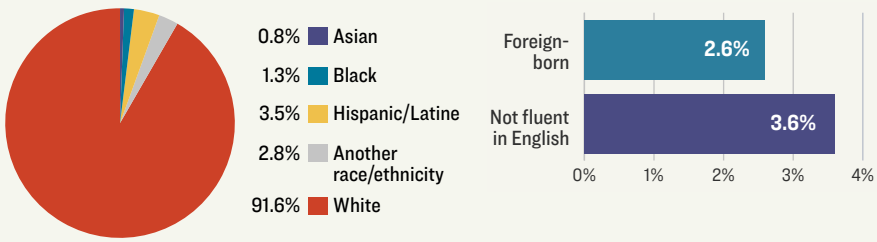
SOCIAL VULNERABILITY INDEX (SVI)

AGE DISTRIBUTION



SEX

RACE/ETHNICITY/LANGUAGE



POPULATION

37,543

MEDIAN HOUSEHOLD INCOME

$97,751

EDUCATIONAL ATTAINMENT

32.2% High school as highest education level

PEOPLE WITH DISABILITIES

15.7%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. COVID-19

SUMMARY HEALTH MEASURES

Category	Measure	Northwest Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	1,141.6	763.5
	Life expectancy: Female (in years)	79.9	81.7
	Life expectancy: Male (in years)	74.2	78.5
	Years of potential life lost before 75	2,605	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.0%	31.1%
	Diabetes prevalence	11.0%	9.7
	Diabetes-related hospitalization rate (per 100,000)	192.0	112.0
	Hypertension prevalence	31.7%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	42.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	867.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	34.4	23.5
	Major cancer incidence rate (per 100,000)*	251.6	260.2%
	Major cancer mortality rate (per 100,000)*	98.0	60.8
	Colorectal cancer screening (adults age 45-75)	71.1%	70.3%
	Mammography screening (women age 50-74)	79.6%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	7.6	3.3
	Percent low birthweight births out of live births	5.3%	6.7%
	Percent preterm births out of live births	9.1%	8.3%
	Child Opportunity Index**	64.1	74.1
BEHAVIORAL HEALTH	Adult binge drinking	18.0%	18.6%
	Adult smoking	14.8%	12.6%
	Drug overdose mortality rate (per 100,000)	26.5	20.9
	Opioid-related hospitalization rate (per 100,000)	145.7	111.1
	Substance-related hospitalization rate (per 100,000)	196.0	167.8
	Poor mental health for 14+ days in past 30 days	15.0%	15.1%
	Suicide mortality rate (per 100,000)	34.4	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,868	2,094.0
	Homicide mortality rate (per 100,000)	7.90	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	9.8%	7.6%
	Children <19 years with public insurance	22.4%	20.4%
	Population without insurance	9.8%	4.7%
	Children <19 years without insurance	15.3%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	5.8%	5.8%
	Children <18 years in poverty	10.0%	6.5%
	Adults 19-64 years unemployed	3.8%	3.7%
	Householders living alone who are 65+ years	23.4%	24.0%
	Households receiving SNAP benefits	7.7%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	11.8%	10.8%
	Vacant housing units	2.8%	3.9%
	Single parent households	18.7%	14.0%
	Commute greater than 60 minutes	10.8%	9.2%

"--" 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: 50

ADULTS

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

Mental health

Diabetes and high blood sugar

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?

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

Obesity and maintaining healthy weight

Substance use

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

Anxiety

Bullying

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".

Safe neighborhoods

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

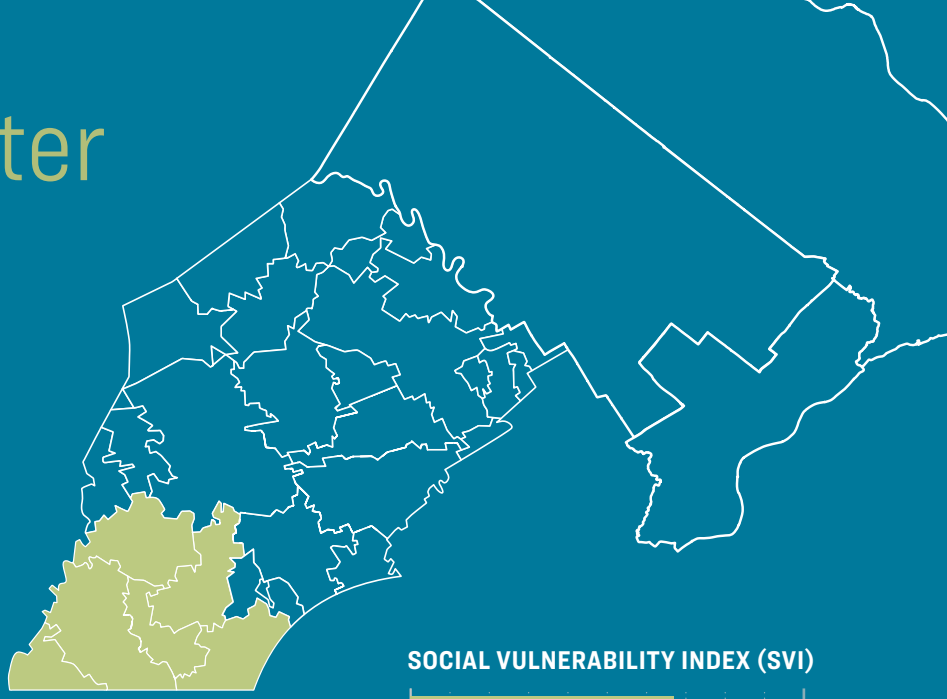
Southern Chester

ZIP Codes: 19330, 19350, 19352, 19362, 19363, 19390

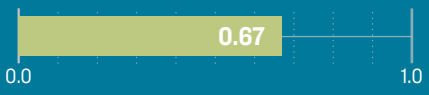
This community is served by:

- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- ChristianaCare – West Grove*
- Main Line Health
- Wills Eye Hospital

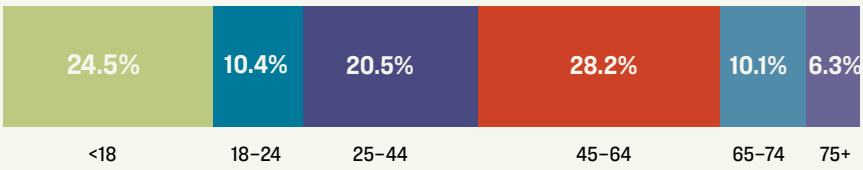
* ChristianaCare - West Grove Campus anticipated opening Summer 2025



SOCIAL VULNERABILITY INDEX (SVI)

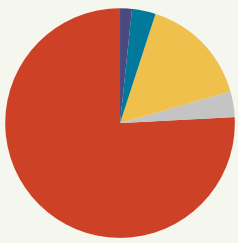


AGE DISTRIBUTION

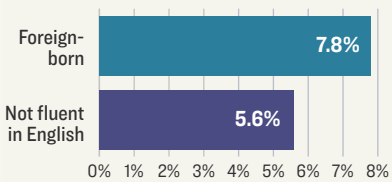


SEX

RACE/ETHNICITY/LANGUAGE



1.8% Asian
3.4% Black
15.4% Hispanic/Latine
3.8% Another race/ethnicity
75.6% White



POPULATION

63,927

MEDIAN HOUSEHOLD INCOME

$123,681

EDUCATIONAL ATTAINMENT

25.7% High school as highest education level

PEOPLE WITH DISABILITIES

11.5%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Accidents

SUMMARY HEALTH MEASURES

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

Category	Measure	Southern Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	645.3	763.5
	Life expectancy: Female (in years)	82.4	81.7
	Life expectancy: Male (in years)	79.3	78.5
	Years of potential life lost before 75	2,423	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	32.8%	31.1%
	Diabetes prevalence	10.5%	9.7
	Diabetes-related hospitalization rate (per 100,000)	94.0	112.0
	Hypertension prevalence	30.3%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	22.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	623.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	23.4	23.5
	Major cancer incidence rate (per 100,000)*	215.6	260.2%
	Major cancer mortality rate (per 100,000)*	48.4	60.8
	Colorectal cancer screening (adults age 45-75)	69.6%	70.3%
	Mammography screening (women age 50-74)	78.4%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	3.7	3.3
	Percent low birthweight births out of live births	5.9%	6.7%
	Percent preterm births out of live births	7.2%	8.3%
	Child Opportunity Index**	58.0	74.1
BEHAVIORAL HEALTH	Adult binge drinking	18.7%	18.6%
	Adult smoking	14.6%	12.6%
	Drug overdose mortality rate (per 100,000)	23.4	20.9
	Opioid-related hospitalization rate (per 100,000)	85.9	111.1
	Substance-related hospitalization rate (per 100,000)	70.3	167.8
	Poor mental health for 14+ days in past 30 days	15.8%	15.1%
	Suicide mortality rate (per 100,000)	14.1	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	1,336	2,094.0
	Homicide mortality rate (per 100,000)	--	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	7.8%	7.6%
	Children <19 years with public insurance	22.7%	20.4%
	Population without insurance	7.7%	4.7%
	Children <19 years without insurance	7.7%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.6%	5.8%
	Children <18 years in poverty	9.1%	6.5%
	Adults 19-64 years unemployed	3.0%	3.7%
	Householders living alone who are 65+ years	24.0%	24.0%
	Households receiving SNAP benefits	5.2%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	9.3%	10.8%
	Vacant housing units	4.8%	3.9%
	Single parent households	22.6%	14.0%
	Commute greater than 60 minutes	12.7%	9.2%

"--" 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: 54

ADULTS

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

Age-related illnesses

Heart conditions

Chronic pain and pain management

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

Anxiety

Depression

Loneliness

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?

Anxiety

Bullying

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".

Safe neighborhoods

Affordable housing

Mental health services

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

Not enough health care services or providers

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

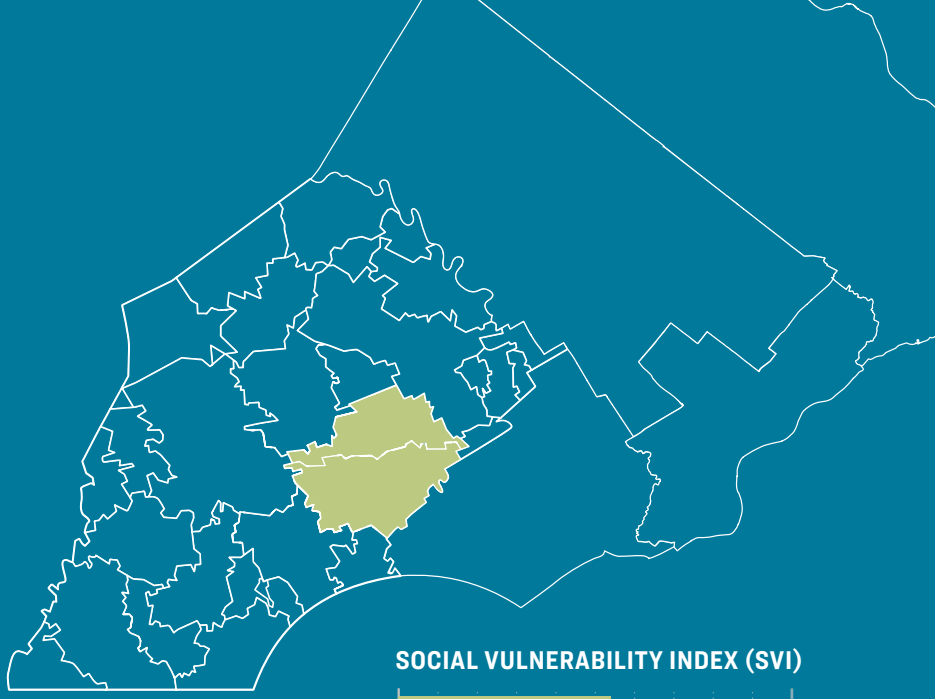
Costs associated with getting healthcare

West Chester

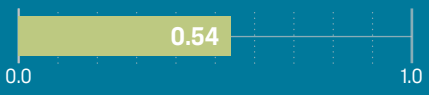
ZIP Codes: 19380, 19382, 19383

This community is served by:

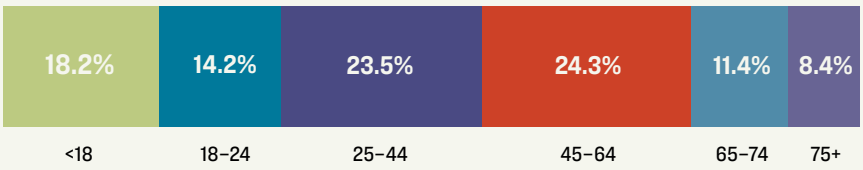
- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital



SOCIAL VULNERABILITY INDEX (SVI)

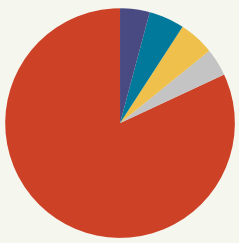


AGE DISTRIBUTION

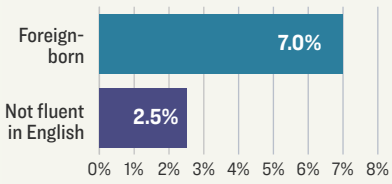


SEX

RACE/ETHNICITY/LANGUAGE



4.4% Asian
4.8% Black
5.2% Hispanic/Latine
3.9% Another race/ethnicity
81.8% White



POPULATION

109,020

MEDIAN HOUSEHOLD INCOME

$124,126

EDUCATIONAL ATTAINMENT

15.1% High school as highest education level

PEOPLE WITH DISABILITIES

9.9%

LEADING CAUSES OF DEATH – All Ages

1. Cancer
2. Heart Disease
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

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

Category	Measure	West Chester	Chester County
GENERAL	All-cause mortality rate (per 100,000)	777.0	763.5
	Life expectancy: Female (in years)	82.9	81.7
	Life expectancy: Male (in years)	79.7	78.5
	Years of potential life lost before 75	3,571	23,520
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	30.0%	31.1%
	Diabetes prevalence	6.8%	9.7
	Diabetes-related hospitalization rate (per 100,000)	129.0	112.0
	Hypertension prevalence	21.8%	28.8%
	Hypertension-related preventable hospitalization rate (per 100,000)	34.0	27.0
	Potentially preventable hospitalization rate (per 100,000)	753.0	604.0
	Premature cardiovascular disease mortality rate (per 100,000)	15.6	23.5
	Major cancer incidence rate (per 100,000)*	271.9	260.2%
	Major cancer mortality rate (per 100,000)*	70.7	60.8
	Colorectal cancer screening (adults age 45-75)	66.7%	70.3%
	Mammography screening (women age 50-74)	77.9%	79.6%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	2.1	3.3
	Percent low birthweight births out of live births	6.3%	6.7%
	Percent preterm births out of live births	7.2%	8.3%
	Child Opportunity Index**	82.9	74.1
BEHAVIORAL HEALTH	Adult binge drinking	19.1%	18.6%
	Adult smoking	11.9%	12.6%
	Drug overdose mortality rate (per 100,000)	11.0	20.9
	Opioid-related hospitalization rate (per 100,000)	98.3	111.1
	Substance-related hospitalization rate (per 100,000)	156.1	167.8
	Poor mental health for 14+ days in past 30 days	20.5%	15.1%
	Suicide mortality rate (per 100,000)	3.7	12.1
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,064	2,094.0
	Homicide mortality rate (per 100,000)	*	2.4
ACCESS TO CARE	Adults 19-64 years with Medicaid	5.7%	7.6%
	Children <19 years with public insurance	14.0%	20.4%
	Population without insurance	2.6%	4.7%
	Children <19 years without insurance	1.6%	4.6%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	6.1%	5.8%
	Children <18 years in poverty	4.7%	6.5%
	Adults 19-64 years unemployed	3.8%	3.7%
	Householders living alone who are 65+ years	24.3%	24.0%
	Households receiving SNAP benefits	4.0%	5.7%
	Households that are housing cost-burdened (% spending >50% of household income)	13.6%	10.8%
	Vacant housing units	3.4%	3.9%
	Single parent households	17.1%	14.0%
	Commute greater than 60 minutes	5.7%	9.2%

"--" 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: 133

ADULTS

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

Cancer

Diabetes and high blood sugar

Age-related illnesses

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

Depression

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

Obesity and maintaining healthy weight

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?

Anxiety

Bullying

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

Safe neighborhoods

Affordable healthy foods

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

Costs associated with getting healthcare

Health insurance is not accepted

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

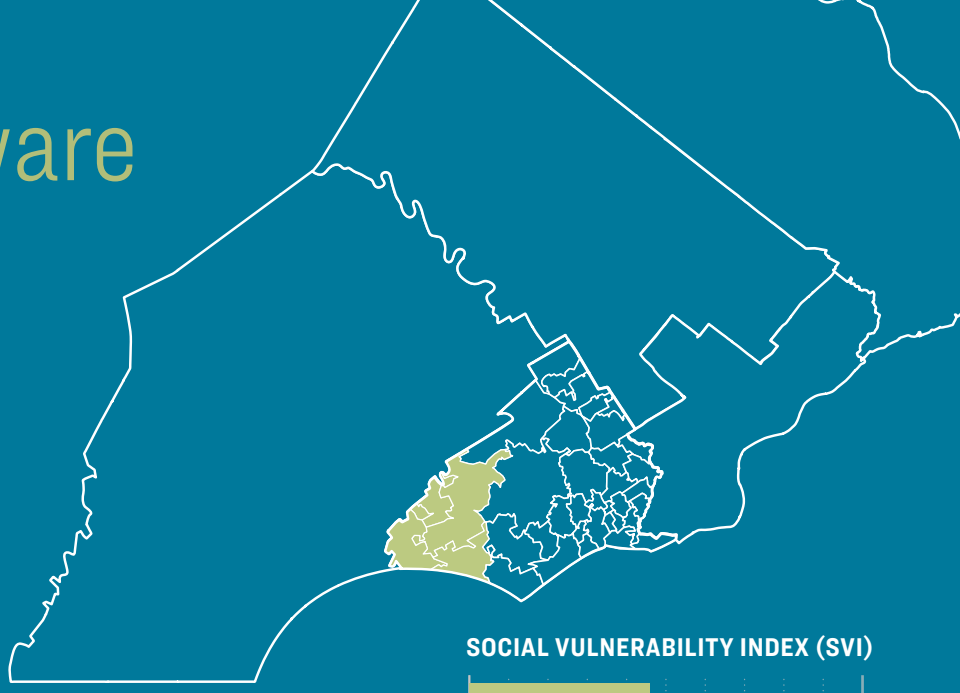
Western Delaware County

ZIP Codes: 19060, 19317, 19319, 19342, 19373

This community is served by:

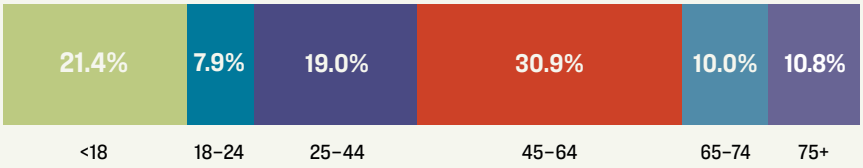
- Bryn Mawr Rehab Hospital
- Chester County Hospital
- Children's Hospital of Philadelphia
- ChristianaCare – West Grove*
- Jefferson Methodist Hospital
- Jefferson Moss-Magee Rehabilitation Hospital
- Main Line Health
- Thomas Jefferson University Hospital
- Wills Eye Hospital

* ChristianaCare - West Grove Campus anticipated opening Summer 2025



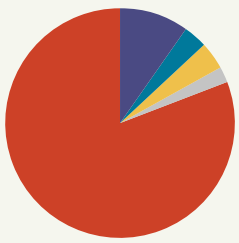
SOCIAL VULNERABILITY INDEX (SVI)

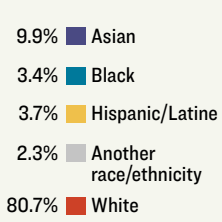
AGE DISTRIBUTION

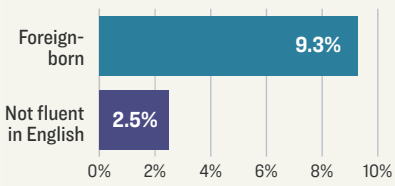


SEX

RACE/ETHNICITY/LANGUAGE







POPULATION

45,975

MEDIAN HOUSEHOLD INCOME

$151,623

EDUCATIONAL ATTAINMENT

18.8% High school as highest education level

PEOPLE WITH DISABILITIES

11.3%

LEADING CAUSES OF DEATH – All Ages

1. Heart Disease
2. Cancer
3. Cerebrovascular Diseases

SUMMARY HEALTH MEASURES

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

Category	Measure	Western Delaware County	Delaware County
GENERAL	All-cause mortality rate (per 100,000)	1058.7	1,020.3
	Life expectancy: Female (in years)	82.3	79.9
	Life expectancy: Male (in years)	78.8	76.0
	Years of potential life lost before 75	1,658	38,302
CHRONIC DISEASE & HEALTH BEHAVIORS	Adult obesity prevalence	25.6%	31%
	Diabetes prevalence	8.6%	10.8%
	Diabetes-related hospitalization rate (per 100,000)	99.0	170.0
	Hypertension prevalence	28.5%	32.6%
	Hypertension-related preventable hospitalization rate (per 100,000)	33.0	45.0
	Potentially preventable hospitalization rate (per 100,000)	649.0	829.0
	Premature cardiovascular disease mortality rate (per 100,000)	26.4	49.2
	Major cancer incidence rate (per 100,000)*	354.4	263.3
	Major cancer mortality rate (per 100,000)*	66.0	80.3
	Colorectal cancer screening (adults age 45-75)	71.4%	68.6%
	Mammography screening (women age 50-74)	80.7%	79.3%
INFANT & CHILD HEALTH	Infant mortality rate (per 1,000 live births)	--	5.9
	Percent low birthweight births out of live births	4.7%	9.0%
	Percent preterm births out of live births	5.8%	9.5%
	Child Opportunity Index**	89.3	59.0
BEHAVIORAL HEALTH	Adult binge drinking	20.5%	18.8%
	Adult smoking	9.3%	13.9%
	Drug overdose mortality rate (per 100,000)	15.4	28.0
	Opioid-related hospitalization rate (per 100,000)	158.5	220.6
	Substance-related hospitalization rate (per 100,000)	213.5	366.0
	Poor mental health for 14+ days in past 30 days	13.3%	15.8%
	Suicide mortality rate (per 100,000)	15.4	12.2
INJURIES	Fall-related hospitalization rate >age 64 (per 100,000 >age 64)	3,077.0	2,661.0
	Homicide mortality rate (per 100,000)	2.2	9.9
ACCESS TO CARE	Adults 19-64 years with Medicaid	3.9%	15.1%
	Children <19 years with public insurance	11.0%	34.2%
	Population without insurance	3.7%	5.0%
	Children <19 years without insurance	5.7%	2.9%
SOCIAL & ECONOMIC CONDITIONS	Population in poverty	1.5%	9.3%
	Children <18 years in poverty	0.3%	11.5%
	Adults 19-64 years unemployed	3.9%	6.2%
	Householders living alone who are 65+ years	26.8%	29.7%
	Households receiving SNAP benefits	3.2%	13.8%
	Households that are housing cost-burdened (% spending >50% of household income)	15.2%	14.3%
	Vacant housing units	4.6%	5.8%
	Single parent households	5.9%	27.1%
	Commute greater than 60 minutes	9.6%	8.8%

"--" 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 residents of the Central and Western Delaware County communities. Individual communities with 35 responses or less are grouped with adjacent areas to ensure inclusion of all responses.

Number of Respondents: 121

ADULTS

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

- Age-related illnesses
- Heart conditions
- Mental health

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

- Depression
- Anxiety
- Loneliness

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
- Injuries

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

- Bullying
- Anxiety
- Depression

COMMUNITY

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

- Affordable housing
- Mental health services
- Good paying jobs

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

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

SPOTLIGHT TOPICS

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

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

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

The Spotlight Topics discussed included:

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

SPOTLIGHT TOPIC

Caring for the Uninsured and Undocumented

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

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

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

Challenges and Barriers

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

DELAYED AND EMERGENCY-ONLY CARE

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

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

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

One participant from Bucks County said,

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

A Delaware County participant explained,

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

Another participant from Bucks recounts,

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

LANGUAGE AND CULTURAL BARRIERS

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

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

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

One participant from Delaware County said,

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

A Bucks County participant explains,

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

A Chester County participant shares,

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

FEAR OF IMMIGRATION CONSEQUENCES

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

According to one Philadelphia participant,

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

A Chester County participant explains,

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

SYSTEM NAVIGATION CHALLENGES

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

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

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

A Chester County participant said,

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

A Bucks County participant added,

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

Another Bucks County participant explained,

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

Special Populations

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

CHILDREN AND YOUTH

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

A provider in Delaware County shared,

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

In another example from the same county,

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

ADULTS WITH DISABILITIES OR MENTAL ILLNESS

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

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

What's Working Well

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

FREE AND SLIDING-SCALE CLINICS

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

The free medical and dental clinic in Doylestown

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

A Chester County participant adds,

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

STRATEGIC USE OF EMERGENCY MEDICAID

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

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

A Bucks County participant says,

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

Another Bucks County participant explains,

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

A Delaware County participant adds,

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

BILINGUAL BENEFITS COORDINATORS

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

A Philadelphia participant asserts,

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

COLLABORATIVE PARTNERSHIPS SUPPORT ACCESS TO LABS AND PREVENTIVE CARE

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

Two Chester County participants share:

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

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

COMMUNITY SUPPORTS

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

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

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

A Chester County participant explains,

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

A Philadelphia participant says,

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

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

Suggested Actions and Solutions

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

EXPAND AND SUSTAIN COMMUNITY-BASED NAVIGATION AND CARE COORDINATION:

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

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

INTEGRATE HEALTH INSURANCE AND SYSTEMS EDUCATION INTO TRUSTED COMMUNITY NETWORKS:

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

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

STRENGTHEN CROSS-SECTOR COLLABORATION AND REFERRAL SYSTEMS:

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

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

ADDRESS FINANCIAL BARRIERS AND ENHANCE AFFORDABILITY.

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

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

INVEST IN LONG-TERM INFRASTRUCTURE AND POLICY CHANGE.

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

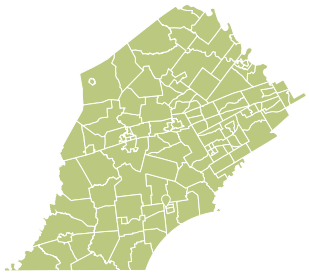
- **"If we're talking about all these health systems in our county… how about we start being able to bill for navigation services where we're getting people out of poverty and into housing."**
- **"So, placing AmeriCorps workers in community-based healthcare settings… calling [patients] and telling them,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

County-Specific Perspectives

BUCKS

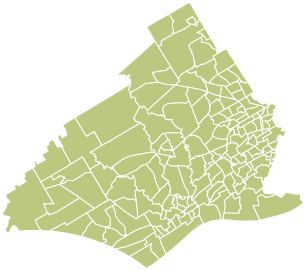
In Bucks, access to mental health care is a major concern, especially for individuals needing culturally competent, bilingual providers. There is also significant fear around seeking help, including domestic violence, due to immigration status. Preventive care is underutilized, and individuals often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

CHESTER



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

DELAWARE



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

MONTGOMERY

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

PHILADELPHIA

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

SPOTLIGHT TOPIC

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.

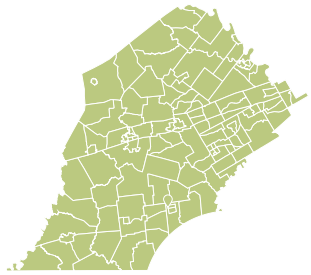
- **"The more partnerships, I guess, hospitals can make, will make it better for in the community also. I mean, it may drive down costs a little bit too, which is good. Again, we need to do it differently. We can't. The hospitals can't. So, they don't have all the answers, and I know that. And I know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

County-Specific Perspectives

BUCKS

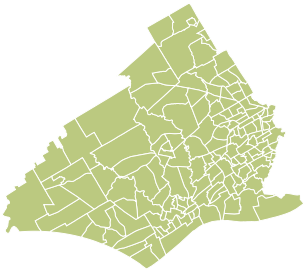
People in Bucks County say there aren't enough mental health providers, especially those who understand different cultures or speak other languages. Transportation and cost are big problems, especially for people with lower incomes. There was also a strong wish for one-stop clinics where people can get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

CHESTER



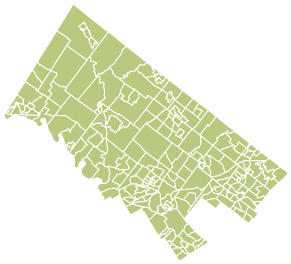
Chester County struggles with a lack of diverse providers, especially for Black, Brown, and immigrant communities. Many residents feel like they must explain their culture to their therapist. Cost is a major issue because many providers don't accept insurance. Community members also pointed out that 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

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."**

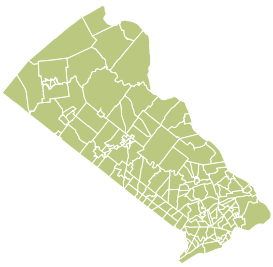
Replicate a "one-stop shop" model for older adult care, where multiple services are integrated into a single location with added support like transportation and comfortable spaces, could enhance convenience and accessibility for older adults in all healthcare practices.

- **"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."**

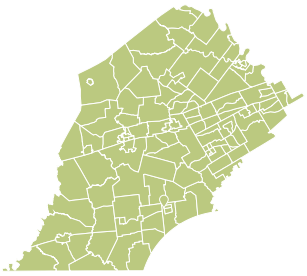
County-Specific Perspectives

BUCKS



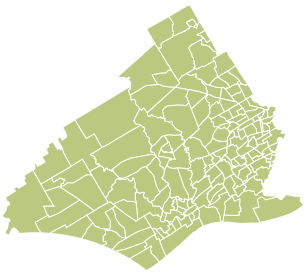
Participants in Bucks County highlighted significant barriers to healthcare access and transportation for older adults, with many emphasizing the financial difficulties that prevent older adults from affording essential medications. Mental health services were a major concern, particularly the stigma 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



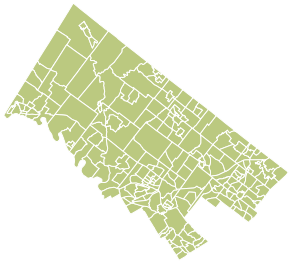
In Chester County, participants stressed the growing need for services that are culturally and linguistically appropriate, reflecting the county's shifting demographics. Digital literacy was a significant barrier, preventing older adults from accessing telehealth and online resources. A common concern 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."**

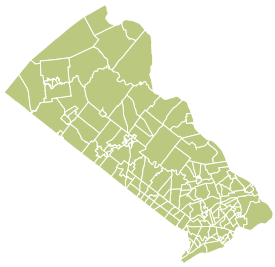
INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS IN THE REGION:

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."**

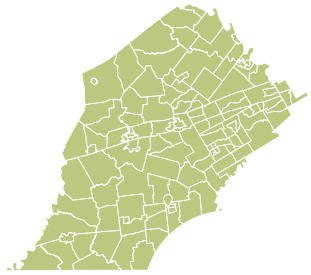
County-Specific Perspectives

BUCKS



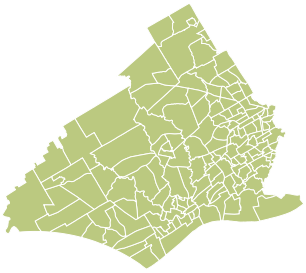
In Bucks County, transportation and logistics to primary care offices and hospitals remains a significant barrier to care – especially when community members seek care in Philadelphia. A partnership between community-based organizations and SEPTA to provide free key cards for clients has proven to be 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.

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%

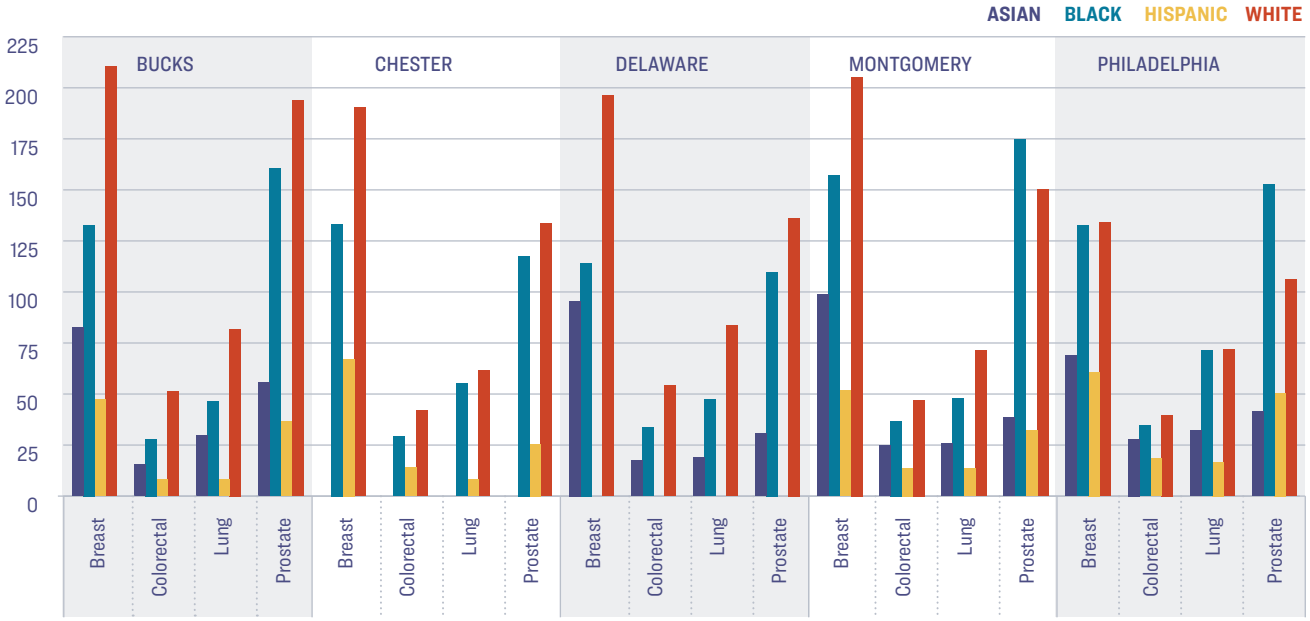
* "Major" cancer defined as: prostate, breast, lung, colorectal cancers; crude rate per 100,000; Vital Statistics, EDDIE (PA Department of Health)

** 2022 Behavioral Risk Factor Surveillance System

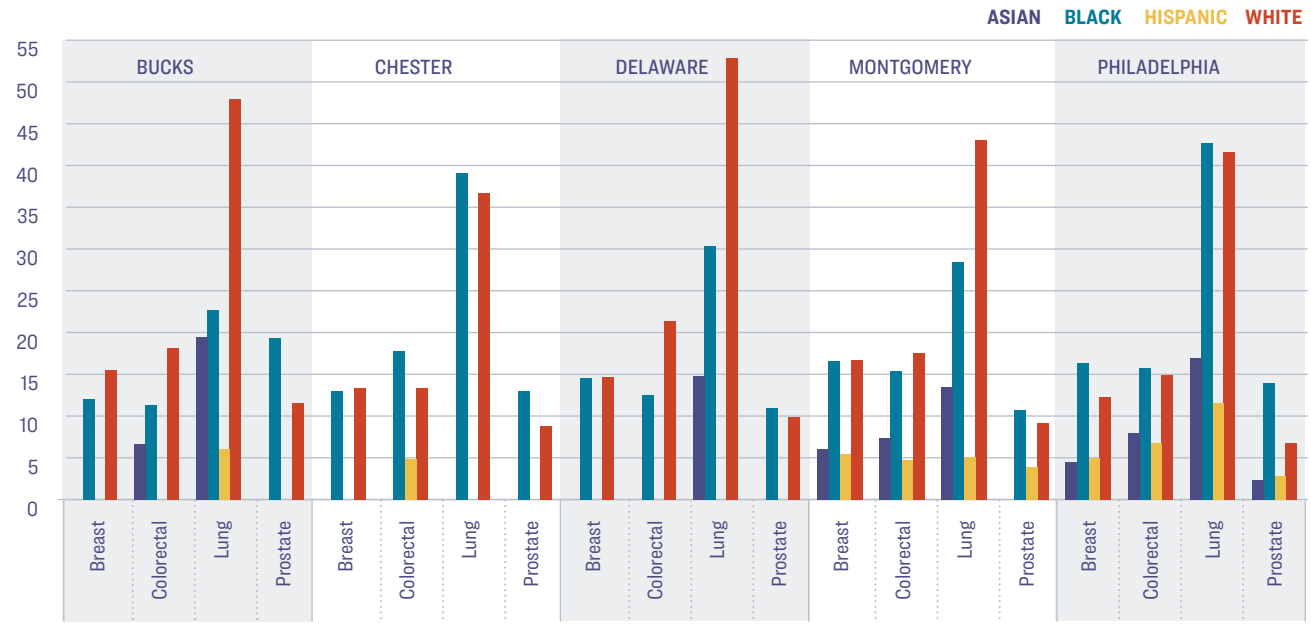
*** CDC PLACES

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.

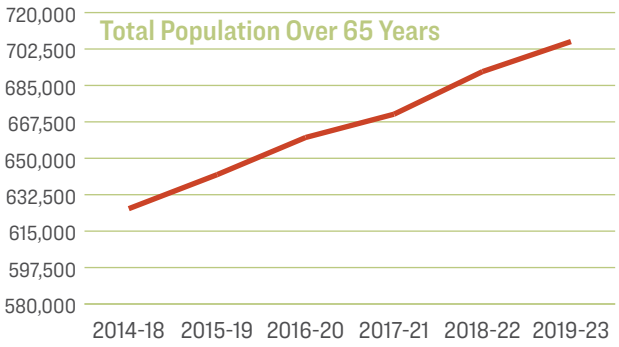
General population voices also revealed awareness of **technical and systemic challenges**—from poorly run paratransit programs to the financial burdens of caregiving. One participant described how unpredictable ride services leave people stranded: **"You never know when your rides are coming… if they're 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.

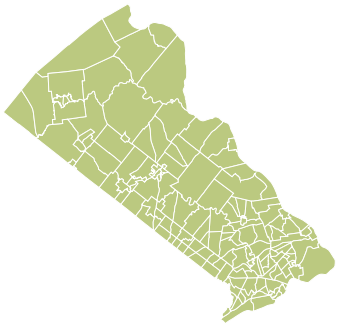
"With our township, they have a newsletter. I get it electronically. I went to the website and signed up for it, but if every resident or household received a paper copy and it contains some community resource phone numbers, that could be a way of reaching people who don't have computers and do read 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

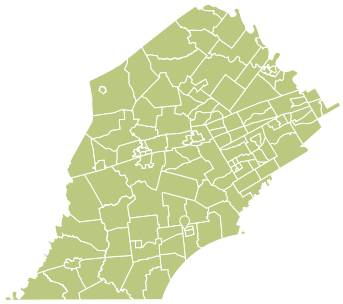
BUCKS



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.

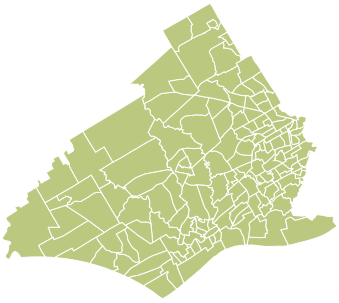
CHESTER



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.

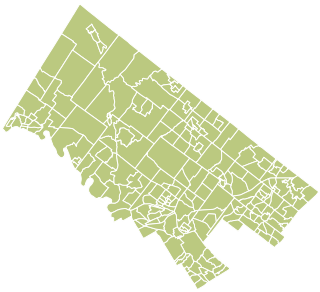
DELAWARE



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.

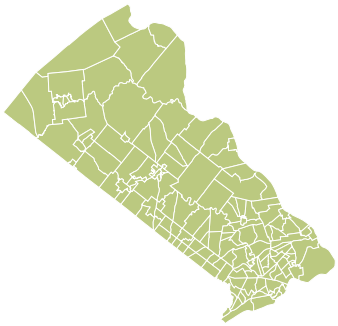
ON BETTER ACCESS TO EDUCATION, COMMUNITY PROGRAMS, AND CAREER READINESS

"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

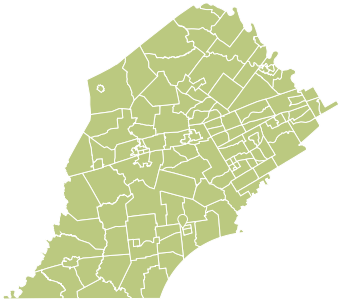
BUCKS



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.

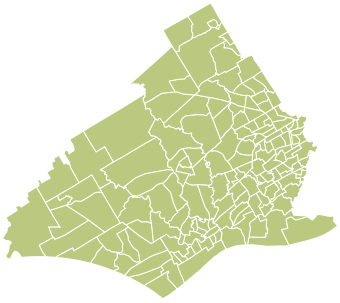
CHESTER



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.

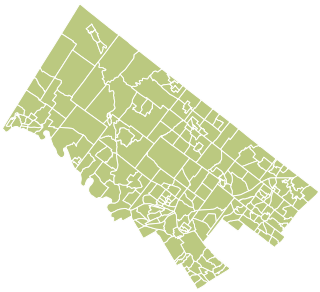
DELAWARE



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.

PRIORITY

1 Youth Mental Health

KEY FINDINGS:

- **Youth and adult community members recognize mental health as the primary health** concern in the region.
- Youth mental health was prioritized at 12 of 15 youth meetings.
- Top issues included: **limited access** to mental health services, **lack of coping skill** resources, harmful effects of **social media**, and widespread feelings of **loneliness**.
- Addressing youth mental health in Southeastern Pennsylvania requires a multifaceted approach, including early intervention, increased access to care, community support, and targeted programs within educational settings.
- **High Prevalence of Mental Health Issues:** In 2022, approximately 12.88% of Pennsylvania youth (around 117,000 individuals) experienced a major depressive episode. Alarmingly, nearly 60% of these youths did not receive any mental health treatment.
- **Impact of the COVID-19 Pandemic:** The pandemic exacerbated mental health challenges among teens. A 2022 survey revealed that 37% of responding teens reported poor mental health during the pandemic, and 44% felt persistently sad or hopeless. This suggests that upwards of 35,000 teens in Philadelphia may require mental health support.
- **Suicidal Ideation Among High School Students:** The 2021 Youth Risk Behavior Survey indicated that 22% of high school students nationwide seriously considered attempting suicide in the past year, with 10% having attempted suicide. These figures underscore the critical need for accessible mental health resources for youth.

POTENTIAL SOLUTIONS:

- **Integrate mental and behavioral health services into primary care and school settings:** Normalize mental health care and reduce stigma by embedding services where youth already go. Participants urged that schools have accessible mental health resources in schools beyond just overwhelmed counselors.
- **Embed trauma-informed and healing-centered care into all services and programming:** Recognize the impact of trauma and promote resilience in all youth-facing programs.
- **Increase education and awareness of youth mental health services for families and caregivers:** Equip trusted adults to recognize warning signs and access timely care. Participants recommended Parent/community education on youth mental health, potentially offered at school events like back-to-school nights. They also suggested mandated parenting education/training to better equip caregivers.
- **Support extracurricular and peer-group activities to enhance social engagement:** Reduce loneliness by fostering safe and inclusive environments for connection.
- **Collaborative Care Model:** Proven approach where primary care teams include behavioral health professionals to improve youth mental health outcomes.
- **Trauma-Informed Schools Model:** Builds supportive learning environments by training staff and embedding school-wide trauma practices. Programs like the Philadelphia school-based mental health initiative, supported by the Independence Blue Cross Foundation and Children's Hospital of Philadelphia (CHOP), have been implemented to train school staff in screening and referring students at risk of mental health issues. This approach aims to create a comprehensive support system within schools.
- **Mental Health First Aid Training:** Prepares educators and youth leaders to identify, understand, and respond to mental health crises.
- **Peer Support Programs (e.g., Youth MOVE National):** Promote youth leadership and mutual support for mental health advocacy. Participants advocated for peer-led support spaces in schools like "Relationships First" circles where trained student leaders facilitate discussions.
- **Community Resources for Youth:** Organizations such as The Lincoln Center for Family and Youth offer services including school-based mental health counseling and alternative education programs to support youth mental health in the greater Philadelphia area.
- **Community-Based Support Centers:** Community Evening Resource Centers (CERC) in Philadelphia provide free, safe spaces and activities for children and teens aged 10 to 17, offering structured activities, homework assistance, and opportunities to build friendships. Youth encouraged reducing stigma through community awareness and generational conversations.
- **Early emotional support:** Participants advocated for incorporating social-emotional learning (SEL) from a younger age, not just in high school.

PRIORITY

2 Lack of Resources/ Knowledge of Resources

KEY FINDINGS:

- 30% of youth meetings prioritized **help with navigating health resources**.
- Youth reported difficulty accessing services due to **lack of awareness, system fragmentation, and limited transportation**.
- Many felt they lacked trusted adults or safe reporting pathways.
- **Complex Healthcare Systems:** The intricacies of the healthcare system can be overwhelming for youth, making it difficult to identify appropriate services and navigate insurance processes.
- **Stigma and Fear of Judgment:** Concerns about stigma, particularly regarding mental health services, deter youth from seeking help due to fear of being judged or misunderstood.
- **Transportation Barriers:** Limited transportation options can prevent youth from accessing health facilities, especially in underserved areas.
- **Financial Constraints:** Even with insurance, out-of-pocket costs and uncertainties about coverage can discourage youth from pursuing necessary health services.
- **Limited School-Based Support:** While schools are pivotal in health education, not all institutions have adequate resources or programs to guide students toward appropriate health services.
- **Cultural and Linguistic Barriers:** Diverse populations may face challenges due to language differences and cultural misunderstandings within the healthcare system.
- **Digital Divide:** Not all youth have reliable internet access or digital literacy, hindering their ability to find and utilize online health resources.
- **Fragmented Services:** The lack of coordination among various health services can make it difficult for youth to receive comprehensive care.

POTENTIAL SOLUTIONS:

- **Engage healthcare providers and care coordinators:** Help youth navigate complex systems through warm handoffs and follow-up.
- **Partner with schools to enhance health education and resource sharing:** Ensure youth know what services are available and how to access them.
- **Community Health Worker (CHW) Models:** Train CHWs to support youth and families in navigating care and building trust.
- **School-Based Health Centers (SBHCs):** One-stop access points for physical and mental health care, especially in underserved areas.
- **Trusted Messenger Programs:** Utilize culturally and age-relevant community members to relay information more effectively.
- **Community Initiatives:** Organizations like CORA Services have launched programs such as the Family Navigation Center to assist families in accessing and navigating health services effectively. Participants also encouraged community events (e.g., Healthy Kids Day) that attract families with incentives (bounce houses, food) while sharing resources.
- **More community-based outreach** instead of just web-based referrals.
- **Increase transportation access** or bringing services closer to communities (e.g., having more rec centers or clinics locally).
- **Youth-friendly formats** like social media campaigns to spread resource awareness.
- **Cultural and language access:** Hiring bilingual staff and making materials culturally relevant.

PRIORITY

3 Substance Use and Related Disorders

KEY FINDINGS:

- Identified in 9 of 15 youth meetings as a major concern.
- Key concerns: **binge drinking**, increased **marijuana** and **vape** use, and **trauma due to drug exposure**.
- Youth reported a need for better navigation of behavioral and treatment services.
- In 2022 according to the National Center for Drug Abuse Statistics (NCDAS), approximately 7.22% of Pennsylvania adolescents aged 12 to 17 reported **using drugs in the past month**, with marijuana being the most commonly used substance. In the same study, 9.19% of Pennsylvania teens reported **using alcohol** in the last month, slightly higher than the national average for this age group.
- **Youth experiencing depressive symptoms are significantly more likely to engage in substance use** compared to their peers with a more positive outlook.

POTENTIAL SOLUTIONS:

- **Youth-focused recovery spaces:** Suggestion of AA-style meetings for adolescents.
- **Safe reporting systems** where youth can help others (e.g., call for overdose support) without fear of punishment.
- **Integrated recovery and workforce development programs:** Pairing mental health support with skill-building and community service.
- **CIT (Counselor-in-Training) programs** and volunteer work for youth as alternatives to substance use and ways to build confidence and responsibility.
- **Develop and expand substance use prevention and education programs:** Deliver age-appropriate, evidence-based curricula in schools and communities.
- **Promote prescription drug take-back initiatives:** Reduce misuse by encouraging safe disposal of medications.
- **Botvin LifeSkills Training:** Proven curriculum that builds personal and social skills to prevent substance use.
- **SBIRT (Screening, Brief Intervention, and Referral to Treatment):** Early intervention tool used in schools and health centers.
- **Communities That Care (CTC):** Data-driven framework engaging local stakeholders to reduce youth risk behaviors through tailored strategies.
- **Treatment and Recovery Programs:** Organizations such as the Anti-Drug & Alcohol Crusaders, Inc. (ADAC) provide substance misuse prevention and intervention services targeting youth and families in Philadelphia.

PRIORITY

4 Bullying

KEY FINDINGS:

- Youth cited **bullying**—especially **cyberbullying**—as a major issue impacting mental health.
- **Discrimination**, **harassment**, and **social media toxicity** were recurring themes.
- Among students aged 12–18 who reported being bullied during the 2021–2022 school year, 21.6% experienced cyberbullying, with a **higher incidence among females** (27.7%) compared to males (14.1%).
- The 2023 Pennsylvania Youth Survey (PAYS) highlighted a **strong correlation between being bullied and experiencing depression or suicidal behaviors** among youth in Philadelphia County.

POTENTIAL SOLUTIONS:

- **Social media etiquette education** starting at young ages to combat online bullying.
- **Safe spaces in schools** to talk about feelings, led by peers or trained youth facilitators.
- **Early interventions** to prevent verbal and cyberbullying from escalating.
- **Support for immigrant and bilingual children** facing bullying due to language barriers.
- **Build conflict resolution skills and outlets for emotional expression:** Empower youth to manage emotions and resolve issues constructively.
- **Provide digital citizenship education:** Teach responsible online behavior and how to respond to cyberbullying.
- **Co-create psychologically safe environments:** Ensure schools and programs promote inclusion, equity, and support.
- **Olweus Bullying Prevention Program:** Evidence-based schoolwide program shown to reduce bullying.
- **Second Step SEL Program:** Social-emotional learning curriculum that builds empathy, emotion regulation, and decision-making.
- **Restorative Practices in Schools:** Shifts discipline from punitive to healing by fostering accountability and connection.
- **Support for LGBTQ+ Students:** The National School Climate Survey by GLSEN reports on the experiences of LGBTQ+ youth in schools, highlighting the need for supportive environments to reduce bullying and harassment.

PRIORITY

5 Gun Violence

KEY FINDINGS:

- Youth recognize gun violence as a top concern, **driven by poverty and easy access to firearms**.
- **Immigrant and LGBTQ+ youth face additional risks**, including IPV and sex trafficking.
- Youth report trauma and **limited access to supports** for healing.
- In 2022, firearms were the **leading cause of death among children and teens aged 1 to 17** in Pennsylvania.
- Studies indicate that **Black youths and those residing in urban communities have higher rates of witnessing gun violence** (21.4%) and hearing gunshots in public (51.6%) compared to their non-Black and non-urban counterparts.
- Stories from local youth highlight the profound personal impact of gun violence, **emphasizing the need for community support and policy change to create safer environments**.

POTENTIAL SOLUTIONS:

- **Reallocation of city funding:** Instead of heavy spending in one area, directing more toward youth mental health and education.
- **Safe community spaces** where youth can express fears and ideas (e.g., community art like the "community plate" activity).
- **Community involvement and cleanup events** to reclaim and uplift neighborhoods.
- **Critical feedback on ineffective policing** and calls for greater investment in actual youth-centered prevention and safety measures.
- **Expand violence prevention and youth recreation programs:** Offer safe spaces and constructive alternatives to violence.
- **Integrate social and mental health supports:** Provide trauma-informed care in schools, clinics, and community programs.
- **Advocate for stronger gun safety and economic policies:** Address root causes like poverty, firearm access, and structural inequality.
- **Cure Violence Model:** Treats violence like a contagious disease, using credible messengers to interrupt cycles.
- **Trauma Recovery Centers (TRCs):** Holistic support for youth who experience or witness violence.
- **Youth Empowerment Solutions (YES):** Engages youth in civic action and community transformation.
- **City Initiatives:** In November 2024, Philadelphia's Office of Public Safety launched the Group Violence Intervention Juvenile (GVIJ) program, targeting individuals aged 12 to 17 who are at high risk of involvement in gun violence, aiming to foster positive outcomes and well-being.

PRIORITY

6 Access to Physical Activity

KEY FINDINGS:

- **Youth associate health with movement** and requested more opportunities for physical activity.
- **Limited access to safe green spaces, parks, and recreation** infrastructure in many neighborhoods.
- 13% reported parks or activity spaces are rarely or never available.
- Regular physical activity **enhances cardiorespiratory fitness, supports healthy bone and muscle development, aids in weight management, and reduces symptoms of anxiety and depression among youth**.
- The **pandemic led to a decline in physical activity** levels among children and adolescents, emphasizing the need for renewed efforts to promote active lifestyles.
- Challenges such as **financial constraints, safety concerns, and limited access to facilities can hinder youth participation** in physical activities. Addressing these barriers is essential to ensure equitable access for all communities.
- The American Public Health Association advocates for **enhancing physical activity opportunities in out-of-school programs and increasing accessibility to reduce disparities** and promote health equity among youth.

POTENTIAL SOLUTIONS:

- **Community gardens and step challenges** tied to school programs.
- **Block parties and community clean-ups** that include physical activity components.
- **Rec centers and gym access** where youth feel welcome and included.
- **Peer involvement at gyms** and modeling healthy physical routines in neighborhood spaces.
- **Teach behavioral strategies for physical activity:** Encourage small, daily changes to increase movement.
- **Invest in active infrastructure:** Expand sidewalks, bike lanes, and parks for safe and equitable access.
- **Foster social networks that promote movement:** Peer-led activities and group fitness can improve consistency and motivation.
- **Safe Routes to School (SRTS):** Enhances walkability and biking through community design and education.
- **Play Streets:** Temporarily convert streets into pop-up play zones in under-resourced neighborhoods.
- **SPARK PE:** Research-based program improving fitness and academic performance through quality physical education.

PRIORITY

7 Activities for Youth

KEY FINDINGS:

- 11 of 15 meetings highlighted a need for more extracurricular options.
- Though 92% of youth participate in some activity, **accessibility—particularly in underserved areas—is a major barrier**.
- Programs like **summer camps, leadership clubs, and STEM activities** were top priorities.
- **Promotes Mental and Emotional Health:** Regular engagement in structured activities like sports, arts, music, and mentorship helps reduce stress, anxiety, and depression. It gives youth a positive outlet and builds emotional resilience.
- **Prevents Risky Behaviors:** Youth with access to after-school and community programs are significantly less likely to engage in substance use, violence, or other high-risk behaviors. These programs offer supervision, structure, and positive role models.
- **Builds Life Skills and Confidence:** Participation in group activities teaches teamwork, leadership, time management, and responsibility—skills that are vital for success in school and life.
- **Provides Safe Spaces:** Especially in neighborhoods impacted by gun violence or under-resourced schools, community centers and rec programs can be sanctuaries where youth feel physically and emotionally safe.
- **Supports Academic Success and Future Opportunity:** Programs that blend academics, mentoring, and enrichment activities help close opportunity gaps, support college and career readiness, and connect youth with pathways to higher education and employment.

POTENTIAL SOLUTIONS:

- **Volunteer and leadership opportunities** like CIT programs, community cleanups, or school clubs.
- **Skills-based training with incentives** (e.g., small stipends or "training pay") even before official working age.
- **Reviving youth programs** (e.g., Girl Scouts, Boy Scouts) and emphasizing mentorship.
- **Creative expression projects** like community plates or mural work to connect youth to their environment and voice.
- **Offer activities that foster connection and purpose:** Design programs that build belonging and life skills.
- **Partner with community orgs to expand access:** Leverage existing networks to offer free or low-cost options.
- **Support youth leadership and intergenerational initiatives:** Promote mentorship and civic engagement across age groups.
- **Positive Youth Development (PYD):** Strengths-based approach helping youth thrive emotionally, socially, and academically.
- **21st Century Community Learning Centers:** Federally funded programs offering afterschool and summer learning.
- **Youth Mentoring Programs:** Build trusted, supportive relationships through structured mentor models.
- **Out-of-School Time (OST) Programs:** Philadelphia offers OST programs for young people in grades pre-K through 12, supporting working families and promoting children's academic, social, and personal development. Activities include arts, sports, and academic enrichment.

PRIORITY

8 Access to Good Schools

KEY FINDINGS:

- Youth emphasized disparities in school quality across counties.
- Needs include **improved mental health support, updated teaching methods, and equitable funding**.
- Desired school traits include **diversity, inclusion, quality educators**, and **modern facilities**.
- Students in the School District of Philadelphia have **demonstrated varied academic performance**. In the 2021-2022 school year, approximately 34% of third- to eighth-grade students met reading standards, a 2% decrease from 2018-2019. Math proficiency was at 17%, down 5% from the same period.
- Access to high-quality schools directly affects a young person's ability to learn, graduate, pursue higher education or vocational training, and secure stable employment. **Education is one of the most powerful tools for breaking cycles of poverty and inequity.**
- When students fall behind in reading and math—as is happening post-pandemic—they are more likely to struggle academically in later years, drop out of school, or face limited job prospects. **Early gaps often widen over time without intervention.**
- Schools are not just for academics—they **provide mental health support, meals, social-emotional learning, and connection to services**. Quality schools help meet the basic needs of youth and families, especially in under-resourced communities.
- Communities with strong public schools often have **lower crime rates and greater social cohesion**. Good schools attract families, increase civic engagement, and help neighborhoods thrive.

POTENTIAL SOLUTIONS:

- **Support for bilingual learners** and anti-bullying efforts to ensure comfort in school environments.
- **Creating welcoming and identity-affirming clubs** for students of all backgrounds.
- **Better sexual health and emotional learning programs** that students feel engaged in.
- **Training for teachers and school staff** to be culturally competent and approachable.
- **Advocate for fair funding and staffing:** Reduce disparities by directing resources to underserved schools.
- **Provide interdisciplinary mental health teams in schools:** Normalize mental wellness as part of academic success.
- **Support mentoring, counseling, and career readiness programs:** Prepare students holistically for life after graduation.
- **Community Schools Model:** Integrates academics with health, social services, and community engagement.
- **Multi-Tiered System of Supports (MTSS):** Data-informed framework addressing academic and behavioral needs at varying intensities.
- **School-Based Mental Health Services:** Aligns with pediatric guidance to offer accessible care within the school setting.

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 here: Appendix