IMPLEMENTATION **STRATEGY**

2022

HEALTH IS WHERE WE LIVE, LEARN AND WORK

Pottstown Hospital
TOWER HEALTH
Advancing Health. Transforming Lives.

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LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

Rich Newell, MPT, DPT

President and Chief Executive Officer,
Pottstown Hospital

Pottstown Hospital is committed to advancing health and transforming lives throughout Berks, Chester, and Montgomery counties while meeting the changing health needs of our communities through the development of programs and services that provide our region with high-quality care close to home.

To achieve this goal, we must first identify the community's evolving health needs. Pottstown Hospital — in collaboration with all Tower Health facilities and our community partners — completed the 2022 Community Health Needs Assessment (CHNA), which identifies our region's health priorities and determines our collective path forward. The data for this CHNA was collected regionally and reported for our hospital service area. Working with our strategic and community partners, Pottstown Hospital has used the results of this assessment as a foundation to develop tactics to address each of the identified health priorities:

- Access to Equitable Care
- Behavioral Health
- Health Education and Prevention
- Health Equity

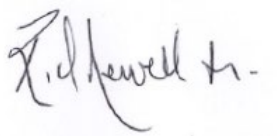
As a leading health care provider, we strive to positively impact the health and well-being of our patients, as well as the broader communities we serve. Many of our programs and services have been developed to address specific regional health needs or overcome barriers to care. These efforts continue to make a difference in the lives of individuals and families. We are grateful for our community partners who work to help make these programs possible.

The most important aspect of the CHNA process is community partnership and engagement. Resident feedback about the health status of the community is integral to planning and executing interventions, programs, and activities. Each of our community partners brings significant and unique expertise. We look forward to an ongoing partnership to ensure that vulnerable individuals receive the care and services they need. We are much stronger together than we would be individually, and the community benefits from our collaboration.

I would like to offer my sincere thanks to the citizens and stakeholder participants throughout all the Pottstown Hospital communities who generously volunteered their time and valuable insights during the comprehensive CHNA process.

I am beyond thankful for your ongoing support and continued involvement in the well-being of our communities. By working together, we can continue to change lives across our region.

Sincerely,



Rich Newell, MPT, DPT

President and Chief Executive Officer,
Pottstown Hospital


ENTER
EMERGENCY
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ADVANCING.
EXPANDING.
EMPOWERING.

ABOUT
THIS REPORT

IMPLEMENTATION STRATEGY (IS)

A Community Health Needs Assessment (CHNA) is an organized process involving the community to identify and analyze community health needs. The process provides a pathway for communities to identify and prioritize health and social needs and to plan and act upon unmet and prioritized community health needs. The CHNA process undertaken by Pottstown Hospital incorporated input from participants who represent the broad interests of the community, including those knowledgeable of public health issues and the vulnerable, underserved, disenfranchised, hard-to-reach, and representatives of those populations served by each hospital. The CHNA documented what and where the need is, along with who is most affected.

Pottstown Hospital's Implementation Strategy includes goals and strategies on how to address and how to solve key findings from the CHNA.

IRS MANDATE

The CHNA report and subsequent Implementation Strategy is a complete review of primary and secondary data analyzing demographic, health, and socioeconomic data at the local, state, and national levels. This report fulfills the requirements of the Internal Revenue Code 501(r)(3), established within the Patient Protection and Affordable Care Act (PPACA), requiring that nonprofit hospitals conduct CHNAs every three years. Pottstown Hospital's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements. Pottstown Hospital is proud to present its 2022 IS report to the community.

POTTSTOWN HOSPITAL

WHO ARE WE?

Pottstown Hospital physicians, nurses, and staff provide a full range of health services, including inpatient and outpatient, medical and surgical, and diagnostic and emergency care in a 219-bed facility. Pottstown Hospital has over 1,150 health care professionals delivering compassionate, safe, quality care, working hard to be a place of healing, caring, and connection for patients and families in the community. Pottstown Hospital is home to many top-tier services, including:

- Cancer Center
- Cardiopulmonary/Respiratory (EKG, Pulmonary Function Lab)
- Center for Orthopedics and Spine
- Emergency Department
- GI/Endoscopy Center
- Imaging
- Inpatient Dialysis
- Intensive Care Unit
- Interventional Radiology
- Inpatient Psychiatric Unit & Geri-Psych
- Laboratory/Pathology
- Neurosciences
- Nuclear Medicine
- Occupational Medicine/Travel Health Services
- Radiology Suite
- Rehabilitation Services
- Surgery
- Women's Health Services
- Wound Care

At Pottstown Hospital, advancing health and wellness is our mission. Pottstown Hospital is accredited by The Joint Commission and has been recognized for its quality outcomes and clinical expertise across many service lines. Its cancer program is nationally recognized. The hospital also is a Primary Stroke Center, Joint Commission certified for hip and knee replacement, and Heart Failure and Chest Pain certified. Its Emergency Room, which is the second busiest in Montgomery County, sees more than 40,000 patients a year.

MISSION

The mission of Pottstown Hospital is to provide compassionate, accessible, high-quality, cost-effective health care to the community; to promote health; to educate health care professionals; and to participate in appropriate clinical research.

VISION

Pottstown Hospital will be an innovative, leading regional health system dedicated to advancing the health and transforming the lives of the people we serve through excellent clinical quality; accessible, patient-centered, caring service; and unmatched physician and employee commitment.

REPORT SERVICE AREA

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute-care services. For this reason, the utilization of hospital services provides the clearest definition of the community. Pottstown Hospital's primary service area includes 11 ZIP codes within Berks, Chester, and Montgomery counties.[1]

Pottstown Hospital's Primary Service Area	
ZIP Codes	**Town/Neighborhood**
19464	Pottstown
19465	Pottstown
19468	Royersford
19512	Boyertown
19518	Douglassville
19519	Earlville
19525	Gilbertsville
19545	New Berlinville (NS)
19548	Pine Forge (NS)
19457	Parker Ford (NS)
19472	Sassamansville (NS)

[1] Note: NS ZIP codes are non-spatial ZIP codes with no population. They are often P.O. boxes.

OUR **FOCUS**

Pottstown Hospital's 2022 Implementation Strategy (IS) is a key component of the community health needs assessment process as it delineates the strategies and goals designed to meet prioritized needs and sets the stage for action and execution of initiatives that effectively impact health outcomes and sustain improvements in health status across our communities.

Much of today's delivery of health care should acknowledge the social and economic factors that influence health. These factors, called social determinants of health (SDOH), include our race, income, education level, and livable home and community environments. Understanding the strong impact of SDOH requires us to step aside from our traditional health care approaches and to pursue innovative best practices to improve health. Therefore, the 2022 Implementation Strategy was built on accomplishments and lessons learned, as well as the challenges and complexities, of 2019 CHNA and IS efforts.

A DEEPER PERSPECTIVE:
CHNA PRIORITIES

The 2022 IS has a deeper focus on the whole person, is patient- and community-centered, and supports the optimal use of a plethora of health care and human service resources to improve health. Community participants emphasized the need to improve access to equitable care and behavioral health and to expand health education and prevention. Inequities such as demographical differences highlight the importance of weaving an equity focus within all areas of health.

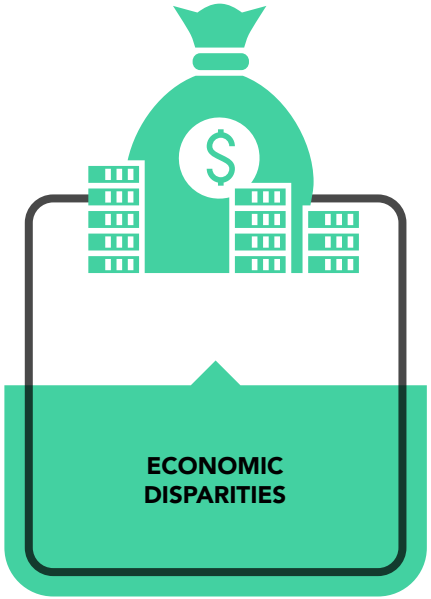
The effectiveness of the 2022 IS is strengthened as we translate our understanding and knowledge of what the community told us into dynamic policies and best practices. Community input guides our efforts to diligently understand past successes and pitfalls in continuously improving the health of our communities through the following areas of focus:

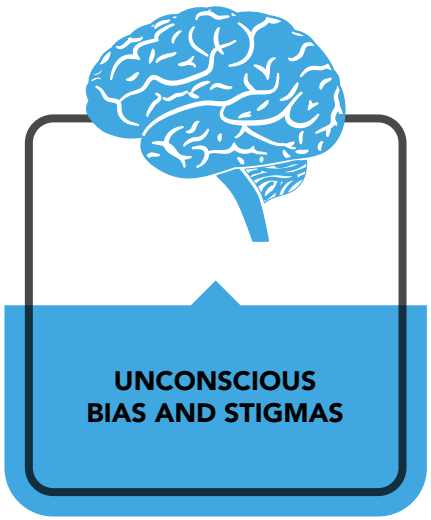
A) ACCESS TO EQUITABLE CARE

Pottstown Hospital deploys continuous improvement efforts to better understand the contributing factors that impede access to equitable care and how best to address identified barriers and gaps in the provision of health care and services. Improving an organization's capacity to provide access to equitable care for vulnerable and ethnic populations is a continuous and evolving process.

The pandemic further highlighted widening gaps in accessing care, such as the lack of knowledge regarding available health services and programs, the high costs of health care and insurance, the lack of trust, and the limited capacity to provide quality and appropriate care because of a lack of cultural competence among providers and limited language services.

COMMENTS FROM PRIMARY DATA COLLECTION:





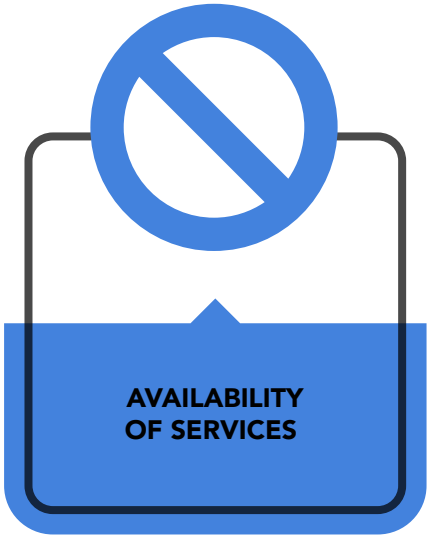
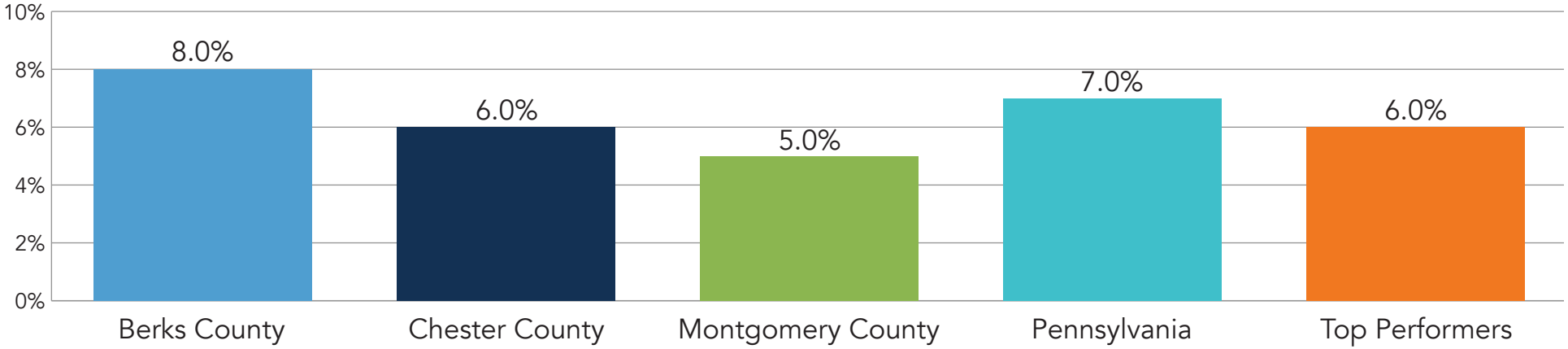


Figure 1 shows the percentages of residents in Berks, Chester, and Montgomery counties who have no health insurance coverage. Over the last few CHNA cycles, we have seen the percentage of insured people steadily rise; however, efforts to improve access to care must continue. Comparing a county's value to top U.S. performers (10% of the nation's counties are doing better than the value displayed for this measure) can provide information about how well the county is doing in a national context.

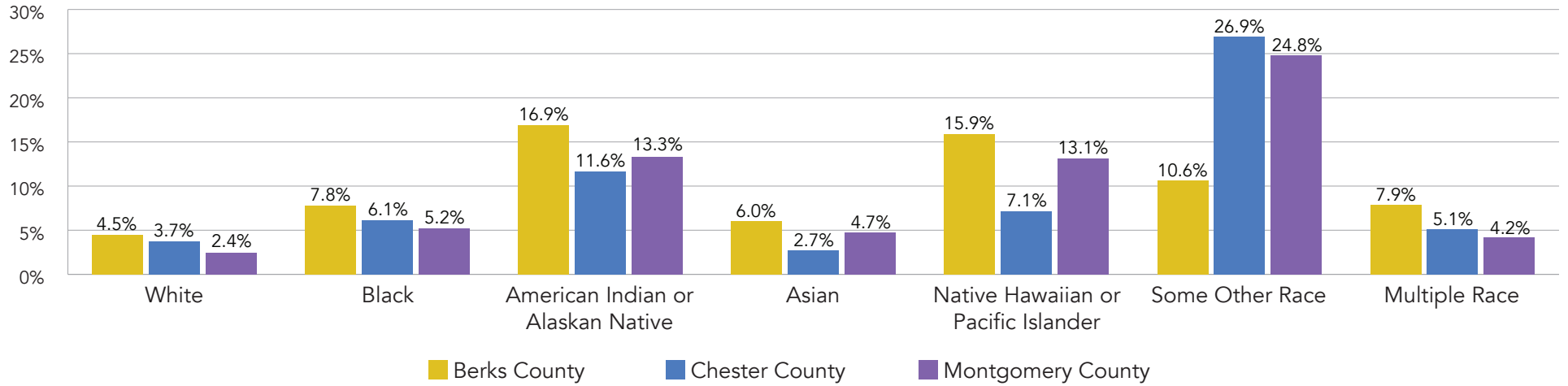
Figure 1: Percentage of Population with No Health Insurance Coverage



Source: County Health Rankings & Roadmaps 2019

One of the key barriers in accessing care is the availability and adequacy of insurance coverage. In Pennsylvania, 5.8% of residents are uninsured. Figure 2 depicts uninsured rates by race in Berks, Chester, and Montgomery counties. The Healthy People 2030 target is to increase the portion of the population covered by health insurance to 92.1% overall. As of 2018, 89.0% of the population under 65 years has medical insurance.

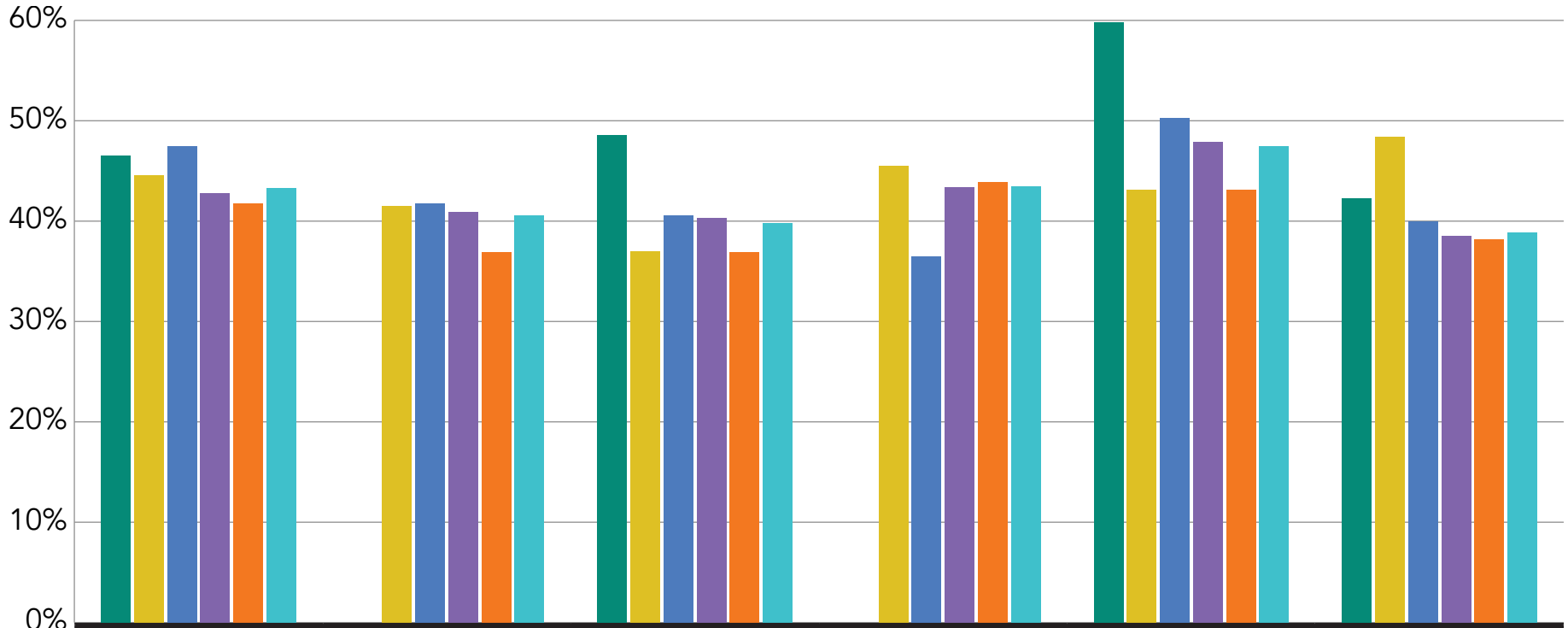
Figure 2: Percentage of Uninsured Population by Race



Source: U.S. Census Bureau, American Community Survey 2019

The PA Health Equity Analysis Tool (HEAT) provides a geographic perspective at the granular level to areas that have opportunities to improve equity.[2] The below figure depicts ZIP codes within Pottstown Hospital's service area related to adults who obtain primary-care visits by ZIP code.

Figure 3: Percentage of Adults with Primary Care Physician Visits



	19464	19465	19468	19512	19518	19525
Asian	46.5	--	48.6	--	59.8	42.3
Black	44.6	41.5	**37.0**	45.5	**43.1**	48.4
Hispanic	47.5	41.8	40.6	**36.5**	50.3	40.0
White	**42.8**	40.9	40.3	**43.4**	47.9	**38.5**
Other Race	**41.8**	**36.9**	**36.9**	43.9	**43.1**	**38.2**
All Adults	**43.3**	**40.6**	**39.8**	**43.5**	**47.5**	**38.9**

Data was not available for ZIP codes 19519, 19545, 19548, 19547, and 19472.

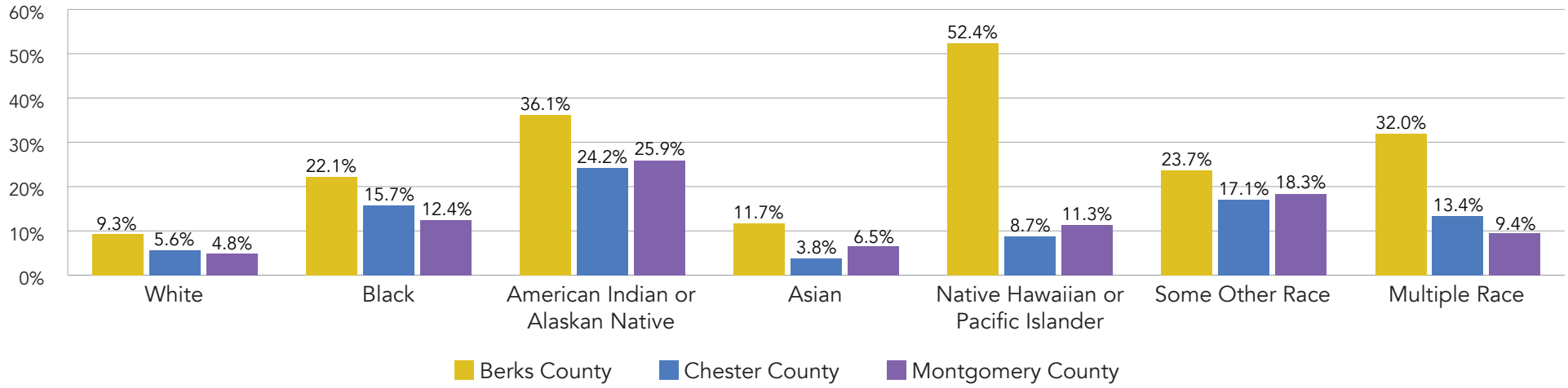
Note: The red figures in bold indicate low percentages of adults with primary-care physician visits when compared to the benchmarked data of all adults within the specific ZIP code.

Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[2] The Department of Human Services (DHS) in collaboration with the Department of Health (DOH) has launched the PA Health Equity Analysis Tool (HEAT). The PA HEAT dashboard is designed to illustrate variation in a variety of health and social determinants of health indicators at the regional, county, ZIP code, and census tract levels.

Figure 4 reports the percentage of the population that is below 100% of the federal poverty line (FPL) by race.[3] The Healthy People 2030 target is to reduce the proportion of people living in poverty to 8.0%. Nationally, in 2018, 11.8% of people lived below the poverty threshold.

Figure 4: Population Below 100% FPL by Race

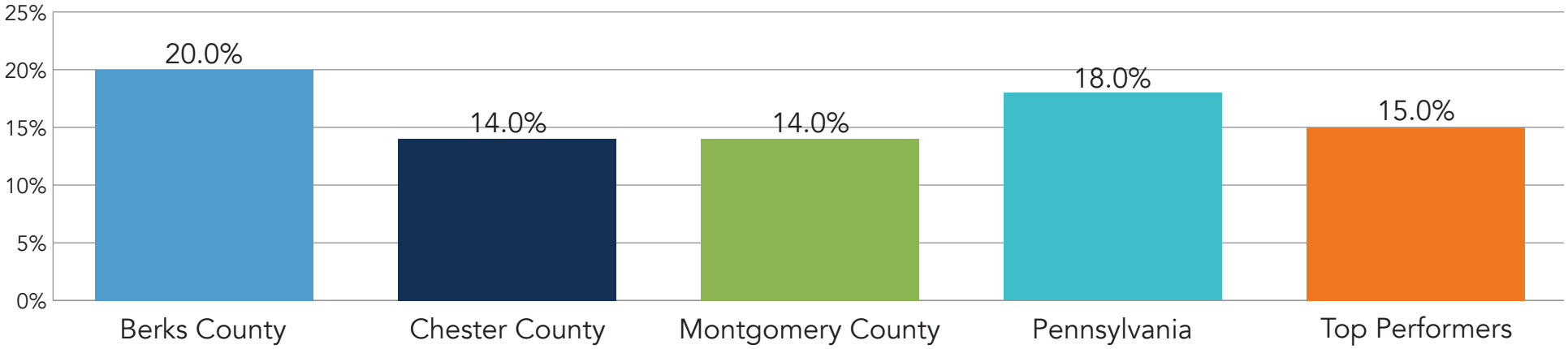


Source: U.S. Census Bureau, American Community Survey 2019

[3] Federal poverty levels (FPL) are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid, and CHIP coverage. For a family or household of four living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2019 was $25,750 and in 2022 it is $27,750.

Figure 5 reveals the percentage of residents in Berks, Chester, and Montgomery counties who reported their health as fair or poor.

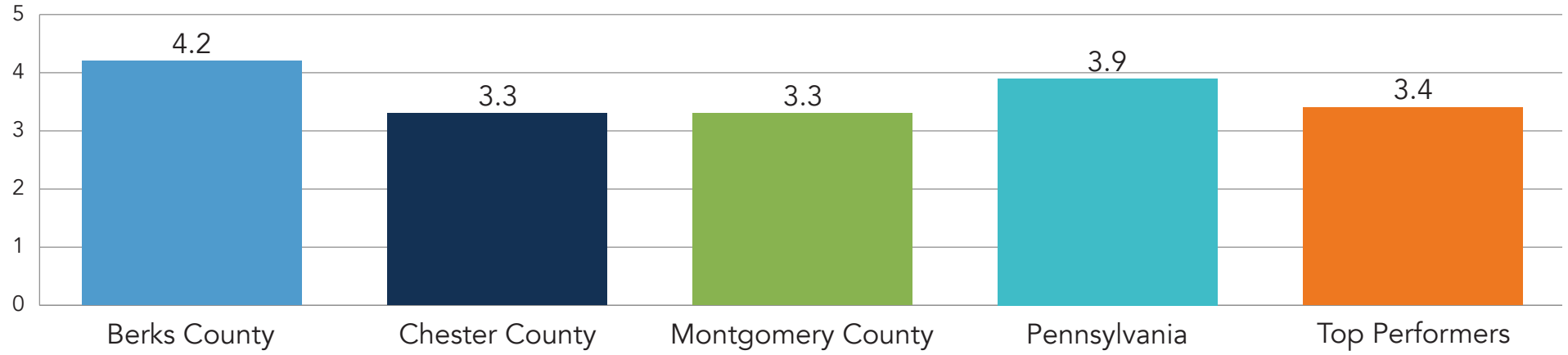
Figure 5: Poor or Fair Health – Age-adjusted



Source: County Health Rankings & Roadmaps 2019

Figure 6 reveals the average number of physically unhealthy days in the past 30 days for residents in Berks, Chester, and Montgomery counties. It is essential to include health-related quality of life measures or how well people live as it helps portrays the characterization of people living with chronic conditions or disabilities.

Figure 6: Poor Physical Health Days (Age-Adjusted)



Source: County Health Rankings & Roadmaps 2019

GOAL:

Increase access to equitable care by community members, particularly those considered vulnerable and/or living in underserved areas.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Identify and address SDOH needs	Screen vulnerable patients for SDOH	X	X	X	Screen 500 patients per year Identify 200 high-risk patients Provide navigation services to 100 patients Decrease unnecessary ED visits for navigation patients by 5% from 2022-2024	Emergency Department Diverse community organizations providing services that address SDOH
	Provide navigation services to high-risk patients	X	X	X		
Improve access to transportation	Utilize Ride Health platform to coordinate free transportation to and from appointments for eligible patients	X	X	X	200 patient rides in 2022 with a 5% increase in 2023 and 2024	Emergency Department Case Management Tri-County Community Network
	Partner with TCN to identify transportation gaps and convene stakeholders for community discussion	X	X		Conduct a transportation study to identify current gaps in service in 2022 Develop and present a strategic plan to address transportation gaps in 2023	
Street Medicine	Implement Street Medicine	X	X	X	200 patient encounters per year Expand services to other ZIP codes in 2023 40 new patients per year 40% of patients referred to primary care complete an in-office visit	Community Health and Dental Care Access Services Creative Health Services
Improve dental care accessibility	Partner with CHDC and the Mobile Dental Unit to coordinate free dental screenings		X	X	Partner with CHDC at least one time per year to offer the mobile dental unit to vulnerable populations	Community Health and Dental Care

GOAL:

Increase access to equitable care by community members, particularly those considered vulnerable and/or living in underserved areas.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Improve access to screening mammograms	Partner with Reading Hospital and the Mobile Mammography Coach to offer onsite mammograms		X	X	Host three mobile mammography events in Pottstown service area each year Provide at least 30 mobile mammograms each year	Reading Hospital Mobile Mammography Coach
Identify opportunities for a community health worker program	Establish a program plan/model and identify funding options and feasibility		X		Completed program plan/model by 2023 Start hiring and training staff in 2024	
	Start program implementation			X	Launch program by end of 2024	
Establish pathway for continued community feedback and perspective	Design a Community Advisory Board and recruit participants	X			Establish a diverse Community Advisory Board composed of a minimum of six community members Hold at least six meetings per year	
	Implement Community Advisory Board		X	X		
Increase care coordination with other health care entities in the service area	Participate in Tri-County Health Council	X	X	X	Attend monthly meetings and monthly sub-work-group meetings Collaborate on three initiatives per year	Community Health and Dental Care Creative Health Services Pottstown Area Health and Wellness Foundation Tri-County Community Network

B) BEHAVIORAL HEALTH

During the COVID-19 pandemic, the need for access to behavioral health services became even more evident. "Social distancing policies, mandatory lockdowns, isolation periods, and anxiety of getting sick, along with the suspension of productive activity, loss of income, and fear of the future, jointly influence the mental health of citizens and workers". (National Institutes of Health). The impact of COVID-19 on the workplace further resulted in mental health issues such as anxiety, depression, post-traumatic stress disorder (PTSD), and sleep disorders. Mental health issues and drug and alcohol use have increased significantly. This impact was noted among health care workers, especially those on the front line, migrant workers, and workers in contact with the public.

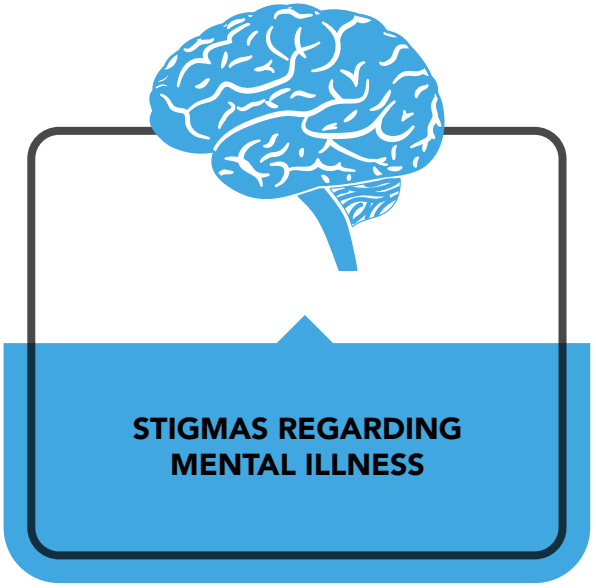
Pottstown's CHNA focus groups, stakeholders, key informants, and survey respondents reported "improving access and availability of behavioral health and mental health services and programs" as having a great impact on the overall health of their surrounding communities and a high priority for improving health status.

COMMENTS FROM PRIMARY DATA COLLECTION:

LACK OF ACCESS TO BEHAVIORAL HEALTH OR MENTAL HEALTH SERVICES

LACK OF ACCESS TO SUBSTANCE ABUSE (DRUG/ALCOHOL) SERVICES

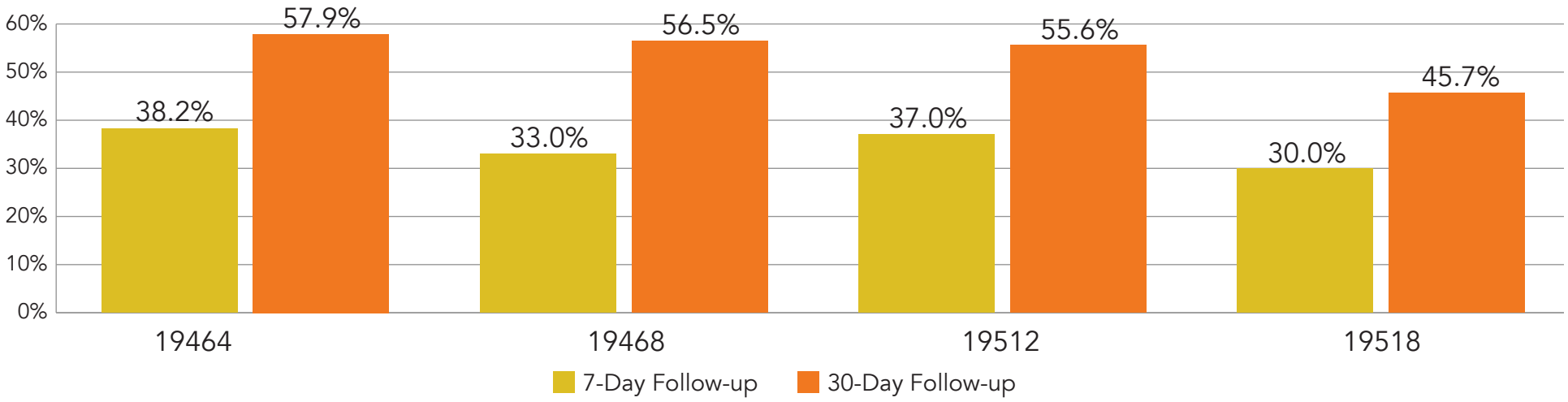
POOR INTEGRATION AND COORDINATION OF HEALTH SERVICES



STIGMAS REGARDING MENTAL ILLNESS

Figure 7 illustrates percentages of adults by ZIP codes of mental health admissions with either a seven-day or 30-day follow-up. Follow-up care after hospitalization for mental illness or intentional self-harm helps improve health outcomes and prevent readmissions. Recommended post-discharge treatment includes a visit with a mental health provider within 30 days after discharge. Ideally, patients should see a mental health provider within seven days after discharge.[4]

Figure 7: Percent of Readmissions by ZIP code

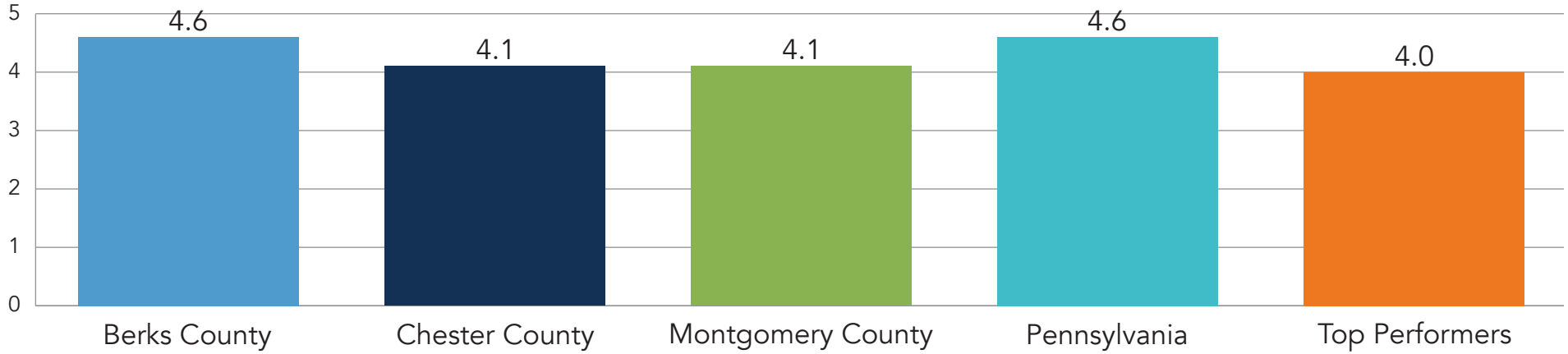


Data was not available for ZIP codes 19465, 19519, 19525, 19545, 19548, 19457, and 19472.
Source: Pennsylvania Health Equity; Pennsylvania Department of Human Services

[4] Medicaid.gov.

Figure 8 illustrates the percentage of adults in the past 30 days who reported poor mental health days grouped for Berks, Chester, Montgomery counties; Pennsylvania; and top performers. Comparing a county's value to top U.S. performers (10% of the nation's counties are doing better than this value for this measure) can provide information about how well the county is doing in a national context.

Figure 8: Poor Mental Health Days (Age-Adjusted)

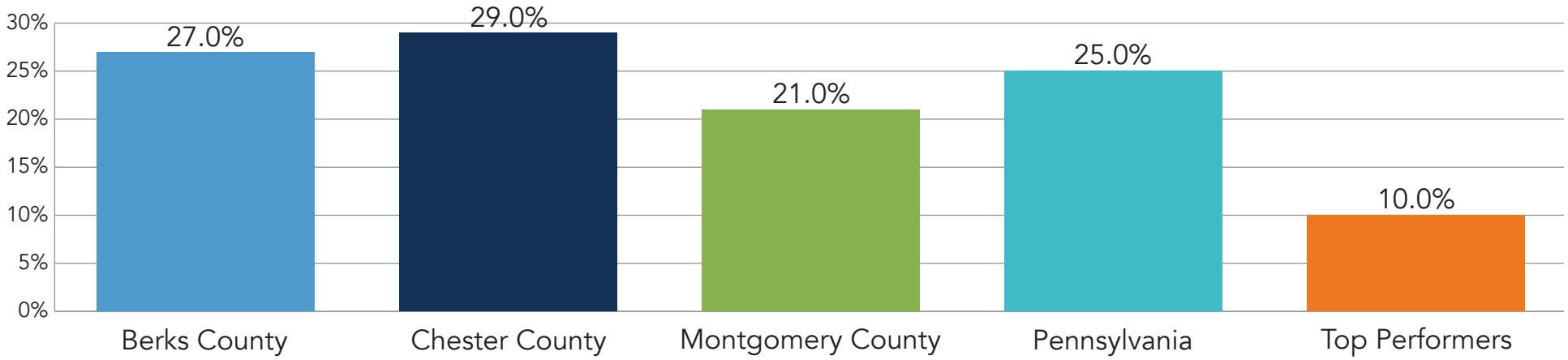


Source: County Health Rankings & Roadmaps 2019

Alcohol and tobacco use are root causes of and can further exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk. When analyzing driving deaths that involve alcohol impairment, rates in Chester County are worse when compared to the remaining counties and the state.

Figure 9 illustrates the percentage of alcohol-impaired driving deaths in Berks County, Pennsylvania, and top performers.

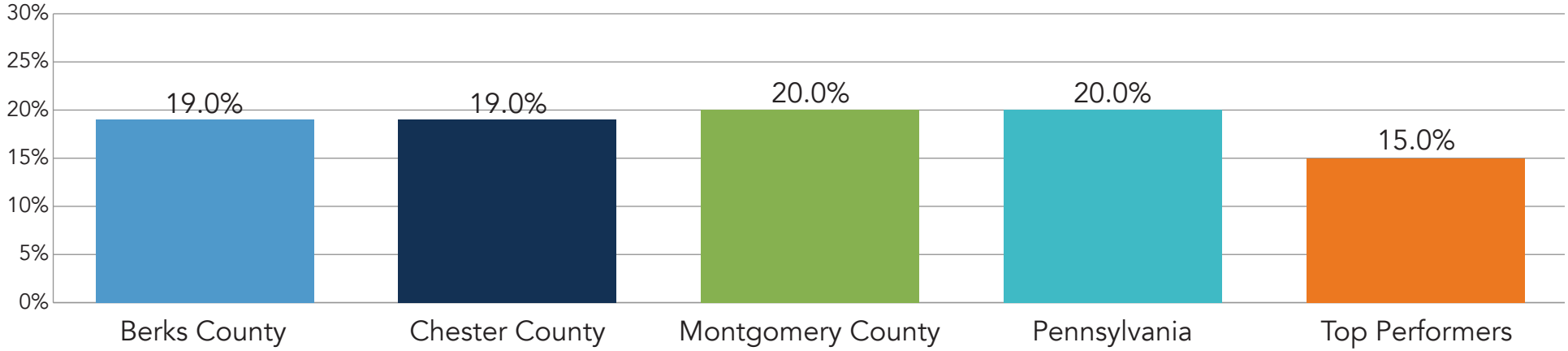
Figure 9: Driving Deaths and Alcohol-Impairment



Source: County Health Rankings & Roadmaps 2016-2020

Figure 10 illustrates the percentage of adults in the past 30 days who reported binge drinking or heavy drinking grouped for Berks, Chester, and Montgomery counties; Pennsylvania; and top performers.

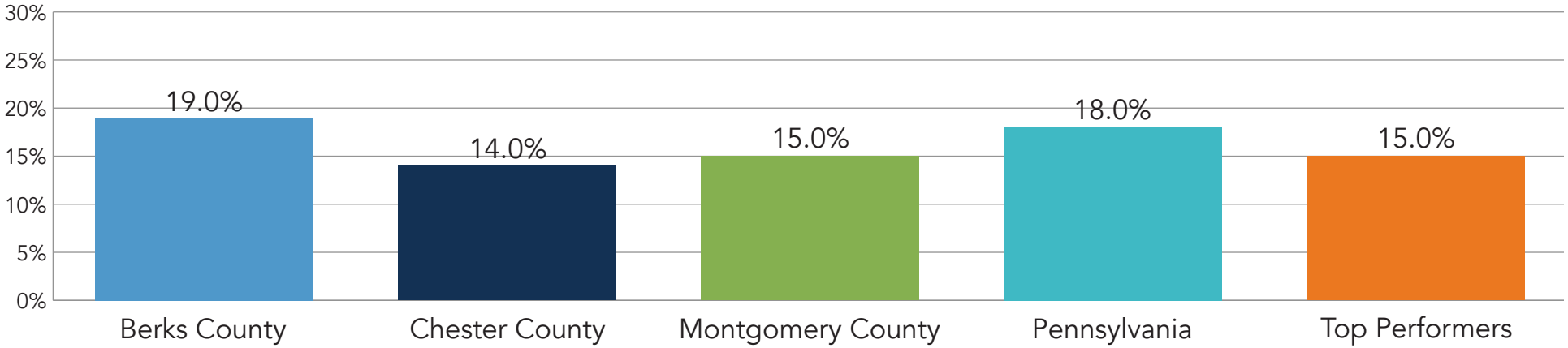
Figure 10: Adult Excessive Drinking[5]



Source: County Health Rankings & Roadmaps 2019

Figure 11 shows adults 18 and older who smoke. A larger percentage of Berks County residents smoke when compared to Chester and Montgomery counties and Pennsylvania. Adult smoking is the percentage of the population in a county who report that they smoke every day or some days and have smoked at least 100 cigarettes in their lifetime. The prevalence of tobacco can alert communities to adverse health outcomes and can be valuable for implementing needed cessation programs or evaluating effectiveness of tobacco control programs.

Figure 11: Adult Smoking — Current Smokers



Source: County Health Rankings & Roadmaps 2019

[5] Heavy drinking is defined as having more than two drinks per day for men and more than one per day for women during the past 30 days. A binge drinker is an adult age 18 and older who reports having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

GOAL:

Improve access to screening, assessment, treatment, and support for behavioral health.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Develop a Street Psych Program	Identify funding and resources available	X			Completed program plan by end of 2022	Access Services Community Health and Dental Care Creative Health Services
	Implement program		X	X	Treat 40 patients per year Connect 30% of patients to routine outpatient therapy	
Community Outreach & Education	Participate in community-based health education and awareness events	X	X	X	Three events attended/hosted 75 participants 75% of attendees learned something new 40% reporting interest in behavior change	
Engage in workforce development opportunities for behavioral health careers	Provide education to high schools and colleges on behavioral health career paths		X	X	Present to at least two schools per year Provide education to 50 students per year Increase interest in behavioral health careers by one	Local high schools, colleges, and universities
	Explore opportunities to host students in behavioral health careers for internships and learning opportunities		X	X	Identify partnerships and programs in need of a host organization by end of 2023 Host a minimum of two students in 2024	
Offer Suicide Prevention Training	Host Suicide Prevention Training in community	X	X	X	Host one training per year Train at least 12 people per year	Montgomery County Suicide Prevention Task Force

GOAL:

Improve access to screening, assessment, treatment, and support for behavioral health.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Explore mental health screening kiosk	Identify funding and resources available	X	X		Funding identified and secured	
	Implement kiosk			X	Screen 300 individuals per year	
Tower Employee Wellness Initiatives	Explore expansion of Schwartz Rounds, multidisciplinary forum for caregivers to discuss social and emotional issues that arise in caring for patients		X	X	Host 9 Schwartz rounds per year	The Schwartz Center for Compassionate Healthcare
	Promote RethinkCare app to support employees' personal, professional, and parental needs	X	X	X	15% of staff actively using app	
	Implement Marvin Telemedicine Program to provide digital behavioral health services for hospital staff		X	X	95% use of service satisfaction rate reported	
	Launch Well-Being Index to assess provider burnout and develop resources to mitigate stressors	X	X	X	100% participation by residents and fellows 40% participation by physicians	Mayo Clinic

C) HEALTH EDUCATION AND PREVENTION

Health education programs help people better understand how to manage an existing health condition and how to prevent further illness, which is paramount to good health. Pottstown Hospital's community education and disease prevention programs are designed to engage and empower individuals and communities to practice healthy behaviors that reduce the risk of developing chronic diseases and to improve management for chronic diseases such as heart disease, diabetes, and high blood pressure. According to the World Health Organization, "health education enables people to increase control over their own health."

The Pottstown CHNA process revealed the need for understanding cultural and language barriers to improving health and the need to promote healthy lifestyles and practices. Health education and health literacy play a vital role in accessing care as knowledge and understanding empowers individuals to make informed health decisions and help them effectively navigate today's complex health care delivery system. Through health education, patients and families can successfully implement treatment plans, manage chronic conditions, and prevent complications and/or hospitalizations. By improving health literacy and education to the broad community, the health organization's paradigm shifts from treating disease to a focus on wellness, healthy behaviors, and positive health outcomes.

COMMENTS FROM PRIMARY DATA COLLECTION:

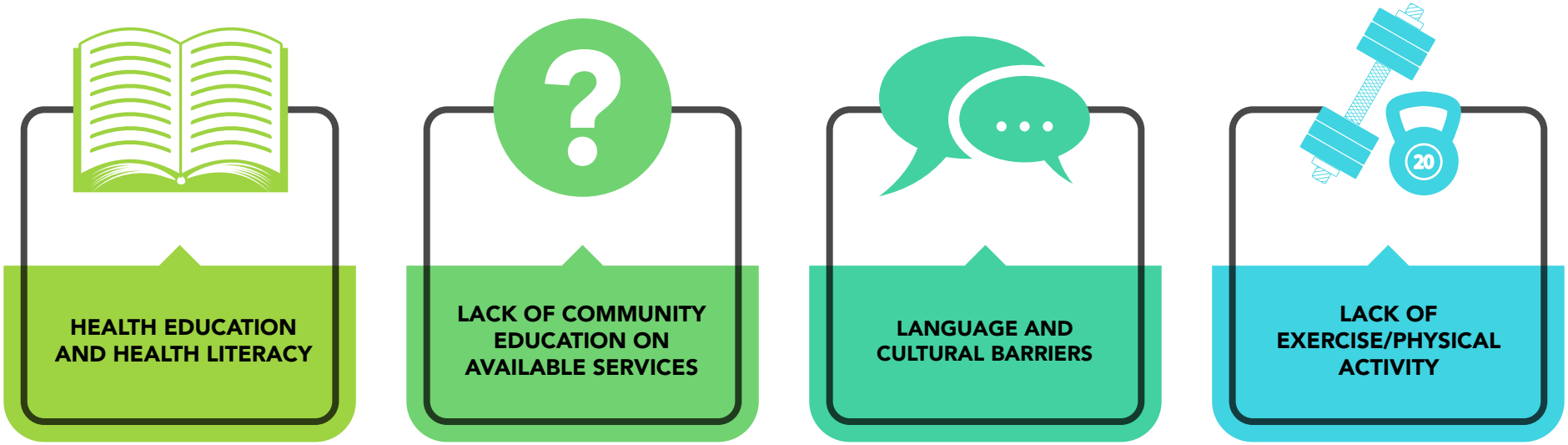
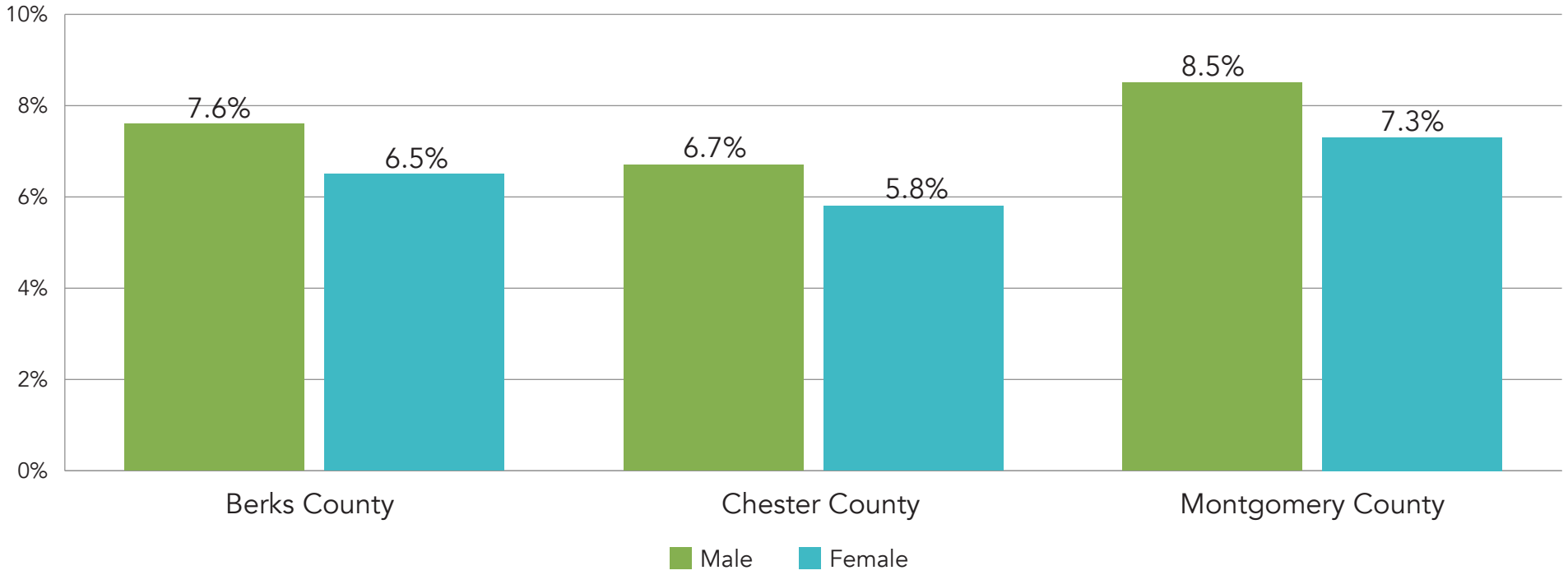


Figure 12 shows the percentage of adults aged 20 and older, by gender, who have been told by a doctor that they have diabetes.

Figure 12: Diabetes by Gender



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2019.

Table 13 reveals the number of patients who completed a health screening/preventative health measure at Pottstown Hospital.

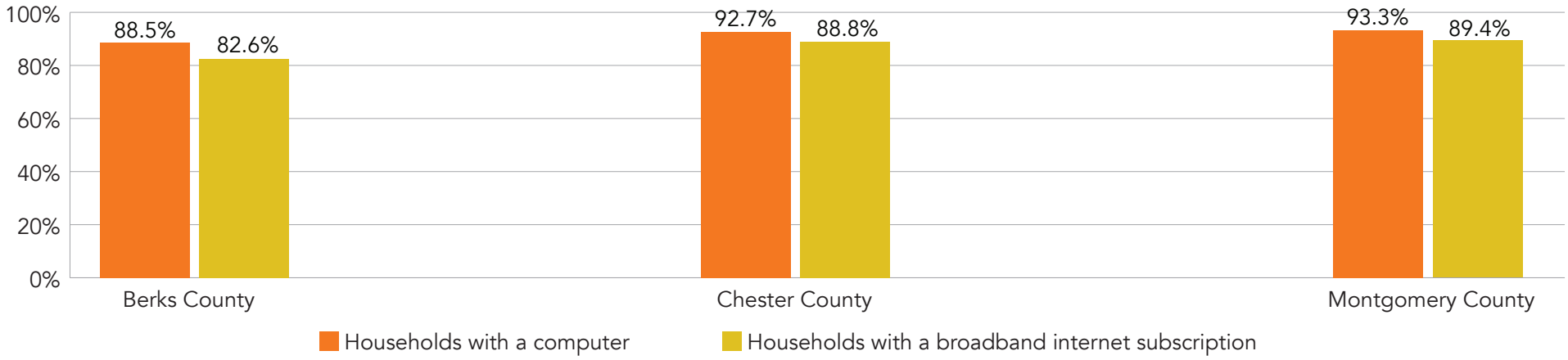
Table 13: Patients who completed Health Screenings/Preventative Health Measure

Year	Mammography	Colonoscopy	Flu Shot	PCP Visit
2018	3,835	1,430	4,109	1,507
2019	7,379	3,068	8,509	12,038
2020	9,199	4,065	10,667	17,982

Source: Epic Clarity

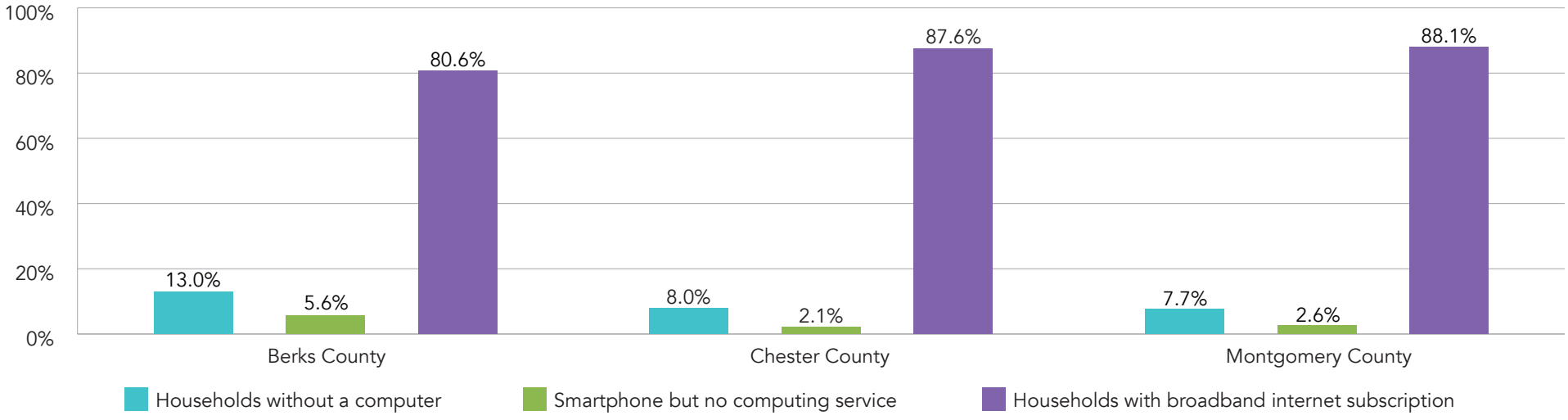
Figure 14 illustrates the percentage of residents in Berks, Chester, and Montgomery counties with a computing device or internet service. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet as a means of reaching targeted audiences. This avenue allows underserved or disenfranchised populations web access to obtain health education.

Figure 14: Percentage of Households with Computer or Internet

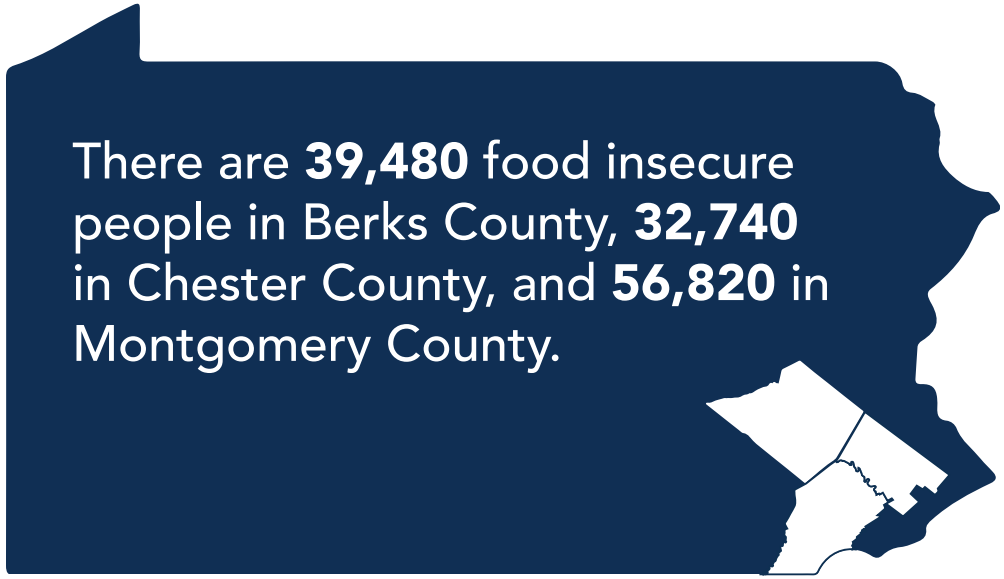


Source: U.S. Census Bureau 2019

Figure 15: Percentage of Households with Limited Technology



Source: The Agency for Healthcare Research and Quality (AHRQ) 2018



Source: Feeding America 2019

The USDA refers to food insecurity as the lack of access (periodically) to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food insecurity may reflect a household's need to make tradeoffs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. Lack of access to healthy foods impacts chronic diseases such as obesity/overweight, diabetes, and high blood pressure.

In early 2020, COVID-19 spread across the United States, creating an economic recession. The pandemic has negatively impacted millions of people who, for the first time, are experiencing food insecurity along with those who experienced food insecurity before the COVID-19 crisis.

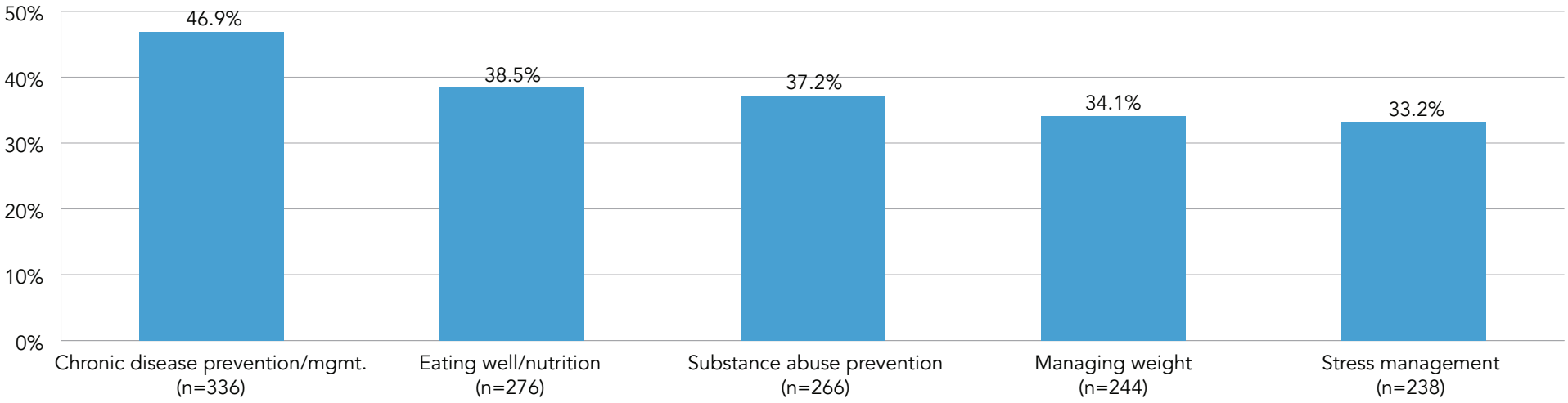
The Supplemental Nutrition Assistance Program (SNAP)[6] reported the following in Berks, Chester, and Montgomery counties:

- 60,344 Berks County residents received $7,310,467 in SNAP benefits; 27,171 Chester County residents received $3,304,238 in SNAP benefits; and 52,779 Montgomery County residents received $6,667,160 in SNAP benefits to help make ends meet in July 2021.
- Low-income SNAP participants spend $1,400, or nearly 25%, less in annual medical costs than low-income adults who don't participate in SNAP.
- SNAP boosts wages for workers who do not earn enough to afford a basic diet and helps those who are between jobs while they search for work.

Source: U.S. Department of Agriculture; Food & Nutrition Service

CHNA stakeholders, key informants, and community survey respondents emphasized the impact of healthy foods, good nutrition, and physical activity on a quality lifestyle and spoke about education, health literacy, and prevention to improve community health and wellness. The following chart from the community health survey depicts survey respondents' viewpoints as related to the value of health education and health literacy:

Figure 16: Top Health Behaviors People in Your Community Need More Information About



[6] SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move toward self-sufficiency.

GOAL:

Implement chronic disease education and prevention programs in the primary service area, specifically targeting vulnerable populations.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Increase access to healthy foods	Youth Grow CSA	X	X	X	Provide 50 families with organic produce each summer Provide at least 2,000 pounds of organic produce 60% of participants report an increase in knowledge of healthy cooking/eating	
	Community Garden	X	X	X	Expand the community garden in 2022 Conduct two health education events at the garden per year Increase knowledge of healthy eating/cooking by 60%	
	Community Fridge	X	X	X	Engage at least one new Community Fridge partner per year Serve at least 5,000 unique individuals per year	
Provide disease specific education	Medicine on the Move	X	X	X	Conduct four Medicine on the Move events per year 60% of participants report an increase in knowledge 40% of participants report willingness to make a behavior change	
	Participate in/host health education events	X	X	X	Attend/host at least five events per year Provide education to at least 300 individuals per year	
Engage with local school districts to further wellness education and programs	Continue to foster relationships with local school districts and attend their wellness committee meetings	X	X	X	Provide three school-based programs per year Engage with 200 students Engage with 50 staff members 60% report increase in knowledge following education	
	Provide school wellness education for staff and students	X	X	X		
Increase access to cancer screenings	Provide education and promote cancer screenings through social media	X	X	X	Promote at least three types of cancer screenings on social media Reach at least 5,000 households	Cancer Center at Pottstown Hospital
	Provide free skin cancer screenings	X	X	X	Hold one screening event per year % referred to care % early detection	

GOAL:

Implement chronic disease education and prevention programs in the primary service area, specifically targeting vulnerable populations.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Tower Employee Wellness Initiatives	Conduct Know Your Numbers Campaign (BMI, BP, lipids, A1C) through Virgin Health app		X	X	30% of staff participating in campaign	
	Engage employees with PCP		X	X	65% of staff attest to establishing care with PCP	
	Encourage engagement with Virgin Health platform for wellness-based education and activities	X	X	X	50% of staff enrolled in platform by 2024	

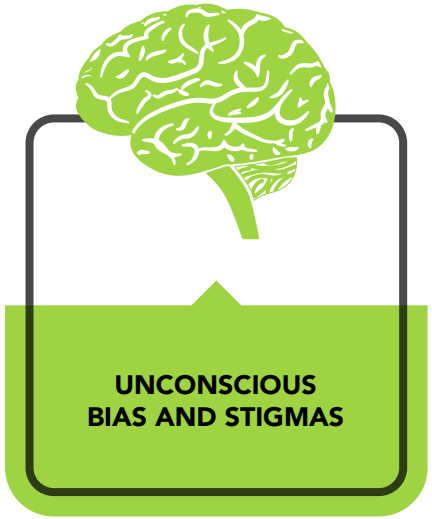
D) HEALTH EQUITY

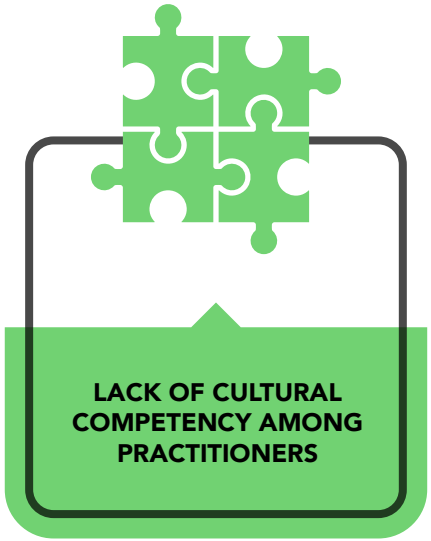
Understanding and addressing the needs of diverse and disparate populations is a significant challenge for health care organizations. As a critical aspect of improving health equity and decreasing health disparities, there is a continued effort to enhance the provision of culturally competent and linguistically appropriate care to a very diverse service area as defined by racial and ethnic communities with various cultural beliefs and perceptions, health practices, and behaviors, as well as a distrust of the health delivery system.

The assessment of the diverse and disparate population uncovered many SDOH and barriers to health care access and services. Barriers such as a lack of transportation, inadequacy of language and interpretation services, lack of insurance coverage, and cultural bias and discrimination have a very dramatic impact on the capacity to provide quality health care and the quality of life for Pottstown Hospital's communities. Interventions that improve health equity and reduce disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently.

The 2022 CHNA IS places a strong focus on health equity as essential to improving health status. Health providers must be equipped with the consciousness, tools, and resources to confront embedded health inequities and to advance equity within and across all aspects of the health care system. Because many health inequities are rooted in historical and contemporary injustices and discrimination, achieving health equity is difficult and daunting work that must be strengthened, amplified, and sustained.

COMMENTS FROM PRIMARY DATA COLLECTION:





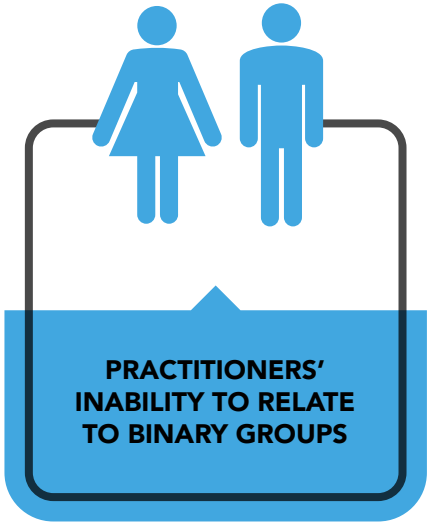
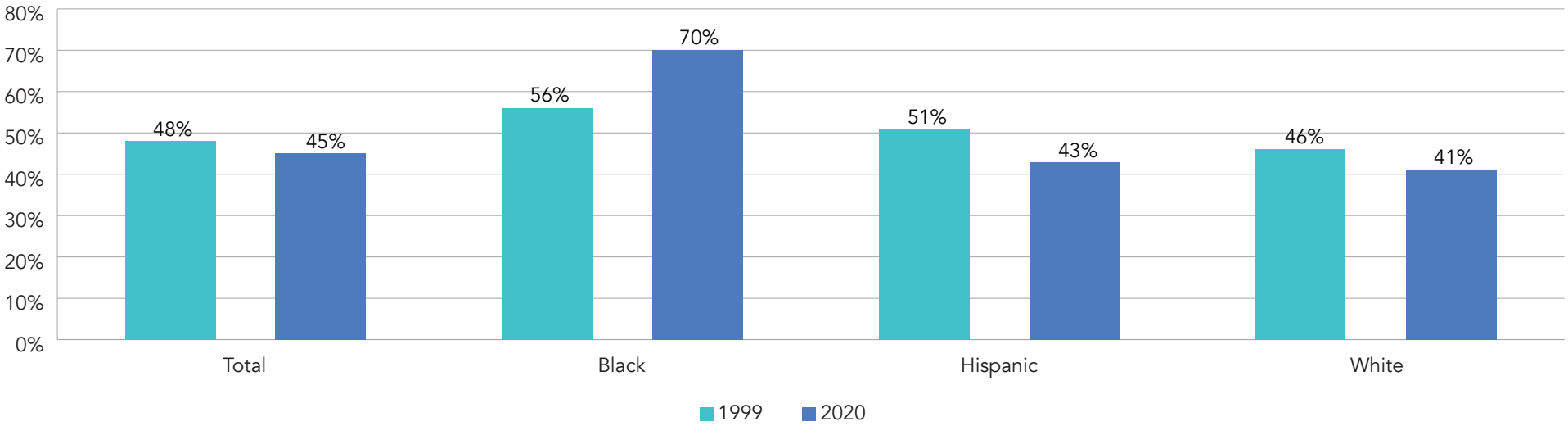


Figure 17 reveals the rates at which people perceive that health care systems mistreat people based on race and ethnicity in the years 1999 and 2020. This data highlights disparities in demographics that should be considered when providing health care services.

Figure 17: Percentage That Thinks the Health Care System Mistreats People Based on Race/Ethnic Background Very Often or Somewhat Often



Source: KFF/The Undefeated Survey on Race and Health 2020

COVID-19 AND HEALTH EQUITY

The response to COVID-19 highlighted issues of health inequity and revealed that those hardest hit by the virus faced economic and housing challenges, lacked health insurance coverage, and had severe food insecurity issues. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC). Nationally, Hispanics are nearly two times more likely to contract the disease than whites. Blacks have been hospitalized at three times the rate of whites, and American Indian/Alaska Natives have lost loved ones at more than double the rate of whites.

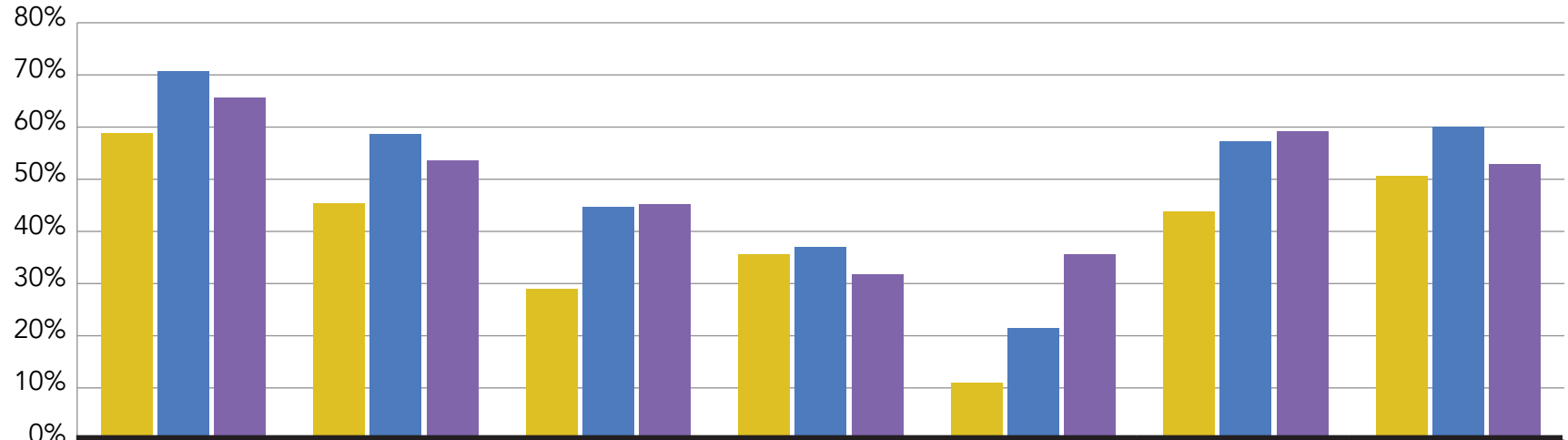
Race and ethnicity are markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation. The CDC reported that essential employees (those in health care, food services, and transportation) were much more likely to die than other workers.

COVID-19 has further exacerbated existing inequalities, with many people suffering from chronic illnesses and other conditions that increase their risk of severe illness. Underserved communities continue to feel the brunt, and the lack of investment in addressing barriers to healthy and productive lives in marginalized communities leads to many other health and social consequences. Independent drivers of disease inequalities and a multi-sectorial approach are needed to reduce the impact of COVID-19 and other health issues among marginalized, disenfranchised, vulnerable, and underserved communities.

More collaboration and community support are necessary to combat issues of health equity. Improvements in health services and patient care experience in rural communities will address existing inadequacies, unique cultural needs, and pitfalls experienced and highlighted through the COVID-19 pandemic.[7] Encouragement and the use of telehealth services provided within service areas should continue to familiarize health care providers and the community on how effective these platforms can fuse the gap between patients and providers.[8]

The impact of looking at the data by age determined multiple, age-specific disparities for Hispanics and non-Hispanic Blacks compared to non-Hispanic whites. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

Figure 18: Full Vaccination Coverage for Races/Ethnicity



	All Races/Ethnicity	White	African American	Asian/Pacific Islander	Native American	Hispanic	Not Hispanic
Berks County	58.8%	45.4%	29.0%	35.6%	11.0%	43.7%	50.6%
Chester County	70.6%	58.7%	44.6%	36.8%	21.5%	57.2%	60.1%
Montgomery County	65.6%	53.6%	45.2%	31.7%	35.5%	59.2%	52.8%

Source: The PA Department of Health

[7] American Medical Association, 2022 AMA Annual Meeting, Public Health. June 2022
[8] Becker's Hospital Review, Strategic Outlook for Hospitals Post-Covid. March 2021

GOAL:

Increase health equity by addressing Social Determinants of Health and providing culturally competent care.

Strategy	Action Items	2022	2023	2024	Metrics	Partners
Health Equity Council	Establish and convene council	X	X		Council convened	
	Create Health Equity Assessment and review Transformation Action Plan	X			Assessment completed TAP Reviewed	
	Create Health Equity Action Plan and Evaluation Plan to identify and address disparities through actionable strategies		X		Health Equity Action Plan adopted Evaluation Plan created Baseline data report compiled 4 priority strategies identified	
	Create Health Equity Dashboard report to communicate plan and progress		X	X	Progress shared annually	
Diversity, Equity and Inclusion training and learning opportunities for staff	Implement the Diversity and Inclusion Council	X	X	X	Hold monthly meetings Increase participation by 25% in 2024	
	Provide cultural competency trainings for leadership and frontline staff		X	X	Provide implicit bias trainings to 75% of leadership staff in 2023 Provide cultural competency training to 50 frontline staff each year	
	Provide education through internal newsletters and communication campaigns	X	X	X	Incorporate 12 educational articles into staff newsletter each year Design and implement 2 D&I communication campaigns	


Pottstown Hospital
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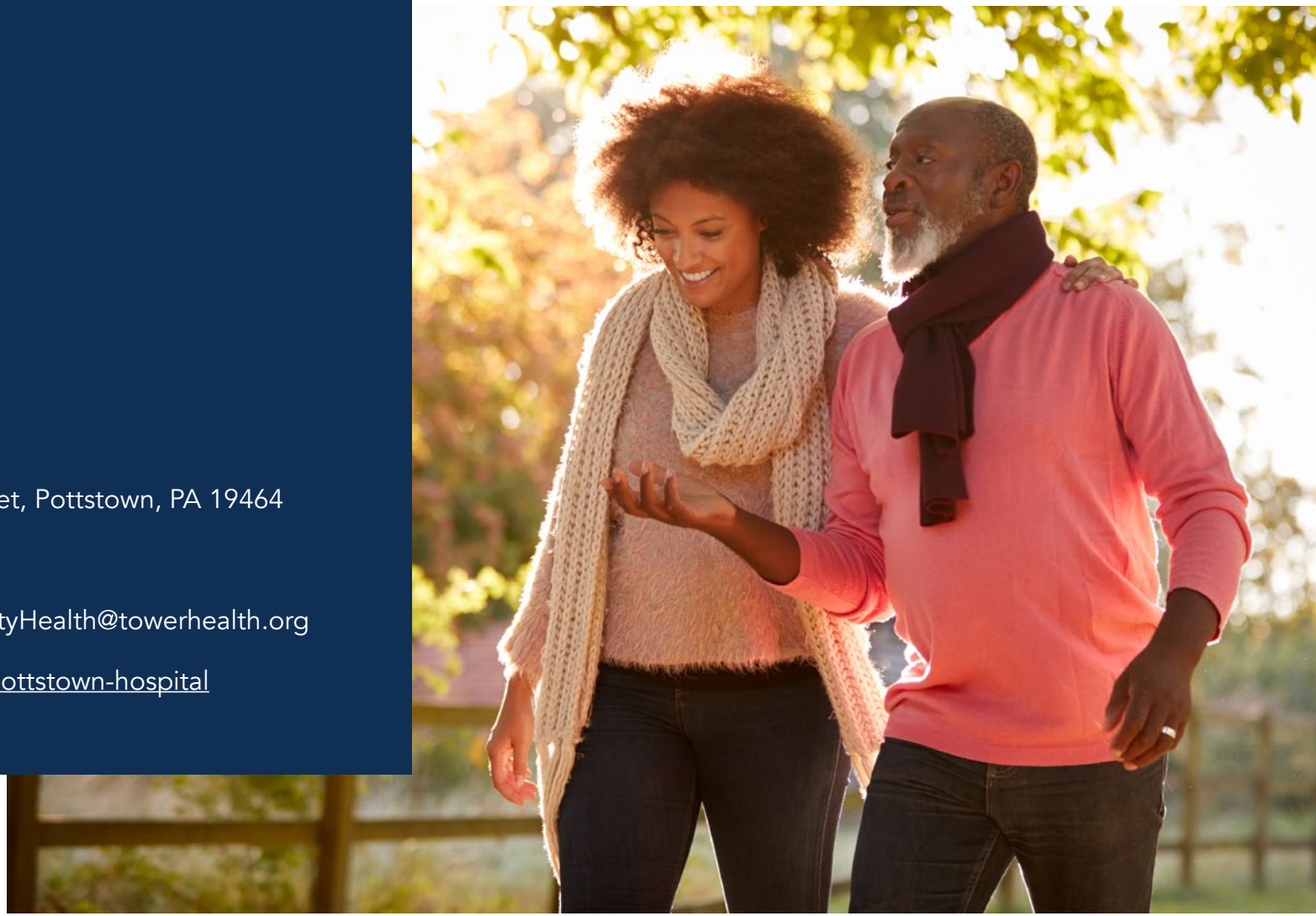

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