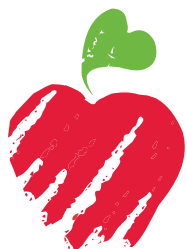




COMMUNITY
HEALTH NEEDS
2022 ASSESSMENT

HEALTH IS WHERE WE LIVE, LEARN AND WORK



St. Christopher's
Hospital for Children

A PARTNERSHIP OF TOWER HEALTH
AND DREXEL UNIVERSITY

Advancing Health. Transforming Lives.





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LETTER FROM THE CEO

OUR MESSAGE TO THE COMMUNITY

At St. Christopher's Hospital for Children, a deep commitment to ensuring health equity is in our very DNA. Providing healthcare for all, regardless of circumstance, has been a major part of our mission since the hospital first opened in 1875.

Though our world and our programs have changed, we continue to operate based on values of respect for all and recognition of diversity as a source of strength. St. Christopher's serves some of the most economically under-resourced neighborhoods in the country, and we are committed to meeting their needs by combatting food insecurity, supporting those affected by gun violence, connecting families to legal support, mitigating stress, and more. We are working to develop programs and services that not only provide high-quality care close to home, but also address social determinants of health.

To achieve this goal, we must first identify the community's evolving health needs. St. Christopher's Hospital for Children — 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.

Don Mueller, FACHE

President and Chief Executive Officer,
St. Christopher's Hospital for Children



Hospitals are required to conduct a CHNA every three years to retain their nonprofit status. The data for this CHNA was collected regionally and reported for our hospital service area. St. Christopher's Hospital for Children will use the results of this assessment as a foundation to develop strategies to address each of the identified regional health priorities: Access to Equitable Care, Behavioral Health, Health Education and Prevention, and Health Equity.

Many of our programs and services have been developed to address specific neighborhood health needs and we are grateful for our community partners who worked to help make these programs possible and whose engagement is an essential aspect of the CHNA process. Feedback from neighborhood residents 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 individuals receive the care and services they need to overcome systemic barriers to care. We are much stronger together than we would be individually, and our collaboration will amplify the work done by our community partners.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Don Mueller".

Don Mueller, FACHE

President and Chief Executive Officer,
St. Christopher's Hospital for Children



Questions or comments regarding the CHNA
can be sent via email to:
StChrisCommunityWellness@towerhealth.org



ABOUT **THIS REPORT**

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT?

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 St. Christopher's Hospital for Children included input from those who represent the broad interests of the community. Representatives served by the hospital facilities, mainly those knowledgeable of public health issues, information related to 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.

In the fall of 2022, St. Christopher's Hospital will release an Implementation Strategy Plan (ISP), which includes goals and strategies to address how to solve key findings from the CHNA.

IRS MANDATE

The CHNA report 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. St. Christopher's Hospital for Children's CHNA report aligns with the parameters and guidelines established by the Affordable Care Act and complies with IRS requirements.

St. Christopher's Hospital for Children is proud to present its 2022 CHNA report and its findings to the community.

CONSULTANT INFORMATION

Tower Health contracted with Tripp Umbach, a private health care consulting firm, to complete a CHNA. Tripp Umbach has conducted more than 400 CHNAs and has worked with more than 800 hospitals. Changes introduced due to the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts among providers, public health agencies, and community organizations to improve the communities' overall health and ensure access to essential services.



CHNA PROCESS — COMMUNITY ENGAGEMENT

The CHNA process began in February 2021, and the collection of quantitative and qualitative data concluded in September 2021.

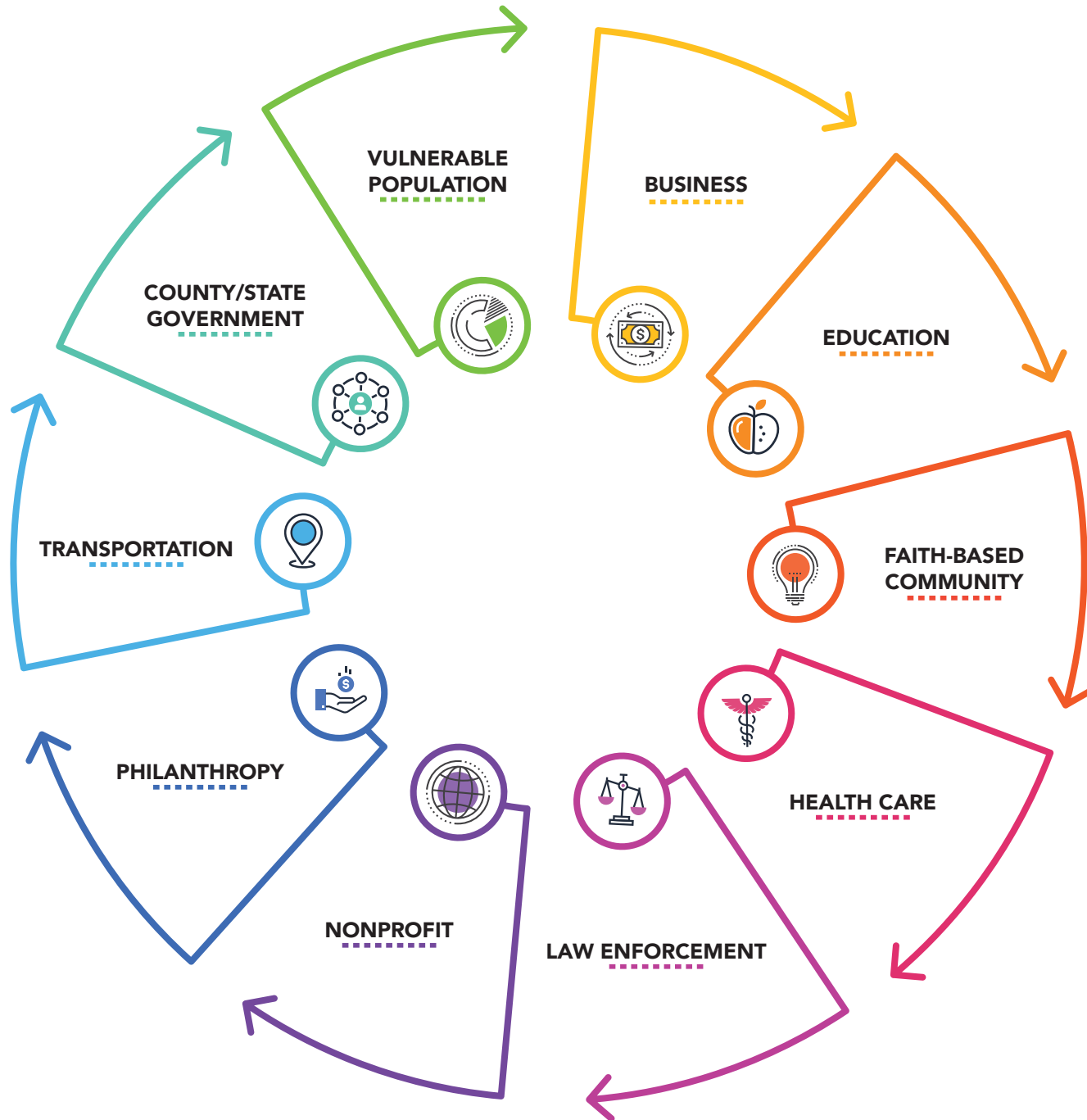
As part of this needs assessment, a vast number of residents, educators, government officials, health care professionals, and health and human service leaders in St. Christopher's Hospital's service area participated in primary data collection. See Figure 1. St. Christopher's Hospital conducted community surveys to capture the perspective of residents. Stakeholder interviews, key informant surveys, and focus groups with hospital leadership and community partners who provide services and care to the region provided a deeper understanding of the high-risk behaviors, barriers, societal issues, concerns, and needs of underserved and vulnerable populations. Various types of data, such as county demographics and chronic disease prevalence, were gathered from local, state, and federal databases to compile secondary data.

Various types of data, such as county demographics and chronic disease prevalence, were gathered from local, state, and federal databases to compile secondary data. Community surveys, key informant surveys, and community stakeholder interviews were dispersed community-wide to garner participation from all members residing or working in the primary service area. The data collected identified the needs, high-risk behaviors, barriers, societal issues, and concerns of the underserved and vulnerable populations. Information from focus groups with hospital leadership and community partners who provide services and care to the region was also included in the collection phase.

While multiple steps made up the overall CHNA process, Tripp Umbach worked closely with members of the working group¹ to collect, analyze, and identify the results to complete the hospital's assessment.

¹ Members of the working group consisted of Dr. Renee Turchi, Pediatrician-in-Chief for St Christopher's Hospital of Children and Chair of Pediatrics for Drexel University College of Medicine; Maura Heidig, Director of Population Health; Eric Thompson, Jr., Chief Medical Officer; Ingrid McGovern, Chief Nursing Officer; and Linda McDonough, Interim Director of Communications, Ha T. Pham, Senior Principal, Tripp Umbach; Barbara Terry, Senior Advisor, Tripp Umbach; and Julia Muchow, Project Manager, Tripp Umbach.

Figure 1: St. Christopher's Hospital for Children's Community Engagement



2021-2023 COMMUNITY HEALTH REGIONAL PRIORITIES

The CHNA roadmap was designed to engage all aspects of the community, from community residents to community-based organizations, health and business leaders, educators, policymakers, and health care payers, to identify health care needs and recommend possible solutions to address health issues identified.

Numerous secondary and quantitative data sources were gathered from noted public health sources to establish the current health status of the population. Primary data was collected specifically from community stakeholder interviews, key informant surveys, focus groups with health care leaders and community leaders, and a broad-based community survey in English and in Spanish. The primary and secondary data created a framework of current health status as outlined in the CHNA roadmap in Figure 2.



Figure 2: Roadmap for Community Health Needs Assessment at St. Christopher's Hospital for Children²



² It is important to note that data collected for the 2022 CHNA has limitations in information. Secondary data utilized for the report is not specific to the hospital's primary service area but rather provides a scope or picture to a larger geographic region. Data was also limited to the most recent publicly available data years. Primary data obtained through interviews and surveys is also limited in representation of the hospital's service area as information was collected through convenience sampling.

ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN

WHO ARE WE?

St. Christopher's Hospital for Children has been a leader in pediatric care and an essential community asset since its founding in 1875 as a charitable ambulatory clinic. Social service and community outreach were an important part of St. Christopher's mission from day one, and volunteers visited families in their homes to offer support for nutrition, hygiene, and more.

Today the hospital offers nationally recognized programs and more than 220 pediatric specialists who provide exceptional care to children throughout the Greater Philadelphia region and beyond. St. Christopher's provides primary pediatric care and a wide range of pediatric specialties and sub-specialties at its main campus and seven satellite locations.

St. Christopher's is home to many programs and centers, including:

- Pediatric Emergency Services including a Level I Pediatric Trauma Center
- Level III Neonatal Intensive Care Unit
- Pediatric Intensive Care Unit
- Pediatric Burn Center
- Pediatric Dialysis Center and Kidney Transplant Program
- Oncology/Infusion Center and Bone Marrow Transplant Unit
- Center for the Urban Child
- Adolescent Medicine and Family Planning Center
- Center for Children and Youth Special Health Needs



 **St. Christopher's
Hospital for Children**

160 East Erie Avenue



MISSION

The Mission of St. Christopher's Hospital for Children is to provide a full range of high-quality healthcare services to all children and youth up to age 21 who seek our care or who are referred to us.

VISION

Our long-term vision is to be the best children's medical center by attaining excellence in patient care, education, and research. We are committed to providing high-quality, family-centered care in a collaborative, nurturing, and culturally diverse environment. We will continue to value, attract, and retain the best people while satisfying our mission through the use of state-of-the-art technological advances in research and constant innovation.

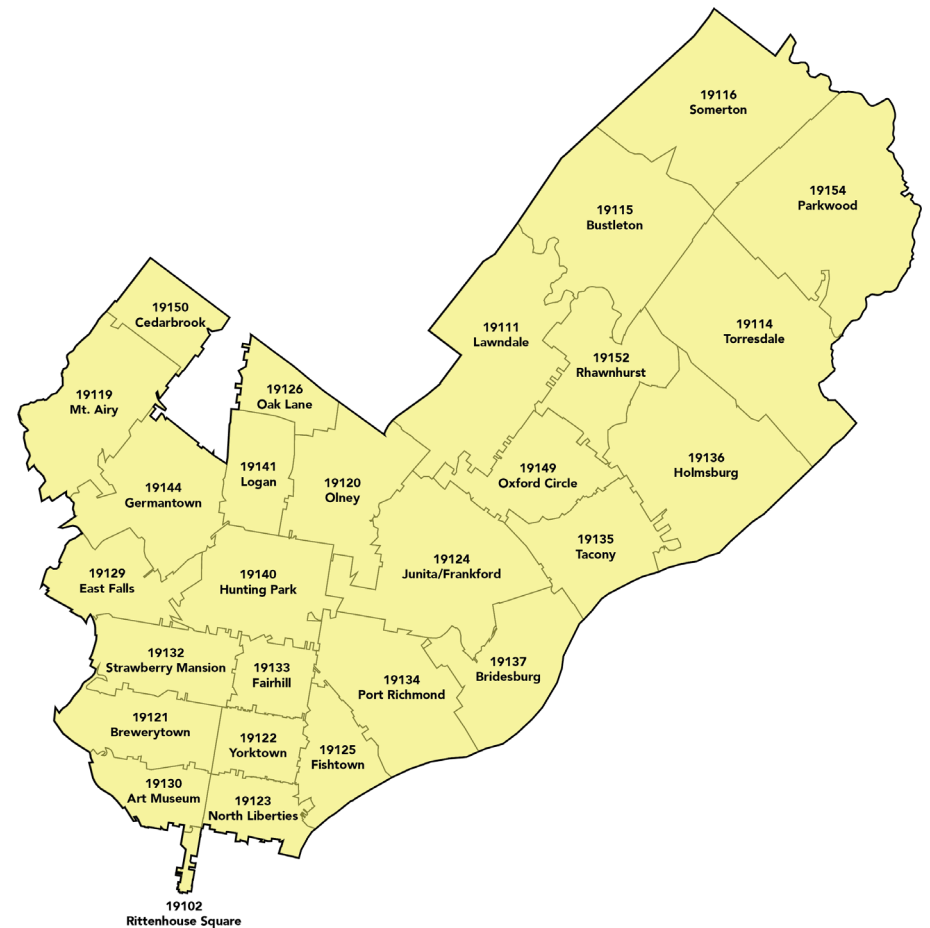


REPORT SERVICE AREA

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.

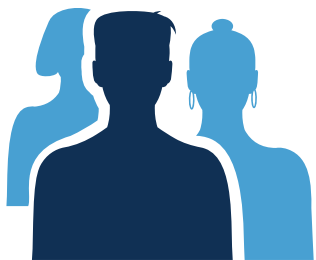
As health care organizations seek new ways to learn about and assume greater accountability for the health status of the populations they serve, a shift in perspective has occurred. Health care organizations have achieved a greater understanding of the health status and health practices of the populations and groups they specifically serve by shifting from looking just at state and national data to drilling down and assessing health and behaviors at the ZIP code level. ZIP code level data provides a more effective understanding of social determinants of health and serves as a firm basis for improving health. Where available, ZIP code level data was provided.

St. Christopher's Hospital for Children's PSA			
ZIP Codes	Town/Neighborhood	ZIP Codes	Town/Neighborhood
19116	Somerton	19120	Olney
19154	Parkwood	19129	East Falls
19115	Bustleton	19140	Hunting Park
19114	Torresdale	19124	Junita/Frankford
19152	Rhawnhurst	19132	Strawberry Mansion
19111	Lawndale	19133	Fairhill
19136	Holmsburg	19134	Port Richmond
19149	Oxford Circle	19137	Bridesburg
19135	Tacony	19121	Brewerytown
19150	Cedarbrook	19122	Yorktown
19119	Mt. Airy	19125	Fishtown
19126	Oak Lane	19130	Art Museum
19144	Germantown	19102	Rittenhouse Square
19141	Logan	19123	North Liberties



THE COMMUNITY AT A GLANCE

The health of an individual is largely influenced by the choices we make for ourselves and our families and the available opportunities to make those positive choices. These influences affect our ability to make healthy choices, afford care and housing, food, and cope with stress factors.



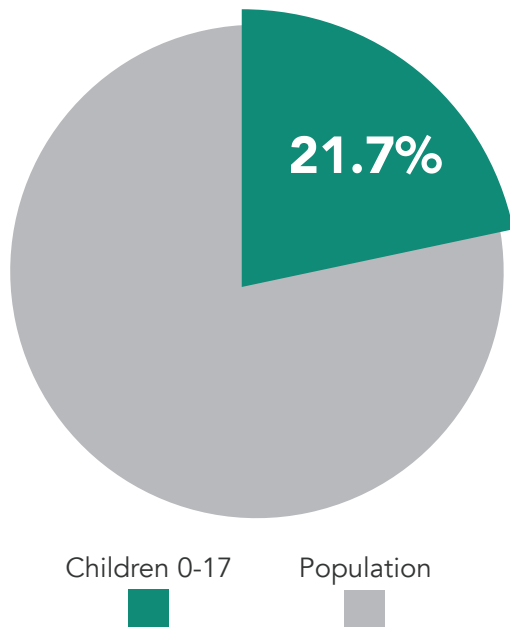
POPULATION

1,579,075 Philadelphia City

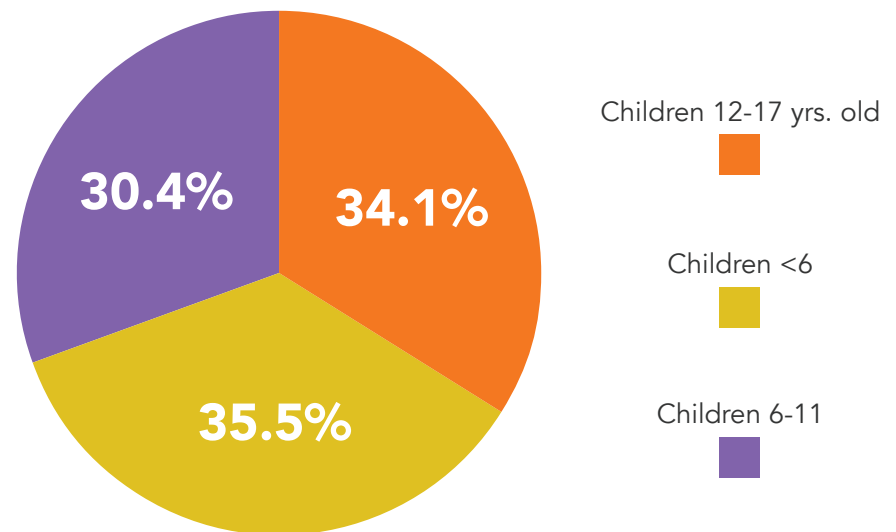
12,791,530 PA

Source: [US Census Bureau, American Community Survey 2015-2019](#)

OVERALL POPULATION

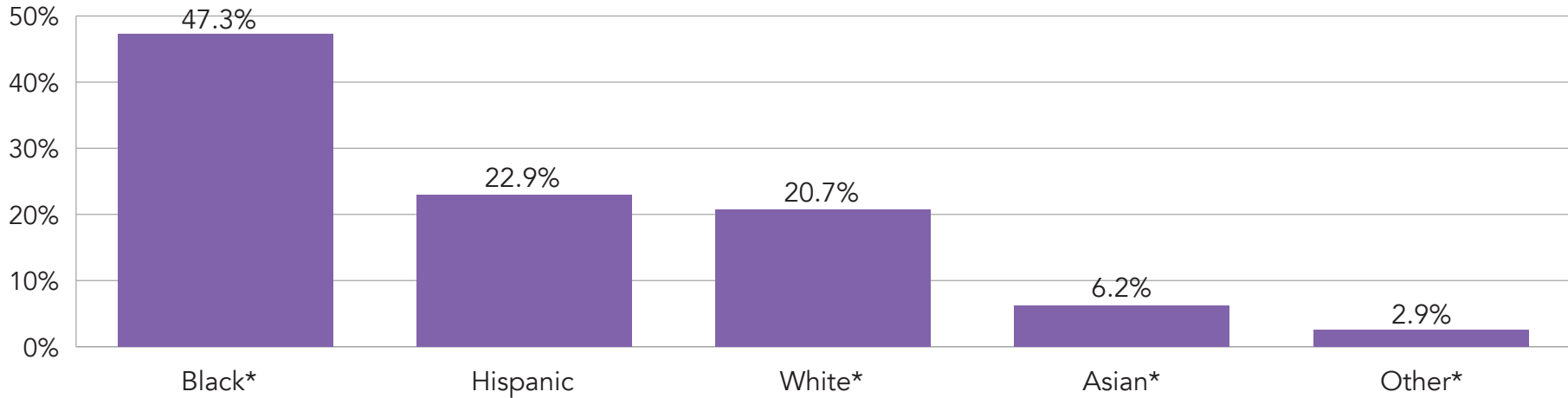


AGE DISTRIBUTION OF CHILDREN IN PHILADELPHIA



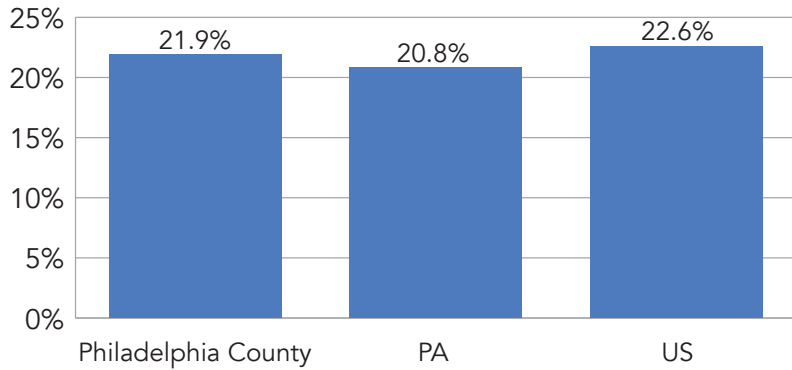
Source: [Growing Up Philly](#)

RACE/ETHNICITY OF CHILDREN IN PHILADELPHIA 2018



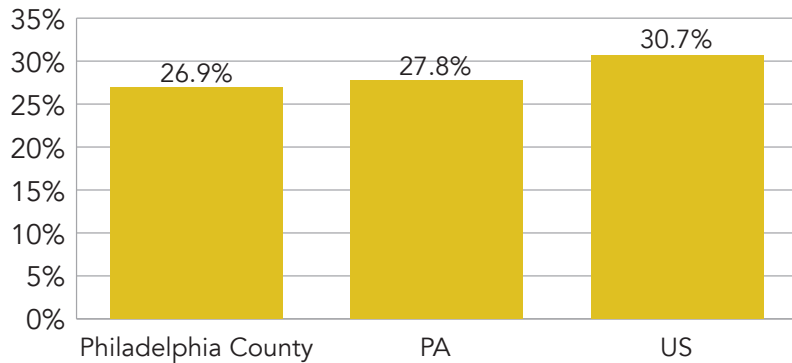
Note: *Non-Hispanic Source: [Growing Up Philly](#)

POPULATION UNDER AGE 18



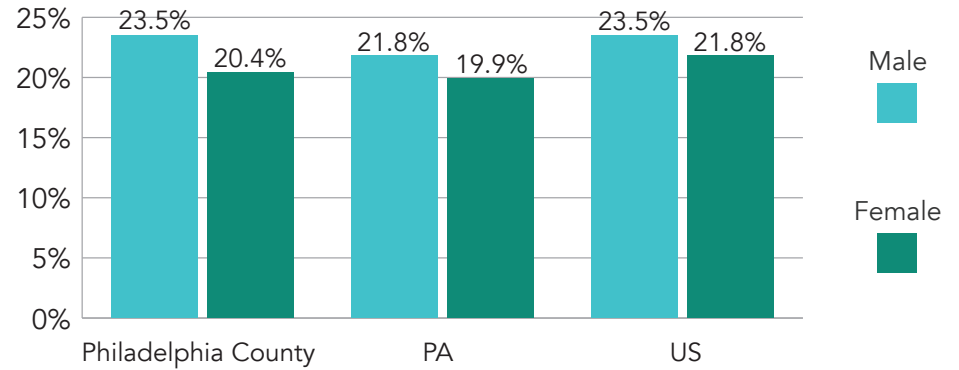
Source: [US Census Bureau, American Community Survey 2015-2019](#)

FAMILIES WITH CHILDREN (UNDER 18 YEARS OLD)



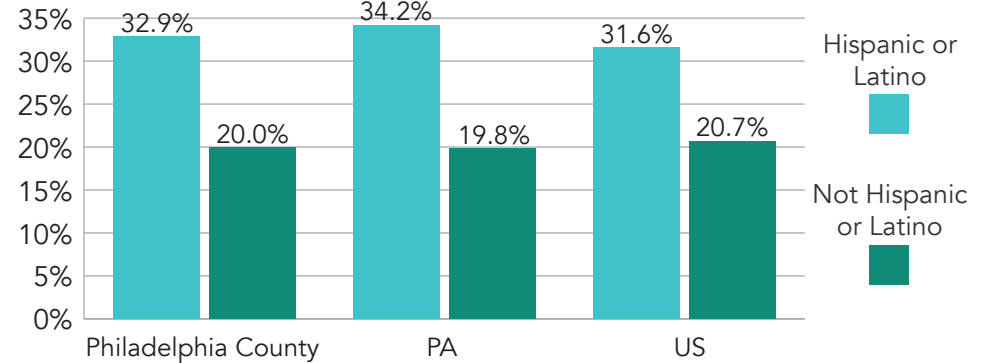
Source: [US Census Bureau, American Community Survey 2015-2019](#)

POPULATION UNDER AGE 18 BY GENDER



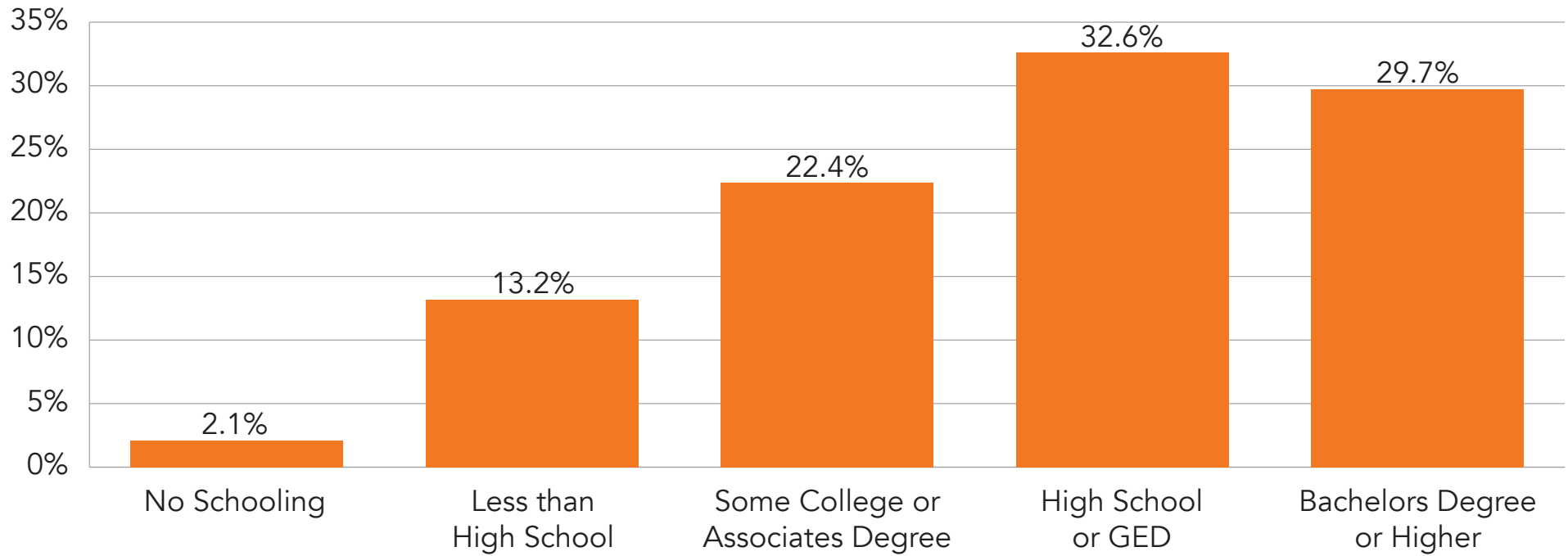
Source: [US Census Bureau, American Community Survey 2015-2019](#)

POPULATION UNDER AGE 18 BY ETHNICITY



Source: [US Census Bureau, American Community Survey 2015-2019](#)

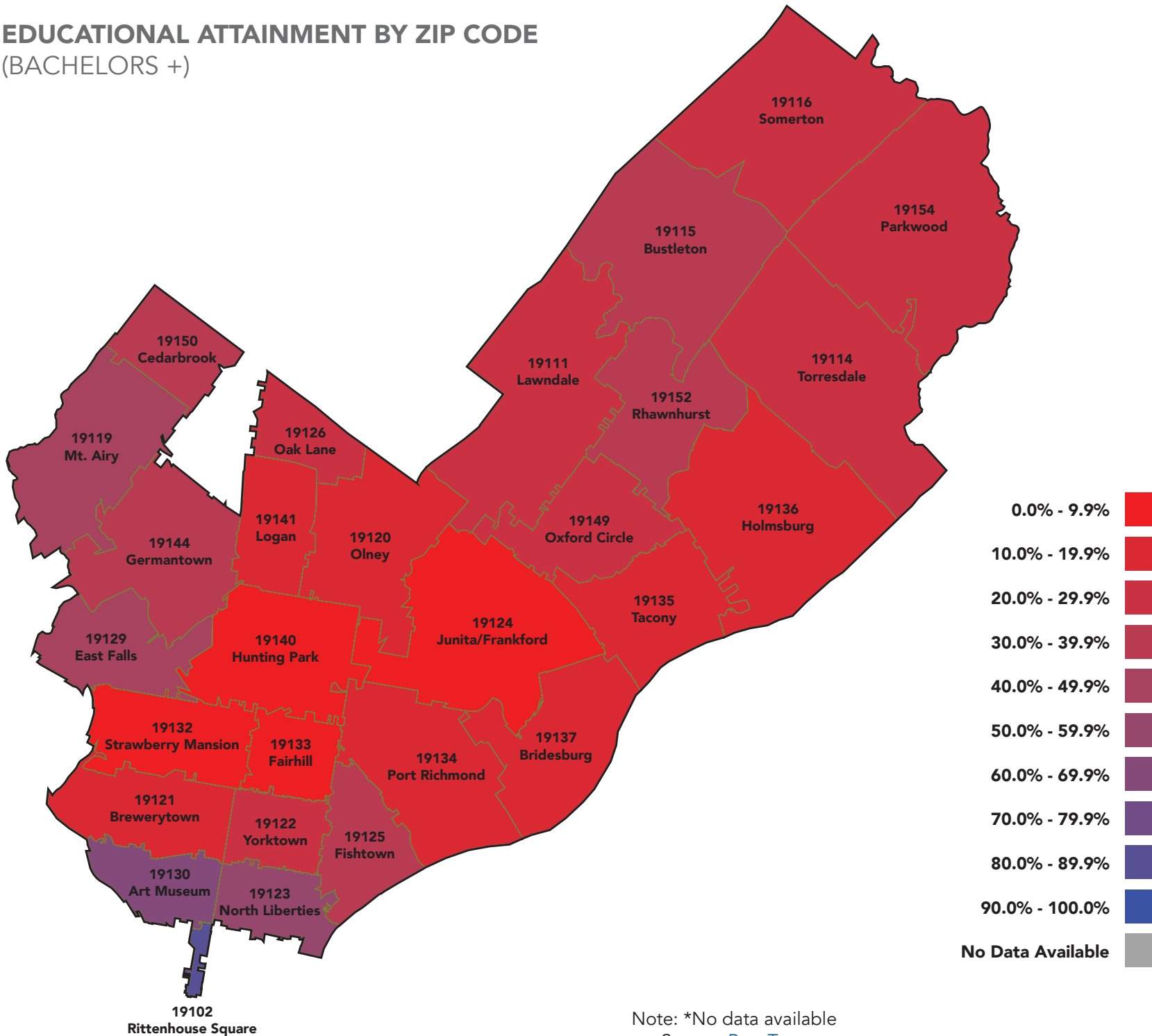
EDUCATIONAL ATTAINMENT (IN PHILADELPHIA COUNTY)



Source: [Towncharts.com](https://www.towncharts.com)

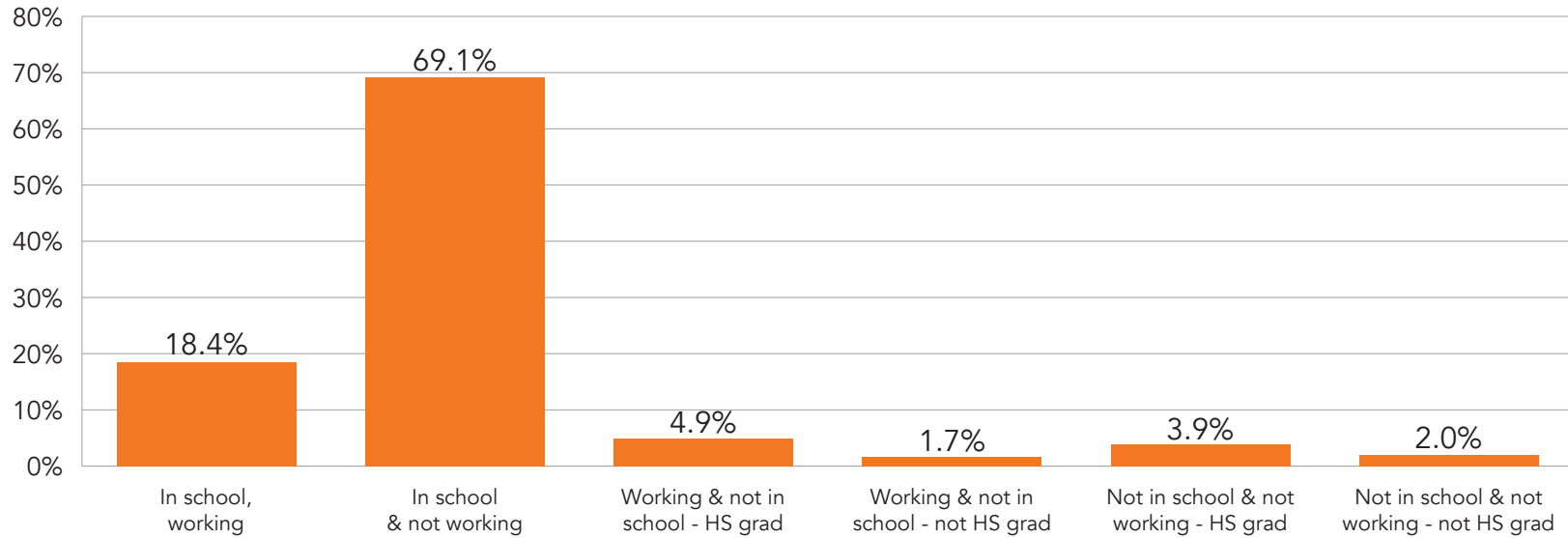


EDUCATIONAL ATTAINMENT BY ZIP CODE (BACHELORS +)



Note: *No data available
Source: [Pew Trust](#)

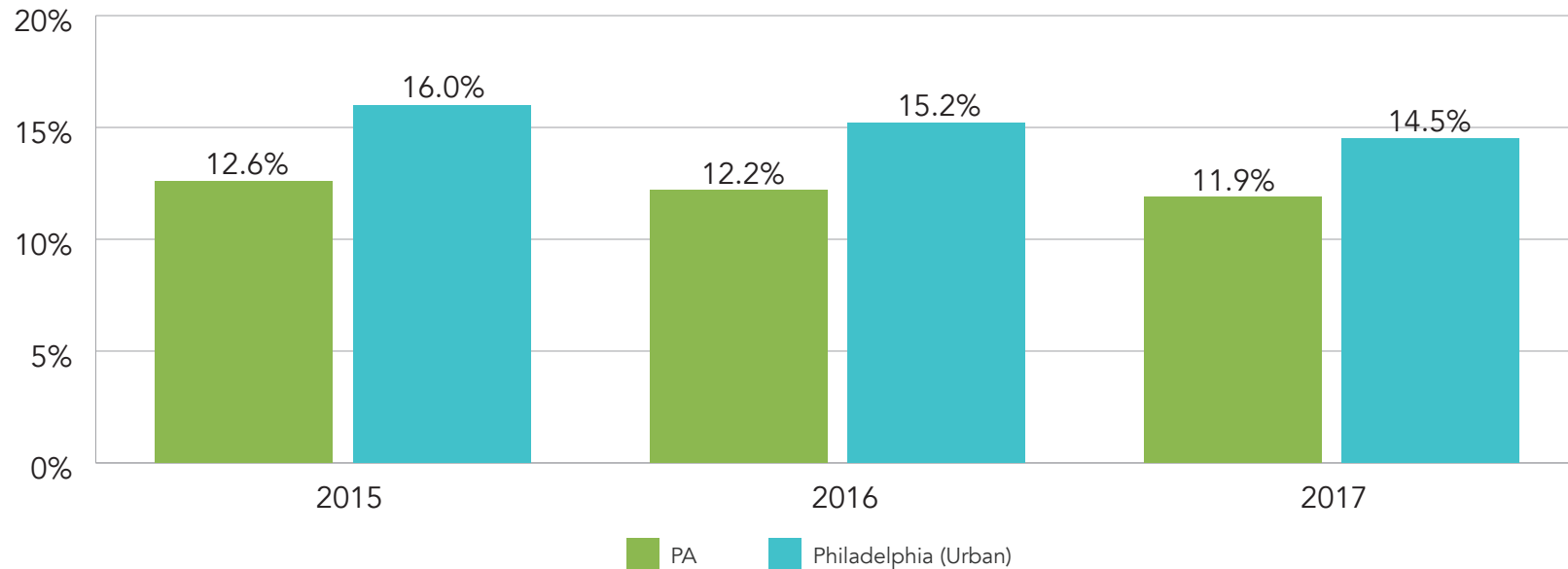
YOUTH (AGE 16-19) BY SCHOOL ENROLLMENT, EMPLOYMENT STATUS, AND EDUCATIONAL ATTAINMENT IN PHILADELPHIA COUNTY, 2019



Source: [Kids Count Data Center 2019](#)

PRENATAL HEALTH CARE AND INFANT CHILD/MORTALITY

BIRTHS TO MOTHERS WITH LESS THAN A HIGH SCHOOL EDUCATION IN PHILADELPHIA COUNTY, 2017



Source: [Kids Count Data Center 2015-2017](#)

**RESIDENT LIVE BIRTHS BY EDUCATION OF MOTHER FOR SELECTED MUNICIPALITIES,
(NUMBER AND PERCENT*)**

Municipality	Total Births	Grade 8 or Less		Grade 9-12		High School Grad/ GED		Some College**		College Degree		Unknown
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
PA	137,771	4,479	3.3%	11,831	8.6%	34,612	25.3%	36,069	26.4%	49,793	36.4%	987
Philadelphia County	21,282	513	2.4%	2,534	12.1%	6,447	30.8%	5,410	25.8%	6,049	28.9%	329

*Percent of total live births for each specified area. Unknowns excluded from calculations

** Includes an associate degree or some college credit, but no degree

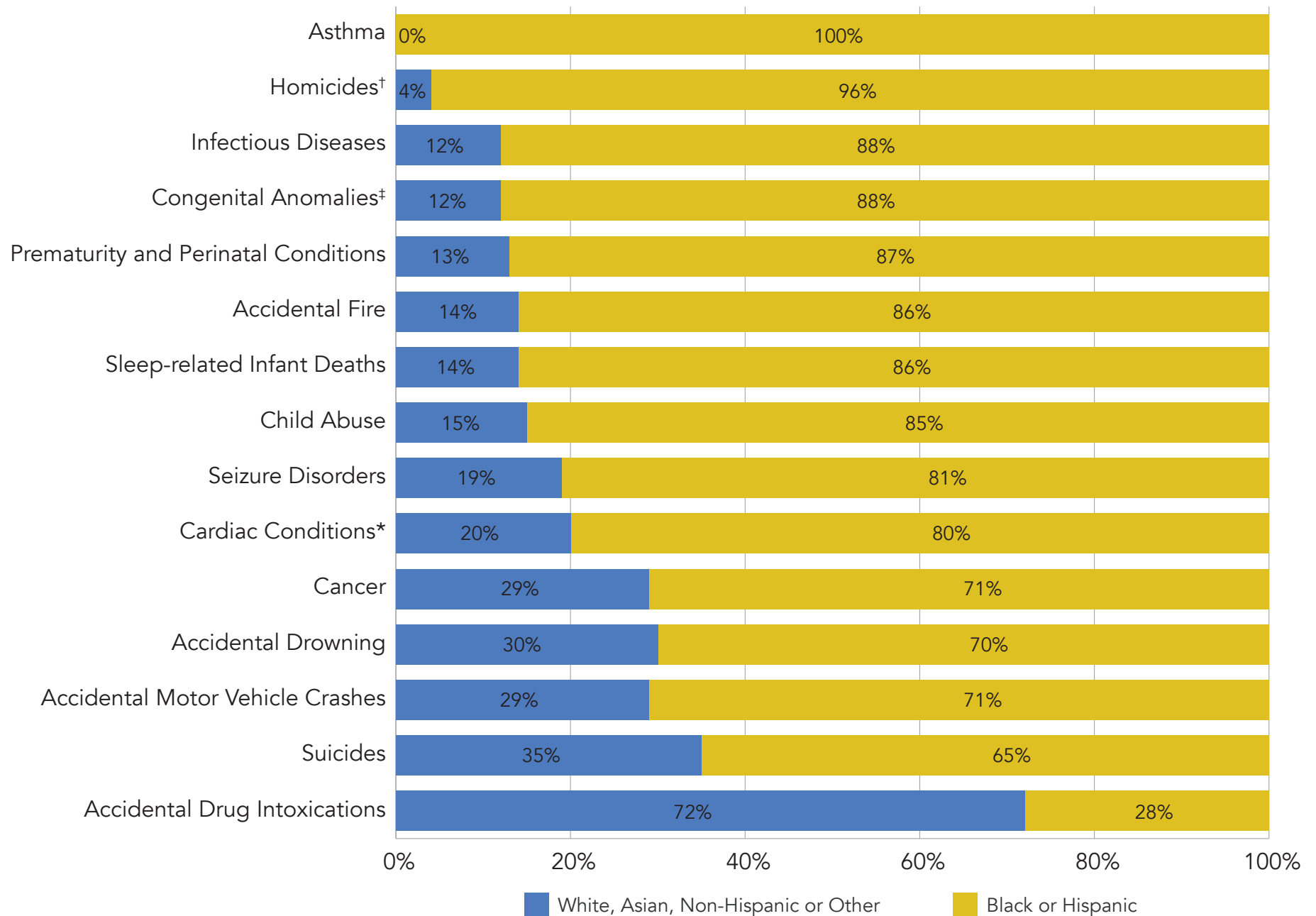
Source: [Pennsylvania Vital statistics, 2017](#)

RESIDENT LIVE BIRTHS BY AGE OF MOTHER FOR SELECTED MUNICIPALITIES

Municipality	Total Births	Under 15	15-19	20-24	25-29	30-34	35-39	40-44	45+	Unknown
PA	137,771	56	5,874	25,273	40,861	41,945	19,682	3,724	328	28
Philadelphia County	21,282	14	1,245	4,287	6,200	5,897	2,984	598	54	3

Source: [Pennsylvania Vital statistics, 2017](#)

LEADING CAUSE OF DEATH AMONG CHILDREN



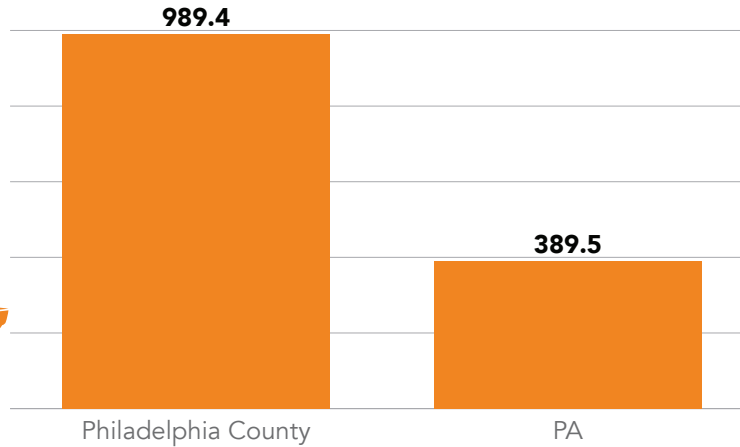
Note: †Does not include homicide by child abuse; ‡ Does not include those of cardiac origin *Includes congenital, cardiomyopathies and other.

Source: [Child Death Review Report, 2011-2017](#)

OUR ENVIRONMENT

VIOLENT CRIME

(per 100,000 population)

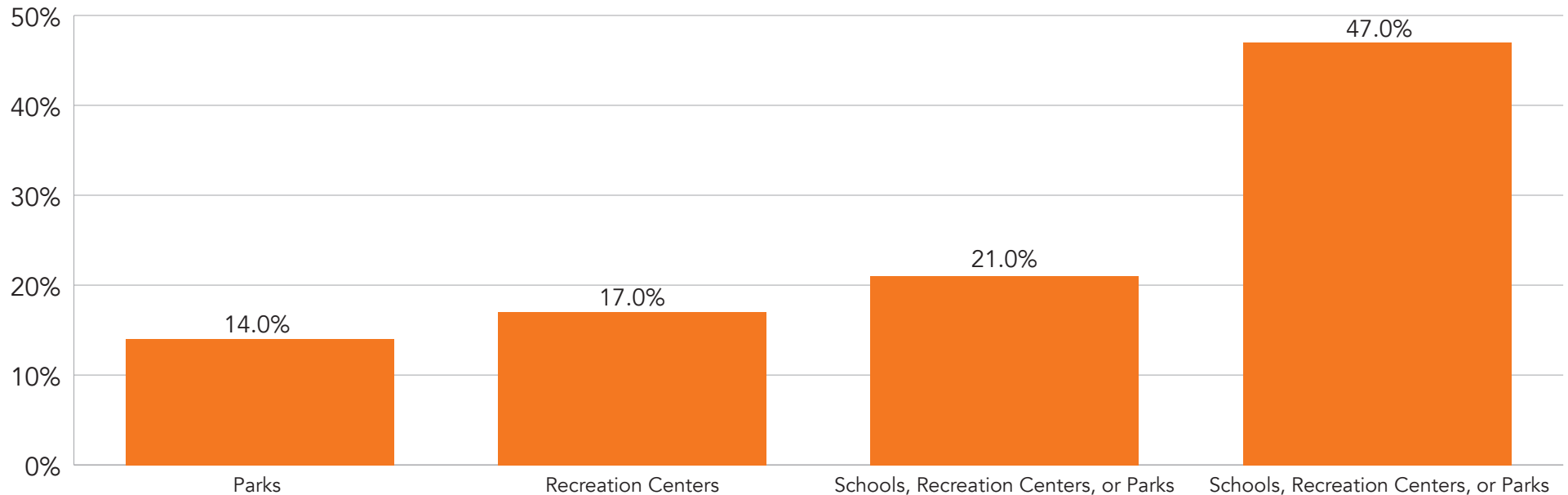


“THROUGHOUT THE COMMUNITY, PEOPLE DESCRIBED **GUN VIOLENCE AS THE GREATEST THREAT TO THEIR LIVES.”**

-THE PHILADELPHIA INQUIRER

Source: [FBI Uniform Crime Reports 2020](#)

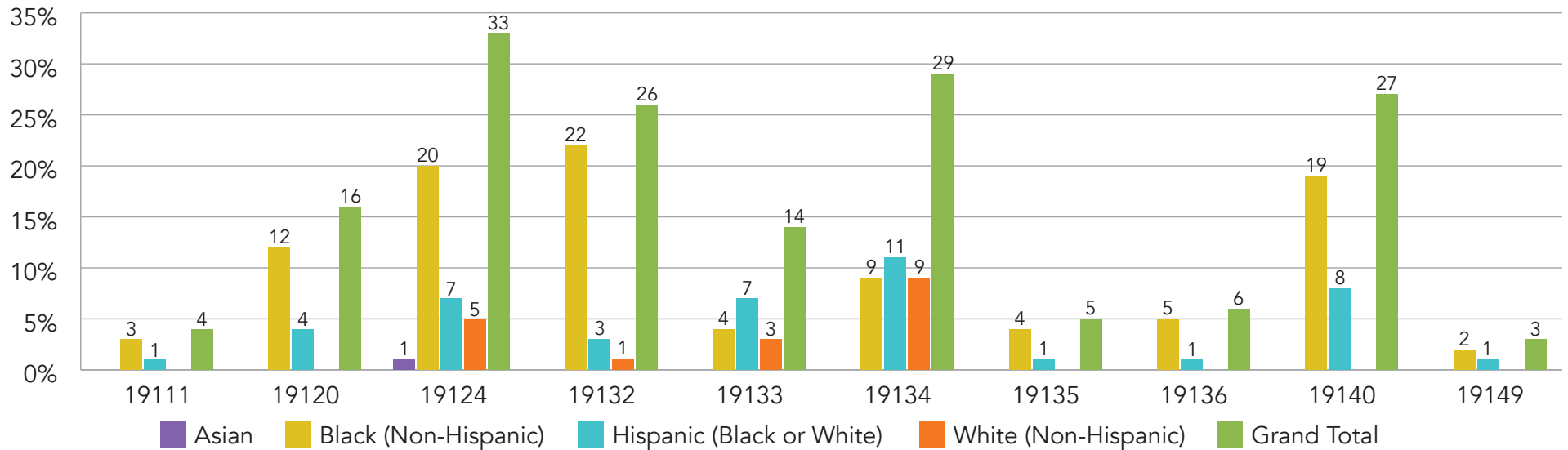
PERCENTAGE OF ALL SHOOTING VICTIMS (1,469) INJURED OR KILLED WITHIN ONE CITY BLOCK OF PUBLIC SPACE



Note: Data from the PA Office of the Controller reports, to date, there have been 88 homicides in 2022, a 6% increase from 2021.

Source: [Philadelphia Police Department Shooting Victims Dataset \(2019\)](#)

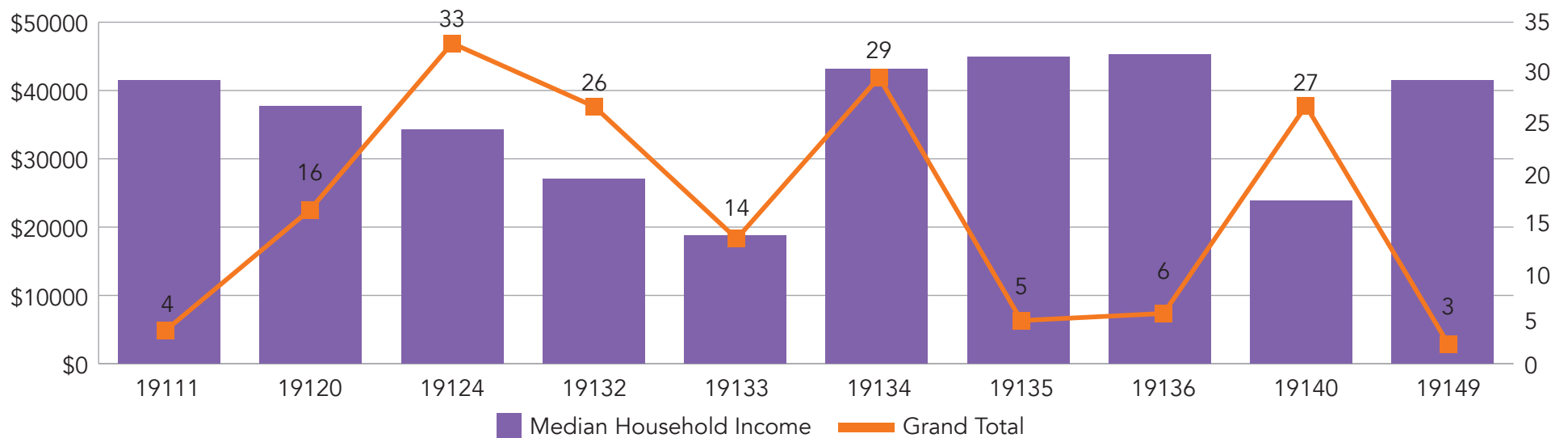
GUNSHOT VIOLENCE BY RACE/ETHNICITY AND ZIP CODE



Note: Gun violence data was provided as of January 1 - March 1, 2021. The total sample size 345.

Source: [Pennsylvania Office of the Controller](#)

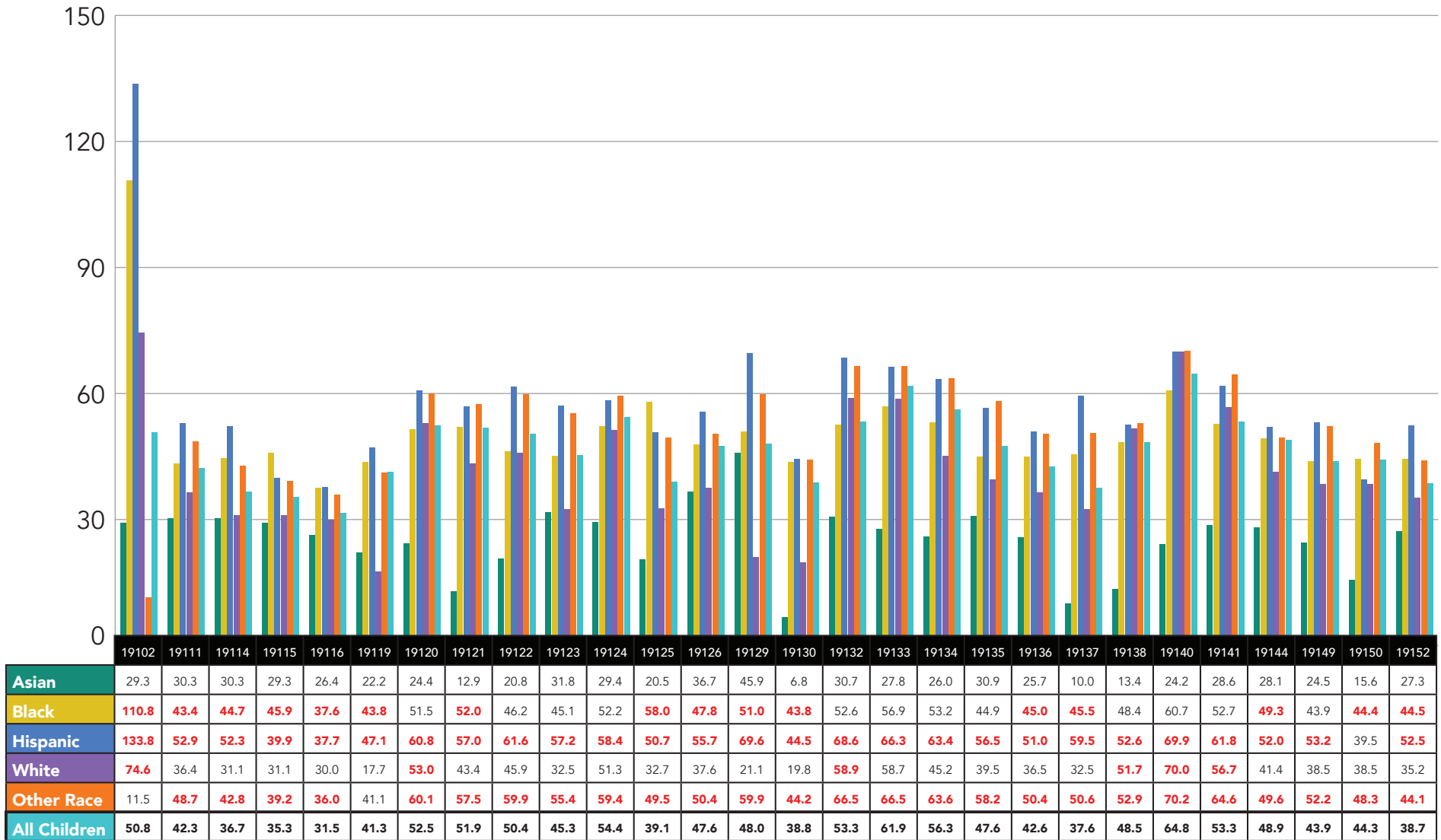
GUNSHOT VIOLENCE BY HOUSEHOLD INCOME AND ZIP CODE



Source: Household Income supplied by St. Christopher's Hospital for Children, 2022; Gun violence data: [Pennsylvania Office of the Controller](#)

CHILDREN EMERGENCY ROOM VISITS PER 1,000 MEMBER/MONTHS ZIP CODE SUMMARY³

The below figure depicts ZIP codes within St. Christopher's primary service area related to children who visit the emergency room per month broken out by race/ethnicity.



Note: The bolded figures indicate high ED visits in each specific ZIP code. The bolded figures indicate high emergency room visits when compared to the benchmarked data of all children within the specific ZIP code.

Source: [Pennsylvania Health Equity](#); [Pennsylvania Department of Human Services](#)

³ 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 truck levels.

DIAGNOSES AND ADMISSIONS AT ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN

In addition to common childhood illnesses and injuries, St. Christopher's sees a high prevalence of Emergency Department visits and Inpatient Admissions related to the following conditions:

- Anemia, failure to thrive, and dental caries linked to nutrient absorption, food insecurity, premature births, and low birth weights.
- Vision impairments as astigmatism, retinopathy of prematurity, and hypermetropia.
- Allergies, asthma, and eczema.
- Obesity and related conditions such as obstructive sleep apnea, and type 2 diabetes mellitus.
- Behavioral health issues such as attention deficit disorder (ADD), anxiety, depression, autism, and developmental delays.
- Chronic health conditions such as HIV, cerebral palsy, sickle cell disease, scoliosis, seizure disorders, diabetes and hypertension, among many others.



Registration

Train Station

WHERE WE LIVE, LEARN, WORK, AND PLAY AND HOW IT AFFECTS OUR LIVES?

Figure 3: Influential Factors



[The World Health Organization](#) (WHO) defines social determinants of health (SDOH) as the economic and social conditions that influence individual and group differences in health status. Where we live, learn, work, and play are important factors that shape one's overall health standing. Communities with access to healthy foods, livable-affordable homes, quality education, and a safe/clean environment are healthier than their counterparts. Our social and physical environments which include factors such as our race, income, education level, and home environment (e.g., livable housing, working utilities, etc.) have strong impacts on our overall health aside from traditional health factors such as genetics.

According to the [Robert Wood Johnson Foundation](#), social inequalities such as poverty are linked to unhealthy behaviors like smoking, poor diet, and lack of exercise. However, community investments in proven programs and policy changes can reduce disparities, allowing residents to make better, healthier choices and reducing illnesses.

FACTORS THAT INFLUENCE OUR HEALTH

SDOH and individual choices play a vital role in one's overall health and well-being; however, those choices must be made available to

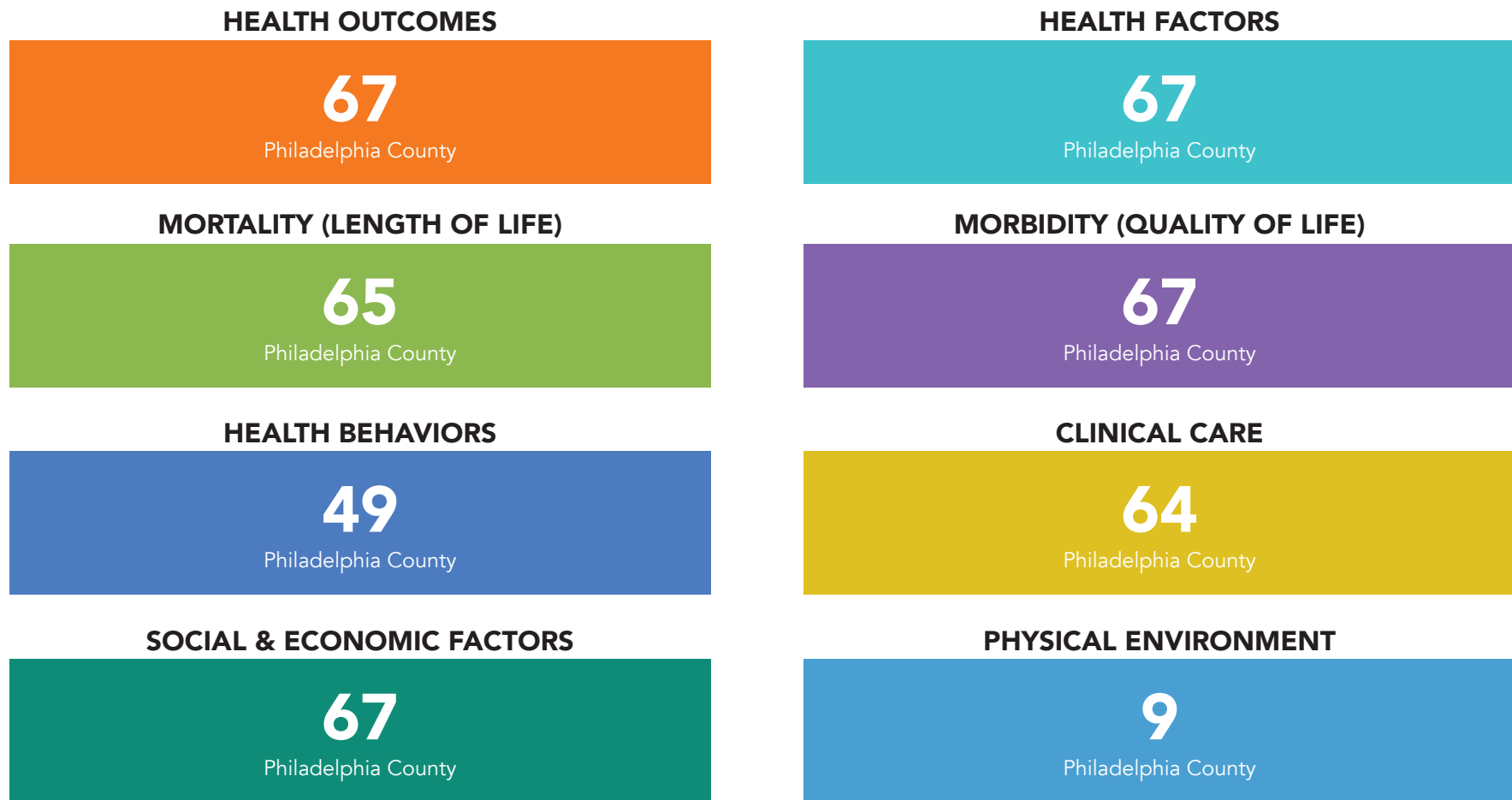
yield a good outcome. SDOH factors, such as income, education, community safety, injury and death, social support, and children in poverty, can significantly affect how well and how long we live. Unfortunately, not everyone has access to the highest quality social and economic opportunities. While health equality would provide all community members with the same resources to achieve personal health, health equity would provide customized tools and options that allow individuals to make the choices that fit their specific circumstances in an attempt to be their healthiest selves.

According to [County Health Rankings & Roadmaps](#), Figure 4 shows Philadelphia County is ranked poorly in multiple categories and ranked highly in physical environment (9/67 counties). Social and economic factors, such as income, education, employment, community safety, injury and death, social support, and children in poverty, can significantly affect how well and how long we live. Pennsylvania has 67 counties; a score of 1 indicates the “healthiest” county for the state in a specific measure.

It is important to note that the information presented in the data is a generalized snapshot of the county and does not display the nuances and specific characteristics of the Philadelphia County ZIP codes identified in St. Christopher’s primary service area.

Figure 4 Illustrates factors that influence the lives of community residents.

Figure 4: County Health Rankings: Philadelphia County
(1-67) (1=Healthiest)

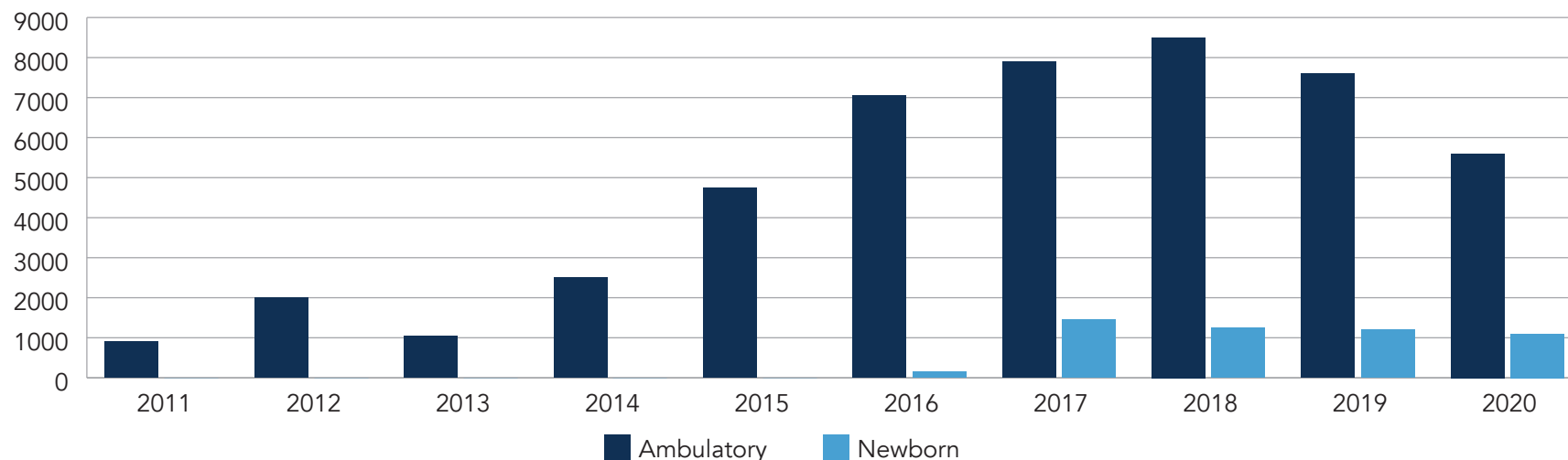


Source: [County Health Rankings and Roadmaps 2021](#)

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

St. Christopher's Hospital for Children was one of the first in the region to begin screening for Social Determinants of Health in 2011, launching a Medical Legal Partnership (MLP) and many other programs, and becoming recognized as a leader in the field.

Figure 5: Annual SDH Screens by Location

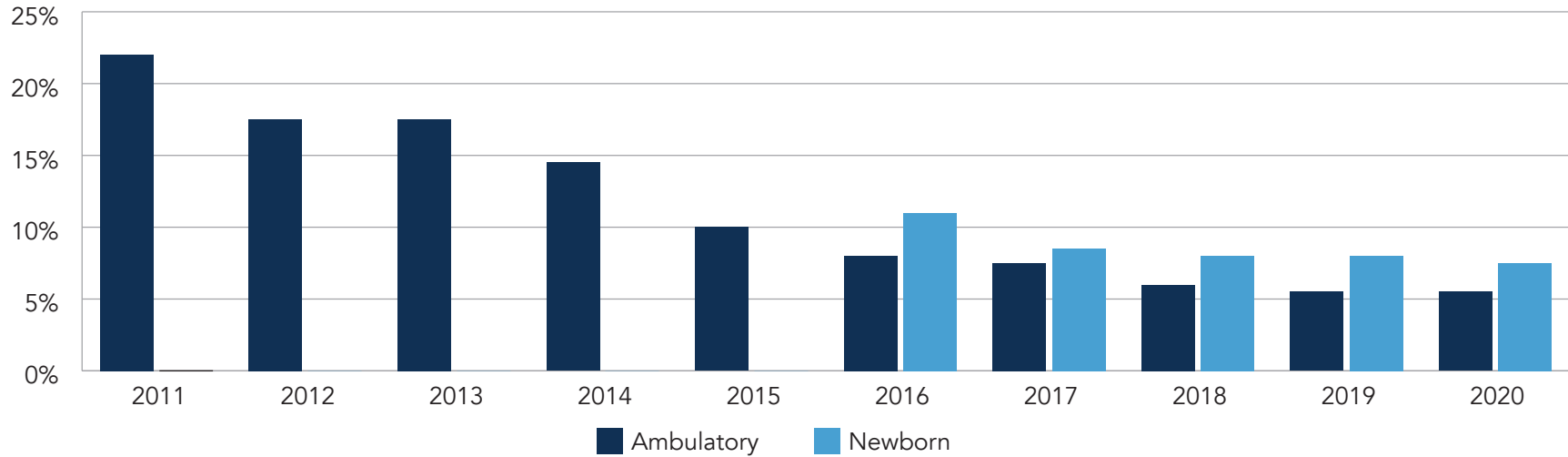


St. Christopher's has conducted over 65,000 screenings since beginning screenings ten years ago. 2020 was a down year due to the COVID-19 pandemic, but the interdisciplinary team provided continuous care for the families.

Screenings for social determinants of health has expanded every year, expanding from the General Pediatric Clinic in the Center for the Urban Child to the Center for Children and Youth with Special Healthcare Needs, NextSteps Program (neonatal follow-up), the Adolescent Clinic, the Center for Collaborative Primary Care (CPC), and the Newborn Program. The Dorothy Mann Center for Pediatric & Adolescent HIV began screenings for social determinants of health in 2017. Screenings were piloted in the inpatient unit as a quality improvement initiative led by pediatric residents in 2019.

Almost 20% of those screened in the Center for the Urban Child identify at least one unmet need. The legal assistance provided to families by the Medical Legal Partnership is quite extensive. This program embeds attorneys in the clinical setting to collaborate with providers on their patients' needs at the time of their visit. The most common needs are family, benefits, housing, and immigration. Food insecurity has decreased from 22% to 6% between 2011 and 2020, but it continues to be one of the highest identified needs. Concerns about public benefits (WIC and SNAP or Food Stamps), insurance, and utilities are the other most commonly identified needs.

Figure 6: Percent Food Insecurity Positive by Location



Screenings are performed in both English and Spanish, allowing for results disaggregated by language. Over the last three years, individuals completing the screener in Spanish have consistently identified a greater number of needs compared to those who completed the screener in English. There have also been observed differences disaggregating by age, with more needs identified in the Newborn Program screens as compared to the Ambulatory Clinics.

Figure 7: Newborn Screens Visits with Any Need by Language (thru May 2021)

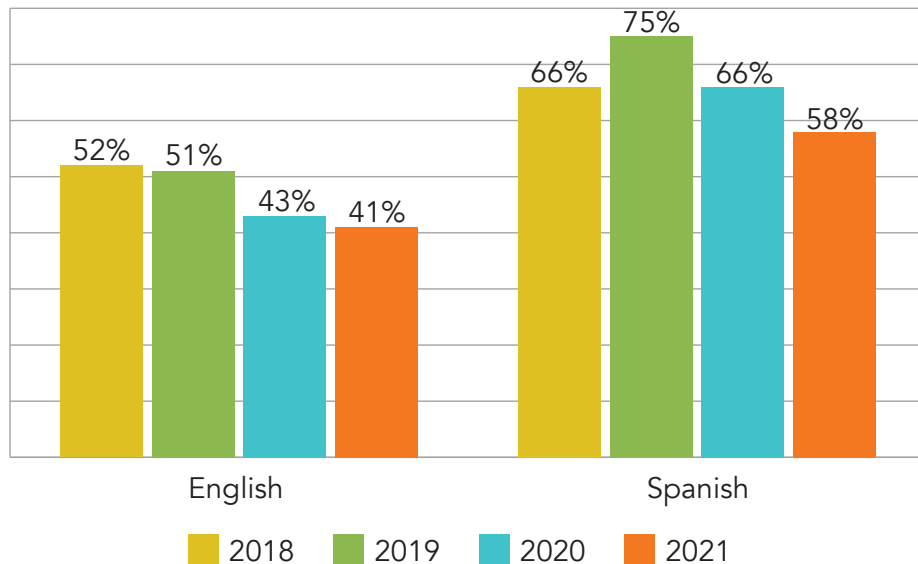
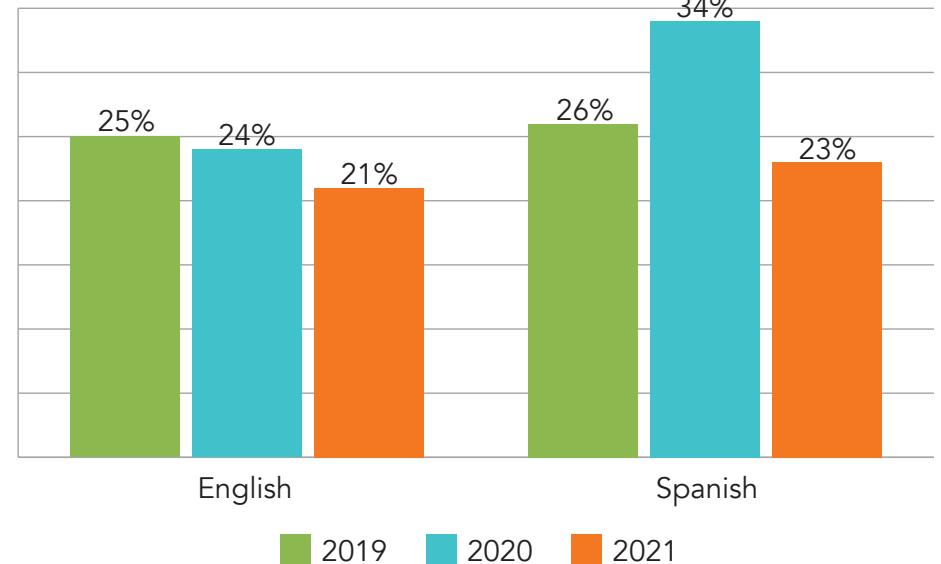


Figure 8: Ambulatory – Screened Visits with Any Need by Language (thru April 2021)



Note: Needs not included: 7-crib; 8-carseat; 9-breastfeeding, 10-other caregiver, 16-another child.

In the Newborn Program, mental health, and breastfeeding concerns were most commonly identified by those completing the screener in English, while insurance, food, and diapers were the most pressing concerns identified by those the screener in Spanish.

Childcare, mental health, and insurance were the most common needs reported in the Newborn Program, while food insecurity, insurance and benefits were identified most often in the Ambulatory Clinics. Understanding these nuances allows providers to address the specific needs of families in different clinical settings.

Figure 9: Newborn – Prevalence by Need Identified
(December 2016-May 2021)

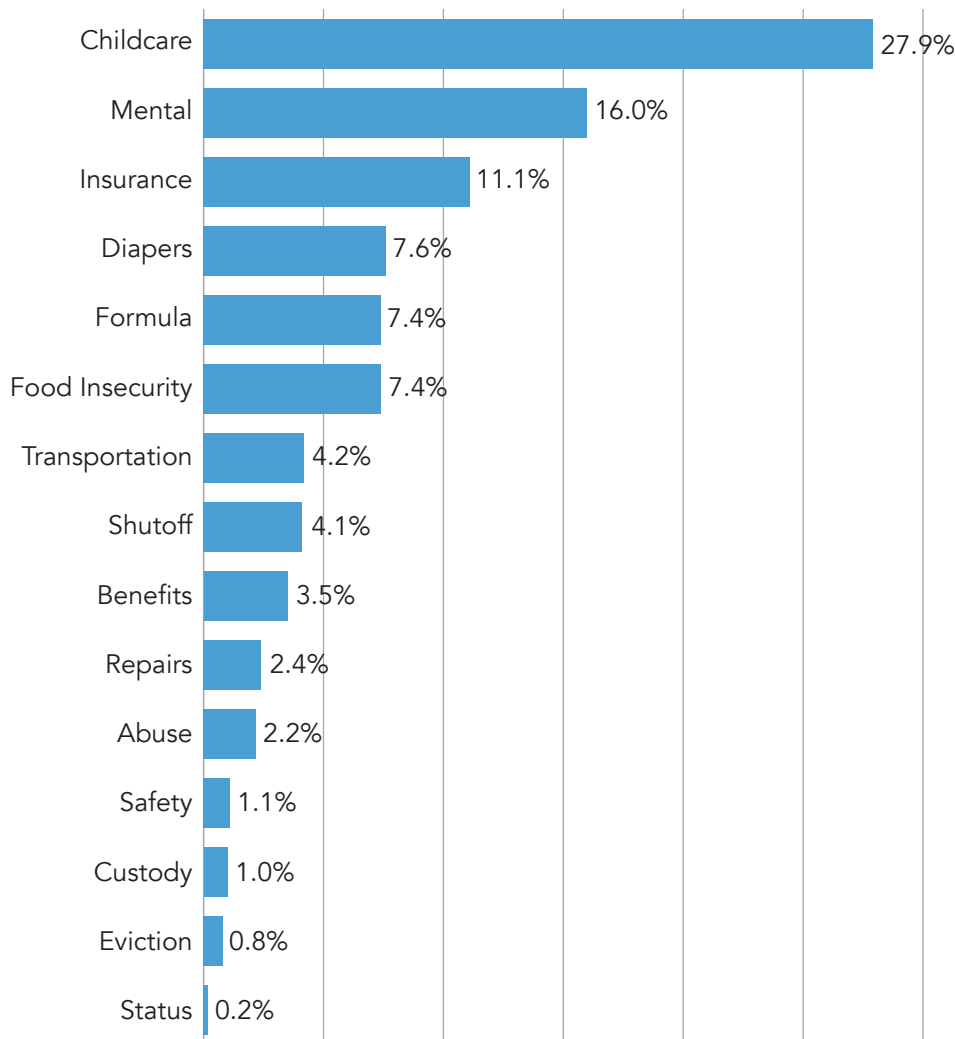
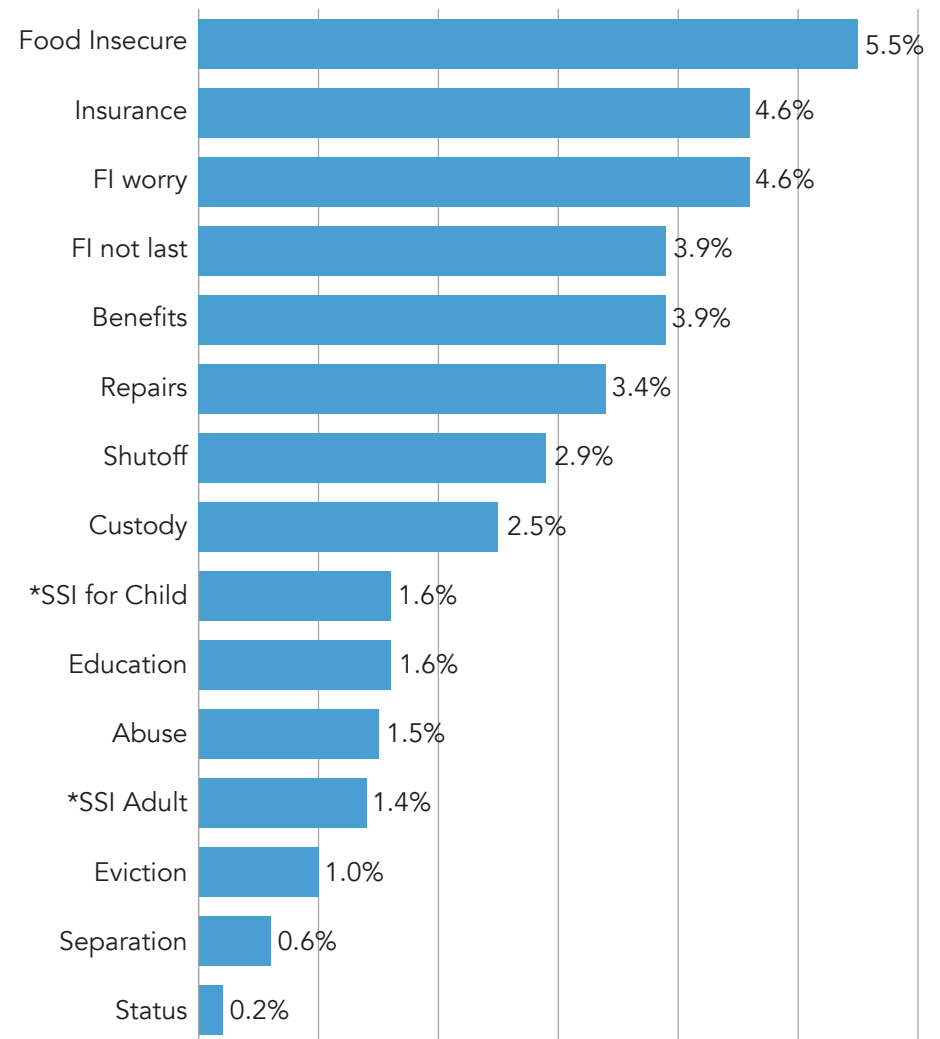


Figure 10: Ambulatory – Prevalence by Need Identified
(2019-April 2021)



Note: FI = Food Insecurity and SSI = Supplemental Security Income

In the Center for Children and Youth with Special Healthcare Needs, the most commonly identified needs included diapers, transportation, utility shut-off support, food insecurity, caregiver and child mental health resources, housing instability, clothing, and school supplies. Additionally, the most commonly identified needs during care coordination assessments were home nursing services, in-school medical support, medical equipment, and prescription refills.

Figure 11: Needs Identified and addressed with CW Consults and Referrals

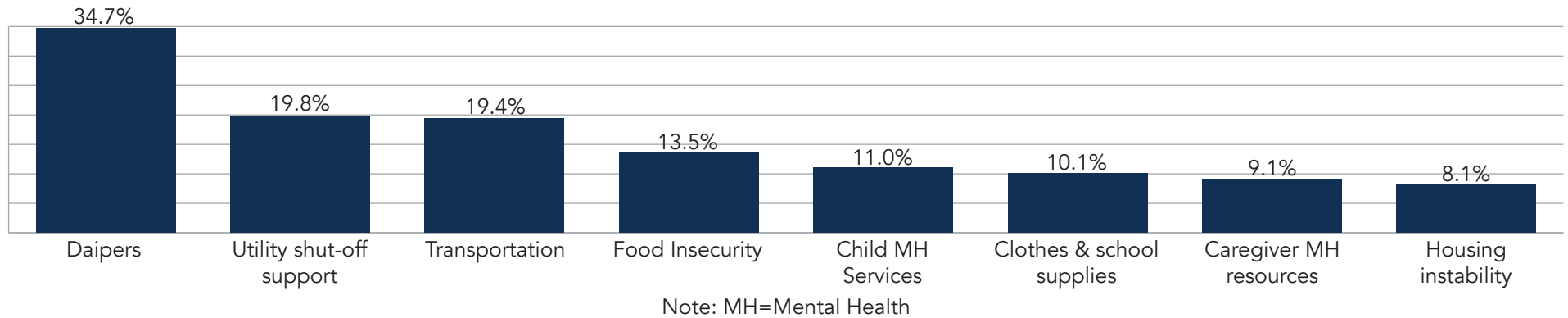


Figure 12: Needs Identified and Addressed with Care Coordination Consults

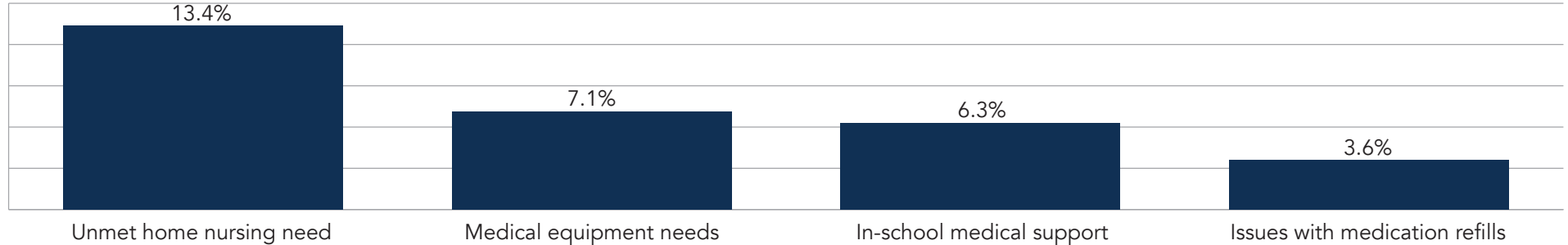
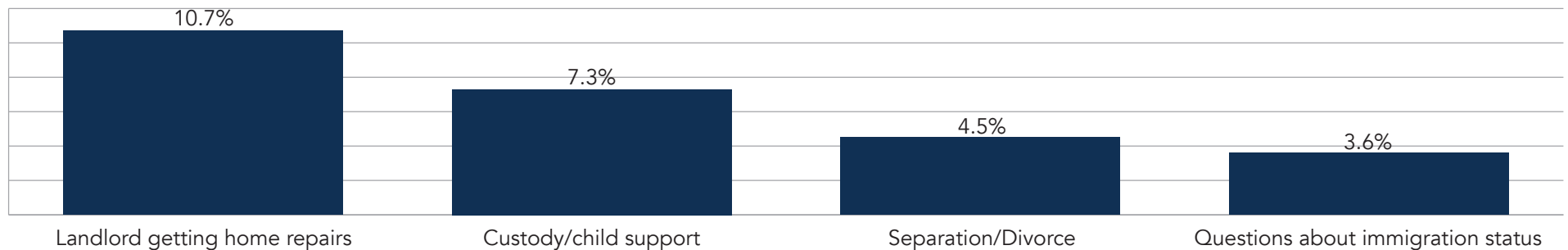


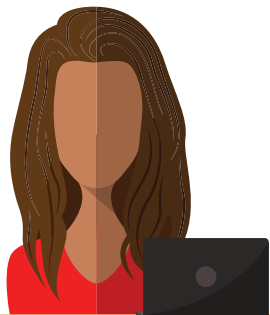
Figure 13: Legal Needs Identified and Referred to MLP



PULLING IT TOGETHER

Building on the vital work that has been underway, St. Christopher's Hospital for Children places an unrelenting focus on what actions should take place to continually improve health and quality of life for its residents. Focus groups with community members and hospital leadership drew similarities in top community health needs.

Figure 14 shows the top community health needs identified by focus groups.





Participants of the CHNA across the various data collection methods 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. We can conclude that plans to improve health can be achieved through the following areas of focus:

- A) Access to Equitable Care
- B) Behavioral Health
- C) Health Education and Prevention
- D) Health Equity

A) ACCESS TO EQUITABLE CARE

St. Christopher's Hospital for Children 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 helped the hospital to realize the even wider gaps that resulted as related to accessing care; a lack of education and awareness of available health services and programs; an even greater digital divide and lack of access to technology; the increased demand for behavioral health services; and the limited capacity to provide quality and appropriate care due to limited language services.

Figure 15 delineated the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.



WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 15: Listening to the Community



FOCUS GROUPS

(LEADERSHIP AND HEALTH EQUITY)

“What are the Contributors and Barriers to People Accessing Equitable Care?”

- Economic disparities and lack of education
- Under and uninsured
- High cost of health care
- Transportation
- Policy challenges that are meant to serve the community (i.e., public education, law, etc.)
- Need for knowledge and awareness on accessing services and resources

“Why are People Treated Differently?”

- Limited English Proficiency
- Education and income



COMMUNITY STAKEHOLDER INTERVIEWS

“What are the Perceived Barriers to Accessing Care and Services?”

- Need for health care coordination and navigators
- Non-flexible scheduling
- Transportation
- Affordability

“What are the Barriers to a Quality Life?”

- Economic disparities
- Navigating the complex health care system
- Lack of after school activities
- Need for integrated care planning
- Lack of affordable, quality housing
- Technology divide and disparities (e.g., access to internet)



KEY INFORMANT SURVEYS

“What are the Perceived Barriers to Accessing Care?”

- Trust
- Availability of services
- Health literacy
- Transportation
- Affordability
- Non-flexible scheduling
- Coordination of healthcare services

“What are the Barriers to a Quality Life?”

- Economic disparities
- High costs of health care/medication
- Employment opportunities
- Perceptions of difficulty in navigating the health system



COMMUNITY SURVEYS

“What are the Perceived Barriers to Accessing Care and Services?”

- Ease of access to health care
- Unemployment/Underemployment
- Need for after school activities/activities for teens
- Need for recreational services
- Transportation
- Need for affordable, quality housing

“What are the Most Important Health Issues?”

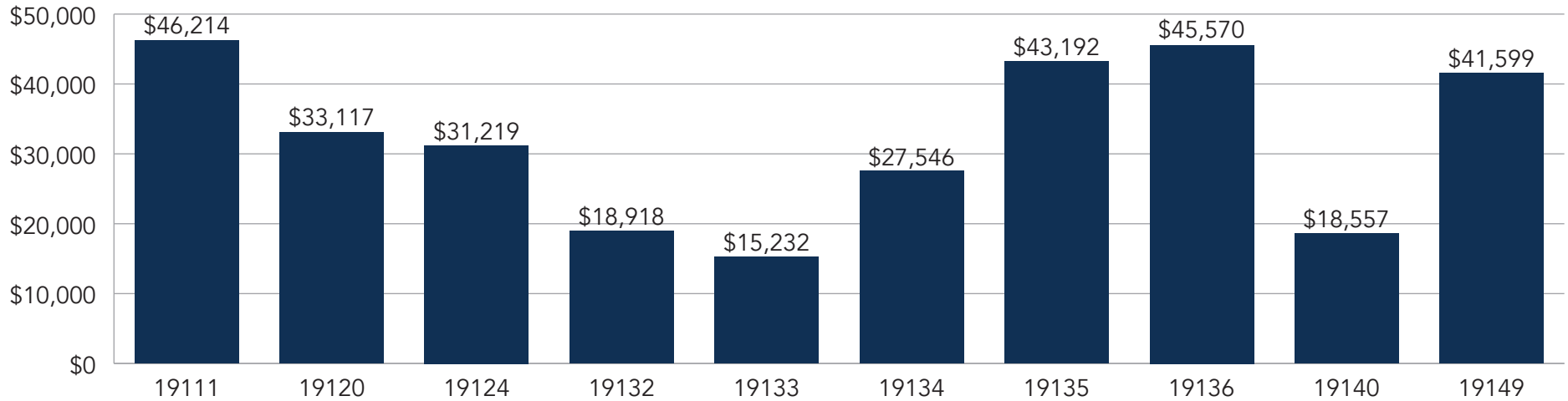
- Behavioral Health/Mental Health
- Obesity, Lack of access to healthy foods

“What are the Barriers to a Quality Life?”

- Low crime/safe neighborhoods
- Quality education for children and youth in school systems
- Clean environments
- Good Jobs and healthy economy
- After school activities

Figure 16 reveals the median household income of St. Christopher’s primary service area by ZIP codes. ZIP code 19133 reports the lowest median household income compared to the remaining ZIP codes in the service area.

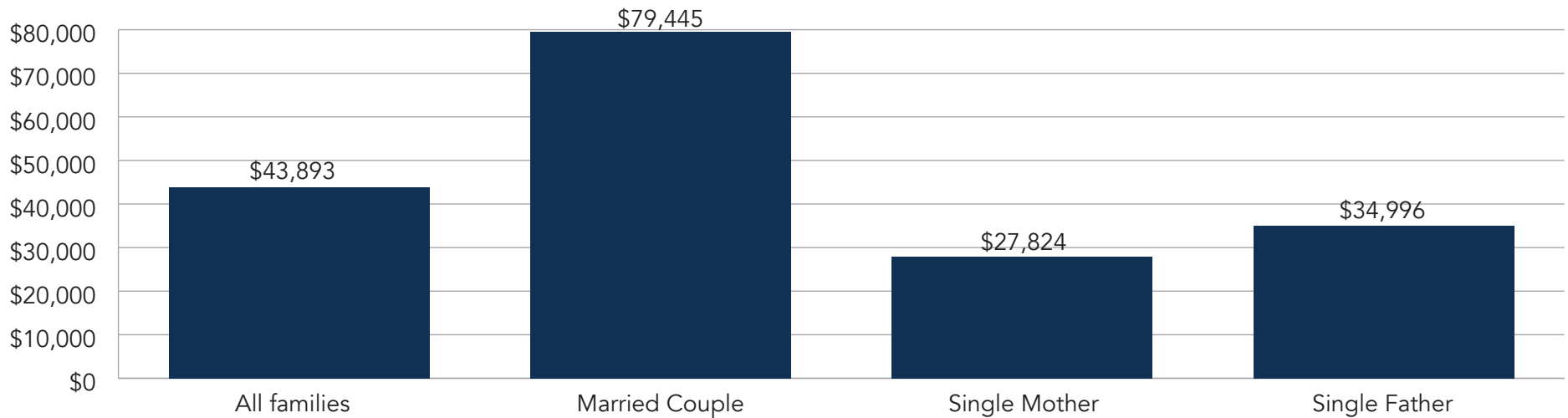
Figure 16: Median Household Income by ZIP Codes



Source: St. Christopher’s for Children

Figure 17 shows median household income by families.

Figure 17: Median household Income for families with children under age 18 by family type in Philadelphia County



Source: [Kids Count Data Center 2019](#)

According to the Children’s Healthcare Report Card report, 128,000 Pennsylvania children were uninsured in 2019. Overall, Pennsylvania has the eighth highest number of uninsured children in the nation. Health care coverage is important for children because it improves access to pediatrician-recommended care and services that support healthy development. When children get the health care they need, they are more likely to succeed in school, graduate from high school and attend college, earn higher wages, and grow up into healthy adults. In Pennsylvania, 4.6% of children do not have insurance (under 19 years of age).⁴

The Children’s Health Insurance Programs (CHIP) began in Pennsylvania in 1992. Pennsylvania is one of only a few states to offer this health insurance option for families who are not eligible for Medicaid but cannot afford private insurance. While most families are enrolled in free CHIP, there has been growth in the full-cost category of enrollments. This demonstrates the real need that is being met to give families this option to provide health care insurance coverage to their children.⁵

Pennsylvania’s uninsured rate increased slightly from 5.4% to 6.1% (from years 2017 – 2019). Pennsylvania was on a positive track with the uninsured rate for children consistently shrinking as more children were connected to health insurance, particularly through Medicaid and the Children’s Health Insurance Program (CHIP).⁶ Unfortunately, the significant progress of insuring children nationwide had started to slip. For the second straight year, more Pennsylvanian kids have lost their health insurance as more kids are headed into a public health emergency without basic health coverage.

Table 18: Underinsured Rates for Children 6-18 years

Underinsured Rates for Children under 6-18 years	2017	2018	2019
PA	5.4	5.6	6.1
U.S.	4.4	4.1	4.5

More than 9,400 Pennsylvania children who were previously covered by Medicaid lost health insurance during 2019.

State of Children’s HealthCare Report

Source: [State of Children’s Health Care Report 2020](#)

Pennsylvania children who are most at-risk of going without health insurance are children younger than six years of age; children from low-income families, and children who identify as American Indian and Alaska Native, Asian, Black or African American, or White who had increasing uninsured rates compared to the prior year. The report also provides the uninsured data by geography, identifying both rural and urban counties where children are most likely not to have health insurance.⁷

⁴ [Children’s Health Care Report Card](#)

⁵ [State of Children’s HealthCare Report](#)

⁶ [Ibid.](#)

⁷ [Ibid.](#)

During COVID-19 The PA CHIP office took immediate actions to get federal approval and implement flexibilities for Pennsylvania kids and families that lasted for the duration of the Public Health Emergency. Those actions included:

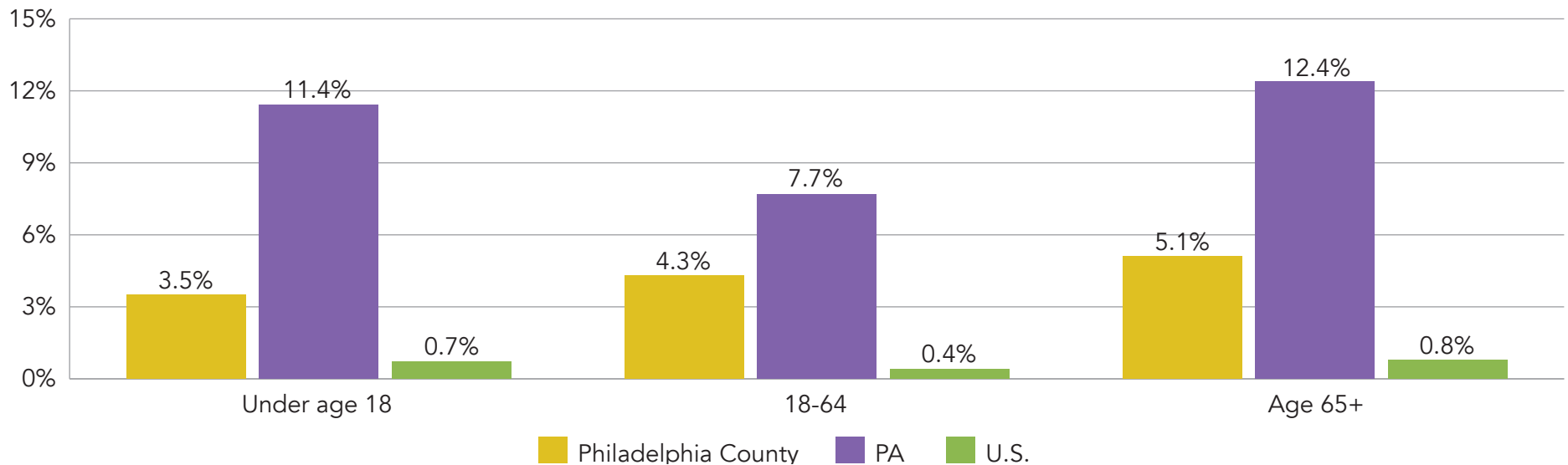
- Accepting self-verification of income;
- Extending renewal deadlines; and
- Delaying premium payments and allow for payment plans when necessary.

Medicaid is the single largest health insurer for Pennsylvania children. Approximately 42% of Pennsylvania’s Medicaid population are children. More than 1.2 million Pennsylvania children with disabilities, children living in low-income families and children living in and aging out of foster care are covered through Medicaid.⁸

Medicaid provides comprehensive benefits for children known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). EPSDT includes prevention services to identify problems early through regular well-child visits, immunizations, tracking physical and mental development, blood lead testing and dental, vision and hearing screenings. EPSDT provides timely appropriate treatment and medical care needed for children.⁹

Figure 19 shows Philadelphia County residents who have no health insurance coverage by age.

Figure 19: Percentage of Population with No Health Insurance Coverage by Age



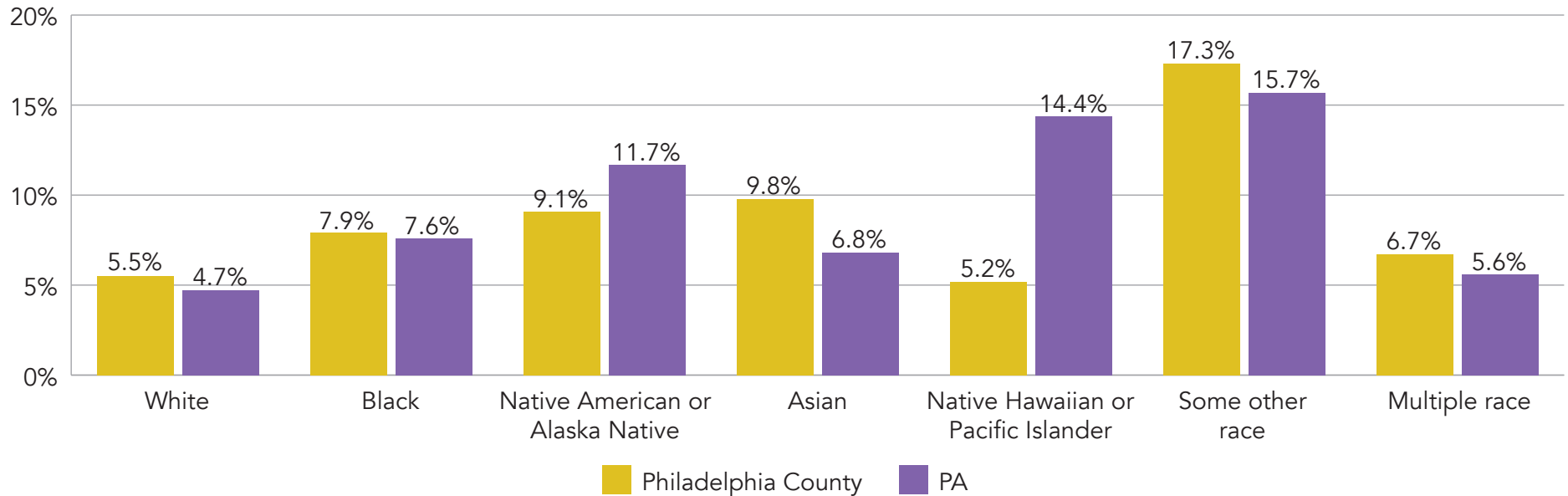
Source: [US Census Bureau, American Community Survey 2015-19](#)

⁸ [State of Children’s Health Care Report](#)

⁹ [Ibid.](#)

Although the percentage of uninsured has increased over the past several years, Figure 20 shows more uninsured Blacks, Native Americans or Alaska Natives, Native Hawaiians or Pacific Islanders, and residents of multiple races as compared to whites. [The Healthy People 2030](#) target is to increase the portion of the population to have health insurance to 92.1 % overall. As of 2018, 89.0% of the population under 65 years have medical insurance.

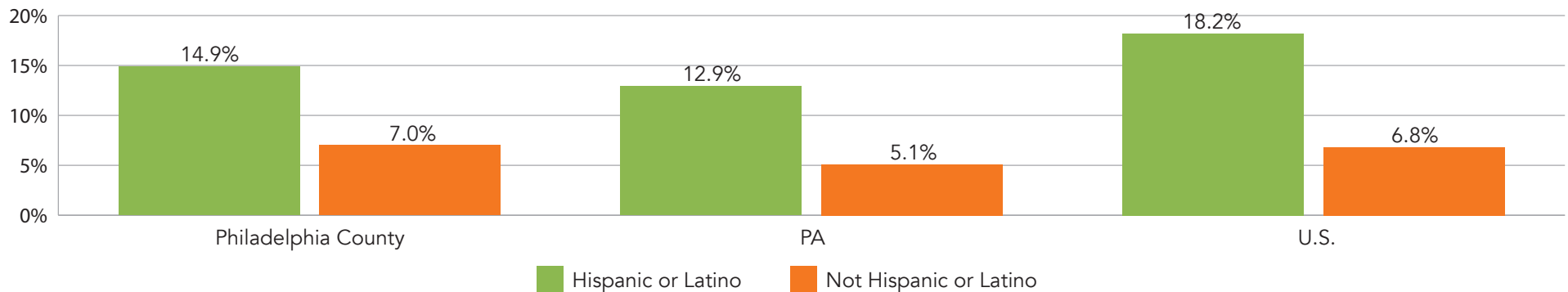
Figure 20: Percentage of Uninsured Population by Race



Source: [US Census Bureau, American Community Survey 2015-19](#)

Figure 21 shows uninsured populations by ethnicity in the county, state, and the nation.

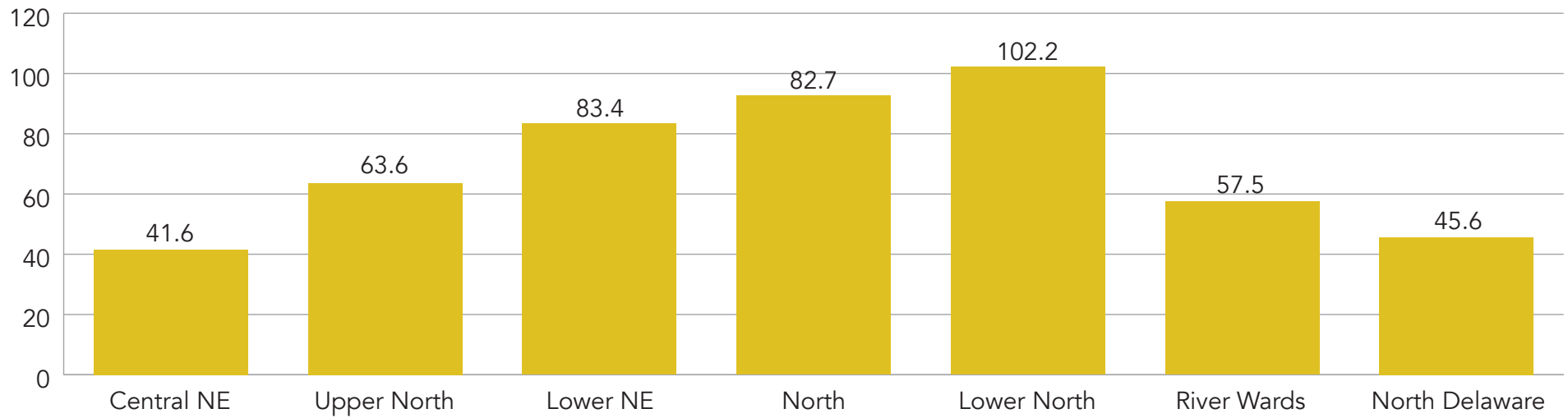
Figure 21: Percentage of Uninsured Population by Ethnicity



Source: [US Census Bureau, American Community Survey 2015-19](#)

Figure 22 shows child mortality rate per 100,000, under 18 years of age by planning district.

Figure 22: Child Mortality per 100,000 population



Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2012-2014](#)

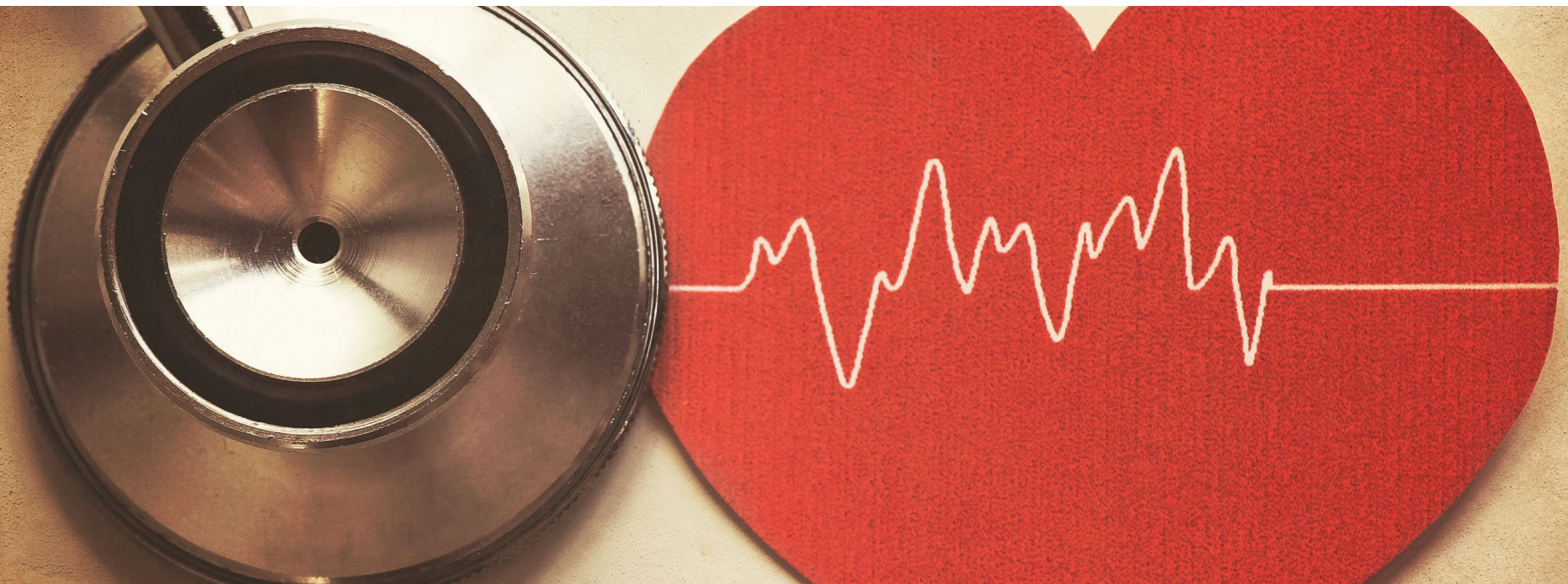
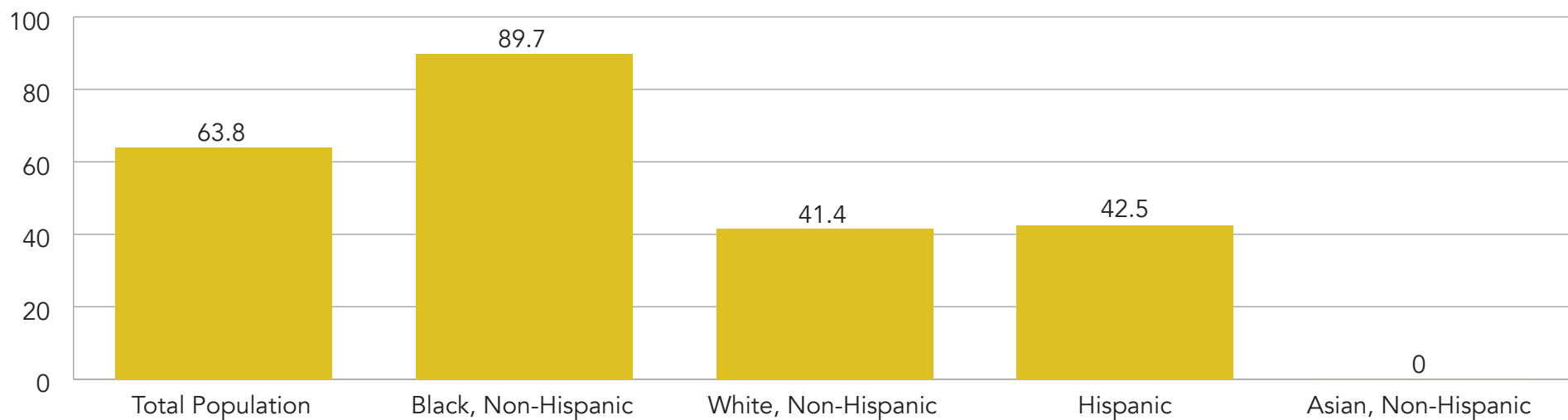




Figure 23 shows child mortality rate under 18 years of age by ethnicity per 100,000 live births by year.

Figure 23: Child Mortality Rate per 100,000 Children; Philadelphia



Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2000-2014](#)



The Philadelphia Department of Public Health launched the Room2Breathe Program to reduce pediatric hospitalizations due to asthma in 2019. St. Christopher's Center for the Urban Child and the Center for Children and Youth with Special Healthcare Needs participate in the Room2Breathe Asthma Home Visiting Program. Community health workers are embedded within St. Christopher's practices to serve patients who meet the eligibility criteria with one inpatient hospitalization over the last year or two emergency room visits due to asthma. St. Christopher's community health workers refer qualified patients to Education Plus Health's Room2Breathe Community Health Workers.

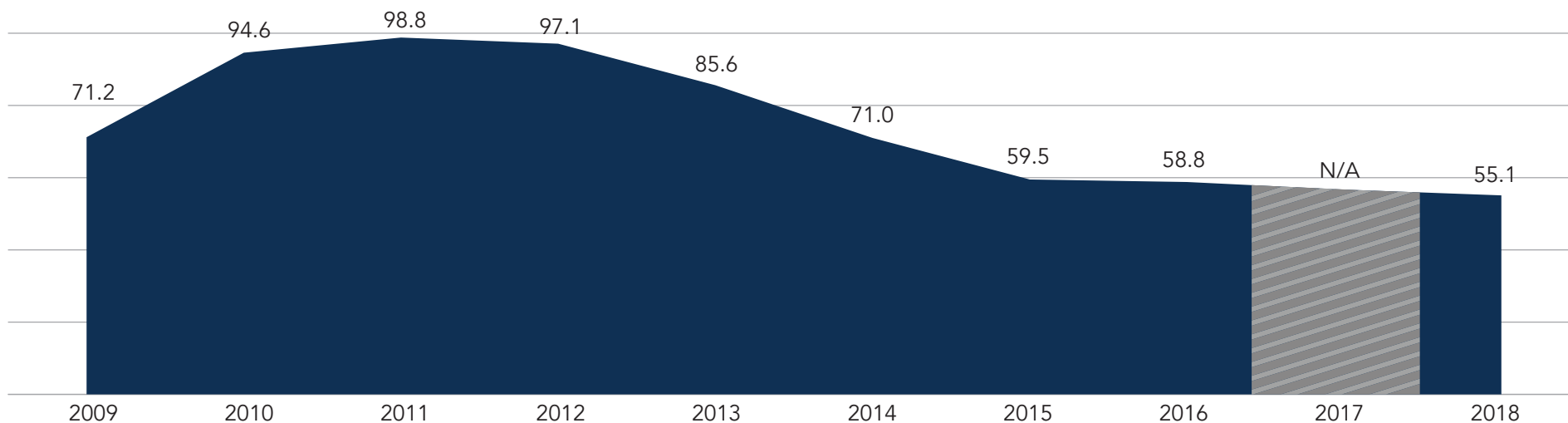
The Room2Breathe Community Health Workers conduct up to seven home visits with eligible families over a 12-month period, helping them manage their asthma in partnership with their doctor and ultimately reducing visits to the hospital because of asthma.

Room2Breathe Community Health Workers:

- Teach families about asthma self-management
- Educate families about reducing asthma triggers in the home
- Provide families with supplies to help control triggers in the home
- Keep practitioners updated by sharing visit summary reports
- Refer families to pest management services as needed
- Connect families to community-based agencies to address the social determinants of health as needed

Hospitalizations for asthma reflect in part the severity of asthma attacks and in part the patterns of medical practice. In 2018, while ED visits for asthma were increasing, the rate of asthma-related hospitalizations among children in Philadelphia declined to a low of 55.1 hospitalizations per 10,000 children.

Figure 24: Asthma Hospitalizations (per 10,000 Children (< age 18))

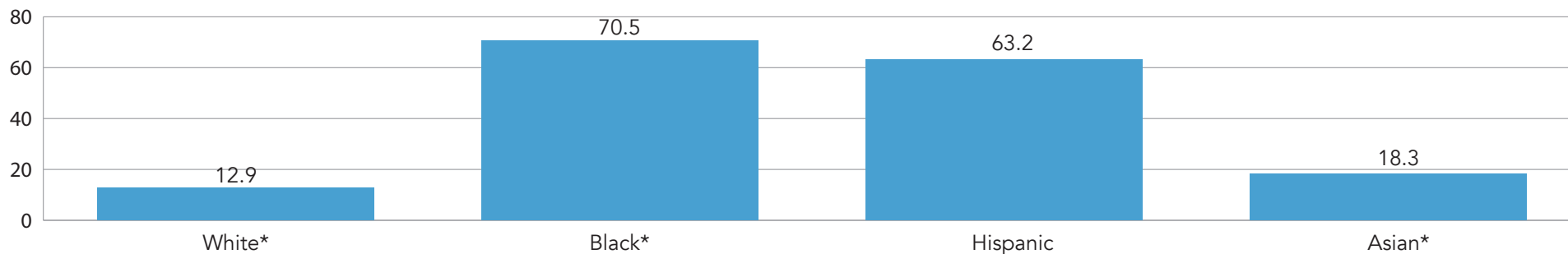


Note: No data provided in 2017.

Source: [Growing Up Philly](#)

In 2018, non-Hispanic black and Hispanic children had the highest rates of asthma-related hospitalizations with rates 5 to 6 times higher than non-white Hispanic white children. Racial/ethnic differences in asthma frequency, illness, and death are highly connected with poverty, housing quality, and indoor asthma triggers.

Figure 25: Asthma Hospitalizations (per 10,000 Children by Race/Ethnicity)

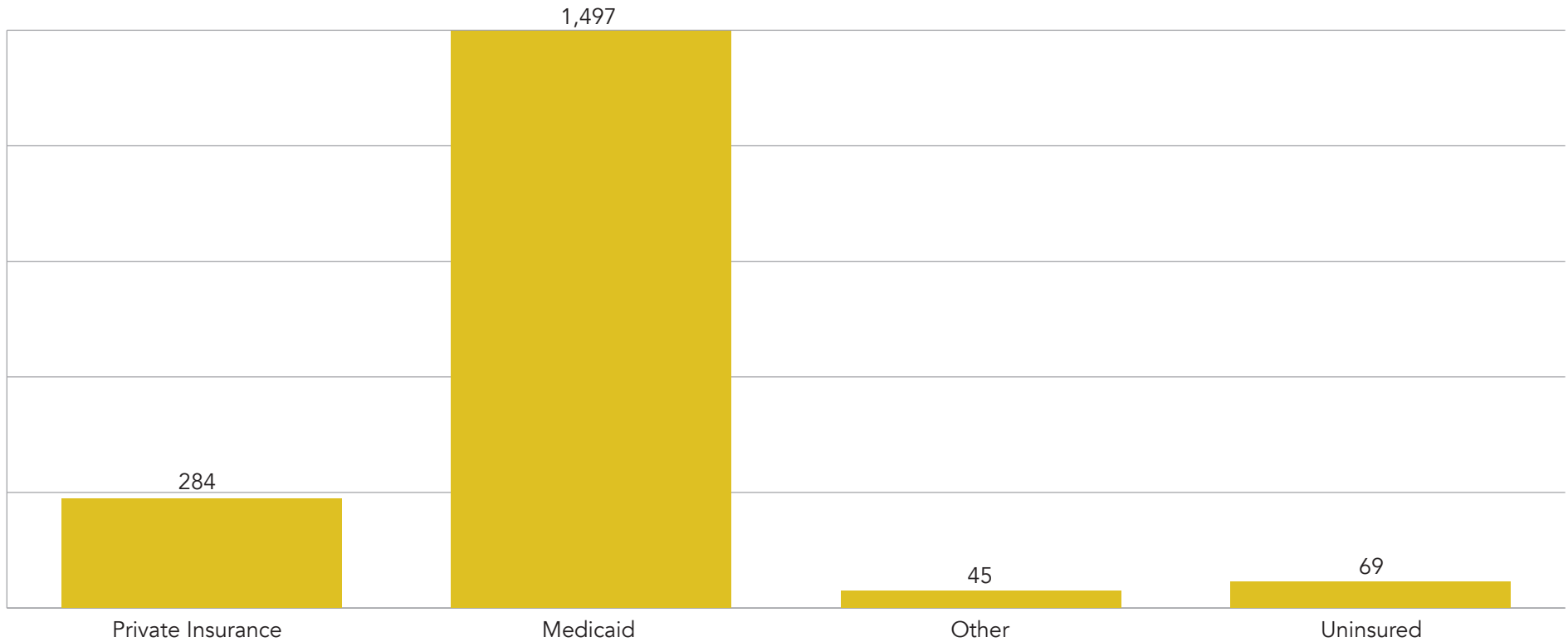


Note: *Non-Hispanic

Source: [Growing Up Philly](#)

Among the 1,865 asthma hospitalizations for children in 2018, 1,497 of the cases were covered under Medicaid public health insurance.

Figure 26: Asthma Hospitalizations Among Children by Health Insurance (2018)



Source: [Growing Up Philly](#)

Asthma accounted for 20 child deaths that occurred from 2011-2017 and were reviewed by the Philadelphia Child Death Review (CDR) teams. Asthma is a medically treatable condition that has variable levels of severity in the people it affects. Except for the worse sufferers, adherence to a properly prescribed asthma medication regimen would not only help prevent most asthmatics from dying, but also prevent many if not most hospital admissions.

Unfortunately, the CDR teams were unable to uncover the full circumstances surrounding the asthma deaths reviewed what was learned is that over the past seven years, asthma deaths occurred equally among males and females, the most common age group was 10-14 years (one reason being that this is the age kids start to have more autonomy with managing their own medicines), and every death occurred in a racial minority (Black, non-Hispanic). Two of the deaths (i.e., 10%) were ultimately determined by the CDR team to be due to parental negligence.

Figure 27: Asthma Deaths by Age, Gender, and Race/Ethnicity, 2011-2017 (n=20)

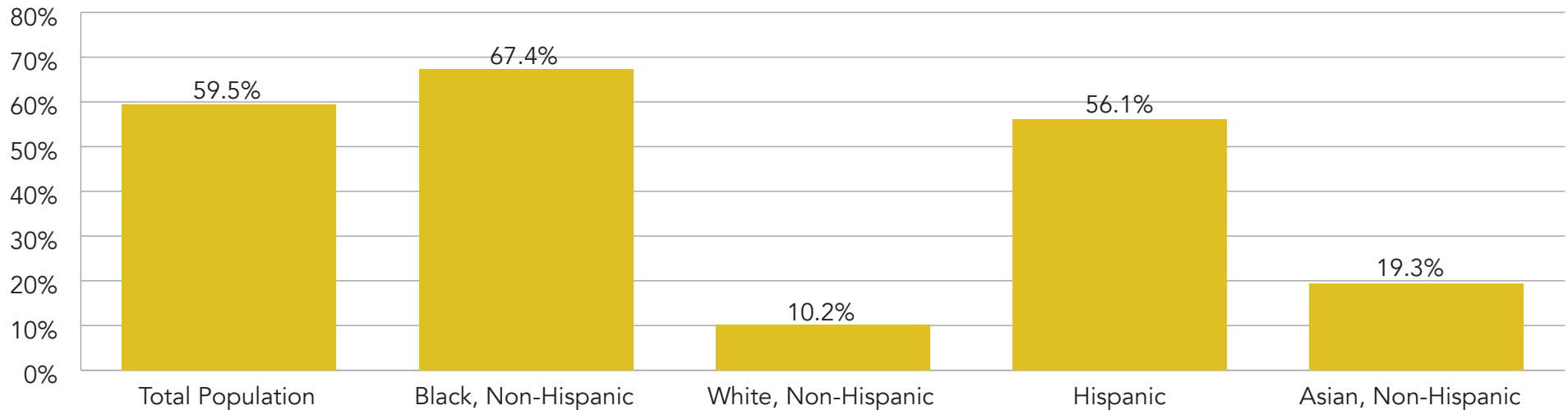
Age					Gender		Race/Ethnicity			
1-4	5-9	10-14	15-19	20-21	Male	Female	White, NH	Black, NH	Asian, NH	Hispanic
3	3	8	1	5	10	10	0	20	0	0
15%	15%	40%	5%	25%	50%	50%	0%	100%	0%	0%

Note: NH= non-Hispanic

Source: [Philadelphia Child Death Review 2011-2017](#)

Figure 28 shows hospitalization of children with asthma per 10,000 population under 18 years by ethnicity.

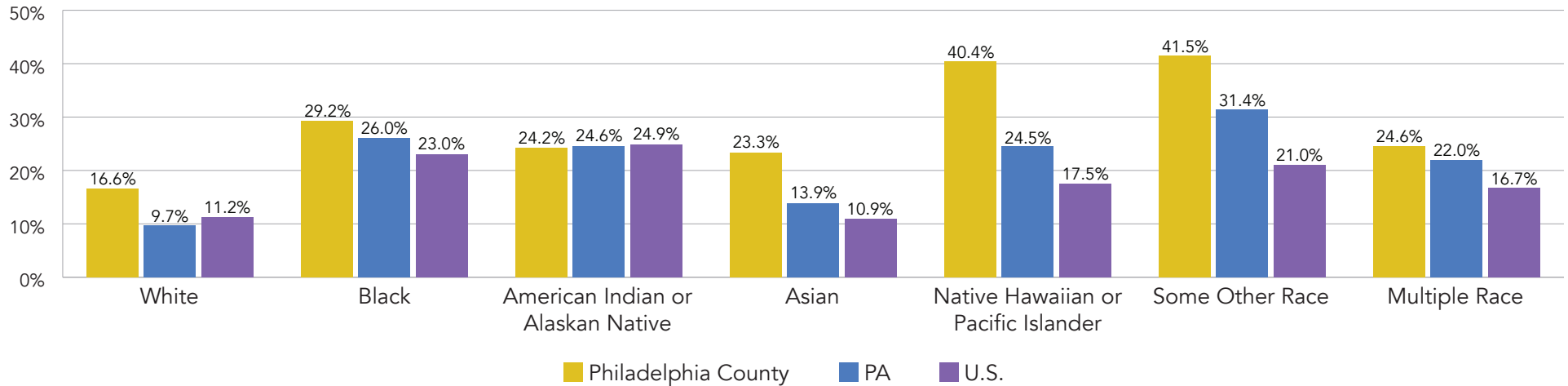
Figure 28: Children Asthma Hospitalization Rate per 10,000 Population; Philadelphia



Source: [Community Health Explorer: Pennsylvania Health Care Cost Containment Council, 2015](#)

Figure 29 reported the percentage of the population below 100% of the [federal poverty line \(FPL\)](#) by race.¹⁰ [The Healthy People 2030](#) target is to reduce the proportion of people living in poverty to 8.0 percent. In 2018, 11.8% of people were living below the poverty threshold.

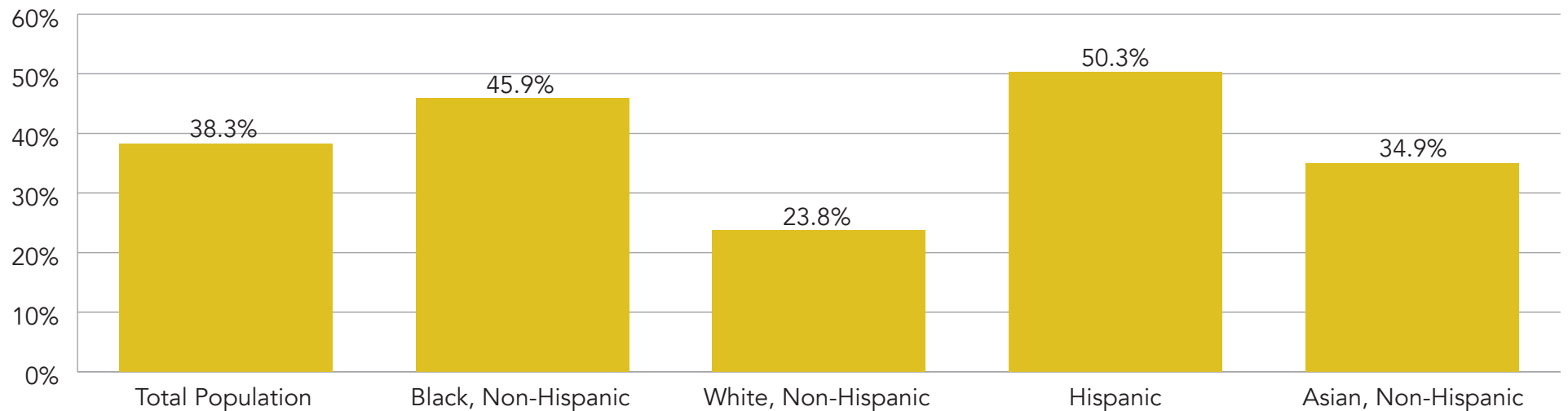
Figure 29: Population Below 100% FPL by Race



Source: [U.S. Census Bureau, American Community Survey 2015-2019](#)

The figure below reveals children under the ages of 18 years old living in poverty by ethnicity.

Figure 30: Children Living in Poverty, < 18 Years of Age; Philadelphia

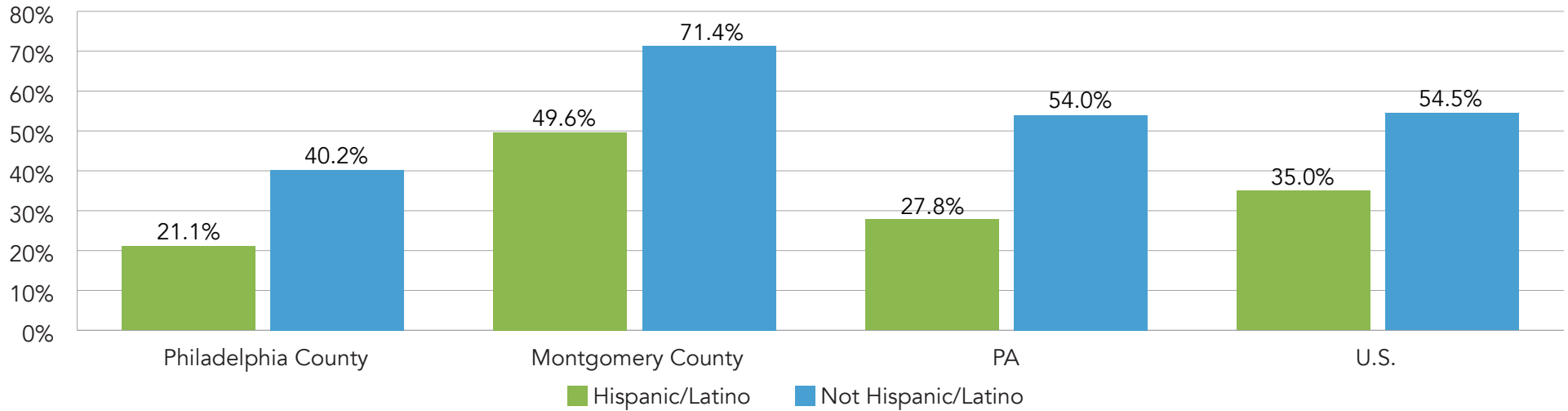


Source: [Community Health Explorer: US Census Bureau, American Community Survey, 1-year estimates, 2015](#)

¹⁰ 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 4 living in one of the 48 contiguous states or the District of Columbia, the poverty guideline for 2021 is \$26,500.

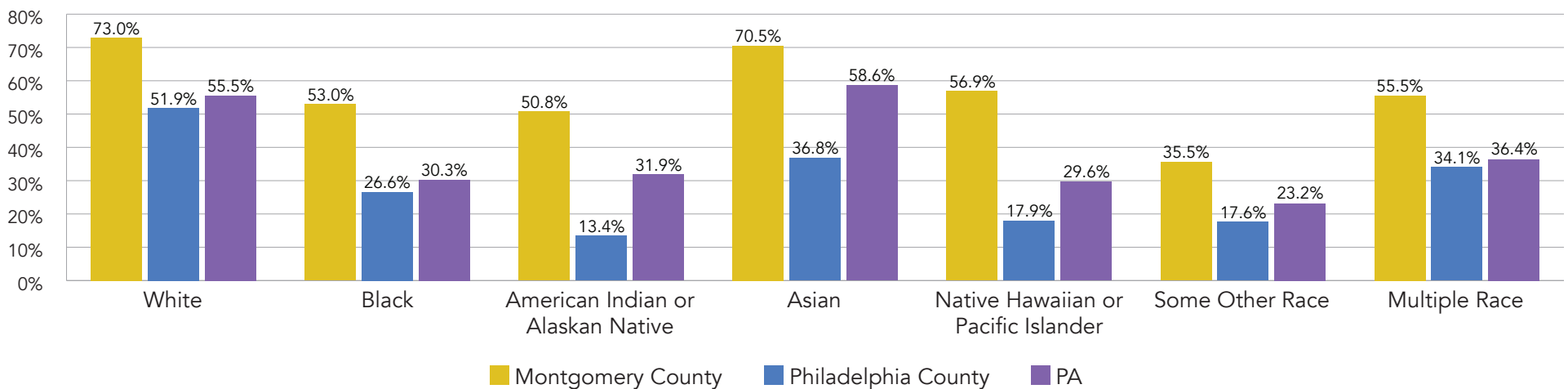
Economic status and income are strongly associated with morbidity and mortality. Income directly influences health and longevity and may perpetuate or exacerbate health disparities. It is noted that income inequality has grown substantially over recent decades.

Figure 31: Families Earning More Than \$75,000 by Ethnicity



Source: [U.S. Census Bureau, American Community Survey 2015-2019](#)

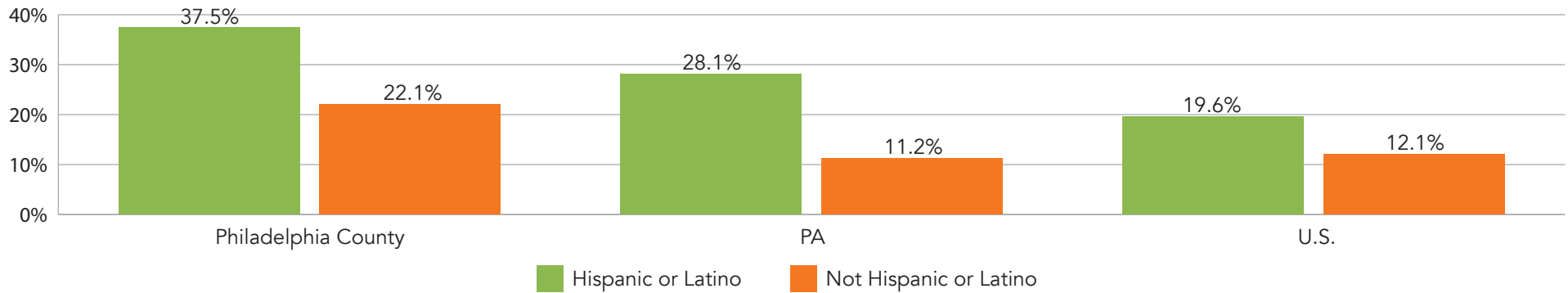
Figure 32: Families Earning More Than \$75,000 by Race Alone



Source: [U.S. Census Bureau, American Community Survey 2015-2019](#)

Figure 33 reports the percentage of the population below 100% of the federal poverty line by ethnicity.¹¹

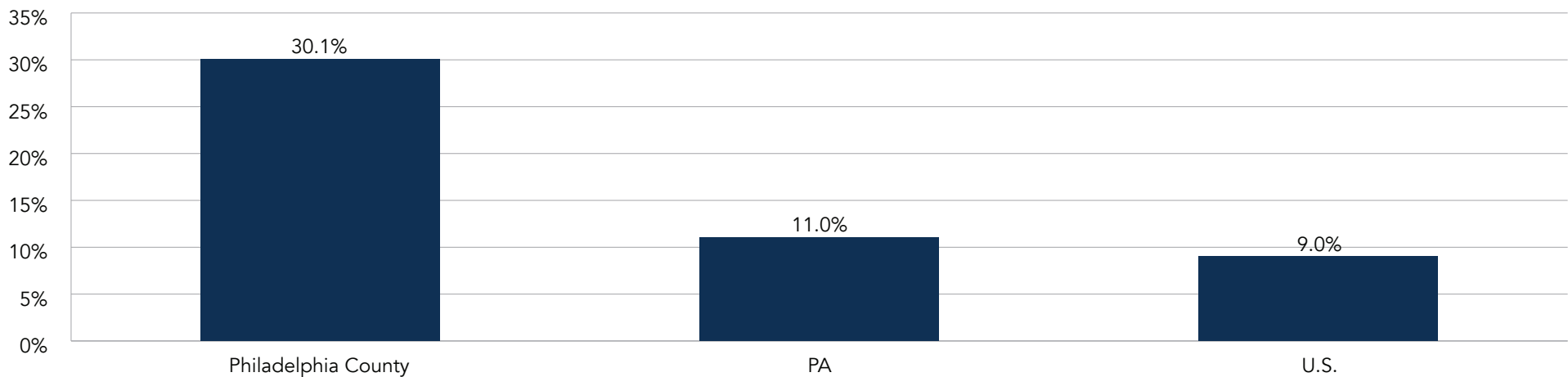
Figure 33: Population Below 100% FPL by Ethnicity



Source: [U.S. Census Bureau, American Community Survey 2015-2019](#)

Figure 34 shows a higher rate of Philadelphia County residents not having a motor vehicle for the years 2015-2019. Lack of reliable transportation can hinder one's ability to get to and from medical appointments, meetings, work, or things needed for daily living.

Figure 34: Households with No Motor Vehicle

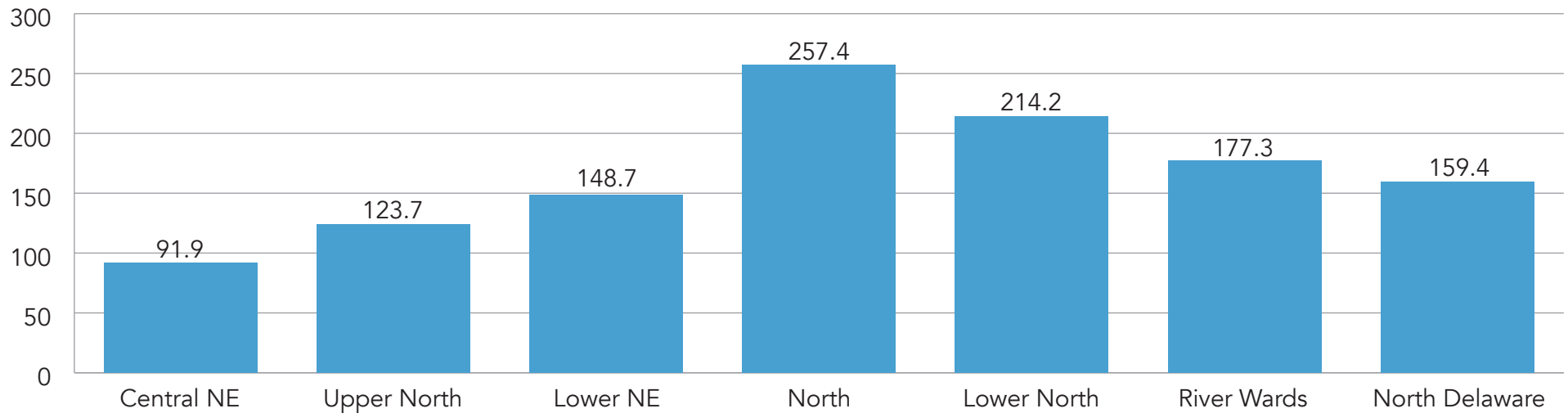


Source: US Census Bureau, American Community Survey. 2015-19

¹¹ Federal poverty levels (FPL) are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, Medicaid,

Figure 35 reported pedestrian and bicycle crashes Involving children under 18 Years of Age.

Figure 35: Crashes Involving Children per 100,000 Children, < 18 Years of Age; 2016

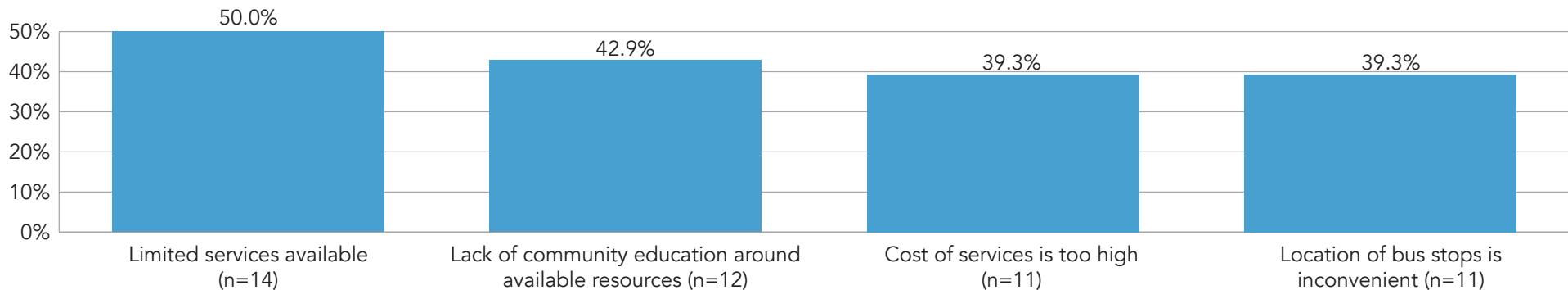


Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Pennsylvania Department of Transportation, 2016](#)

When key informants were asked what contributes to the transportation issues in their community the top three responses include: limited services 50.0% (n=14), lack of community education around available resources 42.9% (n = 12), and cost of services is too high 39.3% (n=11) alongside the location of bus stops is inconvenient 39.3% (n=11).

Figure 36: Contributions to Transportation Issues in the Community (Top Four Responses)



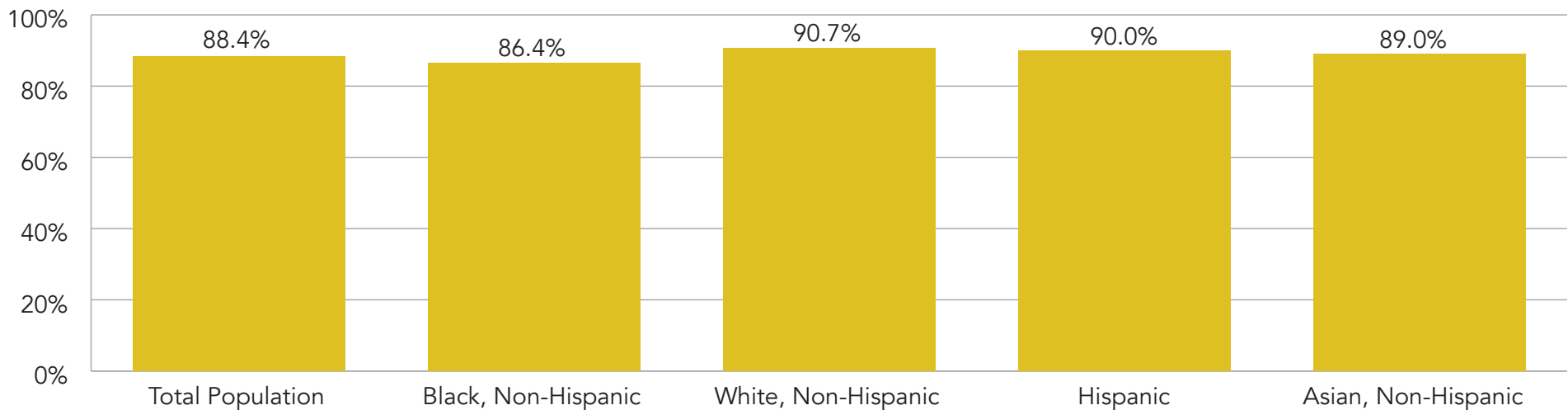
Poverty leaves a lasting impact on the dental health of vulnerable populations, specifically children. The most common chronic disease among children is tooth decay. About 37% of poor children 2 to 9 years old have one or more untreated decayed baby teeth, compared with 17.3% of higher-income children, according to the report for the surgeon general. Low-income children are less likely to receive regular dental care, and the cavities are more likely to go unfilled. Oral infection, especially periodontitis (gum disease), may affect the course and progression of a number of diseases, such as cardiovascular disease, bacterial pneumonia, diabetes mellitus and low birth weight.¹²

Income level is a significant factor in determining a child’s risk for developing tooth decay. Research indicates the rate of untreated dental disease increases as household income decreases. For example, children living below the federal poverty level were over two times more likely to have managing a complex oral health system, lack of transportation, difficulty arranging childcare, or time off work.¹³

Since less than half of kids on Medicaid receive preventive dental services from a dental provider, another strategy to improve children’s access to is to integrate dental care by applying fluoride varnish to strengthen tooth enamel during a well child visit. In Pennsylvania, only 6% of kids on Medicaid receive oral health services from a non-dentist provider, like a pediatrician.¹⁴

Figure 37 reveals children between ages 3-17 years who had dental visits by ethnicity in 2014-2015.

Figure 37: Children with Dental Visit in Past Year; Philadelphia



Source: [Community Health Explorer: Public Health Management Corporation \(PHMC\) Household Health Survey 2014-2015](#)

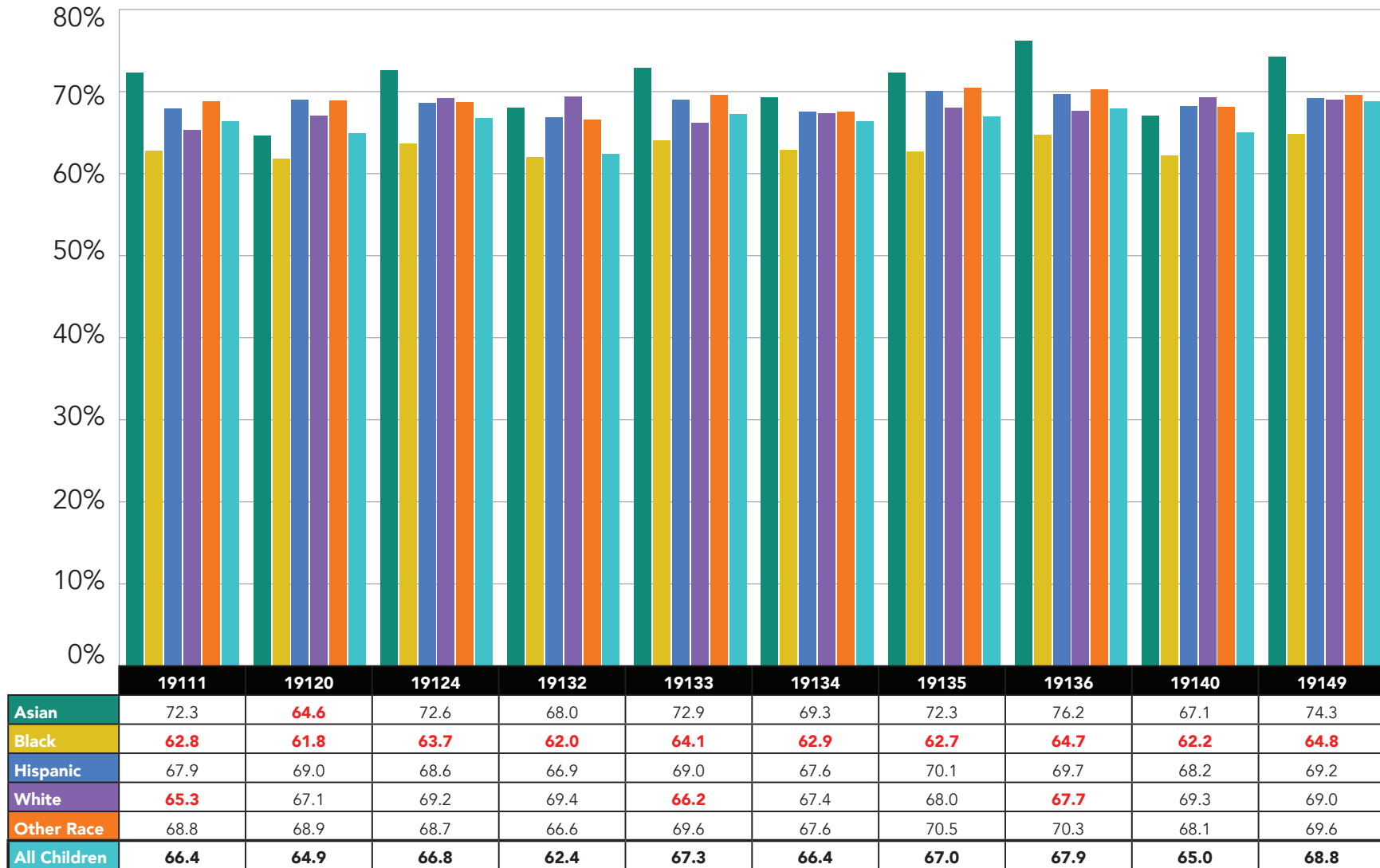
¹² [The Philadelphia Tribute](#)

¹³ [Pennsylvania Partnership for Children](#)

¹⁴ [Ibid.](#)

The PA Health Equity Analysis Tool (HEAT) provides a geographic perspective at the granular level to areas that have opportunities to improve equity.¹⁵ The below figure depicts ZIP codes within St. Christopher’s Hospital for Children’s service area related to children who obtain primary care visits.

Figure 38 Percentage of Children with Primary Care Physician Visits by ZIP Code Summary



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

Source: [Pennsylvania Health Equity](#); [Pennsylvania Department of Human Services](#)

¹⁵ 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.

B) BEHAVIORAL HEALTH

Access to behavioral health services for children is a crisis nationwide. Prior to COVID-19, the Centers for Disease Control and Prevention stated that 1 in 5 children had a mental health diagnosis, yet only 20% of those children received care from a mental health provider.

Similarly, St. Christopher's Hospital for Children's community utilizes the highest percentage of behavioral health services, yet families still experience disparities in outcomes, care and access to services. The roots of many mental health, substance use, and behavioral problems that contribute to morbidity and premature death develop during early childhood and adolescent years. According to the CDC, from March 2020 to October 2020, mental health-related emergency department visits increased 24% for children ages 5 to 11 and 31% for those ages 12 to 17 compared with 2019 emergency department visits.¹⁶ In November 2021, the Children's Hospital Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry declared a national mental health emergency for children and teens.

As such, the Children's Hospital Association has "[Sounded the Alarm for Children's Mental Health](#)" by advocating for the urgency to promote the well-being of the nations' children and engaging children's hospitals and the government to invest in infrastructure for mental health and support the pediatric mental health workforce.

Approximately 13%-20% of US children are seen for a behavioral health disorder each year, and suicide is now the second leading cause of death for ages 10 to 24.¹⁷ But less than 1 in 8 children with identified behavioral health challenges receive treatment.¹⁸ Research has demonstrated that integrating behavioral health care into primary medical care for children and adolescents leads to greater and more consistent access to behavioral health treatment and significant improvements in behavioral health.¹⁹

St. Christopher's is in the nascent stages of building a more effective, accessible, and inclusive care model where behavioral health is central, by integrating the screening, assessment, and treatment of behavioral health disorders within all aspects of physical health care. Access to behavioral health staff within this integrated model leads to a seamless and supportive transition from physician to behavioral health providers. Growth of this model involves capitalizing on existing on-site services to expand access to inpatient services, while continuing to enhance the capacity of the physical and mental health workforce to support pediatric behavioral health. This not only puts behavioral health at the center of St. Christopher's care, but also better prepares practitioners trained in the St. Christopher's model to address the full range of concerns of the community.

¹⁶ Leeb, R. T., et al., [Morbidity and Mortality Weekly Report](#), Vol. 69, No. 45, 2020

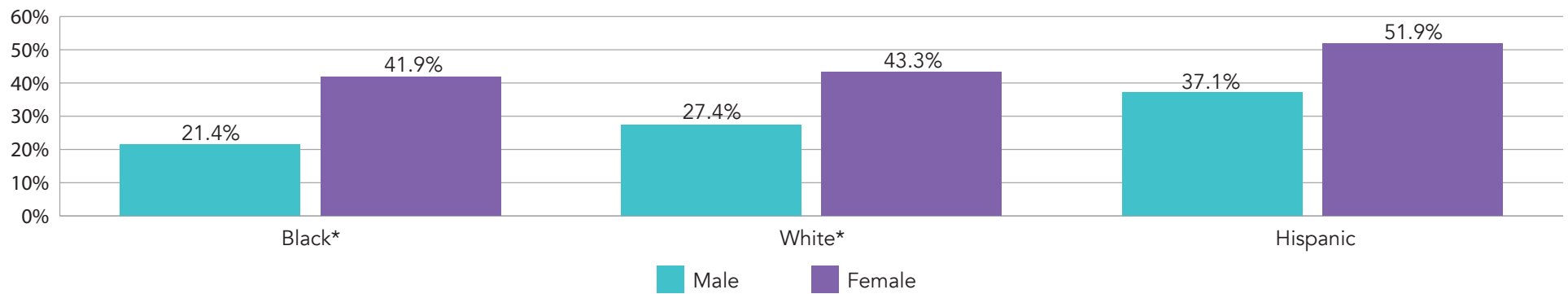
¹⁷ McMillian et al., 2020

¹⁸ Weitzman et al., 2015

¹⁹ Asarnow et al., 2015

Depressive symptoms were highest among Hispanic male teens at 37.1% and Hispanic female teens at 51.9%

Figure 39: Depressive Symptoms among Teens by Race/Ethnicity/Sex

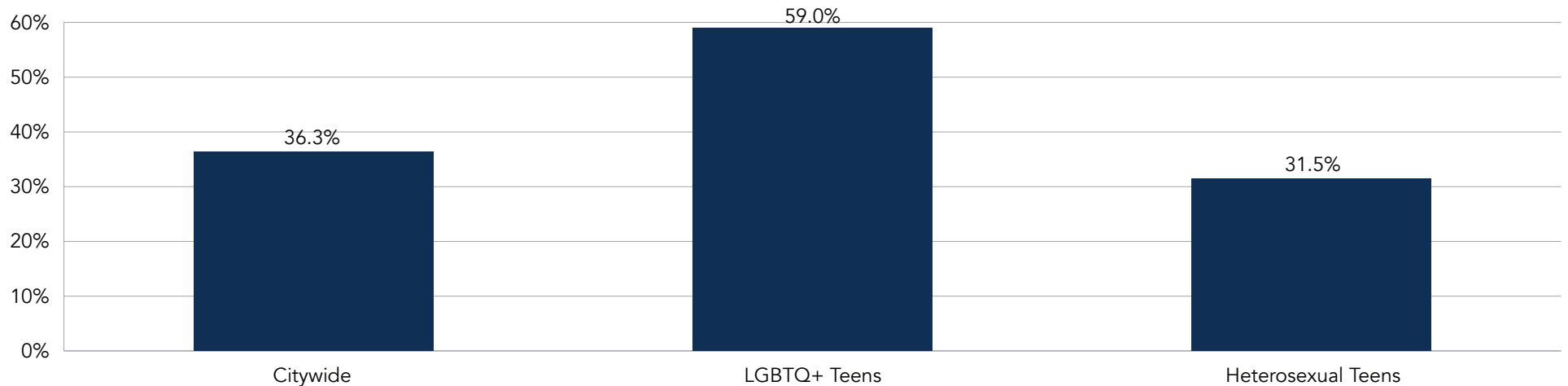


Note: *Non-Hispanic

Source: [Growing Up Philly](#)

In 2017-2019 depressive symptoms were more common among youth that identified as lesbian, bisexual, gay, or transgender, or LGBTQ+ (59%) compared to heterosexual youth (36%). This is similar to the national percentage of depressive symptoms among LGBTQ+ teens (63%). High percentages of depressive symptoms among LGBTQ+ teens are likely due to societal stigma and discrimination that members of the LGBTQ+ community face.

Figure 40: Depressive symptoms among teens by sexual orientation



Source: [Growing Up Philly](#)

WHAT DID WE LEARN FROM THE COMMUNITY?

Improving access and adequacy of behavioral health services and programs has become a high priority for St. Christopher's Hospital's communities in the past several years as more than 43% of community survey respondents noted behavioral health as having the greatest impact on overall community health. The COVID-19 pandemic, social distancing policies, mandatory lockdowns, isolation, and the fear of getting sick made the need for access to behavioral health services even more evident.

Figure 41 delineated the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.

Figure 41: Listening to the Community

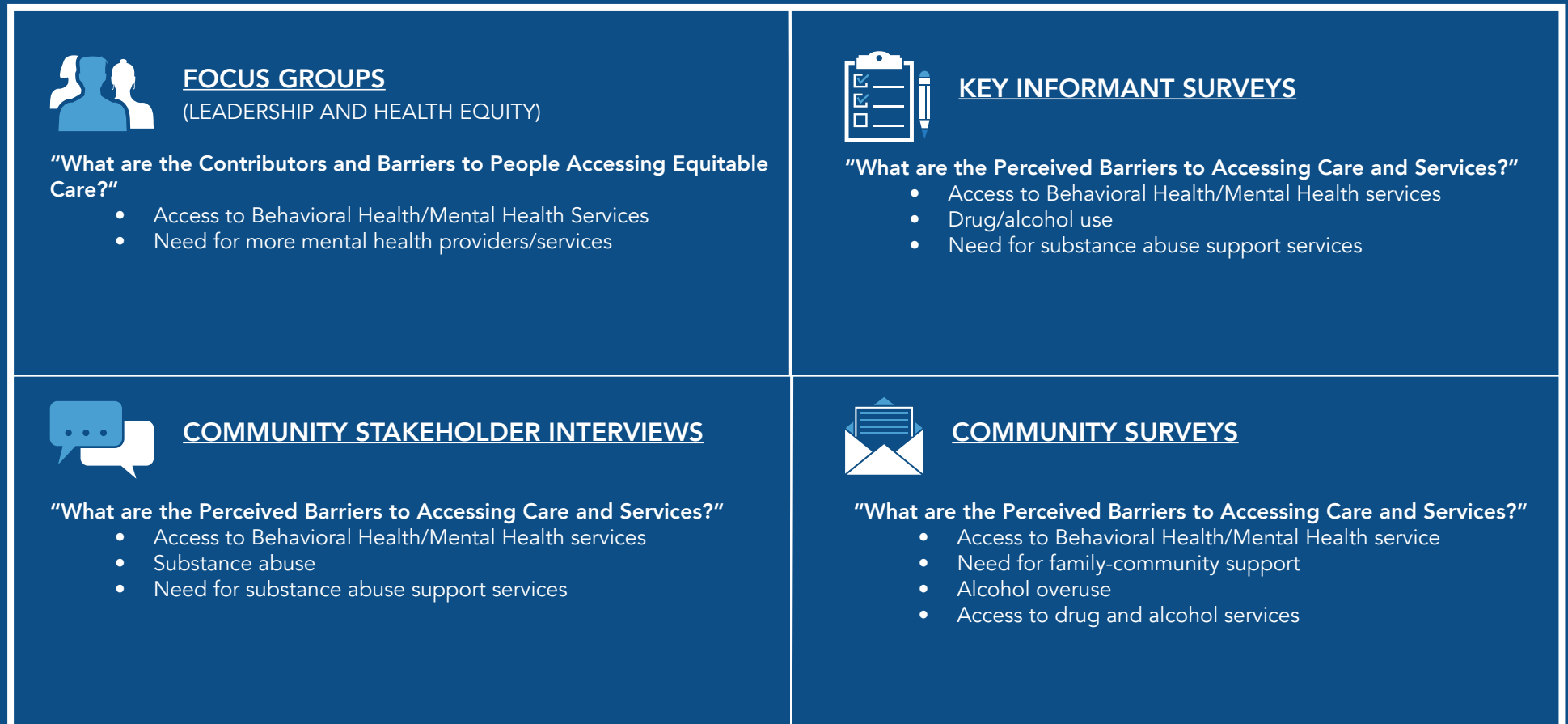


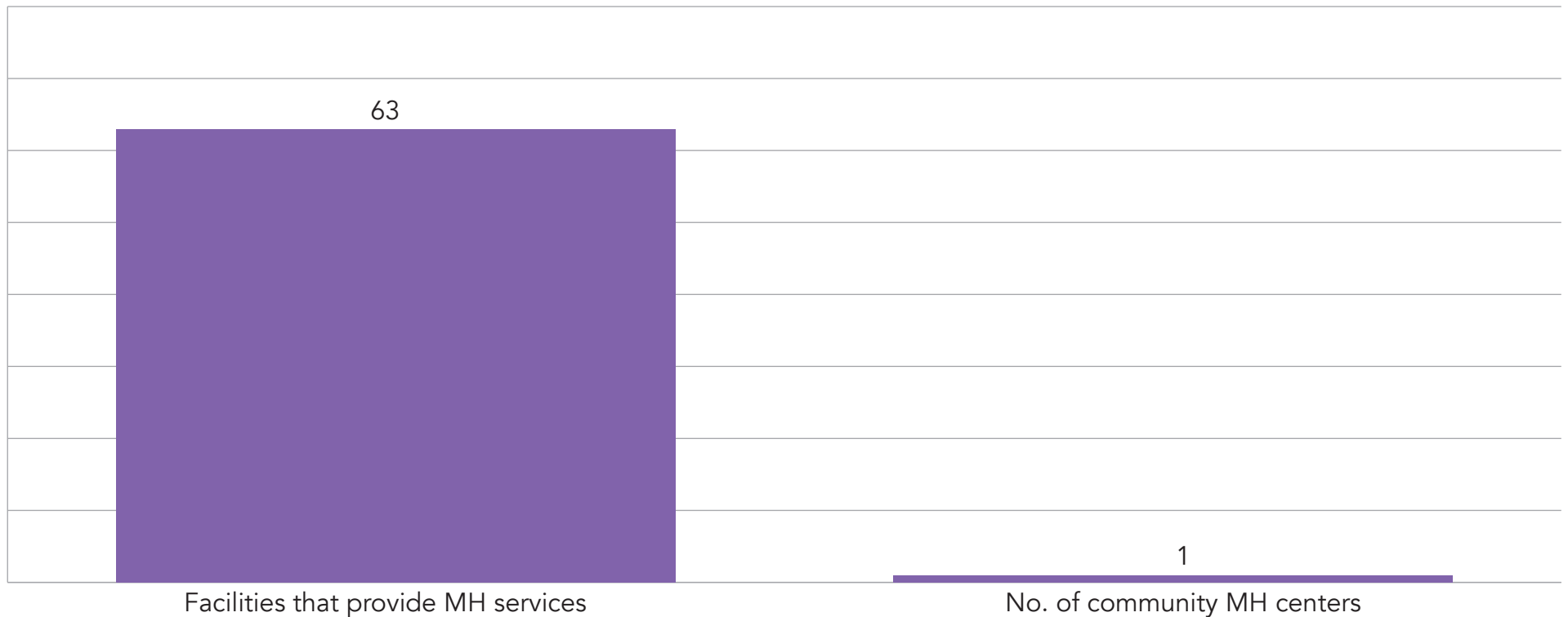


Figure 42 illustrates the number of facilities that provide mental health services and the number of community mental health centers in Philadelphia County.

Community mental health centers (CMHC) fill the need for mental health treatment and services throughout the country. CMHCs are community-based organizations providing mental health services, sometimes as an alternative to the care that mental hospitals provide. CMHC represents a basic change in social acceptance and attitudes related to mental health. CMHCs were designed to move mental health care from the traditional hospital or state “custodial” care to the community where holistic programs, family-centered care, and therapeutic services enhance recovery and restoration.

Community mental health facilities are specific to mental health illnesses. Children, adults, and individuals who are chronically mentally ill or have been discharged from an inpatient mental health facility can be treated at a community mental health center.

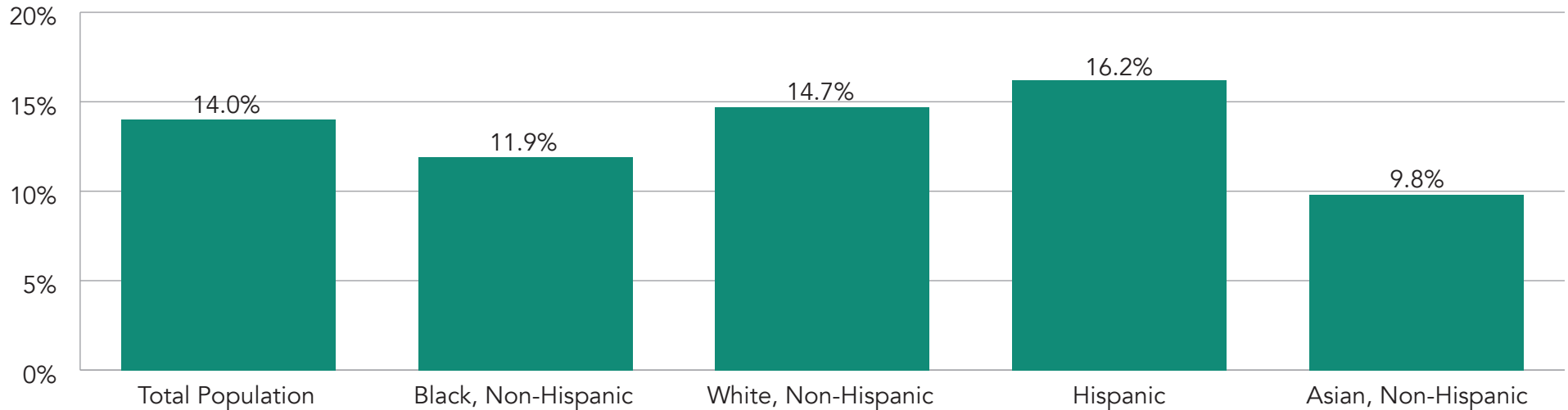
Figure 42: Mental Health Centers and Providers (Philadelphia County)



Source: [The Agency for Healthcare Research and Quality \(AHRQ\) 2018](#)

Figure 43 reveals data related to teens considering suicide between grades 9th – 12th by ethnicity

Figure 43: Teens Considering Suicide; Philadelphia



Source: [Community Health Explorer: Youth Risk Behavior Survey \(YRBS\), 2015](#)

Ninety-six suicides (less than 4% of all child deaths) were reviewed by the CDR teams for years of death 2011-2017. As shown in Figure 44, 66% of the victims were male, 88% were 15-21 years of age, and 42% were Black, Non-Hispanic. Compared to all intentional injury deaths, suicide victims included a higher percentage of 10–14-year-olds, accounting for 13% of all suicide deaths. White, Non-Hispanic children comprised 27% of all suicide fatalities, and half of the suicide victims were 20-21 years of age.

Figure 44: Suicide Deaths by Age, Gender, and Race/Ethnicity, 2011-2017 (n=96)

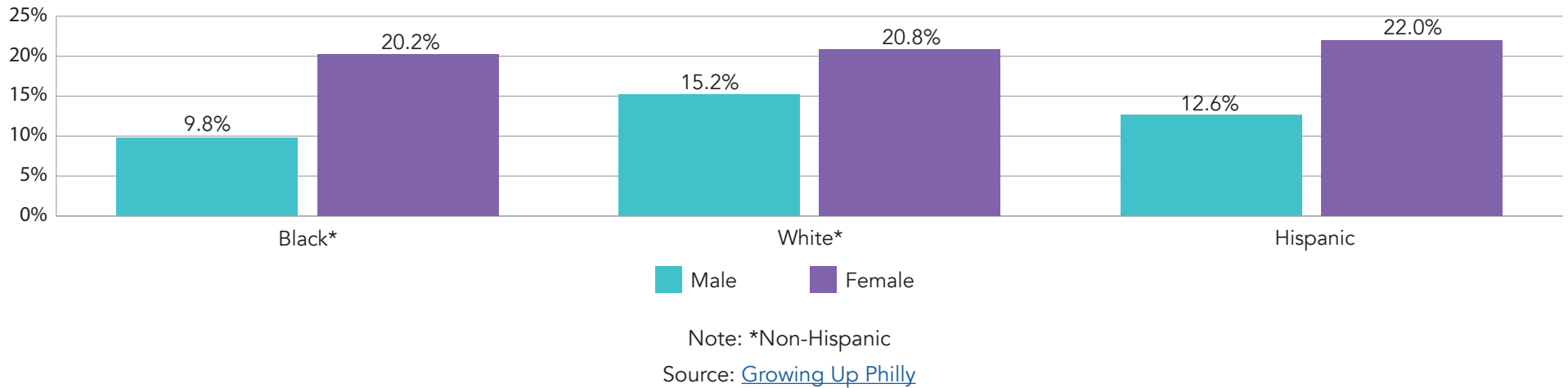
Age			Gender		Race/Ethnicity			
10-14	15-19	20-21	Male	Female	White, NH	Black, NH	Asian, NH	Hispanic
12	36	48	63	33	26	40	11	19
13%	38%	50%	66%	34%	27%	42%	11%	20%

Note: NH = non-Hispanic

Source: [Philadelphia Child Death Review 2011-2017](#)

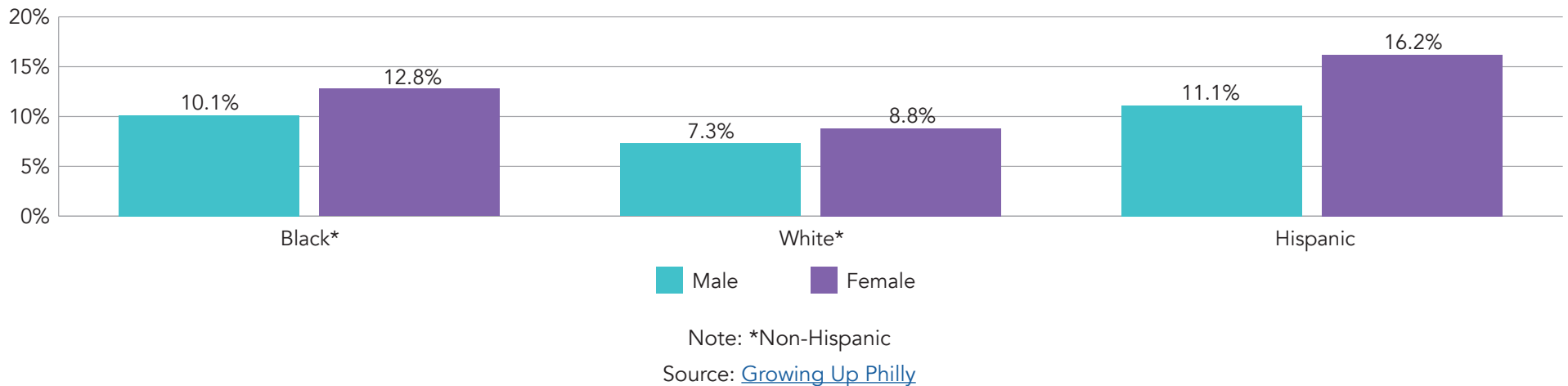
Suicidal ideation among teens was most common among female youth. Suicidal ideation was slightly higher among Hispanic females and non-Hispanic white males.

Figure 45: Suicidal ideation by sex and race/ethnicity



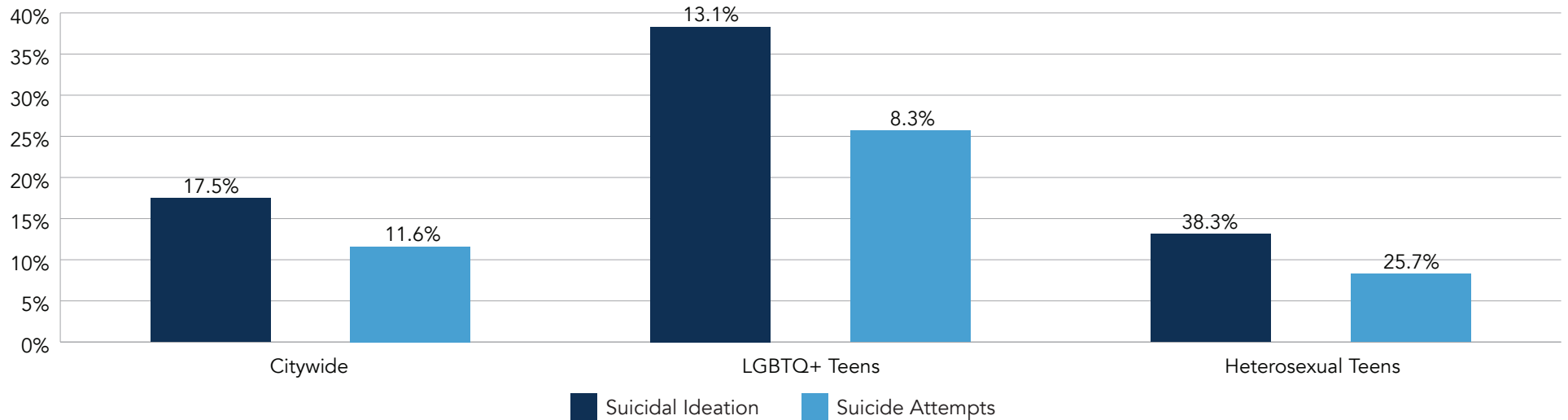
Reports of suicidal ideation and attempts were higher among females than males. Reported suicide ideation was common among all racial/ethnic groups, with female Hispanic youths having a higher proportion of reported suicide attempts at 16.2%.

Figure 46: Suicide attempts by sex and race/ethnicity



Both suicidal ideation and suicide attempts were also higher among LGBTQ+ youth than heterosexual youth and the citywide youth population.

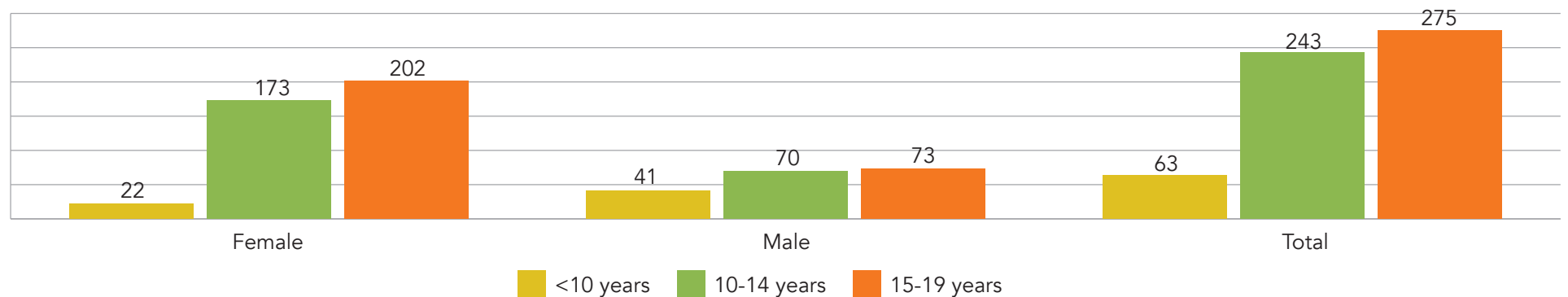
Figure 47: Suicidal ideation and attempts by sexual orientation



Suicide-related emergency department visits were highest among females aged 15-19. This follows a national trend that a higher percentage of female teens are more likely than male teens to attempt suicide (%) and experience suicide-related emergency department visits (3%).

Suicide-related emergency department visits for females are likely higher due to use of less lethal means; males are more likely to use firearms for suicide whereas females are more likely to use other less lethal means. As a result, females are more likely to survive a suicide attempt and require medical attention or be hospitalized for their attempts.

Figure 48: Suicide-related Emergency Department Visits by Age Group and Sex



Source: [Growing Up Philly](#)

Fetal alcohol syndrome disorder (FASD) is a condition in a child that results from alcohol exposure during the mother's pregnancy. People with FAS have central nervous system (CNS) problems, minor facial features, and growth problems. People with FAS can have problems with learning, memory, attention span, communication, vision, or hearing. FAS is 100% preventable if a pregnant woman does not drink any alcohol. While there is no cure for FAS once present, early identification and intervention can improve the prognosis. According to recent studies, the prevalence of FASD in the United States is estimated to be 2.4 – 4.8 in 100. Based upon the number of births in PA in 2014, this rate would mean that between 3,983 and 6,830 children were born with an FASD in PA. Calculated on a daily basis, every day 11-19 Pennsylvania children begin their lives with an FASD.²⁰

CDC studies have identified 0.2 to 1.5 infants with FAS for every 1,000 live births in certain areas of the United States.¹ The most recent CDC study analyzed medical and other records and found FAS in 0.3 out of 1,000 children from 7 to 9 years of age. Studies using in-person assessment of school-aged children in several U.S. communities report higher estimates of FAS: 6 to 9 out of 1,000 children.

In a 2022 Morbidity and Mortality Weekly Report (MMWR), CDC researchers found that nearly 14% (or 1 in 7) pregnant people reported current drinking and about 5% (or 1 in 20) reported binge drinking in the past 30 days. Pregnant people 25–34 years were less likely to report current drinking than those aged 35–49 years. College educated, employed, and unmarried pregnant people were more likely to report current drinking.

The report also found that pregnant people who experienced frequent mental distress (14 or more days of poor mental health in the past 30 days) and those who did not have a usual healthcare provider were more likely to report alcohol use.

A 2020 report published in the American Journal of Preventive Medicine found that both current alcohol use and binge drinking among pregnant women aged 18–44 years in the United States increased slightly from 2011 to 2018.²¹

- Current drinking (having at least one drink of any alcoholic beverage in the past 30 days) increased from 9.2% in 2011 to 11.3% in 2018.
- Binge drinking (having four or more drinks on an occasion during the past 30 days) increased from 2.5% to 4.0% in that same time period.

Alcohol Use During Pregnancy (2018-2020 in the past 30 days)²²

- 1 in 7 pregnant people in the US reported drinking alcohol.
- About 1 in 20 pregnant people reported binge drinking.

Alcohol and tobacco use are root causes and can further exacerbate behavioral health conditions. In Pennsylvania, both alcohol and tobacco use pose a significant health risk. When analyzing alcohol consumption, rates are slightly worse in Philadelphia County when compared to the state.



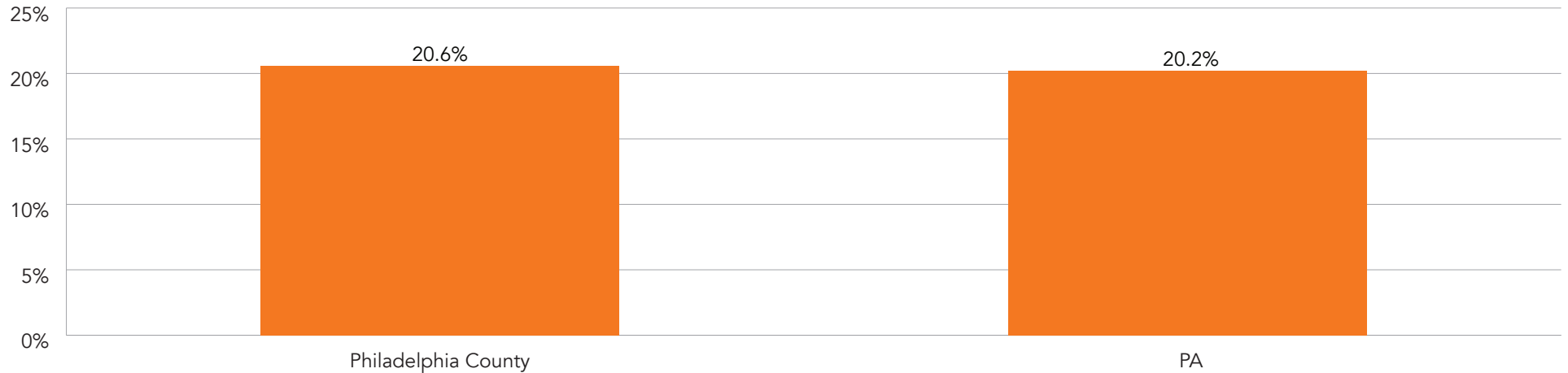
²⁰ [PA Department of Human Services](#)

²¹ [Centers for Disease Control and Prevention](#)

²² [Ibid.](#)

Figure 49 illustrates the percent of adults who are heavy drinkers in Philadelphia County and the state. Heavy drinking is defined as having more than two drinks per day for men and more than one per day for women, over the past 30 days.

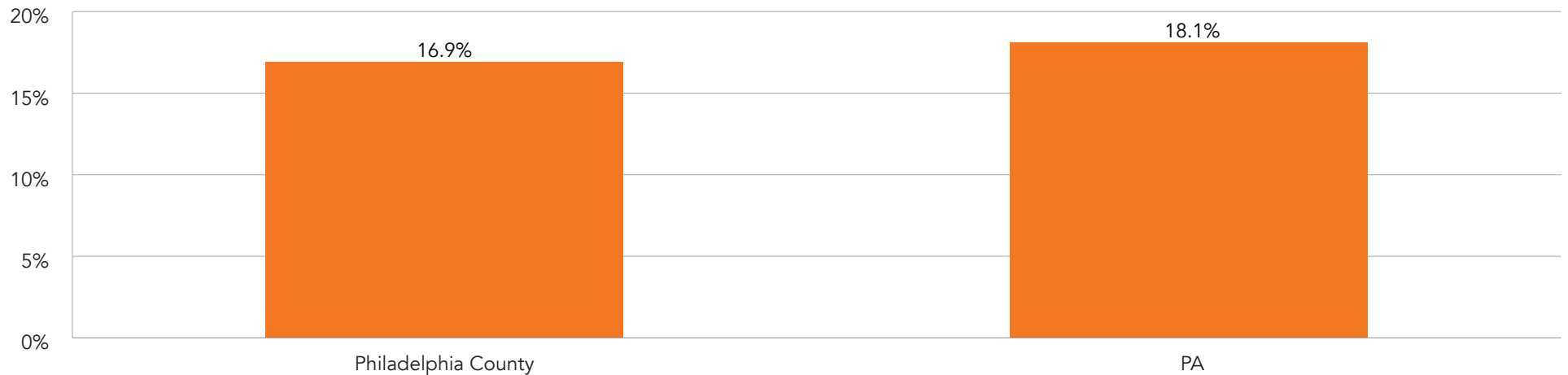
Figure 49: Alcohol Consumption (18 years and older who are heavy drinkers)



Source: [University of Wisconsin Population Health Institute, County Health Rankings, 2018.](#)

Figure 50 illustrates the percentage of adults who are binge drinkers in Philadelphia and the state. A binge drinker is an adult age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

Figure 50: Alcohol Consumption (18 years and Older Who Are Binge Drinkers)

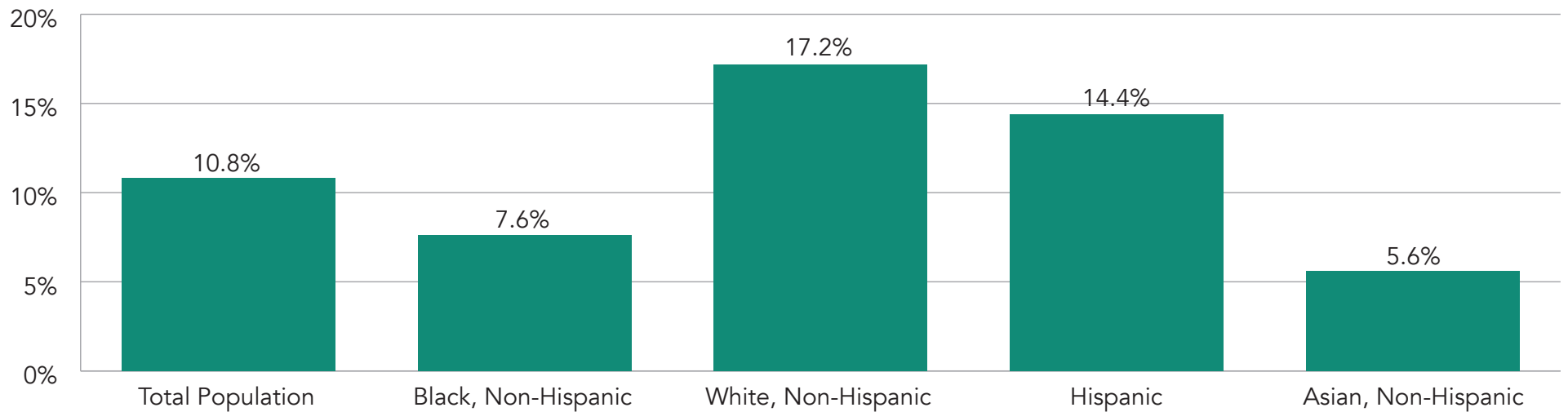


Source: CDC, Behavioral Risk Factor Surveillance System 2018



The below figure displays teen excessive drinking by race and ethnicity in grades 9th-12th.

Figure 51: Teen Excessive Drinking, 9th-12th Grade; Philadelphia



Source: [Community Health Explorer: Youth Risk Behavior Survey \(YRBS\), 2015](#)

C) HEALTH EDUCATION AND PREVENTION

Having access to health education programs that help people better understand how to manage an existing health condition and prevent further illness is paramount to good health. Health education and health literacy play a vital role in accessing care, as knowledge empowers individuals to make informed health decisions and helps them effectively navigate today's complex health care delivery system.

Providing health education and understanding of health issues enables patients and families to successfully implement treatment plans as essential to managing chronic conditions and preventing complications or hospitalizations. By improving health literacy and education in the broader community on how to address and prevent chronic diseases and illness, the health organization's paradigm shifts from treating disease to a focus on wellness, healthy behaviors, and positive health outcomes.

Figure 52 delineated the responses collected from the leadership and health equity focus groups, key informant surveys, community leader stakeholder interviews, and community surveys.



WHAT DID WE LEARN FROM THE COMMUNITY?

Figure 52: Listening to the Community



FOCUS GROUPS

(LEADERSHIP AND HEALTH EQUITY)

“What are the Contributors and Barriers to People Accessing Equitable Care?”

- Access to healthy foods
- Low education
- Awareness. Not sure where/how to access services and resources



KEY INFORMANT SURVEYS

“What are the Perceived Barriers to Accessing Care and Services?”

- Health education and health literacy
- Access to healthy foods
- Poor eating habits
- Inadequate physical activity
- Unsafe sex/non-use of birth control
- Better childcare



COMMUNITY STAKEHOLDER INTERVIEWS

“What are the Perceived Barriers to Accessing Care and Services?”

- Health literacy
- Understanding of treatment plans
- Poor/unhealthy eating habits
- Inadequate physical activity
- Preventive immunizations
- Unsafe sex/non-use of birth control
- Tobacco cessation education



COMMUNITY SURVEYS

“What are the Perceived Barriers to Accessing Care and Services?”

- Anger and stress management
- Health education on parenting, crime prevention and caring for family members
- Overweight/obesity
- Access to healthy foods
- Poor dental health
- Sexual abuse prevention

HEALTHY KIDS AND TEENS WEIGHT MANAGEMENT PROGRAM

There is an ongoing public health crisis in Northern Philadelphia needing our attention. Childhood obesity was recently found to be twice as severe in this area of Philadelphia as the national average with 70% of children aged 9 to 17 overweight or suffering from some level of obesity. The obesity epidemic has been made even worse with the COVID-19 pandemic.

It is well known that obesity is more frequent and the effects more severe in African American and Latinx children and adults. Children with severe obesity are likely to continue suffering with obesity as adults and develop increasingly severe obesity related medical problems such as diabetes, cardiovascular disease and cancer. They are also likely to die at a much earlier age.

With the pediatric population in Northern Philadelphia made up primarily of black and brown children, St. Christopher's has the opportunity to help improve health equity for the diverse population in our community by treating patients with obesity and related diseases.

In response to this overwhelming challenge, the Healthy Kids and Teens Weight Management Program at St. Christopher's Hospital for Children was developed. The first year of the existence of this unique clinic at St. Christopher's cared for 468 children suffering with obesity and obesity related disorders. We have performed weight loss surgery for 10 adolescents most severely affected with the disease of obesity. This demonstrates that families in our community are desperate and willing to seek help for their children.

The Healthy Kids and Teens Weight Clinic deploys nutrition instruction by dietitians, psychological and family structure assistance from social workers, medical consultation and intervention using medications were indicated and weight loss surgery for adolescents with severe obesity. Behavioral Health services are integrated into the Healthy Kids Healthy Teens clinic to provide body-positive behavioral and psychosocial support for patients and their families. The psychologist provides routine screenings for depression, anxiety, eating disorders, and adherence concerns. Brief interventions are provided for lifestyle changes, adherence, and coping with stressors that may impact weight management. These interventions have been proven effective when applied to children and adolescents, and the American Academy of Pediatrics has called for additional access to obesity care for children and adolescents.

In addition to seeing about 750 patients on the nonsurgical side of the clinic in the next year, we expect to perform 60 weight loss operations in the next 12 months and 100 per year starting the following year.

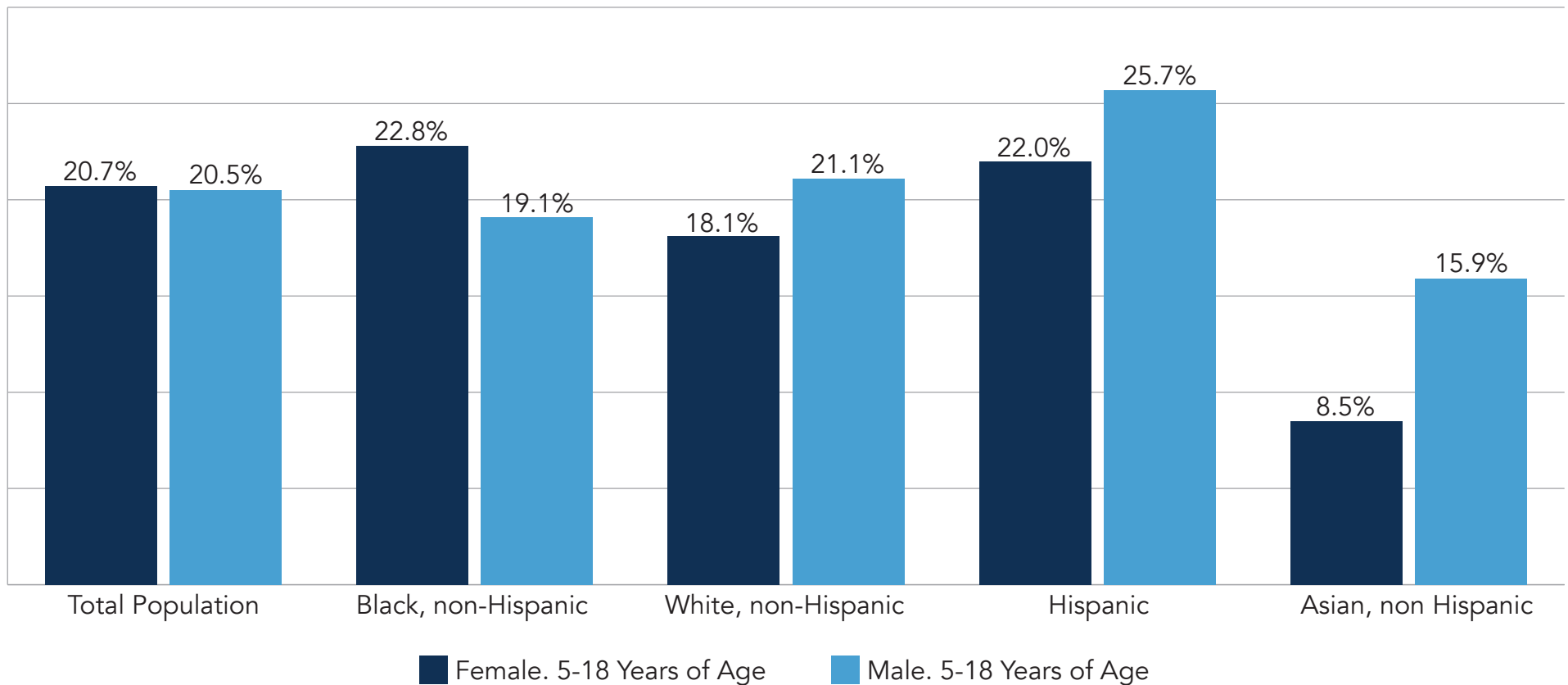


In Pennsylvania, 15.1% of youth ages 10 to 17 have obesity, giving Pennsylvania a ranking of 30 among the 50 states and D.C.²³

- 12.8% of Pennsylvania children ages 2-4 participate in WIC.
- 15.1 of children ages 10-17 are obese in Pennsylvania.
- 15.4% of high school students are obese.

Figure 53 reveals childhood obesity of children in Philadelphia 5-18 years old by ethnicity and gender in years 2014-2015.

Figure 53: Children Obesity 5-18 Years of Age

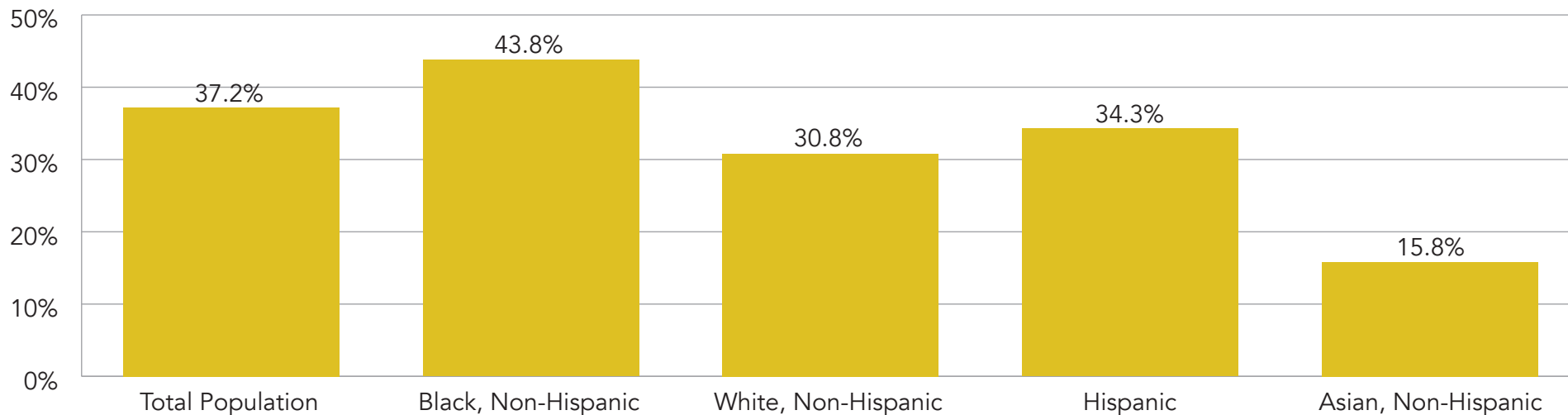


Source: [Community Health Explorer: School District of Philadelphia 2014-2015](https://communityhealthexplorer.org/school-district-of-philadelphia-2014-2015)

²³ State of Childhood Obesity: <https://stateofchildhoodobesity.org/states/pa/>

Figure 54 reveals sexually active teens in grades 9th-12th by ethnicity.

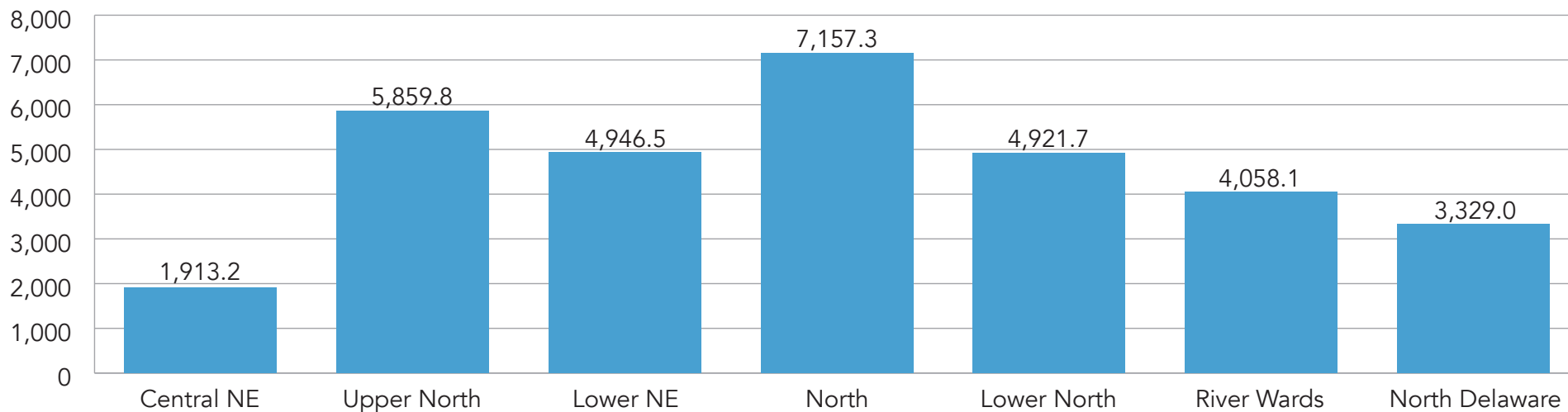
Figure 54: Teens Who are Sexually Active; Philadelphia



Source: [Community Health Explorer: Youth Risk Behavior Survey \(YRBS\), 2015](#)

Figure 55 shows chlamydia rates of teens 15-19 years old per 100,000 in 2015 by planning district.

Figure 55: Teen Chlamydia Rate per 100,000 population

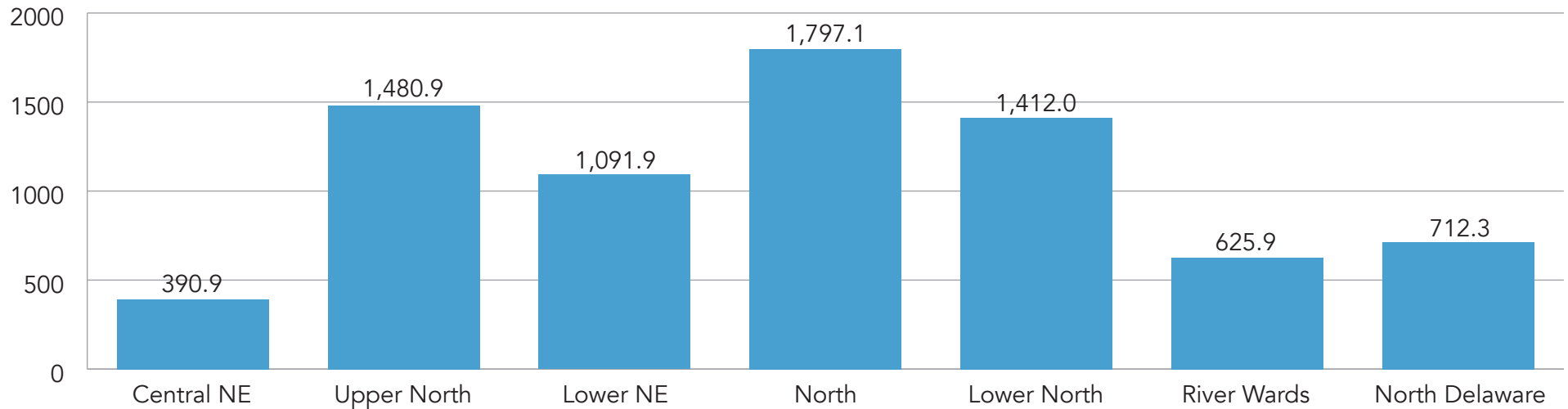


Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Division of Disease Control, Philadelphia Department of Public Health, 2015](#)

Figure 56 shows the gonorrhea rate of teens 15-19 years old per 100,000 in 2015 by planning district.

Figure 56: Teen Gonorrhea Rate per 100,000 population

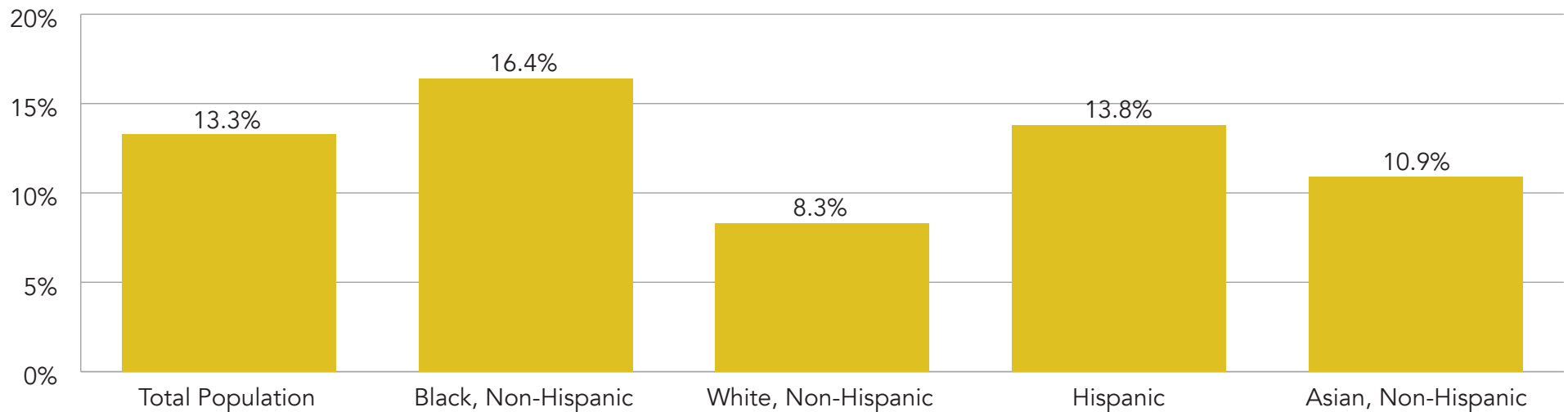


Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Division of Disease Control, Philadelphia Department of Public Health, 2015](#)

Figure 57 reveals late or no prenatal care by ethnicity.

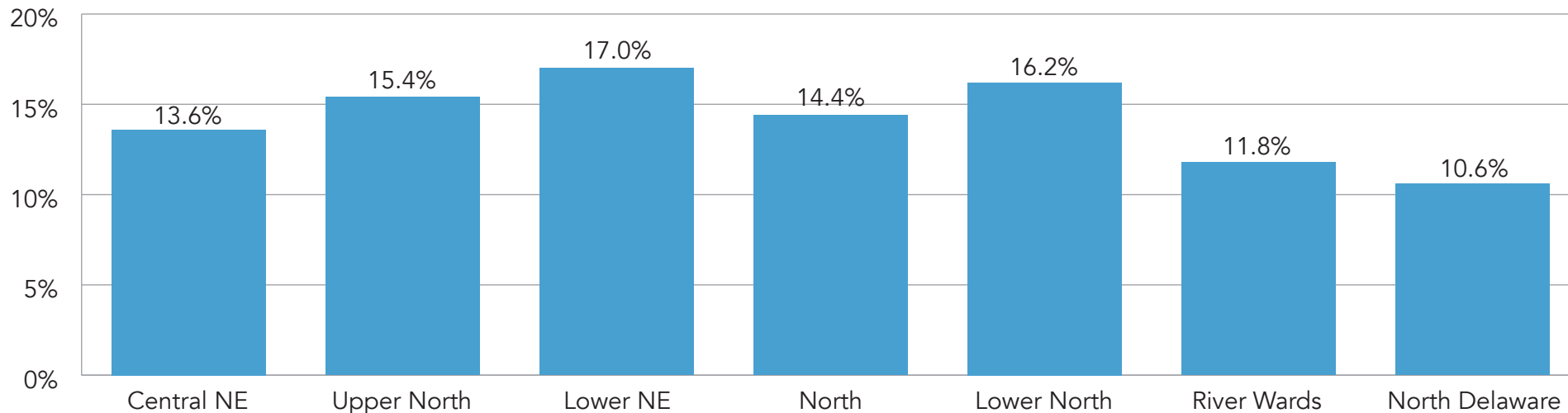
Figure 57: Late or No Prenatal Care; Philadelphia



Source: [Community Health Explorer: Youth Risk Behavior Survey \(YRBS\), 2015](#)

Figure 58: shows late or no prenatal care in 2014 by planning district.

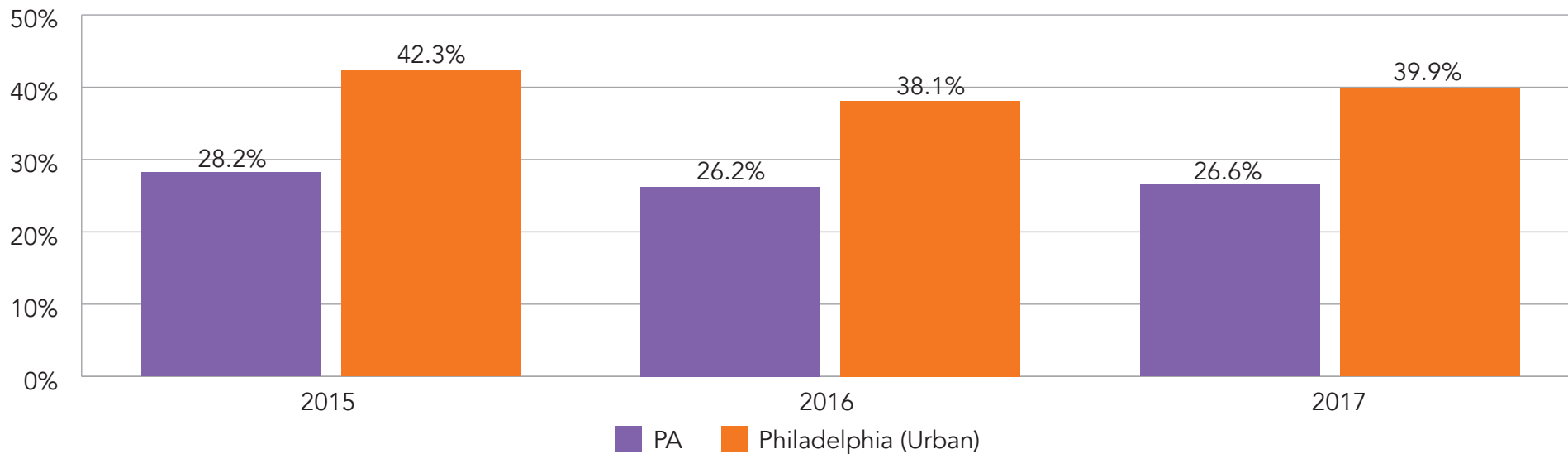
Figure 58: Late or No Prenatal Care



Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2014](#)

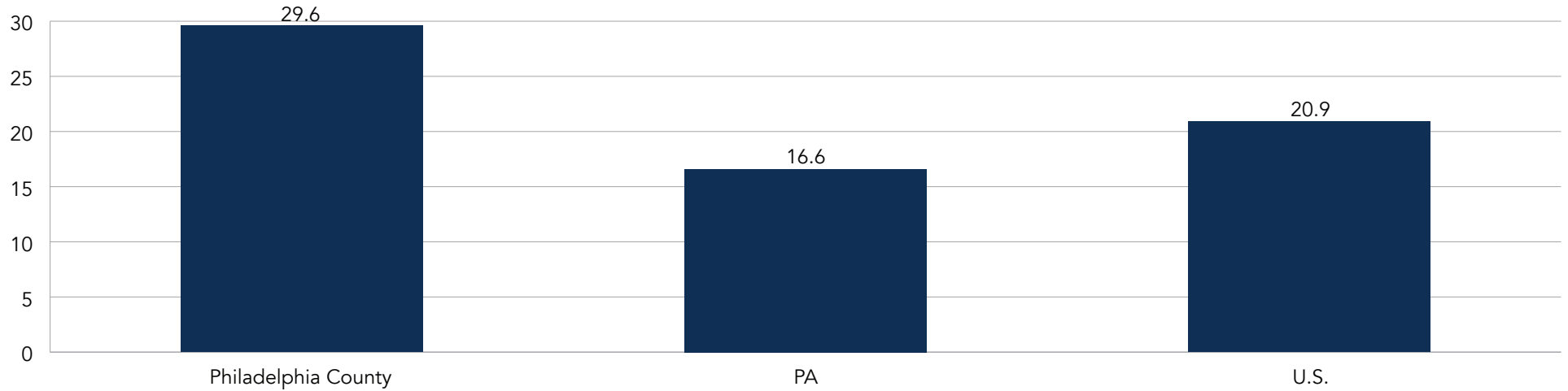
Figure 59: Births to mothers who did not receive early prenatal care in Philadelphia County, 2017



Source: [Kids Count Data Center 2015-2017](#)

Figure 60 shows the percentage of teens who gave birth per 1,000 population.

Figure 60: Teen Births per 1,000 population

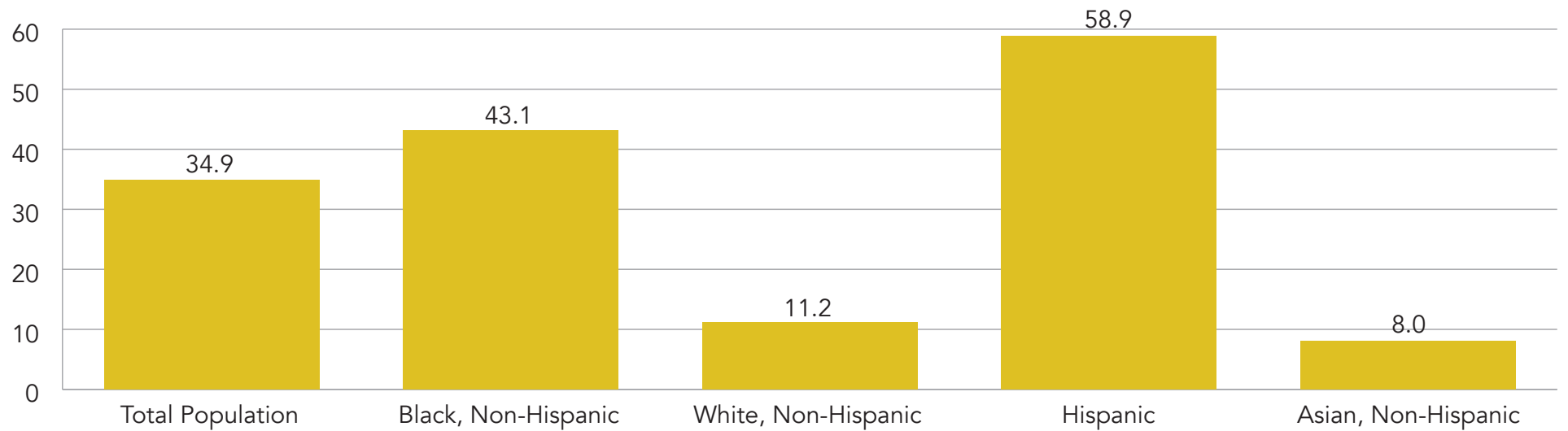


Source: [Community Needs Assessment](#), Centers for Disease Control and Prevention, [National Vital Statistics System](#).

Accessed via [County Health Rankings](#). 2013-2019

Figure 61 reveals teen births 15-19 years of age per 1,000 per population in 2015 by ethnicity.

Figure 61: Teen Births; Philadelphia

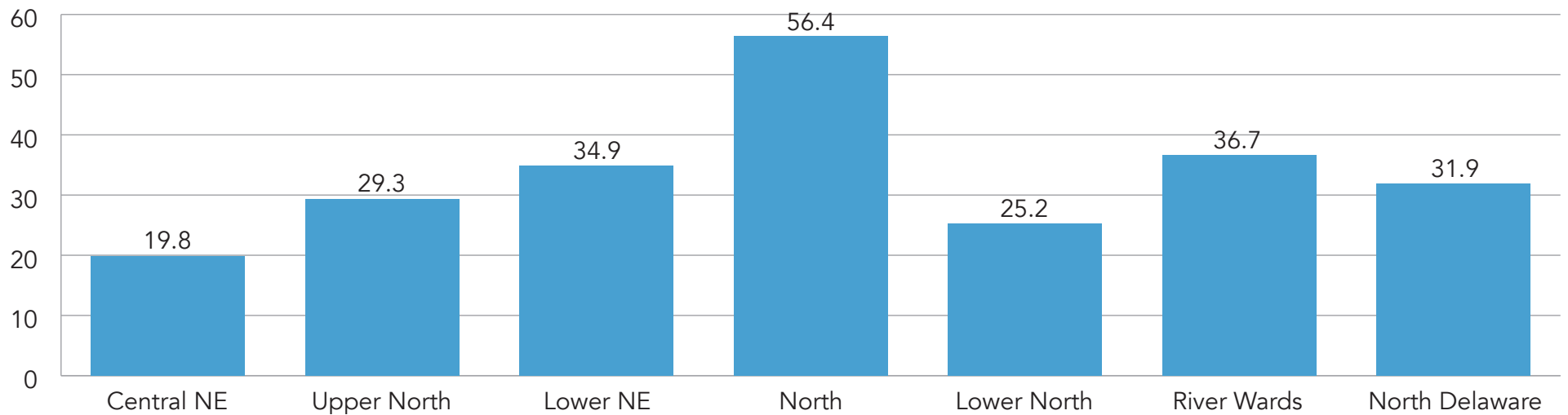


Source: [Community Health Explorer: Vital Statistics for Philadelphia](#), Pennsylvania Department of Health, 2014



Figure 62 shows the rate of teen births (15-19 years old) in 2014 by planning district per 1,000 population.

Figure 62: Teen Births per 1,000 population

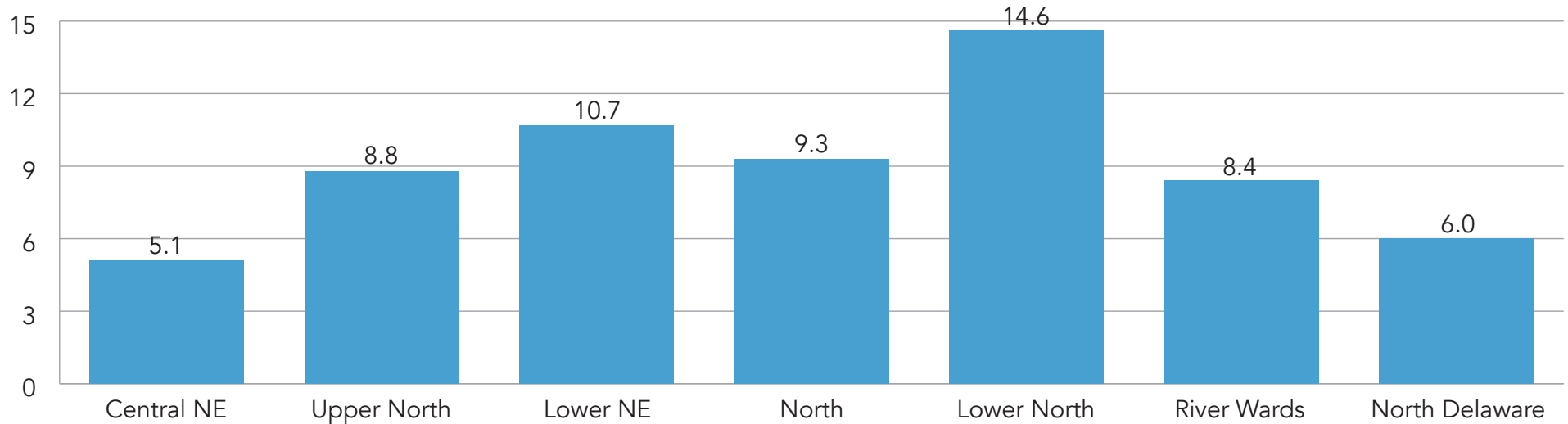


Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health, 2014](#)

Figure 63 shows the infant mortality rate per 1,000 Live Births in 2014 by planning districts.

Figure 63: Infant Mortality Rate per 1,000 Live Births

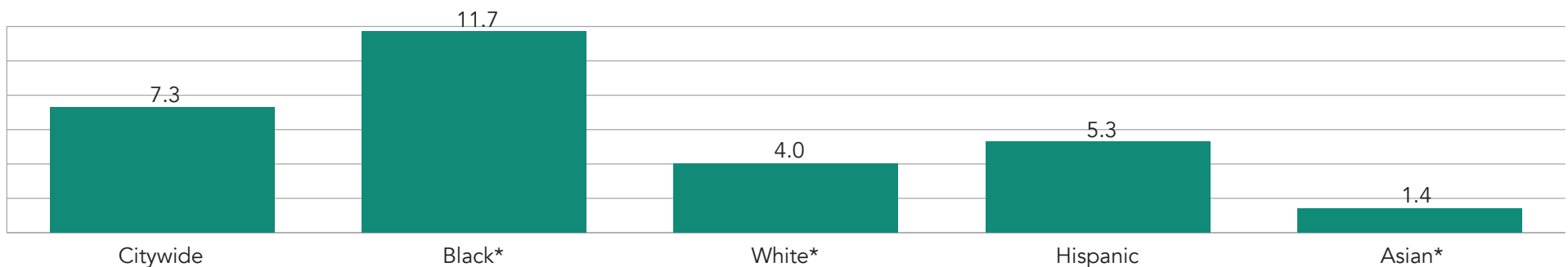


Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health | 2012-2014](#)

Infant mortality includes deaths of those under one year old. After remaining stable for several years, infant mortality declined in Philadelphia in 2019. Non-Hispanic Black babies are three times as likely as non-Hispanic White babies to die before their first birthday. Many of these deaths are related to improper sleep positioning and thus preventable.

Figure 64: Infant Mortality Rate

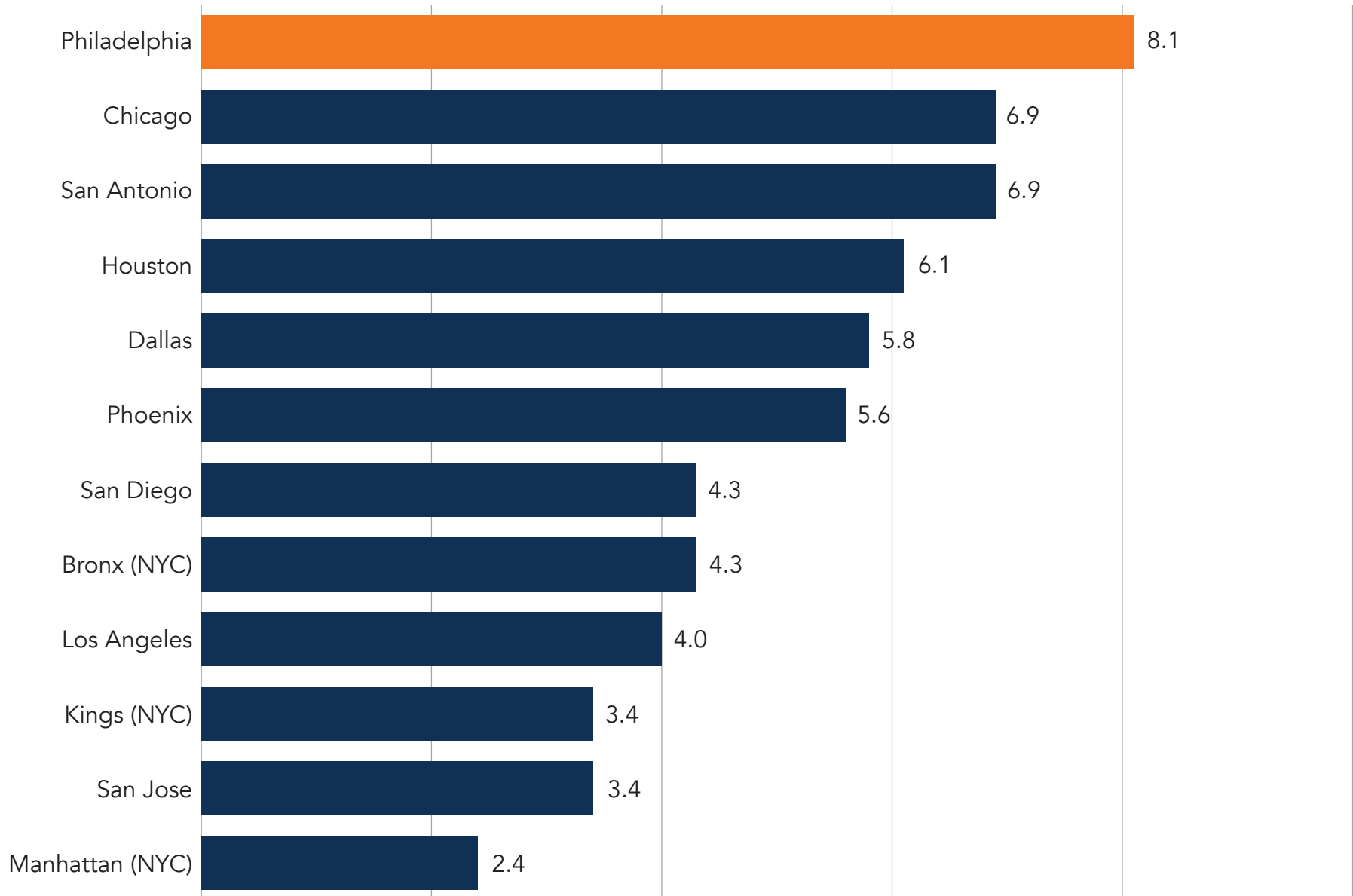


*Non-Hispanic

Source: [Health of the City 2019](#)

In 2018, the most recent year with comparable data, infant mortality was higher in Philadelphia than in other large cities and nationwide. The nationwide rate is 5.7 per 1,000 live births.

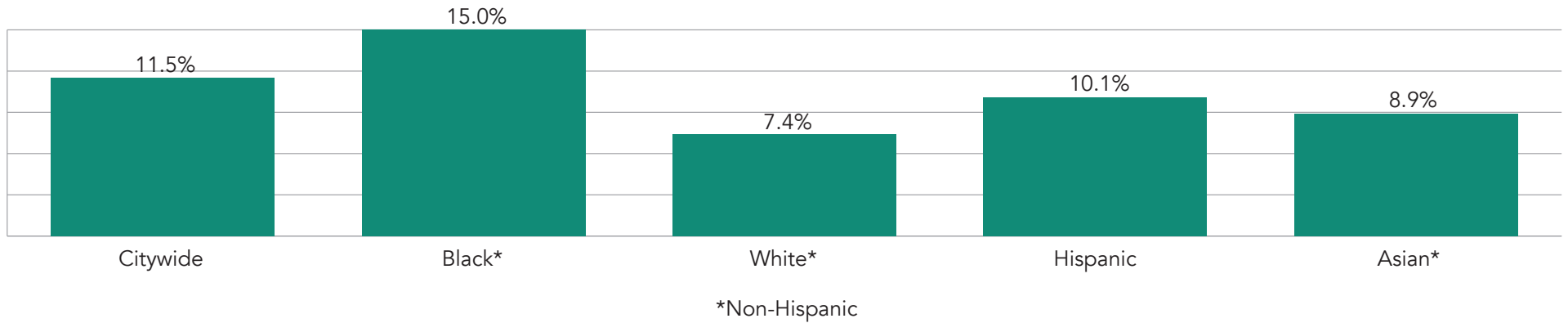
Figure 65: Infant Mortality (per 1,000 Live Births) Top U.S. Cities (2018)



Source: [Health of the City 2019](#)

In 2019, more than 1 out of every 10 babies was born with a low birth weight, defined as less than 2,500 grams. Non-Hispanic Black babies were twice as likely to be born at a low birth weight than non-Hispanic White babies. While overall rates have remained relatively stable, rates among non-Hispanic Blacks have risen in recent years.

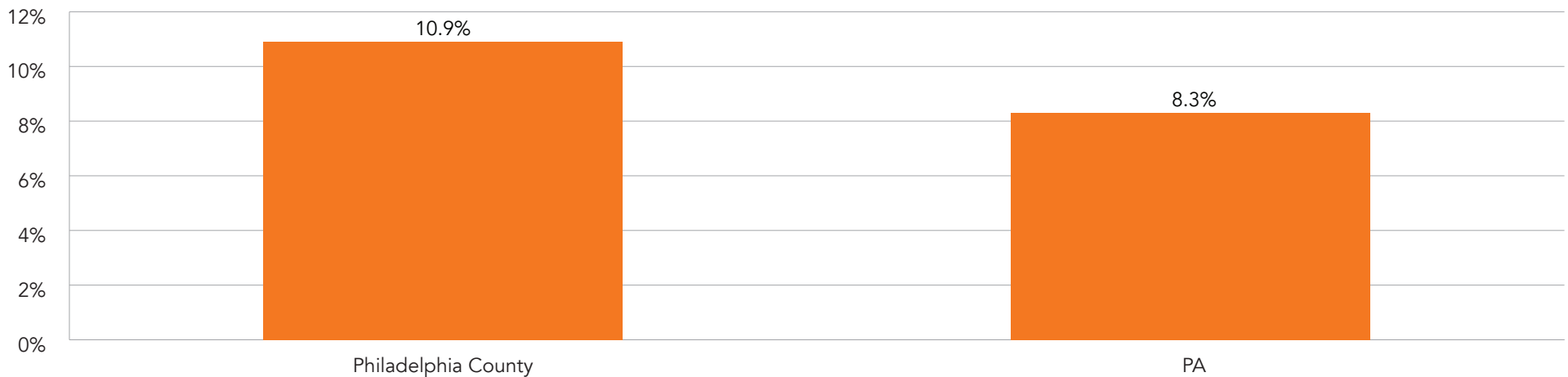
Figure 66: Low Birth Weight Babies (<2,500 Grams) by Mothers Race/Ethnicity



Source: [Health of the City 2019](#)

Figure 67 shows babies under 2,500 grams at birth in Philadelphia County and the state.

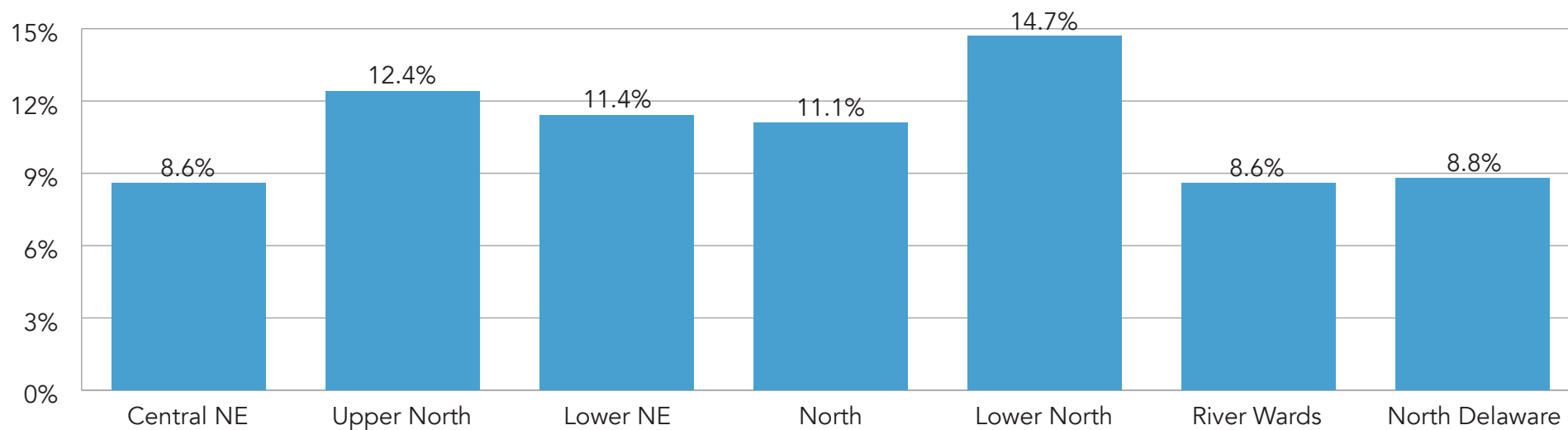
Figure 67: Babies weighing <2,500 grams at birth, 2018



Source: [Community Needs Assessment](#), University of Wisconsin Population Health Institute, [County Health Rankings](#). 2013-2019



Figure 68: Low Birth Weight

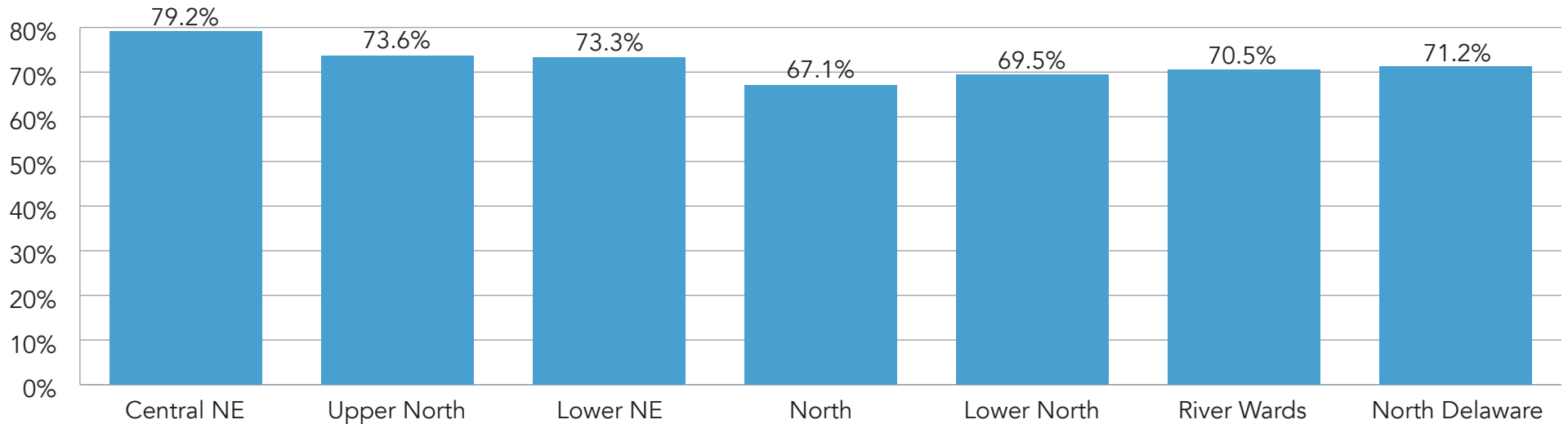


Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2014](#)

Figure 69 shows breastfeeding initiative in 2014 by planning district.

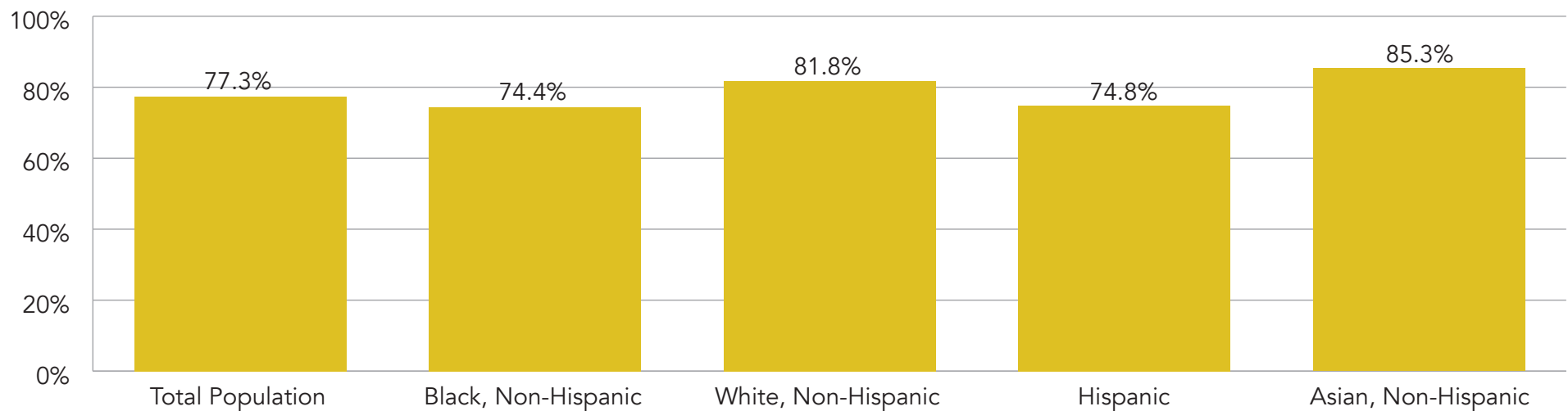
Figure 69: Breastfeeding Initiative



Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2014](#)

Figure 70: Breastfeeding Initiation for children who are up-to-date on Immunizations ages 19-35 Months of Age by ethnicity in Philadelphia.



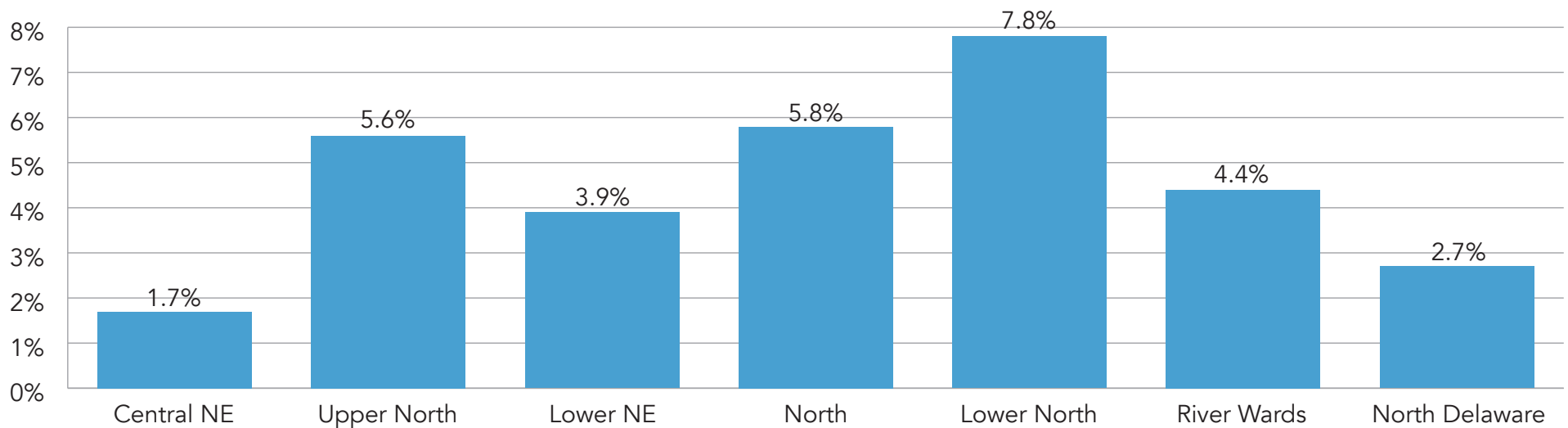
Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2014](#)

Exposure to lead remains a persistent health risk for children. The environment in which children live and play could put them at risk for lead poisoning, and the effects could last a lifetime. The primary source of exposure are lead-based paint chips and dust, but other sources of exposure include drinking water and consumer products like toys and cosmetics. Some studies have shown a significant association between lead exposure and children's IQ.

The American Academy of Pediatrics recognized that even low-level elevation can affect cognitive function and academic performance in children. Pennsylvania children are particularly at risk due to the commonwealth's aging infrastructure, which was recognized by the Pennsylvania Department of Health last year when it declared all of Pennsylvania "at-risk" for lead exposure. Pennsylvania has the 5th largest housing stock in the country, 55% of which was built before 1960. Additionally, the commonwealth is ranked 47th in terms of aging apartment stock, with only 21% built after 1979, the year after lead-paint was banned.

Figure 71 shows data by planning districts for children under six years with elevated blood lead levels.²⁴

Figure 71: Newly Identified Elevated Blood Lead Levels (5-9 mcg/dL) in Children, < 6 Years of Age



Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2014](#)

²⁴ State of Children's Health Care Report: www.papartnerships.org/report/report-state-of-childrens-health-care-in-pennsylvania-2020

A report by the Department of Public Health on Childhood Lead Poisoning states that a major source of childhood lead exposure in Philadelphia is lead paint and the dust it produces. Many homes in Philadelphia built before 1978 have lead paint on the inside and outside of the building. When old paint cracks and peels, or when it is ground between surfaces such as around windows, it makes lead dust. Children can be exposed to lead from ingesting flakes of paint or paint dust that gets on their hands and toys.

Screening rates for lead exposure remain high, as more than 90% of Philadelphia children receive at least one lead screening test before they turn 6 years old. In addition, 76% of children born in 2015 received at least one test before they turned 2 years old, compared to 58% of children born in 2005. However, only 28% of children born in 2015 were tested fully in accordance with The Philadelphia Department of Public Health’s (PDPH) recommendations.²⁵

Table 72: Percentage of children born in 2015 tested for lead at the age of 1 year old and again at the age of 2 by zip code.

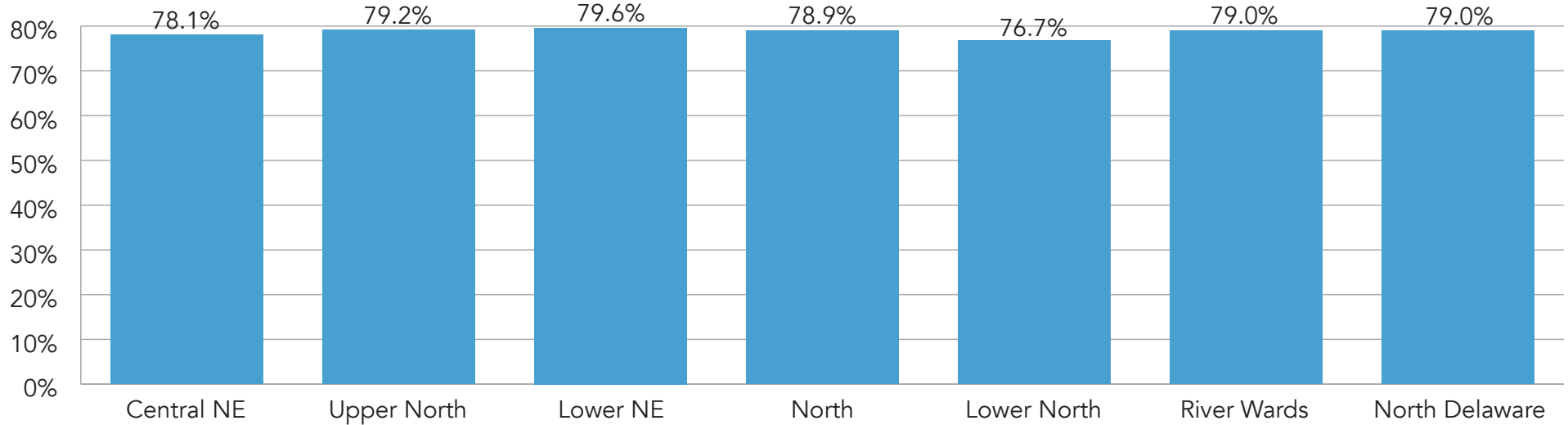
ZIP Code	Percent
19111	10%-18%
19120	19%-28%
19124	19%-28%
19132	19%-28%
19133	29%-36%
19134	29%-36%
19135	19%-28%
19136	10%-18%
19140	19%-28%
19149	19%-28%

Source: [Department of Public Health City of Philadelphia](#)

82 ²⁵ Department of Public Health of Philadelphia: [/www.phila.gov/media/20190319101844/Lead-Surveillance-2017_9.7.2018-final.pdf](http://www.phila.gov/media/20190319101844/Lead-Surveillance-2017_9.7.2018-final.pdf)

Figure 73 shows children up to date on immunizations, 19-35 months of age in 2016 by planning district.

Figure 73: Children Up-to-date Immunizations (19-35 Months of Age)



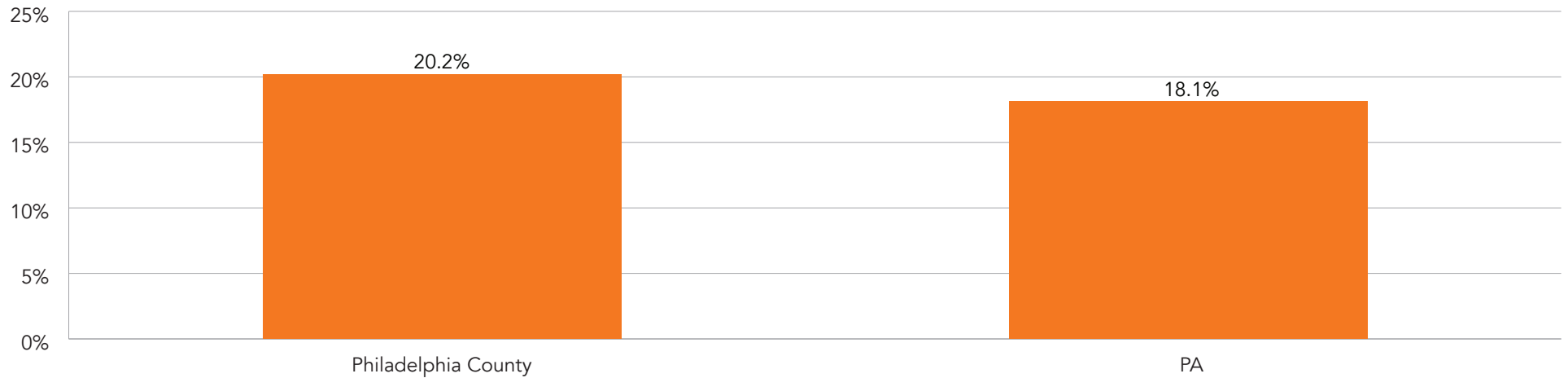
Note: Lower Northeast planning district includes ZIP codes 19124 and 19149. North includes 19132, 19133, and 19140. Lower North includes 19132 and 19133. North Delaware includes ZIP codes 19135 and 19136.

Source: [Community Health Explorer: Vital Statistics for Philadelphia, Pennsylvania Department of Health 2014](#)



Figure 74 shows adults 18 and older who smoke every day or some days in Philadelphia County and the state. Smokers are adults aged 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

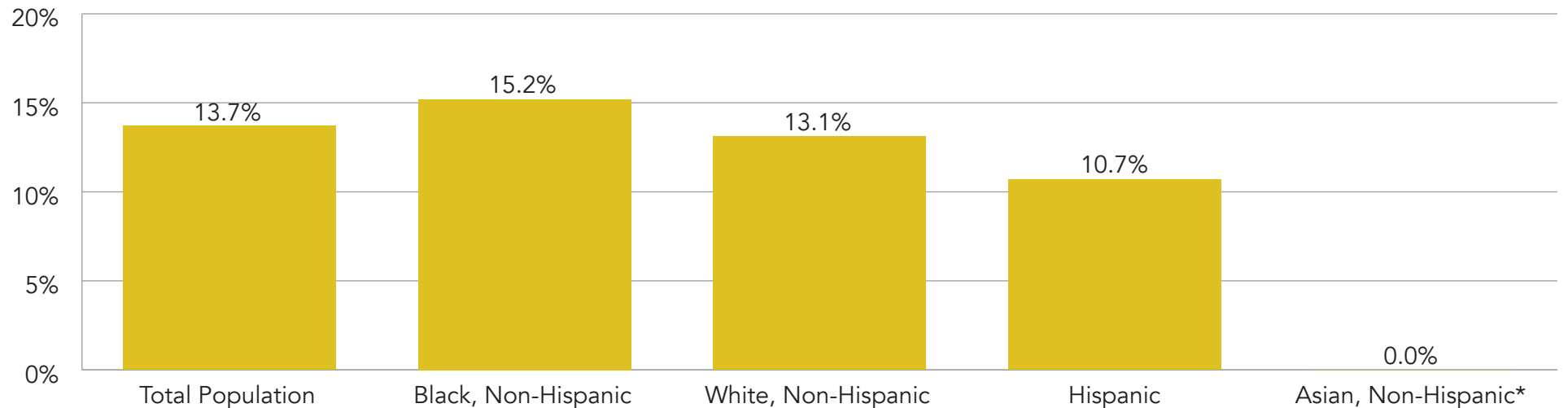
Figure 74: Tobacco Usage — Former/Current Smokers



Source: CDC, Behavioral Risk Factor Surveillance System 2018

Figure 75 reveals the percentage of children under 18 who were exposed to secondhand smoke at home by ethnicity.

Figure 75: Secondhand Smoke Exposure at Home Among Children; Philadelphia

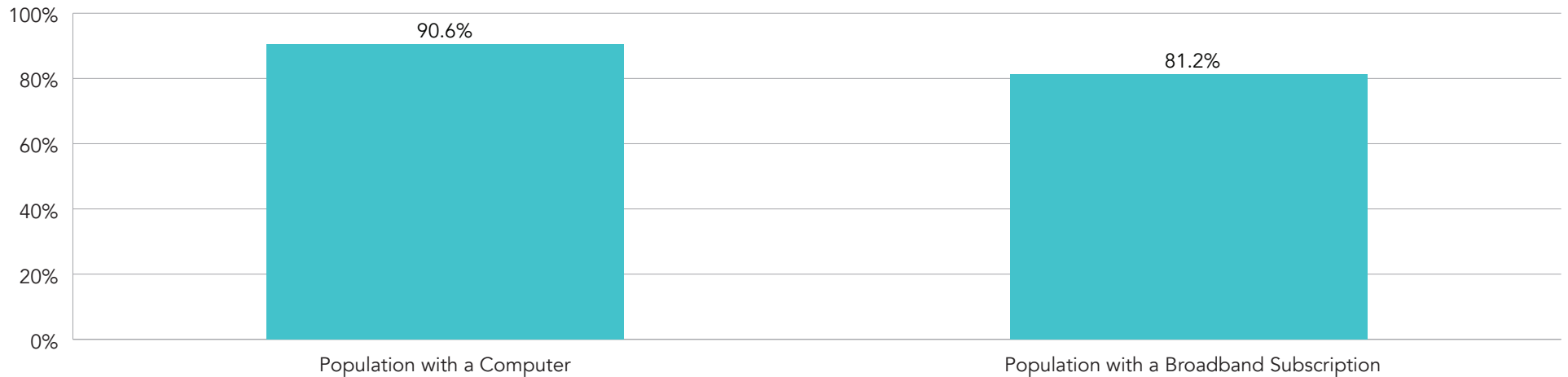


Note: *Data missing for some race/ethnic subgroups due to small sample size

Source: [Community Health Explorer: Public Health Management Corporation \(PHMC\) Household Health Survey, 2014/2015](#)

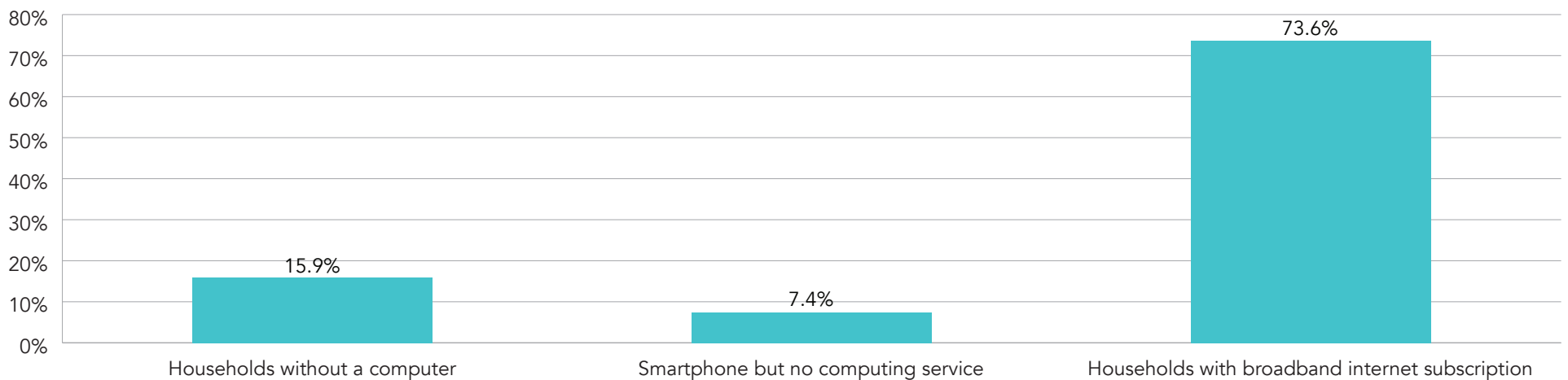
Figure 76 illustrates the percentage of residents in Philadelphia County with a computing device or internet service. With the advent of virtual applications and programs, more health centers and professionals are utilizing the internet as a means of reaching targeted audiences. This avenue allows underserved or disenfranchised populations who may lack web access to obtainable health education.

Figure 76: Percentage of Households with computer or internet (Philadelphia County)



Source: [Community Needs Assessment, US Census Bureau, American Community Survey](#)

Figure 77: Percentage of Households in with Limited Technology (Philadelphia County)



Source: [The Agency for Healthcare Research and Quality \(AHRQ\) 2018](#)

There are **226,890** food insecure people in Philadelphia County.

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 trade-offs 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.

Source: [Feeding America 2019](#)



The Special Supplemental Nutrition Program for Women, Infants, and Children – more commonly known as WIC – aims to curb nutritional risk and provide food security for low-income families. WIC provides nutritious food along with nutrition education, baby formula and breastfeeding support for 188,000 moms and their young children up to age five. From 2019 – 2020 there was a 6% decline statewide over the past year.

WIC aims to curb nutritional risk and provide food security for low-income families. It is an effective program reducing iron deficiency in children and reduces the risk of preterm deliveries. Data from the State of Children’s Health Care Report reveals the largest drop in WIC enrollment over the prior year was for infants, at 12%. More than one-third of kids in Pennsylvania living in low-income families, declined in enrollment are likely due to a decrease in need, rather than burdensome program mandates and other barriers for families. These include the challenges of attending in-person appointments, and ongoing fear about the “public charge” rule and its chilling effect on families with mixed immigration status.

Health Outcomes for WIC Families:

- Decreases infant mortality
- Supports healthier birth weights
- Decreases iron deficiency anemia in children
- Improves intellectual development for nation’s youth

WIC NUTRITION

The WIC Office was first on the SCHC campus in 1979 but had been absent from our campus for decades. In 2010, WIC was recruited back onto the new campus and set up in the conference room in Ambulatory Pediatrics. In 2015 they moved into the Nelson Pavilion where they are currently located. By moving onto campus, the WIC Office is more convenient for families, offering one-stop shopping for critical services for families. The WIC clinic at SCHC has a high percentage of special formulas (7.5%), they work closely with the NICU and subspecialty clinics, and 75% of the staff are bilingual.

In 2016, 202,172 of Pennsylvanians participate in WIC. 26.4% of the head of households in Pennsylvania participating in SNAP were African American in 2018. 0.6% of the head of households in Pennsylvania participating in SNAP were Hispanic in 2018.²⁶

²⁶ [State of Childhood Obesity](#)



The Supplemental Nutrition Assistance Program (SNAP)²⁷ reported the following in Philadelphia County:

- 467,647 Philadelphia County residents received \$61,547,164 in SNAP benefits to help make ends meet in December 2018.
- 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 is also there to help those who are between jobs while they search for work

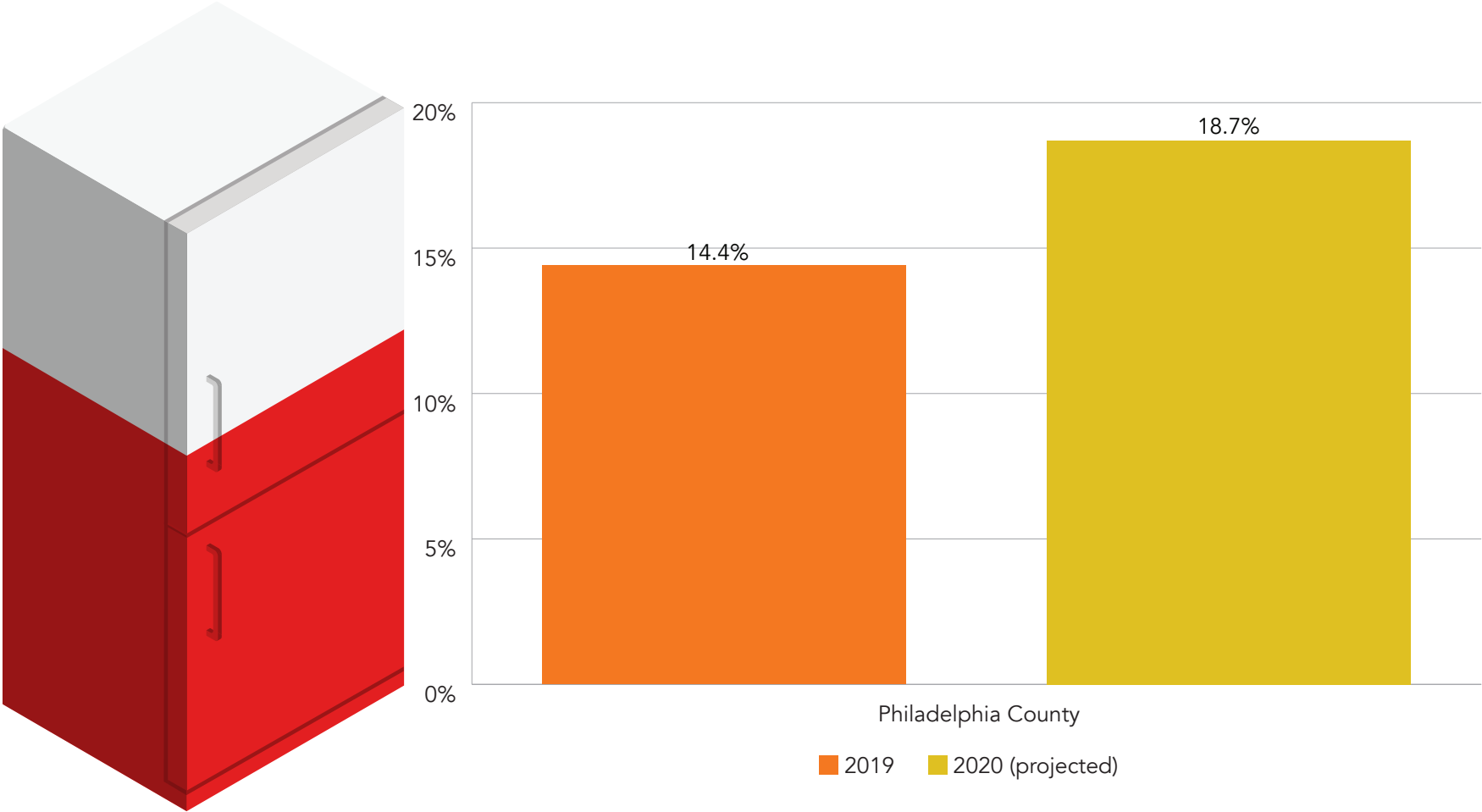
Source: Coalition Against Hunger 2018



COVID-19 AND THE IMPACT ON FOOD INSECURITY

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

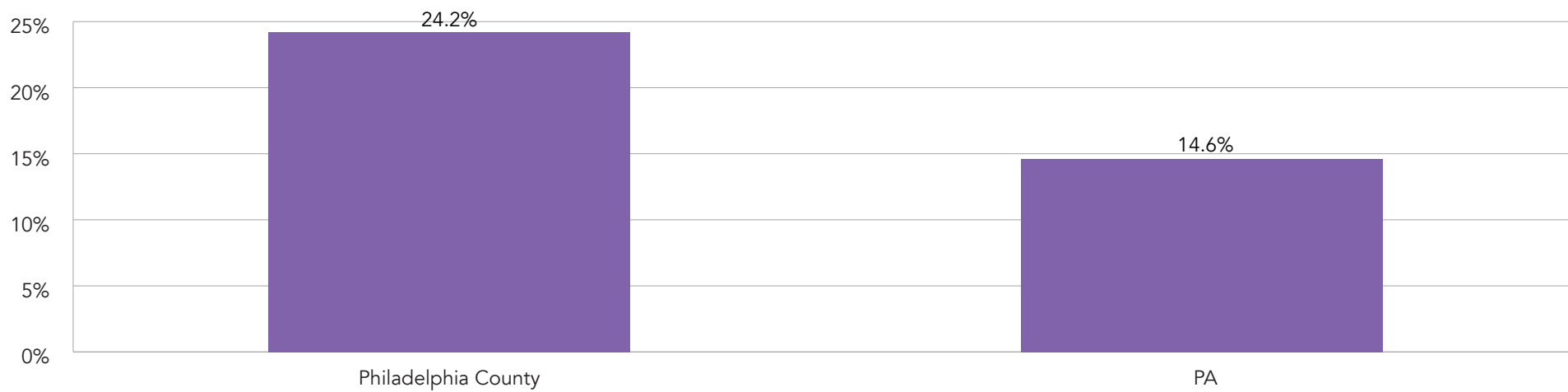
Figure 78: Food Insecurity



Source: [Feeding America 2019](#)



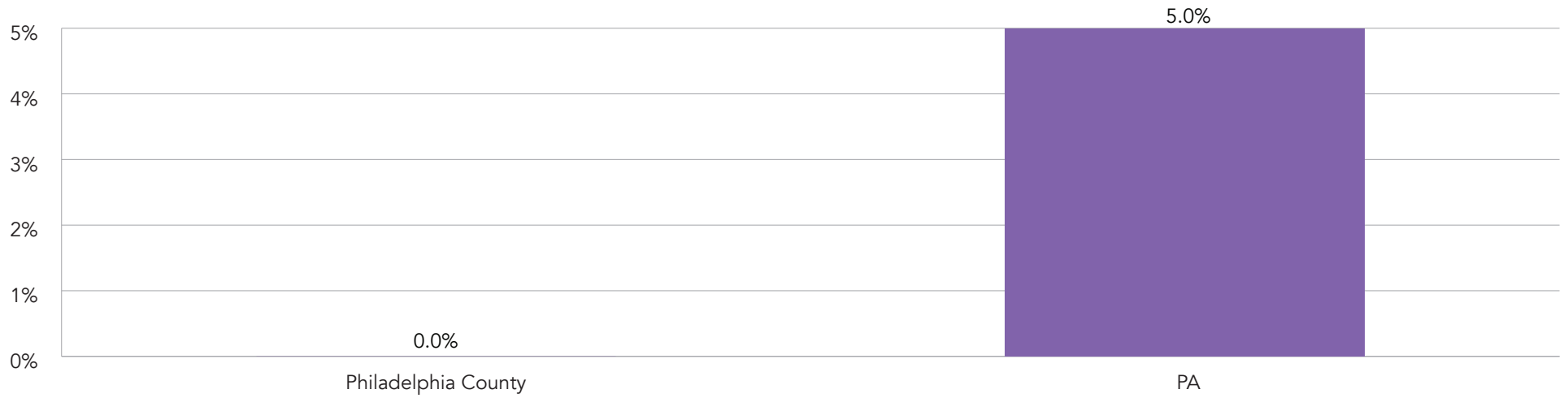
Figure 79: Child Food Insecurity



Source: [Feeding America 2019](#)

Figure 80 reports the percentage of the population who are low-income and do not live close to a grocery store.

Figure 80: Limited Access to Healthy Foods



Source: [County Health Rankings & Roadmaps 2015](#)



Figure 81 the community survey shows health behaviors for which people in the community need more information.

Figure 81: Top Health Behaviors for Which People Need More Information

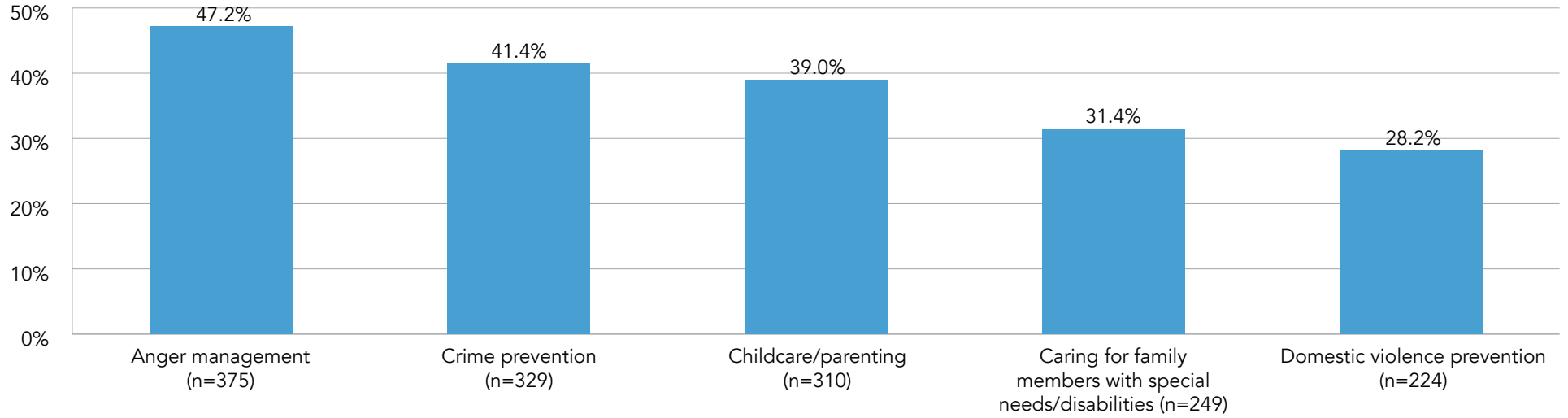
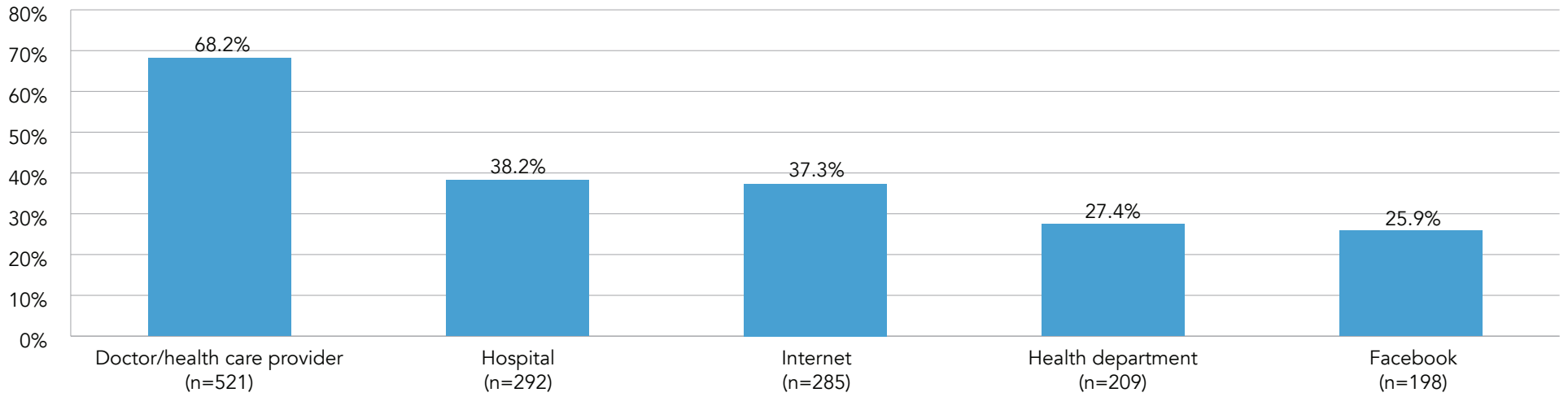


Figure 82 from the community survey reports how the community wants to receive health information.

Figure 82: Top Ways Community Wants to Receive Information



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.

When assessing the diverse and disparate population, many SDOH and barriers to health care access and services were uncovered. 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 St. Christopher's Hospital 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.



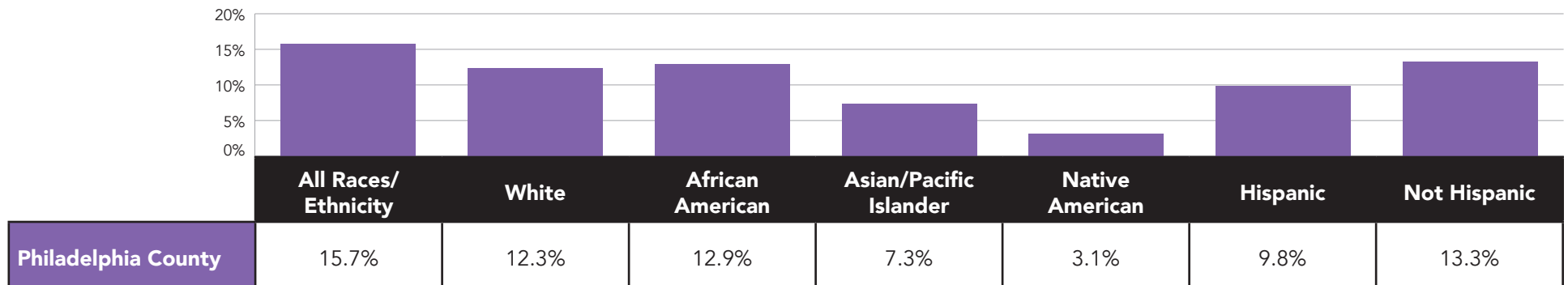
LESSONS LEARNED FROM COVID-19 AND HEALTH EQUITY

The effects of COVID-19 are far-reaching and long-lasting. [The Centers for Diseases Control and Prevention](#) (CDC) reported that essential employees (those in health care, food services, and transportation) were much more likely to die than other workers. Hispanics are nearly two times more likely to contract the disease as 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. Health and social inequities have placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 ([CDC](#)).

In Pennsylvania, non-Hispanic whites experienced 83.2% of all COVID-19 deaths. However, the impact of looking at the data by age revealed 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 83: Full Vaccination Coverage for Races/Ethnicity



Source: [The PA Department of Health](#)

Reviewing data by demographics such as age, gender, race, and ethnicity are markers for other underlying conditions that affect health. Additional factors such as socioeconomic status, access to health care, and exposure to the virus related to occupation are relevant to uncovering the challenges around vaccination access and acceptance, as well as understanding the impact and providing opportunities to develop mitigation solutions.

DRIVERS OF DISEASE INEQUITIES

Multiple factors continue to contribute to poor health outcomes and social and health inequalities in marginalized communities. Unfortunately, the COVID-19 pandemic 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 of and the lack of investment in addressing barriers to health 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.

DISCRIMINATORY POLICIES

Policies impacting healthcare, education, finance, criminal justice, and other formative systems which should serve to protect communities can lead to stress as well as act as barriers towards proper healthcare.

LIMITED ACCESS TO ESSENTIAL SERVICES AND RESOURCES

Barriers towards health insurance, childcare, sick leave, paid leave, or access to PPE, make some demographics more prone to COVID-19 inequities.

HISTORY OF RACISM & SOCIAL DISCRIMINATION

Systemic racism and other forms of social discrimination have contributed to discriminatory policies, limited investment in community well-being, lack of access to quality healthcare, and a poor sense of trust between communities and health and social systems.

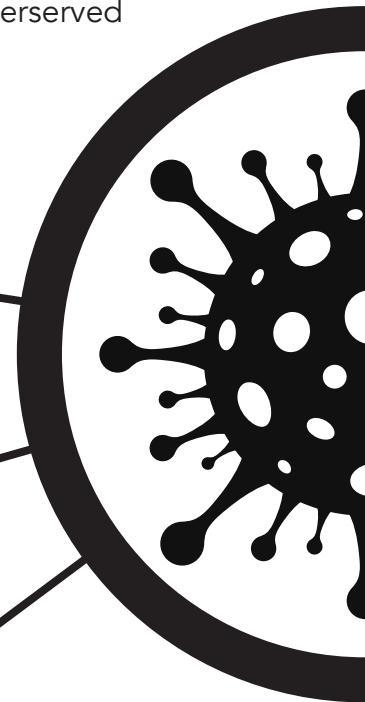
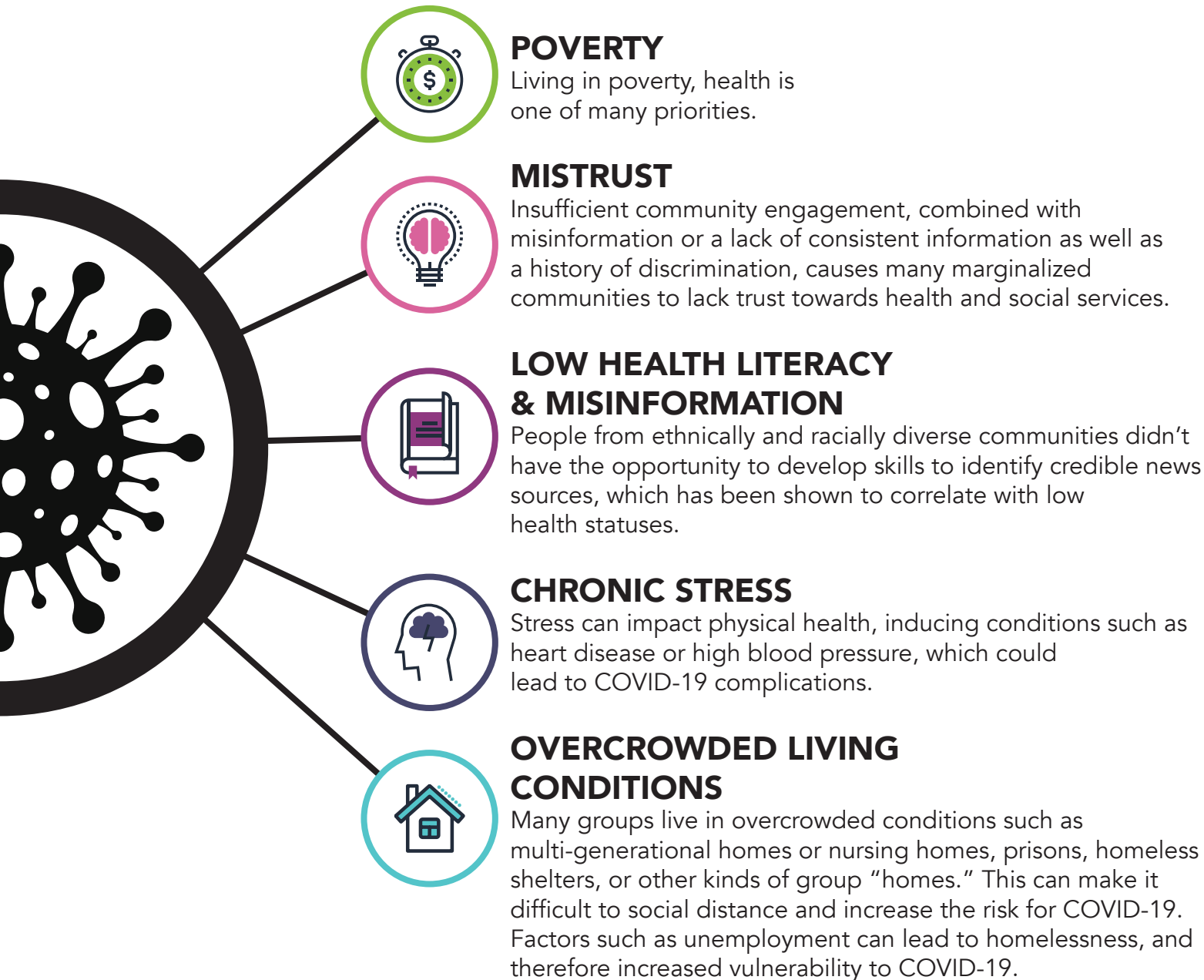


Figure 84: COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities
([The Health Equality Initiative](#))



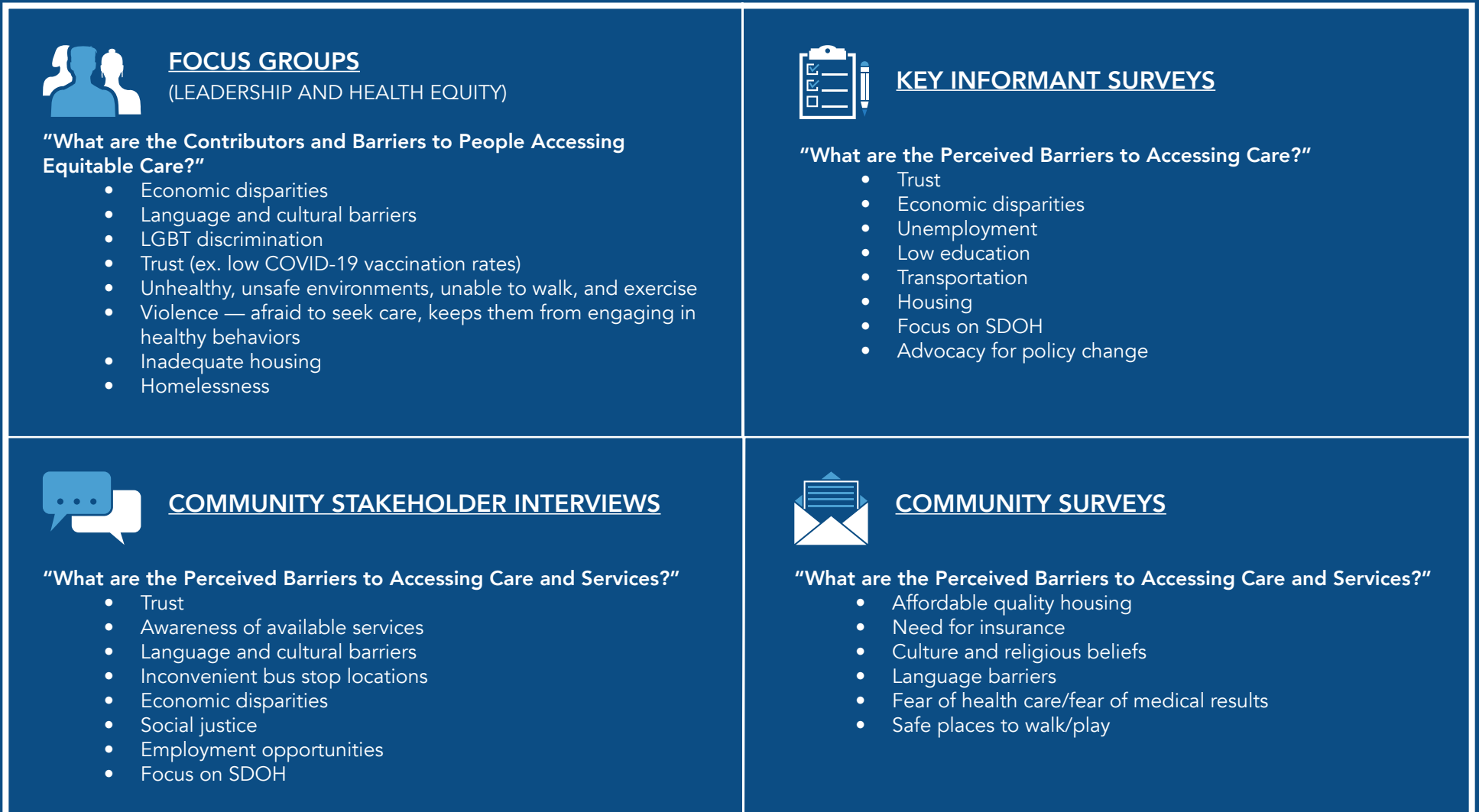
Source: The Health Equality Initiative 2020

WHAT DID WE LEARN FROM THE COMMUNITY?

Capturing the perspectives and insights from the focus groups, stakeholder interviews, key informants, and community survey respondents, “What we heard from the community on equitable care” is portrayed as follows:

Figure 85 delineated the responses collected from the leadership and health equity focus groups, key informant surveys, community stakeholder interviews, and community surveys.

Figure 85: Listening to the Community

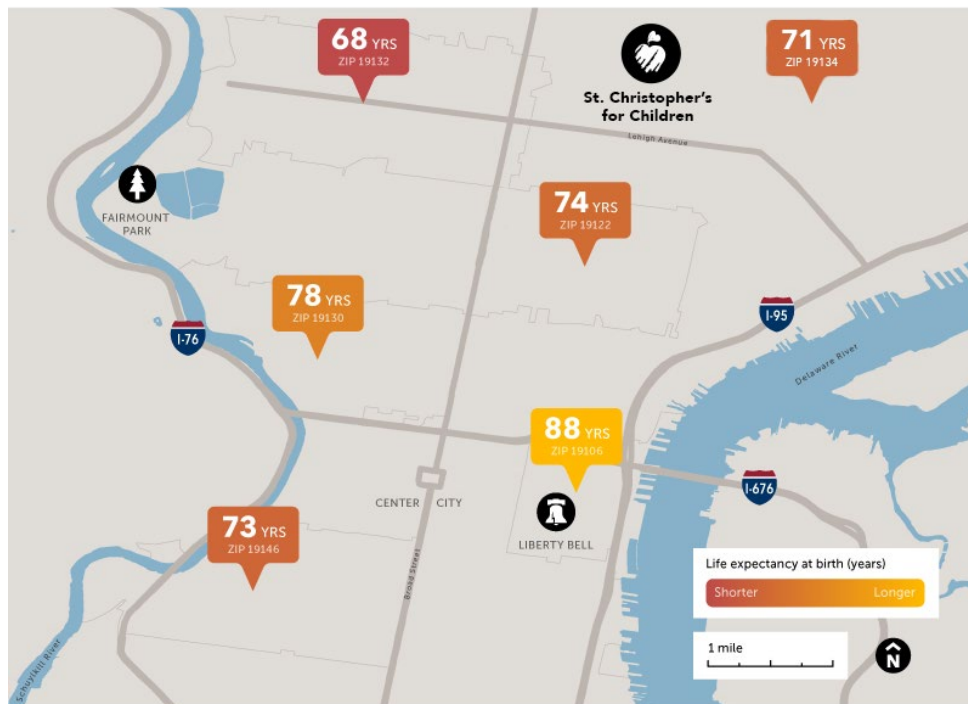




Life expectancy varies considerably by neighborhood in Philadelphia. Living just a mile away can decrease life expectancy by 20 years. Life expectancy is lowest in communities with highest rates of adverse behavioral and economic determinants, including poverty, substance use/abuse, and community violence.²⁸

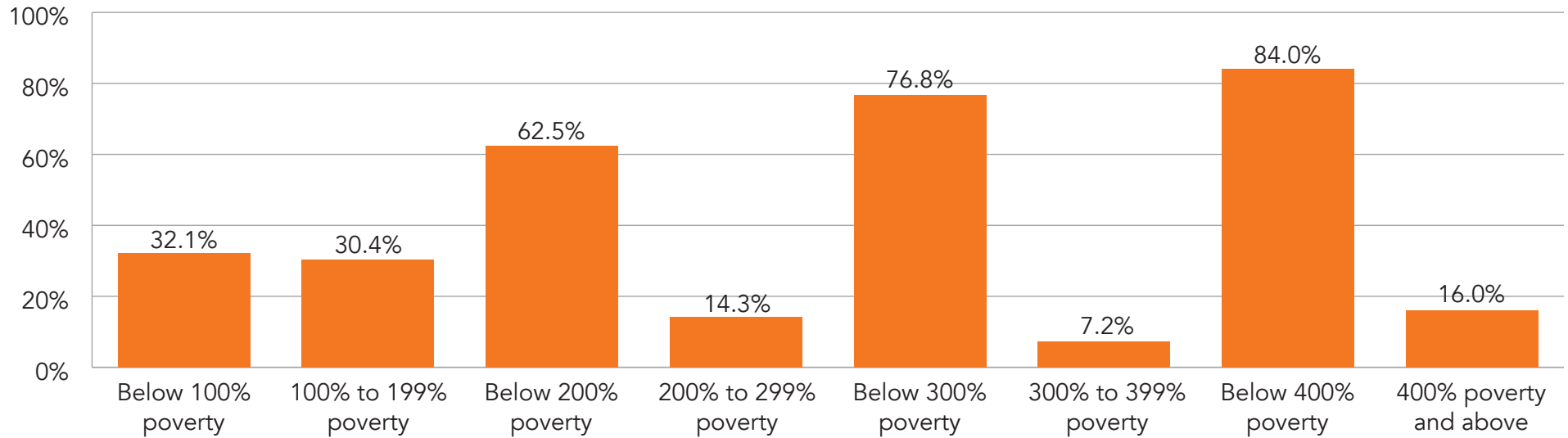
Babies born in Philadelphia ZIP codes only five miles apart face up to a 20-year difference in life expectancy. St. Christopher's for Children is focused on improving the health and mental well-being of the community and addressing social determinants of health which impact of the outcomes of one of the most vulnerable populations: children.

Figure 86: Short Distances to Large Health Gaps in Health



Source: [VCU Center on Society and Health](#)

Figure 87: Poverty Level - Population (age 0-17) in Philadelphia County, 2019

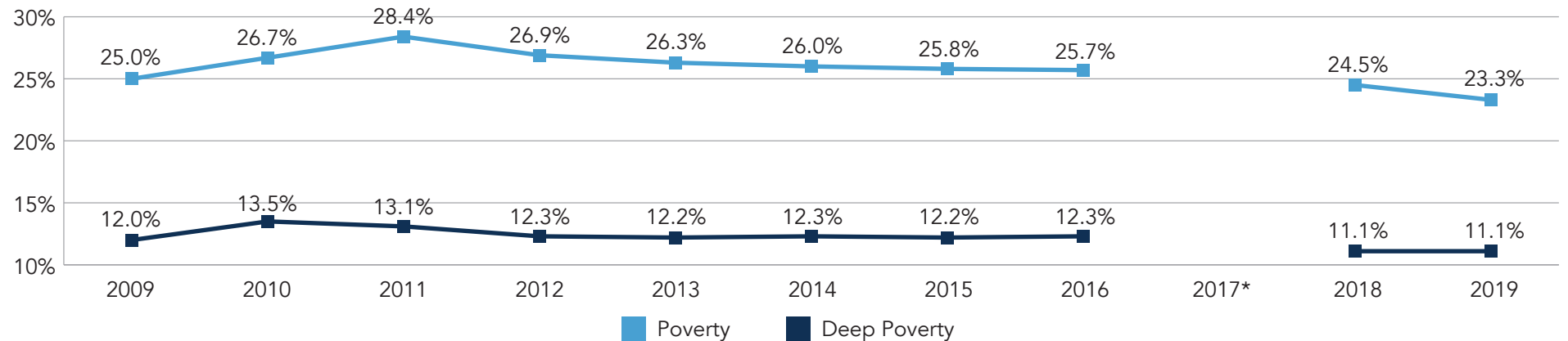


Source: [Kids Count Data Center 2019](#)

POVERTY AND DEEP POVERTY IN PHILADELPHIA, 2009-2019

Philadelphia's poverty rate decreased steadily but modestly over the eight years ending in 2019, falling from a high of 28.4% in 2011 to 23.3% before the pandemic. Similarly, the city's deep poverty rate decreased from a high of 13.5% in 2010 to 11.1% in 2019. A household of four was living in poverty in 2019 if its income was \$25,750 or less, and in deep poverty if its income was \$12,875 or less.

Figure 88: Poverty in Philadelphia



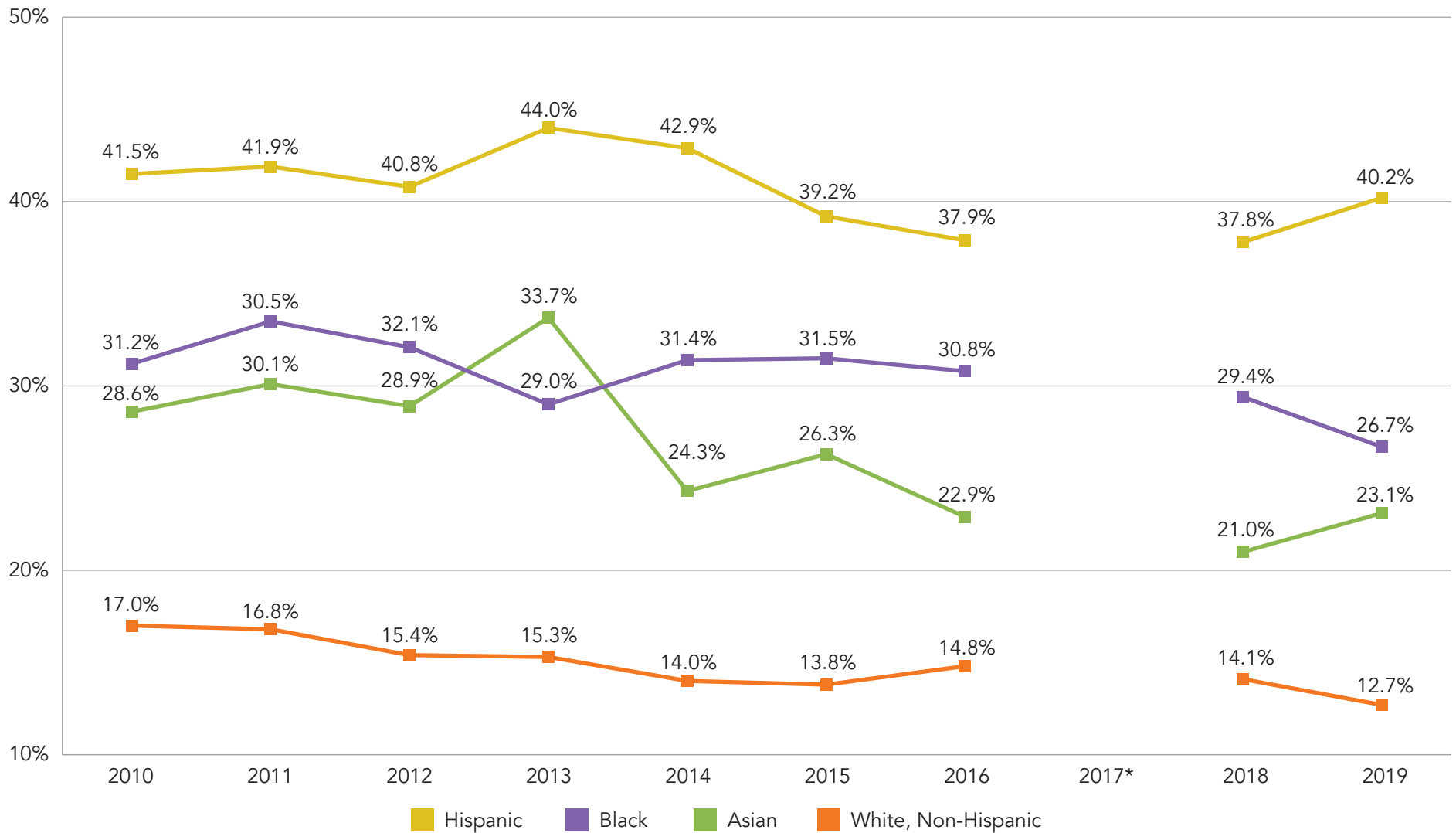
Note: *no data for 2017

Source: [Philadelphia, The State of the City, 2021](#)

POVERTY BY RACE AND ETHNICITY IN PHILADELPHIA, 2010-2019

Relative to members of other racial and ethnic groups, Hispanic Philadelphia residents have the highest poverty rate, more than triple the rate for non-Hispanic White residents. Although the poverty rate went down for all racial and ethnic groups in the city from 2010 through 2019, it increased for Hispanics and Asians from 2018 to 2019.

Figure 89: Poverty by Race/Ethnicity in Philadelphia



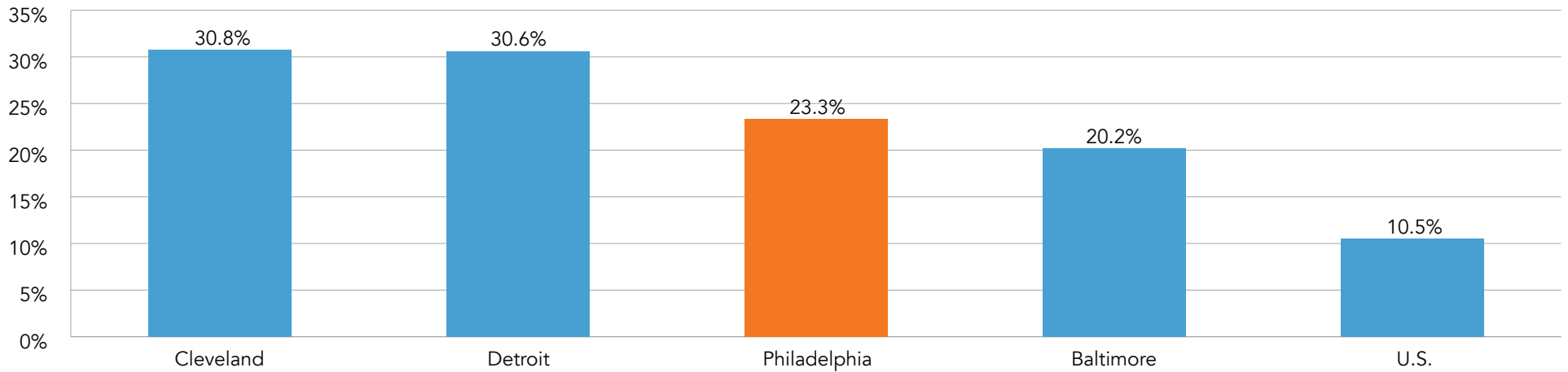
Note: *no data for 2017

Source: [Philadelphia, The State of the City, 2021](#)

POVERTY RATE COMPARED, 2019

In 2019, before the pandemic, Philadelphia continued to have the highest poverty rate among the nation's largest cities and the third highest among the comparison cities. The overall poverty level decreased slightly for all of the cities in 2019; the poverty rate for the United States was 10.5%, down 1.3% from its 2018 average of 11.8%.

Figure 90: Poverty Rate Compared with Other U.S. cities



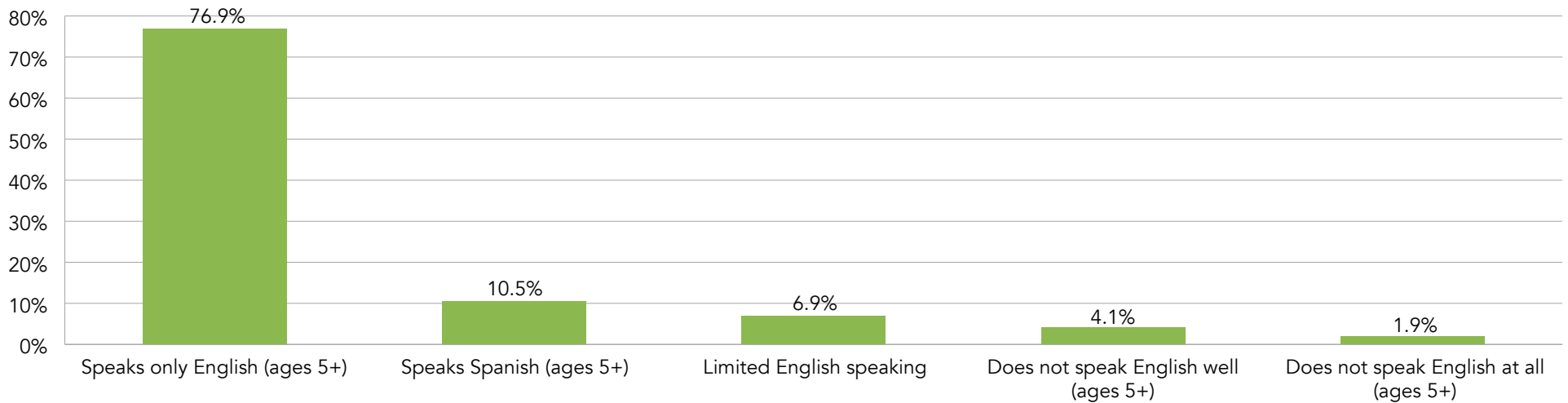
Source: [Philadelphia, The State of the City, 2021](#)



In 2019, the most common non-English language spoken in Philadelphia, PA with Spanish. 11.1% of the overall population of Philadelphia, PA are native Spanish speakers. 2.55% speak Chinese (including Mandarin, Cantonese) and 0.883% speak Arabic, the next two common languages.²⁹

Figure 91 reveals the percentages of residents who speak only English and Spanish and residents who are limited in English speaking.

Figure 91: Households with Residents Speaking English Only, Spanish, and Limited English



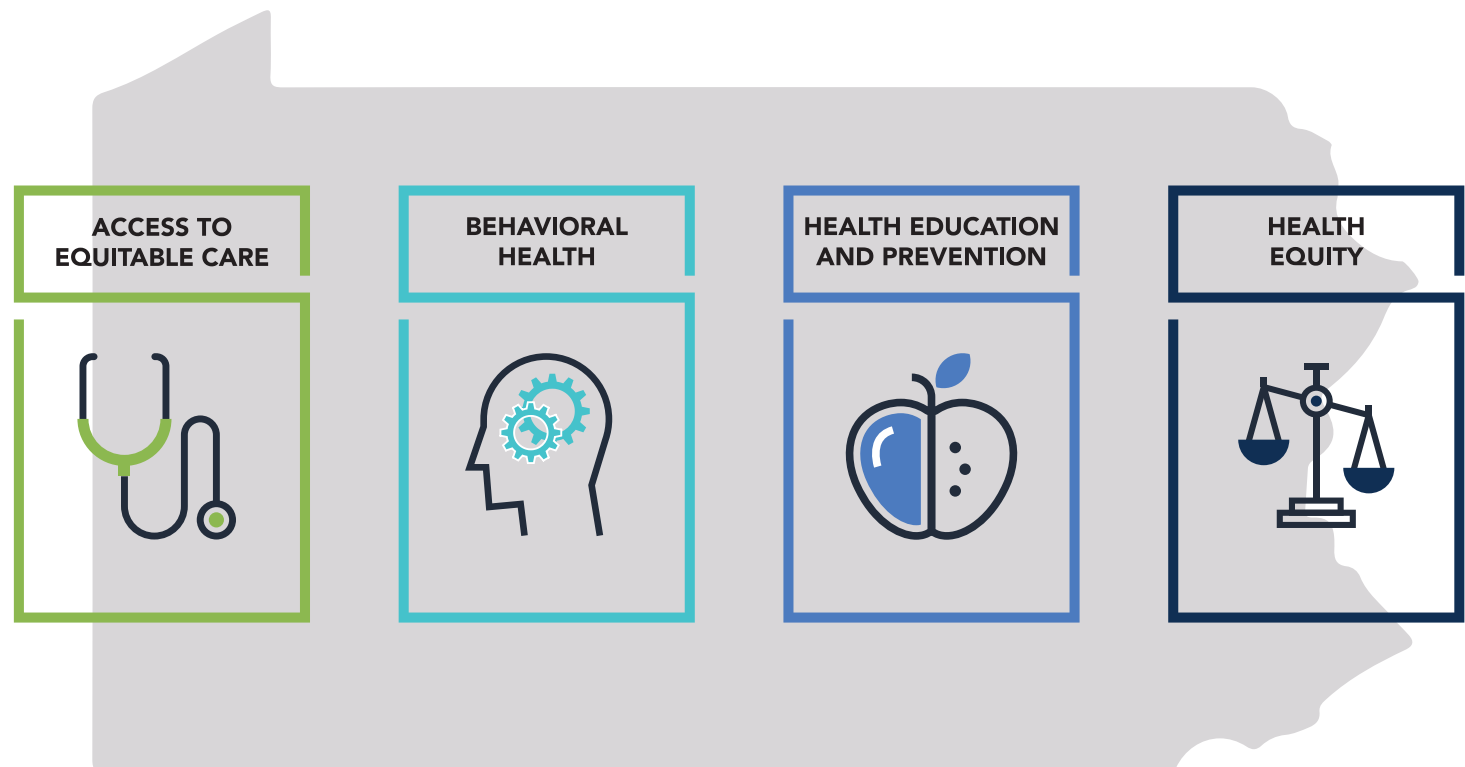
Source: [Philadelphia, The State of the City, 2021](#)



CHNA FOCUS AREAS FOR ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN 2022

In 2021, key need areas were identified during the CHNA process through the gathering of primary and secondary data such as community leader interviews, leadership and health equity focus groups, key informant surveys, a community survey, and a health provider inventory, which highlights organizations and agencies that serve the community.

Equitable care means delivering care that does not differ in quality according to characteristics of the patient or patient group such as age, gender, geographic location, cultural background, ethnicity, religion, and socioeconomic status. With health equity as a focus, "access to care" transformed to "access to equitable care" thus, was strongly emphasized through all aspects of primary data collection. The four identified areas of focus were:



CONCLUSION

WHAT'S NEXT ... IT'S COMPLICATED

One of the most challenging aspects of providing quality health care is the difficulty that populations and individuals experience in navigating the health care system. Access to equitable health care becomes more complicated and complex based on geographic factors – where people were born, live, work, and play – and economic, cultural, educational, and social factors. The health system may provide a plethora of recognized physicians, best practice services, and special programs, but access is complicated if residents lack transportation and insurance. There is a direct correlation between the ease of accessing health care and the overall health of a community.

Access is complicated for vulnerable populations such as the elderly, unemployed/underemployed, and low-income. Those factors serve as barriers to care and limit their ability to seek care early, often resulting in a health crisis, emergency visit, or hospitalization for illness and conditions that could be prevented. Access is complicated for ethnic patients with language barriers, limited English-speaking skills, and low levels of education. Culturally competent and appropriate care and treatment are essential to improving health and ensuring good outcomes. Just because we built it does not mean they will come.

Improving health equity is a daunting task as it extends well beyond the walls of the health system, reaches deep into the community sectors, and travels toward local and state government where health policies and protocols are developed. There has been increased recognition across the health care environment that improving health and achieving health equity demands a multi-sectoral approach. This approach requires the health system to engage and mobilize the broad community to address social, economic, and environmental factors that influence health. For example, the lack of access and availability of public transportation impacts not only access to health care but affects employment, access to affordable healthy food, and many other important drivers of health and wellness.

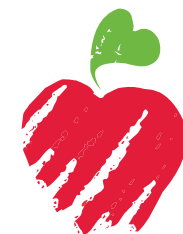
As the next step, St. Christopher's Hospital for Children will advance efforts to align and integrate the many voices and ideas offered from the community as received through the focus groups, a community survey, community leader interviews, and provider interview processes. St. Christopher's Hospital for Children will engage and collaborate with our community partners on the development of the CHNA Implementation Strategy Plan.

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towerhealth.org/locations/st-christophers-hospital-children



St. Christopher's
Hospital for Children

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