Community Health Needs Assessment

Strategic Implementation Plan

Penn Medicine Chester County Hospital

701 East Marshall Street, West Chester, PA 19380

FY 2023 – FY 2025

I. General Information

Contact Person: Michael J. Duncan, President & CEO, Chester County Hospital
Date of Written Plan: September 20, 2022
Date Written Plan was Adopted by Organization's Authorized Governing body: September 20, 2022
Date Written Plan was Required to be Adopted: November 15, 2022
Date Written Plan Posted to Website: September 22, 2022
Authorizing Governing Body that Adopted the Written Plan:
Chester County Hospital and System Board of Directors
Was Written Plan Adopted by Authorized Governing Body on or before the 15th day of the fifth month after the End of Tax Year in Which CHNA was Made Available to the Public? Yes
Date Written Plan Was Made Widely Available: September 22, 2022
Date Facility's Prior Written Plan Was Adopted by Organization's Governing Body: September 10, 2019
Name and EIN of Hospital Organization Operating Hospital Facility:
Chester County Hospital, EIN: 23-0469150
Address of Hospital Organization: 701 East Marshall Street, West Chester, PA 19380

II. Regional Community Health Needs for Southeastern PA

The Affordable Care Act (ACA) mandates that tax-exempt hospitals must conduct a Community Health Needs Assessment (CHNA) every three years and develop a Community Health Improvement Plan (CHIP) plan outlining strategies to address priority needs identified by the assessment. For this three-year reporting period, Chester County Hospital (CCH) participated in a collaborative effort conducted by the Philadelphia Department of Public Health (PDPH) and the Health Care Improvement Foundation (HCIF) to assess the needs of the broader Southeastern PA (SEPA) region, focusing on Bucks, Chester, Delaware, Montgomery, and Philadelphia counties. This process increased collaboration among partner hospitals, reduced duplication of effort and promoted coordination of effort to address needs of high priority.

The complete list of identified priority community health needs for the broader SEPA region are as follows:

Health Issues	Access and Quality of Healthcare and Health Resources	Community Factors
• Chronic disease prevention and management • Mental Health Conditions • Substance use and related disorders	• Access to care (primary and specialty) • Food access • Healthcare and health resources navigation • Culturally and linguistically appropriate care • Racism and discrimination in healthcare	• Community violence • Housing • Socioeconomic disadvantage • Neighborhood conditions

III. List of Community Health Needs to be Addressed by Chester County Hospital

Although the CHNA was produced as part of a joint collaborative that assessed the broader geographic region of SEPA, this plan addresses only those priorities specific to the service area of Chester County Hospital. The goals and strategies presented in this document represent the intentions of Chester County Hospital to address those identified priorities which impact a significant portion of the population served by the hospital and are feasible to address.
The list of identified priority community health needs to be addressed by Chester County Hospital are as follows:

Health Issues	Access and Quality of Healthcare and Health Resources
• Mental health conditions (Priority 1) • Chronic disease prevention and management (Priority 3) • Substance use and related disorders (Priority 4)	• Access to care (primary and specialty) (Priority 2) • Racism and discrimination in healthcare (Priority 5) • Healthcare and health resources navigation (Priority 6) • Culturally & linguistically appropriate care (Priority 7) • Food access (Priority 8)

IV. How Chester County Hospital Plans to Address Each Priority

Below are listed the goals, strategies, and impact measures associated with the prioritized health needs.

Priority 1: Mental Health Conditions

Goal 1: Develop a collaborative plan to offer and expand behavioral health care to the region, while growing behavioral health expertise in the emergency department and other CCH medical services.

Strategy	Impact Measure
a. Provide trainings on suicide screening and prevention to hospital staff.	– Number of staff trained in suicide screening and prevention per year.
b. Increase screening and assessment of patients for suicidal ideation.	– Utilize a suicide screening tool for all inpatients and perform risk level stratifications for patients with positive screens.
c. Collaborate with the University of Pennsylvania to develop safety plans for patients identified as low risk for suicide.	– Establish process to develop and quantify safety planning interventions. – Implement warm-handoff program that will support discharged patients. – Number of coordinated outpatient mental health appointments per year.
d. Provide trainings for hospital staff that enhance de-escalation skills to mitigate potentially violent situations.	– Number of staff trained per year.
e. Improve access to screening, assessment, and referral of patients with identified mental health needs.	– Create Behavioral Health service line to streamline and enhance processes to meet the needs of patients with mental health needs. – Develop Behavioral Health Governance Committee. – Assess and respond to behavioral health team's staffing needs.

Priority 1: Mental Health Conditions

Goal 1: Develop a collaborative plan to offer and expand behavioral health care to the region, while growing behavioral health expertise in the emergency department and other CCH medical services.

Strategy	Impact Measure
f. Provide greater access to treatment for patients with behavioral health needs in the Emergency Department and hospital.	– Assess and increase available staffing of the psychiatric consult liaison team as needed to provide greater access to psychiatric medication management. – Number of brief therapeutic interventions provided by Licensed Behavioral Health Counselors per year.
g. Collaborate with programs throughout the county to better meet the mental health needs of the community.	– Record hospital participation and attendance at relevant community-based work group meetings per year.
h. Identify and collaborate with a behavioral health organization to improve access to inpatient and outpatient mental health treatment.	– Number of meetings with the organization per year. – Provide annual programmatic updates on identified outcome measures.
i. Increase screening for depression in Penn Primary Care practices.	– Percentage of patients screened per year with PHQ-2. – Percentage of patients with positive -PHQ-2 that are screened with PHQ-9 per year.
j. Develop and implement a Penn Integrated Care program to increase access to behavioral health services for Penn Primary Care patients.	– Number of patients referred to behavioral health services per year.
k. Implement education and strategies to incorporate trauma-informed care into clinical practice for maternity patients.	– Implement screening tools for all maternity patients on admission. – Number of trauma-informed care staff trainings per year.

Priority 1: Mental Health Conditions **Goal 2:** Provide community health education programs to raise awareness of mental health issues and to help reduce stigma associated with mental health conditions.	
Strategy	**Impact Measure**
a. Collaborate with community agencies to identify the mental health needs of the community.	– Number of meetings with community agencies per year.
b. Provide suicide prevention trainings for community members.	– Number of trainings per year.
c. Provide mental health resources to the community.	– Promote the PA211 Helpline and the new 988 Suicide and Crisis Lifeline. – Update hospital website with mental health resources at least annually.
d. Collaborate with Chester County Adverse Childhood Experience (ACEs) Coalition to provide evidence-based trainings that help the community understand the impact of trauma, identify prevention strategies, and build resilience.	– Number of trainings per year. – Number of meetings with the ACEs Coalition per year.
e. Collaborate with community-based agencies to provide education and/or training focused on the mental health needs of youth.	– Meetings per year with youth-focused agencies. – Number of educational programs per year focused on youth mental health.
f. Provide Moms Supporting Moms support group led by a Maternal Mental Health Specialist/Clinic RN to provide emotional support for expectant and new mothers.	– Number of groups per year. – Number of participants per year.
g. Provide Dads Support Group to provide emotional support for expectant and new fathers.	– Number of groups per year. – Number of participants per year.

Priority 2: Access to Care (Primary and Specialty)

Goal 1: Develop a collaborative plan to offer needed primary and specialty care to regions currently underserved.

Strategy	Impact Measure
a. Continue to collaborate with community partners to identify healthcare needs of vulnerable populations.	– Number of meetings per year.
b. Support the provision of ancillary services (screenings, lab and diagnostic radiology) to underserved populations in clinics.	– Number of ancillary service registrations at community clinics per year.
c. Collaborate with Penn Medicine at Home providers to identify appropriate patients for both primary and specialty care visits in patients' homes.	– Number of meetings per year with CCH and providers. – Number of in-home patient visits per year.
d. Evaluate and optimize utilization of Penn on Demand to provide telehealth visits to increase access to care.	– Number of telehealth visits per year utilizing Penn on Demand.
e. Continue to collaborate with leadership of independent physician practices to identify healthcare needs of vulnerable populations.	– Number of meetings per year.
f. Coordinate care for new primary care patients in the Chester County Region.	– Number of patients scheduled through New Patient Coordinator per year.

Priority 2: Access to Care (Primary and Specialty)

Goal 2: Provide clinical health services, health screenings, and education to the general community with priority given to areas identified as high-risk.

Strategy	Impact Measure
a. Continue to provide care for OB/Gyn patients seen in CCH's Clinic.	– Number of OB/Gyn clinic visits per year.
b. Provide education and health screenings to evaluate risk for cardiovascular disease, cancer and obesity for high-risk individuals.	– Number of screenings per year. – Number of health education programs per year.
c. Maintain offering of all childbirth education programs for free to patients on Medical Assistance.	– Number of participants per year.
d. Offer free Spanish-language e-classes on childbirth, breastfeeding, and newborn care to our OB clinic patients and/or those in the community with Medicaid or no insurance.	– Number of free e-class participants per year.

Priority 3: Chronic Disease Prevention and Management

Goal 1: Promote optimal health to reduce the impact of chronic diseases (e.g. cancer, obesity, diabetes, heart disease, stroke, etc.) and to enhance overall outcomes and quality of life.

Strategy	Impact Measure
a. Provide multi-session educational programs for people at risk or living with chronic disease.	– Number of multi-session educational programs per year.
b. Offer free, high-quality, interactive wellness programs provided by experts on chronic disease prevention and management that result in increased knowledge and intent to change health behavior.	– Number of presentations by service line/category per year. – Number of participants by service line/category per year. – Annual review of participant evaluations for quality, knowledge and intent to change lifestyle.
c. Offer free health screenings to assess risk for chronic disease, with follow-up education and referrals as needed.	– Number of screenings per year.
d. Collaborate with community partners to provide wellness education and resources at health promotion events.	– Number of health promotion events per year.
e. Provide nutrition counseling at no charge to cancer patients in treatment as appropriate.	– Number of visits per year.
f. Continue to provide support programs for individuals living with chronic disease.	– Number of support groups by condition per year. – Number of participants by condition per year.
g. Continue to respond to community requests for speakers on topics related to health promotion and disease prevention.	– Number of programs delivered per year. – Number of participants per year.
h. Continue to meet American College of Cardiology (ACC) Community Outreach Requirements for Chest Pain Center Accreditation.	– Number of cardiovascular disease screenings per year. – Number of Early Heart Attack Care (EHAC) and Hands-only CPR trainings per year.

Priority 3: Chronic Disease Prevention and Management **Goal 1:** Promote optimal health to reduce the impact of chronic diseases (e.g. cancer, obesity, diabetes, heart disease, stroke, etc.) and to enhance overall outcomes and quality of life.	
Strategy	**Impact Measure**
	– Documented planning meeting with local EMS agencies. – Documented planning meeting with a primary care provider or Advanced Practice Provider (APP).
i. Email monthly newsletter with resources to help support individuals living with heart failure.	– Average monthly number of newsletters sent. – Average monthly open rate.
j. Continue to provide the outpatient Cardiopulmonary Rehabilitation program in compliance with the standards of the American Association of Cardiovascular and Pulmonary Rehab (AACVPR).	– Number of new cardiopulmonary patients enrolled per year.
k. Utilize Penn Primary Care RN's to conduct hypertension clinics that are coordinated with the care management team.	– Number of hypertension clinics held per year. – Number of patients per year. – Number of care gaps (controlled hypertension) closed per year.
l. Utilize Penn Primary Care RN's to conduct diabetes clinics for complication prevention.	– Number of diabetes clinics held per year. – Number of patients per year. – Number of care gaps (A1c, retinal exam, foot exam, microalbuminuria) closed per year.

Priority 4: Substance Use and Related Disorders

Goal 1: Offer evidence-based treatment options for patients with substance use and related disorders.

Strategy	Impact Measure
a. Promote the current standard of care for management of patients with Opioid Use Disorder (OUD) to improve consistency among providers.	– Annual percentage of patients administered Medications for OUD (MOUD). – Annual percentage of patients with active Narcan® prescription. – Annual percentage of discharges Against Medical Advice (AMA).
b. Improve screening of patients for OUD and connect identified patients to appropriate outpatient resources.	– Implement and utilize universal single screening question to identify any substance use disorder during ED triage. – Review and maintain updated list of outpatient resources/providers at least quarterly. – Number of calls per year from CCH to Penn's Care Connect Warmline for resource and care navigation.
c. Provide Naloxone nasal spray (Narcan®) upon discharge to patients identified to be at risk for an opioid emergency/opioid overdose.	– Number of Naloxone nasal spray (Narcan®) provided per year to patients that are identified at risk for an opioid emergency/opioid overdose upon discharge.
d. Increase the number of providers who are X-waivered and can prescribe buprenorphine for MOUD.	– Number of providers per year who can prescribe buprenorphine for MOUD.
e. Provide additional support to patients in the ED and hospital setting who are struggling with addiction of drugs or alcohol via Certified Recovery Specialists (CRS), including warm handoff for continued follow-up within the community.	– Number of patients seen by a CRS through Community Outreach & Prevention Education (COPE) per year. – Number of patients seen per year connected to drug and alcohol treatment services via CRS intervention.

Priority 4: Substance Use and Related Disorders

Goal 1: Offer evidence-based treatment options for patients with substance use and related disorders.

Strategy	Impact Measure
f. Collaborate with community partners for drug and alcohol treatment.	– At least one CCH staff member will participate in quarterly Chester County Drug & Alcohol Task Force meetings.
g. Add drug screening for all obstetric patients in ambulatory care setting.	– Percentage of patients screened per year.
h. Review and renew Opioid Use Agreements annually in the Penn Primary Care practices.	– Percentage of patients on opioids with active opioid agreements per year. – Percentage of medication reconciliations completed per year.
i. Provide education to all clinical staff treating maternity patients with substance use disorder.	– Number of substance use disorder education programs per year provided to clinical staff treating maternity patients.
j. Continue the use of 5Ps screening tool to identify perinatal patients with substance use disorders.	– Percentage of labor-delivery patients screened per year. – Percentage of OB clinic patients screened per year.
k. Identify and update patient education materials and resources for perinatal patients who screen positive for THC.	– Annually take inventory of existing patient education materials and resources for perinatal patients who screen positive for THC. – Number of updated educational materials and resource lists per year.
l. Provide strategies and education pre-discharge regarding postpartum contraception (PPC) for maternity patients identified with substance use disorder.	– Number of maternity patients identified per year with substance use disorder who are educated about postpartum contraception (PPC). – Number of maternity patients identified per year with substance use disorder who receive PPC.

Priority 4: Substance Use and Related Disorders **Goal 2**: Increase community awareness of substance use disorders, resources, and treatment options.	
Strategy	**Impact Measure**
a. Partner with community organizations to provide education programs on substance use disorders, resources and treatment options.	– Number of substance use education programs per year.
b. Maintain hospital website to ensure community resource information for substance use disorders is current.	– Review hospital website to update substance use disorder resources at least once per year.

Priority 5: Racism and Discrimination in Healthcare **Goal 1:** Advance a workplace culture characterized by racial equity and non-discrimination, that supports the delivery of healthcare services reflecting the cultural and ethnic diversity of patients, and ensures a positive healthcare experience for all.	
Strategy	**Impact Measure**
a. Ensure that Diversity, Equity, and Inclusion (DEI) staff training efforts and plans include explicit focus on racism and discrimination.	– Incorporate principles of trauma-informed care into HR policies, practices, and leadership development initiatives. – Number of employee forums per year that help staff recognize discriminatory behaviors. – Number of “Cultures of Belonging” training modules completed by all CCH staff. – Number of “Inclusion, Diversity & Cultural Humility” training modules completed by all CCH staff.
b. Expand and improve training for staff in anti-racism, structural racism, implicit bias, and trauma-informed care.	– Plan and host inaugural annual DEI summit for selected staff from all departments. – Investigate resources and develop proposal for staff training on implicit bias and trauma-informed care.

Priority 5: Racism and Discrimination in Healthcare

Goal 1: Advance a workplace culture characterized by racial equity and non-discrimination, that supports the delivery of healthcare services reflecting the cultural and ethnic diversity of patients, and ensures a positive healthcare experience for all.

Strategy	Impact Measure
c. Provide educational forums for staff that align with diversity recognition awareness months (black history, AAPI, Pride, Hispanic Heritage, etc.).	– Number of diversity forums per year.
d. Collaborate with community leaders to address issues of racism and discrimination in health care.	– Create a DEI Community Advisory Committee. – Number of meetings per year.
e. Identify and attract diverse candidates with lived experience for employment especially for patient facing-clinical roles, medical staff and administrative leadership roles.	– Establish a group that meets to address internal barriers to attracting and retaining talent from under-represented communities.
f. Explore options for training hospital staff in conversational Spanish.	– Number of staff trained per year.
g. Improve recognition of health disparities.	– Report on stratified health outcomes utilizing Race, Ethnicity, Ancestry and Language (REAL) data. – Develop a Community Advisory Board (CAB) to identify opportunities to reduce health disparities.
h. Provide training sessions to all staff on language access.	– Number of New Employee Orientation sessions/ year. – Number of Video Remote Interpreter vendor on-site visits per year.
i. Penn Primary Care Medical Director and Manager will meet to address diversity, equity and inclusion needs.	– Number of meetings per year.

Priority 6: Healthcare and Health Resources Navigation **Goal 1:** Improve the patient experience through efforts to enhance healthcare navigation**.**	
Strategy	**Impact Measure**
a. Continue to provide free transportation for eligible patients receiving cancer treatment.	– Number of rides per year.
b. Maintain a Call Center to register individuals for wellness programs, and refer them to medical services/providers and other community resources.	– Number of wellness registration calls. – Number of medical services/provider referrals per year. – Number of other calls per year.
c. Continue the support of nurse navigators for the Oncology and Heart & Vascular (H&V) and additional service lines as needed.	– Number of oncology patients navigated by category per year. – Number of H&V patients navigated by category per year.
d. Update printed and online medical and community resource directories, and maintain hospital website to ensure community resource information is current.	– Perform update of printed medical resource directory every 18 months. – Number of medical directories ordered every 18 months. – Perform annual update of hospital website's community resource information.
e. Provide convenient access to Medical Assistance (MA) enrollment utilizing CCH Financial Representatives.	– Number of MA applications completed per year. – Number of MA applications approved per year.
f. Continue utilization of cardiovascular nurse navigators to enroll eligible patients into the outpatient cardiac rehabilitation program.	– Achieve a Capture rate (eligible/enrolled) of at least 35% per year.
g. Explore the ability to provide free transportation for eligible parents of NICU.	– Number of rides per year.

Priority 6: Healthcare and Health Resources Navigation **Goal 1:** Improve the patient experience through efforts to enhance healthcare navigation**.**	
Strategy	**Impact Measure**
h. Increase communication with discharged patients through utilization of Penn Medicine Connects.	– Number of outreaches made per year. – Number of answered messages per year. – Number of negative responses (patients with identified problems) per year.
i. Continuum of Care (COC) Social Workers will contact patients post-discharge to ensure smooth transitions back into the community.	– Number of contacts per year.
j. Intake assessments on admitted patients to be done by case management to identify discharge needs.	– Number of assessments per year. – Discharged referrals by category per year.
k. Utilize Penn Partners in Care nurse care managers in each of the Penn primary care practices to assist patients with transitions in care.	– Number of interactions per year.
l. Provide resources to all NICU mothers with positive Social Determinants of Health (SDOH) screenings that indicate financial resource strain, transportation needs, and/or food insecurity.	– Review and update CCH NICU resource website at least annually. – Number of social work consults generated from positive SDOH screenings per year.

Priority 7: Linguistically and Culturally Appropriate Healthcare **Goal 1:** Identify opportunities and implement action plans related to health literacy.	
Strategy	**Impact Measure**
a. Provide community education/training on health literacy to encourage participants to take an active role in their health care.	– Number of programs per year.
b. Implement a pilot project to improve community health literacy in collaboration with the Kennett Library.	– Number of meetings with library leadership. – Number of community health literacy programs.
c. Complete the UPHS Health Literate Organization Assessment.	– Health Literature Organization Assessment Data collected and uploaded by 12/31/22.
d. Re-implement staff “Effective Patient Education” course.	– Number of classes scheduled per year.
e. Identify and implement opportunities for improvement at CCH from the Health Literate Organization Assessment.	– Opportunities and associated outcome measures will be identified for improvement and an action plan created.
f. Participate in Chester County Hospital and regional/statewide health literacy coalition meetings.	– Number of CCH meetings per year. – Number of regional/statewide meetings per year.
g. Promote the Pennsylvania Health Literacy Coalition’s online training modules as available to CCH clinical staff.	– Number of modules per year made available to staff.
h. Train CCH staff on improving patient safety through health literacy.	– Number of users per year who have completed modules of “Stronger Together – Improving Patient Safety through Health Literacy.”

Priority 7: Linguistically and Culturally Appropriate Healthcare **Goal 2:** Provide the resources and materials necessary to ensure a positive healthcare experience for those with language or cultural needs.	
Strategy	**Impact Measure**
a. Provide maternity unit tours utilizing a bilingual nurse educator.	– Number of tours in Spanish per year.
b. Provide Spanish-speaking expectant parents with folders and educational handouts in Spanish.	– Number of Spanish expectant parents' folders distributed per year.
c. Continue to provide a bilingual diabetes educator to counsel Spanish speaking patients with gestational diabetes.	– Number of Spanish-speaking patients with gestational diabetes served per year.
d. Increase the availability of maternal/child educational materials in Spanish.	– Assess current state of educational materials that are provided in Spanish – Annual percentage of materials (written and video) that are available in Spanish.
e. Maintain or increase the number of Spanish-speaking volunteers for hospital-based and community outreach needs.	– Number of Spanish-speaking volunteers per year. – Number of programs per year utilizing volunteers.
f. Create a Maternal Forum with identified community partners to improve continuity of care and clinical outcomes for Spanish-speaking maternity and post-partum patients.	– Identify community partners and their scope of services. – Number of meetings per year. – Annual complication rate of post-partum hemorrhage. – Annual complication rate of post-partum infection.
g. Host community forums in targeted regions to conduct surveys with Spanish-speaking post-partum women to learn about their patient experience in and out of the hospital.	– Conduct at least 4 forums in FY23.

Priority 7: Linguistically and Culturally Appropriate Healthcare **Goal 2:** Provide the resources and materials necessary to ensure a positive healthcare experience for those with language or cultural needs.	
Strategy	**Impact Measure**
h. Provide language interpretation tools for a broad range of languages as needed by clinical and non-clinical areas.	– Number of in-person interpreter minutes per year. – Number of phone interpreter minutes per year. – Number of video interpreter minutes per year. – Number of dual head-set interpreter phones. – Number of video remote interpreter iPad/ carts.
i. Expand the number of qualified bilingual individuals who can interpret in the hospital.	– Annually evaluate the effectiveness and needs of the BOLD Interpreter Supplemental Group with leadership. – Number of bilingual individuals per year trained to interpret.
j. Meet with Clinical Informatics Governance Team at least annually to improve reporting tools around language access.	– Number of meetings per year.
k. Increase interpreter access to behavioral health patients by providing an interpreter for telepsych consults, and an on-call Spanish interpreter for escalated incidents occurring outside of normal business hours.	– Number of telepsych consults using an interpreter per year. – Number of on-call Spanish interpreter consults per year for escalated incidents occurring outside of normal business hours.
l. Provide Spanish translations of critical documents.	– Develop a plan to take inventory of patient education documents available in Spanish. – Explore the use of a translation agency to provide services for personalized discharge instructions. – Number of Spanish Language Patient Handbooks ordered per year. – Number of documents translated into Spanish per year.

Priority 8: Food Access

Goal 1: Increase access to healthy food for patients and community residents who are food insecure

Strategy	Impact Measure
a. Establish a Food Pantry with the Chester County Food Bank for OB clinic patients who have been identified as food insecure.	– Total number of individuals per year who received food from the pantry.
b. Collaborate with the West Chester Food Cupboard to provide supplemental food for patients who have been identified as food insecure.	– Number of food deliveries per year provided by WCFC to the OB clinic for patients receiving food from the pantry.
c. Collaborate with the Chester County Food Bank to provide educational programs to the community to increase the awareness of available resources for food insecurity.	– Provide at least two programs per year.

V. Planned Collaborations to Address Health Needs

Chester County Hospital has many established and long-standing collaborations with community organizations to serve the needs of our shared community:

Aidan's Heart Foundation	Health Promotion Council
Alzheimer's Association, Delaware Valley Chapter	Housing Partnership of Chester Co.
Be a Part of the Conversation	Iglesia de Buen Samaritano
Bethel AME Church West Chester	Jenner's Pond
Brandywine YMCA	Jubilee Evangelistic Ministries
Bridging the Community – Kennett Square	Kennett Area YMCA
BVAA – Brandywine Valley Active Aging	Kennett Consolidated School District
CARN – Coatesville Area Resource Network	Kennett Library
Charles A. Melton Arts and Education Center	LCH Health and Community Services
ChesPenn Health Services	LEAP for Coatesville
Chester Co. ACES Coalition	Longwood Fire Company
Chester Co. Dept. of Aging Services	Maris Grove
Chester Co. Dept. of Community Development	Maternal Child Health Consortium
Chester Co. Dept. of Drug and Alcohol	Minquas Ambulance
Chester Co. Dept. of Emergency Services	MNECC – Minority Nurse Educators of CHESCO
Chester Co. Food Bank	PARN – Phoenixville Area Resource Network
Chester Co. Health Department	Penn State Extension Chester Co.
Chester Co. Library System	SCCON – South Chester Co. Outreach Network
Chester Co. MHIDD	St. Paul's Baptist Church
Chester Co. Suicide Prevention Task Force	Tabernacle Baptist Church
Chester Co. Tobacco-Free Coalition	The Alliance for Health Equity
Coatesville 2nd Century Alliance	The Parkesburg Point
Coatesville Area Public Library	Two Fish Five Loaves Community Café Inc.
Coatesville Center for Community Health	Unionville-Chads Ford School District
Coatesville NAACP	United Way of Chester Co.
Coatesville Youth Initiative	Uwchlan Ambulance
Crescent Foundation	W.C. Atkinson Memorial Community Service Ctr.
CVIM – Community Volunteers in Medicine	West Chester Area School District
East Brandywine Fire Company	West Chester Area Senior Center
Emergency Training Academy	West Chester Area YMCA
FILM – Forward Impact Life Ministries	West Chester Communities That Care
Freedom Village	West Chester Food Cupboard
Gateway Church	West Chester NAACP
Good Fellowship Ambulance & EMS Training Inst.	West Chester University

VI. Health Needs Chester County Hospital Does Not Intend to Address

Following the completion of the CHNA and the identification of all the health priorities, the needs were prioritized using a Modified Hanlon Method to score the need against several criteria. Following this process, the needs were further prioritized based on several feasibility factors to screen out priorities not feasible to address. This process is known as the "PEARL" test and looked at factors of propriety, economics, acceptability, resources and legality associated with each of the health priorities. Any community health need receiving an answer of "no" to any of these factors was removed from the list of priorities. Thus, the ones remaining on the list of priorities to address are all feasible to address.

Health needs that are not feasible for Chester County Hospital to address, and the reasons why, include:

1. **Community Violence**

   Community violence was not identified as a concern within the Chester County community, either statistically or within the community meetings. Furthermore, both local and county resources monitor, manage and offer programs to address community violence.

2. **Housing**

   Chester County Hospital does not have the capacity to address a need for affordable housing within the community. Residents challenged with finding affordable and healthy housing may find assistance within cited county resources.

3. **Socioeconomic Disadvantage**

   Chester County Hospital has chosen to focus on healthcare disparities rather than socioeconomic disadvantages associated with income, education and employment.

4. **Neighborhood Conditions**

   Poor neighborhood conditions were not specifically identified as a community need within the Chester County market. Findings from community meetings conducted in two separate segments identified neighborhood conditions as assets.

Many community needs are addressed directly by the resource guide provided by Chester County. The following link includes information for community residents and providers to access these services.

https://www.chesco.org/DocumentCenter/View/4275/Community-Resource-Guide-August-2022?bidId