COMMUNITY HEALTH NEEDS ASSESSMENT

AHN JEFFERSON

Report

April 2022

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Mission

Jefferson Hospital partners with its employees, communities, and physicians to address current and developing health needs with quality medical, preventative, and related services. All services are delivered with sensitivity to the clinical, emotional, and spiritual needs of the individual.

Vision

Our communities will have confidence that Jefferson Hospital will be available for them in times of need, providing superior care and service and working to improve the region's health.

Core Values

Respect and Dignity

Achievement

Professionalism and Compassion

Integrity and Honesty

Spirituality

Introduction

About Allegheny Health Network (AHN)

The hospitals of Allegheny Health Network, as they have for decades, provide exceptional health care to help people live healthy lives and continue to extend their reach, offering a broad spectrum of care and services.

The tradition continues by using the latest medical innovations to treat patients. Gaining knowledge through research to constantly improve how to prevent, diagnose, and treat illness, AHN staffs each hospital with experienced, expert, and compassionate physicians, nurses, and other health care professionals dedicated to medicine, people, and healing.

AHN is committed to giving patients the proper care, at the right place, at the right time. Physicians from various specialties work as a team to coordinate patients' care from start to finish. AHN explores every possible option for treatment. AHN has established medical facilities in communities throughout the region, so patients have convenient access to care. Also, AHN works around patients' schedules to help maintain their quality of life while receiving treatment and therapy.

AHN can extend its reach to more people as a health network by offering a broad spectrum of care and services. AHN has 14 hospitals and more than 200 primary- and specialty-care practices. AHN has approximately 2,400 physicians in every clinical specialty, 21,000 employees, and 2,000 volunteers. AHN provides world-class medicine to patients in their communities, across the country, and around the world.

AHN's physicians continually explore and develop new treatments that allow us to bring medical discoveries from the laboratory directly to patients. These breakthroughs help save lives and give patients access to the latest treatments for disease and medical conditions. Allegheny Health Network is also committed to educating and training the next generation of doctors by serving as the clinical campus for both Lewis Katz School of Medicine at Temple University and Drexel University College of Medicine.

Allegheny Health Network is an integrated health care system that serves patients from across a four-state region that includes Pennsylvania and portions of New York, Ohio, and West Virginia. AHN has more than 80 medical, surgical, and radiation oncology physician practices; one of the state's most extensive bone marrow transplant and cellular therapy programs; and the nation's largest – and western Pennsylvania's only – radiation oncology network accredited by both the American Society for Radiation Oncology and American College of Radiology. Allegheny Health Network's cancer program has more than 200 clinical trials offered throughout its network of hospitals and clinics.

AHN has received accolades from numerous organizations, including Thomson Reuters, AARP, Healthgrades, and Consumer Reports. These accolades recognize AHN's dedication to excellence and strengthen its ability to tackle diseases so we may find a cure for tomorrow.

About AHN Jefferson

AHN Jefferson is a modern, 341-bed facility located 13 miles south of Pittsburgh. AHN Jefferson is deeply committed to providing residents of South Hills communities with superior medical care in a location close to home. AHN Jefferson offers a complete range of health care services, including emergency treatment, diagnostic testing, medical and surgical treatment, inpatient and outpatient care, and laboratory and pathology work. AHN Jefferson's services include comprehensive care programs for cancer, heart, and lung; behavioral health care; and rehabilitation programs.

Primary nursing has been an essential part of our approach to care. AHN Jefferson features several skilled nursing units where nurses work directly with physicians to develop a personalized plan for patients recovering from illness. A medical staff of more than 400 physicians delivers patient care programs supported by experienced nursing teams.

Most importantly, many of the physicians, nurses, and administrative staff of AHN Jefferson share something fundamental with their patients: a sense of community. Because many of our employees call the South Hills home, they have a personal dedication to providing their neighbors with the highest quality medical care.

Jefferson Hospital's long-standing commitment to clinical and patient care excellence is expressed in its mission, vision, and core values statements. As a provider of quality health care, its mission is not only about medical treatment and care, but it is also about caring for the wellbeing of the whole person, care of the spirit, and compassion for those in need.

Jefferson Hospital's roots date to the turn of the 20th century with the founding of Homestead and St. Joseph's hospitals. Since then, Jefferson has become one of the most successful community-based health care providers in southwestern Pennsylvania. In 2013, the board of directors once again recognized an opportunity to expand Jefferson's service offerings and better serve the needs of those living in the South Hills communities by partnering with Highmark and becoming part of the Allegheny Health Network as Jefferson Hospital.

For more information about AHN Jefferson, please click here.

AHN Jefferson Recognition

Award-Winning Medical Care

- No. 1 hospital in southwestern PA for Medical Excellence in Neurological Care (CareChex 2021)
- Gold Plus Heart Failure Achievement Award and Gold Plus Stroke Quality Achievement Award recognition from American Heart Association/American Stroke Association Get with The Guidelines®
- Blue Distinction Center+SM designation for efficiency in delivering high-quality care and better overall outcomes for spine surgery care.
- NCDR Chest Pain-MI Registry 2021 Silver Performance Achievement Award.

Women's and children's care

- Cribs for Kids® National Safe Sleep Hospital Certification at its highest designation, Gold Safe Sleep Champion.
- International Board of Lactation Consultants (IBCLC) Care Award, for excellence in lactation care and a high level of support for breastfeeding families.
- Keystone 10 designation for Quality Improvement in Breastfeeding.
- First hospital in Allegheny County to earn The Joint Commission's Gold Seal of Approval® for Perinatal Care Certification.

Certified specialty care

- Joint Commission Advanced Primary Stroke Center Certification, May 2018.
- Joint Commission Hip/Knee Replacement Recertification, February 2018.
- Five-star Recipient for Treatment of Heart Failure in 2021 (Healthgrades).

Certified specialty care

- One of Healthgrades America's 50 Best Hospitals for Vascular Surgery™ for three years in a row (2019-2021).
- Recipient of the Healthgrades 2021 Bariatric Surgery Excellence Award™.
- Recognized by Healthgrades in 2021 for Superior Performance in Bariatric Surgery.
- Among the top 10% of hospitals evaluated for Bariatric Surgery in 2021 (Healthgrades).
- Five-star Recipient for Overall Bariatric Surgery for two years in a row (2020, 2021) (Healthgrades).

Frequently Asked Questions

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)?

A community health needs assessment is an effective method of identifying the unmet health care needs of a population and making changes to meet these needs.

WHY WAS A CHNA PERFORMED?

Through comprehensive data and analysis, community health needs assessments identify key health needs and issues locally. Not-for-profit hospitals or charitable-status organizations under section 501(c)(3) of the Federal Internal Revenue Code are required to provide benefits to the community that they serve.

Not-for-profit hospitals must conduct a CHNA and adopt an implementation strategy at least once every three years to meet the identified community health needs. CHNAs identify areas of concern within the community related to the current health status of the region. The identification of the region's health needs provides AHN Jefferson and its community organizations with a framework to improve the health of its residents.

HOW WAS DATA FOR THE CHNA REPORT COLLECTED?

A working group was formed in summer 2021 to complete the CHNA and its initiatives. The information collected is a snapshot of the health of residents in the service area of AHN Jefferson, encompassing socioeconomic information, health statistics, demographics, and mental health issues, etc. The group worked passionately and tirelessly to be the voice of the residents served.

Internal Revenue Service (IRS) Requirements

The Patient Protection and Affordable Care Act (PPACA), which went into effect on March 23, 2010, requires tax-exempt hospitals to conduct a community health needs assessments (CHNA) and implementation strategy plans to improve the health and wellbeing of residents within the communities served by the hospitals. These strategies created by hospitals and institutions consist of programs, activities, and plans specifically targeted toward community populations. The execution of the implementation strategy plan is designed to increase and track the impact of each hospital's efforts.

The requirements imposed by the IRS for tax-exempt hospitals and health systems must include the following:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how the strategy addresses the needs identified in the CHNA and a description of needs that are not being addressed with the reasons why.

The Department of the Treasury and the IRS require a CHNA to include:

1. A separate written report for each hospital (state license designation).
2. Description of the community served by the hospital and how that community is defined.
3. Description of the process and methods used to conduct the CHNA.
4. Information gaps that may impact the ability to assess needs.
5. Identification of any collaborating partners.
6. Identification and qualifications of any third parties assisting with CHNA.
7. Description of how input from the community was used.
8. Prioritized description of all community health needs identified through the CHNA.
9. Description of existing health care facilities within the community available to meet the needs identified.
10. A description of the needs identified that the hospital intends to address, the reasons those needs were selected, and how the hospital will address the selected needs.

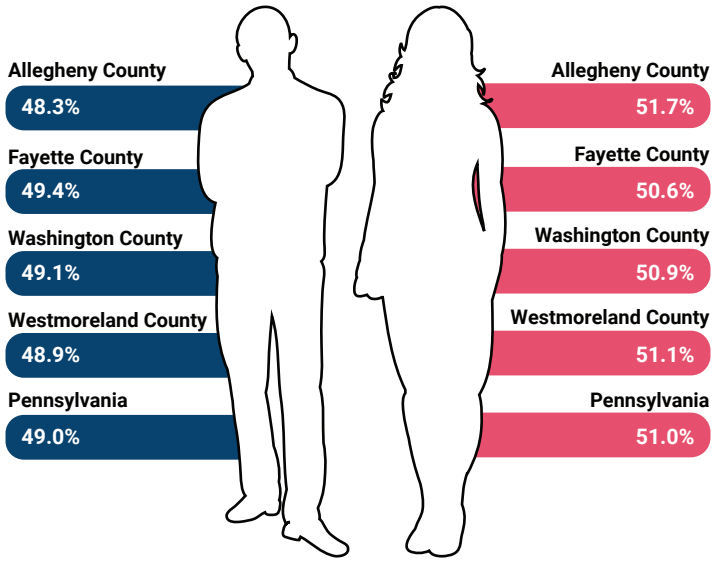
AHN JEFFERSON

Community Profile

Population

Allegheny County	Fayette County	Washington County	Westmoreland County	Pennsylvania
1,221,744	131,302	207,212	352,590	12,791,530
+2.23% from 2010-2020	-5.76% from 2010-2020	+0.74% from 2010-2020	-2.86% from 2010-2020	+2.36% from 2010-2020

Gender



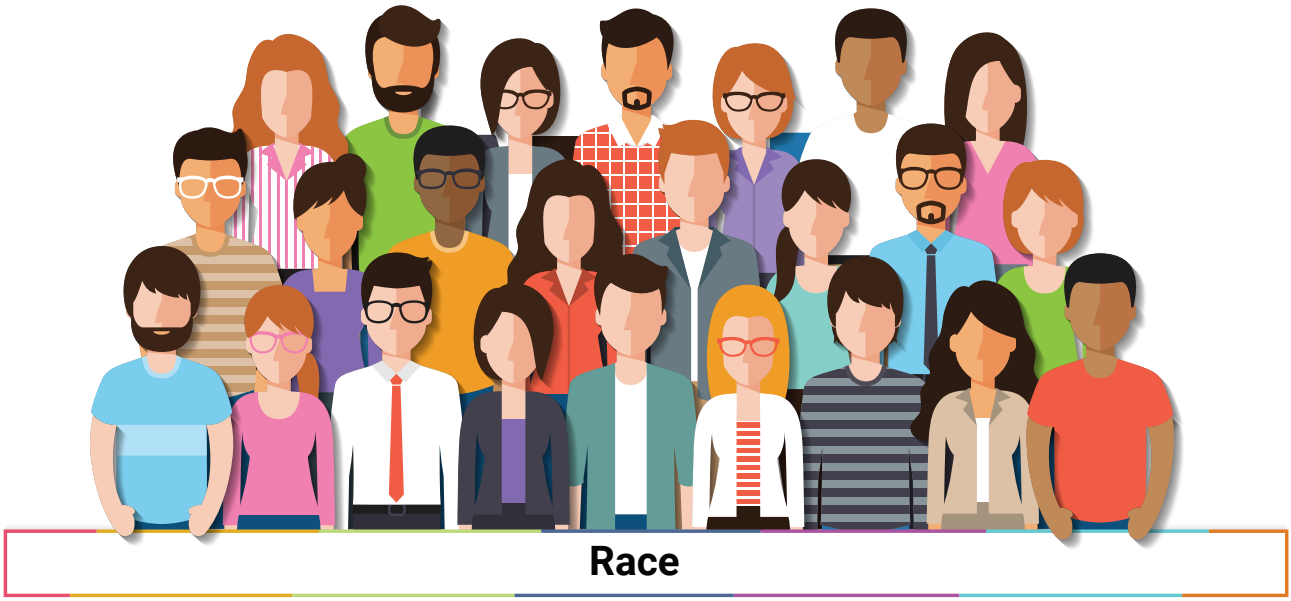
Age	0-4	5-17	18-24	25-34	35-44	45-54	55-64	65+	Median
Allegheny County	5.3%	13.6%	8.9%	15.3%	11.6%	12.4%	14.5%	18.5%	40.8
Fayette County	5.1%	14.2%	7.5%	11.8%	11.5%	13.8%	15.5%	20.6%	45.0
Washington County	5.1%	14.5%	8.5%	11.1%	11.4%	13.8%	15.5%	20.1%	44.5
Westmoreland County	4.5%	13.9%	7.7%	10.5%	10.9%	14.1%	16.3%	22.1%	47.0
Pennsylvania	5.5%	15.3%	9.2%	13.1%	11.7%	13.2%	14.1%	17.8%	40.8

Limited English Proficiency

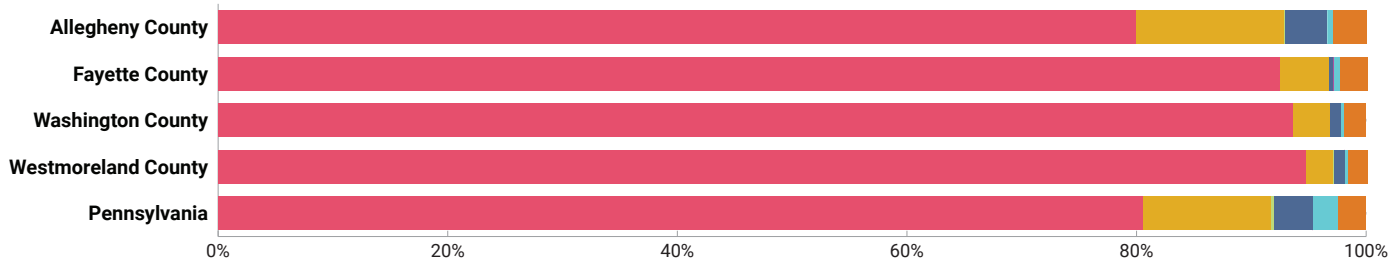
Allegheny County	Fayette County	Washington County	Westmoreland County	Pennsylvania
2.3%	0.8%	0.9%	0.6%	4.3%

Uninsured Population

Allegheny County	Fayette County	Washington County	Westmoreland County	Pennsylvania
3.8%	4.7%	3.9%	3.4%	5.7%

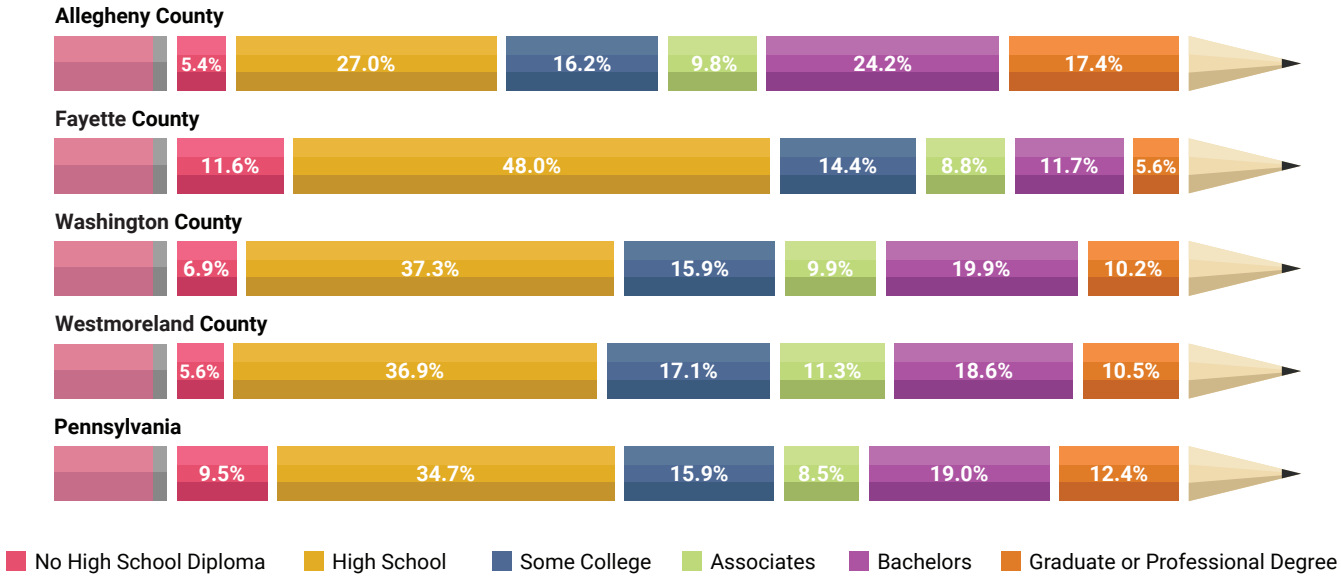


Race



	White	Black	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Allegheny County	79.9%	12.9%	0.1%	3.7%	0.0%	0.5%	2.9%
Fayette County	92.5%	4.2%	0.0%	0.4%	0.1%	0.5%	2.4%
Washington County	93.6%	3.1%	0.1%	1.0%	0.0%	0.2%	2.0%
Westmoreland County	94.7%	2.4%	0.1%	0.9%	0.0%	0.3%	1.7%
Pennsylvania	80.5%	11.2%	0.2%	3.4%	0.0%	2.2%	2.5%

Education



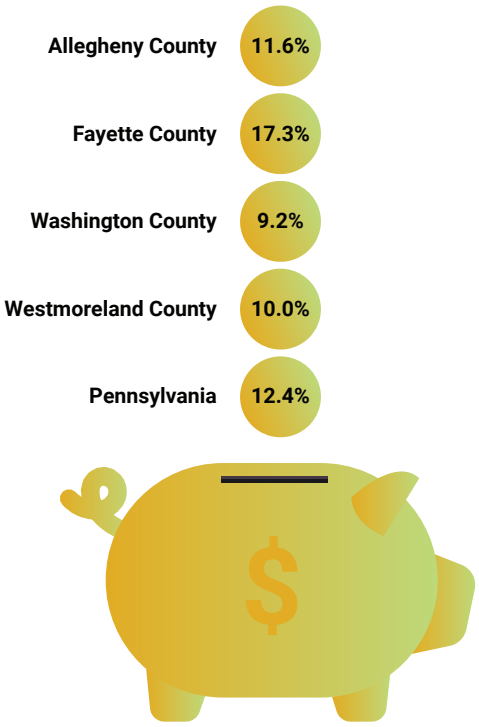
Unemployment Rate

Allegheny County	Fayette County	Washington County	Westmoreland County	Pennsylvania
4.6%	6.5%	4.9%	4.6%	4.9%

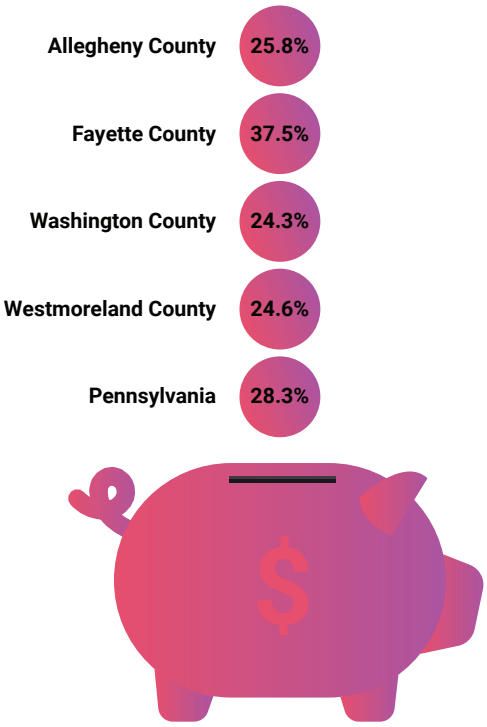
Median Household Income

Allegheny County	Fayette County	Washington County	Westmoreland County	Pennsylvania
$61,043	$47,364	$63,543	$60,471	$61,744

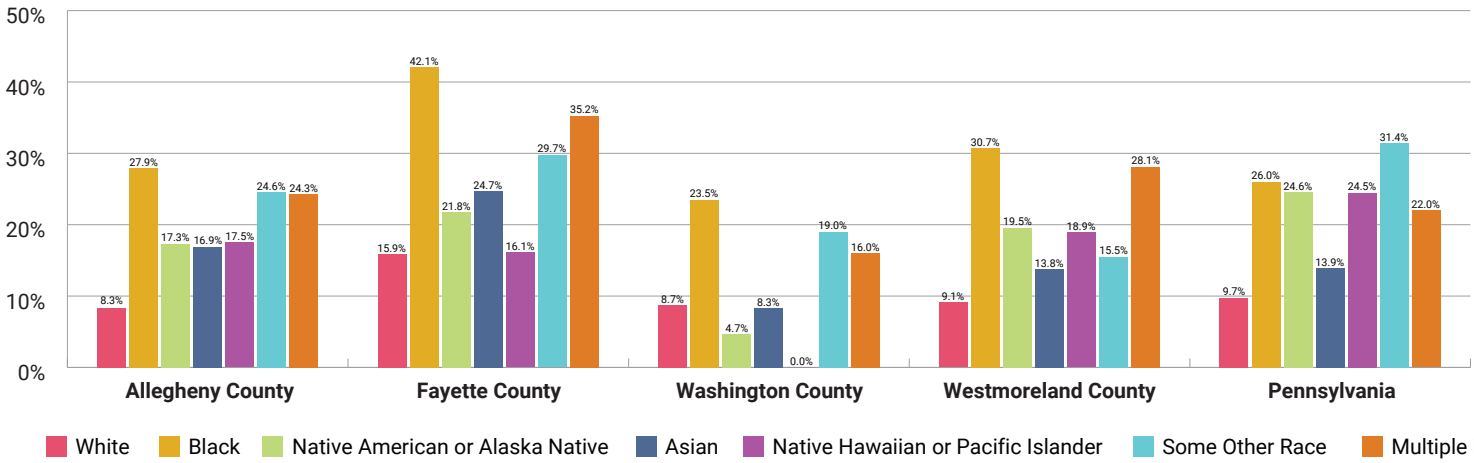
Population Below 100% FPL



Population Below 200% FPL



Population in Poverty by Race Alone



Executive Summary

Project Overview

Allegheny Health Network (AHN) executed a CHNA process that included collecting primary and secondary data. A formation of a working group consisting of members from AHN's Community Affairs oversaw the CHNA along with the project consultant, Tripp Umbach.[1] Representatives from each AHN hospital facility and representatives from departments within AHN formed a steering committee that provided high-level feedback and input on primary and secondary data collected. Organizations and community stakeholders within the primary service area were engaged in identifying the needs of the community. Community organizations, government agencies, educational systems, and health and human services entities were engaged throughout the CHNA. The comprehensive primary data collection phase resulted in contributions from a multitude of regional community stakeholders from organizations.

Input from the community was sought through a customized multi-language community survey, stakeholder interviews, and a provider survey. Community input was aligned with secondary data collections and presented to the CHNA Steering Committee as a framework for assessing current community needs, identifying new/emerging health issues, and advancing health improvement efforts to address identified needs.

Although the multi-language community survey was broadly deployed, the non-English responses were relatively low. However, many of the community agencies that provide health and human services to those specific populations and have knowledge of their health needs participated in the survey process.

The CHNA primary data collection consisted of several project components. In total, 59 community stakeholder interviews were conducted with individuals who represented a) broad interests of the community, b) populations of need, or c) persons with specialized knowledge in public health. Feedback from 2,201 online surveys was collected from AHN providers, and 866 surveys from the community.

An internal planning meeting was held with the AHN Steering Committee to discuss and finalize the CHNA needs for 2021 based on primary and secondary data results. AHN Jefferson recognized their needs from the previous assessment and will build upon those issues, but most importantly, AHN Jefferson identified additional areas of concern that require attention. Collective information from the previous implementation strategy plan along with the needs identified in the current cycle, AHN Jefferson will reinforce and create new strategies to bridge the gap and address the needs of the underserved in their service area.

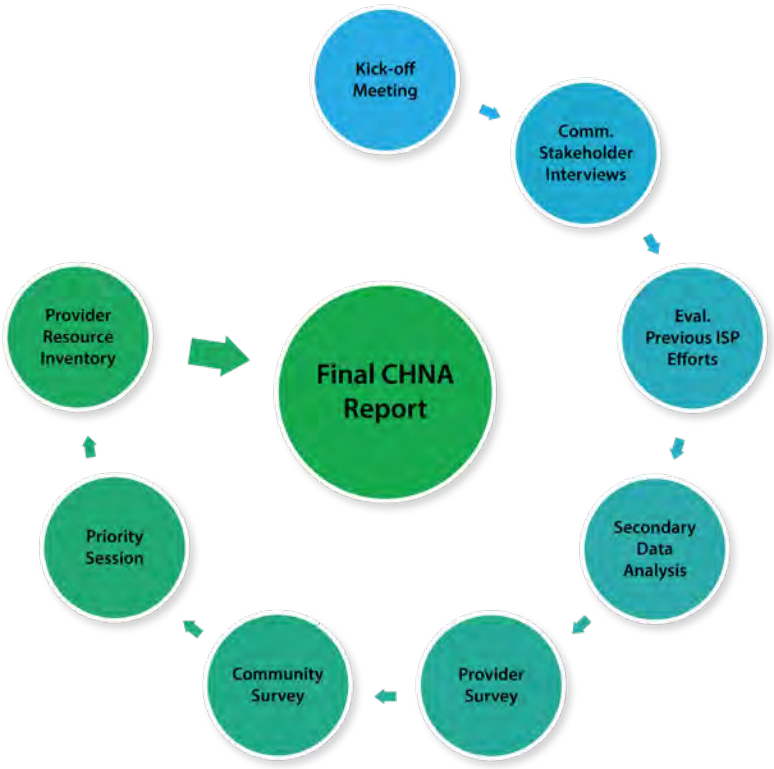
A resource inventory was generated to highlight available programs, services, organizations, and agencies within each of the priority needs in the service area. A significant project piece of the CHNA was compiling a regional profile (secondary data analysis). The regional profile was composed utilizing local, state, and federal figures providing valuable information on a wide array of health, clinical, and social issues. Tripp Umbach, along with the working group, examined and discussed different socioeconomic aspects, health outcomes, and health factors that affect residents' behaviors, specifically the influential factors that impact the health of residents.

The CHNA determined the health status of the community with direct initiatives and planning strategies. Without a doubt, the CHNA connected new partners and solidified relationships with local and regional agencies with the overall goal to improve the health outcomes of residents in the region.

AHN Jefferson is dedicated to providing exceptional care to residents in their communities. Jefferson Hospital offers a full spectrum of comprehensive health services, programs, and resources to support the community they serve and to meet/advance identified community health needs. AHN Jefferson's patient-centered approach to care means a greater focus on coordinated health and wellness services and being accountable and responsive to patients.

The overall CHNA involved multiple steps that are depicted in the below flow chart. The first step of the process included a kick-off meeting. The meeting allowed the group to discuss visions and strategies and create a shared vision for the CHNA. The session delineated the scope of the project and mechanisms for sharing resources and skills necessary to achieve AHN Jefferson's goals and objectives to improve the health of the community.

Figure 1: Overall CHNA Process Flow Chart[2]



2021 Allegheny Health Network Prioritized Findings

AHN Jefferson

The CHNA results, upon review of extensive primary and secondary research, input from community members and stakeholders, and an evaluation of identified key regional priorities, illustrate the continued need for focuses on Social Determinants of Health (SDOH),[3] Behavioral Health, Chronic Disease, and Health Equity. Each key need area had subareas of concentration.

The prioritized needs were selected through the efforts of the CHNA Steering Committee and identified during the previous CHNA cycle. Opportunities to advance those efforts and make a more significant impact are evident. Specific strategies for addressing the needs will be delineated in the implementation strategy plan.

AHN Jefferson

The chart below illustrates the 2021 current CHNA needs of each Allegheny Health Network hospital facility, particularly for AHN Jefferson. The 2021 needs were based on data collected for the assessment and included how AHN Jefferson will build upon its past and new areas of concern.

Table 1: 2021 Prioritized Needs

Allegheny Health Network (AHN)	2021 Prioritized Findings													
	Social Determinants of Health					Behavioral Health			Chronic Disease					Health Equity
	Transportation	Workforce Development	Cost of Care	Access to care*	Food Insecurity, Diet, and Nutrition	Substance Use Disorder	Mental Health Services	Postpartum Depression	Diabetes	Heart Disease	Cancer	COPD	Obesity	Diversity, Equity, and Inclusion**
Allegheny General Hospital	X	X			X	X			X	X	X			X
Allegheny Valley Hospital	X					X	X		X	X				X
Canonsburg Hospital	X			X		X			X	X				X
Forbes Hospital	X					X	X		X	X		X		X
Grove City Medical Center				X			X		X	X			X	X
Jefferson Hospital	X	X	X		X	X					X		X	X
Saint Vincent Hospital	X	X		X	X	X	X	X	X		X		X	X
West Penn Hospital		X			X			X	X		X		X	X
Westfield Memorial Hospital						X	X	X	X	X	X			X
Wexford Hospital					X	X	X	X		X				X
Brentwood Neighborhood Hospital			X	X										
Harmar Neighborhood Hospital			X	X										
Hempfield Neighborhood Hospital			X	X										
McCandless Neighborhood Hospital			X	X										

* Access to care includes primary care, specialty care, and access to general services.

**Diversity, Equity, & Inclusion includes LGBTQ+ and cultural competency.

A) Social Determinants of Health

The World Health Organization (WHO) defines social determinants of health as the economic and social conditions that influence individual and group differences in health status. These economic and social conditions under which people and groups live may increase or decrease the risk of health conditions or diseases among individuals and populations.

Social and economic factors contribute 40% to our health, health behaviors 30%, genetics 10%, the physical environment 10% and clinical care 10%, according to the Center for Health and Learning (CHL), an outgrowth of an initiative by the Center for Disease Control and Prevention's (CDC) Division of Adolescent and School Health. According to the CDC, poverty limits access to healthy foods and safe neighborhoods, while higher educational attainment is a predictor of better health. Differences in health and health outcomes are striking in communities with poor social determinants of health such as unstable housing, low-income levels, unsafe neighborhoods, or substandard education. Addressing SDOH is paramount to creating a healthier community.

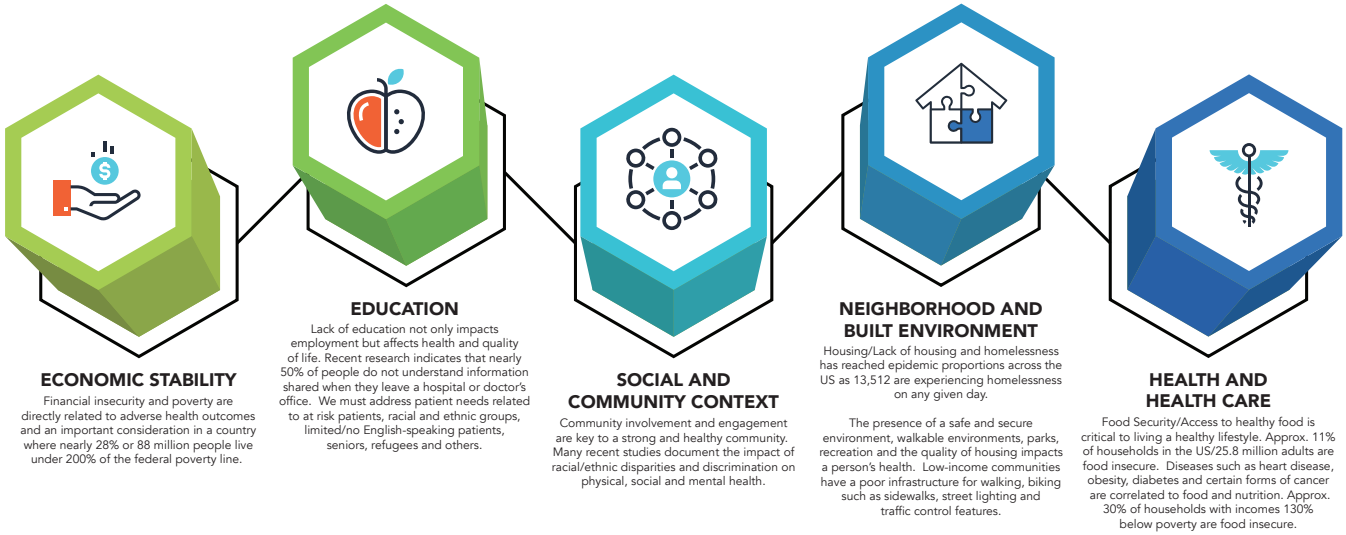
Various domains categorize SDOH; Figure 2 displays five domains as categorized by Healthy People 2030. Data links determinants and domains to health status, such as the correlation of one's ZIP code resulting in drastically different health statuses for patients with the same/similar health conditions. SDOH domains are also contributors to health disparities and inequities across the nation. The literature stresses the need for multi-sector organizations to collaborate to address social determinants and make positive impacts on overall patient health. In addition, targeting specific populations with specialized interventions is imperative to providing equitable health care.

AHN Jefferson

For health equity, these conditions support health and include adequate income, secure employment, good working conditions, quality education, safe neighborhoods, and housing, food security, the presence of social support networks, health care services, and freedom from racism and other forms of discrimination.

AHN Jefferson will identify and address critical SDOH such as cost of care, transportation, food insecurity, diet, nutrition, and workforce development.[4]

Figure 2: Understanding SDOH (Healthy People 2030).



Source: Healthy People 2030

As an example, the lack of access and availability of personal and public transportation impacts not only access to health care but affects employment, reduces access to affordable healthy food, and many other important drivers of health and wellness. AHN Jefferson works closely with its community partners and groups to identify and address social determinants of health and to drive proactive strategies that address health disparities, bridge the gaps in the provision of essential care, and improve health outcomes among disparate groups and populations. Addressing SDOH is paramount to creating a healthier community.

Cost of Care

Access to health care impacts one's overall physical, social, and mental health status and quality of life. Barriers to health services include high cost of care, inadequate or no insurance coverage, lack of availability of services, and lack of culturally competent care. These barriers to accessing health services lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, financial burdens, and preventable hospitalizations/readmissions.

- Millions of Americans – as many as 25% of the population – are delaying getting medical help because of skyrocketing costs.[5]
- A study conducted by the American Cancer Society in May 2019 found 56% of adults report having at least one medical financial hardship.[6]
- The Centers for Disease Control and Prevention found that working-age adults who reported being unable to see a physician due to cost increased from 11.4% in 1998 to 15.7% in 2017, according to a new analysis of the nationwide survey.[7]
- Data shows that 79.6% of providers reported that higher costs of health care for consumers are a 4/5 rating on a rating scale of 1-5 where 1 equals less of a concern and 5 equals more of a concern.
- Community stakeholder interviews reported that the most significant barrier to not receiving care is affordability, availability of services, and no insurance coverage.
- Community stakeholders also reported that the high cost of health care and medications and lack of insurance coverage are significant barriers to improving health and quality of life.

Transportation

Access to health care services has a significant impact on health, including improved overall physical, social, and mental health status; prevention of disease and disability; and better quality of life. Transportation affects residents in rural and urban communities.

Having adequate transportation is often a barrier to accessing services and can significantly affect the quality of people's lives. The lack of vehicle access, cost, long distances, and lengthy times to reach needed services impact travel for residents.

- 3.6 million people in the United States do not obtain medical care due to transportation issues.[8]
- Missed appointments cost the U.S. health care system more than $150 billion a year. They disrupt the continuity of the provision of health care services, add to the dissatisfaction of patients due to delays in getting new appointments, and hinder the detection and treatment of diseases.[9]
- Regardless of insurance status, 4% of children (approximately 3 million) in the United States miss a health care appointment each year due to unavailable transportation; this includes 9% of children in families with incomes of less than $50,000.[10]
- The Agency for Healthcare Research and Quality reported that 10% of Allegheny County workers take public transportation. A smaller percentage of residents in Fayette (0.4%), Washington (1.5%), and Westmoreland (1.2%) counties take public transportation.
- Primary data from the provider survey indicated that limited available services (23.6%) and cost of services (21.0%) contribute to transportation issues in the community.
- The survey also found that 50.8% of providers reported that distance/transportation to health care facilities is a 4/5 rating on a rating scale of 1-5, where 1 equals less of a concern and 5 equals more of a concern.
- Community stakeholders reported that the most significant barrier to not receiving care is a lack of transportation.
- Community stakeholders reported that the lack of available/lack of transportation are barriers to improving health and quality of life.

Transportation challenges affect urban and rural communities. Overall, older, less educated, female, minority, or low-income individuals – or those with a combination of these characteristics – are greatly impacted by transportation barriers. The vulnerable populations are more susceptible to transportation barriers due to social isolation, comorbidities, and a greater need for frequent clinician visits.

Food insecurity, Diet, and Nutrition

Many communities face a dire need for adequate and healthy foods. Food insecurity is when you do not have the money to purchase the essential and needed healthy foods and you may skip meals because of a lack of finances to secure food. Food insecure families struggle with many aspects associated with poverty, under/unemployment, and inconsistent access to sufficient healthy foods. Difficult decisions whether to pay rent, purchase medication, pay utility bills or buy healthy foods are daily struggles for those living in disparate conditions. Surprisingly, food insecurity affects people of all ages and from many walks of life.

Nationally, the USDA defines food security as "having access by all people at all times to enough food for an active, healthy life." Having enough food provides an important foundation for nutrition and health and is especially important for children. The nutritional content of their diets affects not only their current health, but also their physical, mental, and social development— and thus, their future health and well-being.

For children, the effect of hunger impacts adequate child development and success in education. Previous research has shown that children in food-insecure homes, where parents and caregivers struggle to put enough food on the table, are more likely to have adverse outcomes, such as more chronic health conditions, slower progress in math and reading, and more difficulties with social development than do otherwise similar children in food-secure homes.

Food insecurity is a growing problem. In Pennsylvania, 1,353,730 people are facing hunger, including 383,520 children.[11] Concentration in school is more difficult when you are hungry. Hunger can cause children to be cranky, hyperactive, and aggressive. These behavioral issues can distract students from their schoolwork, leading to developmental delays and learning disabilities. Hunger eventually can lead to tripling one's chances of suffering from poor health, tripling the likelihood of obesity among women, and doubling one's chances of developing diabetes. Fifty percent of children facing hunger will need to repeat a grade.[12]

The USDA reports that food insecurity is highest among single mother households with incomes below the poverty level. COVID-19 resulted in more supply chain and demand disruptions following Government restrictions on non-essential economic activity, social distancing requirements, temporary closures of some facilities due to infection concerns, effects of illness on availability of some essential workers, and decisions by consumers to limit travel and other activities. COVID-19 led to reduced income, unemployment, or underemployment for many U.S. households. As a direct result of COVID-19, Feeding America estimates the number of Pennsylvanians facing food insecurity increased from 7.1% in 2018 to 15.4 percent in 2020 – an increase of 45.2 percent in just two years.[13]

Figure 3: What Hunger Looks Like in Pennsylvania

1 in 9 people

struggles with hunger.

1 in 7
children
struggles with hunger.

People facing hunger in
Pennsylvania
are estimated to report needing
$737,258,000
more per year to meet their food needs.

Source: Feeding Pennsylvania

Many do not realize the grave disparities that exist in our own communities as people struggle with hunger. According to Feeding Pennsylvania, 1,401,920 people are struggling with hunger, and 399,270 are children.

Post-Covid, it is anticipated by the PA Department of Agriculture that the numbers of those struggling with hunger will increase substantially from 1.4 million to 1.77 million.[14] More regionally, the Greater Pittsburgh Community Food Bank reports that 1 in 7 or 262,780 persons are currently facing food insecurity across southwestern PA service areas during 2019.[15]

AHN Jefferson

Hunger and health are deeply connected, and the effect of hunger is increased risks of chronic disease, hospitalization, overall poor health, and increased health care costs. It has been well-documented that food security and healthy eating lower the risk of chronic diseases such as heart disease, diabetes, some forms of cancer, to name a few, and impacts the following aspects of human life:

- It may help you live longer
- Keeps skin, teeth, and eyes healthy
- Supports muscles
- Boosts immunity
- Lowers risk of heart disease, type 2 diabetes, and some cancers
- Supports healthy pregnancies and breastfeeding
- Helps the digestive system function
- Helps achieve and maintain a healthy weight

Hunger hurts the local economy by causing increased health care spending, increased costs to charities, lost productivity, and poor education outcomes that affect not just the lifetime earnings of those who are hungry but society as a whole. Hunger costs in Pennsylvania have risen to nearly $3.25 billion a year.[16] Individuals with low food security frequently rely on processed foods, ultimately making individuals more susceptible to obesity and chronic illnesses.

- The U.S. Census Bureau found residents in Fayette County (23.4%) reporting the highest percentage of the population receiving the Supplemental Nutrition Assistance Program (SNAP) benefits; higher than Pennsylvania (14.3%) and the nation (12.5%). There are 12.4% receiving SNAP benefits in Allegheny, 11.7% in Washington, and 11.7% in Westmoreland counties.[17]
- In Pennsylvania, 33.9% of households receiving SNAP benefits have children.[18]
- Providers and community stakeholders reported that access to food is a top health problem in their communities.
- Community stakeholders reported access to healthy foods as an approach to improve the quality of life for residents.

Workforce Development

Being employed and having a steady livable income enables one to have choices and options for a healthy lifestyle. Having a comfortable income can provide a safe home environment, food, transportation, health care, and much more. Data reveal significant income disparities within the counties that AHN Jefferson represents.

- In 2018, the median household income for residents in Allegheny County was $58,383; $61,567 in Washington; and $58,866 in Westmoreland. Fayette County reported having the lowest median household income at $44,476.
- The Department of Labor Statistics reported Fayette County (9.0%) as having the highest unemployment rate compared to Allegheny (6.3%), Washington (6.7%), Westmoreland (6.5%), the state (6.7%), and the nation (5.3%).
- The U.S. Census Bureau cites that those below the Federal Poverty Line (FPL) face barriers to access such as health services, healthy food, and other necessities that contribute to poor health status. In 2015-2019, 17.3% of Fayette County residents were 100% below the FPL. Allegheny County reported 11.6%, with 9.2% in Washington, 10.0% in Westmoreland, 12.4% in Pennsylvania, and 13.4% in the nation.

Broad gaps in employment are related to race as opportunities are less available to populations of color. The gap in employment was significantly widened due to COVID-19. (See Table 2)

Figure 3: What Hunger Looks Like in Pennsylvania

	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some other race	Multiple races
Allegheny County	8.2%	27.9%	17.2%	16.9%	17.4%	24.6%	24.2%
Fayette County	15.8%	42.1%	21.8%	24.6%	16.0%	29.7%	35.1%
Washington County	8.6%	23.5%	4.7%	8.2%	0.0%	19.0%	15.9%
Westmoreland County	9.1%	30.7%	19.4%	13.8%	18.9%	15.4%	28.0%
Pennsylvania	9.7%	25.9%	24.5%	13.8%	24.5%	31.3%	22.0%
U.S.	11.1%	23.0%	24.8%	10.9%	17.5%	21.0%	16.6%

Building upon one's ability to successfully develop skills and obtain the tools needed for business success benefits the employer and the employee. Providing employees with professional development opportunities through seminars, courses, and classes creates a productive work environment. It will be essential for employers to continue to create opportunities for ongoing skill development as the work environment is constantly changing and the capacity to meet the demand for production increases.

B) Behavioral Health

Substance Use Disorder

Falling under the umbrella of behavioral health, substance abuse and mental health impact the lives of families and individuals throughout the United States. The percentage of residents diagnosed with behavioral health problems grew exponentially. Along with the growth, the need for mental health services and substance abuse programs has not diminished. Genetics and socioeconomic factors play vital roles in individuals diagnosed with a mental health problem, and frequently, societal factors increase the likelihood of one engaging in unhealthy life choices such as alcohol and drug use. According to the American Hospital Association, behavioral health disorders affect nearly one in five Americans and have community-wide impacts. Hospitals and health systems provide essential behavioral health care services to millions of Americans every day.[19]

Although progress has been made in lowering rates of substance abuse in the United States, the use of behavior-altering substances continues to take a major toll on the health of individuals, families, and communities nationwide.

- AHRC also reported that Washington County has the lowest number of mental health providers (101.3 per 100,000) compared to Allegheny (292.2), Fayette (307.2), and Westmoreland counties (142.6).
- Allegheny County has the highest number of facilities that provide mental health services at 48, followed by Fayette (10), Washington (9), and Westmoreland (16).
- The CDC in 2019 estimated 14.0% (34.1 million) of U.S. adults smoke cigarettes.
- The provider survey reported that behavioral health was the top persistent health problem in the community. The mentally ill were reported as being the most vulnerable population in the community.
- The survey found that 82.7% of respondents cited mental health, and 60.2% identified suicide prevention as a 4/5 rating on a rating scale of 1-5, where 1 equals less of a concern and 5 equals more of a concern.
- The top responses from the provider survey cited access to behavioral health services, mental health services, and substance abuse support would have the greatest impact on the quality of life for residents in the community.
- Community stakeholders cited drug/alcohol and behavioral/mental health as top health problems in their communities. They also reported substance abuse as being the top high-risk behavior and having access to behavioral health services as the top choice to improve the quality of life for residents.
- The community survey also found that drug/alcohol use (47.2%) was a top health problem in the community and that access to drug/alcohol and mental health services is needed to improve residents' quality of life and health.

C) Chronic Disease

Chronic diseases are a significant cause of disability and death in Pennsylvania and the United States. The seven leading causes of death are heart disease, cancer, stroke, chronic lower respiratory disease (CLRD), unintentional injury, Alzheimer's disease, and diabetes. According to the Pennsylvania Department of Health, chronic disease accounts for about 70.0% of all deaths annually in Pennsylvania. With Pennsylvania's aging population and the advances in health care enabling people to live longer, the cost associated with chronic disease will increase significantly if no changes are made. Clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing the effects of chronic disease and reducing death. Preventive services both prevent and detect illnesses and diseases in their earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs.

Cancer

- In 2015-2019, 162.8 per 100,000 population in Allegheny County died from cancer. This rate is higher than the state rate of 160.5 per 100,000 population and 152.3 for the nation (per 100,000 population). The Healthy People 2030 target is less than or equal to 122.7 per 100,000 population.
- In 2015-2019, 183.6 per 100,000 population in Fayette, 174.4 in Washington, and 163.1 in Westmoreland counties died from cancer.

The leading cause of death in 2017 in Pennsylvania, according to the CDC National Center for Health Statistics, was heart disease (32,312 deaths), followed by cancer (28,387).

- The provider survey identified diabetes, cancers, and heart disease as the top persistent health problems in the community.
- The provider survey also found that 58.1% of respondents reported cancer, and 67.0% said heart disease as a 4/5 rating on a rating scale of 1-5, where 1 equals less of a concern and 5 equals more of a concern.

Community stakeholders reported cancers and heart disease as top health problems in their communities.

Obesity

Being obese is a significant risk factor that often will lead to other health problems such as diabetes, cardiovascular disease, cancers, and other health ailments. Losing weight and engaging in a healthy diet and exercise regimen can reduce the likelihood of developing many of these conditions.

- Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues. In 2017, Allegheny (28.0%), Fayette (36.6%), Washington (38.3%), and Westmoreland (30.0%) counties reported adults aged 20 and older with BMIs greater than 30.0, higher than Pennsylvania (30.5%) and the nation (29.5%).[20]
    - Allegheny County reports the lowest percentage of adults aged 20 and older who self-report a BMI greater than 30.0 within the study area.
- Allegheny and Washington counties' adult obesity rankings worsened from 2019 to 2021, according to County Health Rankings & Roadmaps.[21] Fayette and Westmoreland counties' rankings improved or stayed the same. Pennsylvania has 67 counties, with a ranking of 1 indicating the best ranking compared to other counties within the state.
    - Allegheny County: Ranking of 29 in 2021; ranking of 28 in 2019 (worsen)
    - Fayette County: Ranking of 37 in 2021, ranking of 41 in 2019 (improved)
    - Washington County: Ranking of 38 in 2021, ranking of 31 in 2019 (worsen)
    - Westmoreland County: Ranking of 30 in 2021, the same as in 2019 (same)
- In 2019 the Behavioral Risk Factor Surveillance Survey and 2018-2019 Pennsylvania Growth Screening Index reported that 33% of Pennsylvania adults and 18% of children in grades K-12 were affected by obesity.[22]
- Nationally, the Centers for Disease Control and Prevention (2017-2018) reported the prevalence of obesity was approximately 42% in adults and 19% in children.[23]

AHN Jefferson

D) Health Equity

Diversity, Equity, & Inclusion

In recent years, health systems, public and private agencies, and community-based organizations have increasingly focused on the concept of "health equity." Health equity is described as "both the absence of systematic obstacles and the creation of opportunities for all to be healthy." The American Medical Association (AMA) Center for Health Equity imagines health equity as "providing health care that values people equally and treats them equitably and a nation in which all people live in thriving communities where resources work well; systems are equitable and create no harm nor exacerbate existing harms; where everyone has the power, conditions, resources, and opportunities to achieve optimal health."

Significant effort is required to provide equitable and culturally/linguistically appropriate care to a variety of racial and ethnic communities, each with its own cultural traits, health beliefs, and barriers to health care access. Improving health equity extends well beyond the walls of the hospital, reaches deep into the community sectors, and involves both local and state governments where health policies and protocols are developed.

Achieving health equity requires the health system to cast a broad lens across a plethora of health services, medical programs and topics, diverse and disenfranchised people and populations. It is further noted that health equity is impacted by a variety of factors that impact health called social determinants such as affordable, safe, and stable housing; safe places to live, work and play; physical activity and exercise; economic security and financial resources; ending discrimination based on race, gender, religion, or other factors; access to affordable and healthy food; livelihood security and employment opportunity; educational opportunities; English language proficiency; and access to safe and affordable transportation.

Health equity must be the focus, at all levels of the organization, and embedded into our practices, processes, actions, and outcomes. AHN Jefferson places a strategic focus on health equity through understanding and addressing the social determinants of low-income, under/unemployed, minority, and vulnerable populations. Health systems can enhance the quality of care their organizations provide, improve operations and reduce health disparities among their patients by guiding efforts to improve health equity.

Therefore, interventions to improve health equity and reduce health 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. Health equity is realized when all people have the opportunity to be as healthy as possible and no one is limited in achieving good health because of their social and economic status.

Health equity objectives are to end past infrastructures and workplace cultures that treat people inequitably based on demographic factors such as gender, age, ethnicity, race, sexual orientation, and other factors. Health inequities are rooted in historical and current policies and systems that may favor one group over others. These historical and structural inequities take their toll on health and the quality of life through economic, cultural, political, social, and physical factors. Health is simply deeply connected and rooted to where people live, work, learn, and play.

Recognition is increasing across the health care environment. Improving health and achieving health equity demands a broad, multi-pronged approach and requires community engagement and addressing economic, social, and environmental factors that influence health. For example, prejudice and discrimination can lead to delays in medical diagnosis and treatment. The New England Journal of Medicine published a study reporting that women were seven times more likely than men to be misdiagnosed and discharged in the middle of having a heart attack due to the medical concepts of most diseases being based on understandings of male physiology and women having different symptoms than men when having a heart attack.[24]

Health inequities unveil startling contrasts in health among different people. The Pennsylvania Department of Health reported vast disparities among its residents.

Publication data from 2018 reveal Black residents had significantly higher age-adjusted cancer incidence rates than whites in the below areas:[25]

- Prostate
- Lung and bronchus
- Kidney and renal pelvis
- Pancreas
- Liver and intrahepatic bile duct
- Myeloma
- Stomach

Blacks: The age-adjusted incidence rate among Black Pennsylvania residents for liver/intrahepatic bile duct cancer (17.2 per 100,000 population) was more than two times that of white residents (7.8 per 100,000 population) in 2015. Myeloma also had an incidence rate of more than two times higher among Black residents (13.5) than white residents (6.3 per 100,000 population).

Asians and Pacific Islanders: In 2015, the age-adjusted incidence rate among Asians/Pacific Islanders for stomach cancer (9.7 per 100,000 population) and cancer of the liver/intrahepatic bile duct (13.9 per 100,000 population) was almost two times the rate among whites (5.7 and 7.8, per 100,000 population respectively).

Hispanics: In 2015, Hispanics had a significantly higher age-adjusted incidence rate than whites for liver/intrahepatic bile duct cancer. Specifically, the Hispanic liver/intrahepatic bile duct cancer rate (13.9 per 100,000 population) was almost two times that of whites (7.8 per 100,000 population).

Publication data from 2018 reveal the following discharge rates were significantly higher among Black residents compared to whites:[26]

- Asthma (various age groups)
- Non-fatal spinal cord injuries
- Heart failure (ages 65-74)
- Heart failure (ages 75-84)

The following discharge rates were significantly higher among Hispanic residents compared to whites:[27]

- Asthma (various age groups)
- Heart failure (ages 65-74)
- Heart failure (ages 75-84)

Blacks: During 2014, hospital discharge rates per 10,000 for young childhood asthma (under 5) were several times higher among Black residents than white residents, 72.4 versus 13.8. In addition, hospital discharge rates for asthma among Black residents were at least two times higher than white residents in all other age groups. Another major disparity occurred for hospital discharge rates of heart failure among the ages 65-74. The rate was two times higher among black residents (16.6) than white residents (7.4).

Hispanics: Like Black residents, in 2014, Hispanic residents had elevated hospital discharge rates for asthma compared to white residents. Specifically, the hospital discharge rate per 10,000 for asthma among Hispanic residents under five years of age (38.2) was about three times higher than white residents under 5 (13.8). The hospital discharge rate for asthma among Hispanic residents ages 5 to 64 was more than two times the rate for whites.

COVID-19 related reductions in life expectancy disproportionately affected people of color. People living in rural areas have a lower quality of health care and less access to services in urban and suburban areas.

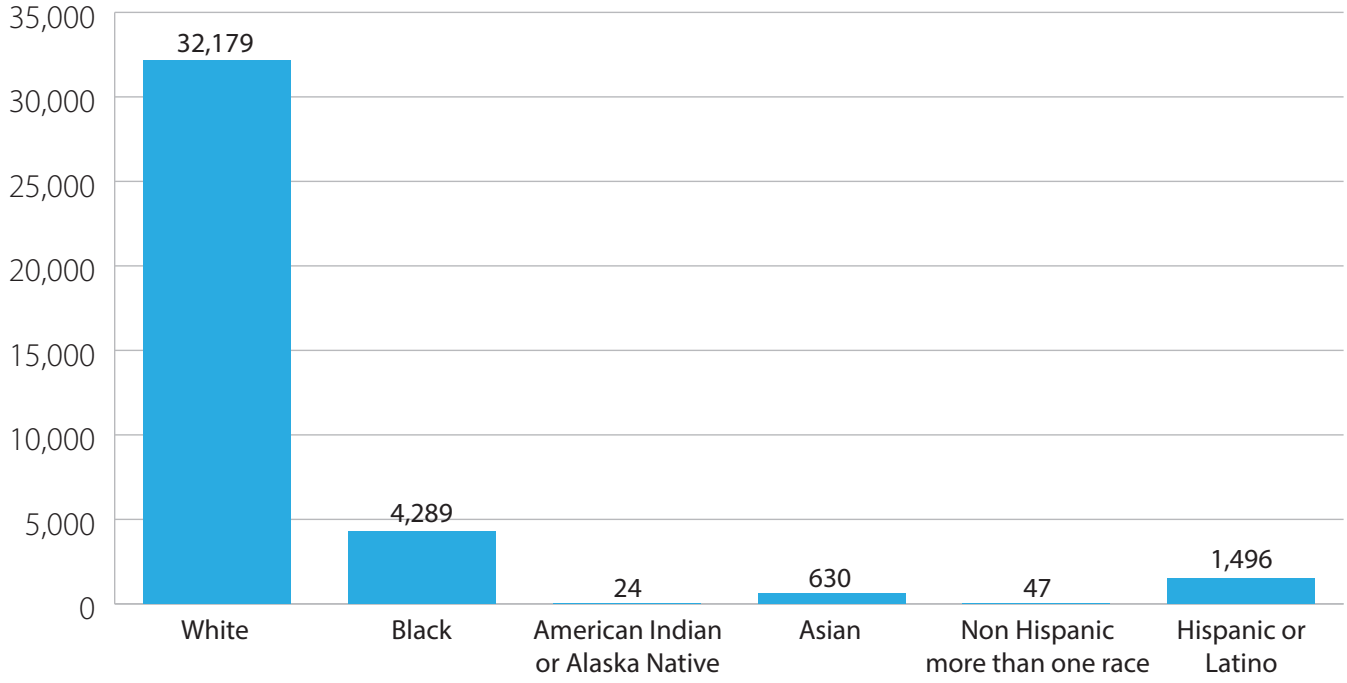
Improving health equity engages all community sectors and partners to promote health equity and sustainability through job creation and economic development, transportation access and mobility, access to foods and nutrition, physically active and safe neighborhoods, and improved educational status. Most importantly, to improve access to equitable health care, health equity must be the focus as an organization at all levels and embedded into our practices, processes, actions, and outcomes.

Impact of COVID-19 on Health Equity

The effects of COVID-19 have been 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 were nearly two times as likely to contract the disease as Whites. Blacks were 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.

Figure 4 shows the distribution of COVID-19 deaths is disproportionally higher among Blacks when compared to American Indian/Alaska Native, Asian, Non- Hispanic more than one race, and Hispanic or Latino. The graph reports the number of COVID-19 deaths for each race and Hispanic group.

Figure 4: Pennsylvania COVID-19 Death by Race and Hispanic Origin in 2020-2022
(updated as of January 2022)



Source: Centers for Diseases Control and Prevention 2020

Race and ethnicity are also 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 placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

There are multiple factors that continue to contribute to poor health outcomes 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 and the lack of investment in addressing barriers to health and productive lives in marginalized communities leads to many other health and social consequences.

It has been reported that 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.

Figure 5: COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities

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.

POVERTY
Living in poverty, health is one of many priorities.

MISTRUST
Insufficient community engagement, combined with misinformation or a lack of consistent information as well as a history of discrimination, causes many marginalized communities to lack trust towards health and social services.

LOW HEALTH LITERACY & MISINFORMATION
People from ethnically and racially diverse communities didn't have the opportunity to develop skills to identify credible news sources, which has been shown to correlate with low health statuses.

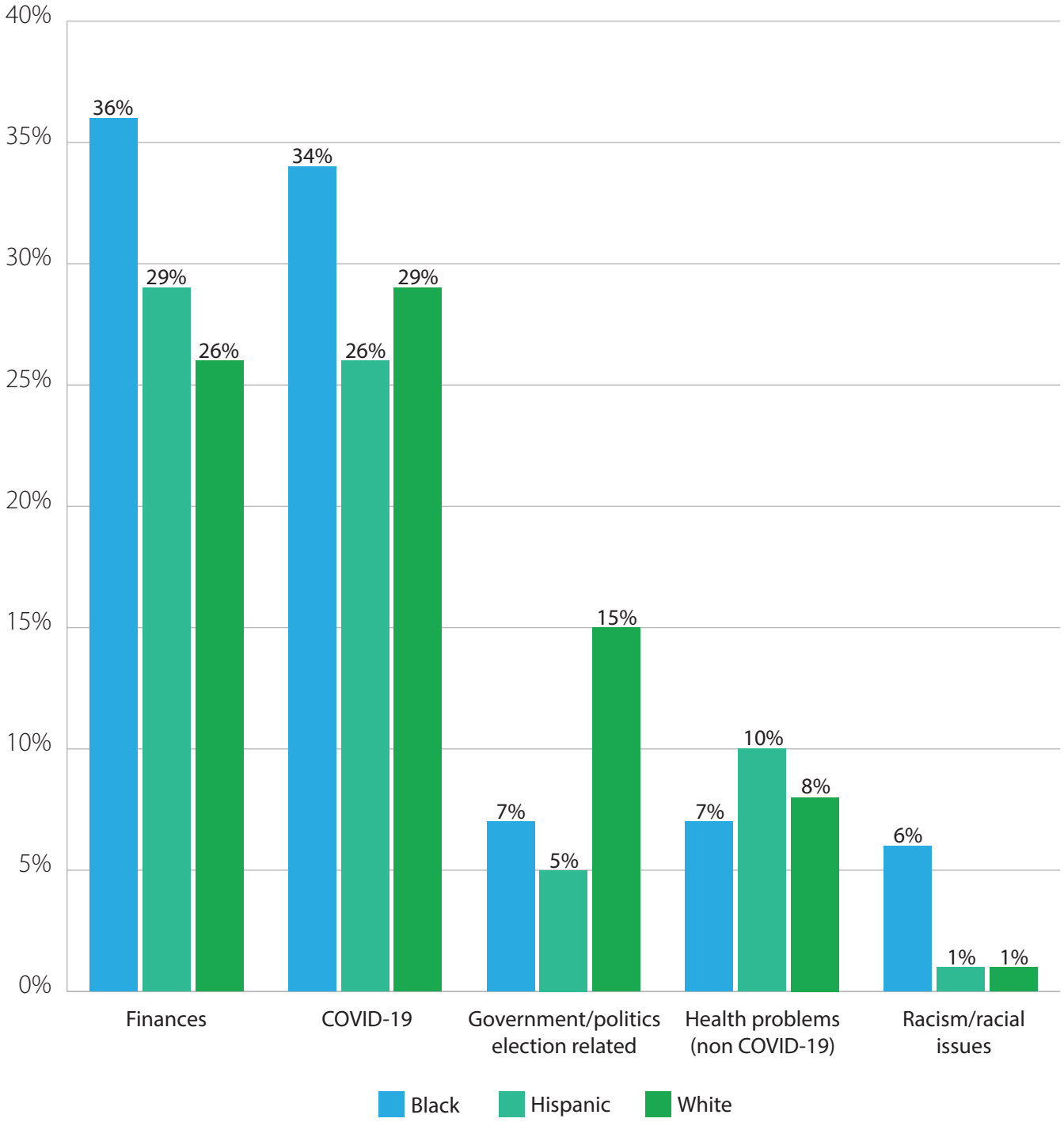
CHRONIC STRESS
Stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications.

OVERCROWDED LIVING CONDITIONS
Many groups live in overcrowded conditions such as multi-generational homes or nursing homes, prisons, homeless shelters, or other kinds of group "homes." This can make it difficult to social distance and increase the risk for COVID-19. Factors such as unemployment can lead to homelessness, and therefore increased vulnerability to COVID-19.

Source: The Health Equality Initiative 2020

Figure 6 depicts the largest concerns families face broken down by race. More than one-third of Black adults cite financial issues and a similar share (34%) cite concerns related to the COVID-19 pandemic. These are also the top two concerns mentioned by White and Hispanic adults, though Black adults are 10 percentage points more likely than White adults to name financial challenges among their top concerns (36% vs. 26%). Notably, six percent of Black adults cite issues related to racism as being among their top concerns.

Figure 6: Biggest Concerns Facing Individuals & Families 2020
(Open Ended)



Source: The Health Equality Initiative 2020

Conclusion

AHN Jefferson places a strong emphasis on providing exceptional care, ensuring access to equitable health care services, and programs for its surrounding communities. Its efforts to address challenges and complexities of care in serving vulnerable populations such as the homeless, elderly, unemployed/underemployed, ethnic, low-income and diverse populations are recognized at community, state, and national levels.

AHN Jefferson aspires to improve health, well-being, and health equity for all and understands that "health is more than the absence of disease." Health is based not only on geographic factors- where people were born, live, work and play- but also on economic, cultural, educational, and social factors. By addressing barriers and identifying social and economic factors called social determinants of health that hinder access to equitable health care, AHN Jefferson aims to heighten overall community health status and to improve quality of life for the diverse communities they serve. The health system may provide a plethora of recognized physicians, best practice services, noteworthy programs and services but if residents lack transportation and insurance, access to care can be difficult. There is a direct correlation between the ease of accessing health care and the overall health of a community.

As this next CHNA cycle evolves, AHN Jefferson will engage and collaborate with community partners on the development of the 2022-2025 CHNA Implementation Strategy Plan (ISP). The implementation strategy planning process will align with both the strategic direction of the hospital and the AHN system level. Delineated implementation plan strategies will build on past goals and accomplishments, continue efforts to improve access to equitable health care, and measure the progress and the impact of services provided to targeted and vulnerable populations. AHN Jefferson's implementation strategies will advance the following priority areas:

- Social Determinants of Health
- Behavioral Health
- Chronic Disease
- Health Equity

AHN Jefferson has addressed many obstacles and accomplished a measurable impact on the community, however, there are still many community health issues that need to be addressed to achieve health equity and anticipated health outcomes. With a focus on the top priorities mentioned above, major and meaningful health concerns for the AHN Jefferson communities will be resolved.

Defined Community

A community is defined as the geographic area from which a significant number of the patients utilizing hospital services reside. While the CHNA considers other types of health care providers, the hospital is the single largest provider of acute-care services. For this reason, the utilization of hospital services provides the most precise definition of the community.

The defined community (or primary service area (PSA)) of AHN Jefferson encompasses 42 ZIP codes located in Allegheny, Fayette, Washington, and Westmoreland counties. Map 1 shows AHN Jefferson's defined community.

Map 1: 2021 CHNA Study Area/Counties

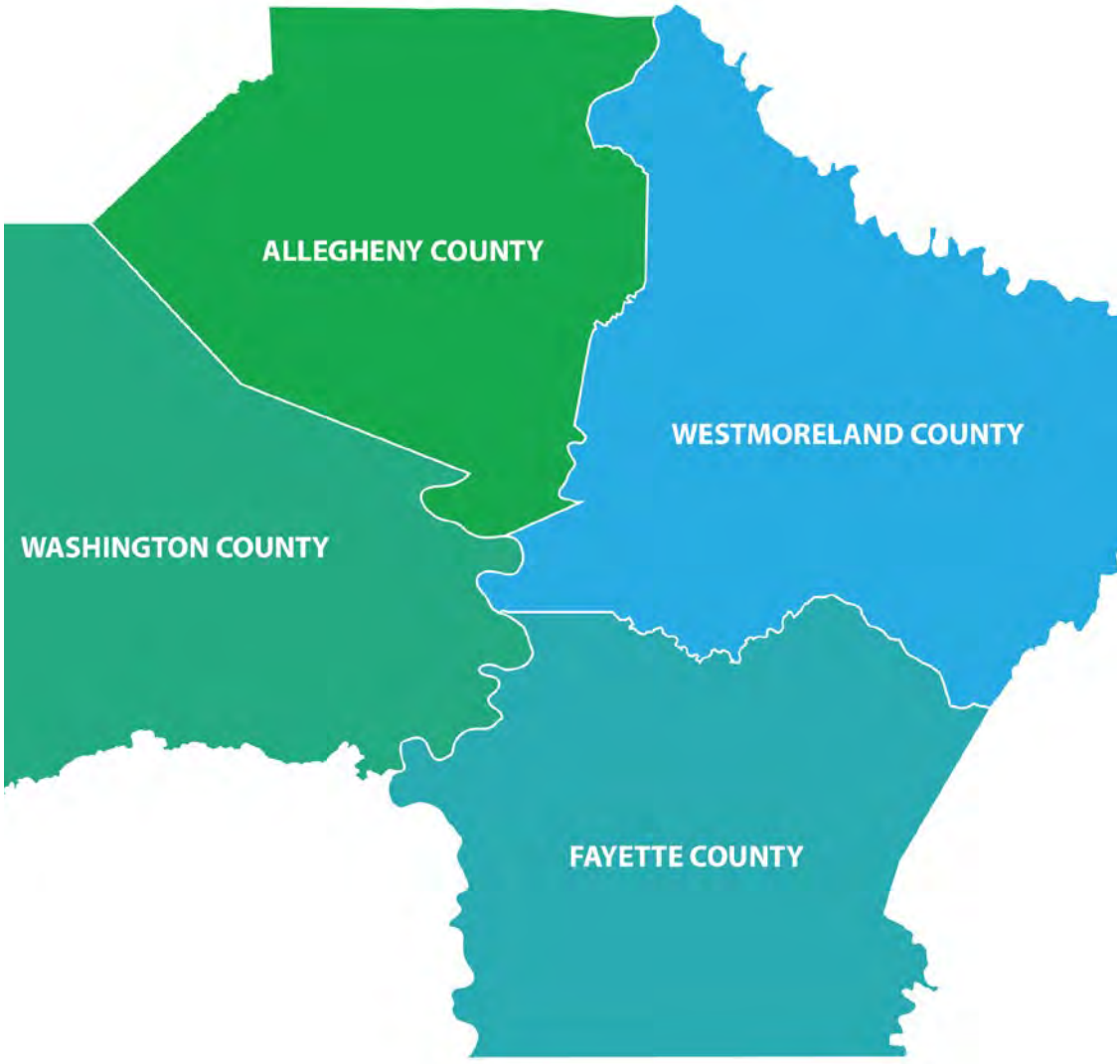


Table 2: Primary Service Area ZIP Codes

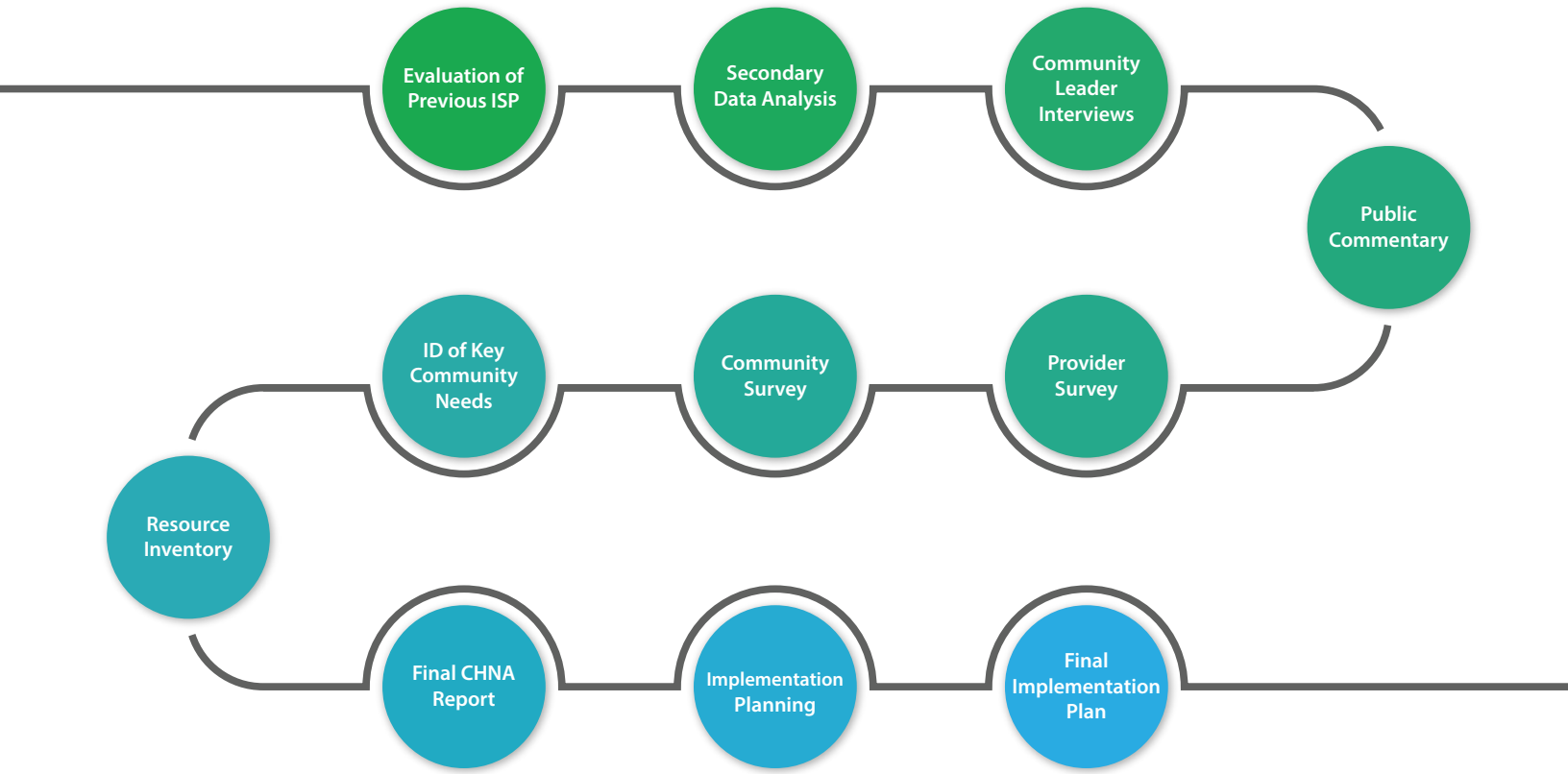
ZIPS	Town	County
15018	Buena Vista	Allegheny
15025	Clairton	Allegheny
15034	Dravosburg	Allegheny
15037	Elizabeth	Allegheny
15045	Glassport	Allegheny
15102	Bethel Park	Allegheny
15110	Duquesne	Allegheny
15120	Homestead	Allegheny
15122	West Mifflin	Allegheny
15129	South Park	Allegheny
15131	McKeesport	Allegheny
15123	McKeesport	Allegheny
15133	McKeesport	Allegheny
15135	McKeesport	Allegheny
15207	Pittsburgh	Allegheny
15210	Pittsburgh	Allegheny
15216	Pittsburgh	Allegheny
15226	Pittsburgh	Allegheny
15227	Pittsburgh	Allegheny
15234	Pittsburgh	Allegheny
15236	Pittsburgh	Allegheny
15012	Belle Vernon	Fayette
15473	Perryopolis	Fayette
15482	Star Junction	Fayette
15022	Charleroi	Washington
15033	Donora	Washington
15063	Monongahela	Washington
15067	New Eagle	Washington
15332	Finleyville	Washington
15412	Allenport	Washington
15432	Dunlevy	Washington
15434	Elco	Washington
15477	Roscoe	Washington
15483	Stockdale	Washington
15062	Monessen	Westmoreland
15083	Sutersville	Westmoreland
15089	West Newton	Westmoreland
15479	Smithton	Westmoreland
15637	Herminie	Westmoreland
15642	Irwin	Westmoreland
15647	Larimer	Westmoreland
15678	Rillton	Westmoreland

Methodology

Tripp Umbach, a planning and research firm specializing in health care, education, government, and corporate clients to improve communities' economic, social, and physical wellbeing, was contracted by Allegheny Health Network to conduct the system's 2021 CHNA. The CHNA report complies with the Internal Revenue Service's guidelines for charitable 501(c)(3) tax-exempt hospitals and includes input from individuals representing the broad interests of the communities served by Allegheny Health Network, including those with direct knowledge of the needs of the medically underserved, disenfranchised populations, and populations suffering from chronic diseases.

The CHNA process began in late June 2021, and it is positioned to conclude in the early spring of 2022 with a final implementation strategy planning report. While multiple steps make up the overall CHNA process, Tripp Umbach will continue to work closely with the CHNA working group members to collect, analyze, and identify the results to complete AHN Forbes' assessment. The data collected and the information being composed will allow further group engagement of internal and external stakeholders to inform the CHNA needs and deliverables.

Figure 7: Data Collection Roadmap

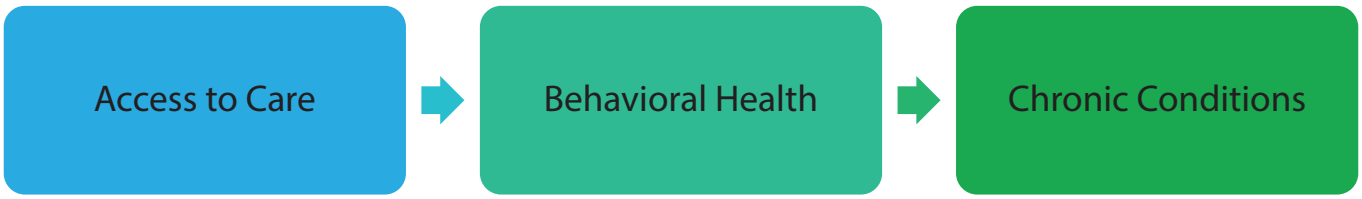


Community Health Needs Assessment Data Collection

AHN Jefferson, along with Tripp Umbach, participated in a 39-person steering group consisting of system-level leadership and hospital personnel who have direct patient care/contact and are instrumental in their community. The steering group members have a vast knowledge of the needs of underserved and disenfranchised populations, specifically those who have chronic diseases, behavioral health issues, and socioeconomic challenges. To fulfill IRS requirements related to the Affordable Care Act (ACA), AHN Jefferson's methodology employed both qualitative and quantitative data.

Evaluation of 2018 Implementation Strategy Plan

The flow chart identified the health needs of AHN Jefferson in 2018. AHN Jefferson concentrated efforts and plans to address the health needs identified in the previous assessment.



AHN Jefferson worked over the last three years to address, develop, and implement strategies to tackle the CHNA issues and evaluate the effectiveness of the strategies in meeting goals and providing strategies to improve the health in the community.

AHN Jefferson tackled problem statements and strategies and developed ways to address its success. AHN Jefferson modified some of its goals to better achieve the identified needs from the 2018 CHNA. The self-assessment has indicators to denote improving and tracking each goal and strategy within the three years and beyond. Specific metric information/measurable indicators can be obtained from AHN Community Affairs.

Health Priority: Access to Care

Goal 1: Reduce costs that may have a direct benefit to reducing patients' out-of-pocket and risk-adjusted per member per month insurance health care expenses.

Impact: (1) Increased use of generic medication; (2) decreased out-of-pocket costs for patients' medication; (3) reduced readmission rates; and (4) reduced ED visits due to negative side effects or ineffective antibiotic treatment.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Implement at least one project(s) aimed at reducing Rx expenditures.	Review patient's high-cost Rx, target restricting high-cost generics for lower-cost manufacturers for identical generic medication.	X	X	X	The cost savings of moving the patients to the lower-cost medications.
	Engage AHN Quality Specialists to provide PCP and specialists with educational campaigns designed to promote the use and benefits of generics and other lower-cost options to patients.	X	X	X	
Reduce incidence of negative side effects or ineffective antibiotic treatment for infection.	Pharmacists will be involved in the culture follow-up process for ED visits for UTIs, wound infections, throat cultures, and STDs.	X	X	X	Percent of appropriate antibiotics based on bacteria. Percent of appropriate duration of treatment based on the type of infection. Percent of readmissions return visits to ED for the same issue or side-effect from treatment drug.
	Develop an algorithm or a standardized protocol by which pharmacists can recommend appropriate actions.	X	X	X	

Strategies	Action Steps	2019	2020	2021	Metrics per year
Implement a project to address the medication needs of discharged patients.	Develop Meds to Bed program to improve patient outcomes with medication adherence through upfront education, clarification of questions, and resolution of insurance issues.	X	X	X	Number of patients utilizing the Meds to Beds program. Number of patients utilizing Meds to Beds with medication-related readmissions.

Goal 2: Address the Social Determinants of Health to improve health outcomes.

Impact: Decreased non-urgent ED visits; decreased readmission rates; increased community referrals; increased number of food packages provided; improved adherence to medical appointments and follow-up appointments; and improved quality of life.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Implement Phase I of Front Door Initiative for Social Emergency Medicine grant to address SDOH.	Screen/assess social factors impacting patient health and acute physical emergencies	X	X	X	ED utilization for the target population. Hospital readmissions for the target population. Referrals to needed community services.
	Engage AHN Quality Specialists to provide PCP and specialists with educational campaigns designed to promote the use and benefits of generics and other lower-cost options to patients.		X	X	
	Establish a referral process with community partners for coordinated care outside of the ED.		X	X	
	Reinforce a sense of pride and trust of the ED by the community as a central asset.		X	X	
	Establish an advisory council inclusive of internal staff, community organizations, and visionaries.		X	X	

Strategies	Action Steps	2019	2020	2021	Metrics per year
	Review national models of excellence in Social Emergency Medicine.		X	X	Number of patients utilizing the Meds to Beds program. Number of patients utilizing Meds to Beds with medication-related readmissions.
	Understand and analyze community and ED population data.		X	X	
	Improve referral and follow-up process.		X	X	
	Implement staff training on cultural competency, social determinants of health, ENCP.		X	X	
	Integrate Social Determinants of Health screening tool in EPIC for ED patients.		X	X	

Health Priority: Behavioral Health

Goal 1: Improve awareness of mental health conditions and treatment options.

Impact: Increased number of patients that attend education sessions, increased awareness of available resources to support recovery; increased number of Behavioral Health Consultants in practices; and improved PHQ9 score.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Provide education to the public about mental health issues and treatment options.	Collaborate with Jefferson Regional Foundation to sponsor Mental Health First Aid train-the-trainer and community MHFA training to the public.	X	X	X	Number of events Number of participants Increased awareness of signs of mental health illness.
Recruit, hire, train and integrate Behavioral Health Consultants (BHC) into ambulatory practices.	Identify patients who may need behavioral health support.	X	X	X	Number of BHCs integrated into physician & ambulatory practices. Behavioral Health and psycho-social issue reduction by monitoring PHQ-9 scores.

Strategies	Action Steps	2019	2020	2021	Metrics per year
	Review national models of excellence in Social Emergency Medicine.		X	X	Number of patients utilizing the Meds to Beds program. Number of patients utilizing Meds to Beds with medication-related readmissions.
	Understand and analyze community and ED population data.		X	X	
	Improve referral and follow-up process.		X	X	
	Implement staff training on cultural competency, social determinants of health, ENCP.		X	X	
	Integrate Social Determinants of Health screening tool in EPIC for ED patients.		X	X	

Health Priority: Behavioral Health

Goal 1: Improve awareness of mental health conditions and treatment options.

Impact: Increased number of patients that attend education sessions, increased awareness of available resources to support recovery; increased number of Behavioral Health Consultants in practices; and improved PHQ9 score.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Provide education to the public about mental health issues and treatment options.	Collaborate with Jefferson Regional Foundation to sponsor Mental Health First Aid train-the-trainer and community MHFA training to the public.	X	X	X	Number of events Number of participants Increased awareness of signs of mental health illness.
Recruit, hire, train and integrate Behavioral Health Consultants (BHC) into ambulatory practices.	Identify patients who may need behavioral health support.	X	X	X	Number of BHCs integrated into physician & ambulatory practices. Behavioral Health and psycho-social issue reduction by monitoring PHQ-9 scores.

Strategies	Action Steps	2019	2020	2021	Metrics per year
	Administer the PHQ-2 at every primary care visit and PHQ-9 for patients who screen positive on the PHQ-2.	X	X	X	
	Offer consultation & treatment with the practice's BHC.	X	X	X	
	Monitor PHQ-9 scores over time for improvement.	X	X	X	

Health Priority: Chronic Conditions

Goal 1: To improve quality outcomes associated with diabetes.

Impact: Increased number of RN Navigators; decreased A1c levels in the managed population; improved outcomes for diabetes measures; and improved quality of life for diabetic patients.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Develop chronic disease specialty centers in all AHN hospitals.	Embed RN Navigators at all AHN hospitals.	X	X		Number of RN Navigators at AHN hospitals. A1C levels for the target population.
Provide support to PCP with data about performance on diabetes measures and support for quality improvement activities to enhance performance on diabetes care.	Continue partnership with Primary Care Redesign.	X	X		Performance on diabetes measures: • HbA1c at goal • retinal eye exam • statin therapy • BP control • annual urine microalbumin re: nephropathy • foot exam • % of diabetics who are non-smokers

Strategies	Action Steps	2019	2020	2021	Metrics per year
	Provide quarterly data of practice and region performance on diabetes measures and on-demand patient-level data via the EMR to guide population health management activities.	X	X		
	Provide training and workflow redesign support for diabetes QI efforts via coaching from a practice transformation specialist and consultation with endocrinologists from the AHN Diabetes Primary Care Support Initiative.	X	X		

Goal 2: Reduce the number of cancer-related deaths.

Impact: Increased number of education events at AHN hospitals; increased number of hospital employees trained on tobacco cessation counseling; increased number of trained community partners; (4) increased number of cancer screenings; and (5) increased the number of early cancer diagnoses.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Provide a resource to help individuals stop the use of tobacco products.	Collaborate with Jefferson Regional Foundation to provide a grant to Consumer Health Coalition to train tobacco cessation counselors and organize quitting workshops.		X		Number of educational events. Number of participants.
	Train hospital employees on tobacco cessation counseling.		X		
	Offer workshops at Jefferson Hospital.		X		
Increase the number of adults who receive timely age-appropriate cancer screenings based on the most recent guidelines.	Plan free cancer screenings for prostate, breast, skin, cervical, colon/rectal, and lung cancer.	X			Number of screenings performed. Number of abnormal screenings identified and referred for additional testing. Number of individuals screened for at least one cancer.
	Distribute booklet on age-appropriate cancer screenings.	X			

Goal 3: Improve the lives of those diagnosed with cancer.

Impact: Increased number of education events at AHN hospitals; increased number of patients accessing services provided by cancer support programs.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Increase the volume of patients participating in programs that help people deal with a cancer diagnosis and the challenges related to treatment.	Promote Cancer Care Center's Cancer support group.	X	X	X	Number of programs Number of participants
	Promote The Look Good Feel Better	X	X	X	
	Promote AHN Cancer Institute. Started pre-chemo treatment visits for all patients undergoing chemotherapy at Jefferson Hospital.	X	X	X	
	Partners with Our Clubhouse to offer Living Life Post Cancer Treatment.	X	X	X	
	Partner with the American Cancer Society to promote a Free Wig Salon.	X	X	X	
	Provide Satchels of Caring for cancer patients.	X	X	X	
	Provide free nutrition consultation to oncology patients.	X	X	X	
	Engage an oncology social worker to offer free assistance to oncology patients with their social determinants of need.	X	X	X	
	Utilize a nurse navigator to provide coordination of care as patients go through their cancer journey.	X	X	X	

Goal 4: Reduce the rate of obesity in the service area.

Impact: Increased number of children educated on physical activity; increased number of people enrolled in physical activity programs; increased number of community events; and increased opportunities for physical activity and nutrition.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Implement a program to reduce obesity in adults.	Offer Eat Healthy, Be Active Community Workshops (Office of Disease Prevention and Health Promotion) or similar programs.	X			Number of community-based education events. Number of participants. Number of activities.
Improve health literacy on issues related to obesity.	Establish a Speakers Bureau to provide education to community organizations on nutrition, diabetes, and exercise.		X	X	Number of programs provided Number of participants
Offer support to individuals working on weight management.	Offer a monthly support group to share personal experiences, feelings, and coping strategies on weight management.	X	X	X	Number of programs provided Number of participants

CHNA Needs Not Being Further Addressed

AHN Jefferson will eliminate behavioral health and diabetes from the CHNA ISP planning efforts. However, AHN Jefferson will continue to make diabetes services and behavioral health care available through its hospital-based focus to assist patients and families to manage and prevent chronic diseases, including diabetes, and to ensure access to behavioral health care and services through the Allegheny clinic.

Secondary Data Analysis

Secondary data sources at the local, state, and national levels included disparity data, public health priorities related to disease prevalence, socioeconomic factors, health outcomes, and health determinants to create a regional community health data profile based on the location and service areas of Allegheny Health Network. Secondary data was gathered primarily through Community Commons, a publicly available dashboard of multiple health indicators drawn from several national data sources that allowed for the review of past developments and changes related to demographics, health, social, and economic factors. Additional data sources include County Health Rankings, Community Needs Index, and U.S. Census Bureau. The data is also peer-reviewed and substantiated, providing a deep level of validity as a source.

The robust community profile generated a greater understanding of regional issues, mainly identifying regional and local health and socioeconomic issues.

The secondary quantitative data collection process included:

- American Community Survey
- Centers for Disease Control and Prevention
- Centers for Medicare and Medicaid Services
- County Health Rankings and Roadmaps
- Dartmouth College Institute for Health Policy and Clinical Practice
- FBI – Uniform Crime Reports
- Health Resources and Services Administration (HRSA)
- Kaiser Family Foundation (KFF)
- Pennsylvania Department of Health – State Cancer Profiles
- Pennsylvania Department of Health and Vital Statistics
- The Agency for Healthcare Research and Quality (AHRQ)
- U.S. Census Bureau
- U.S. Department of Education National Center for Education Statistics
- U.S. Department of Health and Human Services
- U.S. Department of Labor

Community Stakeholder Interviews

As part of the CHNA phase, telephone interviews were completed with community stakeholders to understand the changing environment. The interviews offered stakeholders an opportunity to provide feedback on the needs of the region they serve and other information relevant to the study. Overall, 59 community stakeholder interviews were conducted for AHN in July-October 2021. Community stakeholders targeted for interviews encompassed a wide variety of professional backgrounds, including:

1. Businesses
2. County and state government representatives
3. Economic development
4. Education
5. Faith-based communities
6. Foundations/philanthropic
7. Health care representatives
8. Law enforcement
9. Non-profits
10. Representatives of underserved populations
11. Social service representatives

Within the interview and discussion process, overall health needs, themes, and concerns were presented. Within each of the overarching themes, additional topics fell under each category. Below are the overall key findings from the interviews identified throughout the discussions.

Community Stakeholder Interviews Common Themes

Community Problems

Top 3 Persistent Health Problems:
1. Behavioral health (65.1%)
2. Access to foods (39.7%)
3. Un/Underemployment (39.7%)

Offer Community to Address Persistent Chronic Diseases
1. Community Health Workers (46.0%)
2. Population Specific Interventions (15.9%)

Top 3 High Risk Behaviors
1. Substance abuse (81.0%)
2. Poor eating/unhealthy eating habits (61.9%)
3. Lack of exercise/inadequate physical activity (49.2%)

Community

Top 3 Barriers to Improving health/quality of life
1. Economic disparities/poverty (58.7%)
2. Difficulties navigating health care system (55.6%)
3. High cost of health care/medications (54.0%)

Top 3 Would Improve Quality of Life
1. Access to health foods (57.1%)
2. Mental health services (appointments, bilingual providers) (57.1%)
3. Access to behavioral health services (52.4%)

Transportation Issues
1. Limited available transportation services (80.7%)
2. Location of bus stops is inconvenient (51.6%)
3. Lack of education around available resources (40.3%)

Information

Top 3 Vulnerable Populations
1. Children/youth (66.1%)
2. Older adults (66.1%)
3. Low-income (58.1%)

Solutions to Help Vulnerable Populations
1. Care coordinators (79.4%)
2. Flexible medical appts. (63.5%)
3. Addressing SDOH (57.1%)

Ten interviews were conducted with community stakeholders who represented AHN Jefferson's community. The qualitative data collected are the perceptions and opinions from community stakeholders as part of the CHNA process. The information provides insight and adds great depth to the qualitative data. Community stakeholders interviewed represented the following organizations:

1. AHN Center for Inclusion Health
2. AHN Jefferson Front Door Initiative
3. Allegheny County Health Department
4. Bhutanese Community Association of Pittsburgh (BCAP)
5. Jefferson Regional Foundation
6. Mon Valley Initiative
7. Mt. Olive Baptist Church
8. Salvation Army
9. South Hills Interfaith Movement (SHIM)

Public Commentary

Tripp Umbach solicited comments related to the 2018 CHNA and Implementation Strategy Plan (ISP) as part of the assessment. Feedback was obtained from community stakeholders identified by the working group. Observations allowed community representatives to react to the methods, findings, and subsequent actions taken due to the 2018 CHNA and implementation planning process. Stakeholders were posed questions developed by Tripp Umbach. Collectively, feedback was collected from 59 community stakeholders from July-October 2021. The public comments below are a summary of stakeholders' input regarding the former documents.

- When asked whether the assessment "included input from community members or organizations," 54.9% reported that it did.
- In the survey reviewed, 41.2% reported that the report did not exclude community members or organizations that should have been involved.
- In response to the question, 43.1% of respondents agreed when posed the question, "Were the implementation strategies directly related to the need identified in the CHNA?"

According to community stakeholders, the CHNA and the ISP benefited them and their community in the following manner (in no specific order):

- It created greater community awareness, greater relationship building, and highlighted partnerships.
- Addressed concerns and ways to improve concerns.
- We use part of the report to develop programs and use it for funding. The report shows what is going on in our community and tracks the progress of our county and its residents.
- CHNAs provoke one to think about the many never-ending needs of the community. We must become more innovative for the community's future. Example: Multi-Cultural Male Mentoring Programs will be an ongoing need that will ultimately lessen gangs, gun violence, and substance abuse/suicide/homicide statistics.
- The presence of AHN has increased significantly. Took the findings into practicum and increased/enhanced status in communities.
- It resulted in better services and providers.
- Implementation was around community wellbeing, and health systems participated financially to bring blue zones project – good effort.
- Hospitals are implementing parts of the plan, and we can see results as there are good motives and intentions.
- Not sure how to evaluate program effectiveness due to COVID-19.
- Knowing that the feedback that we provided solidifies some of these choices to prioritize. Making ways to solve serious issues.
- I would like the opportunity for follow-up/further involvement in the process.
- Better understanding allows for the development of extended partnerships/relationships in the impact areas.
- You are allowing the community to listen to concerns. The effort to improve the life of residents and let them know we care.
- Increased awareness of social determinants of health (SDOH) and broader attention to behavioral health.
- Responses from community members gave specific issues. The implementing agency had some space to plan programs to meet particular needs.
- We need more focus on SDOH.
- I would ideally like to have more community engagement in the process.
- It was understood that there are many challenges, and being proactive leads to greater quality of life and overall health.
- Recognized actual issues and focus on SDOH and not just relaying it to insurance coverage.
- Improved the health care services that were allocated to the residents.
- We saw the outcome of the work produced as well as the opportunity to educate people. Saw continued support for food accessibility in the community.

Additional feedback community stakeholders believed was not covered (in no particular order):

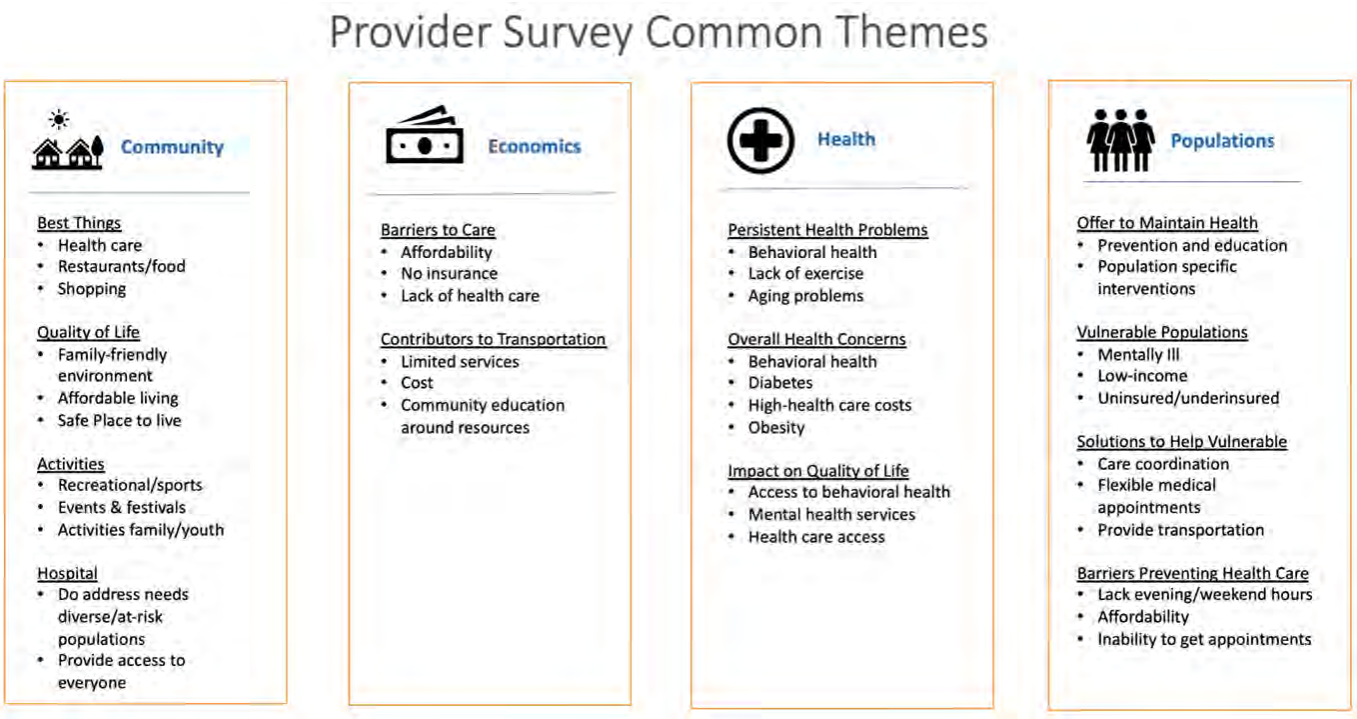
- Once CHNA/implementation plans are completed, bring back interviewees to review/discuss results.
- Allowing agencies like this to think outside the box and think like a client.
- Helping communities understand what it means and the overall impact.
- Focus on changing regional demographics. There is a growing Asian population along with residents moving out of the city. There are also challenges regarding services to transportation.
- Outreach to as many community organizations as possible to provide additional input.

Provider Survey

A provider survey was implemented to collect data from providers from the hospital's service areas and region to identify the community's needs and vulnerable populations and those partners/ organizations that will be instrumental in addressing prioritized needs. Providers internal and external to Allegheny Health Network received a survey link. In total, 26,616 providers received a survey link; 2,201 surveys were returned/submitted.

A survey instrument was developed and used to obtain vital information through the lens of local providers. Collecting data through the provider survey will allow individuals who provide care to populations most in need. The provider audience is also essential to gauge how patients and residents have adjusted their health needs during the pandemic and how providers assisted them.

The provider survey was active in July-August 2021. Below are common themes providers reported in their community.



Community Survey

A community survey was employed to collect input from populations within Allegheny Health Network's service area to identify health risk factors and health needs in the community. Working with leadership from Community Affairs, the community survey was promoted on social media platforms, hospital websites, relationships with community-based organizations, and clinics. An email was sent from Tripp Umbach to community residents requesting survey participation. A $250 gift card was provided as an incentive for community residents to encourage participation.

Collecting surveys from community residents whose primary language was not English was an essential driver of the initiative. The community survey was available in English, Spanish, Nepalese, Chinese, and Arabic. An email was sent to more than 43,000 residents in the AHN service area for engagement. A total of 857 English surveys and nine non-English surveys were collected for analysis.

Survey data was collected from Survey Monkey from mid-August 2021 to early October 2021. In total, 866 surveys were used to assure statistical accuracy. A response rate of 1.98% was achieved. Below are common themes from community residents.

Community Survey Common Themes

Community

Top 3 Health Problems in Community

English Speakers

1. Aging problems
2. Drug/alcohol
3. Behavioral/mental health

Non-English Speakers

1. Access to healthy foods
2. Dental health
3. Lack of exercise

Top 3 Factors that Contribute to Healthy Community (English & Non-English Speakers)

1. Low crime/safe neighborhoods
2. Easy access to health care
3. Good schools

Community

Needed to Improve Quality of Life and Health

English Speakers

1. Affordable health care services
2. Access to drug/alcohol and mental health services
3. Elder care

Non-English Speakers

1. Access to drug/alcohol and mental health services
2. Better/more recreational facilities
3. Dental care access

Information

Top Place Go for Health Care (English & Non-English Speakers)

1. Physician offices

Health Screenings Needed to Stay Healthy

English Speakers

1. Blood pressure
2. Cholesterol
3. Well check-ups

Non-English Speakers

1. Dental screenings
2. Well check-ups
3. Cholesterol

Community Survey Common Themes

Information

Top 3 Behaviors People Need more Information About:

English Speakers

1. Chronic disease prevention/mgmt.
2. Substance abuse prevention
3. Care for family members w/special needs/disabilities

Non-English Speakers

1. Chronic disease prevention/management
2. Eating well/nutrition
3. Exercising/fitness

Personal Health

Describe One's Overall Health

English Speakers

1. Excellent/very good – 35.2%

Non-English Speakers

1. Excellent/very good – 66.7%

Top 3 Health Personal Challenges

English Speakers

1. Joint, muscle, and back pain
2. Overweight/obesity
3. High blood pressure

Non-English Speakers

1. Arthritis
2. Joint, muscle, and back pain
3. High blood pressure

Personal Health

Preventative Procedure in past 12 months:

English Speakers

1. Blood pressure
2. Physical exam
3. Flu shot

Non-English Speakers

1. Blood pressure
2. Flu shot
3. Cholesterol screenings

COVID-19

Received COVID-19 Vaccination

English Speakers

- Yes- 84.9%

Non-English Speakers

- Yes - 100.0%

Top 3 Areas Impacted by COVID-19

English Speakers

1. Social
2. Emotional
3. Quality of life

Non-English Speakers

1. Emotional
2. Fear of sickness
3. Social

Identification of Key Community Needs

The AHN CHNA Steering Committee, composed of interdisciplinary representatives from each of the hospitals as well as service leaders, reviewed primary data and secondary data sources to identify community needs and trends. Building on the needs identified in the previous cycle and the accomplishments of the previous implementation strategies, the community needs were assessed to identify continued gaps in services, changes in population health status, and areas in need of further effort and support. Those discussions served as a basis for prioritizing the 2021 community needs and the deployment of resources and community assets to meet those needs.

Resource Inventory

An inventory of programs and services available in the region was developed by Tripp Umbach. This inventory highlights available programs and services within all the counties that fall under each of the priority need areas.

The inventory identifies the range of organizations and agencies in the community that serve the various target populations within each of the priority needs. It provides program descriptions and collects information about the potential for coordinating community activities and creating linkages among agencies.

Data Limitations

Data collected for the 2021 CHNA has limitations in information. Primary data obtained through interviews and surveys are also limited in representing the hospital's service area as information was collected through convenience sampling. Secondary data is not specific to the hospitals' primary service area; however, the report provides an opportunity to gauge and envision issues within a large geographic region.

Steering Committee Members

AHN Steering Committee	
AHN Allegheny General	Alex Matthews
AHN Allegheny Valley	Kimberly Giovanelli
AHN Canonsburg	Keith Zimmer
AHN Forbes	Krista Bragg
AHN Forbes	Kelly Wooddell
AHN Grove City	Dr. David Tupponce
AHN Jefferson	Erin Joyce
AHN Saint Vincent	Henry Ward
AHN West Penn	Robin Nitkulinec
AHN Westfield	Karen Surkala
AHN Westfield	Rodney Buchanan
AHN Wexford	Laurin Scanlon
AHN Neighborhood Hospitals	Julie Ference
AHN Allegheny Clinic	Margaret Palumbo
AHN Cardiovascular Institute	Peggy McGowan
AHN Center for Inclusion Health	Kristin Lazzara
AHN Community Affairs	Nina Ferraro
AHN Community Affairs	Kannu Sahni
AHN Community Affairs	Amie Signorella
AHN Community Affairs	Nina Sexton
AHN Corporate Communications	Julie Emanuel
AHN Corporate Taxes	Jeff Manners
AHN Corporate Taxes	Bernard Azinon
AHN Development	Allie Quick
AHN Diversity, Equity & Inclusion (DEI)	Dr. Margaret Larkins-Pettigrew
AHN Diversity, Equity & Inclusion (DEI)	Veronica Villalobos
AHN Diversity, Equity & Inclusion (DEI)	Mark Jones
AHN Institute Planning	Michele Steigerwald
AHN Marketing	Manfred Woodall
AHN Marketing	Kelly Dennin
AHN Marketing	Jesse Miller
AHN Medicine Institute	Dr. Paul Lebovitz
AHN Nursing	Claire Zangerle
AHN Oncology	Crystal Ross
AHN Prehospital Services	Jonah Thompson
AHN Prehospital Services	Robert Twaddle
AHN Social Determinants of Health (SDOH)	Amanda Mihalko
AHN Social Determinants of Health (SDOH)	Mary Ann Matreselva
AHN Women & Children's Institute	Joan Washburn

Additional Information

With the conclusion of the CHNA, AHN and AHN Jefferson will begin the implementation planning phase to identify and leverage AHN's collective strengths and resources to best address the communities' health needs.

For additional information about the CHNA and its specific findings, please contact Community Affairs at Highmark Health and Allegheny Health Network at communityaffairs@ahn.org.

AHN Jefferson

Endnotes

[1] Allegheny Health Network contracted with Tripp Umbach, a private health care consulting firm to complete a community health needs assessment. Tripp Umbach has worked with more than 400 communities in all 50 states. In fact, more than one in five Americans lives in a community where our firm has worked.

[2] For additional information on the primary and secondary data collected as part of the CHNA, please refer to the methodology section of the report.

[3] In 2018, Access to care was the overarching community need. In 2021, after internal review and discussions, SDOH replaced access to care as the focus. Understanding SDOH helps identify the many underlying factors and issues that serve as barriers to accessing care. Addressing the conditions of one's environment, such as where people work, play, live, can dramatically affect the quality of life for many residents.

[4] AHN Jefferson's primary service area counties encompass Allegheny, Fayette, Washington, and Westmoreland counties. Secondary data was supplied related to identified counties.

[5] The Guardian: www.theguardian.com/us-news/2020/jan/07/americans-healthcare-medical-costs

[6] Science Daily: www.sciencedaily.com/releases/2019/05/190502100818.htm

[7] Modern Healthcare: www.modernhealthcare.com/insurance/despite-aca-coverage-gains-more-people-cant-afford-care

[8] American Hospital Association: www.aha.org/ahahret-guides/2017-11-15-social-determinants-health-series-transportation-and-role-hospitals

[9] Journal of Family Medicine and Disease Prevention: https://clinmedjournals.org/articles/jfmdp/journal-of-family-medicine-and-disease-prevention-jfmdp-4-090.pdf

[10] Grant, R., Gracy, D., Goldsmith, G., Sobelson, M. & Johnson, D. (2014). Transportation barriers to child health care access remain after health reform. JAMA Pediatrics, 168(4): 385- 386.

[11] Feeding America: www.feedingamerica.org/hunger-in-america/pennsylvania

[12] Feeding America: www.feedingamerica.org/hunger-blog/3-ways-hunger-affects-your-body

[13] Economic Research Service; US Department of Agriculture: www.ers.usda.gov

[14] Pennsylvania Department of Agriculture: www.agriculture.pa.gov

[15] Feeding America: www.feedingamerica.org

[16] Just Harvest: www.justharvest.org/wp-content/uploads/2015/06/Just-Harvest-Fact-Sheet-on-Hunger-in-Allegheny-County-2017.pdf

[17] The Supplemental Nutrition Assistance Program is a federal program that provides nutrition benefits to low-income individuals and families that are used at stores to purchase food.

[18] Feeding America: www.feedingamerica.org/hunger-in-america/pennsylvania

[19] American Hospital Association: www.aha.org/advocacy/access-and-health-coverage/access-behavioral-health

[20] Weight that is higher than what is considered healthy for a given height is described as overweight or obesity. Body Mass Index (BMI) is a screening tool for overweight and obesity. BMI that is 30.0 or higher falls within the obesity range. Centers for Diseases Control and Prevention: www.cdc.gov/obesity/adult/defining.html

[21] The County Health Rankings & Roadmaps program compares the health of nearly all counties in the United States to others within its own state and supports coalitions tackling the social, economic, and environmental factors that influence health. The major goal of the Rankings is to raise awareness about the many factors that influence health, and that health varies from place to place, not to produce a list of the healthiest 10 or 20 counties in the nation.

[22] The Pennsylvania Department of Health: www.health.pa.gov/topics/programs/Pages/Obesity.aspx

[23] Ibid.

[24] The New England journal of Medicine: www.nejm.org/doi/full/10.1056/NEJM200008243430809

[25] The Pennsylvania Department of Health: www.health.pa.gov/topics/HealthStatistics/MinorityHealthStatistics/Documents/Minority_Cancer_Incidence_2015.pdf

[26] The Pennsylvania Department of Health: www.health.pa.gov/topics/HealthStatistics/MinorityHealthStatistics/Documents/Minority_Hosp_for_Select_Conditions_2014.pdf

[27] Ibid.

AHN Jefferson Hospital

565 Coal Valley Rd,
Jefferson Hills, PA 15025