JEFFERSON
REGIONAL MEDICAL CENTER

2012 Community Health Needs Assessment

Strategy
solutions, inc.

This page is intentionally blank

TABLE OF CONTENTS

JEFFERSON REGIONAL MEDICAL CENTER

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

JEFFERSON REGIONAL MEDICAL CENTER

TABLE OF TABLES

TABLE OF TABLES (continued)

TABLE OF FIGURES

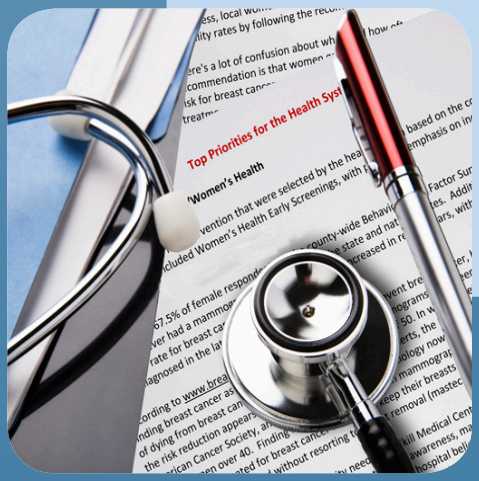
TABLE OF FIGURES (continued)

TABLE OF FIGURES (continued)

TABLE OF FIGURES (continued)

This page is intentionally blank

JEFFERSON
REGIONAL MEDICAL CENTER



2012 Community Health Needs Assessment
EXECUTIVE SUMMARY

Strategy solutions, inc.

This page is intentionally blank

MESSAGE TO THE COMMUNITY

Jefferson Regional Medical Center is proud to present its 2012-2013 Community Health Needs Assessment (CHNA) Report. This report includes a comprehensive review and analysis of data regarding the health issues and needs of the individuals residing in the service region of Jefferson Regional. The overall service region encompasses the lower Monongahela Valley and South Hills regions of Allegheny County, the southwest corner of Westmoreland County and the northwest section and selected communities in the northwest corners of Fayette and Washington counties. The primary service region includes the communities (defined by zip code) of Pleasant Hills, Clairton/Jefferson Hills, West Mifflin, Brentwood, Homestead/Waterfront, Elizabeth, Belle Vernon, Bethel Park, South Park, Finleyville, Mount Oliver, McKeesport, Glassport, Monongahela, Liberty/Port Vue and Hazelwood.

This study was conducted to identify the health needs and issues of the region and to provide useful information to public health and health care providers, policy makers, collaborative groups, social service agencies, community groups and organizations, churches, businesses, and consumers who are interested in improving the health status of the community and region. The results enable the medical center, local health department and other providers to more strategically establish priorities, develop interventions and commit resources.

Improving the health of the community is the foundation of the mission of Jefferson Regional Medical Center and an important focus for everyone in the service region, individually and collectively. In addition to the education, patient care and program interventions provided through the medical center, we hope the information in this study will encourage additional activities and collaborative efforts to improve the health status of the community.

This page is intentionally blank

EXECUTIVE SUMMARY

The 2012-2013 Jefferson Regional Medical Center Community Health Needs Assessment was conducted to identify primary health issues, current health status and needs and to provide critical information to those in a position to make a positive impact on the health of the region's residents. The results enable community members to more strategically establish priorities, develop interventions and direct resources to improve the health of people living in the community.

To assist with the CHNA , Jefferson Regional retained Strategy Solutions, Inc., a planning and research firm with the mission to create healthy communities, to facilitate the process and formed a Steering Committee. Planning for the assessment began in late 2011, following best practices as outlined by the Association of Community Health Improvement, a division of the American Hospital Association in their CHNA Toolkit. The process was also designed to ensure that the report meets the requirements in the latest draft IRS 990 guidelines. This Community Health Needs Assessment included a detailed examination of the following areas that became the chapters outlined in the study:

- Demographics and Socio-Economic Indicators
- Infectious Disease
- Access to Quality Health Care
- Mental Health & Substance Abuse
- Chronic Disease
- Physical Activity and Nutrition
- Healthy Environment
- Tobacco Use
- Healthy Mothers, Babies & Children
- Injury

Secondary data on disease incidence and mortality as well as behavioral risk factors were gathered from the PA Department of Health and the Centers for Disease Control as well as the Healthy People 2020 website for the hospital's total service area encompassing parts of Allegheny, Fayette, Washington and Westmoreland counties. Aggregate utilization data was included from Jefferson Regional Medical Center patient records as well as the Pennsylvania Health Care Cost Containment Council. Demographic data was collected from the Nielsen Claritas (www.claritas.com) demographic database as well as primary data collected specifically for this study were based on the primary service area, including a more focused geography including the communities of Pleasant Hills, Clairton/Jefferson Hills, West Mifflin, Brentwood, Homestead/Waterfront, Elizabeth, Belle Vernon, Bethel Park, South Park, Finleyville, Mount Oliver, McKeesport, Glassport, Monongahela, Liberty/Port Vue and Hazelwood. A telephone survey of 400 respondents following the Behavioral Risk Factor Surveillance Survey (BRFSS) Methodology was conducted, along with nine Focus Groups and seven in-depth Stakeholder Interviews.

After review and analysis, the data suggested 39 distinct issues, needs and possible priority areas for intervention. After prioritization and discussion, the Steering Committee identified Women's Health as the top priority area for intervention and action planning. The Jefferson Regional Board of Directors approved the implementation strategy/ action plan on May 20, 2013.

METHODOLOGY

Jefferson Regional Medical Center formed a Steering Committee that consisted of medical center board members, community leaders and staff to guide this study. The Steering Committee met a total of nine times between April 2012 and January 2013 to provide guidance on the components of the Community Health Needs Assessment. Fundamental to the community health needs assessment was community support and engagement. This support and engagement came by way of participation of the Steering Committee as well as through a community survey of 400 residents, focus groups and interviews. Individuals and organizations engaged included those with special knowledge or expertise in public health, state, regional and local health-related agencies with current data and other information relevant to the needs of communities served by the hospital as well as leaders and representatives of medically underserved, low-income or minority populations and populations with chronic disease needs.

The CHNA process follows best practices as outlined by the Association of Community Health Improvement, a division of the American Hospital Association, and ensures compliance with Internal Revenue Service (IRS) guidelines (IRS Notice 2011-52) for charitable 501(c)(3) tax-exempt hospitals. In addition, the Jefferson Regional CHNA process was supported by and meaningfully engaged a cross section of community leaders, agencies and organizations with the goal of working together to achieve healthier communities. This report provides an overview of the needs of the primary service area.

Service Area Definition

At the time that this community health needs assessment process was conducted, the Internal Revenue Service (IRS) had not finalized its guidelines for Community Health Needs Assessments. Available information published by the IRS and American Hospital Association suggested that the service area selected for the study equal the geography from which 75% of the hospital discharges originate. This study was designed to collect disease incidence and prevalence data for the entire service territory, and to focus the primary data collection efforts (Behavioral Risk Factor Surveillance Survey, Focus Groups and Stakeholder Interviews) in the primary service area. The overall service area encompasses the lower Mon Valley and South Hills regions of Allegheny County, the southwest corner of Westmoreland County and the northwest sections of Fayette and Washington counties. The primary service area includes the communities of Pleasant Hills, Clairton/Jefferson Hills, Brentwood, Homestead/Waterfront, Elizabeth, Belle Vernon, Bethel Park, South Park, Finleyville, Mount Oliver, McKeesport, Glassport, Monongahela, Liberty/Port Vue and Hazelwood.

Asset Inventory

Jefferson Regional identified the existing health care facilities and resources within the community. Information included in the asset inventory and map was extracted from the Jefferson Regional senior services and case management databases.

Qualitative and Quantitative Data Collection

In an effort to examine health-related needs of the service area residents of the service area and to meet all known guidelines and requirements of the published IRS 990 standards, the consulting team employed both qualitative and quantitative data collection and analysis methods. The Steering Committee members and consulting team made significant efforts to ensure that the entire primary service territory, all socio-demographic groups and all underrepresented populations were included.

The secondary data collection process included demographic and socioeconomic data obtained from Nielsen/Claritas and the US Census Bureau (www.census.gov), disease incidence and prevalence data obtained from the Pennsylvania Departments of Health and Vital Statistics, BRFSS data collected, the Centers for Disease Control, Healthy People 2020 goals (www.healthypeople.gov/2020), and the US Department of Agriculture. Selected inpatient and outpatient utilization data were obtained from Jefferson Regional Medical Center, the Pennsylvania Health Care Cost Containment Council and the County Health Rankings (www.countyhealthrankings.org).

The primary data collection process included a Behavioral Risk Factor Surveillance Survey following the data collection protocols and questions designed by the Centers for Disease Control with a representative sample of 400 Primary Service Area residents, conducted by Strategy Solutions, Inc. and Moore Research Services. Seven individual stakeholder interviews were conducted by members of the consulting team to gather a personal perspective from those who have insight into the health of a specific population group or issue, the community or the region, along with nine focus groups to gather information directly from various groups that represent a particular interest or area.

Needs/Issues Prioritization Process

On September 25, 2012, the Steering Committee reviewed the primary and secondary data collected through the needs assessment process and discussed and identified key needs and issues present in the community. On October 10, 2012, the Steering Committee reviewed the needs and issues identified in the Community Needs Assessment Process and prioritized the issues in order to identify potential intervention strategies and an action plan. In preparation for the October 10 meeting, four criteria were identified for evaluation of issues: accountable entity, magnitude, variance against benchmarks and capacity to implement evidence based solutions. The participants completed the prioritization exercise using the OptionFinder audience response polling technology to quickly rate/rank the issues based on the various criteria.

Action Planning Process

Following prioritization, Jefferson Regional staff met to discuss the identified priorities and possible intervention strategies and action plans. The top five priority need areas were discussed relative to the medical center's mission, current capabilities and focus areas. On November 5, the Steering Committee recommended the key focus for intervention action plans. The group consensus during that discussion was that "Access to Women's Health" would be the focus area for intervention.

Following concurrence of the Steering Committee, clinical and administrative leaders developed implementation strategies and an action plan along with time frame and budget associated with the activities. Needs identified by the CHNA that are not part of the implementation strategy are being addressed by existing community assets, necessary resources to meet these needs are lacking, or these needs fall outside of the Jefferson Regional areas of expertise.

Review and Approval

The final implementation strategies and action plan were presented to and approved by the Jefferson Regional Board of Directors on May 20, 2013.

GENERAL FINDINGS

Demographics

The population of the Jefferson Regional Service Area was estimated to be 269,289 in 2012. During the past twenty years, the population has declined and is expected to continue to decline during the next five years by an additional 2.2%. The population of the Jefferson Regional Service area is predominantly white, at more than 85% of the service area population. The African-American population represents 10.8% of the service territory population, with the remainder made up of a combination of small populations of other races. A significant percentage of the population is age 55 or older (31.5%). A slight majority of residents are female (52.5%). The largest percentage of the service area population is married with spouse present (47%), although about a third of the population (30.7%) has never been married. The largest percentage of residents (39.6%) have graduated from high school (or have a GED). The second largest percentage of the population of the service area (18.3%) has some college education but does not have a degree.

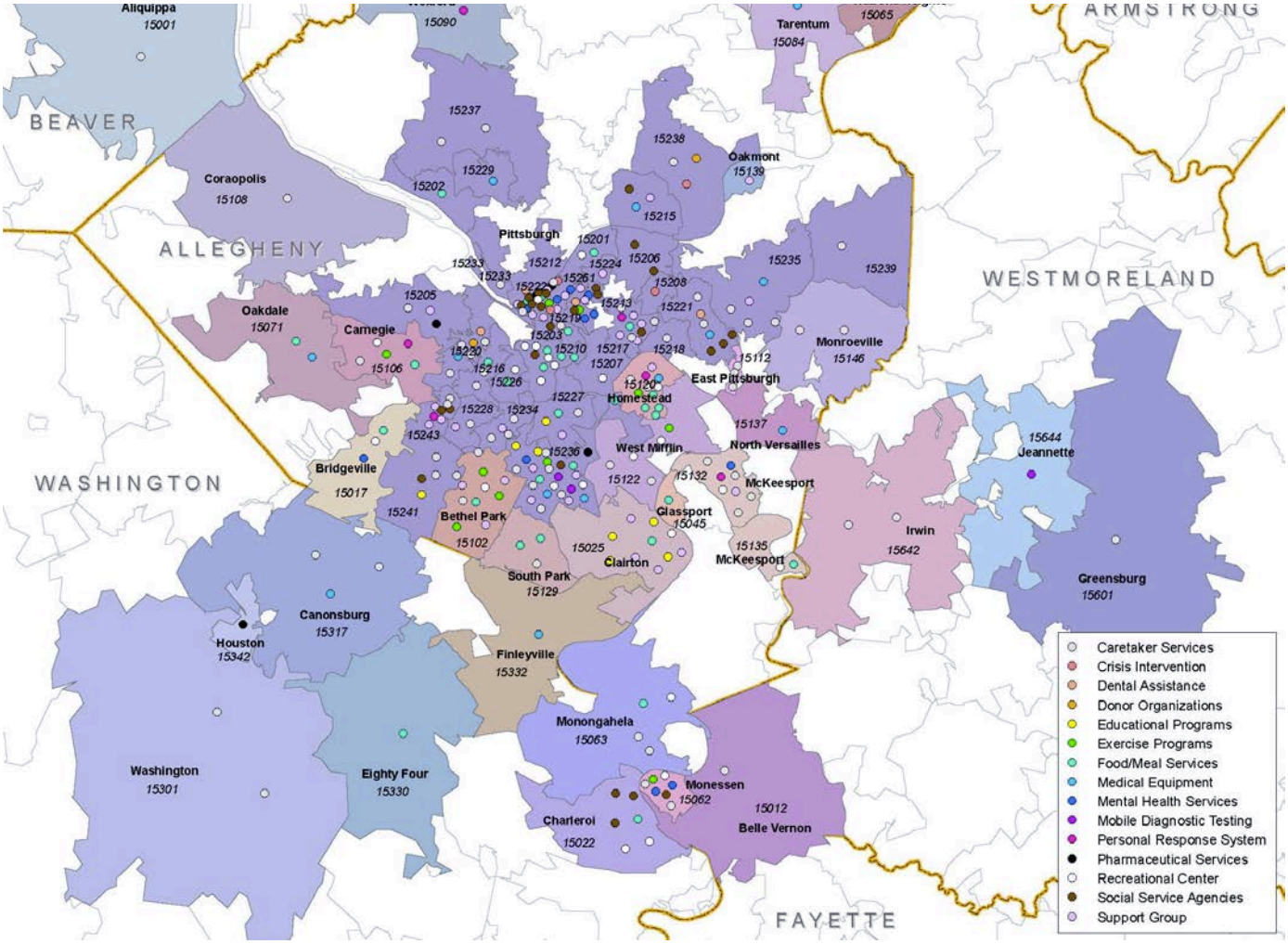
The average household income in the service area is $54,344; the median household income is $42,896 and the estimated per-person income is $23,981. Although the largest percentage of the residents of the service area (19.2%) has incomes between $50,000 and $74,999, almost half of the population (41.3%) of the service area has incomes less than $35,000/year. Approximately 10% of the families of the service area and 7.6% of the families with children live in poverty. African American households have the lowest household income at $25,061 as compared to White households at $45,600. Asian/Pacific Islander households have the highest household income at $78,125.

A sizable portion (13.7%) of households do not own a vehicle. Additionally, much of the service area is not served by public transportation. More than a third of the residents (38%) are currently not in the labor force. Only about a quarter (24%) of the service area population travels less than 15 minutes per day to work. The largest percentage of residents (32.6%) travels between 15 and 29 minutes to work. The remainder (43.4%) travels more than a half hour to work. Overall, the average travel time to work in minutes for the service area population is 30.2 minutes.

Asset Inventory

The community assets and resources identified for the Jefferson Regional service area are organized into two categories: Medical Services and Senior Care Services. Many of the assets and resources are concentrated in the northern portion of the service area, and within the city of Pittsburgh.

Jefferson Regional Medical Center Asset Map



Service Area Key Findings

The results of the service area BRFSS and public health data analysis indicate that the region is comparable to state and national rates for many indicators. However, many rates have not met the Healthy People 2020 goals, including the percentage of adults with no health insurance, who did not see a doctor or get prescriptions in the past year due to cost, current smokers and the percentage of females receiving a pap test in the past 3 years. The rates of adult obesity are higher than the Commonwealth and national rates, as is the percentage of adults who have ever been told they have diabetes, diabetes mortality rates, and type 1 and 2 diabetes in children. Breast cancer rates are increasing, are above the Commonwealth rate as well as the Healthy People 2020 goal. Ovarian and prostate cancer rates are increasing along with other maternal/child health indicators including low birth weight babies, mothers on Medicaid and teen pregnancy rates in select portions of the service area.

The following tables provide a summary of the quantitative data:

Key Findings

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Yellow signifies that some of the service area region(s) is better and some are worse than the comparison. Red indicates that the regional data is worse than the comparison and green indicates better than the comparison.

The tables presented on the next few pages highlighting the key findings of the secondary data and Behavioral Risk Fator Survey.

	BRFSS Service Area	Allegheny	Westmoreland	Fayette, Greene, Washington	PA	US	HP 2020	PA	US	HP 2020
Behavior Risk	2012	2008-10	2008-10	2008-10	2008-10	2010	Goal	Comp	Comp	Comp
ACCESS										
Reported Health Poor or Fair	24.5%	14.0%	16.0%	22.0%	15.0%	14.7%		+/-	+/-	
Physical Health Not Good for 1+ Days in the Past Month		36.0%	33.0%	38.0%	37.0%			+/-		
Poor Physical or Mental Health Preventing Usual Activities 1+ Days in the Past Month		21.0%	19.0%	20.0%	21.0%			+/-		
No Health Insurance (Ages 18-64)	9.3%	12.0%	13.0%	15.0%	13.0%	17.8%	0%	+/-	-	+
No Personal Health Care Provider		13.0%	8.0%		11.0%		16.1%	+/-		-
No Personal Health Care Provider (Age 18-44)		24.0%	12.0%	10.0%	17.0%		16.1%	+/-		+/-
Routine Check-up Within the Past 2 Years	87.1%	83.0%	84.0%	85.0%	83.0%			+/-		
Needed to See a Doctor But Could Not Due to Cost, Past Year	9.3%	10.0%	7.0%	10.0%	11.0%		4.2%	-		+
Percent who saw a dentist in past 12 months	62.8%						90.0%			-
Percent of emergency room visits in past 12 months	29.0%									
Percent Urgent Appointment with Doctor same day	34.0%									
Percent Routine Appointment with Doctor Within a week	61.6%									
Percent need prescription (s) but couldn't due to costs in past 12 months	13.8%						2.8%			+
CHRONIC DISEASE										
Percent of females who have had a mammogram < 2 years	29.1%									
Percent of females who have had a Pap test in past 3 years	38.5%					81.5%	93.0%		-	-
Percent of males who have ever had a PSA test (age 65+)	74.0%									
Percent 65+ who have had sigmoidoscopy or colonoscopy	62.0%									
Percent who had been told they have High Blood Pressure (age 65+)	56.8%									
Percent last time Blood Pressure taken <12 Months (age 65+)	91.0%									
Percent told by provider to Reduce Cholesterol (age 65+)	39.2%									
Percent who have had blood cholesterol checked (age 65+) in last year	86.5%									
Percent having" A One C" test in Past 12 months	40.6%									
Adults Who Were Ever Told They Have Heart Disease- Age 35 and older		6.0%	8.0%	9.0%	7.0%	4.1%		+/-	+	
Adults Who Were Ever Told They Had a Heart Attack- Age 35 and Older		6.0%	8.0%	10.0%	6.0%	4.2%		+/=	+	
Adults Who Were Ever Told They Had a Stroke- Age 35 and older		3.0%	5.0%	4.0%	4.0%	2.7%		+/-	+	
Adults Who Were Ever Told They Had a Heart Attack, Heart Disease, or Stroke- Age 35 and Older		11.0%	15.0%	16.0%	12.0%			+/-		
Overweight (BMI 25-30)		35.0%	41.0%	36.0%	36.0%	36.2%		+/-	+/-	
Obese (30-99.99)		28.0%	28.0%	30.0%	28.0%	27.5%	30.5%	+/=	+	-
Percent of Overweight and Obese Adults	65.5%	63.0%	69.0%	66.0%	64.0%	63.5%		+/-	+/-	
Adults Who Were Ever Told They Have Diabetes	11.8%	9.0%	9.0%	11.0%	9.0%	8.7%		+/=	+	
HEALTHY ENVIRONMENT										
Adults Who Have Ever Been Told They Have Asthma	16.3%	15.0%	14.0%	13.0%	14.0%	13.8%		+/-	+/-	
Currently Have Asthma		9.0%	10.0%	10.0%	10.0%	9.1%		-/=	+/-	
INFECTIOUS DISEASE										
Received seasonal flu vaccine	43.8%									
Adults Who Had a Pneumonia Vaccine, Age 65 and older	59.5%	77.0%	76.0%	68.0%	70.0%	68.8%	90.0%	+/-	+	-
Ever Tested for HIV, Ages 18-64		32.0%	27.0%	28.0%	34.0%		18.9%	-		+
MENTAL HEALTH AND SUBSTANCE ABUSE										
Satisfied or Very Satisfied With Their Life		95.0%	96.0%	92.0%	94.0%			+/-		
Never/Rarely Get the Social or Emotional Support They Need		7.0%	9.0%	10.0%	8.0%			+/-		
Mental Health Not Good 1+ Days in the Past Month	45.2%	34.0%	33.0%	37.0%	34.0%			+/-		
Percent currently taking medication or receiving treatment for a mental health condition	14.8%									
Percent has a family member who has mental health needs not being met	7.2%									
Percent who had at least one drink in past 30 days	32.1%					54.1%			-	
Adults Who Reported Binge Drinking (5 drinks for men, 4 for women on one occasion)		19.0%	14.0%	19.0%	17.0%	17.1%	24.4%	+/-	+/-	-
At Risk for Heavy Drinking (2 drinks for men, 1 for women daily)		6.0%	4.0%	4.0%	5.0%			+/-		
Reported Chronic Drinking (2 or more drinks daily for the past 30 days)		6.0%	5.0%	5.0%	6.0%	5.0%		-/=	+/=	
Percent who drove at least 1 day in past 30 days while drinking	2.8%									

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Yellow signifies that some of the service area region(s) is better and some are worse than the comparison. Red indicates that the regional data is worse than the comparison and green indicates better than the comparison.

	BRFSS Service Area	Allegheny	Westmoreland	Fayette, Greene, Washington	PA	US	HP 2020	PA	US	HP 2020
Behavior Risk	2012	2008-10	2008-10	2008-10	2008-10	2010	Goal	Comp	Comp	Comp
Percent who have been affected by the use of Illegal drugs, prescription drugs, or alcohol	4.0%									
Percent living with someone who used illegal street drugs or abused prescription medications	3.8%									
Percent ever had intimate partner threaten physical violence	9.3%									
PHYSICAL ACTIVITY AND NUTRITION										
Percent who eat fruits daily	56.6%									
Percent who eat vegetables daily	25.5%									
Percent who eat beans daily	6.6%									
No Leisure Time/Physical Activity in the Past Month		24.0%	25.0%	29.0%	25.0%	23.9%	32.6%	+/-	+	-
Percent frequency of adding salt to food - most of the time	16.5%									
TOBACCO USE										
Adults Who Reported Never Being a Smoker		54.0%	57.0%	50.0%	54.0%	56.6%		+/-	+/-	
Adults Who Have Quit Smoking at Least 1 Day in the Past Year (of adults who smoke daily)		48.0%	49.0%		50.0%		80.0%	-		-
Adults Who Reported Being a Current Smoker		18.0%	15.0%	24.0%	20.0%	17.3%	12.0%	+/-	+/-	+
Percent using smokeless tobacco on some days	5.5%									
Adults Who Reported Being An Everyday Smoker	23.5%	13.0%	12.0%	20.0%	15.0%	12.4%		+/-	+/-	
Adults Who Reported Being a Former Smoker		28.0%	28.0%	25.0%	26.0%	25.1%		+/-	+/-	
Percent smokes 6-10 cigarettes per day	31.0%									
Percent smokes 11-15 cigarettes per day	8.6%									
Percent smokes 16+ cigarettes per day	34.5%									
Percent who smoke cigarettes that want to quit	69.0%									
Percent told they have COPD, Emphysema or Chronic Bronchitis	12.5%									
UNINTENTIONAL INJURY										
Percent have knowledge of Elder Abuse	1.3%									
Percent of respondents who experienced a fall with in past 3 months	22.0%									
Percent who always wear seatbelt	80.0%				76.9%	93.3%		+	-	
ADDITIONAL INFORMATION										
Percent who receive Health Information from Physician, Nurse, or other Health Care Professional	57.0%									
Respondents who own 1 or more pets (Cat and/or Dog and other)	57.0%									

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Yellow signifies that some of the service area region(s) is better and some are worse than the comparison. Red indicates that the regional data is worse than the comparison and green indicates better than the comparison.

	Allegheny					Trend	Fayette					Trend	PA (the last year)	US	HP 2020	PA	US	HP Goal
Public Health Data	2006	2007	2008	2009	2010	+/-	2006	2007	2008	2009	2010	+/-	Rate	Rate	Goal	Comp	Comp	Comp
CHRONIC DISEASE																		
Breast Cancer Rate per 100,000	70.3	72.8	79.0	76.1	73.2	+	60.7	60.9	57.9	54.9	70.8	+	71.5	121.9	41.0			
Breast Cancer Mortality Rate per 100,000	14.1	14.3	14.4	16.1	12.0	-	14.5	17.5	13.8	13.8	15.0	+	13.1	22.2	20.6			
Bronchus and Lung Cancer Rate per 100,000	73.2	81.6	79.7	76.8	73.6	+	69.2	85.7	88.3	85.1	75.0	-	69.1					
Bronchus and Lung Cancer Mortality Rate per 100,000	56.8	57.7	54.5	53.4	52.2	-	50.4	70,6	60.6	57.9	63.0	-	48.7		45.5			
Colorectal Cancer Rate per 100,000	50.6	50.2	47.2	49.5	41.3	-	49.9	50.5	55.6	64.7	43.4	-	47.6		38.6			
Colorectal Cancer Mortality Rate per 100,000	20.2	19.6	19.1	17.0	15.9	-	14.2	17.5	19.8	25.8	18.4	-	17.0	16.9	14.5			
Ovarian Cancer Rate per 100,000	14.2	12.6	13.7	12.2	13.9	-	11.5	14.3	9.3	9.9	14.5	-	13.3					
Ovarian Cancer Mortality Rate per 100,000	10.4	10.8	8.5	8.3	9.2	-	9.6	9.9	11.7	12.1	11.0	+	8.1					
Prostate Cancer Rate per 100,000	130.4	156.0	136.0	126.0	116.7	+	143.0	160.8	125.5	102.9	129.6	-	139.6					
Prostate Cancer Mortality Rate per 100,000	25.5	24.2	22.2	20.3	19.9	-	14.1	22.2	16.1	23.4	27.7	+	21.2	21.9	21.2			
Heart Disease Mortality Rate per 100,000	232.1	222.8	210.7	191.5	185.4	-	244.8	240.8	249.8	230.1	239.7	-	185.3	179.1				
Heart Attack Mortality Rate per 100,000	23.6	49.6	47.2	40.9	36.2	-	22.4	16.0	17.2	19.9	17.5	-	38.2					
Coronary Heart Disease Mortality Rate per 100,000	170.0	162.7	156.4	140.4	135.4	-	175.9	182.4	185.6	174.9	176.0	-	123.0	113.6	100.8			
Cardiovascular Mortality Rate per 100,000	294.9	284.8	268.2	243.1	236.4	-	318.7	309.9	306.8	311.1	298.9	-	237.6					
Cerebrovascular Mortality Rate per 100,000	46.8	46.7	43.3	38.6	39.2	-	53.6	48.0	37.0	50.4	40.1	+	38.9	39.1	33.8			
Diabetes Mortality Rate per 100,000	22.1	19.4	19.9	16.2	17.4	-	38.6	35.1	36.5	29.2	24.2	-	19.6	20.8	65.8			
All Cancers Male, per 100,000	578.5	613.7	589.8	574.7	531.7	+	579.7	639.4	599.5	594.0	592.0	+	107.3					
All Cancers Female, per 100,000	456.0	470.3	494.4	483.1	465.4	+	422.5	450.8	425.1	425.5	450.3	+	108.1					
Type I Diabetes, Students	0.31	0.30%	0.29%	0.32%		+	0.36	0.43%	0.36%	0.37%		-	0.30%					
Type II Diabetes, Students	0.07	0.08%	0.07%	0.08%		-	0.03	0.50%	0.05%	0.50%		-	0.07%					
HEALTHY MOTHERS, BABIES AND CHILDREN																		
Prenatal Care First Trimester	83.8%	84.2%	85.6%	87.1%	88.8%	+	78.1%	76.8%	79.1%	80.9%	83.0%	+	71.3%		77.9%			
Non-Smoking Mother During Pregnancy	82.3%	82.1%	83.0%	83.8%	84.8%	+	63.2%	61.3%	66.2%	62.4%	66.1%	+	84.1%		98.6%			
Non-Smoking Mother 3 Months Prior to Pregnancy	78.8%	79.0%	80.1%	80.9%	81.9%	+	58.7%	56.8%	60.9%	57.0%	58.7%	+	78.2%					
Low Birth-Weight Babies Born	9.0%	8.6%	8.9%	8.1%	8.0%	-	9.7%	9.1%	9.9%	9.1%	10.4%	+	8.3%		7.8%			
Mothers Reporting WIC Assistance	31.5%	31.4%	31.3%	32.1%	31.5%	+	56.2%	51.0%	50.4%	54.8%	55.4%	+	40.1%					
Mothers Reporting Medicaid Assistance	32.1%	32.6%	33.6%	32.0%	22.9%	-	57.3%	56.0%	54.3%	59.3%	57.6%	+	32.7%					
Percent of Population Eligible for Medicaid				15.7%	16.8%	+				25.0%	25.6%	+						
Breastfeeding	61.9%	62.9%	64.0%	68.5%	68.4%	+	41.9%	43.3%	45.3%	45.1%	47.3%	+	70.0%		81.9%			
Teen Pregnancy Rate per 1,000, Ages 15-19	39.0	40.1	41.7	38.0	38.2	-	55.8	51.4	47.3	51.3	53.7	+	39.6	34.2	36.2			
Teen Live Birth Outcomes, Ages 15-19	57.2%	57.7%	57.1%	59.1%	58.1%	+	77.5%	84.4%	80.8%	82.5%	83.7%	+	68.0%					
Infant Mortality Rate per 1,000	7.7	7.3	8.3	7.4	7.6	-			11.1	10.8	11.1%	+	7.3	6.2	6.0			
Overweight BMI, Grades K-6					17.4%						18.2%							
Obese BMI, Grades K-6					15.9%						24.3%				15.7%			
Overweight BMI, Grades 7-12					17.5%						17.2%							
Obese BMI, Grades 7-12					15.0%						24.8%				16.0%			
Students with Diagnosed ADHD	3.9%	3.90%	4.02%	4.32%		+	4.0%	4.05%	4.22%	4.17%		+	5.23%					
INFECTIOUS DISEASE																		
Influenza and Pneumonia Mortality Rate per 100,000	17.6	18.4	17.8	16.9	17.3	-	18.1	10.0	10.1	10.0	7.9	-	13.4	16.2				
Chlamydia Rate per 100,000	401.3	401.3	428.2	403.4	412.1	+	186.2	144.5	203.5	240.3	342.7	+	374.1	426.0				
MENTAL HEALTH AND SUBSTANCE ABUSE																		
Mental & Behavioral Disorders Mortality Rate per 100,000	38.0	36.8	36.3	35.4	41.5	+	40.9	30.7	34.1	37.3	30.9	-	37.6					
Drug-Induced Mortality Rate per 100,000	11.9	16.8	18.6	17.8	18.6	+	12.8	14.1	17.7	18.0	21.1	+	15.5		11.3			
TOBACCO USE																		
Emphysema Mortality Rate per 100,000	4.8	3.9	4.3	2.8	4.0	-			6.0		5.2	+	3.0			+		
INJURY																		
Auto Accident Mortality Rate per 100,000	6.0	6.3	6.5	6.2	6.7	+	16.2	22.8	25.0	27.9	19.2	+	10.5	11.9	12.4			
Suicide Mortality per 100,000	11.1	11.0	10.1	10.6	9.8	-	9.3	8.8	9.6	11.8	13.7	-	11.7	12.1	10.2			
Fall Mortality Rate per 100,000	6.7	7.1	10.0	8.5	12.2	-	5.9		8.9	10.0	8.9	+	8.3	8.1	7.0			
Firearm Mortality Rate (Accidental, Suicide, Homicide)	13.3	11.3	13.1	12.2	11.2	+		7.7	7.2		7.8	-	10.0	10.1	9.2			

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Yellow signifies that some of the service area region(s) is better and some are worse than the comparison. Red indicates that the regional data is worse than the comparison and green indicates better than the comparison.

	Washington					Trend	Westmoreland					Trend	PA (the last year)	US	HP 2020	PA	US	HP Goal
Public Health Data	2006	2007	2008	2009	2010	+/-	2006	2007	2008	2009	2010	+/-	Rate	Rate	Goal	Comp	Comp	Comp
CHRONIC DISEASE																		
Breast Cancer Rate per 100,000	71.5	67.2	79.8	69.7	59.3	+	67.3	66.1	69.5	76.5	67.6	+	71.5	121.9	41.0			
Breast Cancer Mortality Rate per 100,000	19.0	16.8	14.7	14.2	17.3	-	12.3	12.9	17.6	12.8	13.1	+	13.1	22.2	20.6			
Bronchus and Lung Cancer Rate per 100,000	78.6	76.2	64.9	74.2	63.4	-	67.9	72.1	68.4	68.8	71.0	+	69.1					
Bronchus and Lung Cancer Mortality Rate per 100,000	58.8	56.6	63.8	58.3	53.0	+	51.1	55.3	52.0	47.8	49.2	-	48.7		45.5			
Colorectal Cancer Rate per 100,000	51.7	58.0	49.7	50.5	50.6	+	53.8	56.2	49.1	51.5	43.8	-	47.6		38.6			
Colorectal Cancer Mortality Rate per 100,000	20.4	17.7	20.3	20.7	16.2	+	18.0	21.3	14.7	17.7	17.1	-	17.0	16.9	14.5			
Ovarian Cancer Rate per 100,000	14.2	13.2	19.1	11.5	10.1	+	12.0	14.4	10.0	16.3	14.0	+	13.3					
Ovarian Cancer Mortality Rate per 100,000	8.9	8.1	18.6	10.3	13.3	+	8.1	8.2	9.6	10.0	10.4	+	8.1					
Prostate Cancer Rate per 100,000	148	151.7	171.6	127.2	17.8	+	157.3	152.9	124.0	128.7	22.8	-	139.6					
Prostate Cancer Mortality Rate per 100,000	25.4	31.5	17.7	29.8	21.9	-	23.4	26.2	22.8	31.5	17.7	-	21.2	21.9	21.2			
Heart Disease Mortality Rate per 100,000	217.6	214.1	203.8	189.0	172.3	-	233.8	221.6	216.6	206.7	185.6	-	185.3	179.1				
Heart Attack Mortality Rate per 100,000	25.4	40.9	38.5	32.4	27.4	-	24.0	64.7	58.6	54.8	53.9	-	38.2					
Coronary Heart Disease Mortality Rate per 100,000	149.7	150.0	141.5	126.6	120.1	-	160.9	158.5	147.2	142.2	125.0	-	123.0	113.6	100.8			
Cardiovascular Mortality Rate per 100,000	277.4	271.4	264.8	254.2	224.0	-	302.2	285.8	274.1	258.8	237.0	-	237.6					
Cerebrovascular Mortality Rate per 100,000	41.2	45.7	46.0	47.3	33.5	-	46.7	45.4	41.3	36.5	40.2	-	38.9	39.1	33.8			
Diabetes Mortality Rate per 100,000	29.8	29.2	35.8	23.8	32.8	+	23.1	25.9	23.1	23.5	23.5	-	19.6	20.8	65.8			
All Cancers Male, per 100,000	610.8	596.4	614.4	567.6	509.5	+	608.3	594	530.2	573.3	514.1	+	107.3					
All Cancers Female, per 100,000	455.8	465.9	481.6	443.3	420.2	+	446.0	430.6	450.1	450.6	451.1	+	108.1					
Type I Diabetes, Students	0.31	0.30%	0.33%	0.36%		+	0.29	0.31%	0.30%	0.33%		+	0.30%					
Type II Diabetes, Students	0.05	0.06%	0.04%	0.08%		=	0.07	0.05%	0.05%	0.08%		+	0.07%					
HEALTHY MOTHERS, BABIES AND CHILDREN																		
Prenatal Care First Trimester	78.8%	77.0%	78.7%	80.9%	82.7%	+	82.0%	80.5%	81.2%	83.1%	86.1%	+	71.3%		77.9%			
Non-Smoking Mother During Pregnancy	76.2%	76.2%	75.4%	78.4%	77.4%	+	78.0%	77.3%	78.7%	78.8%	79.1%	+	84.1%		98.6%			
Non-Smoking Mother 3 Months Prior to Pregnancy	69.8%	71.5%	70.8%	74.0%	73.4%	+	71.1%	71.0%	72.7%	72.4%	73.8%	+	78.2%					
Low Birth-Weight Babies Born	7.4%	7.1%	7.6%	7.3%	8.5%	+	7.4%	7.5%	7.2%	7.8%	8.0%	+	8.3%		7.8%			
Mothers Reporting WIC Assistance	37.8%	37.0%	37.3%	35.8%	36.1%	-	35.2%	34.5%	35.4%	35.9%	35.2%	+	40.1%					
Mothers Reporting Medicaid Assistance	32.3%	32.6%	33.5%	30.7%	30.4%	-	33.1%	33.5%	34.2%	38.1%	33.6%	+	32.7%					
Percent of Population Eligible for Medicaid				14.6%	15.0%	+				14.7%	15.2%	+	17.9%					
Breastfeeding	55.9%	58.6%	58.2%	62.7%	60.9%	+	59.4%	60.1%	61.6%	63.3%	66.0%	+	70.0%		81.9%			
Teen Pregnancy Rate per 1,000, Ages 15-19	29.4	33.1	33.1	33.7	28.8	-	29.1	30.6	32.4	28.0	25.9	-	39.6	34.2	36.2			
Teen Live Birth Outcomes, Ages 15-19	74.3%	76.0%	75.5%	70.4%	73.2%	-	67.1%	69.3%	70.5%	69.6%	64.5%	-	68.0%					
Infant Mortality Rate per 1,000	6.2	7.1	6.4	7.7	7.2		5.4	6.8	6.2	7.9	7.2		7.3	6.2	6.0			
Overweight BMI, Grades K-6					14.7%						16.7%							
Obese BMI, Grades K-6					16.6%						16.9%				15.7%			
Overweight BMI, Grades 7-12					14.8%						16.7%							
Obese BMI, Grades 7-12					18.2%						18.2%				16.0%			
Students with Diagnosed ADHD	3.8%	3.80%	3.97%	4.51%		+	3.5%	4.13%	3.95%	4.36%		+	5.23%					
INFECTIOUS DISEASE																		
Influenza and Pneumonia Mortality Rate per 100,000	17.4	13.4	21.2	12.6	14.5	+	20.3	15.4	21.1	16.6	14.7	+	13.4	16.2				
Chlamydia Rate per 100,000	188.8	178.5	212.7	175.5	223.8	+	111.1	111.5	111.5	121.5	137.5	+	374.1	426.0				
MENTAL HEALTH AND SUBSTANCE ABUSE																		
Mental & Behavioral Disorders Mortality Rate per 100,000	28.5	29.8	37.6	35.3	34.0	-	34.3	33.3	40.1	36.4	36.4	+	37.6					
Drug-Induced Mortality Rate per 100,000	10.1	11.6	10.9	9.1	22.9	+	14.6	15.6	16.4	18.8	19.7	+	15.5		11.3			
TOBACCO USE																		
Emphysema Mortality Rate per 100,000			4.7				3.9	5.7	5.1	5.0	4.6	-	3.0					
INJURY																		
Auto Accident Mortality Rate per 100,000	35.2	13.3	12.7	13.3	11.8	-	44.9	18.0	15.7	12.1	13.2	-	10.5	11.9	12.4			
Suicide Mortality per 100,000	13.8	9.1	14.1	14.9	14.0	+	12.9	11.3	12.1	10.5	11.8	+	11.7	12.1	10.2			
Fall Mortality Rate per 100,000	7.2	6.7	10.7	6.1	9.7	+	7.8	8.3	12.3	9.4	9.4	+	8.3	8.1	7.0			
Firearm Mortality Rate (Accidental, Suicide, Homicide)	9.1	7.9	10.4	11.8	7.5	+	10.5	7.3	7.3	8.0	8.6	+	10.0	10.1	9.2			

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Yellow signifies that some of the service area region(s) is better and some are worse than the comparison. Red indicates that the regional data is worse than the comparison and green indicates better than the comparison.

	Allegheny			Trend	Fayette			Trend	PA (the last year)	US	HP 2020	PA	US	HP Goal
Public Health Data	2010	2011	2012	+/-	2010	2011	2012	+/-	Rate	Rate	Goal	Comp	Comp	Comp
ACCESS														
Mammogram Screenings		57.0%	58.0%	+		60.0%	61.0%	-	67.0%		81.1%			
HEALTHY ENVIRONMENT														
Unemployment Rates	5.0%	6.9%	7.7%	+	7.0%	9.2%	10.1%	+	8.7%	8.9%				
High School Graduation Rates	83.0%	83.0%	83.0%	=	74.0%	77.0%	70.0%	-	79.0%		82.4%			
Children Living in Poverty	16.0%	17.0%	16.0%	+	31.0%	34.0%	32.0%	+	19.0%					
Children Living in Single Parent Homes	8.0%	33.0%	33.0%	=	9.0%	37.0%	37.0%	+	32.0%					
Number of Air Pollution Ozone Days	22	14	14	-	5	1	1	-	8					
PHYSICAL ACTIVITY AND NUTRITION														
Fast Food Restaurants			47.0%				48.0%		48.0%					

	Washington			Trend	Westmoreland			Trend	PA (the last year)	US	HP 2020	PA	US	HP Goal
Public Health Data	2010	2011	2012	+/-	2010	2011	2012	+/-	Rate	Rate	Goal	Comp	Comp	Comp
ACCESS														
Mammogram Screenings		56.0%	55.0%	-		60.0%	59.0%	-	67.0%		81.1%			
HEALTHY ENVIRONMENT														
Unemployment Rates	5.0%	7.7%	8.2%	+	5.0%	7.9%	8.3%	+	8.7%	8.9%				
High School Graduation Rates	87.0%	86.0%	89.0%	+	87.0%	88.0%	88.0%	+	79.0%		82.4%			
Children Living in Poverty	13.0%	14.0%	14.0%	+	12.0%	14.0%	16.0%	+	19.0%					
Children Living in Single Parent Homes		25.0%	25.0%	=		25.0%	25.0%	=	32.0%					
Number of Air Pollution Ozone Days	16	8	8	-	14	4	4	-	8					
PHYSICAL ACTIVITY AND NUTRITION														
Fast Food Restaurants			50.0%				48.0%		48.0%					

Hospital Utilization Rates – Ambulatory Care Sensitive Conditions

The table below outlines the overall number of cases and inpatient utilization rates for specific ambulatory care sensitive conditions. COPD, Heart Failure and Pneumonia have higher rates of inpatient admission.

Inpatient Utilization	FISCAL YEAR CASE COUNT				Utilization Rate (per 10,000)		
DRG Type	2010	2011	2012	TOTAL	2010	2011	2012
Alcohol and Drug Abuse	87	98	74	259	3.2	3.6	2.7
Breast Cancer	21	19	26	66	0.8	0.7	1.0
Bronchitis & Asthma	295	257	212	764	11.0	9.5	7.9
Cancer	48	41	47	136	1.8	1.5	1.7
Heart Failure	688	674	552	1,914	25.5	25.0	20.5
COPD	878	871	892	2,641	32.6	32.3	33.1
Fractures	50	34	50	134	1.9	1.3	1.9
Hypertension	46	40	48	134	1.7	1.5	1.8
Pneumonia	476	532	573	1,581	17.7	19.8	21.3
Reproductive Disorders	7	6	4	17	0.3	0.2	0.1

The table below outlines the overall number of Emergency Department cases for specific ambulatory care sensitive conditions. These conditions should be managed outside of the acute care setting. Diabetes, COPD, kidney/urinary tract infection, severe ear, nose and throat infections and gastroenteritis are conditions with high utilization.

PREVENTABLE CONDITIONS [and ICD-9-CM CODES] (By Primary Diagnosis Unless Otherwise Noted)	FISCAL YEAR			YTD NOV
AVOIDABLE ILLNESSES	2010	2011	2012	2013
Congenital Syphilis [090]	0	0	0	0
Failure to thrive [783.41]	4	2	4	2
Dental Conditions [521-523, 525, 528]	156	153	154	67
Vaccine Preventable Conditions [032, 033, 037, 041.5, 045, 052.1, 052.9, 055-056, 070.0-070.3, 072, 320.2*, 320.3, 390, 391, 771.0]	4	2	6	3
Iron Deficiency Anemia [280.1, 280.8, 280.9]	266	599	515	224
Nutritional Deficiencies [260-262, 268.0, 268.1]	1	1	2	5
ACUTE CONDITIONS	2010	2011	2012	2013
Bacterial Pneumonia [481, 482.2, 482.3, 482.9, 483, 485, 486]	432	480	571	368
Cancer of the Cervix [180.0-180.1, 180.8-180.9]	2	6	16	2
Cellulitis [681, 682, 683, 686]	2	10	15	4
Gastroenteritis [558.9]	552	589	553	159
Hypoglycemia [251.2]	24	52	33	19
Kidney/Urinary Infection [590.0, 599.0, 599.9]	1,571	2,416	2,431	1,115
Pelvic Inflammatory Disease [614]	0	0	0	0
Severe Ear, Nose, & Throat Infections [382*, 462, 463, 465, 472.1]	872	1,330	1,026	373
Skin Grafts with Cellulitis {DRGs: 263 & 264} For 2008: {DRGs: 573, 574, 575}	26	20	30	3

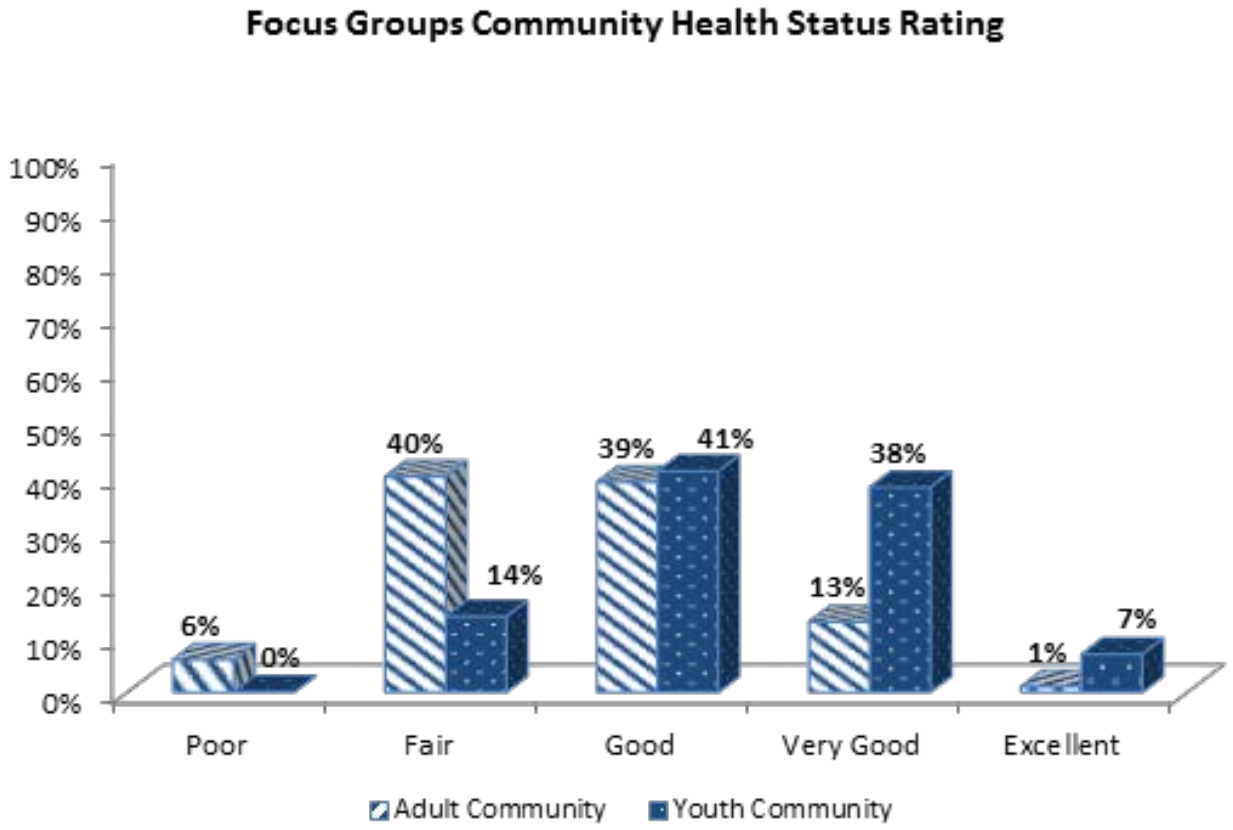
PREVENTABLE CONDITIONS [and ICD-9-CM CODES] (By Primary Diagnosis Unless Otherwise Noted)	FISCAL YEAR			YTD NOV
CHRONIC CONDITIONS	2010	2011	2012	2013
Angina [411.1, 411.8, 413]	2	10	17	2
Chronic Obstructive Pulmonary Disease [466.0*, 491, 492, 494, 496]	2,319	2,416	2,486	1,200
Congestive Heart Failure [402.01, 402.11, 402.91, 428, 518.4]	2	3	5	1
Diabetes with ketoacidosis or hyperosmolar coma or other coma [250.1-250.33]	6	12	31	15
Diabetes with other specified or unspecified complications [250.8-250.93]	1,014	928	818	349
Diabetes mellitus without mention of complications or unspecified hypoglycemia [250-250.04]	4,159	9,323	10,266	4,284
Hypertension [401.0, 401.9, 402.00, 402.10, 402.90]	2,111	7,058	7,963	3,521
Tuberculosis (Non-Pulmonary) [012-018]	1	0	0	0
TOTAL	13,526	25,410	26,942	11,716

The table below outlines the overall number of Emergency Department cases for specific mental health diagnoses. These conditions should be managed outside of the acute care setting as well. Drug related conditions, anxiety and depression have the highest utilization.

MENTAL HEALTH CASES by ICD9	FISCAL YEAR			YTD NOV
DESCRIPTION	2010	2011	2012	
Dementia	146	88	102	23
Alcohol	1,517	1,597	1,645	755
Drug Related	3,510	3,749	3,829	1,495
Transient organic psychotic conditions	93	80	104	47
Other organic psychotic conditions (chronic)	1,372	1,566	903	213
Schizophrenia	474	466	473	195
Manic Disorders	0	0	0	0
Depression	2,228	2,286	2,123	828
Bipolar	1,292	1,209	1,419	540
Paranoia/Psychosis	889	998	1,081	359
Anxiety	2,749	2,709	3,026	1,207
Phobias	39	35	20	10
Personality Disorders	275	252	278	85
Sexual Deviations and Disorders	2	1	0	0
Psychogenic Disorders	13	8	12	0
Sleep Disorders	4	0	2	0
Eating Disorders	9	8	10	4
Stress Related	58	70	83	30
Adjustment Related	144	187	221	122
Conduct/Social Disturbances	29	70	97	31
Emotional Disorders (youth)	0	1	0	0
TOTAL	14,843	15,380	15,428	5,944

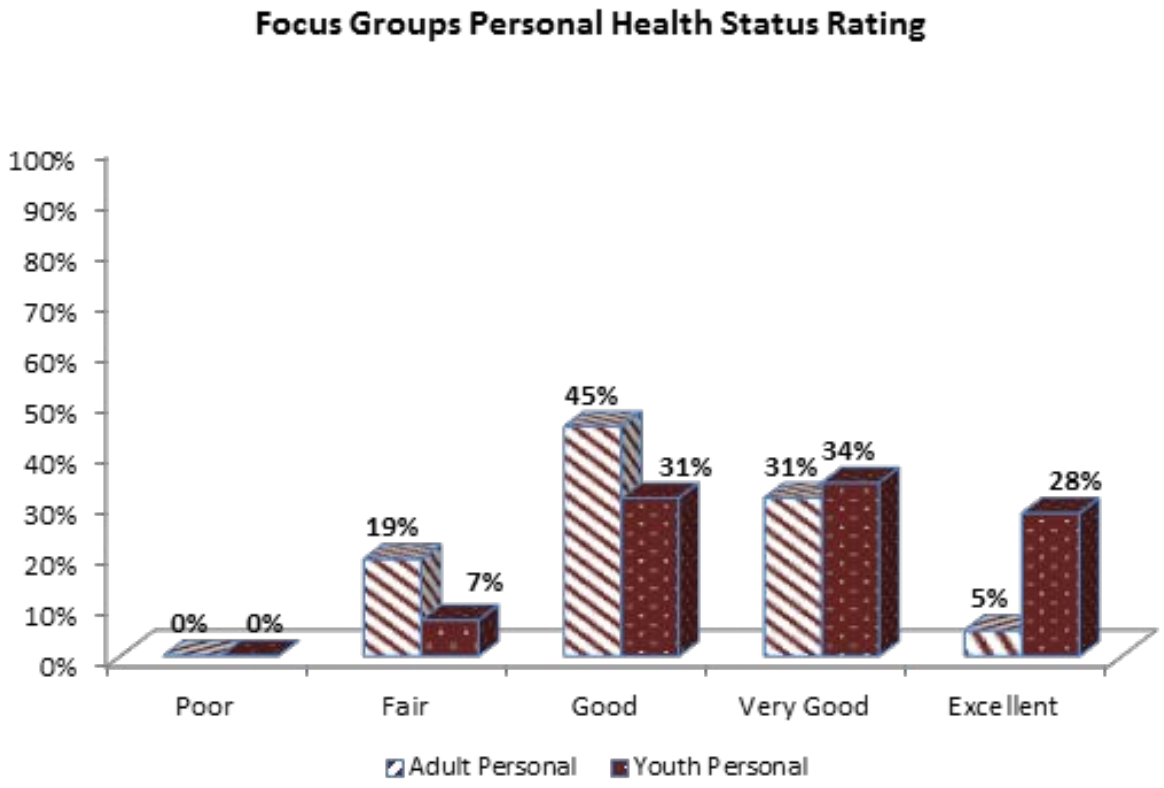
Focus Groups

Focus group participants (both youth and adults; n=110) were asked to rate the health status of the community. Youth were more likely to rate the health status of the community as very good or excellent, whereas adults were more likely to rate the health status as fair or poor.



Those who rated the health status of the community as good or as very good expressed that they felt that there were many health care providers in the community who are easily accessible. There is also a sense that many members of the community are health conscious, even though the community is aging. There is a perception that people are paying more attention to nutrition and even young people are eating healthier.

Those who tended to rate the health status of the community as fair or poor cited that a lot of people in the community simply can't afford health care. Even if people have health insurance (which many do not), they often can't afford the out of pocket expenses and co-pays. Sometimes cultural barriers prevent people from accessing needed care. Transportation is also seen as an imporant issue in the area; most bus routes have been reduced or eliminated. There are parts of the Jefferson Regional service territory that do not have doctors or dentists in the area. Drugs, alcohol, mental health issues, tobacco use, high cancer rates and air quality problems were all identified as issues driving the perceived health status of the community. Youth participants in the focus group also were more likely than the adults to rate their personal health status as very good or excellent.

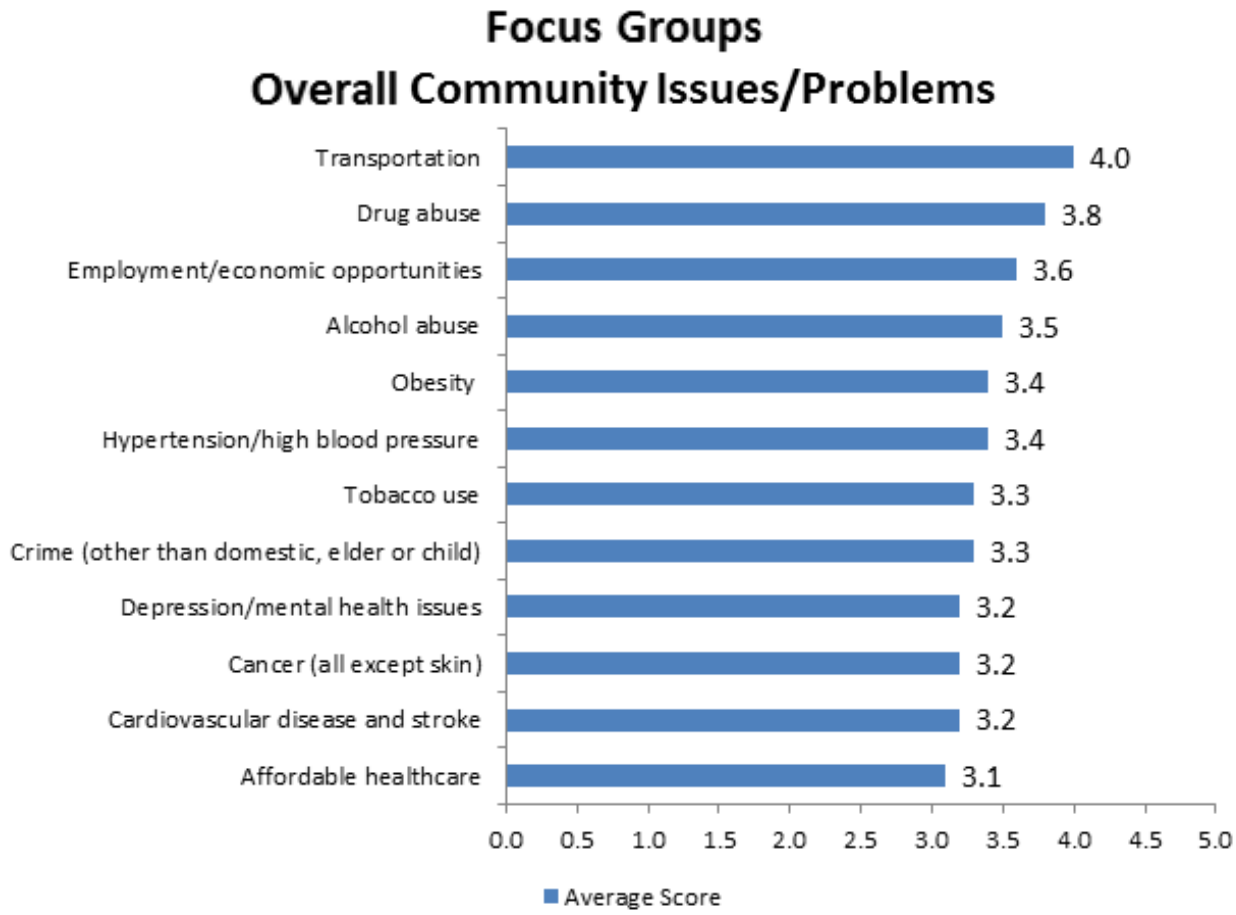


Focus group participants talked about the link between individual health status and the health of the community. When people care about their individual health, there is a domino effect and the health status of both the individual and community improve. There is also a perception that people in the Jefferson Hills area work together and should work together more to improve the health status of the community.

While most individuals tended to rate their personal health status higher than the community health status, some mentioned that individuals will forego health care if they do not have insurance and cannot afford it.

Focus group participants were also asked to rate the extent to which a list of community needs was a problem for them personally, in their local community and for Jefferson Regional's overall service territory. Items were rated on a 5 point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Most participants (both youth and adults) tended to rate problems in their local community as more serious than the extent to which those same items were a problem in the overall service area or in their individual family.

Highest rated problems identified across all groups are outlined below:

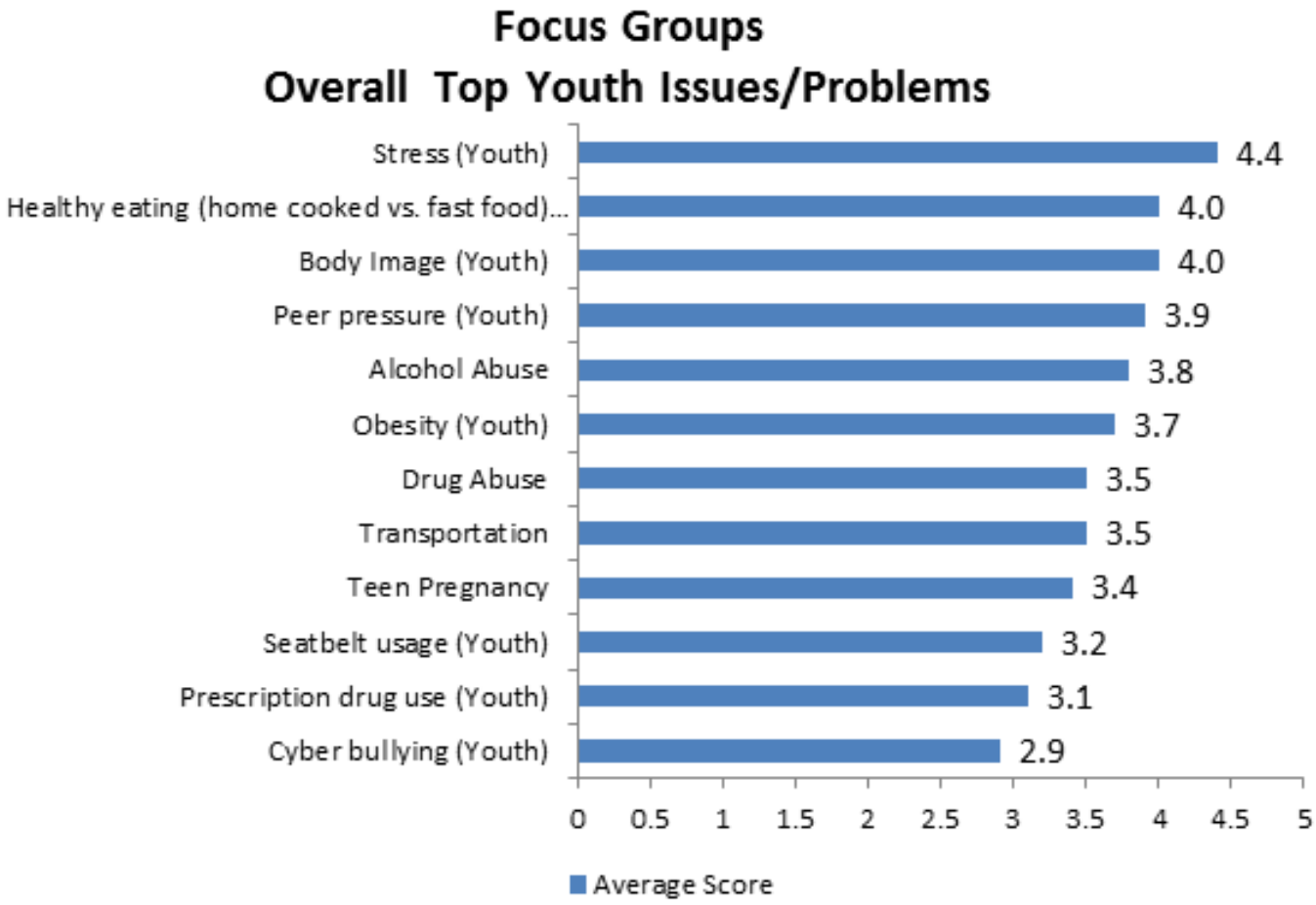


After rating and ranking, participants discussed the items that they rated as higher priorities, identified those that they felt were the highest priority and discussed the reasons why they picked those items as the most serious problem areas.

Exceptions are Access to Women's Health Care, arthritis, asthma and air/water quality (environmental), economic opportunities, blight and crime, which were identified by specific groups as one of their "top five" priority concerns.

In addition to the general list of community issues and problems that were rated by the adult groups, the youth group brainstormed and identified a list of problems and issues that they felt were particularly important to young people. Members of the youth group also rated these items higher than any of the other community health needs.

Stress was identified as the number one need by the youth group, associated with juggling jobs, sports, homework and a social life, and the pressure that is put on students by teachers who are perceived to have forgotten what it's like to be a teenager. Students who work have higher stress levels because of the additional expectations on them. Healthy eating is a problem because young people perceive they don't have time to eat healthy and the fruits and vegetables served in school lunches are not appetizing and most get thrown away. There is a perceived double standard where girls are judged differently than boys and youth are talking about sex at younger ages. Peer pressure is also perceived to be a problem at younger and younger ages.



The qualitative findings from the focus group and stakeholder interviews follow.

Access

Access to comprehensive, quality healthcare is important for the achievement of health equity and for increasing the quality of life for everyone. Poverty, employment and affordability; education; transportation and location; communication; and quality and availability of providers all affect access. There is great concern in this community about access to healthcare and how it affects the overall quality of life and other health indicators.

Focus Group Input

Transportation was mentioned as a serious problem by all of the focus groups. Lack of transportation limits access not only to medical care, but to employment and to healthy food. There is a perception that Access, a transportation system for elderly and disabled, is often late. There is a need for satellite clinics in the region and outreach through community organizations.

Affordability of healthcare is an issue; many people in the community lack health insurance and even those who have insurance have difficulty affording the co-pays. Availability of specialists is a problem in the service area, particularly in Homestead, where it was noted that you have to leave the community to get specialty services. Focus group participants also shared concerns regarding the quality of care available locally; the perception is that the care in some services was substandard. Focus group participants identified the need for OB/GYN, pediatrics/childrens care, physical therapy/rehab, dermatology and aging services.

Access to children's mental health services is also a problem. There is also not enough attention on primary care and prevention activities. Support for returning veterans is also a concern.

Stakeholder Interview Input

The economy is directly related to healthcare access. Insurance costs are rising, and for the unemployed, coverage is largely unavailable. Jefferson Regional Medical Center treats all patients, regardless of coverage, although the lack of coverage creates access issues for many service area residents.

Medical misinformation, false notions and a lack of awareness form a barrier to healthcare access. There is a need for patient education through physicians, lectures and forums throughout the community. Lack of transportation was a particular access concern to stakeholders who were interviewed. Access to public transportation is challenging due to the hilly, sprawled-out terrain and private transportation is expensive. Jefferson Regional Medical Center has satellite locations to accommodate access.

Many service area residents are unaware of the services Jefferson Regional Medical Center provides and how to access services. Though the community needs better access to women's health, Jefferson Regional Medical Center provides quality specialists and medical services, as well as an urgent care facility adjacent to the Emergency Department.

There is a perception of fear and distrust in regard to community needs, and a sense of entitlement among the elderly. There is a perception that the elderly get access and attention that young people are not getting. The community needs general assistance across the board, not just for the elderly. The community should be seen as vulnerable and in need of access to education, basic needs, and preventative care.

Chronic Disease

Conditions that are long-lasting, with relapses, remissions and continued persistence can be categorized as chronic diseases.

Focus Group Input

Focus group participants had a lot of discussion regarding chronic diseases, both as drivers of community health status as well as top problems in the community. There is a very high cancer rate in the service area, and some participants noted that there is a particularly high cancer rate in the northern part of Baldwin. The perception is that cancer is very prevalent in the community. Breast cancer is a concern for women. Everybody knows someone who has cancer, and some expressed concern that the numbers are underreported.

The age of the population was mentioned as a factor contributing to the high incidence rates of chronic diseases, especially cardiovascular disease. Hypertension is a problem in the community because a lot of people (even young ones) are not aware that they have it. Some recognize that the high tobacco use rate in the community contributes to the cancer rate, although some noted that they feel genetics plays a role. Arthritis was mentioned by one of the groups as a top priority; it is something that older people have to deal with.

Stakeholder Interview Input

Stakeholders identified heart disease, lung disease, and cancer as chronic conditions that exist in the Jefferson Regional Medical Center service area. Some of these conditions are affected by environmental quality issues like poor air and water quality and tobacco use, which both contribute to diseases like asthma and Chronic Obstructive Pulmonary Condition (COPD). Comments documenting health concerns specifically driven by environmental factors such as air and water, or tobacco use, are further discussed in the sections titled Healthy Environment and Tobacco Use.

Heart, lung disease and diabetes were top issues listed by stakeholders. Nearly all discussions surrounding heart and lung disease were in relation to disease causes, including environmental factors, and preventative care education. Discussions surrounding diabetes were in relation to patient education and preventative care, physical activity and nutrition. Cancer was also listed by many interviewees as a concern. It was felt that local oncology resources, especially for rising gynecological cancer rates, can be improved. There is question among some community members whether or not environmental factors like air or water quality could also be playing a role in these chronic conditions.

Stakeholders mentioned that more emphasis should be placed on prevention and diabetes education, and improved services for cardiovascular, pulmonary care as well as cancer care.

Healthy Environment

Environmental quality is a general term which can refer to varied characteristics of the natural environment such as air and water quality, pollution, noise, weather and the potential effects on physical and mental health caused by human activities. Environmental quality also refers to socioeconomic characteristics of a given community or area, including economic status, education, crime and geography.

Focus Group Input

There was a lot of discussion regarding environmental issues, particularly in the focus groups held in Clairton and Homestead. Blight is a significant concern in parts of the service area. Crime is also a problem in a number of areas. Violence is an issue, particularly gun violence and there is a perception that crime was rated higher because of the violence that exists in the community. Gang violence related to drugs is increasing; dealing is a crime which is part of the problem. There is also a high drop-out rate in some school districts, which impacts the crime rate.

Environmental pollution was identified as one of the top priorities in several of the groups. The rivers are polluted because of the mills. While the rivers have become cleaner, there are areas, including Elizabeth, where river pollution is still a concern. The perception is that Liberty Boro has one of the highest rates of air pollution in the country. There is uneasiness with the Marcellus Shale drilling, because of lack of understanding of potential environmental impacts. Participants expressed concern that the environmental impact information would not be made public.

Participants also expressed the need for better employment opportunities, particularly since it is difficult to live and raise a family on a part-time job. Part-time jobs don't offer health care insurance, impacting access to care. Housing is also an issue in the region. Lack of appropriate housing sometimes impacts patient discharges. There is a need for affordable housing for adults and seniors.

Stakeholder Interview Input

Some of the stakeholders interviewed discussed air and water quality as a possible detriment to the Jefferson Regional Medical Center service area. Crime and violence were also key concerns for the stakeholders. From steel mills to natural gas drilling, areas around Jefferson Regional Medical Center are affected by increased air and water pollution. Many stakeholders expressed concerns related to air quality and the environmental issues related to industrial plants and Marcellus Shale fracking.

There is a perception among stakeholders that local school districts are deficient with limited resources, and as a result, communities struggle to support quality education.

School faculty are overworked due to understaffing; services have been cut, and jobs have merged. Academic and social supports are lacking, especially with student needs not being met at home. It is perceived that Duquesne and Clairton are among the worst school districts in Pennsylvania.

Increased violence was a major concern among the stakeholders. Unemployment contributes to an increase in crime, and finding employment with a criminal background is very difficult. Violence is prevalent in the area and produces victims/emotional issues. When unemployment is high, people participate in the illegal economy. Most offenses stem from individuals "protecting their turf." After being released from prison, people need help reintegrating into the community—finding treatment options, housing, work, and other critical services.

Healthy Mothers, Babies, and Children

Improving the well-being of mothers, babies and children is a critical and necessary community health need identified for the Jefferson Regional Medical Center service area by focus group participants and stakeholders. The well-being of children determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The Healthy Mothers, Babies and Children section addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life for the entire community.

Focus Group Input

Participants of the Youth focus group talked about youth who are having sex at a young age.. Risk behaviors at younger ages (especially in middle school) are a concern. Some participants in the adult focus groups expressed a need for mental health services for children. Teen pregnancy was mentioned as a high priority in several of the groups. Although teen pregnancy rates are dropping, the number of intact families are becoming less prevalent. The region has a great many single parent situations and "babies having babies." Students are dropping out of high school.

Focus group participants commented that there are not many services available for children. Children's Hospital is far, and there are not many satellite care locations. Some concerns were expressed specifically related to youth injury care. There is no youth sports medicine program locally, a concern due to the number of youth involved in sports.

Stakeholder Interview Input

The list of specific needs identified by interviewees included focus on the need for local obstetrics and gynecological care, local pediatric care, and improved education for children of all ages. The service area has a high population of teen pregnancy in high schools. There is a need for better access to women's healthcare and pediatrics; there is a general lack of providers in the area and some access issues regarding money/insurance plans that are not accepted. Obstetrics and gynecology are top priorities for Jefferson Regional Medical Center.

Infectious Disease

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. These diseases can be grouped in three categories: diseases which cause high levels of mortality; diseases which place on populations heavy burdens of disability; and diseases which owing to the rapid and unexpected nature of their spread can have serious global repercussions (World Health Organization).

Infectious disease was not a major concern discussed in the focus groups or by stakeholders.

Stakeholder Interview Input

Among concerns listed by stakeholders was proper diagnosis and care for infectious diseases. Sexually transmitted diseases and MRSA were mentioned as specific cases. These concerns included anecdotes about a misdiagnosed infection, an overlooked diagnosis of MRSA and an overlooked diagnosis of a sexually transmitted disease.

Mental Health and Substance Abuse

Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the World Health Organization's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease." It is related to promotion of well-being, prevention of mental disorders, and treatment and rehabilitation of people affected by mental disorders.

According to the World Health Organization, Substance Abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome-a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

Focus Group Input

Mental health and drug and alcohol abuse issues received a great deal of discussion. Participants discussed the need for more mental health providers in the community. The stress of living in communities that are considered unsafe creates anxiety and depression that are a concern.

Drug abuse is a significant concern because it affects the entire community. What was once seen as a youth only problem is now impacting all ages. The group observed that people are self-medicating and abusing prescription drugs and participants tied this to joblessness and hopelessness that exist in the community. There is a perception that there is a lot of marijuana use in the community, particularly among young people. Drug and alcohol detox and rehabilitation programs are seen as a top priority in the community.

Marijuana and cocaine have long been issues but the police are now seeing a rise in drugs such as meth, heroin and prescription drugs. Even in the wealthier communities, drugs are a problem. Participants were also not aware of programs available in this area to address drug and alcohol use.

Stakeholder Interview Input

Adequate care for those with mental illnesses is a great need. The population with mental health needs continues to grow with unemployment, violence, and returning veterans, and services must address these complex needs. The local community college has seen an increase in veterans who need mental health services. The college provides academic support for those with mental health issues, but does not have medical capabilities. Clairton needs mental health/drug and alcohol treatment services.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. Substance abuse alters behaviors and decision-making and has negative health consequences for communities. Many stakeholders discussed substance abuse as a major health need as well as a driving force of negative consequences on overall quality of life. Alcohol, abuse of prescription drugs and illegal drug abuse were listed as concerns.

Physical Activity and Nutrition

Focus Group Input

There was a great deal of discussion regarding physical activity and nutrition, especially related to obesity, which was identified as one of the top priority needs overall and in many of the individual groups. There is a perception that good nutrition comes with a person's level of education and economics. Compared to other areas in the region, the service area has easier access and more healthy choices. People are becoming more interested in nutrition and diet.

Access to healthy foods was discussed. There are areas of the service region that do not have grocery stores; many people buy food at the dollar store, where there are no healthy food options. The lack of recreation facilities is a problem. There are a few after school programs and youth need something to keep their interest, some observed.

Stakeholder Interview Input

Physical activity and nutrition were listed as a top priority by nearly every stakeholder. Within this topic area, obesity and diabetes were specifically mentioned. Many see barriers to physical wellness linked to education, awareness, and lack of healthy options. Individuals' ability to understand how wellness and nutrition affect their overall health and how and where to seek help to change unhealthy behaviors is of high priority.

Stakeholders expressed concern that there is a lack of resources; there is no grocery store/farmer's market near Clairton and other areas. Transportation is a barrier to get to access healthy diet options. There is a need for health education: lifestyle choices, eating habits, exercise.

Tobacco Use

Focus Group Input

While tobacco use on its own was not a topic of significant discussion, a number of participants noted the connection between tobacco use and cancer rates. Participants noted there is a need for smoking cessation programs.

Stakeholder Interview Input

Tobacco use remains an issue. Stakeholders expressed that there are still too many smokers; smoking cessation programs are needed.

Unintentional/Intentional Injury

Focus Group Input

Injury was discussed within the focus groups as it relates to crime and violence. Focus group participants expressed concerns related to the increase in violent activities.

Stakeholder Interview Input

One pressing concern stakeholders discussed was increased violence. With increased violence, both unintentional and intentional injuries occur and have both mental and physical consequences for the community.

Conclusions

Overall findings from the data analysis and needs assessment discussions include:

Access

- The percentage of the population in the service region with no regular health care provider (between 8 and 13%) is better than the Healthy People 2020 goal. However, almost a quarter of the population in Allegheny County age 18-44 (24%) does not have a regular health care provider. Additionally, almost one in four persons (24.5%) rate their personal health status as fair or poor.
- Although the service region rate suggests that only 9.3% do not currently have health insurance. The Healthy People 2020 goal is 0%.
- The percentage of people in the service area (77%) who have seen a doctor in the past 12 months is much lower than the Healthy People goal of 90%.
- The percentage of service area respondents who did not see a doctor when they needed to because of cost is 9.3%, more than double the Healthy People 2020 goal of 4.2%.
- The percentage of service area respondents who could not get a prescription that they needed due to cost in the last 12 months is 13.8%, much higher than the Healthy People 2020 goal of 2.8%.
- Focus group participants identified access to care as an area of high need. Lack of insurance coverage and economic challenges that make affording co-pays difficult even with health insurance coverage make access a continuing problem. The lack of providers makes access to mental health care a challenge. Transportation was identified as the top priority issue in the service region. Additional OB/GYN providers are needed.
- Stakeholders identified the economy as directly related to healthcare access. Insurance costs are rising, and for the unemployed, coverage is largely unavailable. Medical misinformation, false notions and a lack of awareness form a barrier to healthcare access. There is a need for patient education through physicians, lectures and forums throughout the community. Lack of transportation was a particular access concern to stakeholders who were interviewed. The community is in need of access to education, basic needs, and preventative care.
- Between 15 and 25% of the service region population is eligible for Medicaid. The Jefferson Regional Emergency Department utilization for ambulatory care sensitive conditions has been increasing during the past 3 years.

Chronic Disease

- The percentage of women who have had a pap test in the past 3 years in the service area is only 38.5%, substantially lower than the Healthy People 2020 goal of 93%.
- The percentage of service area respondents who have been told that they have heart disease, diabetes, or had a heart attack is higher than the national rates.
- Compared to the Commonwealth, the service region has low rates for screenings that would identify early stage chronic diseases.

- The service region has higher percentages of persons told by a health professional that they have diabetes (11.8%), heart disease and/or a heart attack (between 6 and 10 percent) compared to the Commonwealth.
- Many areas of the service region has a higher rate of persons told they have asthma (16.3%) compared to the Commonwealth (13.8%).
- Breast cancer incidence rates are lower in Fayette County than they are in the rest of the region, and have been declining during the past three years. Rates have been rising in other counties of the service area and across Pennsylvania overall.
- Colorectal cancer rates are increasing in Fayette County and are significantly higher than the state. Colorectal cancer mortality rates in the region have declined in most counties except for Fayette.
- Lung cancer incidence rates are significantly higher in Allegheny and Fayette counties than they are in other parts of the service territory. The lung cancer mortality rates have declined slightly during the past few years.
- Prostate cancer incidence rates have been declining in the service region during the past few years. Prostate cancer mortality rates have been declining in all counties in the service region, except Fayette.
- Ovarian cancer incidence rates have been declining in all counties of the service region except Westmoreland, which has been increasing. Ovarian cancer mortality rates have also been increasing in Fayette, Washington and Westmoreland Counties.
- Heart disease mortality rates have been declining during the past few years in every county of the service region except Fayette.
- Although the heart attack mortality rates have been declining in all counties of the service region, heart attack mortality rates are significantly higher in Westmoreland County than they are in the other counties in the service region and the overall Pennsylvania rate.
- Cardiovascular disease mortality rates have been declining in all counties of the service region during the past few years, except in Fayette, which has remained relatively stable. For three of the last four years, the Fayette County rate was significantly higher than the Commonwealth rate.
- Coronary heart disease mortality rates are significantly higher than the state rates in Allegheny and Fayette Counties for the last four years and in Westmoreland County in two of the last four years. However, the rates in all counties and across the state are declining. All rates are significantly higher than the Healthy People 2020 goal.
- Heart failure mortality rates are declining during the past four years across the Commonwealth of Pennsylvania, and in Allegheny and Washington Counties. The rates are increasing during the last four years in Fayette and Westmoreland Counties.
- Diabetes mortality rates have been declining in most counties of the service area and across the state over the past few years. However, the rates have been increasing in Washington County. The rates in Allegheny County are significantly lower than the state during the past few years and higher in Fayette, Washington and Westmoreland.
- Emergency Department utilization for Diabetes and Hypertension related issues has been increasing during the last 3 years.
- Focus group participants identified the cancer rates as one the top priorities in the community and identified the aging population and lifestyle-related risk factors as contributors to the incidence and prevalence of chronic diseases in the area.
- Stakeholders interviewed identified heart disease, lung disease and cancer as key needs within the service area and suggested that oncology related resources need to be improved. More emphasis should be placed on prevention and education.

Healthy Environment

- Asthma hospitalization rates in Fayette County are one of the highest in the Commonwealth, although hospital inpatient utilization rates in the service region have declined during the past few years.
- Emergency Department utilization for Chronic Obstructive Pulmonary Disease (COPD) has increased during the last three years.
- Focus group participants had a great deal of discussion regarding environmental issues impacting health. Blight, housing, crime, gang and other violence, the economy and lack of jobs, and environmental pollution (both air and water quality) are all needs and issues. These issues impact health status because of the ability to access health insurance and medical care. The stress that the economy and violence places on people increases the need for mental health related services as well.
- Stakeholders discussed air and water quality concerns, problems within the public education system, violence, unemployment, and housing as critical issues. Those interviewed also identified the need to support formerly incarcerated persons, as it is difficult for persons with a criminal background to find employment.

Healthy Mothers, Babies, and Children

- The percentage of women who smoke during pregnancy is significantly higher in Fayette, Washington and Westmoreland Counties, although the rates have been decreasing slightly in all counties during the past few years.
- While the percentage of women who breastfeed has been increasing during the last few years in Pennsylvania overall and in Allegheny County, the percentages in Fayette and Washington have remained steady and have been decreasing in Westmoreland County. All four counties have rates that are significantly lower than the Commonwealth of Pennsylvania rates.
- The majority (94%) of the students in the Duquesne School District and 88% of the students in the Clairton City School Districts are eligible for free and reduced price lunches.
- Focus group participants, particularly youth, identified sexual activity and risk factors associated with it as key issues for young people in the area. Teenage pregnancy, the need for parenting support and education, and increased children's health services (especially mental health) were also identified as important needs.
- Stakeholders identified the need for local obstetric and gynecological care, local pediatric care and improved education for children of all ages to address issues of teen pregnancy and other risk behaviors. They also identified the need for better access to women's healthcare. In particular obstetrics/gynecology and pediatrics should be top priorities for Jefferson Regional Medical Center.

Infectious Disease

- The percentage of people age 65 and over who have received a pneumonia vaccine in the service region (59.5%) is much lower than the Healthy People 2020 goal (90%).
- Among the concerns listed by stakeholders throughout the interview process was proper diagnosis and care for infectious diseases. Sexually transmitted diseases and MRSA were mentioned as specific cases. Concerns included anecdotes about a misdiagnosed infection, an overlooked diagnosis of MRSA and an overlooked diagnosis of a sexually transmitted disease.

Infectious Disease (continued)

- The chlamydia rates in Allegheny County are significantly higher than the Commonwealth rates for the past few years and although the rates in Fayette, Washington and Westmoreland are all significantly lower than the state rates for the same few years, the rates have been increasing.
- Emergency Department utilization for Bacterial Pneumonia and Ear, Nose and Throat infections have increased during the last 3 years.

Mental Health and Substance Abuse

- The percentage of respondents in the service area this year (45.2%) that indicated that their mental health was not good one or more days in the last 30 is much higher than any of the individual county data from last year.
- The percentage of local survey respondents who indicated that they had one or more alcoholic beverages in the last 30 days (32.1%) is much lower than the national rate of 54.1%.
- Slightly more than 3% of the respondents to the local survey admitted that they have driven after drinking alcoholic beverages in the last 30 days. Between 4 and 6% of the service area population is at risk for heavy and/or chronic drinking.
- Mental and behavioral disorder mortality rates have risen during the last four years in all counties of the service region with the exception of Fayette.
- A sizable portion of the service area population (almost 15%) indicated that they were currently taking medicine and/or receiving treatment for a mental health condition. An additional 7.2% indicate that they have a family member whose mental health needs are not being met. Almost 4% admitted to living with a family member who is using/abusing illegal or prescription drugs.
- Focus group participants identified mental health and drug and alcohol abuse as high priority need areas. Participants discussed the need for more mental health providers in the community. Drug abuse is a significant concern. People are self-medicating and abusing prescription drugs and participants tied this to joblessness and hopelessness that exists in the community. There is a perception that there is heavy marijuana use in the community, particularly among young people. Drug and alcohol detox and rehabilitation programs are seen as a top priority in the community.
- It is perceived that marijuana and cocaine have long been available but recently there is a rise in drugs such as meth, heroin and prescription drugs. Awareness of programs to address drug and alcohol use is low.
- According to stakeholders, adequate care for those with mental illnesses is a great need in the communities. The population with mental health needs continues to grow with unemployment, violence, and returning veterans and services must address these complex needs. The local community college has seen an increase in veterans who need mental health services; the college provides academic support for those with mental health issues, but does not have medical capabilities. Clairton needs mental health/drug and alcohol treatment services.
- Emergency Department utilization for mental health related issues has increased during the past three years.

Physical Activity and Nutrition

- More than a quarter of the service region population reports no physical activity within the past 30 days. Only slightly more than half of the service region population reports eating fresh fruits daily, and only about a quarter eat fresh vegetables daily.
- Between 22 and 33% of the service region population has limited access to grocery stores.
- The majority (approximately 2/3 or more) of the service region population is overweight or obese.
- There was a great deal of discussion within the focus groups regarding physical activity and nutrition, especially related to obesity, which was identified as one of the top needs overall and in many of the individual focus groups. Access to healthy foods is a critical issue because of the transportation issues and lack of grocery stores in different parts of the service area.
- Physical activity and nutrition-related issues were identified as a top priority by almost all stakeholders interviewed; many identified a lack of resources such as grocery stores, transportation and education as barriers to healthy lifestyle choices.

Tobacco Use

- Almost a quarter of the service region population reports that they are current smokers, and an additional 5% indicate that they use smokeless tobacco on at least some days, although 69% of current smokers indicate that they would like to quit.
- 12% of the service area population has been told that they have COPD, Emphysema or Chronic Bronchitis. Inpatient utilization rates for these conditions in the service region are quite high (31.1 per 10,000) and increasing slightly during the past three years.

Unintentional/Intentional Injury

- A small percentage (1.3%) of the service area population report knowledge of elder abuse.
- Almost one in four (22%) adults in the service area admit that they have fallen at least once in the last three months.
- The majority of the region's population (80%) report that they always use a seatbelt.
- Suicide mortality rates have risen during the past four years in every county of the service territory with the exception of Allegheny County.
- Homicide rates due to firearms are significantly higher in Allegheny County than the state rates, and the rate has increased during the past four years.
- Almost 10% of the respondents indicated that an intimate partner has threatened them with physical violence.

Prioritization Process

At the end of the data presentation and discussion, a list of 39 needs, issues and potential priorities were identified.

Access to Quality Health Services - Transportation to/from Medical Services	Social Environment - Violence
Access to Quality Health Services - Affordability of health care/insurance costs/copays	Healthy Mothers, Babies & Children - Tobacco Use During Pregnancy
Access to Quality Health Services - Perception of quality of local care	Healthy Mothers, Babies & Children - Low Birthweight Babies
Access to Quality Health Services - Availability of Broader Community Based Services	Healthy Mothers, Babies & Children - Breastfeeding
Access to Quality Health Services - Early Screening	Healthy Mothers, Babies & Children - Teen Pregnancy
Access to Quality Health Services - Eldercare	Healthy Mothers, Babies & Children - Lack of Children's Services/Youth Development
Access to Quality Health Services - Access to Women's Health/OB Services	Infectious Disease - Flu & Pneumonia
Access to Quality Health Services - Access to Mental Health Services	Infectious Disease - STDs
Chronic Disease - Cardiovascular Disease (Heart Disease, Cholesterol, etc.)	Mental Health/Substance Abuse - Alcohol & Drugs
Chronic Disease - Hypertension	Mental Health/Substance Abuse - Domestic Violence
Chronic Disease - Cerebrovascular Disease (Stroke)	Mental Health/Substance Abuse - Lack of support systems for Veterans
Chronic Disease - Diabetes	Mental Health/Substance Abuse - Stress Management
Chronic Disease - Lung Cancer	Physical Activity/Nutrition: Lack of Physical Activity
Chronic Disease - Other Cancers	Physical Activity/Nutrition: Eating Habits
Chronic Disease - Obesity	Tobacco Use
Healthy Environment - air and water quality/Asthma/COPD related issues	Injury - Homicide due to firearms
Social Environment - availability and location of day care centers	Injury - Falls
Social Environment - Affordable Housing for Seniors	Injury - Seat Belt use
Social Environment - Crime	Injury - Suicide
Social Environment - Lack of Jobs/unemployment	

During the prioritization process, the Steering Committee rated each of the issues that were identified in the data collection process on a 1 to 10 scale for each criterion using the OptionFinder audience response polling system.

Prioritization Criteria

Item	Definition	Scoring		
		Low (1)	Medium	High (10)
Accountable Entity	Extent to which the issue is an important priority to address in this action planning effort for either the health system or the community	This is an important priority for the community to address	This is important but is not for this action planning effort	This is an important priority for the hospital/health system to address
Magnitude of the problem	Degree to which the problem leads to death, disability or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers of people affected; no risk for epidemic	Moderate numbers/ % of people affected and/or moderate risk	High numbers/ % of people affected and/or risk for epidemic
Variance against benchmarks or goals	This would include variance with selected benchmarks, state standards or state data, Healthy People 2010 goals and/or other prevention agenda standard or state data	Local/regional rates meet or exceed the goal or standard	Local/regional rates are somewhat worse than the goal or standard	Local/regional rates are significantly worse than the goal or standard
Capacity (systems and resources) to implement evidence -based solutions	This would include the capacity to and ease of implementing evidence-based solutions	There is little or no capacity (systems and resources) to implement evidence based solutions	Some capacity (system and resources) exist to implement evidence based solutions	There is solid capacity (system and resources) to implement evidence based solutions in this area

The results of the ratings for the magnitude, variance and capacity criteria were added together and then sorted high to low. Those items that had "high" total scores on the 3 criteria as well as high averages scores on the Accountable Entity criterion (average score of 7 or higher) were identified as the highest priorities for the health system.

Those items that had high total scores on the three criteria and low average scores on the Accountable Entity criterion were identified as high priorities for the community. The outcome of the rating process was a prioritized list. The highest priorities are as follows:

Prioritization Results

Issue	Discussion/Rationale	Accountability Criterion	Magnitude of the problem Criterion	Variance against bench Criterion	Capacity Criterion	Combined
Access to Quality Health Services - Transportation to/from Medical Services	Overall lack of transportation - bus stop is at bottom of hill as opposed to stopping at the hospital, bus routes continue to be cut which limits access, people are not satisfied with current Access transportation noting long waits, having to call night before, etc.	7.5	7.0	8.1	4.9	20.0
Access to Quality Health Services - Availability of Broader Community Based	There are areas that are lacking providers (medical, dental, mental health, etc.) suggesting need for additional satellite offices	7.9	7.2	5.7	6.9	19.8
Access to Quality Health Services - Access to Women's Health/OB Services	General lack of services in area	8.1	6.6	6.1	6.9	19.6
Access to Quality Health Services - Perception of quality of local care	Feeling for many in Pittsburgh area that UPMC is place to go for care - perception that we can't get anything good in our community	8.6	6.9	4.7	7.8	19.4
Access to Quality Health Services - Affordability of health care/insurance	Insurance is costly, many employers do not offer or people can't afford, many people make just enough that they do not qualify for assistance programs	4.8	6.4	5.4	3.0	14.8
Physical Activity/ Nutrition: Lack of Physical Activity	Sedentary lifestyle and need for people to have more opportunities (especially affordable opportunities) for recreation - also need for education on what is available and importance of it	4.8	6.4	4.9	3.4	14.7
Healthy Environment - air and water quality/ Asthma/COPD related issues	Concerns over pollution related to industry, etc. in the area and the impact that has on health - sense that there are increased rates of asthma and COPD as result of historic impact of industry	2.7	5.9	6.4	2.1	14.4

Implementation Strategies and Action Plan

The implementation strategies and action plan to address the priorities is designed to focus on increasing access to women's health services in Jefferson Regional Medical Center's service area. The hospital will expand women's health services in its service area, add access to pre- and post-natal care and obstetrical care in the service area, add additional women's subspecialists to the service area, expand office hours and services in the southern part of the service area and expand women's health services in the Clairton area. It is expected that, over time, by increasing access to education and women's health services, various other health needs of women and families will be addressed, as women are the primary gatekeepers to health care for families. The following table outlines Jefferson Regional Medical Center's implementation strategies and action plan.

Review and Approval

The 2013 Community Health Needs Assessment and Action Plan was presented and approved by the Jefferson Regional Medical Center's Board of Directors on May 20, 2013.

JEFFERSON REGIONAL MEDICAL CENTER

COMMUNITY ACTION PLAN 2013

GOAL 1: Increase access to Women's Health Services in the Jefferson Regional Medical Center Service Area					
Objectives		**Action Steps**	**Accountability / Organization Responsible for**	**Time Frame**	**Evaluation Metrics / Measures**
A.	*Expand Women's Health Services in Jefferson Regional Medical service area*	• Add women's midlife gynecology specialist, three days per week • Add women's behavioral health & other wellness programs • Expand mammography services • Add additional women's health specialists • Support at least two women's health education events	Marcie Caplan/ Rosanne Saunders	12/30/13	Number of sessions, number of women served, events offered, physicians present. Develop baseline.
B.	*Add access to Pre & Post Natal Care Obstetrical Care in our service area*	• Appoint Site Director for Obstetrics at Jefferson Regional Medical Center • Increase visibility and access to other obstetricians in the market • Add additional obstetricians/gynecologists to the market • Support at least two pregnancy related educational events in the market	Marcie Caplan/Rosanne Saunders/Debbi Linhart	3/30/14	Number of events held and attendance, number of women served.
C.	*Add additional Women's Subspecialists to Jefferson Regional service area*	Recruit the following specialists: • Gynecology-Oncology • Urology-Gynecologist • Maternal Fetal Medicine/High Risk Obstetrician Specialist	Marcie Caplan/Debbi Linhart	12/30/13	Presence in the marketplace, number of women served.
D.	*Expand office hours & services in southern part of service area*	• Add more hours of gynecology services • Increase awareness of women's services in the southern part of the service area.	Dr. Anthony Gentile/Marcie Caplan/Debbi Linhart	6/30/14	Number of women served.
E.	*Expand Women's Health Services in the Clairton area*	• Identify and implement Outreach Team • Identify under-served population in the area • Establish Gynecology presence in the Clairton area	Marcie Caplan/Debbi Linhart	6/30/14	Number of women served.

This page is intentionally blank

This page is intentionally blank

Background and Community Benefit

Background and Community Benefit

Message to the Community

Jefferson Regional Medical Center is a 370–bed, award–winning hospital south of Pittsburgh, Pennsylvania, where nearly 400 physicians provide patients with their expertise in more than 40 specialties. Jefferson Regional includes comprehensive emergency services and inpatient and outpatient surgical services, as well as The Heart Institute, The Joint Care Center, The Women's Diagnostic Center, The Sleep Disorder Center and Therapy Services. Spiritual Care, comprehensive Behavioral Health Services and Palliative Care are also offered. Besides the Medical Center's Jefferson Hills campus, several convenient outpatient centers are located in Baldwin, Belle Vernon, Bethel Park, Brentwood, Charleroi, Homestead, Jefferson Hills, McMurray, Pleasant Hills, Speers, Squirrel Hill, Uniontown, West Mifflin and Whitehall.

As part of the ongoing efforts toward enhancing the patient experience and encouraging patients to be active participants in their healthcare, Jefferson Regional offers a range of Community Education Programs, including the nationally accredited Diabetes Education Program and the scientifically proven Dr. Dean Ornish Program for Reversing Heart Disease. Jefferson Regional also offers seminars to help manage depression and osteoporosis; support groups for cancer, kidney failure or stroke; and countless wellness programs for everything from nutrition to stress management.

Jefferson Regional offers approximately $7.3 million per year in charitable care and approximately $1.8 million per year in other community benefits. Over the last fiscal year, the community education/benefit programs offered included:

Program	Description
Stroke Awareness	Clairton Municipal Building; Jefferson Regional; Elizabeth; and Homestead
A Teaspoon of Sugar	Jefferson Regional's diabetes staff presented to the Department of Energy
World Kidney Day	Held on campus presented by one of Jefferson Regional's dietitians
Five Wishes Program	Presented to the stroke support group by Jefferson Regional's nurses
Diabetes Prevention	Speaker for the stroke support group
Diabetes Prevention and Healthy Lifestyles	Life Enrichment Club (St. Joan of Arc Church)
Your Guide to Veteran's Healthcare Benefits	Program at Jefferson Regional

Program	Description
Drug and Alcohol Abuse Program	West Jefferson Hills School District Behavioral Health Jefferson Regional's staff and ER doctor were panelists for this parent/student program.
National Healthcare Decisions Day	Staff from the Ethics/Palliative Care Committee were available throughout the day for visitors, staff questions and education.
Bone Density Screening	JRMC Diagnostic Services Lab offered at the Bethel Park Campus.
Taking Charge of Your Healthcare	Palliative Care nurse presented to the Overbrook Women's Club.
Sleep Disorders	Presentation for the employees at Bettis
Cervical Cancer	One of Jefferson Regional's gynecologists presented to the employees at Bombardier (Lunch and Learn).
Cervical Cancer Awareness Month	Jefferson Regional's gynecologist and staff answered questions and passed out information on cervical cancer screening and vaccines (Bethel Park Campus)
Knee Arthritis	A presentation was held at Court Time Sports Center in Elizabeth.
Celiac Disease	One of Jefferson Regional's nutritionists presented to the Southwestern Pennsylvania Nurses Club.
Breast Cancer Awareness Presentation	Jefferson Regional's oncology nurse navigator presented a lunch and learn session for Bombardier, West Mifflin and for the Department of Energy in Pleasant Hills.
Osteoporosis	One of Jefferson Regional's gynecologists presented this topic for the St. Therese Seniors Group (Munhall).
Senior Expo/Health Fair	Eight departments participated with interactive displays, health education and screenings in South Park.

Program	Description
Community Recognition Night	Members of the community health council, mayors and local government, EMS, police and fire chiefs were honored. Legislators and Jefferson Regional senior management and Board of Directors attended.
Intermediate Unit of Allegheny County Health Fair	JRMC Diagnostic Services Lab offered bone density for employees.
Arthritis Expo	Jefferson provided bone density, a physician speaker and other staff from the Orthopedic Department.
Medicare Update	Jefferson presented at Paramount Assisted Living.
Medicare, Costs, Coverage and Comparisons	This program took place on campus and offered assistance with medical insurance – by appointment.
Bettis Health Fair	Health Fair offered to employees of the Bettis plant.
Finleyville Community Day	Numerous departments participated
Diabetes Prevention and Healthy Lifestyles	Jefferson Regional had an RN from the Diabetes Management Program address the Liberty Borough Seniors.
West Jefferson Hills School District Career Fair	RN from our Surgery Center and a representative from Human Resources addressed the students.
Infection Control practices and common infectious diseases of school age children	Presented to a class at California University by Jefferson Regional's Infection Control Manager.
National High Blood Pressure Month	Ornish staff offered information on preventative programs, high blood pressure, and food sampling of healthy recipes at the Bethel Park Campus.
Speech and Hearing Month	Staff provided free hearing screening and testing at the Bethel Park Campus.
Osteoporosis	Two of Jefferson Regional's gynecologists presented the program; one took place at the Mon Valley YMCA and the other at Jefferson Regional.

Program	Description
Central Fire Hall (Elizabeth, PA) Health Fair	Seven departments participated (interactive displays, screenings and health information).
Cancer Survivors' Day	Yearly event for cancer survivors; Jefferson Regional's Oncology and Behavioral Health departments collaborated.
Diabetes Prevention and Healthy Lifestyles	RN presentation to Jefferson Regional's stroke support group.
Health Fair Methouse in Munhall	Conducted blood pressures and introduced advance directives.

Well Worth It – Blood pressure/health education clinics held monthly (ten months out of the year) at four off-site locations in Bethel Park and Whitehall; took place at two apartment complexes and two Lifespan senior centers

Community Stroke Outreach Screening – Conducted at various off-sites (six times per year) in the community and free of charge. Screening for cholesterol, glucose, percent of body fat, blood pressure, etc.

Hip and Knee Pain Seminars – Conducted at three to four sites in the community on a monthly basis

Stroke Survivors' Support Group – Conducted weekly on campus for survivors of stroke and their family members

CPAP/BIPAP Clinic – Walk-in once every week to have a staff professional assists with equipment difficulties

Behavioral Health Lunch and Learn – Monthly lunchtime program open to the community at the Caste Village Mall

Medicare Insurance Counseling – Ongoing appointments throughout the year for seniors approaching age 65 conducted by Senior Services, providing 20 to 40 hours of appointment time per month

Health for Her – Monthly programming with average attendance between 80 and 120 women

Topics for fiscal year 2012 were:

1. The Right Bite: Diabetes Prevention and Management
2. Does Your Heart March to the Beat of a Different Drummer? Atrial Fibrillation and other arrhythmias (repeated twice on two different months due to the extensive "waiting list")
3. Abnormal Uterine Bleeding: Options for Your Care
4. Fitting in Fitness: Be Your Own Personal Trainer
5. Lentils and Lemons, Curry and Cinnamon: Healthy Foods Across Cultures
6. De-stress with Gentle Yoga
7. T'ai Chi
8. Your Image is important: Breast Cancer Imaging
9. Music: The Pen of the Soul
10. An Ornish Way to a Better Life

Health Care Career Crew – Invitation to local school districts to our program which spotlights the various health professionals and the work that they do; held twice a year

Central Blood Bank – Conducts quarterly blood drives on our campus and the Bethel Park Campus

Cancer Support Group – Held monthly and open to the general public

AARP Driver's Safety classes – Held monthly (ten times per year)

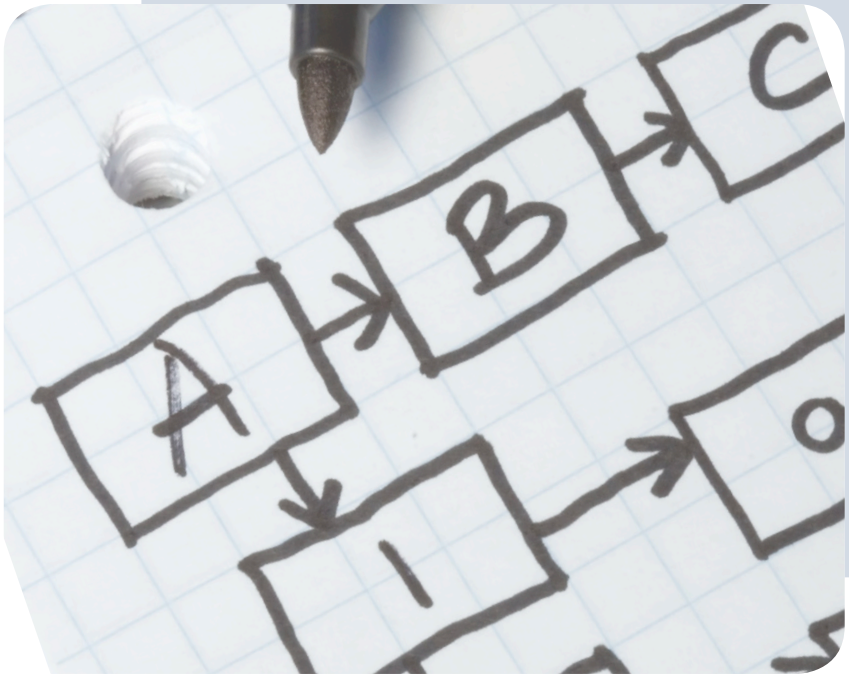
Tax Preparation for the Elderly (TCE) – By appointment (Senior Services)

Lifespan Homestead Park Center – Staff from Stroke Outreach take blood pressure on multiple months of the year

Christian Mothers Group/St. Joseph Parish/Homestead Park (Lifespan)/CLWP Social Hall (Duquesne) – Stroke outreach RN provides blood pressure screening

This page is intentionally blank

This page is intentionally blank



Methodology

JEFFERSON
REGIONAL MEDICAL CENTER

Methodology

Community Health Needs Assessment and Planning Approach

The process of completing the 2012 Jefferson Regional Medical Center (Jefferson Regional) Community Health Needs Assessment (CHNA) began in late 2011, with the formal kickoff in April 2012. The purpose of this study is to complete a comprehensive assessment of the health status and healthcare access needs of residents living in the Jefferson Regional primary service region.

The CHNA and planning process is a significant step toward meeting the goal and mission of Jefferson Regional to improve the health of the community. This initiative brought the health system, public health and other community leaders together in a collaborative approach to:

- Identify the current health status of community residents to include baseline data for benchmarking and assessment purposes
- Identify the availability of treatment services, strengths, service gaps and opportunities
- Determine unmet community health needs and target priorities
- Develop a plan to direct community benefit and allocation of resources to meet targeted needs
- Enhance strategic planning for future services

As illustrated in Figure 1, the CHNA process develops a system that is better able to meet the needs of our communities while avoiding duplicative efforts and achieving economies of scale. This process supports the commitment of a cross section of community agencies and organizations working together to achieve healthier communities. The CHNA Process facilitated by Strategy Solutions, Inc. in 2012, follows best practices as outlined by the Association of Community Health Improvement, a division of the American Hospital Association in their CHNA Toolkit and follows the latest draft IRS 990 guidelines.

Figure 1: Schematic of the CHNA process

To support the CHNA process, Jefferson Regional assembled a Steering Committee led by a member of the Jefferson Regional Foundation Board. The Steering Committee included a diverse group of community leaders representing various facets of the community. The Steering Committee membership is outlined in Table 1.

Table 1: Steering committee membership

Name	Affiliation	
Linda Lewis	Director, Treasury, Tax and Financial Systems	Jefferson Regional Medical Center
Mary Beth Lowery	Director, Marketing and Communications	Jefferson Regional Medical Center
John Echement	Board Member	Jefferson Regional Medical Center Board of Directors
Harry J. Sichi	Board Member	Jefferson Regional Medical Center Foundation Board
Barbara Magnotti	Board Member	Jefferson Regional Medical Center Foundation Board
James C. Cooper	Senior Executive Vice President	Jefferson Regional Medical Center
Rosanne Saunders	Senior Vice President and Chief Human Resources Officer	Jefferson Regional Medical Center
Blanche Buscanics	Manager, Community Outreach	Jefferson Regional Medical Center
JoAnne Hahey	Senior Vice President and Chief Financial Officer	Jefferson Regional Medical Center
Joseph Cvitkovic, PhD	Director, Behavioral Health	Jefferson Regional Medical Center
Mildred E. Morrison	Administrator	Allegheny County Dept. of Human Services, Agency on Aging
Sister Mary Parks, C.S.J.	Executive Director	Sister's Place, Inc.
Marv Levin	Associate Broker and Regional Director	Coldwell Banker Real Estate
Brenda S. Trettel, Ed.D.	Dean of Academic Affairs	Community College of Allegheny County, South Campus
Jefferson Brooks	Workforce Development Director	Mon Valley Initiative
Charles Modispacher	Board Chair	Jefferson Regional Medical Center Board of Directors
Evan Frasier	Senior Vice President, Community Affairs	Highmark

Table 2 outlines the Steering Committee meeting dates and agenda items.

Table 2: Steering committee dates and agenda topics

Date	Meeting Location	Topic
April 20, 2012	Jefferson Regional Board Room	Steering Committee Mission, Geographic Scope and Service Area Definition, Current Initiatives, Preliminary Disease Data, Assets, BRFSS Question Review
May 23, 2012	Jefferson Regional Board Room	Current Initiatives, Preliminary Disease Data, Assets, BRFSS Question Review, Key Stakeholder Identification
August 1, 2012	Jefferson Regional Board Room	BRFSS Questionnaire Finalization and Preliminary Report of Qualitative Data from Stakeholder Interviews
September 25, 2012	Jefferson Regional Board Room	Presentation of Overall Primary and Secondary Data and Discussion
October 10, 2012	Jefferson Regional Board Room	Identification of Priorities and Action Planning Instructions given to Steering Committee members
November 7, 2012	Jefferson Regional Board Room	Discussion of Action Plans
March 15, 2013	Jefferson Regional Board R	Review of Action Plans
April 15, 2013	Jefferson Regional Board R	Review Revised Action Plan

Service Region Definition

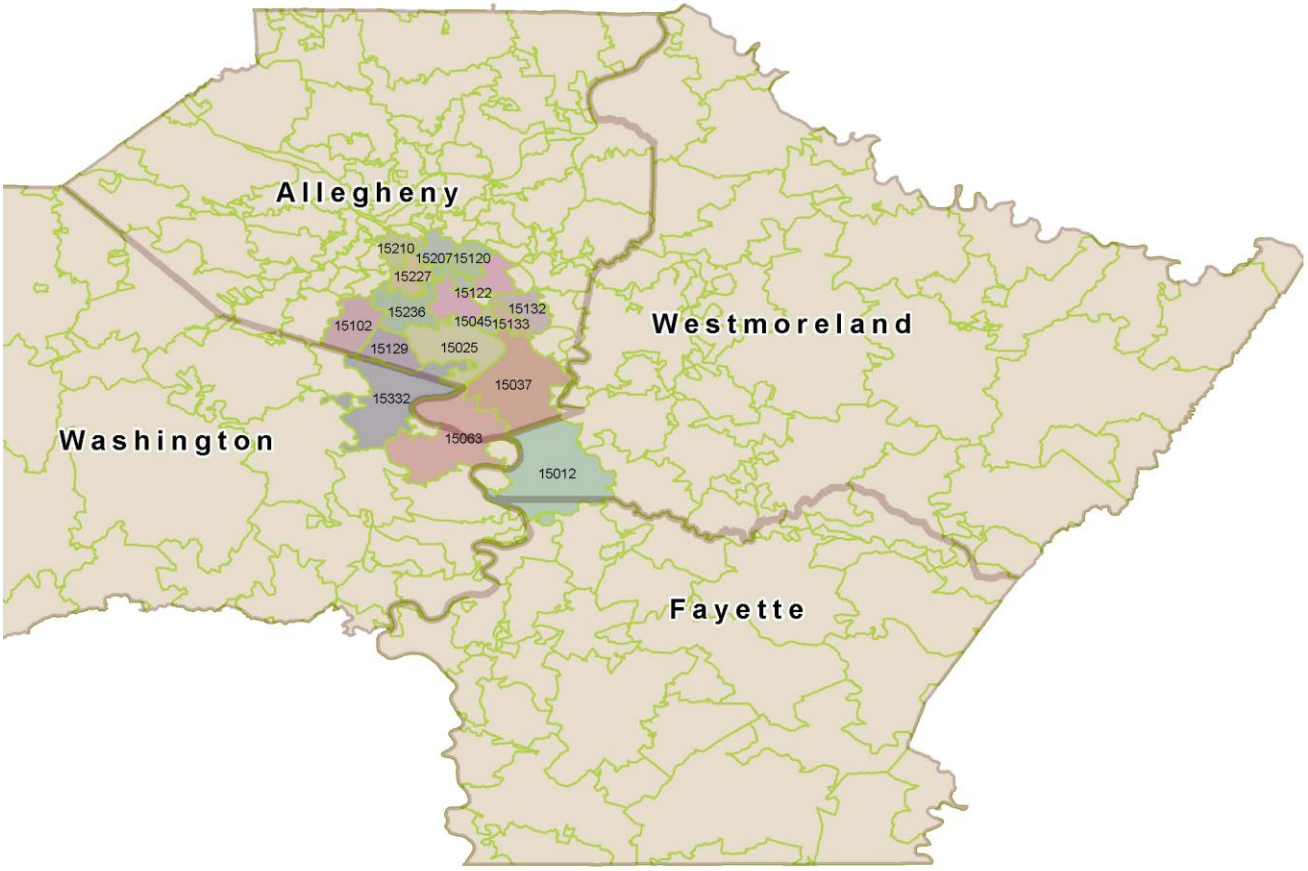
At the time that this CHNA process was conducted, the Internal Revenue Service (IRS) had not finalized its guidelines for CHNAs. However, this process was developed to ensure compliance with the draft guidelines as of May, 2012. The available information published by the IRS and American Hospital Association suggested that the service region selected for the study equal the geography from which the majority of the hospital discharges originate. The geography selected for the study was the primary service region of Jefferson Regional and includes the following zip codes as outlined in Table 3.

Table 3: Jefferson Regional primary service region

Zip Code
15236-Pleasant Hills
15025-Clairton/Jefferson Hills
15122-West Mifflin
15227-Brentwood
15120-Homestead/Waterfront
15037-Elizabeth
15012-Belle Vernon
15102-Bethel Park
15129-South Park
15332-Finleyville
15210-Mount Oliver
15132-McKeesport
15045-Glassport
15063 Monongahela
15133-Liberty/Port Vue
15207-Hazelwood

Figure 2 illustrates Jefferson Regional's primary service region.

Figure 2: Jefferson Regional service region map



Strategy Solutions, Inc., a planning and research firm with the mission to create healthy communities, was retained to facilitate the process. The Strategy Solutions, Inc. consulting team that was involved in the project included:

Debra Thompson, BS, MBA, President, served as the Project Director, completed stakeholder interviews and assisted with development of the final report.
Toni Felice, Ph.D., Director of Research, Evaluation and Strategy, completed the secondary data analysis, designed and analyzed the Behavioral Risk Factor Survey (BRFSS) based on the secondary data collected, and presented the findings to the Steering Committee.
Rob Cotter, BA, MS, Research Analyst, completed the secondary data analysis, facilitated community focus groups, and completed the demographic analysis and mapping required for the project.
Kathy Roach, BA, Research Analyst, coordinated development of the final report.
Jacqui Lanagan, BA, MS, Director of Nonprofit and Community Services, completed utilization graphs, facilitated focus groups and analyzed the focus group data, conducted stakeholder interviews, facilitated the prioritization process and guided the action planning process.
Laurel Swartz, MA, Research Coordinator, assisted with focus group and interview scheduling and logistics.
Diane Peters, Office Manager, managed the focus group and interview scheduling and logistics.
Ann DiVecchio, Research Assistant, assisted with the report development and writing.
Stacy Weber, Project Coordinator, provided logistics coordination, data presentation and reporting support.
Melissa Rossi, Operations Manager, provided report development and logistics coordination support.
Aaron Loncki, Project Coordinator, provided report development and graphic support.
Connie Barringer, AAS, Administrative Assistant, provided editing support.
Moore Research Services, Erie, Pennsylvania provided the data collection and field work to complete the Behavioral Risk Factor Surveillance Survey.

Asset Inventory

Jefferson Regional identified the existing healthcare facilities and resources within the service area that are available to respond to the health needs of the community. The information included in the asset inventory and map is a subset of the information maintained in internal Senior Services and Case Management Department databases. Medical care service categories that are part of the inventory include: Donor Organizations, Educational Programs, Exercise Programs, Food/Meal Programs, Medical Equipment, Mental Health Services, Mobile Diagnostic Testing, Personal Response Systems, Pharmaceutical Services, Recreational Centers, Social Service Agencies and Support Groups. The Senior Services Department categories that are part of the inventory include: Alzheimer's Care, Companion Services, Geriatric Assessment, Geriatric Care Management, Personal Care Homes, Retirement Communities, Senior Housing, Adult Day Care and Elder Abuse.

Qualitative and Quantitative Data Collection

In an effort to examine the health-related needs of the residents of the service area and to meet all of the known guidelines and requirements of the IRS 990 standards that had been published to date, the consulting team employed both qualitative and quantitative data collection and analysis methods. Qualitative methods ask questions that are exploratory in nature and are typically employed in interviews and focus groups. Quantitative data is data that can be displayed numerically. In addition, both primary and secondary data were collected. Primary data is data that was collected specifically for this study by the consulting team. Secondary data includes data and information that was previously collected and published by another source and publically available.

The consulting team and steering committee determined that the data collected would be defined by hypothesized needs within the following categories (that define the various chapters of this study):

- Access to Quality Healthcare
- Chronic Diseases
- Healthy Environment
- Healthy Mothers, Babies and Children
- Infectious Diseases
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

The Steering Committee members and consulting team made significant efforts to ensure that the entire primary service region, all socio-demographic groups and all underrepresented populations were included in the study to the extent possible, given the resource constraints of the project. This was accomplished by identifying focus groups and key stakeholders that represented various subgroups in the community. In addition, the process included public health participation and input, through extensive use of Pennsylvania Department of Health and Centers for Disease Control data.

The secondary data collection process included:

- Demographic and socioeconomic data obtained from Nielsen/Claritas (www.claritas.com) and the US Census Bureau (www.census.gov).
- Disease incidence and prevalence data obtained from the Pennsylvania Department of Health and Pennsylvania Vital Statistics.
- The Centers for Disease Control and Prevention (CDC) and the Pennsylvania Department of Health conduct an extensive BRFSS each year. The BRFSS data is conducted by telephone and includes questions regarding health risk behaviors, preventive health practices, and healthcare access primarily related to chronic diseases and injury. The health-related indicators included in this report for the US in 2010 are BRFSS data collected by the CDC. The health-related indicators included in this report for Pennsylvania are BRFSS data collected by the Pennsylvania Department of Health. CDC: http://www.cdc.gov/brfss/
- CDC Chronic Disease Calculator, available at http://cdc.gov/chronicdisease/resources/calculator/index.htm
- In 1979, the Surgeon General began the Healthy People program to set goals for a healthier nation. Since then, this program has set ten year science-based objectives for the purpose of moving the nation toward better health. Available *Healthy People 2020* goals are included in this report and are available at http://www.healthypeople.gov/2020/default.aspx
- Selected inpatient and outpatient utilization data on ambulatory care sensitive conditions, which are indicators of appropriate access to healthcare, were obtained from Jefferson Regional and from the Pennsylvania Healthcare Cost Containment Council.
- County Health Rankings, a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute are available at www.countyhealthrankings.org

The primary data collection process included:

- A BRFSS following the data collection protocols and questions designed by the Centers for Disease Control (CDC) with a representative sample of 400 primary service region residents conducted by Strategy Solutions, Inc. and Moore Research Services.
- A total of seven individual stakeholder interviews were conducted by members of the consulting team to gather a personal perspective from those who have insight into the health of a specific population group or issue, the community or the region.
- A total of nine focus groups were conducted by members of the Strategy Solutions consulting team to gather information directly from various groups that represent a particular interest group or area.

Behavioral Risk Factor Surveillance Survey

In 2012, Jefferson Regional recognized that community health information was not available at the local level for a number of health indicators such as access to healthcare, healthy behaviors, certain health conditions, and many other health issues of concern. Jefferson Regional decided that a telephone survey of households in the area was the most efficient and effective approach for identifying the health issues of most concern to residents in the Jefferson Regional primary service region.

When preparing for the development of the BRFSS, in order to ensure that the true needs of the community were analyzed and understood, the Steering Committee hypothesized that the demographics of the community suggested that socio-demographic and health status differences may exist within individual zip codes, specifically within Clairton/Jefferson Hills zip codes. As a result of this discussion the survey sample was adjusted to oversample Clairton/Jefferson Hills, as outlined in Table 4.

Table 4: Jefferson Regional 2012 BRFSS sample

Zip Code	Pop Estimate 2012	% of Region Pop	Sample 400	Adjustment for Clairton/Jefferson Hills
15236-Pleasant Hills	30,423	11.30%	45	43
15025-Clairton/Jefferson Hills	16,542	6.14%	25	50
15122-West Mifflin	19,694	7.31%	29	27
15227-Brentwood	27,412	10.18%	41	39
15120-Homestead/Waterfront	18,884	7.01%	28	26
15037-Elizabeth	10,922	4.06%	16	14
15012-Belle Vernon	16,321	6.06%	24	22
15102-Bethel Park	29,256	10.86%	43	35
15129-South Park	10,841	4.03%	16	14
15332-Finleyville	8,535	3.17%	13	11
15210-Mount Oliver	25,809	9.58%	38	36
15132-McKeesport	20,813	7.73%	31	29
15045-Glassport	4,541	1.69%	7	11
15063 Monongahela	11,847	4.40%	18	16
15133-Liberty/Port Vue	6,275	2.33%	9	12
15207-Hazelwood	11,174	4.15%	17	15
	269,289	100.00%	400	400

The Steering Committee worked with Strategy Solutions, Inc. to develop the survey draft based on the secondary data already collected and the current community needs that were hypothesized by the group. As the draft survey began taking shape, it was recognized that not every health-related question of interest could be asked in a brief telephone survey. The final survey was trimmed to 60 questions that could be answered in less than 20 minutes. The questionnaire included ten topic areas as shown in Table 5. A copy of the administered questionnaire is included in Appendix A.

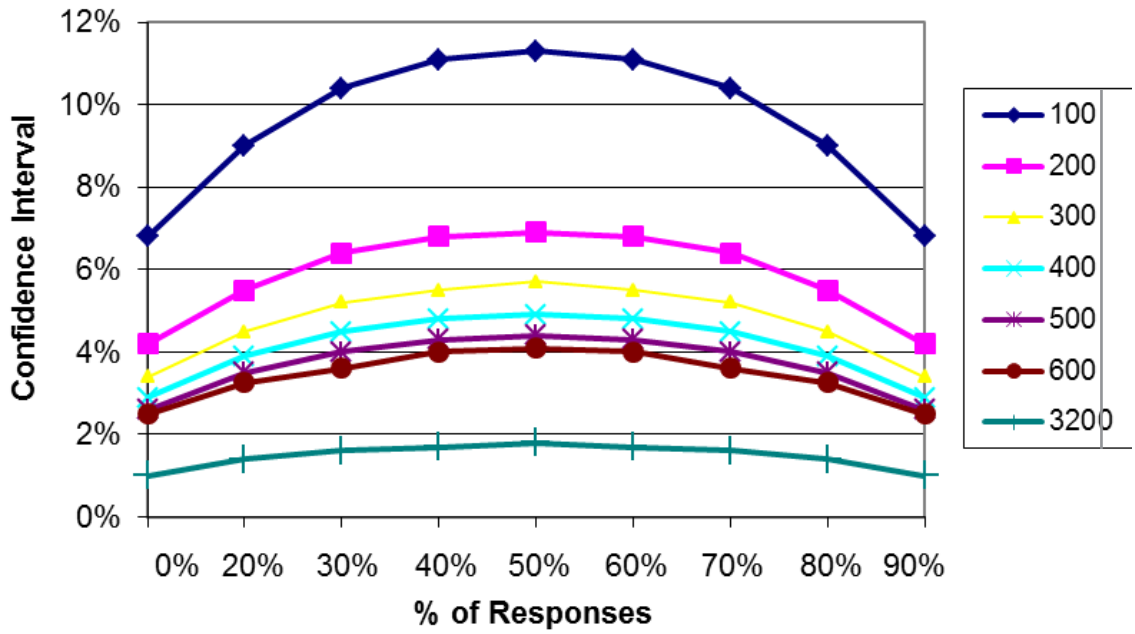
Table 5. BRFSS question type and frequency

Section	Questions	Section	Questions
Demographics	13	Infectious Diseases	2
Health Status & Health Information	2	Mental Health & Substance Abuse	6
Access	11	Physical Activity & Nutrition	7
Screening	7	Tobacco Use	3
Chronic Diseases	5	Intentional & Unintentional Injury	4
		Total	60

Many of the Jefferson Regional survey questions were similar or identical to questions used in national and state BRFSS. That allowed comparison to BRFSS data with those collected by the Pennsylvania Department of Health and the CDC's 2010 national BRFSS data.

Moore Research Services, Inc. located in Erie, Pennsylvania, administered the telephone survey. The Moore researchers worked closely with the Committee and Strategy Solutions, Inc. to ensure that the questions were worded appropriately for a telephone survey and to improve the flow of the questionnaire. The telephone surveys began on August 7, 2012 and were completed on September 4, 2012 and followed the data collection protocol recommended by the CDC.
The final data, composed of 400 completed questionnaires, yields a confidence interval of plus-or-minus five percentage points around any response rate for the entire sample (see Figure 3 below). There is always statistical error associated with the act of collecting data from a sample of the population, assuming that the sample data represent the population. A confidence interval of plus-or-minus five percent tells us that we are confident that the true population responses lie within four percentage points above or below the sample response. Survey Data findings are presented throughout the CHNA report where the data has relevance to specific health issues.

Figure 3: Statistical error ranges associated with various sample sizes



Hospital Utilization Data

According to the Institute of Medicine, primary or ambulatory care functions to provide comprehensive and continuous care, address the majority of an individual's healthcare needs, develop the provider-patient relationship and create healthier individuals and communities. More recently, researchers and providers have identified Ambulatory Care Sensitive Condition (ACSC) hospitalizations as a measure of access to healthcare. ACSCs are conditions for which hospitalization could be prevented through early intervention and sustained ambulatory care. The report includes inpatient hospitalization utilization rates for the following: hypertension, CHF, breast cancer, other cancers, pneumonia, pregnancy complications, reproductive disorders, asthma, drug and alcohol-related issues, COPD and fractures.

Table 6 indicates the Diagnosis Related Group (DRG) classification system that was employed to illustrate the hospitalization rates for ACSC.

Table 6. Classification system employed for inpatient ACSC

DRG Reported	DRG Classification
Hypertension	304 – Hypertension w/ MCC 305 – Hypertension w/o MCC
Congestive heart failure	291 – Heart failure & shock w/ MCC 292 – Heart failure & shock w/ CC 293 – Heart failure & shock w/o CC/MCC
Breast cancer	582 – Mastectomy for malignancy w/ CC/MCC 583 – Mastectomy for malignancy w/o CC/MCC 597 – Malignant breast disorders w/ MCC 598 – Malignant breast disorders w/ CC 599 – Malignant breast disorders w/o CC/MCC
Cancer	374 – Digestive malignancy w/ MCC 375 – Digestive malignancy w/ CC 376 – Digestive malignancy w/o CC/MCC 754 – Malignancy, female reproductive system w/ MCC 755 – Malignancy, female reproductive system w/ CC 756 – Malignancy, female reproductive system w/o CC/MCC
Pneumonia	193 – Simple pneumonia & pleurisy w/ MCC 194 – Simple pneumonia & pleurisy w/ CC 195 – Simple pneumonia & pleurisy w/o CC/MCC
Complications baby	774 – Vaginal delivery w complicating diagnosis 777 – Ectopic pregnancy 778 – Threatened abortion
Reproductive disorder	760 – Menstrual & other female reproductive system disorders w/ CC/MCC 761 – Menstrual & other female reproductive system disorders w/o CC/MCC
Bronchitis & Asthma	202 – Bronchitis & asthma w/ CC/MCC

DRG Reported	DRG Classification
	203 – Bronchitis & asthma w/o CC/MCC
Alcohol & drug abuse	894 – Alcohol/drug abuse or dependence, left AMA 895 – Alcohol/drug abuse or dependence w rehabilitation therapy 896 – Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC 897 – Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC
Fracture	533 – Fractures of femur w/ MCC 534 – Fractures of femur w/o MCC 535 – Fractures of hip & pelvis w/ MCC 536 – Fractures of hip & pelvis w/o MCC
Bronchitis & Asthma	202 – Bronchitis & asthma w/ CC/MCC 203 – Bronchitis & asthma w/o CC/MCC

Table 7 outlines the various ICD-9 codes associated with various ambulatory care sensitive conditions that should be seen in a primary care physician's office, but are often presenting to a hospital Emergency Department. The hospital utilization for these conditions for the past 3 fiscal years and YTD through November 2012 is included in the report.

Table 7: Emergency department ACSC

AMBULATORY CARE SENSITIVE CONDITIONS	
PREVENTABLE CONDITIONS [and ICD-9-CM CODES] (By Primary Diagnosis Unless Otherwise Noted)	COMMENTS
AVOIDABLE ILLNESSES	
Congenital Syphilis [090]	Secondary diagnosis for newborns only
Failure to thrive [783.41]	Age < 1 Year
Dental Conditions [521-523, 525, 528]	
Vaccine Preventable Conditions [032, 033, 037, 041.5, 045, 052.1, 052.9, 055-056, 070.0-070.3, 072, 320.2*, 320.3, 390, 391, 771.0]	*Haemophilus meningitis [320.2] for ages 1-5 only
Iron Deficiency Anemia [280.1, 280.8, 280.9]	Primary & Secondary Diagnoses
Nutritional Deficiencies [260-262, 268.0, 268.1]	Primary & Secondary Diagnoses
ACUTE CONDITIONS	
Bacterial Pneumonia [481, 482.2, 482.3, 482.9, 483, 485, 486]	
Cancer of the Cervix [180.0-180.1, 180.8-180.9]	
Cellulitis [681, 682, 683, 686]	
Convulsions [780.3]	
Dehydration - Volume Depletion [276.5]	Primary & Secondary Diagnoses
Gastroenteritis [558.9]	

AMBULATORY CARE SENSITIVE CONDITIONS	
PREVENTABLE CONDITIONS [and ICD-9-CM CODES] (By Primary Diagnosis Unless Otherwise Noted)	COMMENTS
Hypoglycemia [251.2]	
Kidney/Urinary Infection [590.0, 599.0, 599.9]	
Pelvic Inflammatory Disease [614]	
Severe Ear, Nose, & Throat Infections [382*, 462, 463, 465, 472.1]	
Skin Grafts with Cellulitis {DRGs: 263 & 264} For 2008: {DRGs: 573, 574, 575}	Excludes admissions from SNF/ICF
CHRONIC CONDITIONS	COMMENTS
Angina [411.1, 411.8, 413]	
Asthma [493]	
Chronic Obstructive Pulmonary Disease [466.0*, 491, 492, 494, 496]	*Includes acute bronchitis {466.0} only with secondary diagnosis of 491, 492, 494, 496
Congestive Heart Failure [402.01, 402.11, 402.91, 428, 518.4]	
Diabetes with ketoacidosis or hyperosmolar coma or other coma [250.1-250.33]	
Diabetes with other specified or unspecified complications [250.8-250.93]	
Diabetes mellitus without mention of complications or unspecified hypoglycemia [250-250.04]	
Grand Mal & Other Epileptic Conditions [345]	
Hypertension [401.0, 401.9, 402.00, 402.10, 402.90]	
Tuberculosis (Non-Pulmonary) [012-018]	
Pulmonary Tuberculosis [011]	

Table 8 outlines the various ICD-9 codes associated with various mental health conditions that should be managed in an outpatient setting, but will sometimes present to a hospital emergency department. The hospital utilization for these conditions for the past three fiscal years and YTD through November 2012 is included in the report.

Table 8: Mental health ICD-9 codes

CODE	DESCRIPTION
Dementia	
290	DEMENTIA
290	SENILE DEMENTIA UNCOMP
290.1	PRESENILE DEMENTIA
290.1	PRESENILE DEMENTIA UNCMP
290.11	PRESENILE DELIRIUM

CODE	DESCRIPTION
290.12	PRESENILE DELUSION
290.13	PRESENILE DEPRESSION
290.2	SENILE DELUSION/DEPRESS
290.2	SENILE DELUSION
290.21	SENILE DEPRESSIVE
290.3	SENILE DELIRIUM
290.4	VASCULAR DEMENTIA
290.4	VASCULAR DEMENTIA,UNCOMP
290.41	VASC DEMENTIA W DELIRIUM
290.42	VASC DEMENTIA W DELUSION
290.43	VASC DEMENTIA W DEPRESSN
290.8	SENILE PSYCHOSIS NEC
290.9	SENILE PSYCHOT COND NOS
Alcohol Related	
291	ALCOHOL-INDUCED DISORD
291	DELIRIUM TREMENS
291.1	ALCOHOL AMNESTIC DISORDR
291.2	ALCOHOL PERSIST DEMENTIA
291.3	ALCOH PSY DIS W HALLUCIN
291.4	PATHOLOGIC ALCOHOL INTOX
291.5	ALCOH PSYCH DIS W DELUS
291.8	OTHER ALCOHOL DISORDER
291.81	ALCOHOL WITHDRAWAL
291.89	ALCOHOL MENTAL DISOR NEC
291.9	ALCOHOLIC PSYCHOSIS NOS ALCOHOL MENTAL DISOR NOS
303	ALCOHOL DEPENDENCE SYNDR
303	AC ALCOHOL INTOXICATION
303	AC ALCOHOL INTOX-UNSPEC
303.01	ALCOHOL INTOX-CONTIN
303.02	AC ALCOHOL INTOX-EPISOD
303.03	AC ALCOHOL INTOX-REMISS
303.9	ALCOHOL DEPEND NEC/NOS
303.9	ALCOH DEP NEC/NOS-UNSPEC
303.91	ALCOH DEP NEC/NOS-CONTIN
303.92	ALCOH DEP NEC/NOS-EPISOD
303.93	ALCOH DEP NEC/NOS-REMISS
305	ALCOHOL ABUSE
305	ALCOHOL ABUSE-UNSPEC
305.01	ALCOHOL ABUSE-CONTINUOUS

CODE	DESCRIPTION
305.02	ALCOHOL ABUSE-EPISODIC
305.03	ALCOHOL ABUSE-IN REMISS
Drug Related	
292	DRUG-INDUCED DISORDER
292	DRUG WITHDRAWAL
292.1	DRUG PSYCHOTIC DISORDER
292.11	DRUG PSYCH DISOR W DELUS
292.12	DRUG PSY DIS W HALLUCIN
292.2	PATHOLOGIC DRUG INTOX
292.8	OTHER DRUG MENTAL DIS
292.81	DRUG-INDUCED DELIRIUM
292.82	DRUG PERSISTING DEMENTIA
292.83	DRUG PERSIST AMNESTC DIS
292.84	DRUG-INDUCED MOOD DISORD
292.89	DRUG MENTAL DISORDER NEC
292.9	DRUG MENTAL DISORDER NOS
304	DRUG DEPENDENCE
304	OPIOID DEPENDENCE
304	OPIOID DEPENDENCE-UNSPEC
304.01	OPIOID DEPENDENCE-CONTIN
304.02	OPIOID DEPENDENCE-EPISOD
304.03	OPIOID DEPENDENCE-REMISS
304.1	SED,HYP,ANXIOLYT DEPEND
304.1	SED,HYP,ANXIOLYT DEP-NOS
304.11	SED,HYP,ANXIOLYT DEP-CON
304.12	SED,HYP,ANXIOLYT DEP-EPI
304.13	SED,HYP,ANXIOLYT DEP-REM
304.2	COCAINE DEPENDENCE
304.2	COCAINE DEPEND-UNSPEC
304.21	COCAINE DEPEND-CONTIN
304.22	COCAINE DEPEND-EPISODIC
304.23	COCAINE DEPEND-REMISS
304.3	CANNABIS DEPENDENCE
304.3	CANNABIS DEPEND-UNSPEC
304.31	CANNABIS DEPEND-CONTIN
304.32	CANNABIS DEPEND-EPISODIC
304.33	CANNABIS DEPEND-REMISS
304.4	AMPHETAMINE DEPENDENCE
304.4	AMPHETAMINE DEPEND-UNSPEC

CODE	DESCRIPTION
304.41	AMPHETAMINE DEPEND-CONTIN
304.42	AMPHETAMINE DEPEND-EPISOD
304.43	AMPHETAMINE DEPEND-REMISS
304.5	HALLUCINOGEN DEPENDENCE
304.5	HALLUCINOGEN DEP-UNSPEC
304.51	HALLUCINOGEN DEP-CONTIN
304.52	HALLUCINOGEN DEP-EPISOD
304.53	HALLUCINOGEN DEP-REMISS
304.6	DRUG DEPENDENCE NEC
304.6	DRUG DEPEND NEC-UNSPEC
304.61	DRUG DEPEND NEC-CONTIN
304.62	DRUG DEPEND NEC-EPISODIC
304.63	DRUG DEPEND NEC-IN REM
304.7	OPIOID/OTHER DRUG DEPEND
304.7	OPIOID/OTHER DEP-UNSPEC
304.71	OPIOID/OTHER DEP-CONTIN
304.72	OPIOID/OTHER DEP-EPISOD
304.73	OPIOID/OTHER DEP-REMISS
304.8	COMB DRUG DEPENDENCE NEC
304.8	COMB DRUG DEP NEC-UNSPEC
304.81	COMB DRUG DEP NEC-CONTIN
304.82	COMB DRUG DEP NEC-EPISOD
304.83	COMB DRUG DEP NEC-REMISS
304.9	DRUG DEPENDENCE NOS
304.9	DRUG DEPEND NOS-UNSPEC
304.91	DRUG DEPEND NOS-CONTIN
304.92	DRUG DEPEND NOS-EPISODIC
304.93	DRUG DEPEND NOS-REMISS
305	NONDEPENDENT DRUG ABUSE
305.1	TOBACCO USE DISORDER
305.2	CANNABIS ABUSE
305.2	CANNABIS ABUSE-UNSPEC
305.21	CANNABIS ABUSE-CONTIN
305.22	CANNABIS ABUSE-EPISODIC
305.23	CANNABIS ABUSE-IN REMISS
305.3	HALLUCINOGEN ABUSE
305.3	HALLUCINOG ABUSE-UNSPEC
305.31	HALLUCINOG ABUSE-CONTIN
305.32	HALLUCINOG ABUSE-EPISOD

CODE	DESCRIPTION
305.33	HALLUCINOG ABUSE-REMISS
305.4	SED,HYP,ANXIOLYTIC ABUSE
305.4	SED,HYP,ANXIOLYTC AB-NOS
305.41	SED,HYP,ANXIOLYTC AB-CON
305.42	SED,HYP,ANXIOLYTC AB-EPI
305.43	SED,HYP,ANXIOLYTC AB-REM
305.5	OPIOID ABUSE
305.5	OPIOID ABUSE-UNSPEC
305.51	OPIOID ABUSE-CONTINUOUS
305.52	OPIOID ABUSE-EPISODIC
305.53	OPIOID ABUSE-IN REMISS
305.6	COCAINE ABUSE
305.6	COCAINE ABUSE-UNSPEC
305.61	COCAINE ABUSE-CONTINUOUS
305.62	COCAINE ABUSE-EPISODIC
305.63	COCAINE ABUSE-IN REMISS
305.7	AMPHETAMINE ABUSE
305.7	AMPHETAMINE ABUSE-UNSPEC
305.71	AMPHETAMINE ABUSE-CONTIN
305.72	AMPHETAMINE ABUSE-EPISOD
305.73	AMPHETAMINE ABUSE-REMISS
305.8	ANTIDEPRESSANT ABUSE
305.8	ANTIDEPRESS ABUSE-UNSPEC
305.81	ANTIDEPRESS ABUSE-CONTIN
305.82	ANTIDEPRESS ABUSE-EPISOD
305.83	ANTIDEPRESS ABUSE-REMISS
305.9	DRUG ABUSE NEC/NOS
305.9	DRUG ABUSE NEC-UNSPEC
305.91	DRUG ABUSE NEC-CONTIN
305.92	DRUG ABUSE NEC-EPISODIC
305.93	DRUG ABUSE NEC-IN REMISS
Transient organic psychotic conditions	
293	TRANSIENT DISOR OTR COND
293	DELIRIUM D/T OTHER COND
293.1	SUBACUTE DELIRIUM
293.8	OTH TRANSIENT DISORD OTH
293.81	PSY DIS W DELUS OTH DIS
293.82	PSY DIS W HALLUC OTH DIS
293.83	MOOD DISORDER OTHER DIS

CODE	DESCRIPTION
293.84	ANXIETY DISORDER OTH DIS
293.89	TRANSIENT MENTAL DIS NEC
293.9	TRANSIENT MENTAL DIS NOS
Other organic psychotic conditions (chronic)	
294	PERSIST DISORD OTH COND
294	AMNESTIC DISORD OTH DIS
294.1	DEMENTIA OTHER COND
294.11	DEMENTIA W BEHAVIOR DIST
294.8	MENTAL DISOR NEC OTH DIS
294.9	MENTAL DISOR NOS OTH DIS
Schizophrenia	
295	SCHIZOPHRENIC DISORDERS
295	SIMPLE SCHIZOPHRENIA
295	SIMPL SCHIZOPHREN-UNSPEC
295.01	SIMPL SCHIZOPHREN-SUBCHR
295.02	SIMPLE SCHIZOPHREN-CHR
295.03	SIMP SCHIZ-SUBCHR/EXACER
295.04	SIMPL SCHIZO-CHR/EXACERB
295.05	SIMPL SCHIZOPHREN-REMISS
295.1	HEBEPHRENIA
295.1	HEBEPHRENIA-UNSPEC
295.11	HEBEPHRENIA-SUBCHRONIC
295.12	HEBEPHRENIA-CHRONIC
295.13	HEBEPHREN-SUBCHR/EXACERB
295.14	HEBEPHRENIA-CHR/EXACERB
295.15	HEBEPHRENIA-REMISSION
295.2	CATATONIC SCHIZOPHRENIA
295.2	CATATONIA-UNSPEC
295.21	CATATONIA-SUBCHRONIC
295.22	CATATONIA-CHRONIC
295.23	CATATONIA-SUBCHR/EXACERB
295.24	CATATONIA-CHR/EXACERB
295.25	CATATONIA-REMISSION
295.3	PARANOID SCHIZOPHRENIA
295.3	PARANOID SCHIZO-UNSPEC
295.31	PARANOID SCHIZO-SUBCHR
295.32	PARANOID SCHIZO-CHRONIC
295.33	PARAN SCHIZO-SUBCHR/EXAC
295.34	PARAN SCHIZO-CHR/EXACERB

CODE	DESCRIPTION
295.35	PARANOID SCHIZO-REMISS
295.4	SCHIZOPHRENIFORM DIS
295.4	SCHIZOPHRENIFORM DIS NOS
295.41	SCHIZOPHRENIC DIS-SUBCHR
295.42	SCHIZOPHREN DIS-CHRONIC
295.43	SCHIZO DIS-SUBCHR/EXACER
295.44	SCHIZOPHR DIS-CHR/EXACER
295.45	SCHIZOPHRENIC DIS-REMISS
295.5	LATENT SCHIZOPHRENIA
295.5	LATENT SCHIZOPHREN-UNSP
295.51	LAT SCHIZOPHREN-SUBCHR
295.52	LATENT SCHIZOPHREN-CHR
295.53	LAT SCHIZO-SUBCHR/EXACER
295.54	LATENT SCHIZO-CHR/EXACER
295.55	LAT SCHIZOPHREN-REMISS
295.6	RESIDUAL SCHIZOPHRENIA
295.6	SCHIZOPHR DIS RESID NOS
295.61	SCHIZOPH DIS RESID-SUBCH
295.62	SCHIZOPHR DIS RESID-CHR
295.63	SCHIZO RESID SUBCHR/EXAC
295.64	SCHIZOPH RESID-CHRO/EXAC
295.65	SCHIZOPH DIS RESID-REMIS
295.7	SCHIZOAFFECTIVE DISORDER
295.7	SCHIZOAFFECTIVE DIS NOS
295.71	SCHIZOAFFECTV DIS-SUBCHR
295.72	SCHIZOAFFECTIVE DIS-CHR
295.73	SCHIZOAFF DIS-SUBCH/EXAC
295.74	SCHIZOAFFTV DIS-CHR/EXAC
295.75	SCHIZOAFFECTVE DIS-REMIS
295.8	SCHIZOPHRENIA NEC
295.8	SCHIZOPHRENIA NEC-UNSPEC
295.81	SCHIZOPHRENIA NEC-SUBCHR
295.82	SCHIZOPHRENIA NEC-CHR
295.83	SCHIZO NEC-SUBCHR/EXACER
295.84	SCHIZO NEC-CHR/EXACERB
295.85	SCHIZOPHRENIA NEC-REMISS
295.9	SCHIZOPHRENIA NOS
295.9	SCHIZOPHRENIA NOS-UNSPEC
295.91	SCHIZOPHRENIA NOS-SUBCHR

CODE	DESCRIPTION
295.92	SCHIZOPHRENIA NOS-CHR
295.93	SCHIZO NOS-SUBCHR/EXACER
295.94	SCHIZO NOS-CHR/EXACERB
295.95	SCHIZOPHRENIA NOS-REMISS
Manic Disorders	
296.1	MANIC, RECURRENT EPISODE
296.1	RECUR MANIC DIS-UNSPEC
296.11	RECUR MANIC DIS-MILD
296.12	RECUR MANIC DIS-MOD
296.13	RECUR MANIC DIS-SEVERE
296.14	RECUR MANIC-SEV W PSYCHO
296.15	RECUR MANIC-PART REMISS
296.16	RECUR MANIC-FULL REMISS
296.81	ATYPICAL MANIC DISORDER
Depression	
296.2	DEPRESS PSYCHOSIS
296.2	DEPRESS PSYCHOSIS-UNSPEC
296.21	DEPRESS PSYCHOSIS-MILD
296.22	2DEPRESSIVE PSYCHOSIS-MOD
296.23	DEPRESS PSYCHOSIS-SEVERE
296.24	DEPR PSYCHOS-SEV W PSYCH
296.25	DEPR PSYCHOS-PART REMISS
296.26	DEPR PSYCHOS-FULL REMISS
296.3	RECURR DEPR PSYCHOS
296.3	RECURR DEPR PSYCHOS-UNSP
296.31	RECURR DEPR PSYCHOS-MILD
296.32	RECURR DEPR PSYCHOS-MOD
296.33	RECUR DEPR PSYCH-SEVERE
296.34	REC DEPR PSYCH-PSYCHOTIC
296.35	RECUR DEPR PSYC-PART REM
296.36	2RECUR DEPR PSYC-FULL REM
296.82	ATYPICAL DEPRESSIVE DIS
311	DEPRESSIVE DISORDER NEC
Bi-polar	
296	EPISODIC MOOD DISORDER
296	BIPOL 1 SINGLE MANIC
296	BIPOL I SINGLE MANIC NOS
296.01	BIPOL I SINGLE MANC-MILD
296.02	BIPOL I SINGLE MANIC-MOD

CODE	DESCRIPTION
296.03	BIPOL I SING-SEV W/O PSY
296.04	BIPO I SIN MAN-SEV W PSY
296.05	BIPOL I SING MAN REM NOS
296.06	BIPOL I SINGLE MANIC REM
296.4	BIPOL 1 CURRENT MANIC
296.4	BIPOL I CURRNT MANIC NOS
296.41	BIPOL I CURNT MANIC-MILD
296.42	BIPOL I CURRNT MANIC-MOD
296.43	BIPOL I MANC-SEV W/O PSY
296.44	BIPOL I MANIC-SEV W PSY
296.45	BIPOL I CUR MAN PART REM
296.46	BIPOL I CUR MAN FULL REM
296.5	BIPOL 1 CUR DEPRESSED
296.5	BIPOL I CUR DEPRES NOS
296.51	BIPOL I CUR DEPRESS-MILD
296.52	BIPOL I CUR DEPRESS-MOD
296.53	BIPOL I CURR DEP W/O PSY
296.54	BIPOL I CURRNT DEP W PSY
296.55	BIPOL I CUR DEP REM NOS
296.56	BIPOL I CURRNT DEP REMIS
296.6	BIPOL 1 CURRENT MIXED
296.6	BIPOL I CURRNT MIXED NOS
296.61	BIPOL I CURRNT MIX-MILD
296.62	BIPOL I CURRNT MIXED-MOD
296.63	BIPOL I CUR MIX W/O PSY
296.64	BIPOL I CUR MIXED W PSY
296.65	BIPOL I CUR MIX-PART REM
296.66	BIPOL I CUR MIXED REMISS
296.7	BIPOLOR I CURRENT NOS
296.8	BIPOLAR DISORDER NOS/NEC
296.8	BIPOLAR DISORDER NOS
296.89	BIPOLAR DISORDER NEC
296.9	EPISOD MOOD DIS NOS/NEC
296.9	EPISODIC MOOD DISORD NOS
296.99	EPISODIC MOOD DISORD NEC
Paranoia/Psychosis	
297	DELUSIONAL DISORDER
297	PARANOID STATE, SIMPLE
297.1	DELUSIONAL DISORDER

CODE	DESCRIPTION
297.2	PARAPHRENIA
297.3	SHARED PSYCHOTIC DISORD
297.8	PARANOID STATES NEC
297.9	PARANOID STATE NOS
298	OTH NONORGANIC PSYCHOSES
298	REACT DEPRESS PSYCHOSIS
298.1	EXCITATIV TYPE PSYCHOSIS
298.2	REACTIVE CONFUSION
298.3	ACUTE PARANOID REACTION
298.4	PSYCHOGEN PARANOID PSYCH
298.8	REACT PSYCHOSIS NEC/NOS
298.9	PSYCHOSIS NOS
300.1	HYSTERIA DISSOCIATIVE DISORDER
300.1	HYSTERIA NOS
300.11	CONVERSION DISORDER
300.12	DISSOCIATIVE AMNESIA
300.13	DISSOCIATIVE FUGUE
300.14	DISSOCIATVE IDENTITY DIS
300.15	DISSOCIATIVE REACT NOS
300.16	FACTITIOUS DIS W SYMPTOM
300.19	FACTITIOUS ILL NEC/NOS
300.3	OBSESSIVE-COMPULSIVE DIS
300.4	DYSTHYMIC DISORDER
300.5	NEURASTHENIA
300.6	DEPERSONALIZATION DISORD
300.7	HYPOCHONDRIASIS
300.8	SOMATOFORM DISORDER
300.81	SOMATIZATION DISORDER
300.82	UNDIFF SOMATOFORM DISRDR
300.89	SOMATOFORM DISORDERS NEC
300.9	NONPSYCHOTIC DISORD NOS
Anxiety	
300	ANXIETY/DISSOC/SOM DIS
300	ANXIETY STATES
300	ANXIETY STATE NOS
300.01	PANIC DIS W/O AGORPHOBIA
300.02	GENERALIZED ANXIETY DIS
300.09	ANXIETY STATE NEC
Phobias	

CODE	DESCRIPTION
300.2	PHOBIC DISORDERS
300.2	PHOBIA NOS
300.21	AGORAPHOBIA W PANIC DIS
300.22	AGORAPHOBIA W/O PANIC
300.23	SOCIAL PHOBIA
300.29	3ISOLATED/SPEC PHOBIA NEC
Personality Disorders	
301	PERSONALITY DISORDERS
301	PARANOID PERSONALITY
301.1	AFFECTIVE PERSONALITY
301.1	AFFECTIV PERSONALITY NOS
301.11	CHRONIC HYPOMANIC PERSON
301.12	CHR DEPRESSIVE PERSON
301.13	CYCLOTHYMIC DISORDER
301.2	SCHIZOID PERSONALITY
301.2	SCHIZOID PERSONALITY NOS
301.21	INTROVERTED PERSONALITY
301.22	SCHIZOTYPAL PERSON DIS
301.3	EXPLOSIVE PERSONALITY
301.4	OBSESSIVE-COMPULSIVE DIS
301.5	HISTRIONIC PERSONALITY
301.5	HISTRIONIC PERSON NOS
301.51	CHR FACTITIOUS ILLNESS
301.59	HISTRIONIC PERSON NEC
301.6	DEPENDENT PERSONALITY
301.7	ANTISOCIAL PERSONALITY
301.8	OTHER PERSONALITY DIS
301.81	NARCISSISTIC PERSONALITY
301.82	AVOIDANT PERSONALITY DIS
301.83	BORDERLINE PERSONALITY
301.84	PASSIVE-AGGRESSIV PERSON
301.89	PERSONALITY DISORDER NEC
301.9	PERSONALITY DISORDER NOS
Sexual deviations and disorders	
302	HOMOSEXUALITY EGO-DYSTONIC SEX ORIENT Description Updated
302	SEXUAL DISORDERS SEXUAL/GENDER ID DISORD Description Updated
302.1	ZOOPHILIA No Change

CODE	DESCRIPTION
302.2	PEDOPHILIA No Change
302.3	TRANSVESTISM TRANSVESTIC FETISHISM Description Updated
302.4	EXHIBITIONISM No Change
302.5	TRANS-SEXUALISM No Change
302.5	TRANS-SEXUALISM NOS
302.51	TRANS-SEXUALISM, ASEXUAL
302.52	TRANS-SEXUAL, HOMOSEXUAL
302.53	TRANS-SEX, HETEROSEXUAL
302.6	GENDR IDENTITY DIS-CHILD
302.7	PSYCHOSEXUAL DYSFUNCTION
302.7	PSYCHOSEXUAL DYSFUNC NOS
302.71	HYPOACTIVE SEX DESIRE
302.72	INHIBITED SEX EXCITEMENT
302.73	FEMALE ORGASMIC DISORDER
302.74	MALE ORGASMIC DISORDER
302.75	PREMATURE EJACULATION
302.76	DYSPAREUNIA,PSYCHOGENIC
302.79	PSYCHOSEXUAL DYSFUNC NEC
302.8	PSYCHOSEXUAL DIS NEC
302.81	FETISHISM No Change
302.82	VOYEURISM No Change
302.83	SEXUAL MASOCHISM
302.84	SEXUAL SADISM
302.85	GEND IDEN DIS,ADOL/ADULT
302.89	PSYCHOSEXUAL DIS NEC
302.9	PSYCHOSEXUAL DIS NOS
Psychogenic Disorders	
306	PSYCHOGENIC MALFUNCTION
306	PSYCHOGEN MUSCULSKEL DIS
306.1	PSYCHOGENIC RESPIR DIS
306.2	PSYCHOGEN CARDIOVASC DIS
306.3	PSYCHOGENIC SKIN DISEASE
306.4	PSYCHOGENIC GI DISEASE
306.5	PSYCHOGENIC GU DISEASE
306.5	PSYCHOGENIC GU DIS NOS
306.51	PSYCHOGENIC VAGINISMUS
306.52	PSYCHOGENIC DYSMENORRHEA
306.53	PSYCHOGENIC DYSURIA
306.59	PSYCHOGENIC GU DIS NEC

CODE	DESCRIPTION
306.6	PSYCHOGEN ENDOCRINE DIS
306.7	PSYCHOGENIC SENSORY DIS
306.8	PSYCHOGENIC DISORDER NEC
306.9	PSYCHOGENIC DISORDER NOS
Sleep disorders	
307.4	NONORGANIC SLEEP DISORD
307.4	NONORGANIC SLEEP DIS NOS
307.41	TRANSIENT INSOMNIA
307.42	PERSISTENT INSOMNIA
307.43	TRANSIENT HYPERSOMNIA
307.44	PERSISTENT HYPERSOMNIA
307.45	CIRCADIAN RHYTHM SLEEP
307.46	SLEEP AROUSAL DISORDER
307.47	SLEEP STAGE DYSFUNC NEC
307.48	REPETIT SLEEP INTRUSION
307.49	NONORGANIC SLEEP DIS NEC
Eating disorders	
307.1	ANOREXIA NERVOSA
307.5	EATING DISORDERS NEC/NOS
307.5	EATING DISORDER NOS
307.51	BULIMIA NERVOSA
307.52	PICA
307.53	RUMINATION DISORDER
307.54	PSYCHOGENIC VOMITING
307.59	EATING DISORDER NEC
Stress Related	
307.6	ENURESIS
307.7	ENCOPRESIS
307.8	PSYCHOGENIC PAIN DISORD
307.8	PSYCHOGENIC PAIN NOS
307.81	TENSION HEADACHE
307.89	PSYCHOGENIC PAIN NEC D
307.9	SPECIAL SYMPTOM NEC/NOS
308	ACUTE REACTION TO STRESS
308	STRESS REACT, EMOTIONAL
308.1	STRESS REACTION, FUGUE
308.2	STRESS REACT, PSYCHOMOT
308.3	ACUTE STRESS REACT NEC
308.4	STRESS REACT, MIXED DIS

CODE	DESCRIPTION
308.9	ACUTE STRESS REACT NOS
Adjustment related	
309	ADJUSTMENT REACTION
309	ADJUSTMNT DIS W DEPRESSN
309.1	PROLONG DEPRESSIVE REACT
309.2	ADJUST REACT/OTH EMOTION
309.21	SEPARATION ANXIETY
309.22	EMANCIPATION DISORDER
309.23	ACADEMIC/WORK INHIBITION
309.24	ADJUSTMENT DIS W ANXIETY
309.28	ADJUST DIS W ANXIETY/DEP
309.29	ADJ REACT-EMOTION NEC
309.3	ADJUST DISOR/DIS CONDUCT
309.4	ADJ DIS-EMOTION/CONDUCT
309.8	OTHER ADJUST REACTION
309.81	POSTTRAUMATIC STRESS DIS
309.82	ADJUST REACT-PHYS SYMPT
309.83	ADJUST REACT-WITHDRAWAL
309.89	ADJUSTMENT REACTION NEC
309.9	ADJUSTMENT REACTION NOS
Conduct/social disturbances	
312	CONDUCT DISTURBANCE NEC
312	UNSOCIALIZED AGGRESSION
312	UNSOCIAL AGGRESS-UNSPEC
312.01	UNSOCIAL AGGRESSION-MILD
312.02	UNSOCIAL AGGRESSION-MOD
312.03	UNSOCIAL AGGRESS-SEVERE
312.1	UNSOCIALIZ, UNAGGRESSIVE
312.1	UNSOCIAL UNAGGRESS-UNSP
312.11	UNSOCIAL UNAGGRESS-MILD
312.12	UNSOCIAL UNAGGRESS-MOD
312.13	UNSOCIAL UNAGGR-SEVERE
312.2	SOCIALIZED CONDUCT DIS
312.2	SOCIAL CONDUCT DIS-UNSP
312.21	SOCIAL CONDUCT DIS-MILD
312.22	SOCIAL CONDUCT DIS-MOD
312.23	SOCIAL CONDUCT DIS-SEV
312.3	IMPULSE CONTROL DIS NEC
312.3	IMPULSE CONTROL DIS NOS

CODE	DESCRIPTION
312.31	PATHOLOGICAL GAMBLING
312.32	KLEPTOMANIA
312.33	PYROMANIA
312.34	INTERMITT EXPLOSIVE DIS
312.35	ISOLATED EXPLOSIVE DIS
312.39	IMPULSE CONTROL DIS NEC
312.4	MIX DIS CONDUCT/EMOTION
312.8	OTHR CONDUCT DISTURB NEC
312.81	CNDCT DSRDR CHLDHD ONST
312.82	CNDCT DSRDR ADLSCNT ONST
312.89	OTHER CONDUCT DISORDER
312.9	CONDUCT DISTURBANCE NOS
Emotional Disorders (Youth)	
313	EMOTIONAL DIS CHILD/ADOL
313	OVERANXIOUS DISORDER
313.1	MISERY & UNHAPPINESS DIS
313.2	SENSITIVITY & WITHDRAWAL
313.21	SHYNESS DISORDER-CHILD
313.22	INTROVERTED DIS-CHILD
313.23	SELECTIVE MUTISM
313.3	RELATIONSHIP PROBLEMS
313.8	OTH EMOTIONAL DIS CHILD
313.81	OPPOSITION DEFIANT DISOR
313.82	IDENTITY DISORDER
313.83	ACADEMIC UNDERACHIEVMENT
313.89	EMOTIONAL DIS CHILD NEC
313.9	EMOTIONAL DIS CHILD NOS

Focus Groups

In an effort to obtain in-depth feedback related to what community leaders and residents feel are the biggest challenges and assets in the community, a series of focus groups were conducted. The goal was to obtain a broad and diverse picture of healthcare, health-related behaviors, needs and issues that have an impact on the residents of the Jefferson Regional service area. A total of nine focus groups were completed during the course of the study. A copy of the interview guide is included in Appendix B. Table 9 identifies the focus groups and number of participants in each group.

Table 9: Focus groups

Facilitator	Date	Group	Location	Number of Participants
Jacqui Lanagan	August 21, 2012	Senior Citizens	Presbyterian Church, Pleasant Hills	14
Jacqui Lanagan	August 21, 2012	Mental Health and Drug & Alcohol Providers	Jefferson Regional Medical Center Counseling Services	7
Jacqui Lanagan	August 29, 2012	Community Health Advisory Panel	Jefferson Room, Jefferson Regional Medical Center	9
Jacqui Lanagan	August 29, 2012	Social Workers/ Case Managers	James Bibro Building, Jefferson Regional Medical Center	8
Jacqui Lanagan	August 29, 2012	Community College of Allegheny County Faculty and Partners	CCAC South Campus	7
Jacqui Lanagan/ Rob Cotter	September 14, 2012	High School Students	Thomas Jefferson High School	29
Jacqui Lanagan/ Rob Cotter	September 26, 2012	Low Income Women/ Families, Clairton	Sister's Place, Clairton	19
Jacqui Lanagan/ Rob Cotter	September 26, 2012	Low Income/Job Seekers	Mon Valley Initiative, Homestead	12
Rob Cotter	September 20, 2012	Business Leaders/Jefferson Hills Chamber of Commerce		5
Total number of participants:				110

Key Stakeholder Interviews

In an effort to obtain in-depth feedback related to what community leaders feel are the biggest challenges and assets in the community, key stakeholder interviews were conducted with selected individuals that represented key topic areas, issues or interests. The goal was to obtain a broad and diverse picture of healthcare, health-related behaviors and issues that have an impact of the residents of the service area region. Key Stakeholder interviews were conducted at the end of July 2012. A copy of the interview guide is included in Appendix C. Table 10 outlines the individual stakeholders who participated in interviews.

Table 10: Individual Stakeholders

SSI Interviewer	Contact	Department/Position	Date of Interview
Jacqui Lanagan	Dr. Brenda Trettel	Community College of Allegheny County	July 23 - 8:30 AM
Debra Thompson	Sister Mary Parks	Sister's Place	July 23 - 9:00 AM
Debra Thompson	Jefferson Brooks	Mon Valley Initiative	July 24 - 3:00 PM
Jacqui Lanagan	Marv Levin	Jefferson Regional Community Health Council Chair	July 25 - 10:30 AM
Jacqui Lanagan	Mildred Morrison	Administrator, Allegheny County Area Agency on Aging	July 26 - 3:30 PM
Jacqui Lanagan	Dr. Anthony Gentile	Dir., Gynecological Services, Jefferson Regional Medical Center	July 26 - 11:45 AM
Jacqui Lanagan	Dr. Richard Sullivan	Associate Director, Emergency Department, Jefferson Regional Medical Center	July 26 - 8:00 AM

Numerous attempts were made during a three week period to complete an interview with Rep. Tim Murphy, US Congressman from the 18th district, but were ultimately unsuccessful.

Needs/Issues Prioritization Process

On September 25, 2012, the Steering Committee met to review all of the primary and secondary data collected through the needs assessment process and to identify key needs and issues that they felt were present in the community. On October 10, 2012, the Steering Committee met again to review needs and issues identified in the Community Needs Assessment Process and to prioritize the issues in order to identify potential intervention strategies and an action plan. The meeting was facilitated by Jacqui Lanagan, director of Nonprofit and Community Services for Strategy Solutions, who conducted the prioritization exercise using the OptionFinder audience response polling technology. In preparation for the meeting the group identified four criteria by which the issues would be evaluated. These criteria included:

		Scoring		
Item	Definition	Low (1)	Medium	High (10)
1. Accountable Entity	The extent to which the issue is an important priority to address in this action planning effort for either the medical center or the community	This is an important priority for the community to address	This is important but is not for this action planning effort	This is an important priority for the medical center to address
2. Magnitude of the problem	The degree to which the problem leads to death, disability or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers of people affected; no risk for epidemic	Moderate numbers/ % of people affected and/or moderate risk	High numbers/ % of people affected and/or risk for epidemic
3. Variance against benchmarks or goals	This would include variance with selected benchmarks, state standards or state data, Healthy People 2010 goals and/or other prevention agenda standard or state data	Local / regional rates meet or exceed the goal or standard	Local/ regional rates are somewhat worse than the goal or standard	Local/ regional rates are significantly worse than the goal or standard
4. Capacity (systems and resources) to implement evidence based solutions	This would include the capacity to and ease of implementing evidence based solutions	There is little or no capacity (systems and resources) to implement evidence based solutions	Some capacity (system and resources) exist to implement evidence based solutions	There is solid capacity (system and resources) to implement evidence based solutions in this area

The participants completed the prioritization exercise using the OptionFinder audience response polling technology to quickly rate/rank the issues based on the various criteria during the October 10th session.

Action Planning Process

Following the prioritization session, the Jefferson Regional staff involved in the CHNA process met to discuss the top priorities and identify possible intervention strategies and action plans. The top rank priority need areas were discussed to identify the greatest needs to the hospital's mission, current capabilities and focus areas. On November 5th, the team met with the members of the Steering Committee to identify the key areas that will be the focus of intervention action plans. The group consensus during that discussion was that "Access to Women's Health" would be the focus area for intervention.

Following this discussion, clinical and administrative leaders developed an action plan along with the timeframe and budget associated with the activities.

Review and Approval

The final implementation action plan was presented to the Jefferson Regional Medical Center Board on May 20, 2013.

Methodology

Community Health Needs Assessment and Planning Approach

The process of completing the 2012 Jefferson Regional Medical Center (Jefferson Regional) Community Health Needs Assessment (CHNA) began in late 2011, with the formal kickoff in April 2012. The purpose of this study is to complete a comprehensive assessment of the health status and healthcare access needs of residents living in the Jefferson Regional primary service region.

The CHNA and planning process is a significant step toward meeting the goal and mission of Jefferson Regional to improve the health of the community. This initiative brought the health system, public health and other community leaders together in a collaborative approach to:

- Identify the current health status of community residents to include baseline data for benchmarking and assessment purposes
- Identify the availability of treatment services, strengths, service gaps and opportunities
- Determine unmet community health needs and target priorities
- Develop a plan to direct community benefit and allocation of resources to meet targeted needs
- Enhance strategic planning for future services

This page is intentionally blank

This page is intentionally blank

Demographics

This page is intentionally blank

Demographics

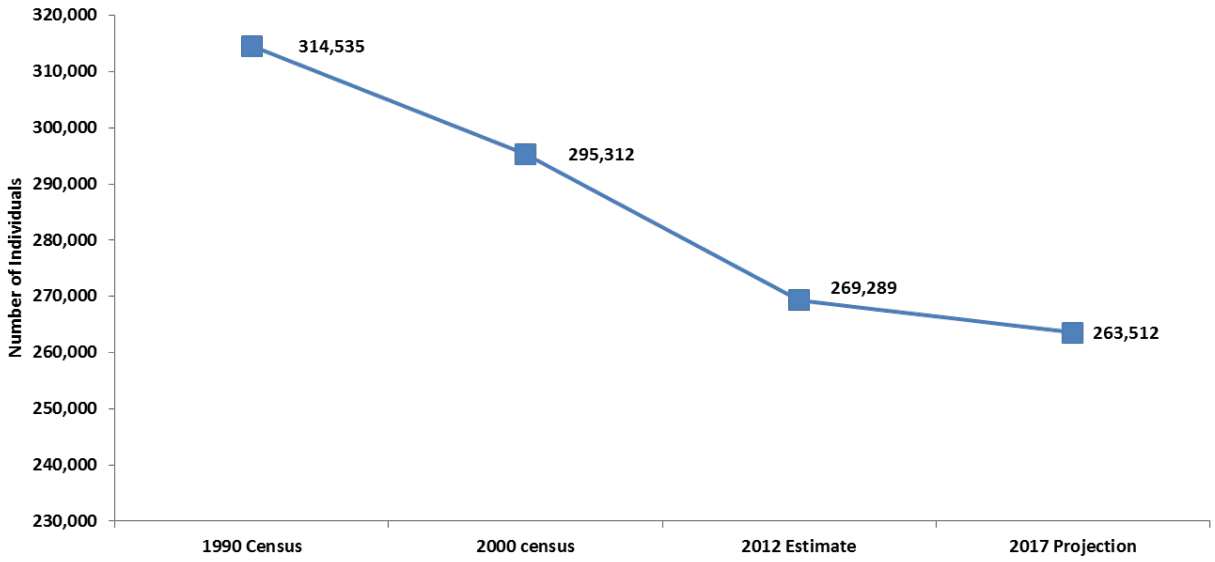
Table 11 illustrates the sample comparison for the Jefferson Regional service area population and 2012 Service Region BRFSS sample. With the exceptions of Clairton/Jefferson Hills, Pittsburgh (15236), and Finleyville, The percent of the sample is similar to the percent of population. The Clairton/ Jefferson Hills zip code (15025) was oversampled because the zip code actually covers two communities with very different socio-demographics. This resulted in the slight variation of sample distribution versus overall population distribution.

Table 11: Population and BRFSS sample comparisons

Zip Code Area	Number of Respondents	Percent of Sample	Population	Percent of Population
Belle Vernon - 15012	23	5.80%	16321	6.70%
Clairton, Jefferson Hills - 15025	50	12.50%	16542	6.80%
Elizabeth - 15037	14	3.50%	10922	4.50%
Glassport - 15045	16	4.00%	4541	1.90%
Monongahela - 15063	16	4.00%	5178	2.10%
Bethel Park - 15102	35	8.80%	12395	5.10%
Munhall, Homestead - 15120	28	7.00%	18884	7.70%
West Mifflin - 15122	27	6.80%	19694	8.10%
South Park - 15129	14	3.50%	4404	1.80%
McKeesport - 15132	25	6.30%	20813	8.50%
Liberty, Port Vue - 15133	9	2.30%	6275	2.60%
Pittsburgh - 15207	12	3.00%	11174	4.60%
Pittsburgh, Mt. Oliver - 15210	37	9.30%	25809	10.60%
Pittsburgh, Brentwood - 15227	39	9.80%	27412	11.20%
Pittsburgh - 15236	44	11.00%	13352	5.50%
Finleyville - 15332	11	2.80%	30423	12.50%
Total	400	100%	244139	100%

Figure 4 illustrates the Jefferson Regional primary service region total population from the 1990 and 2000 censuses, as well as a 2012 estimate and 2017 projection. The total population of the region is 269,289 people. The highest population in the Jefferson Regional service area occurred in 1990, and a decreasing trend is projected to continue into 2017.

Figure 4: Jefferson Regional Medical Center service region: Population trend



Source: Nielsen/Claritas

Table 12 illustrates total population from Allegheny, Fayette, Washington and Westmoreland counties from the 1990 and 2000 censuses, as well as a 2012 estimate and 2017 projection. The population of the total service area overall is expected to continue to decline by 0.57 percent between 2012 and 2017, as well as within many of the individual counties. Washington and Westmoreland counties are projected to grow by an additional 1.87 percent and 0.37 percent, respectively by 2017. Allegheny and Fayette counties are expected to decrease by 1.10 percent and 2.12 percent, respectively by 2017. Fayette County was the only county to show an increase in the population from 1990 to 2000.

Table 12. Jefferson Regional Medical Center primary service area population by county

	PSA Total	PSA Allegheny	PSA Fayette	PSA Washington	PSA Westmoreland
2017 Projection	1,917,304	1,204,794	132,601	213,107	366,802
2012 Estimate	1,928,309	1,218,188	135,475	209,192	365,454
2000 Census	2,003,200	1,281,666	148,644	202,897	369,993
1990 Census	2,056,705	1,336,449	145,351	204,584	370,321
Change					
Growth 2012-2017	(0.57%)	(1.10%)	(2.12%)	1.87%	0.37%
Growth 2000 - 2012	(3.74%)	(4.95%)	(8.86%)	3.10%	(1.23%)
Growth 1990-2000	(2.60%)	(4.10%)	2.27%	(0.82%)	(0.09%)

Source: Nielsen/Claritas

Figure 5 and Figure 6 illustrates the service area population and 2012 Service Region BRFSS respondents by gender. The service area and BRFSS respondents are almost identical in terms of Gender.

Figure 5: Service area by gender

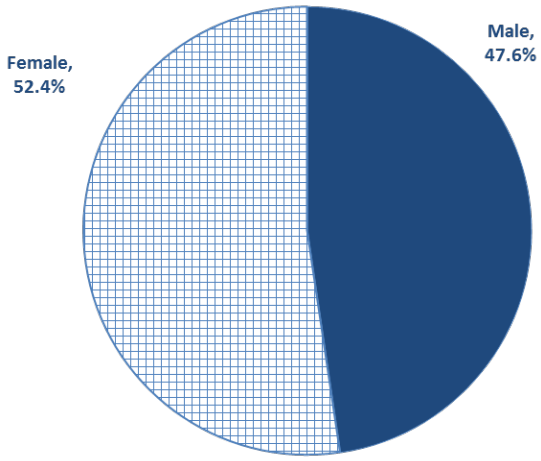
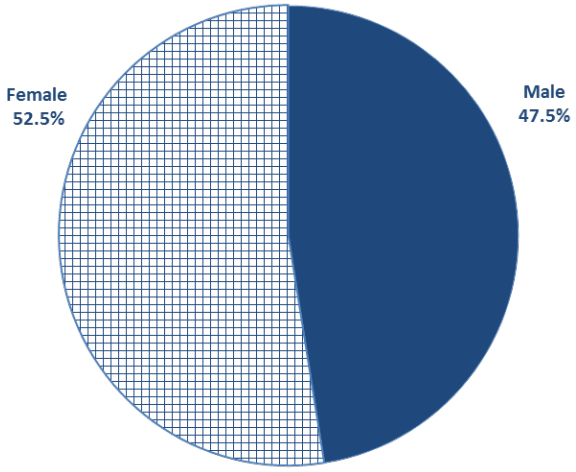


Figure 6: 2012 BRFSS by gender



Source: Nielsen/Claritas, 2012 Jefferson Regional Medical Center BRFSS

Figure 7 and Figure 8 illustrates the service area population and 2012 Service Region BRFSS respondents by gender. The majority of the primary service area (40.4 percent) and BRFSS respondents (47.6 percent) are between the ages of 25 to 54, while approximately 18 percent of both the primary service area and BRFSS respondents are age 65 and older.

Figure 7: Service area by age

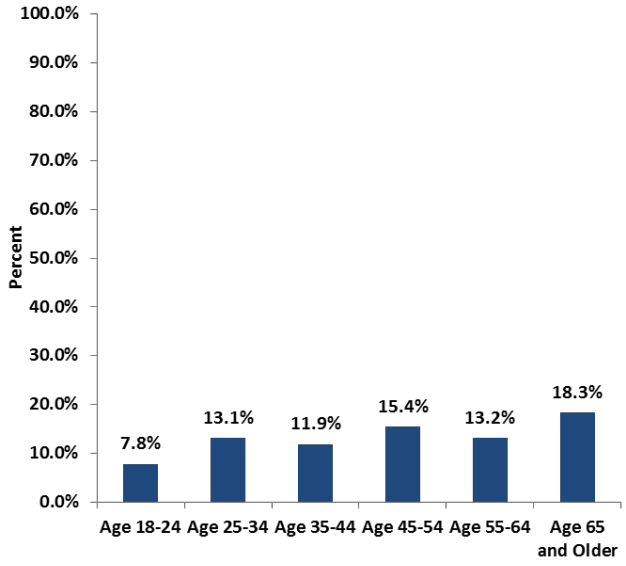
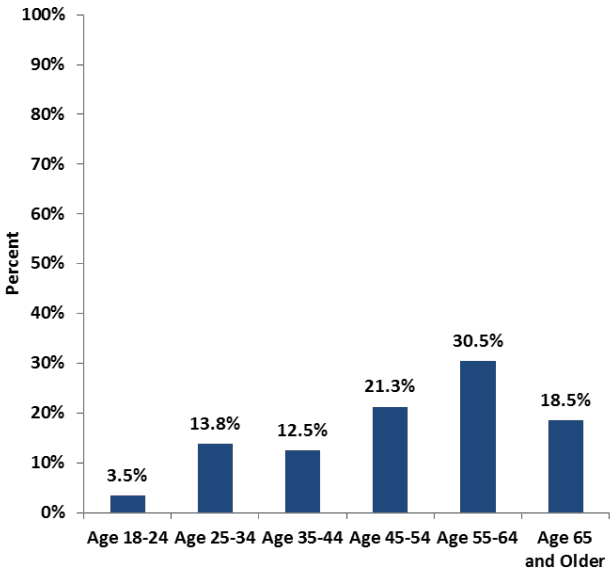


Figure 8: 2012 BRFSS by age



Source: Nielsen/Claritas, 2012 Jefferson Regional Medical Center BRFSS

Figure 9 and Figure 10 illustrates the service area population and 2012 Service Region BRFSS respondents by race. Both the service area and 2012 BRFSSS respondents were predominately white, while African Americans made up 10.8 percent of the service area and 8.3 percent of the BRFSS.

Figure 9: Service area by race

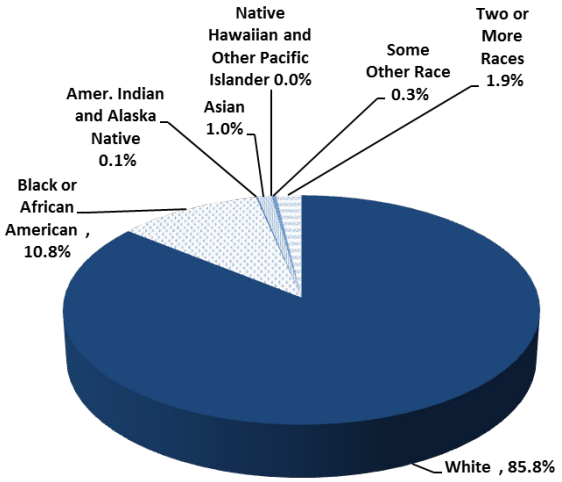
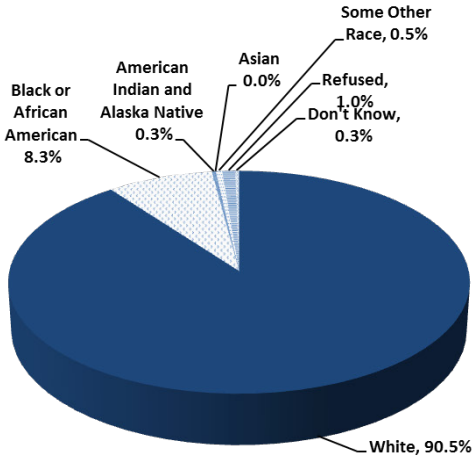


Figure 10: 2012 BRFSS by race



Source: Nielsen/Claritas, 2012 Jefferson Regional Medical Center BRFSS

Figure 11 and Figure 12 illustrates the service area population and 2012 Service Region BRFSS respondents by income. The service area and BRFSS respondents were similar in terms of income, with 57.7 percent of the service area and 51.0 percent of the BRFSS earning under $50,000.

Figure 11: Service area by income

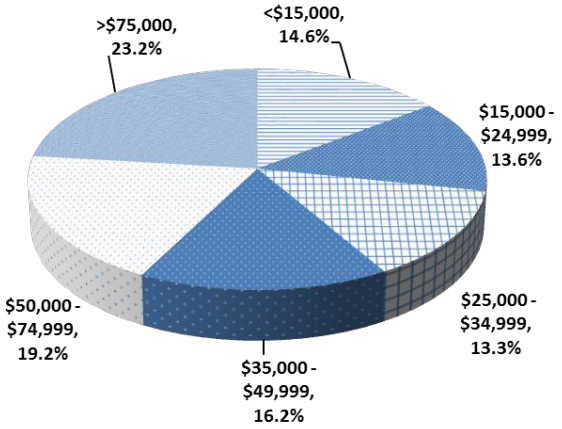
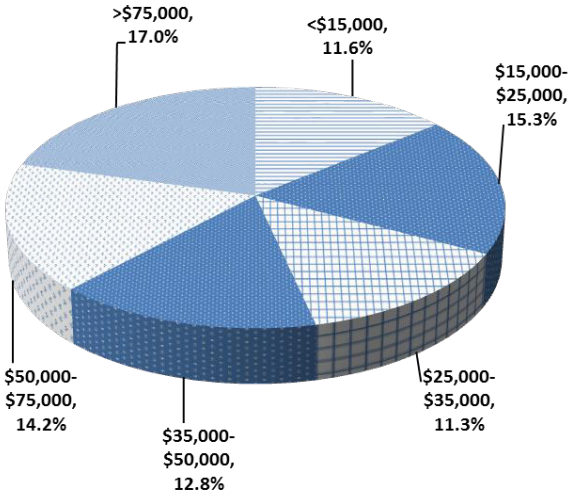


Figure 12: 2012 BRFSS by income



Source: Nielsen/Claritas, 2012 Jefferson Regional Medical Center BRFSS

Figure 13 and Figure 14 illustrates the service area population and 2012 Service Region BRFSS respondents by income. The service area and BRFSS respondents were similar in terms of education, with 39.6 percent of the service area and 32.5 percent of the BRFSS respondents having a high school education, and 22.3 percent and 29.5 percent having 4 or more years of college, respectively.

Figure 13: Service area by education

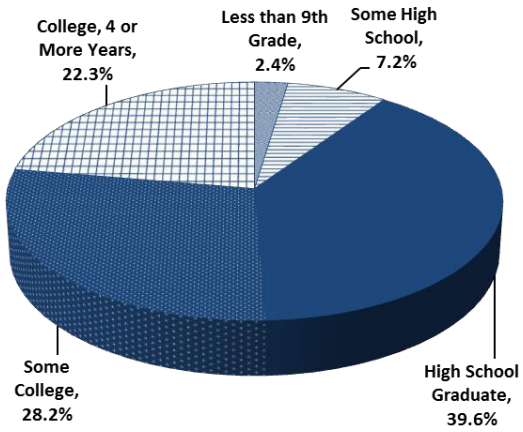
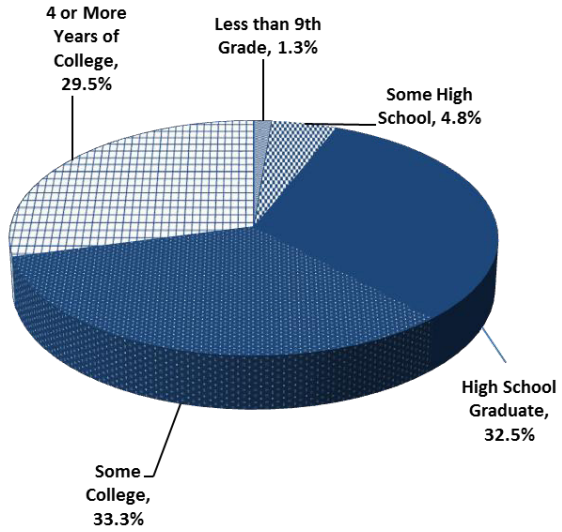


Figure 14: 2012 BRFSS by education



Source: Nielsen/Claritas, 2012 Jefferson Regional Medical Center BRFSS

Figure 15 and Figure 16: illustrates the service area population and 2012 Service Region BRFSS respondents by marital status. The service area and BRFSS respondents were similar in terms of marital status, with 47.0 percent of the service area and 52.3 percent of the 2012 BRFSS respondents being married.

Figure 15: Service area by marital status

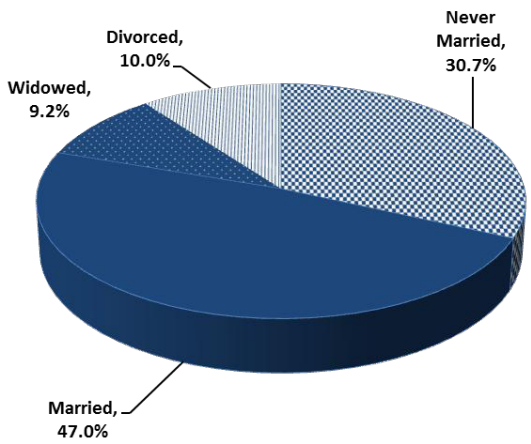
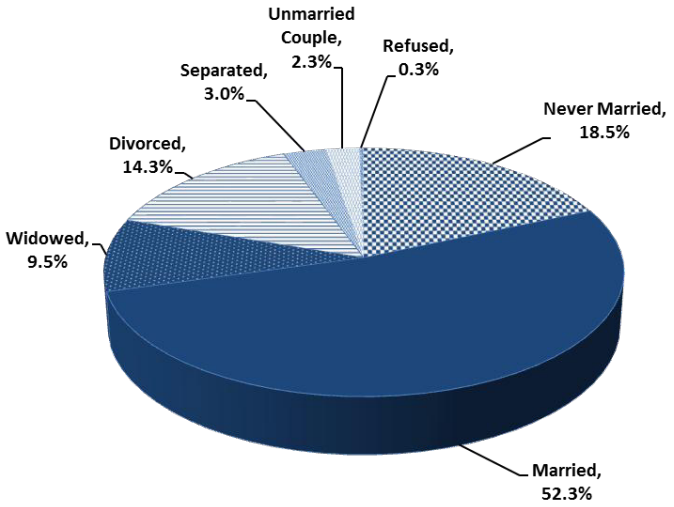


Figure 16: 2012 BRFSS by marital status



Source: Nielsen/Claritas, 2012 Jefferson Regional Medical Center BRFSS

Figure 17 and Figure 18 illustrates the service area population and 2012 Service Region BRFSS respondents by employment. The service area and BRFSS respondents were similar in terms of employment, with 57.3 percent of the service area and 44.0 percent of the 2012 BRFSS respondents employed.

Figure 17: Service area by employment

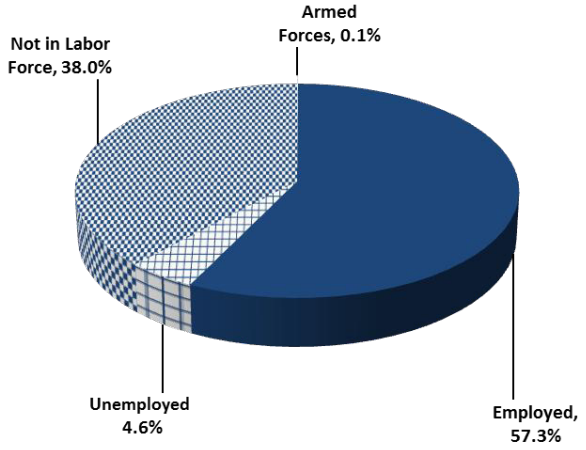
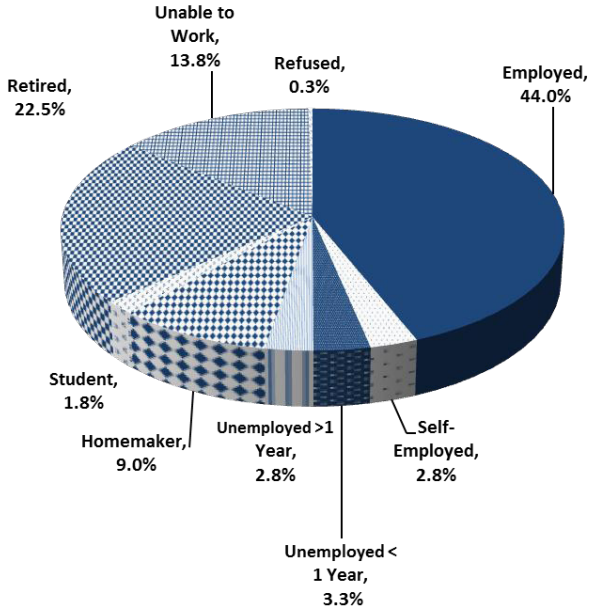


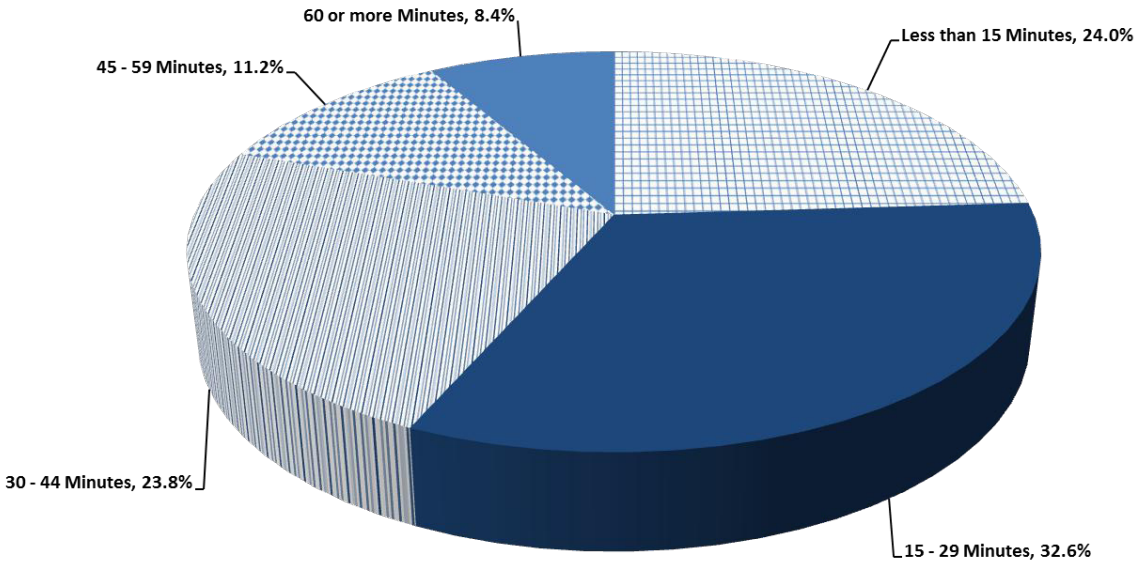
Figure 18: 2012 BRFSS by employment



Source: Nielsen/Claritas, 2012 Jefferson Regional Medical Center BRFSS

Figure 19 illustrates the Jefferson Regional primary service area travel time to work. Approximately one quarter (24.0 percent) of the service region population travels less than 15 minutes per day to work. The largest percentage of residents (32.6 percent) travel between 15 and 29 minutes to work. The remainder (43.4 percent) travel more than a half hour to work. Overall, the average travel time to work in minutes for the service region population is 30.2 minutes.

Figure 19: Jefferson Regional Medical Center service region: Average travel time to work

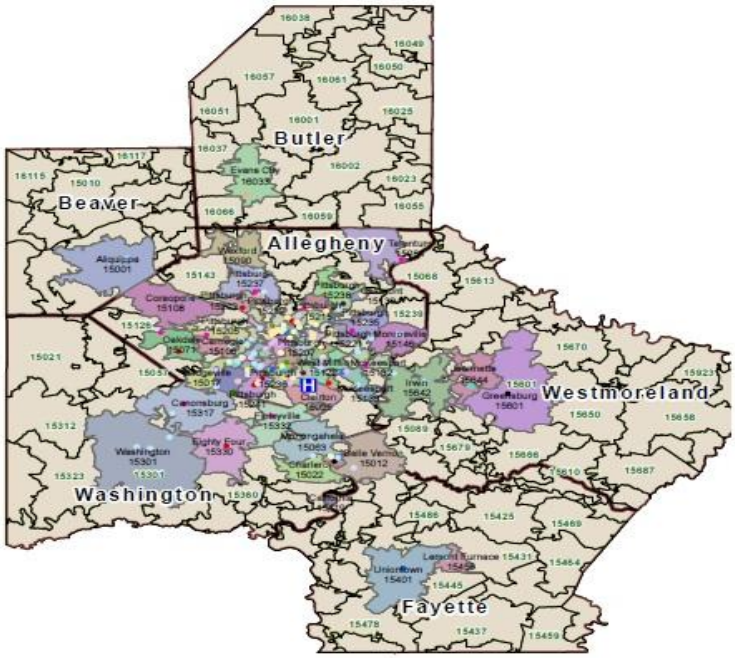


Source: Nielsen/Claritas

Community Assets

The following map, Figure 20, depict the Jefferson Regional inventory of community assets and resources that the CHNA steering committee as well as internal Jefferson Regional leaders and staff identified as important to the health of the community. Table 13 follows the map and lists the community assets for the primary service region, including crisis intervention, senior services, caregivers, dental assistance, donor organizations, food/meal services, food stamps, educational programs, exercise programs, mobile diagnostic testing, personal response system, medical equipment, mental health services, pharmaceutical services, support groups, social service agencies, recreational centers and telephone reassurance.

Figure 20. Jefferson Regional primary service area: Asset listing



Legend

- Telephone Resources
- Support Groups
- Social Service Agencies
- Senior Service Care Givers Registry
- Recreational Centers
- Pharmacy Services
- Personal Response System
- Mobile Diagnostics
- Mental Health Services
- Medical Equipment
- Food and Meal Services
- Food Stamps
- Exercise Programs
- Educational Programs
- Donor Organizations
- Dental Assistance
- Crisis Intervention

Table 13. Jefferson Regional primary service area: Asset listing – table 1 of 6

Crisis Intervention	Address	City	State	Zip
Allegheny County Behavioral Health	One Smithfield Street, Suite 300	Pittsburgh	PA	15062
Chestnut Ridge Counseling	100 New Salem Road	Uniontown	PA	15401
Mental Health Therapist	565 Coal Valley Road	Pittsburgh	PA	15401
Resolve	333 North Braddock Avenue	Pittsburgh	PA	15208
United Way of Allegheny County HelpLine	PO Box 735	Pittsburgh	PA	15230
Center For Victims Crime	900 Fifth Avenue	Pittsburgh	PA	15219
Westmoreland County MH Service Crisis Hot Line	40 N. Pennsylvania Avenue	Greensburgh	PA	15601
Senior Services: Caregivers	**Address**	**City**	**State**	**Zip**
Always Best Care	37 McMurray Road, Building 1, Suite LL2	Pittsburgh	PA	15241
Asera Care Hospice	300 Penn Center Boulevard, Suite 602	Pittsburgh	PA	15235
Adair Associates, Inc	520 Washington Road, Suite 202	Pittsburgh	PA	15228
Amedisys Home Health Care	100 Stoops Drive, Suite 300	Monongahela	PA	15063
Associated Home Health	604 Oak Street	North Huntingdon	PA	15642
Alzheimer's Association Greater Pennsylvania Chapter	1100 Liberty Avenue, Suite E- 201	Pittsburgh	PA	15222
Anova Home Health Care Service	1580 Broad Avenue Extension, Suite 1	Belle Vernon	PA	15012
Brannon Home and Health Care	3045 West Liberty Avenue, Suite 6	Pittsburgh	PA	15216
BrightStar Healthcare	300 Mt. Lebanon Boulevard, Suite 210A	Pittsburgh	PA	15234
Caring Angels	4939 Buttermilk Hollow Road	West Mifflin	PA	15122
Community Care, Inc.	1150 Washington Road, Suite 205	Washington	PA	15301
Concerned Care, Inc.	1121 Boyce Road, Suite 2700-A	Pittsburgh	PA	15241
The Cedars	4328 Northern Pike	Monroeville	PA	15146
Jewish Family,Children Srvcs	5743 Bartlett Street	Pittsburgh	PA	15217
Family Hospice/Palliative Care	50 Moffet Street	Pittsburgh	PA	15243
Gateway Hospice	9380 McKnight Road, 201 Arcadia Court	Pittsburgh	PA	15237
Griswold Special Care	2339 Concord Street	Aliquippa	PA	15001
Granny Nannies	200 Main Street	Monongahela	PA	15063
Hands-2-Help	3075 Clairton Road, 3rd Floor, Century III Mall	Clairton	PA	15123
Vitas Innovative Hospice Care	235 Alpha Drive, Suite 101	Pittsburgh	PA	15238
Helping Hands Home Care	1003 Castle Shannon Boulevard	Pittsburgh	PA	15234
Home Instead Senior Care	3612 Main Street	Homestead	PA	15120
Home Instead Senior Care	2000 Oxford Drive, Suite 470	Bethel Park	PA	15102
HomeInstead	52 Murtland Avenue	Washington	PA	15300
Asera Care Hospice	300 Penn Center Boulevard, Suite 602	Pittsburgh	PA	15235
Heartland Home Health/Hospice	750 Holiday Drive, Plaza 9	Pittsburgh	PA	15220
Comfort Keepers	5824 Brownsville Road	Pittsburgh	PA	15236
Liken Home Care, Inc.	400 Penn Center Boulevard, Suite 100	Pittsburgh	PA	15235
Maxim Healthcare Services	1501 Reedsdale Street	Pittsburgh	PA	15233
Medi-Home Health Agency	1123 Vance Avenue	Corapolis	PA	15108
Nursefinders	510 E. Main Street	Carnegie	PA	15106
Nightingale Home Healthcare	2790 Mosside Boulevard, Suite 235	Monroeville	PA	15146
Odyssey Hospice	190 Bilmar Drive	Pittsburgh	PA	15205
Loving Care Agency of Pittsburgh	875 Greentree Road, Building 3, Suite 325	Pittsburgh	PA	15220
Allegheny County Area Agency on Aging	441 Smithfield Street	Pittsburgh	PA	15222
PRN Health Service, Inc.	573 Braddoc Avenue	East Pittsburgh	PA	15112
Renaissance Home Care, Inc.	1145 Bower Hill Road, Suite 201	Pittsburgh	PA	15243
New Steps Rehab	13898 Route 30	North Huntingdon	PA	15642
Right At Home	1514 Electric Avenue	East Pittsburgh	PA	15112
Senior Bridge	Seven Parkway Center, Suite 612	Pittsburgh	PA	15220
Care Registry	5645 Marlborough Road	Pittsburgh	PA	15217

Table 14. Jefferson Regional primary service area: Asset listing – table 2 of 6

Senior Services: Caregivers	Address	City	State	Zip
Sivitz Jewish Hospice	200 JHF Drive	Pittsburgh	PA	15217
Southwestern Pennsylvania AAA	Eastgate 8	Monessen	PA	15062
Superior Home Care, Inc	4304 Walnut Street, Suite A	Mckeesport	PA	15132
TCM Home Health	1050 Jefferson Avenue	Washington	PA	15301
Stay at Home Care	110 Youngstown Road	Lemont Furnace	PA	15456
Care Unlimited, Inc.	3288 Babcock Boulevard	Pittsburgh	PA	15237
UPMC/JR Home Health	800 Regis Avenue	Pittsburgh	PA	15236
Visiting Angels	332 W. Pike Street	McMurray	PA	15317
Visiting Angels Living Assistance Services	4146 Library Road, Suite 6	Pittsburgh	PA	15234
Westmoreland County AAA	100-B Seventh Street	Monessen	PA	15062
Dental Assistance	**Address**	**City**	**State**	**Zip**
AARP Dental Insurance Plan Delta Dental Insurance Company	PO Box 2059	Mechanicsburg	PA	17055
Dr. Hassan Bakri	1010 Greentree Road	Pittsburgh	PA	15220
Dental Society of Western PA	900 Cedar Avenue	Pittsburgh	PA	15212
University of Pittsburgh School of Dental Medicine	3501 Terrace Street	Pittsburgh	PA	15261
Donor Organizations	**Address**	**City**	**State**	**Zip**
Central Blood Bank	875 Greentree Road	Pittsburgh	PA	15220
Center for Organ Recovery	204 Sigma Drive	Pittsburgh	PA	15238
Food/Meal Services	**Address**	**City**	**State**	**Zip**
Allentown Center	631 Warrington Avenue	Pittsburgh	PA	15210
LifeSpan - Bridgeville Center	The Villa, 601 McMillen Street	Bridgeville	PA	15017
Lifespan - Steel Valley Center	530 Miller Avenue	Clairton	PA	15025
Lifespan - Hillsdale Avenue	1444 Hillsdale Avenue	Pittsburgh	PA	15216
Carrick Center	2019 Brownsville Road	Pittsburgh	PA	15210
Finleyville Area Food Pantry	3595 Washington Avenue	Eighty Four	PA	15330
Glassport Center	544 Monogahela Avenue	GlassPort	PA	15045
Hazelwood Senior Center	5344 Second Avenue	Pittsburgh	PA	15207
Hunger Services Network	204 37th Street	Pittsburgh	PA	15201
Lifespan - Heritage House Center	314 East Eight Avenue	Homestead	PA	15120
Lifespan - Homestead Park Center	4231 Shady Avenue	Homestead	PA	15120
Knoxville Center - Elder-Ado	320 Brownsville Road	Pittsburgh	PA	15210
LifeSpan - Leland Center	5230 Wolfe Road	Pittsburgh	PA	15236
Therese of Lisieux Church	1 St. Therese Court	Homestead	PA	15120
Mollies Meals	200 JHF Drive	Pittsburgh	PA	15217
Monogahela Center	102 West Main Street	Monongahela	PA	15063
North Hills Community Outreach	100 S. Jackson Avenue, 6 East	Pittsburgh	PA	15202
Lifespan - Oakdale Center	104 Seminary Road, PO Box 25	Oakdale	PA	15071
Allegheny County Area Agency on Aging	441 Smithfield Street	Pittsburgh	PA	15222
Rainbow Kitchen	135 East Ninth Avenue	Homestead	PA	15120
Seton Center	1900 Pioneer Avenue	Pittsburgh	PA	15226
LifeSpan - Bethel Park Center	5151 Park Avenue	Bethel Park	PA	15102
St. Elizabeth Church	Cloverleaf Area Ecumenicial Assistance Program, Grove Place	Pittsburgh	PA	15236
SouthHills Interfaith Ministry	5301 Port Avenue	Bethel Park	PA	15102
Southside Center	12th and Bingham Streets	Pittsburgh	PA	15203
Southwestern Pennsylvania AAA	305 Chamber Plaza	N. Charleroi	PA	15022
Lifespan - Chartiers Center	300 Lincoln Avenue	Carnegie	PA	15106
Food Stamps	**Address**	**City**	**State**	**Zip**
Public Welfare Department Allegheny County Assistance Office	300 Liberty Avenue, Room 301-A	Pittsburgh	PA	15222

Table 15. Jefferson Regional primary service area: Asset listing – table 3 of 6

Educational Programs	Address	City	State	Zip
AARP Driver Saftey Program	South Hills Medical Building, Suite 107	Clairton	PA	15025
Personal Nutrition Coaching	712 Clairton Boulevard	Pittsburgh	PA	15236
Sleep Disorder Center	3720 Brownsville Road	Pittsburgh	PA	15227
Silver Scholars	380 Carmel Drive	Upper St Clair	PA	15241
The Woman's Diagnostic Center	575 Coal Valley Road, Suite 309	Clairton	PA	15025
Wellness Center JRMC	712 Clairton Boulevard	Pittsburgh	PA	15236
Exercise Programs	**Address**	**City**	**State**	**Zip**
Arthritis Foundation of WPA	100 W. Station Square Drive, Suite 1950	Pittsburgh	PA	15219
Center in the Woods ADC	130 California Road	Brownsville	PA	15417
Chartiers Resource Center	300 Lincoln Avenue	Carnegie	PA	15106
Schenly Gardens	3890 Bigelow Boulevard, Level G4	Pittsburgh	PA	15213
Silver Sneakers Healthrax Fit and Wellness	1000 Higbee Drive	Bethel Park	PA	15102
Silver Sneakers Carnegie Library of Homestead	510 10th Avenue	Homestead	PA	15120
Physical and Aquatic Therapy	550 Coal Valley Road	Pittsburgh	PA	15236
Silver Sneakers Lifeforce Fitness Center	270 Curry Hollow Road	Pittsburgh	PA	15236
Silver Sneakers Bally Total Fitness	3000 Oxford Drive	Bethel Park	PA	15102
Silver Sneakers Fitness 247	2260 Lebanon Church Road	West Mifflin	PA	15122
St. Valentine Church	2730 Ohio Street	Bethel Park	PA	15102
Westmoreland County AAA	100-B Seventh Street	Monessen	PA	15062
Mobile Diagnostic Testing	**Address**	**City**	**State**	**Zip**
Jefferson Mobile Laboratory	565 Coal Valley Road	Pittsburgh	PA	15236
Phlebotomy Home Draws	701 Wylie Avenue	Jeanette	PA	15644
Tri-State Mobile X-Ray	4684 Clairton Boulevard	Pittsburgh	PA	15236
Personal Response System	**Address**	**City**	**State**	**Zip**
Automated Security Alert	3500 Main Street, Munhall	Homestead	PA	15120
The Caring Mission	554 Washington Avenue	Carnegie	PA	15106
Elder Alert	5743 Bartlett Street	Pittsburgh	PA	15217
Link to Life	297 North Street	Pittsfield	PA	01201
Philips Lifeline Systems Inc. Personal Response and Support Services	PO Box 139	Wexford	PA	15090
Medical Equipment	**Address**	**City**	**State**	**Zip**
Aardvark Adaptive Modification	18 First Street	Pittsburgh	PA	15215
Able Mobility Center	7857 Steubenville Pike	Oakdale	PA	15071
Apria Healthcare	250 Technology Drive	McMurray	PA	15317
BLACKBURN'S	301 Corbet Street	Tarentum	PA	15084
Barrier Free Stairlifts	275 Curry Hollow Road	Pittsburgh	PA	15236
Three Rivers Center for Independent Living	900 Rebecca Avenue	Pittsburgh	PA	15221
Delatorre	575 Coal Valley Road, Suite 260	Pittsburgh	PA	15236
Get Up and Go Mobility	3526 Marion Avenue	Finleyville	PA	15332
Health Care Solutions	3411 5th Avenue	North Versailles	PA	15137
Hiland Presbyterian Church	845 Perry Highway	Pittsburgh	PA	15229
UPMC Home Medical Equipment	1370 Beulah Road	Pittsburgh	PA	15235
Neighbor Care	501 Parkway View Drive	Pittsburgh	PA	15205
South Minister Presbyterian Church Personal Assistance Equipment Lending Library	799 Washington Road	Pittsburgh	PA	15205

Table 16. Jefferson Regional primary service area: Asset listing – table 4 of 6

Mental Health Services	Address	City	State	Zip
Allegheny County Behavioral Health	Human Services Building, One Smithfield Street, Suite 300	Pittsburgh	PA	15222
Chartiers Community MH/MR Center	437 Railroad Street	Bridgeville	PA	15017
Counseling Center Caste Villiage Mall - M123	5301 Grove Road	Pittsburgh	PA	15236
Chestnut Ridge Counseling	100 New Salem Road	Uniontown	PA	15401
Mental Health Therapist	565 Coal Valley Road	Pittsburgh	PA	315236
Mon Yough Community Services	500 Walnut Street, 3rd Floor	Mckeesport	PA	15132
National Alliance/Mentally Ill	2149 N 2nd Street	Harrisburg	PA	17110
Center for Hearing and Deaf Services	1945 Fifth Avenue	Pittsburgh	PA	15219
Late Life Depression Prgm-UPMC	100 North Bellefield Street	Pittsburgh	PA	15213
Western Psych Institution and Clinic	3811 O'Hara Street	Pittsburgh	PA	15213
Southwestern Pennsylvania Behavioral Health	2 Eastgate Avenue, Suite 102	Monessen	PA	15062
Pharmaceutical Services	**Address**	**City**	**State**	**Zip**
American Cancer Society Western Region	320 Bilmar Drive	Pittsburgh	PA	15205
Consumer Health Coalition	650 Smithfield Street, Suite 2130	Pittsburgh	PA	15222
PACE	PO Box 8806	Pittsburgh	PA	17105
Pennsylvania Patient Assistance Program (PAP)	4000 Crums Mills Road	Harrisburg	PA	17112
RX Blue Star Solutions	107 George Road	Evans City	PA	16033
Physician Medicine Assistance Program Family Professional Center PC	330 Curry Hollow Road	Pittsburgh	PA	15236
Rx Saver Senior Support Program	PO Box 41161	Houston	PA	77241
Veterans Affairs, U.S. Department of Veterans Affairs	1000 Liberty Avenue	Pittsburgh	PA	15222
Support Groups	**Address**	**City**	**State**	**Zip**
Arden Courts Alzheimer's Assisted Living	380 Wray Large Road	Clairton	PA	15025
A1-Anon	Jefferson Hospital	Pittsburgh	PA	15236
Alcoholics Anonymous	J Café, 2nd Floor JRMC	Pittsburgh	PA	15236
Alzheimer's Association	1100 Liberty Avenue, Suite E201	Pittsburgh	PA	15219
American Cancer Society Southwest Region	320 Bilmar Drive	Pittsburgh	PA	15205
Arthritis Foundation of Western Pennsylvania	100 W. Station Square Drive, Suite 1950	Pittsburgh	PA	15219
Center In the Woods	130 California Rd	Brownsville	PA	15417
Cancer Caring Center	4117 Liberty Avenue	Pittsburgh	PA	15224
Compassionate Friends	PO Box 17388	Pittsburh	PA	15235
Cancer Support Group	565 Coal Valley Road	Pittsburgh	PA	15236
Family Hospice/Palliative Care	50 Moffet Street	Pittsburgh	PA	15243
Good Grief Center	2717 Murray Avenue	Pittsburgh	PA	15217
Jewish Family/Children Services	5743 Bartlett Street	Pittsburgh	PA	15217
Lupus Foundation of Pennsylvania	Landmark Building, Suite 1920, 100 West Station Square Drive	Pittsburgh	PA	15219
St. Margaret Geriatric Care Center	815 Freeport Road	Pittsburgh	PA	15215
Multiple Sclerosis Service Society	4638 Center Ave	Pittsburgh	PA	15213
National Kidney Foundation	109 Forbes Avenue, Suite 101	Pittsburgh	PA	15219
Narcotics Anonymous	PO Box 2902	Pittsburgh	PA	15230
Obsessive Compulsiveness Anonymous	None Available	Clairton	PA	15025
PALS Program	120 Fifth Avenue, Suite P5501	Pittsburgh	PA	15222
Pleasant Hills Presbyterian Community Church	199 Old Clairton Road	Pittsburgh	PA	15236
The Pines of Mt. Lebanon	1537 Washington Road	Pittsburgh	PA	15228

Table 17. Jefferson Regional primary service area: Asset listing – table 5 of 6

Support Groups	Address	City	State	Zip
Prime Time Adult Day Care Christ United Methodist Church	44 Highland Road, Room F101	Bethel Park	PA	15102
Self Help Group Network	1250 Penn Avenue, PO Box 735	Pittsburgh	PA	15222
Slater Funeral Home Bereavement Aftercare Program	4201 Brownsille Road	Pittsburgh	PA	15227
Stroke Survivor Connection	JRMC, 565 Coal Valley Road	Jefferson Hills	PA	15025
Center For Victims Crime	5916 Penn Avenue	Pittsburgh	PA	15206
Woodcliffe Manor	5347 Brightwood Road	Bethel Park	PA	15102
Woodside Place	1215 Hulton Road	Oakmont	PA	15139
Social Services Agencies	**Address**	**City**	**State**	**Zip**
Southwestern Pennsylvania AAA	305 Chamber Plaza	Charleroi	PA	15022
Catholic Long Term Care Network	5300 Stanton Avenue	Pittsburgh	PA	15206
Southwestern Pennsylvania Human Services	301 Chamber Plaza	Charleroi	PA	15022
Three Rivers Center for Independent Living	900 Rebecca Avenue	Pittsburgh	PA	15221
United Cerebral Palsy	4638 Centre	Pittsburgh	PA	15213
Community Life	2400 Ardmore Boulevard, Suite 700	Pittsburgh	PA	15221
Easter Area Adult Service	901 West Street	Pittsburgh	PA	15221
AgeWell Pittsburgh	200 JHF Drive	Pittsburgh	PA	15217
Easter Seal Society	2525 Railroad Street	Pittsburgh	PA	15222
Goodwill Industries of Pittsburgh	2600 East Carson Street	Pittsburgh	PA	15203
Hill House Association	2038 Bedford Avenue	Pittsburgh	PA	15219
Jefferson Hospital Case Management Department (JRMC Social Services)	565 Coal Valley Road	Pittsburgh	PA	15236
Northern Area Multi Services	209 13th Street	Pittsburgh	PA	15215
LifeSpan	314 East Eighth Avenue	Homestead	PA	15120
Allegheny County Area Agency on Aging	441 Smithfield Street	Pittsburgh	PA	15222
Institute on Aging	200 Lothrop Street	Pittsburgh	PA	15213
Ursuline Senior Services Inc	2717 Murray Avenue	Pittsburgh	PA	15217
United Way Of Allegheny County	1250 Penn Avenue	Pittsburgh	PA	15222
Westmoreland County AAA	100-B Seventh Street	Monessen	PA	15062
CheckMates	345 Kane Blvd	Pittsburgh	PA	15243
Carrier Alert	441 Smithfield Street	Pittsburgh	PA	15222
Carrick Center (Elder Care)	2019 Brownsville Road	Pittsburgh	PA	15210
Family Services of Western PA	6401 Penn Avenue, 4th floor	Pittsburgh	PA	15206
PALS Program	120 Fifth Avenue, Suite P5501	Pittsburgh	PA	15222
Rec Centers	**Address**	**City**	**State**	**Zip**
Allentown Center	631 Warrington Avenue	Pittsburgh	PA	15210
Beltzhoover Center	900 Delmont Avenue	Pittsburgh	PA	15210
LifeSpan - Boston Commons	5739 Smithfield Street	Mckeesport	PA	15135
LifeSpan - Bridgeville Center	601 McMillen Street	Bridgeville	PA	15017
Lifespan - Steel Valley Center	530 Miller Avenue	Clairton	PA	15025
Century Extenstion Program	Centry III Mall by Dicks	West Mifflin	PA	15122
Riverside Place - Charlero Senior Center	303 Chamber Place	Charleroi	PA	15022
LifeSpan - Hillsdale Center	1444 Hillsdale Avenue	Pittsburgh	PA	15216
Elderberry Junction	118 52nd Street	Pittsburgh	PA	15201
Elder-Aldo - Mt. Oliver	320 Brownsville Road	Pittsburgh	PA	15210
Elder-Ado	2019 Brownsville Road	Pittsburgh	PA	15210
Hazelwood Senior Center	5344 Second Avenue	Pittsburgh	PA	15207

Table 18. Jefferson Regional primary service area: Asset listing – table 6 of 6

Rec Centers	Address	City	State	Zip
Lifespan - Heritage House Center	314 East Eight Avenue	Homestead	PA	15120
Lifespan - Homestead Park Center	4231 Shady Avenue	Homestead	PA	15120
Knoxville Center	320 Brownsville Road	Pittsburgh	PA	15210
Lifespan - Leland Center	5230 Wolfe Road	Pittsburgh	PA	15236
Monogahela Center	102 West Main Street	Monongahela	PA	15063
Allegheny County Area Agency on Aging	441 Smithfield Street	Pittsburgh	PA	15222
Pleasant Hills Center	400 Bruceton Road	Pittsburgh	PA	15236
LifeSpan - Bethel Park Center	5151 Park Avenue	Bethel Park	PA	15102
Seton Senior Center	1900 Pioneer Avenue	Pittsburgh	PA	15226
Southwestern Pennsylvania AAA	305 Chamber Plaza	Charleroi	PA	15022
New Traditions	624 Lysle Boulevard	Mckeesport	PA	15132
Westmoreland County AAA	100 - B Seventh Street	Monessen	PA	15062
West Mifflin Community Professional Extension	3000 Lebanon Church Road	West Mifflin	PA	15122
Telephone Reassurance	**Address**	**City**	**State**	**Zip**
Always Best Care	37 McMurray Road	Pittsburgh	PA	15241

Demographic Conclusions

A number of conclusions can be drawn from the demographic data. They include:

- From the 1990 to 2001 census the population of the Primary Service Area has steadily declined and the 2017 projection shows this trend continuing.
- The Primary Service Area and BRFSS respondents were very similar in terms of gender, with a slightly higher percentage of females.
- The majority, 40.4 percent for the service area, and 47.6 percent of the 2012 BRFSS respondents are between the ages of 25-54.
- The Primary Service Area and BRFSS respondents, while predominately white, had a similar population of African Americans at 10.8 percent and 8.3%, respectively.
- The Primary Service Area and BRFSS respondents were similar in terms of income, with 57.7 percent of the Service Area earning under $50,000 and 51.0 percent of the BRFSS Respondents.
- The Primary Service Area and BRFSS respondents were similar in terms of education, with 39.6 percent of the Service Area having a high school education, and 22.3 percent having at least four years of college, 32.5 percent and 29.5 percent for the BRFSS respondents.
- In the Primary Service Area, 47.0 percent were married, while the percentage for BRFSS respondents was 52.3 percent.
- In the Primary Service Area, 44.0 percent were employed, while the percentage for BRFSS respondents was 44.0 percent.
- The majority (32.6 percent) of the service area population average travel time to work was 15-29 minutes, while 8.4 percent needed to travel 60 minutes or more.

This page is intentionally blank

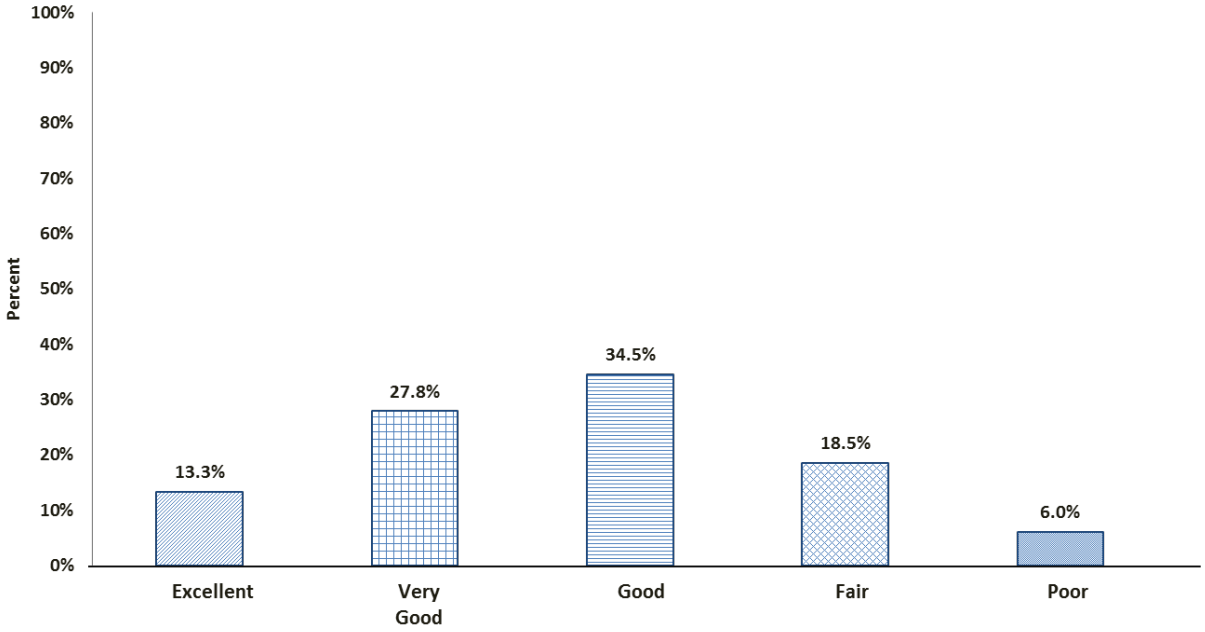
Access to Quality Health Care

Access to Quality Health Care

Access to comprehensive, quality healthcare is important for the achievement of health equity and for improving the quality of life for everyone in the community. Access related topics include: health statues, physical health, health insurance, healthcare provider, routine checkups, healthcare cost, mammogram screenings, health literacy, transportation and inpatient and emergency department ambulatory care-sensitive conditions (ACSC) utilization. When available for a given health indicator, Healthy People 2020 (HP 2020) goals and state and national rates were included.

Figure 21 illustrates the respondent's health from the 2012 Service Area BRFSS when asked how they would rate their general health. The majority (34.5 percent) felt that they were in good health. A small percentage rated their health as poor (6.0 percent).

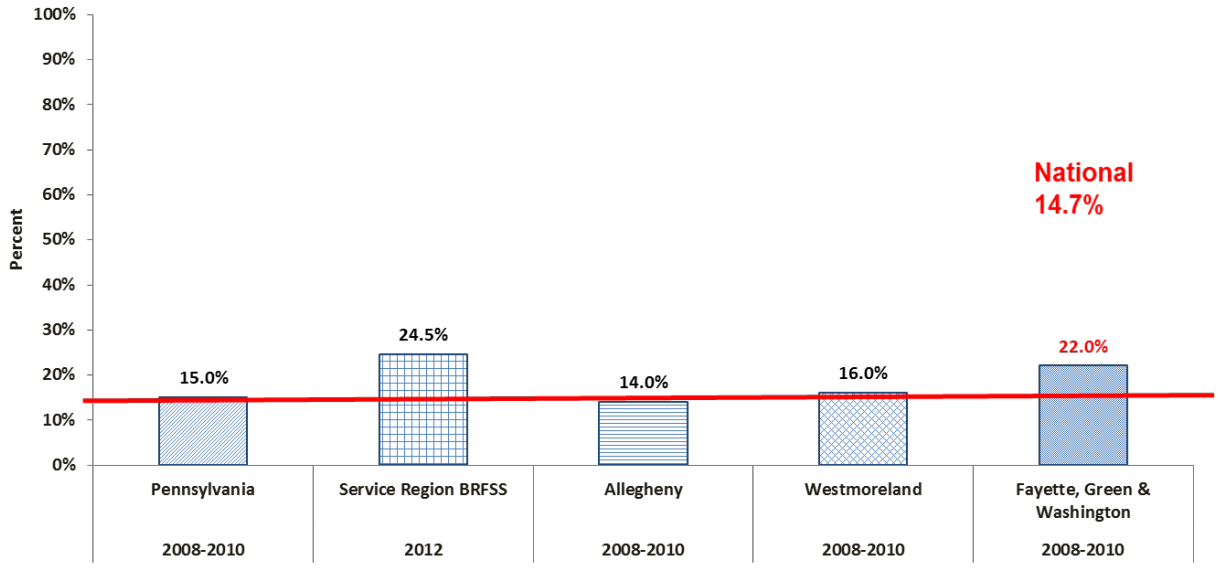
Figure 21: 2012 BRFSS: How would you rate your general health



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 22 illustrates the percentage of adults from the 2012 Service Area BRFSS who reported poor or fair health in the United States, the Commonwealth of Pennsylvania and throughout the counties of the service area for the years 2008 through 2010. The service area rates ranged from 14.0 percent to 22.0 percent. Fayette, Greene and Washington counties had rates that were significantly higher than the state rate at 15.0 percent. Allegheny County had rates (14.0) that were lower than both the state and national rates.

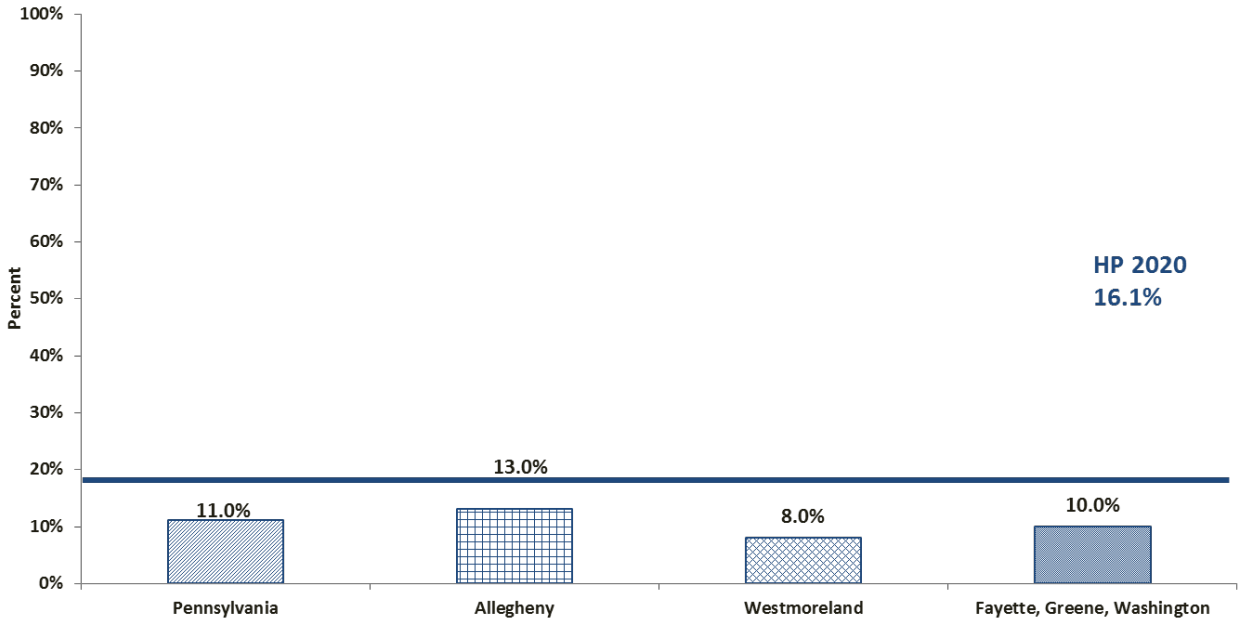
Figure 22: 2012 BRFSS: Percentage of individuals who described their general health as either fair or poor



Source: Pennsylvania Department of Health, Centers for Disease Control, 2012 Jefferson Regional Medical Center BRFSS

Figure 23 illustrates the percentage of adults age 18 and older who reported not having a personal healthcare provider in the Commonwealth of Pennsylvania, as well as throughout the counties of the service region. The rates range between 8.0 percent in Westmoreland County to 13.0 percent in Allegheny County. Overall, county-level data was comparable to the state and less than the HP 2020 goal of 16.1 percent.

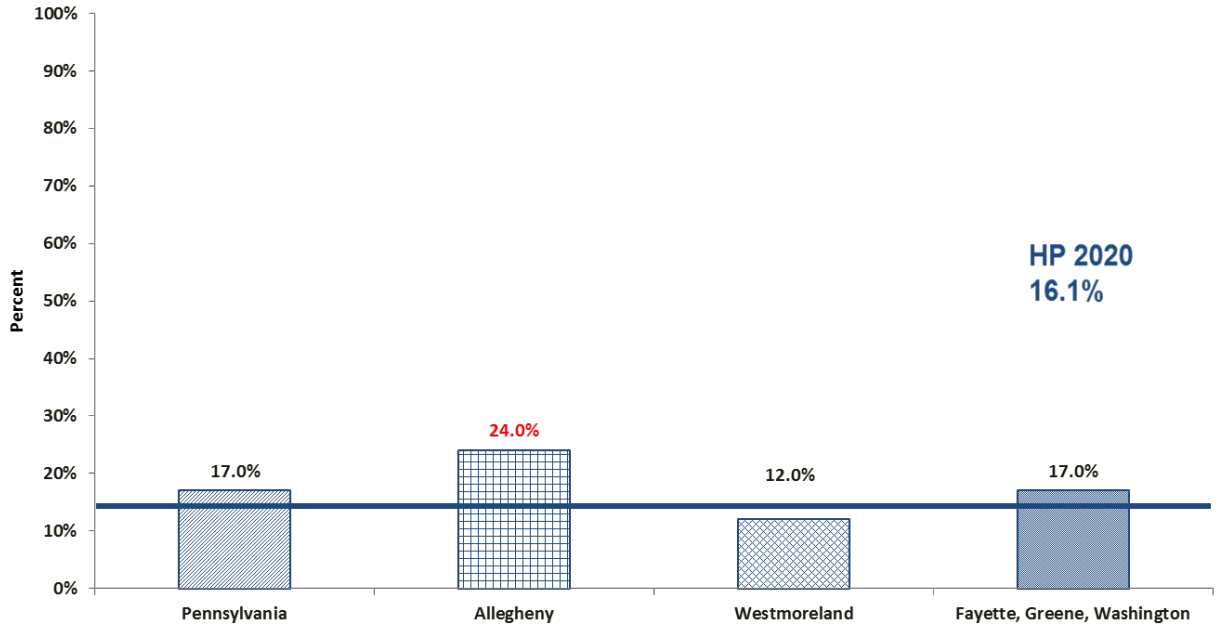
Figure 23: Percentage of all adults age 18 and older who reported not having a personal healthcare provider



Source: Pennsylvania Department of Health, www.healthypeople.gov

Figure 24 illustrates the percentage of adults age 18 to 44 who reported not having a personal healthcare provider in the Commonwealth of Pennsylvania as well as throughout the counties of the service region. A significantly higher percentage (24.0 percent) of adults ages 18 to 44 in Allegheny County do not have a personal healthcare provider. The rate in Westmoreland County (12.0 percent) was less than the state, while the other counties were comparable to the state rate. Every county was higher than the Healthy People 2020 goal of 16.1 percent, with the exception of Westmoreland County.

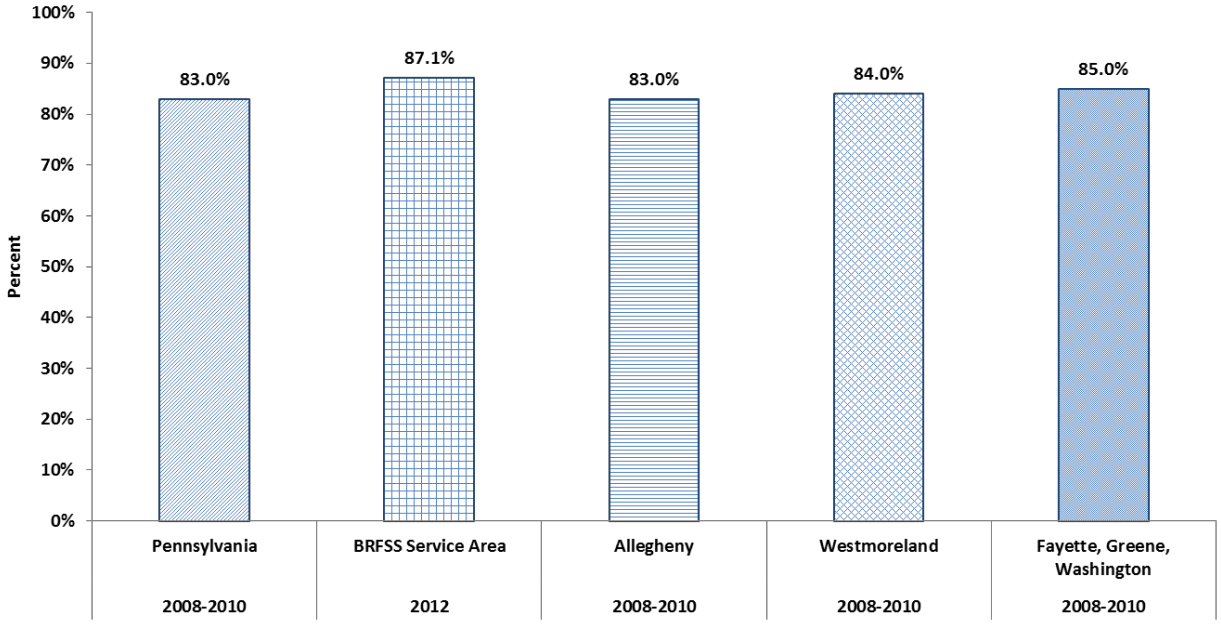
Figure 24. BRFSS-Percent of adults age 18-44 who reported no personal healthcare provider



Source: Pennsylvania Department of Health, www.healthypeople.gov

Figure 25 illustrates the percentage of adults age 18 and older who had a routine check-up in the past two years in the Commonwealth of Pennsylvania, the service area and throughout the counties of the service region. A vast majority of respondents had a routine check-up in the past two years (ranging between 80.0 and 85.0 percent). The county-level and service area rates are comparable to the state.

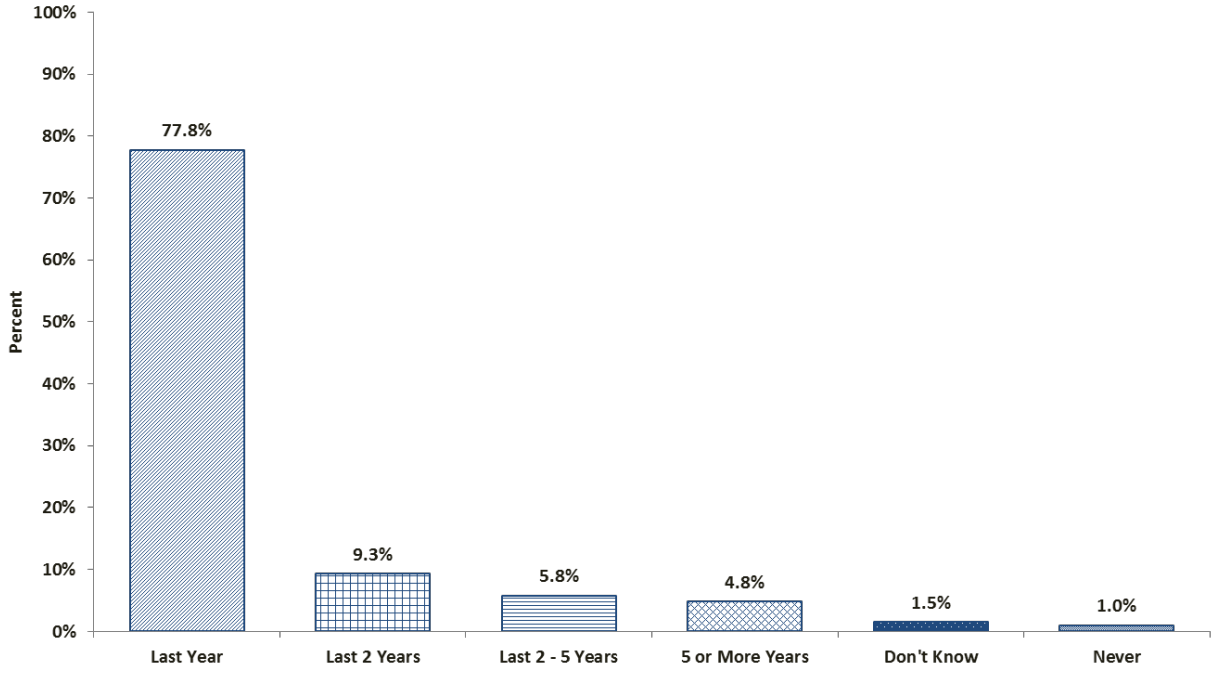
Figure 25. Percentage of adults age 18 and older who had a routine check up in the past two years 2008-2010



Source: Pennsylvania Department of Health, 2012 Jefferson Regional Medical Center BRFSS

Figure 26 illustrates the percentage of adults who had had routine check-ups and how long ago they had them from the 2012 Service Area BRFSS. The majority of respondents had a check-up in the last year (77.8 percent), while about 10 percent had not had one for two years or more.

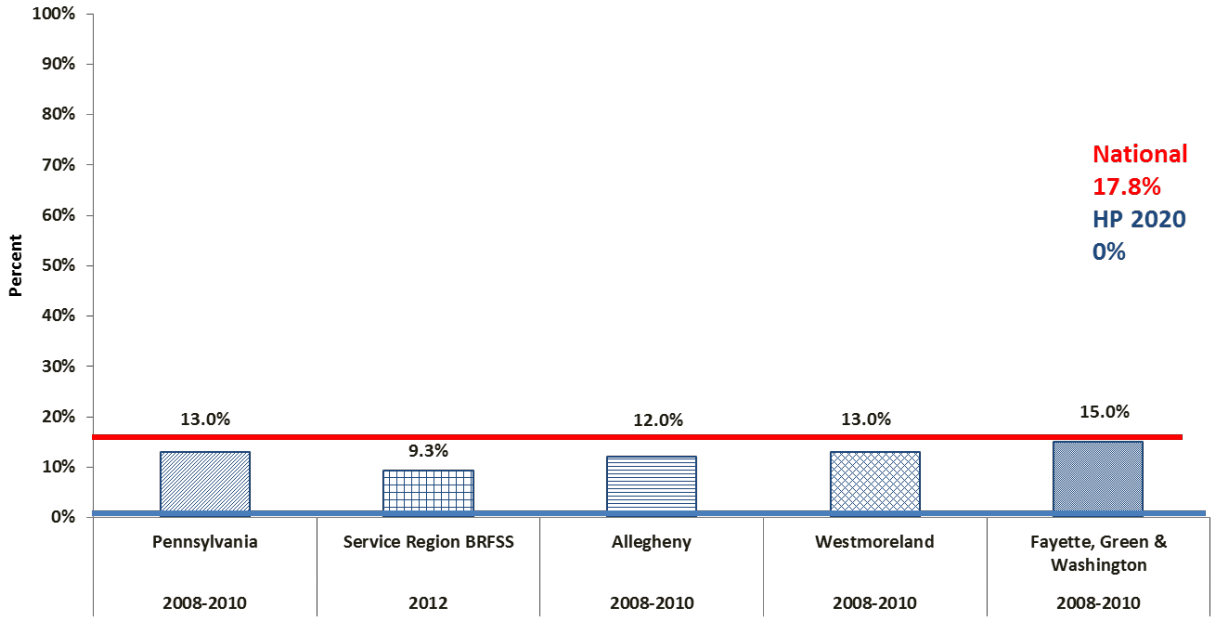
Figure 26: 2012 BRFSS Respondents time since last routine check-up



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 27 illustrates the percentage of adults age 18 through 64 who reported no health insurance in the United States, the Commonwealth of Pennsylvania, the service area and throughout the counties of the service region from 2008 through 2010. County level rates were comparable to the state rate, ranging between 12.0 and 15.0 percent, but lower than the national rate of 17.8 percent. When looking at the service region, state and national percentage of adults who reported no health insurance, the state and all counties in the service area are all above the Healthy People 2020 goal of 0 percent.

Figure 27: BRFSS-Percentage of adults who reported no health insurance ages 18 through 64



Source: Pennsylvania Department of Health, Centers for Disease Control, 2012 Jefferson Regional Medical Center BRFSS

Table 19 outlines the respondents' reasons for not having health insurance from the 2012 Service Area BRFSS. Most respondents did not have insurance due to losing a job or changing employers (3.8 percent), while others could not afford to pay the premiums (2.8 percent).

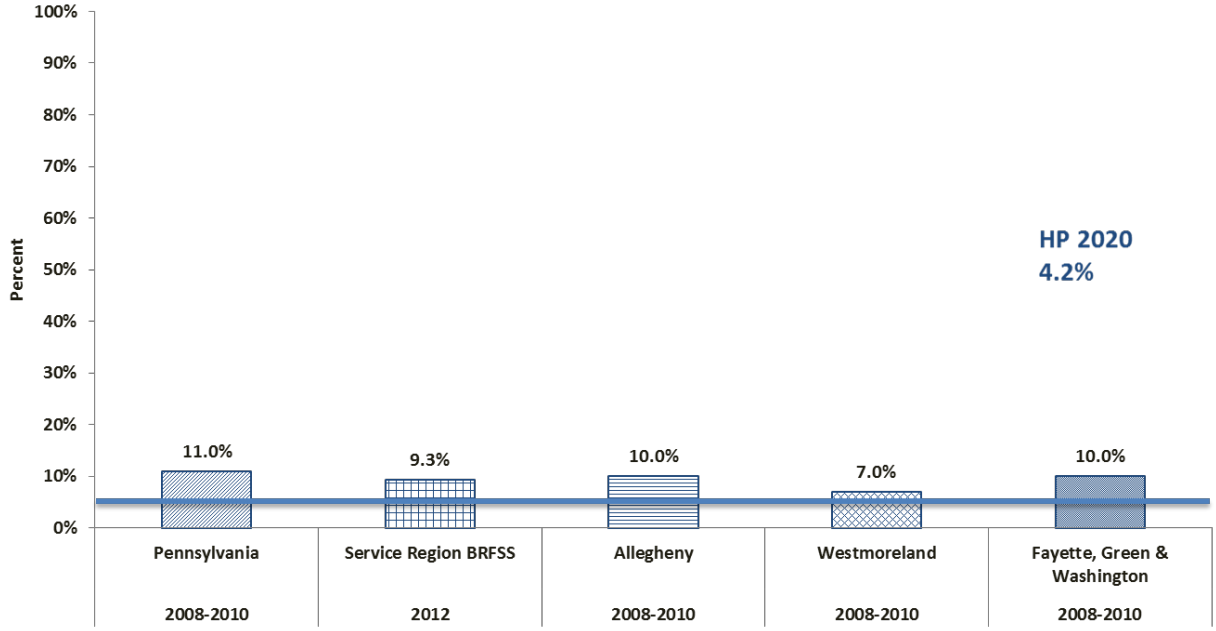
Table 19: 2012 BRFSS: Reasons for not having health insurance

Reason	Frequency	Percent of Those Without Insurance
Lost job or changed employers	15	3.8%
Spouse or parent lost job or changed employers	1	0.3%
Became divorced or separated	1	0.3%
Became ineligible because of age or because left school	2	0.5%
Employer doesn't offer or stopped offering coverage	3	0.8%
Benefits from employer or former employer ran out	1	0.3%
Couldn't afford to pay the premiums	11	2.8%
Lost Medicaid or medical assistance eligibility	3	0.3%
Refused	1	0.3%
Total	38	9.5%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 28 illustrates the percentage of respondents in the last twelve months who have needed to see a doctor, but could not due to insurance costs in the Commonwealth of Pennsylvania, the service area, and throughout the counties of the service region. In the service region, 9.3 percent of the respondents indicated that they needed to see a doctor but could not due to costs, which is lower than the state rate of 11.0 percent. The Commonwealth of Pennsylvania and all service area counties are above the Healthy People 2020 goal of 4.2 percent.

Figure 28: Adults who needed to see a doctor in the past year but could not due to cost



Source: Pennsylvania Department of Health, 2012 Jefferson Regional Medical Center BRFSS, www.healthypeople.gov

Table 20 illustrates the number of emergency department visits in the past 12 months reported by the respondents of the 2012 Service Area BRFSS. The majority (71.0 percent) never visited the emergency department in the last 12 months, while 19 percent visited once.

Table 20: 2012 BRFSS: Number of emergency department visits in the past 12 months

Number of Visits	Number of Responses	Percent
Never	287	71.0%
Once	77	19.3%
Twice	19	4.8%
Three Times	6	1.5%
Four Times	7	1.8%
Five Times	1	0.3%
Six Times	0	0.0%
Seven Times	1	0.3%
Eight Times	1	0.3%
Nine Times	0	0.0%
Ten Times	1	0.3%
Total	400	100.0%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 29 shows the number of respondents who could not take or fill their prescription medication in the last 12 months due to costs from the 2012 Service Area BRFSS. Most were able to fill their prescriptions without cost being an issue.

Figure 29. 2012 BRFSS-Cost of prescription medications

	Yes	No	Total
At any time during the last 12 months, were you unable to take any prescription medication as it was directed because of costs?	28	27	55
Was there a time in the past 12 months when you needed to fill a prescription but could not because of cost?	10	333	343
Total	38	360	398

Source: 2012 Jefferson Regional Medical Center BRFSS

Table 21 illustrates the length of time it took for the 2012 Service Area BRFSS respondents to make an urgent or routine appointment with the respondents' doctor. 34.0 percent were able to make an immediate appointment within the same day and 33.8 percent had an immediate appointment made within a week. 50.8 percent were able to have a routine appointment made within a week.

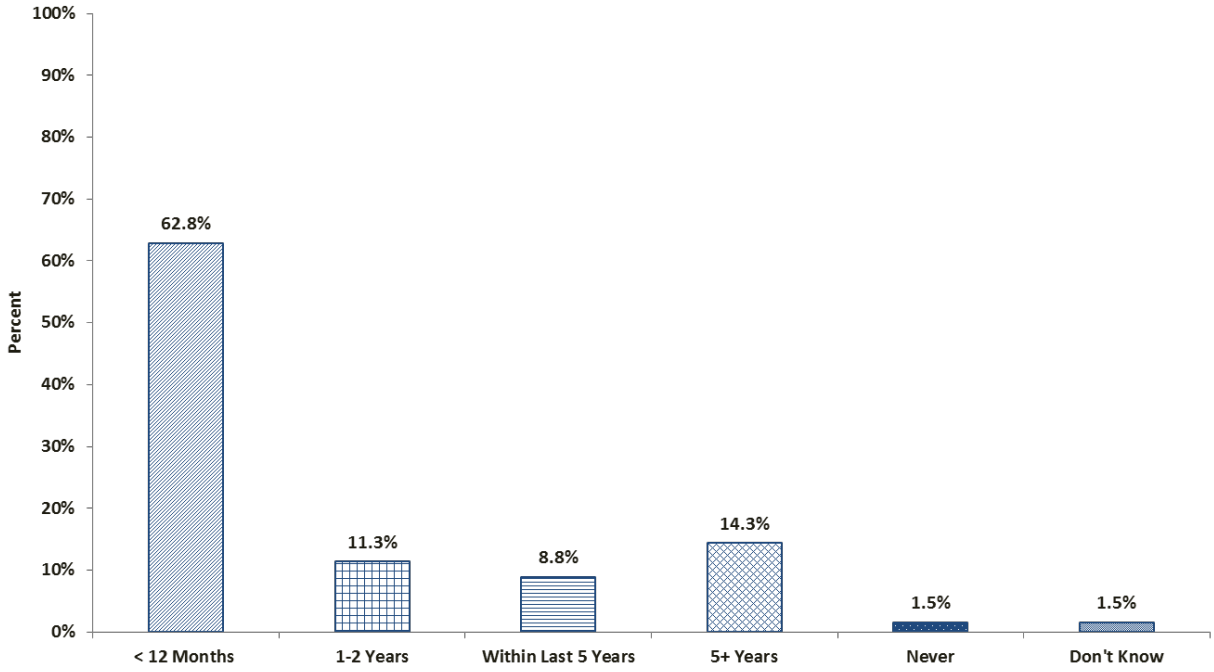
Table 21: 2012 BRFSS: Length of time it took to make an urgent or routine appointment with doctor

	Needed an Immediate Appointment		Needed a Routine Appointment	
	Number of responses	Percent	Number of Responses	Percent
Same day	136	34.0%	39	9.8%
Within a week	135	33.8%	203	50.8%
Other	41	10.3%	97	24.3%
Too long; I went somewhere else	8	2.0%	5	1.3%
Too long; I didn't get care	5	1.3%	3	0.8%
Don't Know/Not Sure	72	18.0%	53	13.3%
Refused	3	0.8%	0	0.0%
Total	400	100.0%	400	100.0%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 30 illustrates the responses related to the length of time since the respondents' last dental appointment from the 2012 Service Area BRFSS. The majority (62.8 percent) of respondents stated it had been less than twelve months since their last dental checkup. A sizable portion of the respondents (14.3 percent) indicated that it has been more than five years since they have seen a dentist.

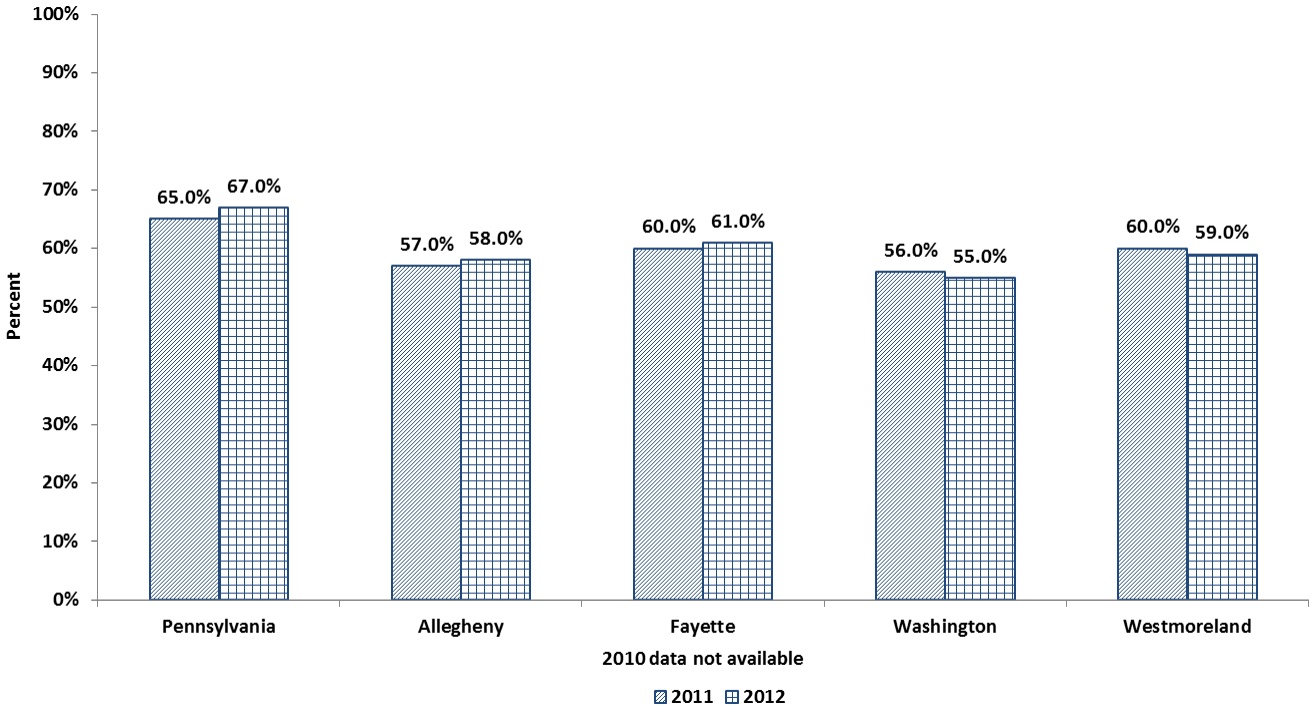
Figure 30: 2012 BRFSS: Time since last dental visit



Source: 2012 Jefferson Regional BRFSS

Figure 31 illustrates mammogram screenings in the Commonwealth of Pennsylvania and throughout the counties of the service region for the years 2011 and 2012. All county level rates are below the state percentages. No data was available for 2010.

Figure 31. Mammogram screenings



Source: www.countyhealthrankings.org

There are a number of ways in which health literacy is defined. In the fall of 2012, the University Center for Social and Urban Research at the University of Pittsburgh conducted a telephone study of the Southwest Pennsylvania region. The Health Literacy Survey of the Pittsburgh Metropolitan Statistical Area asked respondents how often they had difficulty reading and understanding healthcare information, as well as how confident they were filling out healthcare forms.

Figure 32 and 33 illustrate health literacy rates based on the difficulty of reading and understanding health information. A sizable portion (15.7 percent) of the respondents indicated that they have difficulty reading healthcare information at least sometimes, while 13.5 percent indicated that they have difficulty understanding health information at least sometimes.

Figure 32. Health literacy: Reading

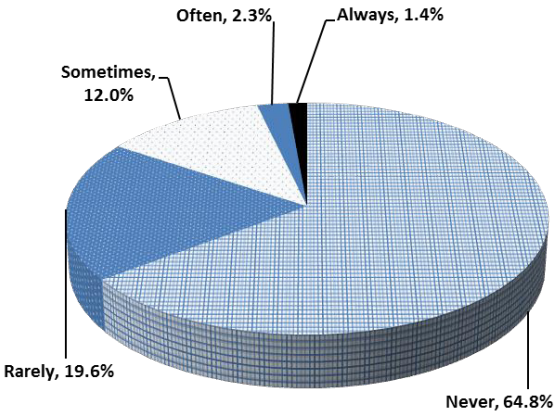
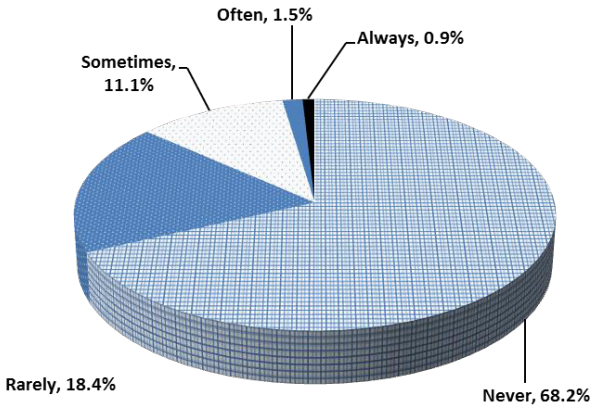


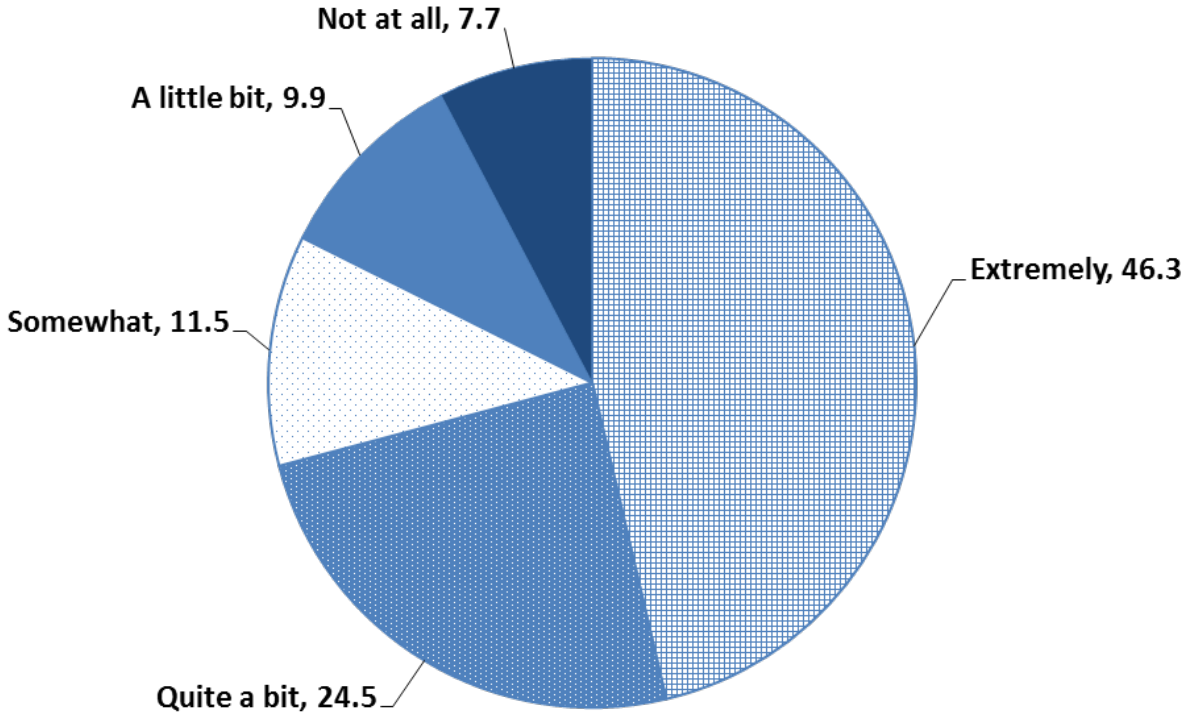
Figure 33. Health literacy: Understanding



Source: University of Pittsburgh University Center for Social & Urban Research. "Health Literacy Survey of the Pittsburgh Metropolitan Statistical Area." prepared for Regional Health Literacy Coalition, September 2012.

Figure 34 illustrates the level of which respondents are able to understand healthcare forms. Less than half of the respondents (46.3 percent) indicated that they were extremely confident filling out forms.

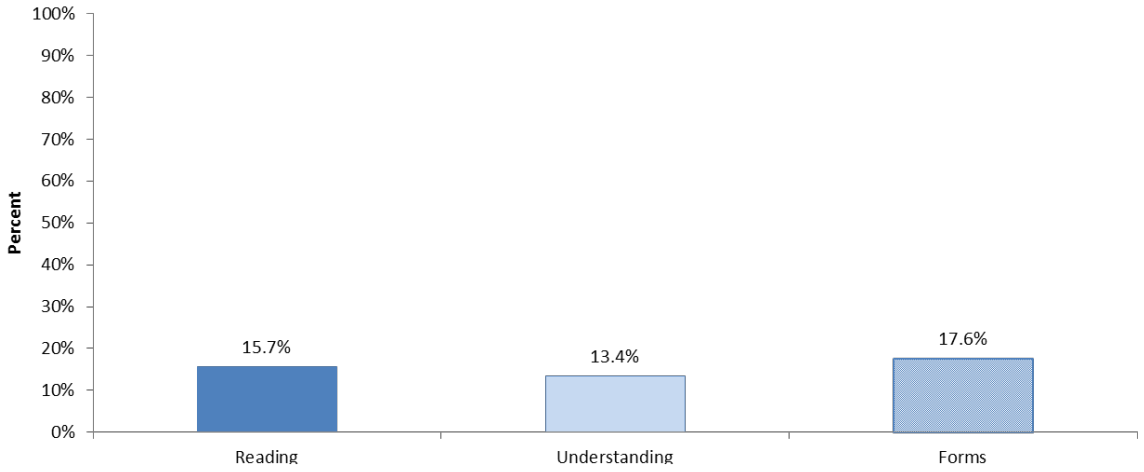
Figure 34. Health literacy: Forms



Source: University of Pittsburgh University Center for Social & Urban Research. "Health Literacy Survey of the Pittsburgh Metropolitan Statistical Area." prepared for Regional Health Literacy Coalition, September 2012.

Figure 35 summarizes the estimated low health literacy rates for the service region, depending on the definition for the overall service region.

Figure 35. Low health literacy rates



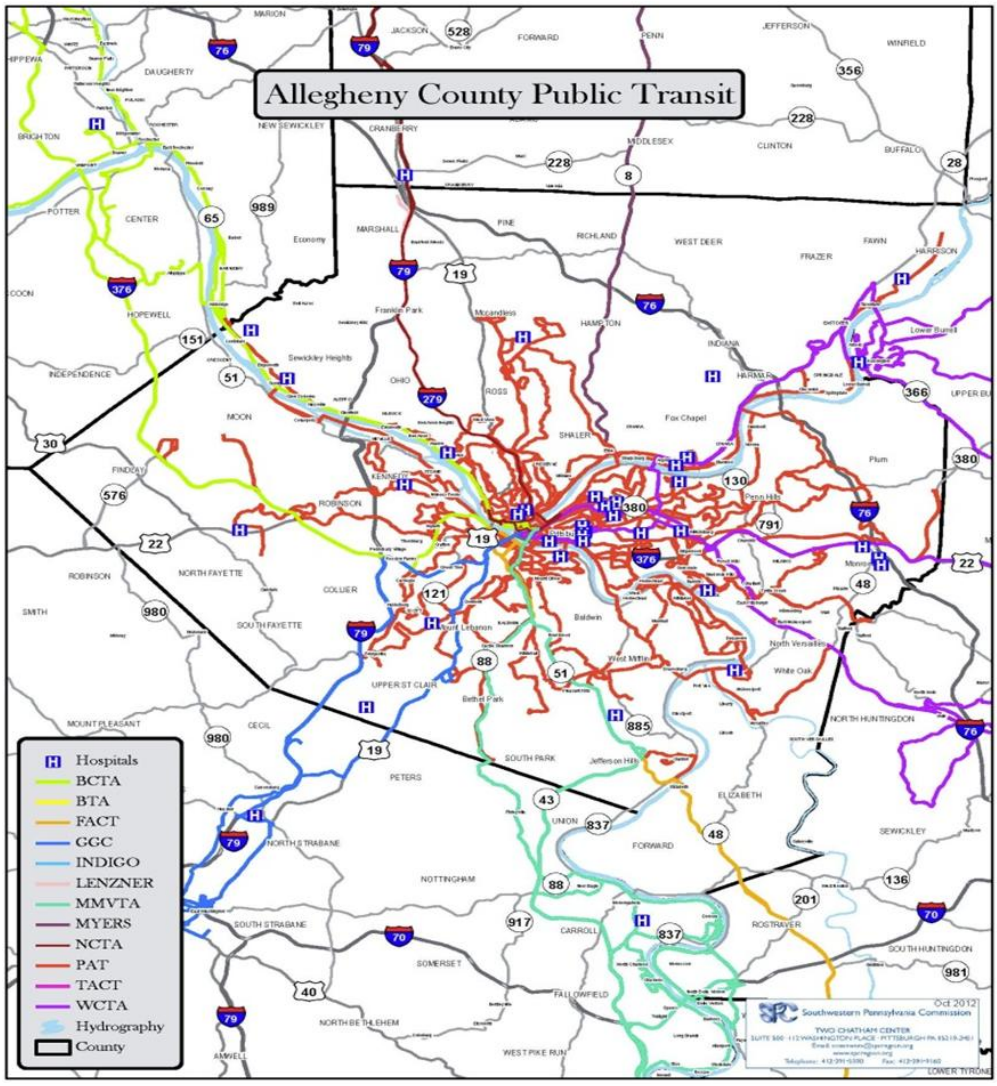
Source: University of Pittsburgh University Center for Social & Urban Research. "Health Literacy Survey of the Pittsburgh Metropolitan Statistical Area." prepared for Regional Health Literacy Coalition, September 2012.

The *Health Literacy Survey of the Pittsburgh Metropolitan Statistical Area* highlighted a number of key findings related to literacy rates. They include:

- The estimated prevalence of low health literacy in the Pittsburgh metropolitan statistical area (MSA) ranges from 13.4 to 17.6 percent, depending on which indicator is used.
- Slightly fewer respondents reported problems learning about medical conditions because of difficulty understanding written information; slightly more reported low confidence filling out medical forms by themselves.
- On the key single item literacy screener, 15.7 percent of Pittsburgh MSA residents reported needing someone to help read instructions, pamphlets, or other written material from doctors or pharmacies at least sometimes.
- Given a margin of error for this estimate of approximately +/- 3 percent and an adult population of the MSA of 1,881,314 (2010 Decennial Census), this represents an estimated 295,266 adults, with 95 percent confidence that the number lies somewhere between 238,926 and 351,806.
- Using the reading criterion, young people (18-29) had the highest rate of low health literacy.
- Males have higher rates of low health literacy.
- Those who were single/never married had the highest low health literacy rate.
- Hispanics had higher rates of low health literacy than non-Hispanics.
- Rates of low health literacy were significantly higher for non-whites using all three criteria.
- Those with lower socioeconomic status (less education, lower income, lack of employment) were much more likely to be classified as low healthy literacy.

Figure 36 illustrates the Allegheny County Public Transit System. While difficult to read, the series of public transit maps that follow illustrate that the fixed route public transportation system does not serve significant portions of Allegheny County and the surrounding counties.

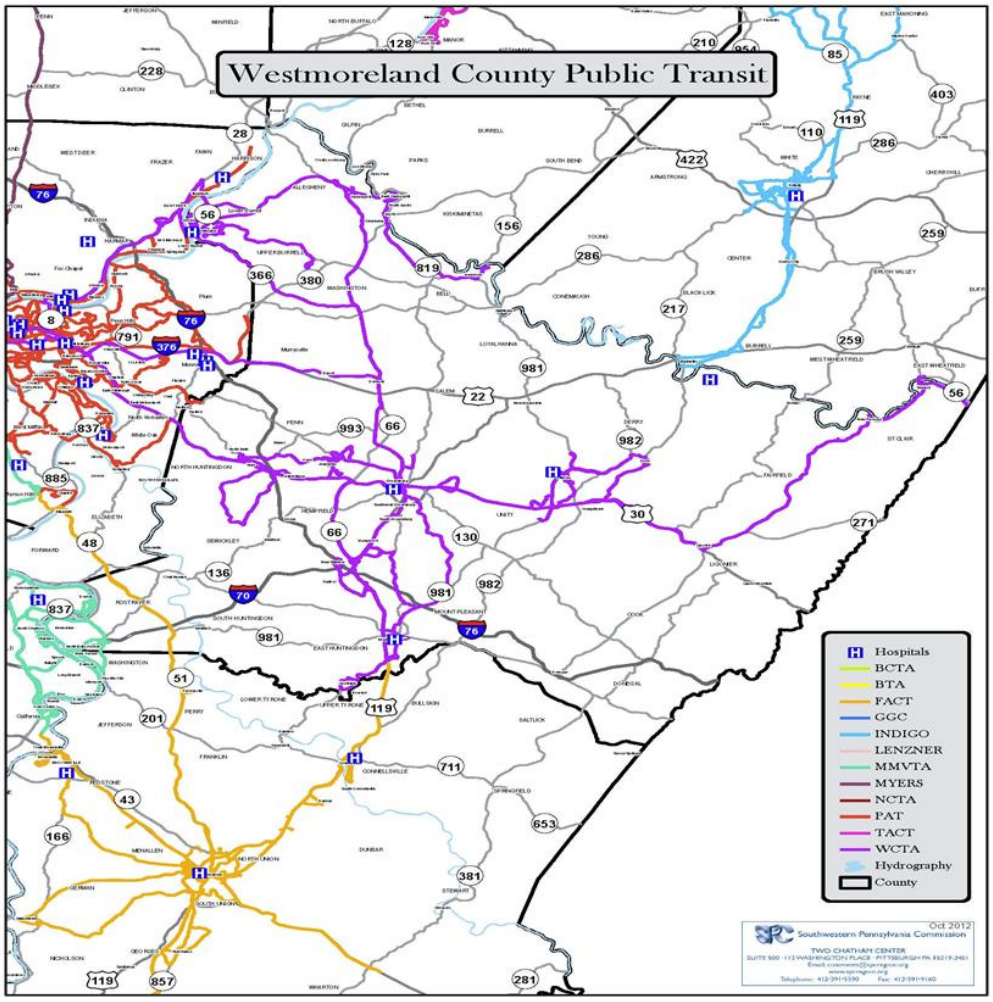
Figure 36. Allegheny county public transit



Source: Southwestern Pennsylvania Commission

Figure 37 illustrates the Westmoreland County public transit system.

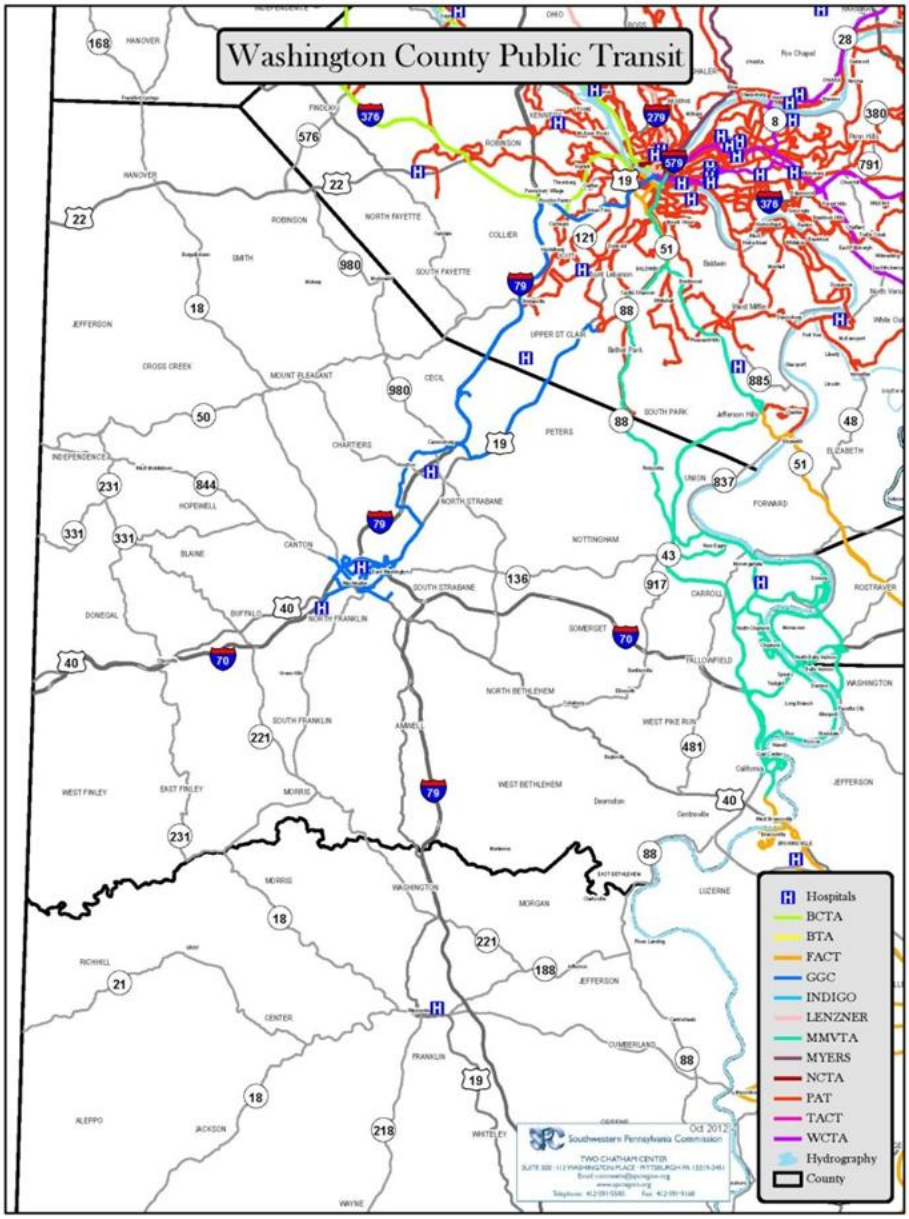
Figure 37. Westmoreland county public transit



Source: Southwestern Pennsylvania Commission

Figure 38 illustrates the Washington County public transit system.

Figure 38. Washington county public transit



Source: Southwestern Pennsylvania Commission

Table 22 outlines the overall number of cases and inpatient utilization rates for specific ambulatory care sensitive conditions. COPD, heart failure and pneumonia have higher rates of inpatient admission. COPD and pneumonia utilization rates have increased during the past three years while Heart Failure utilization rates have decreased.

Table 22: Inpatient utilization ambulatory care sensitive conditions

Inpatient Utilization	FISCAL YEAR CASE COUNT				Utilization Rate per 10,000		
DRG Type	2010	2011	2012	TOTAL	2010	2011	2012
Alcohol and Drug Abuse	87	98	74	259	3.2	3.6	2.7
Breast Cancer	21	19	26	66	0.8	0.7	1.0
Bronchitis and Asthma	295	257	212	764	11.0	9.5	7.9
Cancer	48	41	47	136	1.8	1.5	1.7
Heart Failure	688	674	552	1,914	25.5	25.0	20.5
COPD	878	871	892	2,641	32.6	32.3	33.1
Fractures	50	34	50	134	1.9	1.3	1.9
Hypertension	46	40	48	134	1.7	1.5	1.8
Pneumonia	476	532	573	1,581	17.7	19.8	21.3
Reproductive Disorders	7	6	4	17	0.3	0.2	0.1

Source: 2012 Jefferson Regional Medical Center

Table 23 outlines the overall number of Emergency Department cases for specific ambulatory care sensitive conditions. Overall, the number has been increasing throughout the past several years; these conditions should be managed outside of the acute care setting.

Table 23. Emergency department ambulatory care sensitive conditions

PREVENTABLE CONDITIONS [and ICD-9-CM CODES] (By Primary Diagnosis Unless Otherwise Noted)	FISCAL YEAR			YTD NOV
AVOIDABLE ILLNESSES	**2010**	**2011**	**2012**	**2013**
Congenital Syphilis [090]	0	0	0	0
Failure to thrive [783.41]	4	2	4	2
Dental Conditions [521-523, 525, 528]	156	153	154	67
Vaccine Preventable Conditions [032, 033, 037, 041.5, 045, 052.1, 052.9, 055-056, 070.0-070.3, 072, 320.2*, 320.3, 390, 391, 771.0]	4	2	6	3
Iron Deficiency Anemia [280.1, 280.8, 280.9]	266	599	515	224
Nutritional Deficiencies [260-262, 268.0, 268.1]	1	1	2	5
ACUTE CONDITIONS				
Bacterial Pneumonia [481, 482.2, 482.3, 482.9, 483, 485, 486]	432	480	571	368
Cancer of the Cervix [180.0-180.1, 180.8-180.9]	2	6	16	2
Cellulitis [681, 682, 683, 686]	2	10	15	4
Convulsions [780.3]	0	0	0	0
Dehydration - Volume Depletion [276.5]	0	0	0	0
Gastroenteritis [558.9]	552	589	553	159
Hypoglycemia [251.2]	24	52	33	19
Kidney/Urinary Infection [590.0, 599.0, 599.9]	1,571	2,416	2,431	1,115
Pelvic Inflammatory Disease [614]	0	0	0	0
Severe Ear, Nose, & Throat Infections [382*, 462, 463, 465, 472.1]	872	1,330	1,026	373
Skin Grafts with Cellulitis {DRGs: 263 & 264} For 2008: {DRGs: 573, 574, 575}	26	20	30	3
CHRONIC CONDITIONS				
Angina [411.1, 411.8, 413]	2	10	17	2
Asthma [493]	0	0	0	0
Chronic Obstructive Pulmonary Disease [466.0*, 491, 492, 494, 496]	2,319	2,416	2,486	1,200
Congestive Heart Failure [402.01, 402.11, 402.91, 428, 518.4]	2	3	5	1
Diabetes with ketoacidosis or hyperosmolar coma or other coma [250.1-250.33]	6	12	31	15
Diabetes with other specified or unspecified complications [250.8-250.93]	1,014	928	818	349
Diabetes mellitus without mention of complications or unspecified hypoglycemia [250-250.04]	4,159	9,323	10,266	4,284
Grand Mal & Other Epileptic Conditions [345]	0	0	0	0
Hypertension [401.0, 401.9, 402.00, 402.10, 402.90]	2,111	7,058	7,963	3,521
Tuberculosis (Non-Pulmonary) [012-018]	1	0	0	0
Pulmonary Tuberculosis [011]	0	0	0	0

Source: 2012 Jefferson Regional Medical Center

Table 24 outlines the overall number of Emergency Department cases for specific mental health diagnoses. These conditions should be managed outside of the acute care setting as well and have been increasing over the past three years.

Table 24. Mental health cases by ICD 9

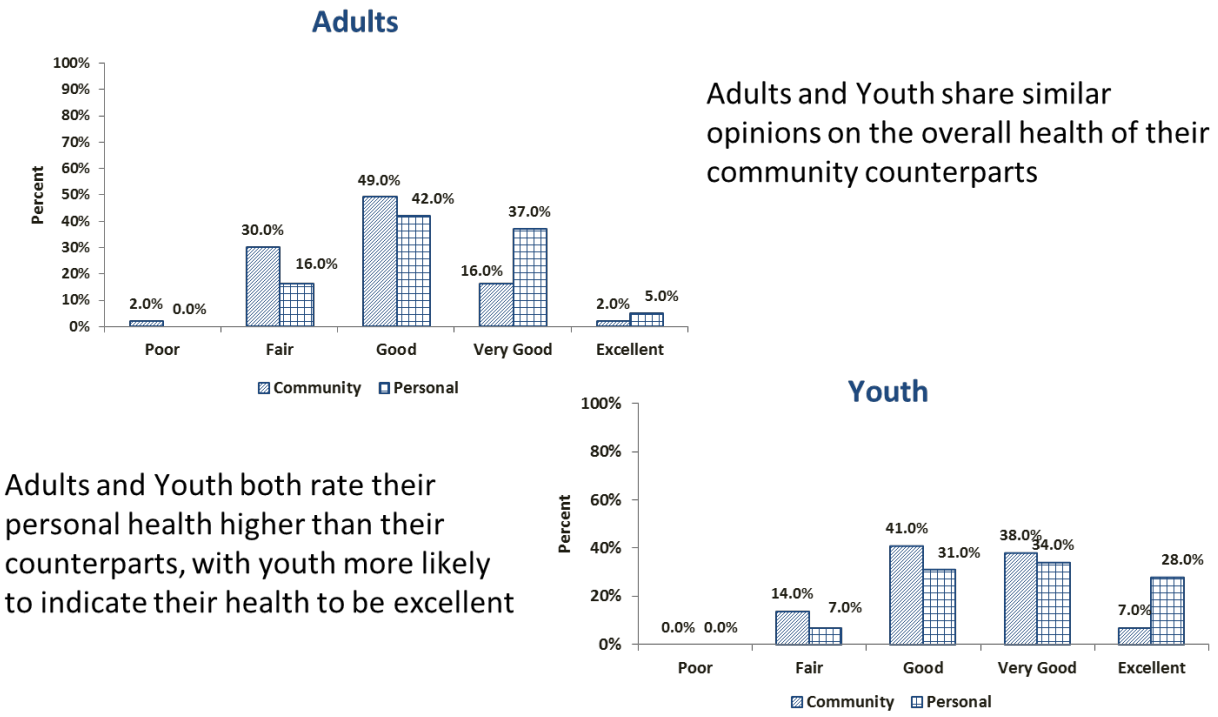
DESCRIPTION	2010	2011	2012	YTD NOV
Dementia	146	88	102	23
Alcohol	1,517	1,597	1,645	755
Drug Related	3,510	3,749	3,829	1,495
Transient organic psychotic conditions	93	80	104	47
Other organic psychotic conditions (chronic)	1,372	1,566	903	213
Schizophrenia	474	466	473	195
Manic Disorders	0	0	0	0
Depression	2,228	2,286	2,123	828
Bi-Polar	1,292	1,209	1,419	540
Paranoia/Psychosis	889	998	1,081	359
Anxiety	2,749	2,709	3,026	1,207
Phobias	39	35	20	10
PERSONALITY DISORDERS	275	252	278	85
Sexual Deviations and Disorders	2	1	0	0
Psychogenic Disorders	13	8	12	0
Sleep Disorders	4	0	2	0
Eating Disorders	9	8	10	4
Stress Related	58	70	83	30
Adjustment Related	144	187	221	122
Conduct/Social Disturbances	29	70	97	31
Emotional Disorders (youth)	0	1	0	0
Mental Retardation	88	92	100	37

Source: 2012 Jefferson Regional Medical Center

Focus Group Input

Figure 39 illustrates the rating of overall health status by adult (age 18 and older) and youth (high school student) focus group participants. Adults are more likely to rate the health of the community as good or fair, while youth are more likely to rate the health of the community as good or very good. Both groups, adults and youth, also tended to rate their personal health better than the health status of the community. Youth are more likely to indicate their personal health to be excellent.

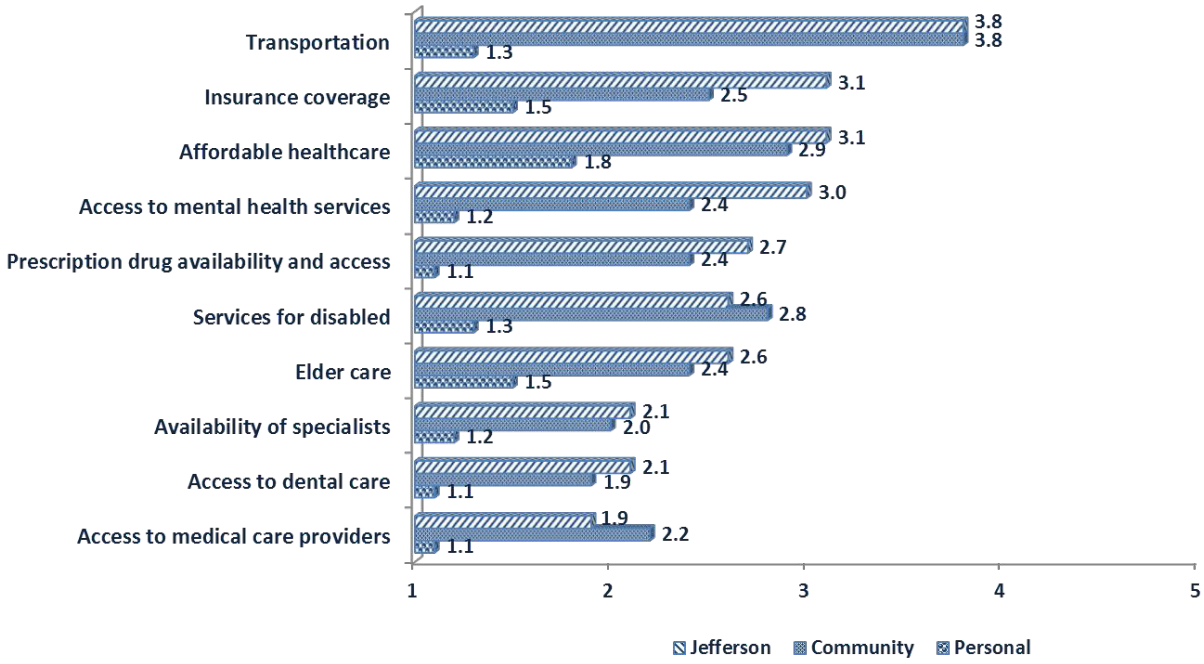
Figure 39. Focus groups: Overall health status



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

Focus Group participants were asked to rate the extent to which a number of issues are a problem in the community, in the Jefferson Regional service region overall and in their personal life. Items were rated based on a 5-point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 40 illustrates the rank ordering of the issues related to Access to Quality Health Care. Issues were rank ordered based on the average score of how much of a problem the issue is perceived to be by the participants in the Jefferson Regional service region overall. As seen below, transportation is the highest rated problem in the service region with an average score of 3.8. Insurance coverage and affordable health care were also seen as somewhat serious issues in the service region.

Figure 40. Access to Quality Healthcare



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

Top Health Community Related Issues by Focus Group

Focus group participants were asked to identify and discuss the topics they felt were the top health or health-related problems in their community. The following problems were identified as related to access to services, barriers to services or possible service needs.

Transportation was listed as a major concern. Several participants felt that bus fare is higher in the Pittsburgh area than it is in New York, Chicago, and Washington D.C. They also felt that it is very difficult to get around in the Pittsburgh area. The perception among medical care providers and professionals working in Emergency Medical Services is that people often call the ambulance just to get transportation to the Emergency Room for non-emergency conditions and questions.

People also discussed access to health insurance. There are gaps in prescription coverage for people on Medicare. Many types of health insurance are not affordable, even when people are earning a decent salary. Participants commented that they see students either stay in college to remain on parents insurance or jump into a job just to have insurance. This is also creating the situation where people wait to receive care as opposed to seeking care with first symptoms.

A number of barriers to health care access were discussed and focus group participants identified service needs as a problem. They included a need for physicians, Pediatrics/Children's care, Physical Therapy/Rehab, Dermatology and Aging services.

Stakeholder Interview Input

Healthcare access is directly related to economic status. For low-income residents, insurance costs are rising, and for the unemployed, coverage is largely unavailable. Jefferson Regional treats all patients, regardless of coverage, although the lack of coverage creates access issues for many service area residents.

Medical misinformation, false notions and a lack of awareness form a barrier to healthcare access. There is a need for patient education through physicians, lectures and forums throughout the community. Lack of transportation was a particular access concern to stakeholders who were interviewed. Access to public transportation is challenging due to the hilly, sprawled-out terrain and private transportation is expensive. Jefferson Regional has satellite locations to accommodate access.

Many service region residents are unaware of the services Jefferson Regional provides and how to access services. Though the community needs better access to women's health and pediatrics, Jefferson Regional provides quality specialists and medical services, as well as urgent care facilities.

In the Jefferson Regional service region, there is a perception of fear and distrust in regard to community needs, and a perception of entitlement among the elderly. There is a perception that the elderly get access and attention that young people are not getting. The mentality exists that the elderly deserve services and the youth do not. The community needs general assistance across the board, not just for the elderly. The community should be seen as vulnerable and in need of access to education, basic needs, and preventative care.

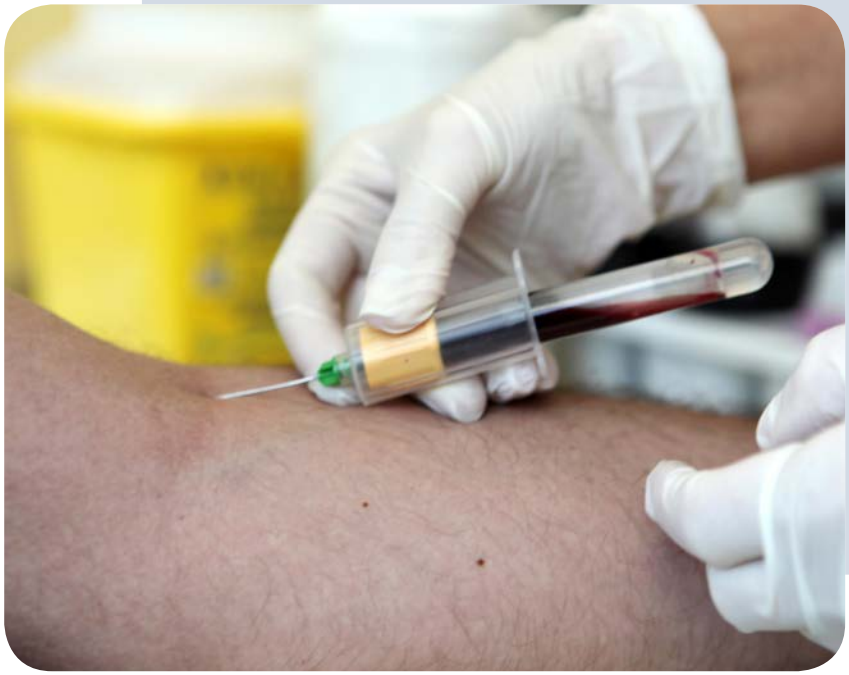
Access Conclusions

There are a number of observations and conclusions that can be derived from the data related to Access to quality health care. They include:

- In Pennsylvania, Allegheny County, and Westmoreland County, the percentage of adults who rated their general health as fair or poor was comparable, and compared to the state (15.0 percent) was significantly higher for Fayette County (22.0 percent).
- The Majority of BRFSS respondents (34.5 percent) rated their general health as good, while 24.5 percent rated it fair or poor.
- The percentage of adults not having a personal healthcare provider was lower than the Healthy People 2020 goal of 16.1 percent for the state and all counties; however, the age group 18 to 44 (24.0 percent) was significantly higher than the state (17.0 percent).
- Between the state, BRFSS Service Area, and counties, there were no significant differences for adults who visited a doctor in the past two years for a routine check-up.
- The majority of BRFSS respondents (77.8 percent) had a routine check-up in the past year.
- The percentage of adults aged 18 to 64 with no health insurance was comparable between the state, BRFSS respondents, and counties, and all below the nation at 17.8 percent.
- BRFSS respondents reported the highest frequency for not having health insurance as a lost job or change in employment at 3.8 percent, followed by the inability to pay premiums at 2.8 percent.
- Although comparable, the state and counties were above the HP 2020 goal of 4.2 percent of adults who needed to see a doctor in the past year but could not due to cost.
- The majority of BRFSS respondents (71.0 percent) reported never needing to visit the emergency room in the past year, while 19.3 percent made one visit.
- Twenty-eight BRFSS respondents could not fill or take medication as directed because of cost in the past year.
- The majority of BRFSS respondents (50.8 percent) were able to make an appointment with a doctor within one week, while only 0.8 percent responded they did not get care because it took too long.
- The majority of BRFSS respondents (62.8 percent) saw a dentist in the past year, 1.5 percent reported never seeing a dentist.
- According to the county health rankings, between 55 percent and 60 percent of the women in the service area counties have appropriately had mammogram screenings.
- Somewhere between 15 percent and 17 percent of adults in the service area have low health literacy, depending on the definition used.
- Focus groups ranked transportation as the most serious problem to access to care for the Primary Service Area and community.

This page is intentionally blank

This page is intentionally blank



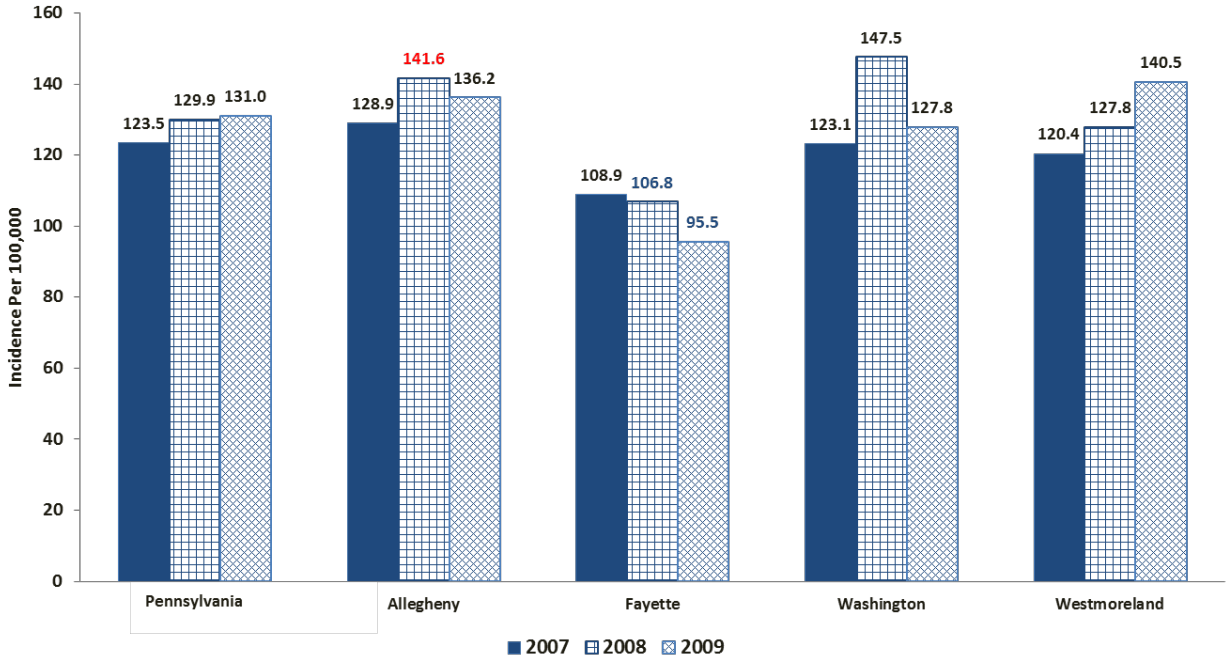
Chronic Disease

Chronic Disease

Conditions that are long-lasting, with relapses, remissions and continued persistence can be categorized as chronic diseases. Chronic disease topics explored include: breast cancer, bronchus and lung cancer, colorectal cancer, prostate cancer, heart disease, heart attack, coronary heart disease, stroke, overweight, obesity and diabetes. When available for a given health indicator, Healthy People 2020 (HP 2020) goals and state and national rates were included.

Figure 41 illustrates the breast cancer incidence rates in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2009. The rate in Allegheny, Washington and Westmoreland Counties has increased during the last three years and the rate in Allegheny County was significantly higher than that state rate in 2008, although the rate fell in 2009. The rates have been declining in Fayette County throughout the past few years, and were significantly lower than the state rates the last two years.

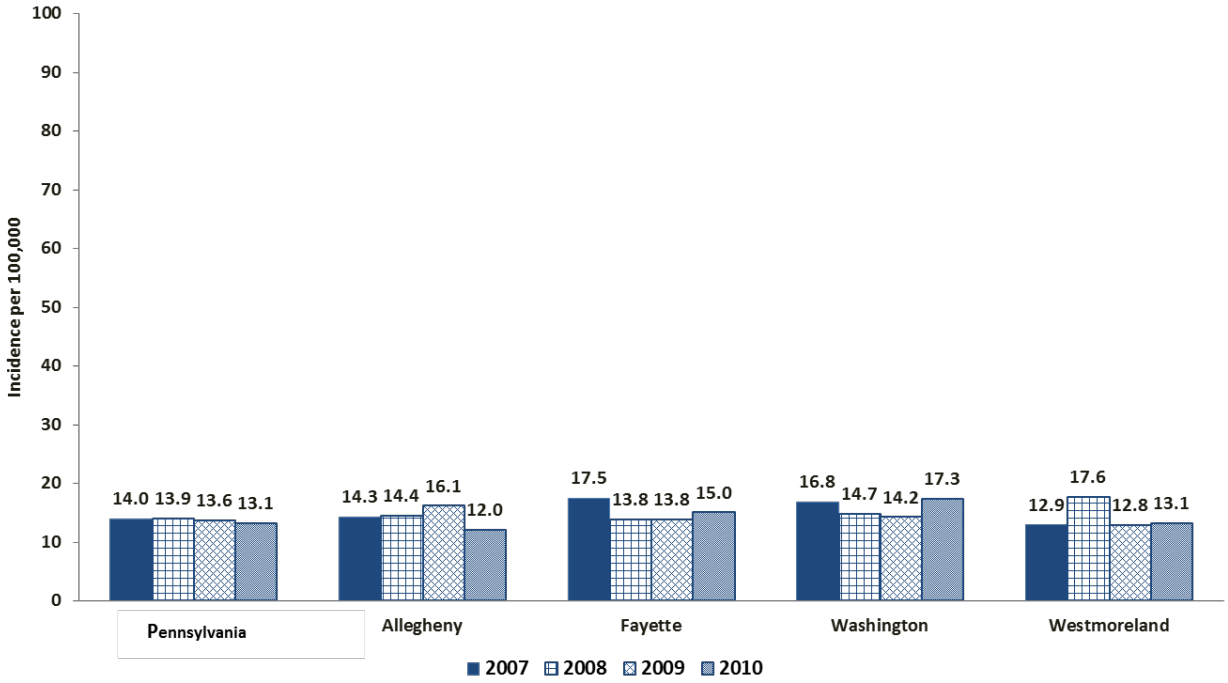
Figure 41: Breast cancer incidence rate



Source: Pennsylvania Department of Health

Figure 42 illustrates the breast cancer mortality rates from the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. The rates have been declining slightly at the state level throughout the past few years, and have been fluctuating within the counties of the service region. Allegheny County's rate in 2010 was lower than the previous three years; Fayette, Washington and Westmoreland county rates have increased slightly.

Figure 42: Breast cancer mortality rate



Source: Pennsylvania Department of Health

Figure 43 illustrates the length of time since the respondents' last mammogram. Almost a quarter (22.3 percent) of the 2012 Senior Area BRFSS respondents had a mammogram within the past 12 months. Table 25 illustrates the number and percent of women who have never had a mammogram. The majority (50.0 percent) of women who have never had a mammogram range between the ages of 25 to 34.

Figure 43: 2012 BRFSS: Length of time since last mammogram

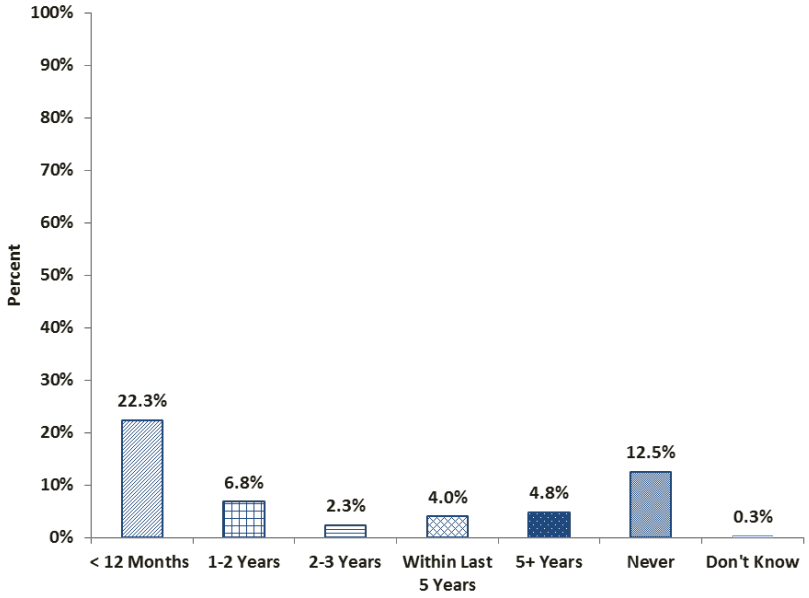


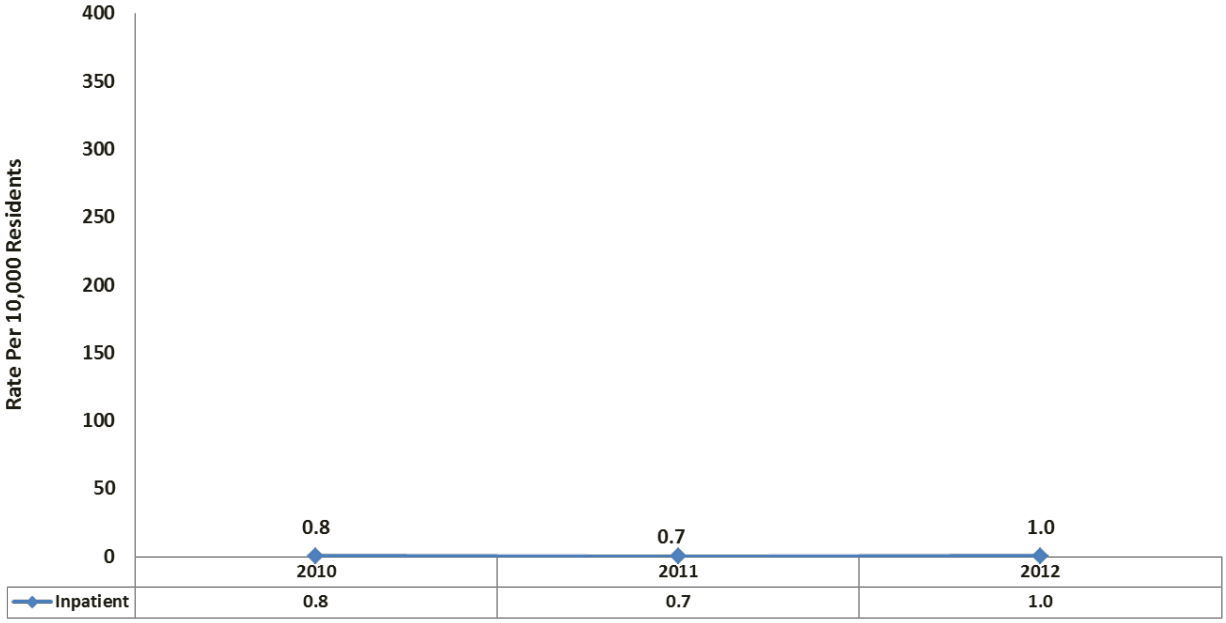
Table 25: Number of women by age never had a mammogram

Age	Number of Responses	Percent
18-24	5	10.0
25-34	25	50.0
35-44	11	22.0
45-54	4	8.0
55-64	3	6.0
65 +	2	4.0
Total	50	100.0

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 44 illustrates the number of breast cancer inpatient discharges per 10,000 residents for the Jefferson Regional service territory from 2010 through 2012. Although the rates are very low, 2012 saw the highest rate of inpatient discharges with a rate of 1.0 per 10,000 residents.

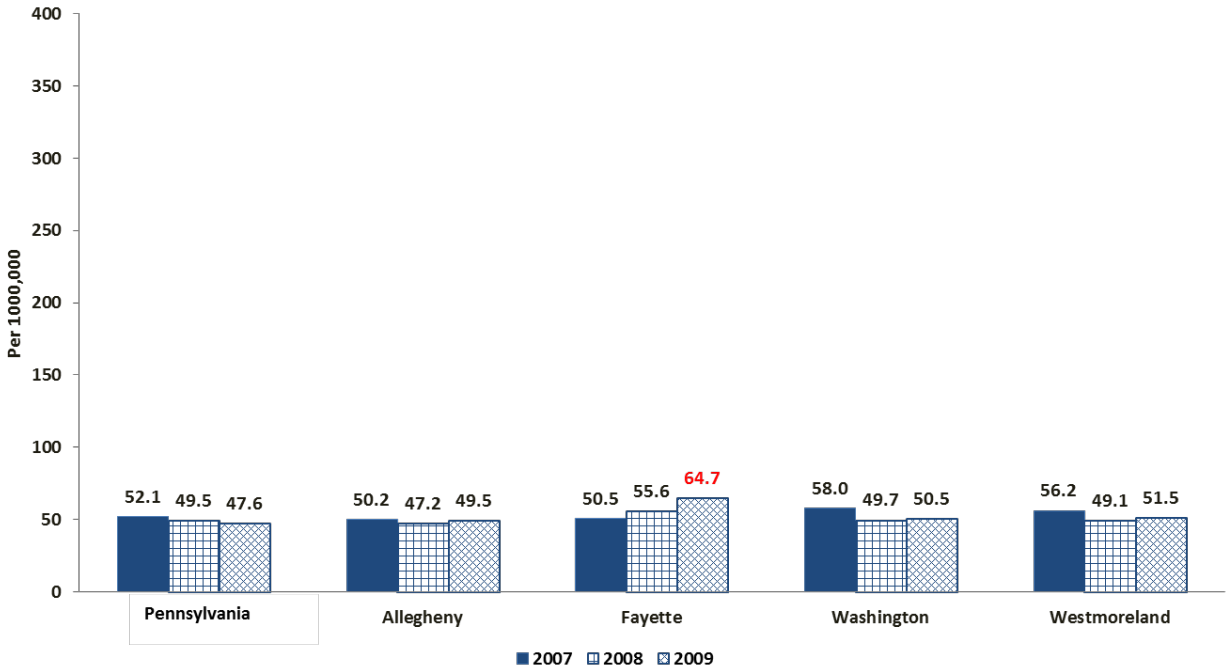
Figure 44: Breast cancer inpatient discharges



Source: Pennsylvania Healthcare Cost Containment Council

Figure 45 illustrates colorectal cancer incidence rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland Counties from 2007 through 2009. The rate has been declining across the state for the past few years, a trend which is mirrored in Allegheny, Washington and Westmoreland counties. The rate, however, in Fayette County has been increasing and was significantly higher in 2009 compared to the state.

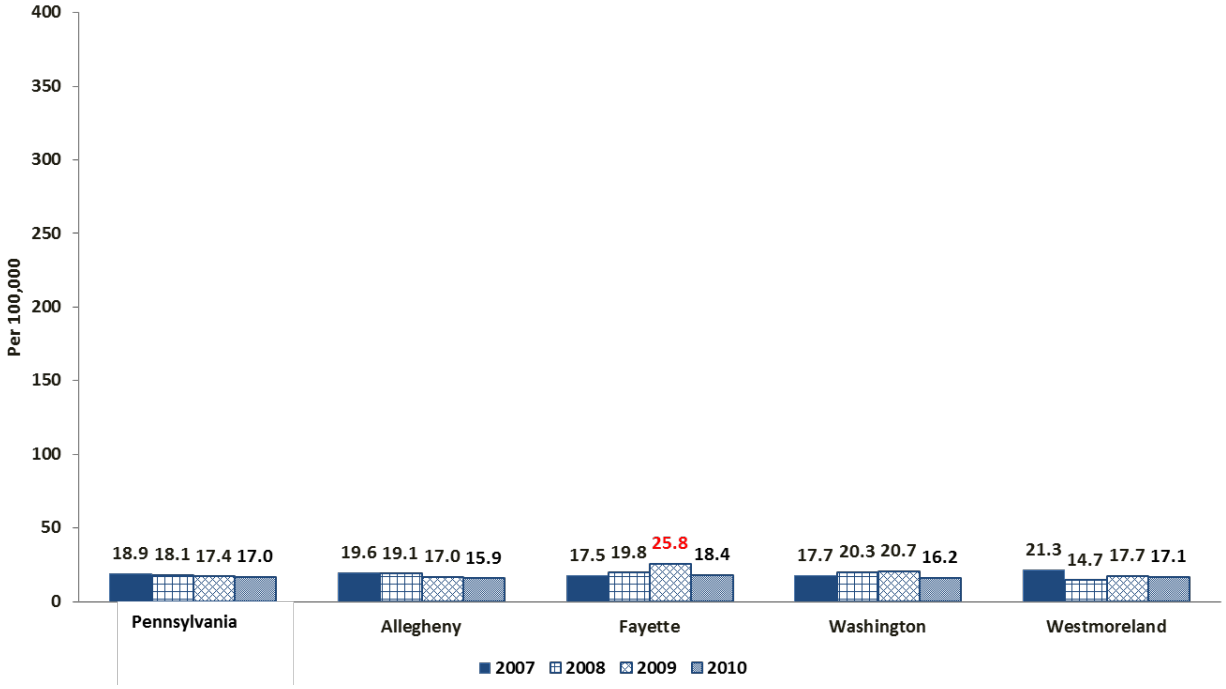
Figure 45: Colorectal cancer incidence rate



Source: Pennsylvania Department of Health

Figure 46 illustrates the colorectal cancer mortality rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. The rates have been declining during the past few years across the state, as well as within the counties of the service region. However, in Fayette County for the year 2009, the rate was significantly higher compared to the state.

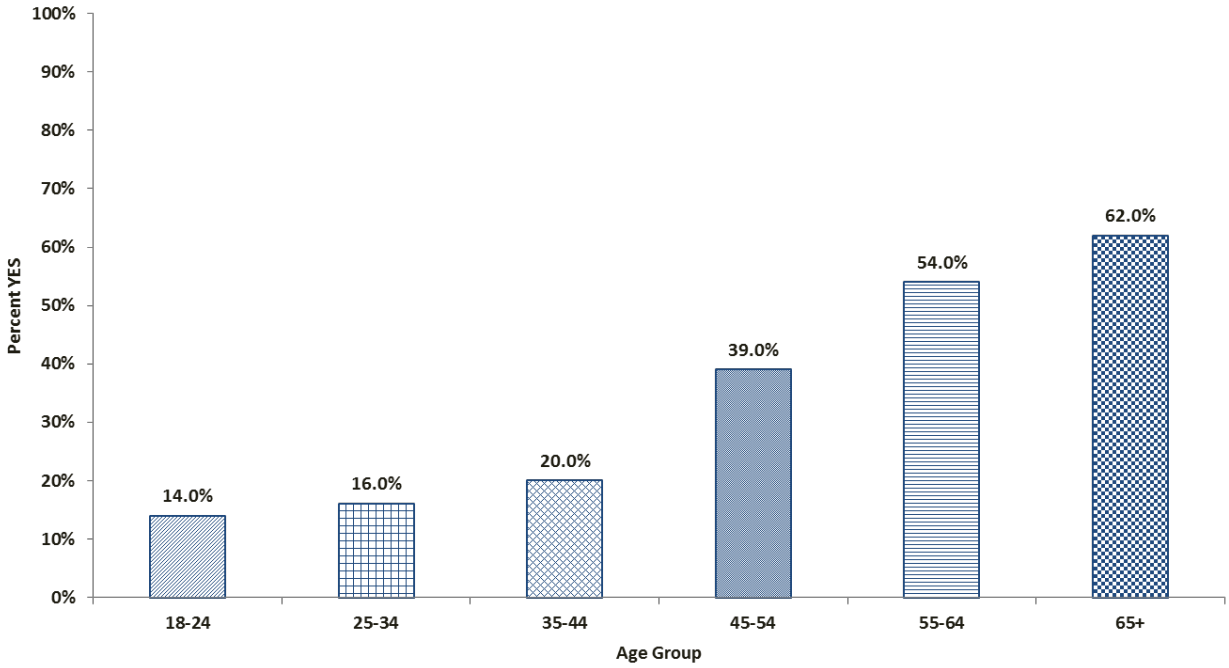
Figure 46: Colorectal cancer mortality rate



Source: Pennsylvania Department of Health

Figure 47 illustrates the BRFSS responses, by age group, when asked if they have had a colonoscopy. The percentage of respondents who have had a colonoscopy increases with age. The majority (62.0 percent) of those ages 65 and older have had a colonoscopy.

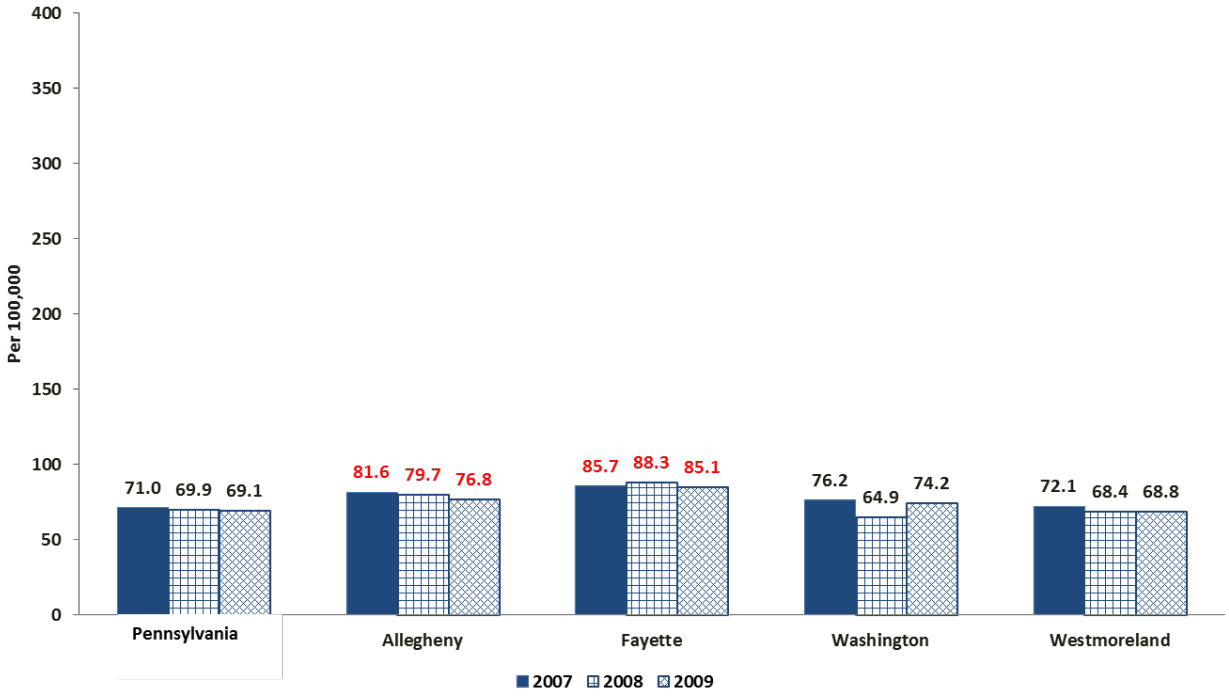
Figure 47: 2012 BRFSS: Colonoscopy by age



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 48 illustrates the bronchus and lung cancer incidence rates in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties per 100,000 residents from 2007 through 2009. The rates across the state have been declining during the past few years as well as in the counties of the service region. However, Allegheny and Fayette counties have rates that are significantly higher than the state rates all three years.

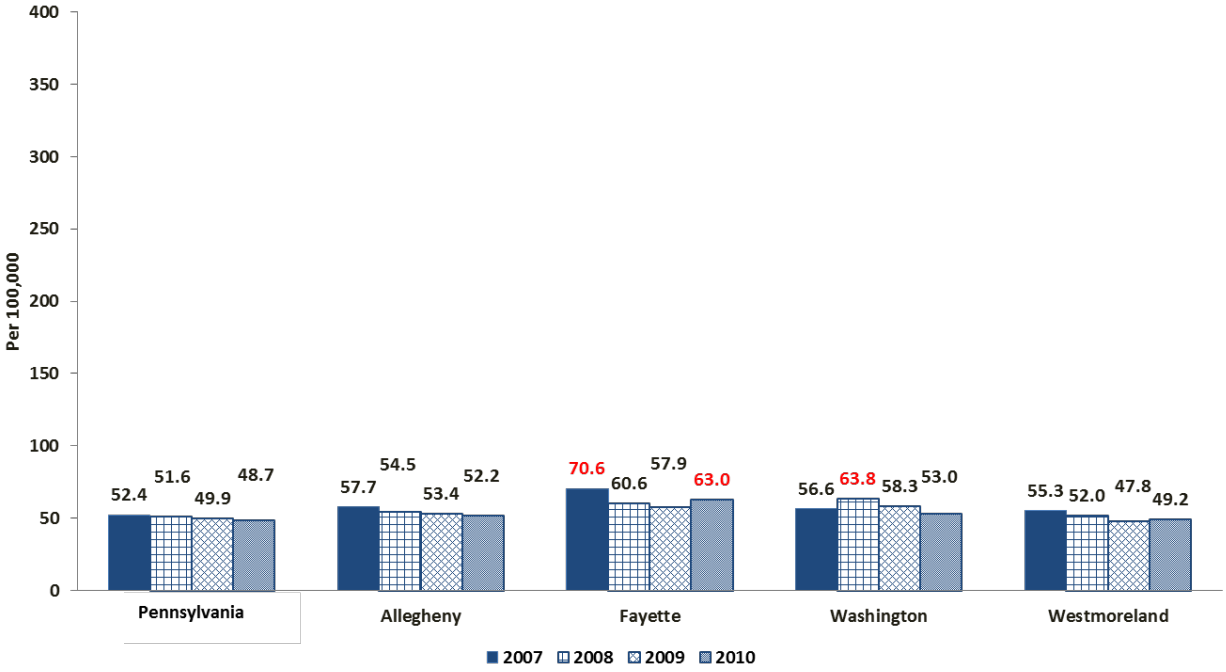
Figure 48: Bronchus and lung cancer incidence



Source: Pennsylvania Department of Health

Figure 49 illustrates the bronchus and lung cancer mortality rates in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties per 100,000 residents from 2007 through 2010. The rates have been declining across the state the past few years as well as in all counties of the service region; however, the rate was significantly higher in Fayette County in 2007 and 2010, and Washington County in 2008.

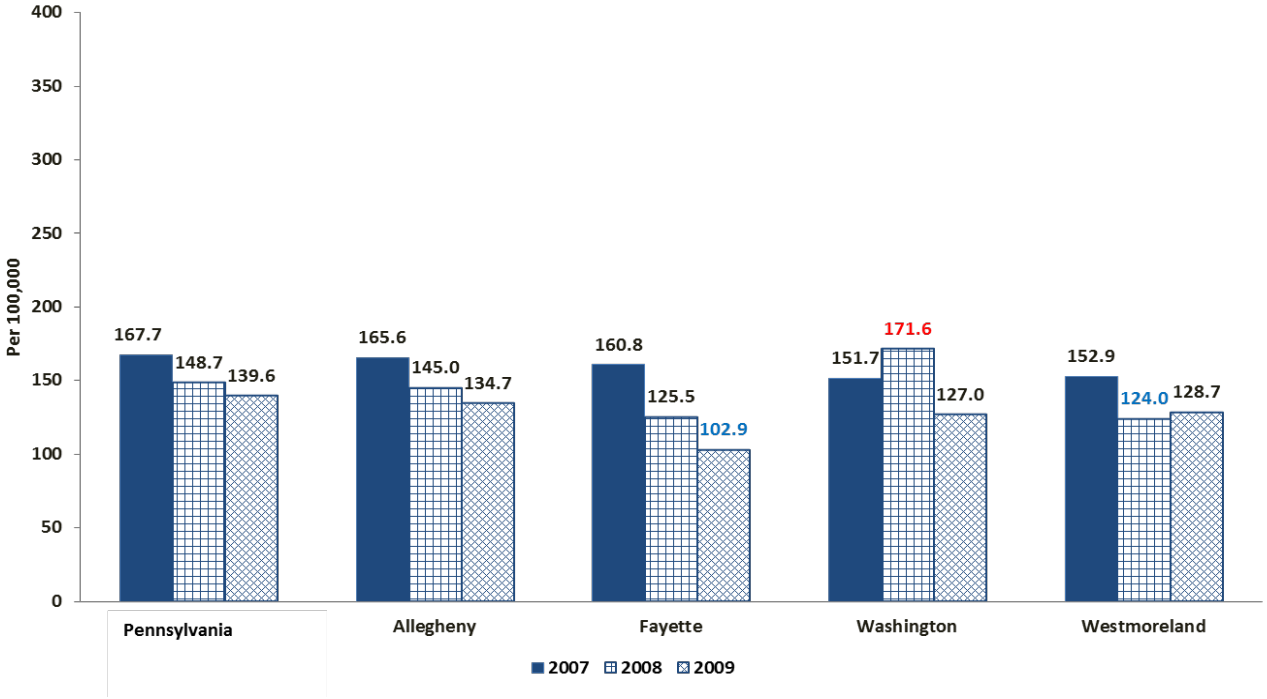
Figure 49: Bronchus and lung cancer mortality rate



Source: Pennsylvania Department of Health

Figure 50 illustrates prostate cancer incidence rates in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties per 100,000 residents from 2007 through 2009. The rates have been declining across the state as well as within all counties of the service region. However, the rate in Washington County in 2008 was significantly higher than the state rate, and the rates in Fayette County in 2009 and in Westmoreland County in 2008 were significantly lower than the state rate.

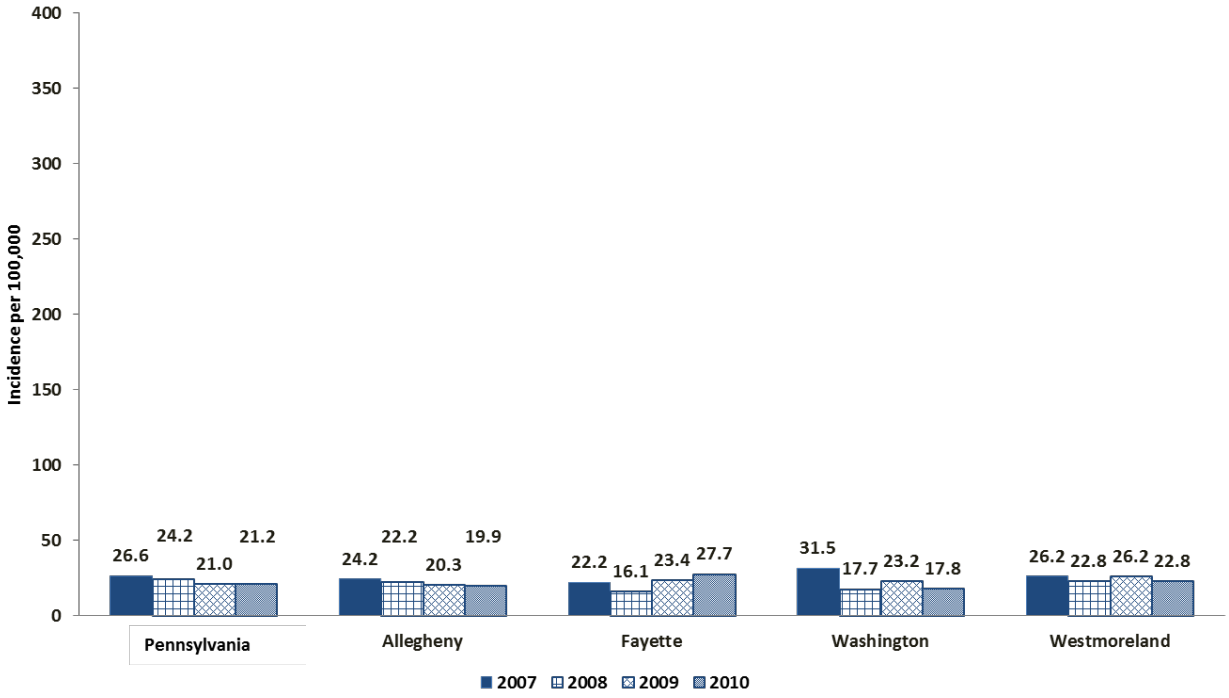
Figure 50: Prostate cancer incidence rate



Source: Pennsylvania Department of Health

Figure 51 illustrates the prostate cancer mortality rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. While the rates have been decreasing across the state the last few years and in Allegheny, Washington and Westmoreland counties, the rate has been increasing in Fayette County.

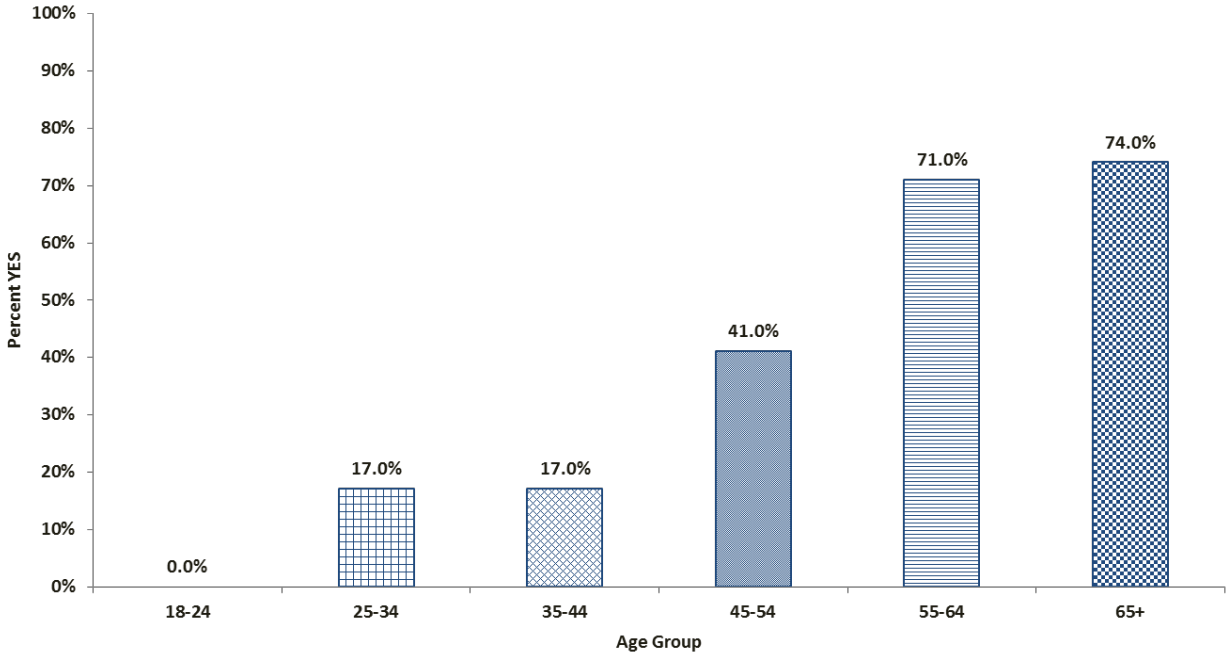
Figure 51: Prostate cancer mortality rate



Source: Pennsylvania Department of Health

Figure 52 illustrates the 2012 Service Area BRFSS male responses by age group, when asked if they have received a PSA (Prostate Specific Antigen) Test. PSA testing increased with age. The majority of respondents (74.0 percent) age 65 or older have had a PSA Test.

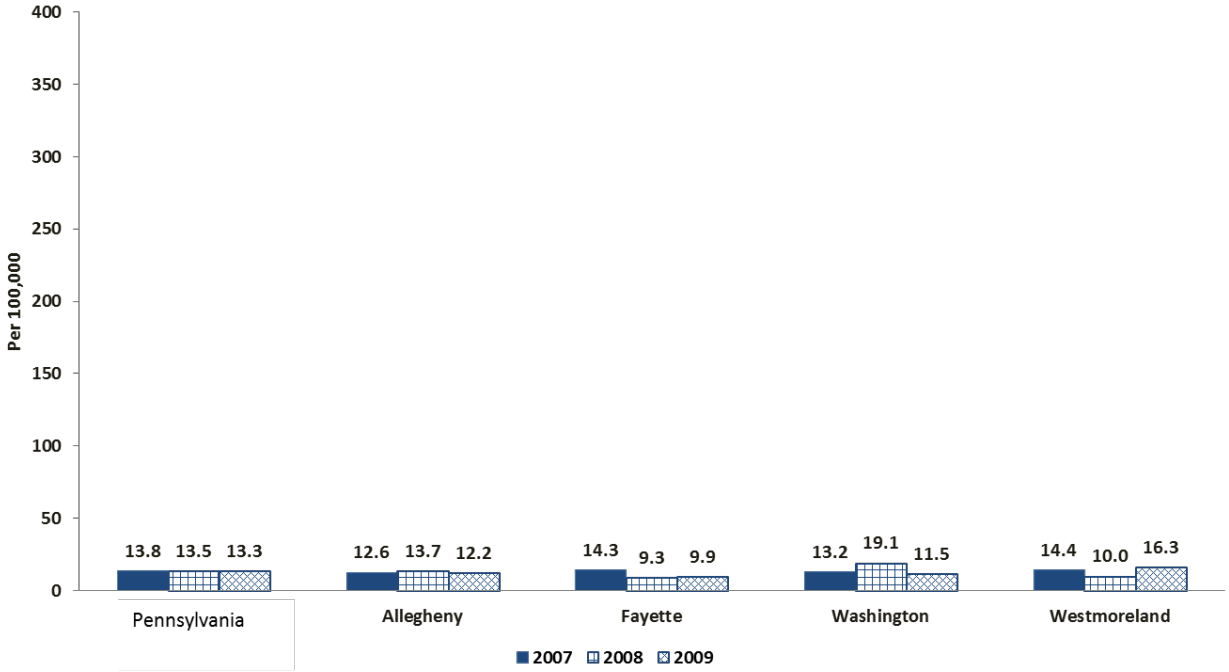
Figure 52: 2012 BRFSS: PSA test by age



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 53 illustrates ovarian cancer incidence rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2009. While the rates are declining across the state as well as in Allegheny, Fayette and Washington counties throughout the past few years, the rate in Westmoreland County has increased. Although the rate in Washington County shows a decrease from 13.2 in 2007 to 11.5 in 2009, it should be noted that the rate did increase in 2008 to 19.1.

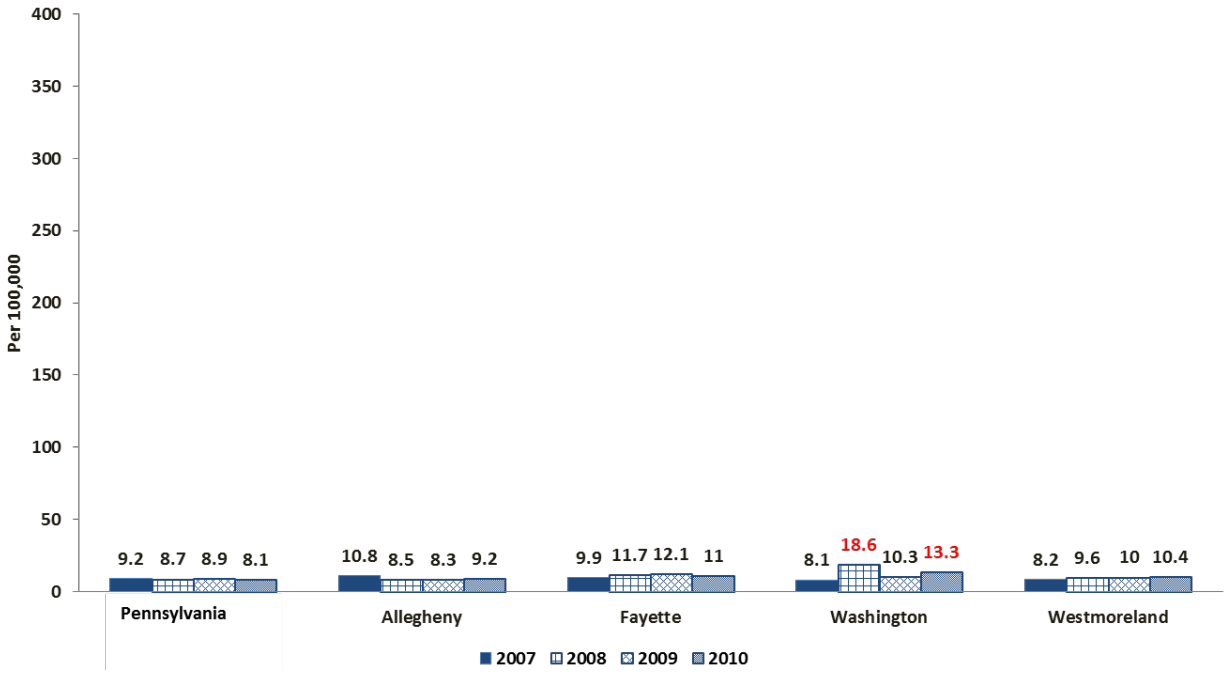
Figure 53: Ovarian cancer incidence



Source: Pennsylvania Department of Health

Figure 54 illustrates the ovarian cancer mortality rate per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. While the state and Allegheny County rates have declined slightly during the past few years, Fayette, Washington and Westmoreland county rates have increased. The rate in Washington County was significantly higher than the state rate in 2008 and 2010.

Figure 54: Ovarian cancer mortality



Source: Pennsylvania Department of Health

Figure 55 illustrates the 2012 Service Area BRFSS responses when asked the length of time since the respondent had a Pap Test. The largest percentage (23.0 percent) responded that they have had a Pap test within the last 12 months. Table 26 illustrates the number of women, by age groups, who have not had a Pap test in the last 3 years. The largest percentage (32.0 percent) is within the ages of 45 to 54.

Figure 55: 2012 BRFSS: Length of time since last PAP test

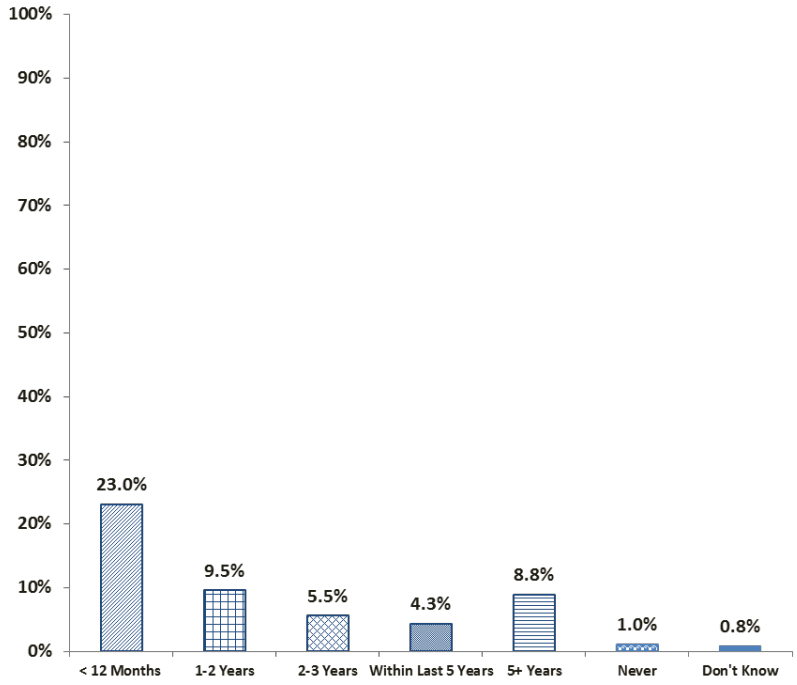


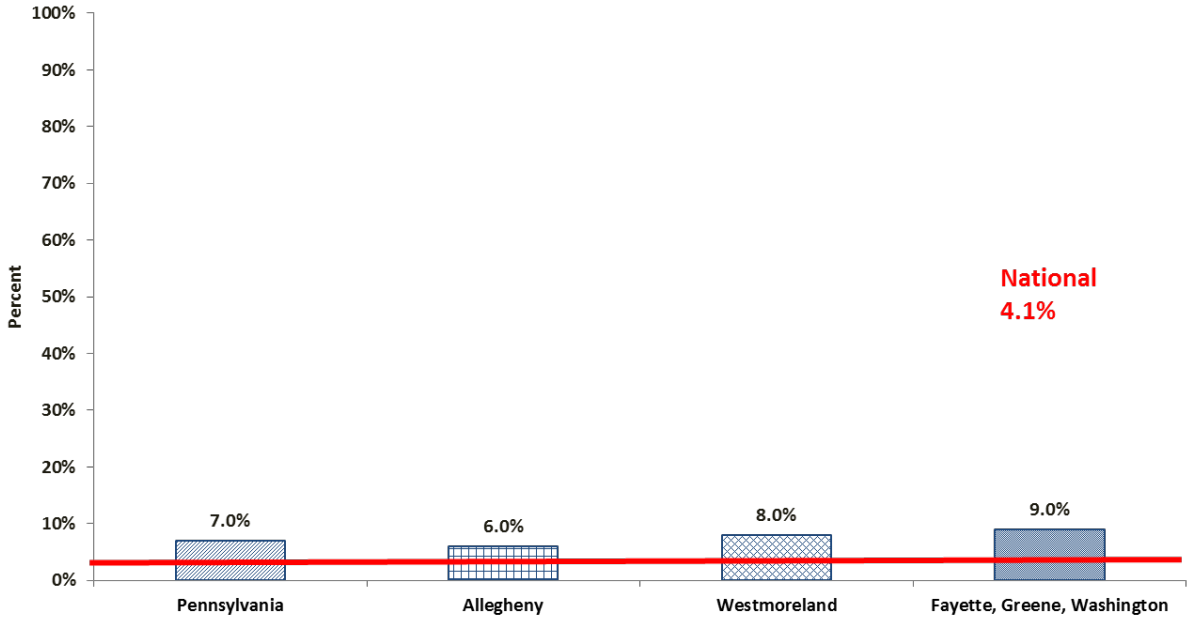
Table 26: Number of women by age no PAP test in >3 years

Age	Number of Responses	Percent
18-24	0	0.0
25-34	7	21.0
35-44	1	4.0
45-54	11	32.0
55-64	21	6.0
65 +	19	28
Total	50	100.0

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 56 illustrates the percentage of responses of the 2010 BRFSS of adults from the Commonwealth of Pennsylvania, as well as Allegheny, Westmoreland, Fayette, Greene, and Washington counties who were told by a health care professional they had heart disease. The percentage of adults in the service region that have heart disease ranges from 6 to 9 percent, which is higher than the national percentage of 4.1.

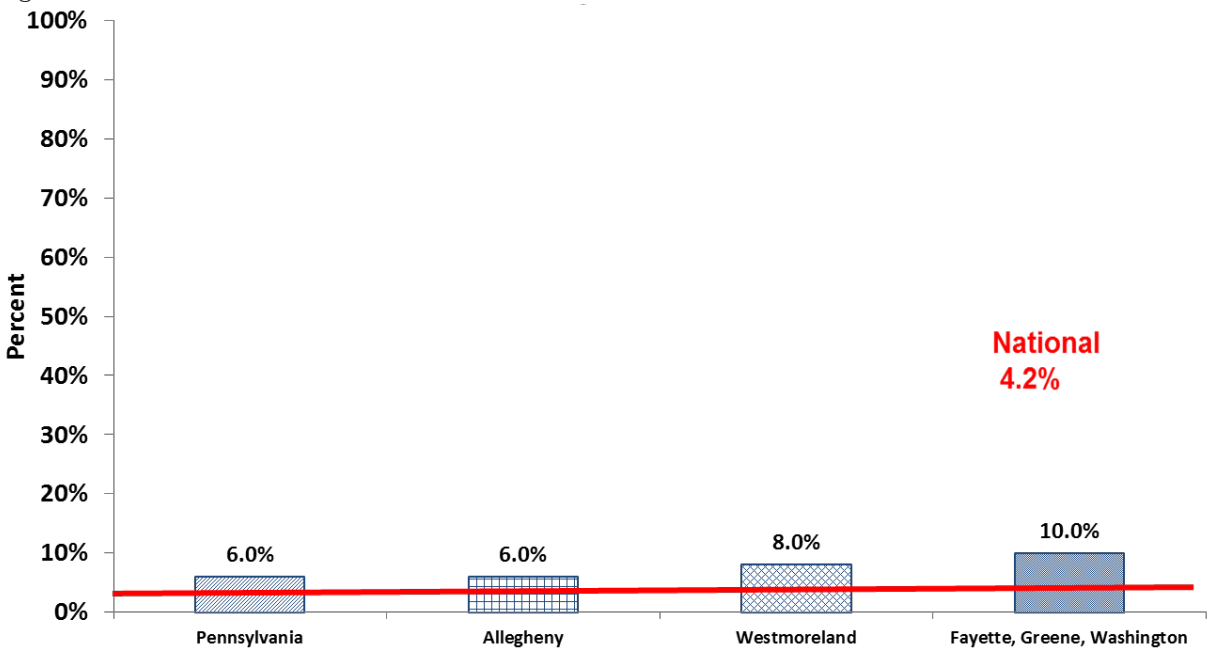
Figure 56: Heart disease



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 57 illustrates the responses of the 2010 BRFSS for adults age 35 and older from the Commonwealth of Pennsylvania, as well as Allegheny, Westmoreland, Fayette, Greene, and Washington counties who were told they had a heart attack. The percentage of adults in the service region over age 35 who have had a heart attack ranges between 6 and 10 percent, which is higher than the national rate of 4.2.

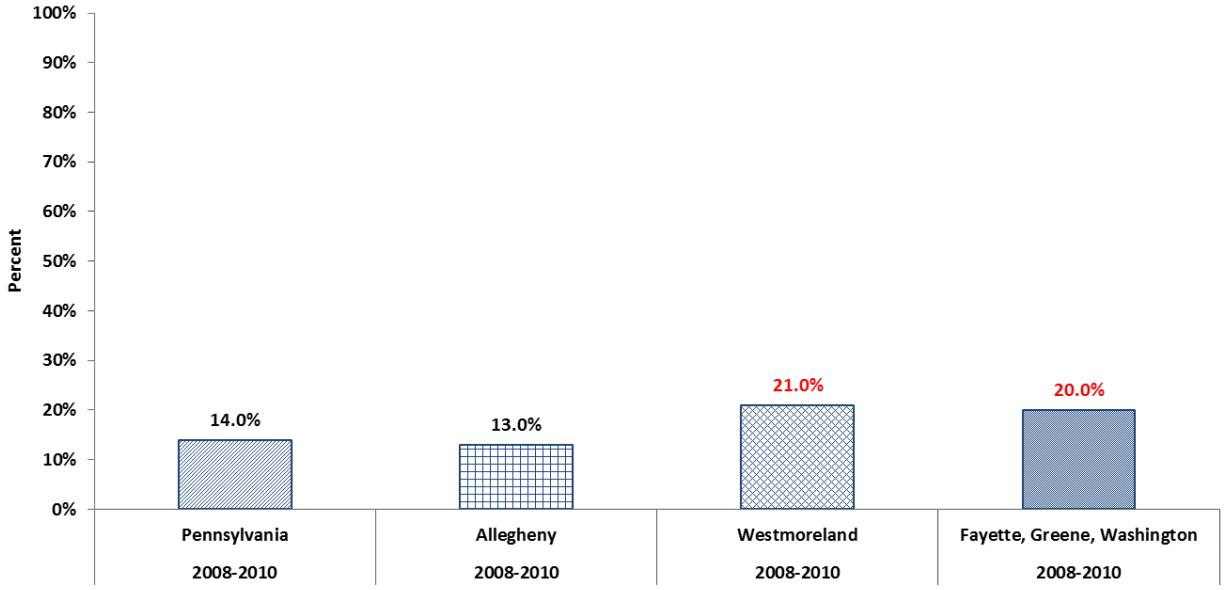
Figure 57: Heart attack



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 58 illustrates the responses of adults age 65 and older who were told they had a heart attack. Those over age 65 in Westmoreland and Washington counties were significantly more likely to have been told they had a heart attack as compared to the state.

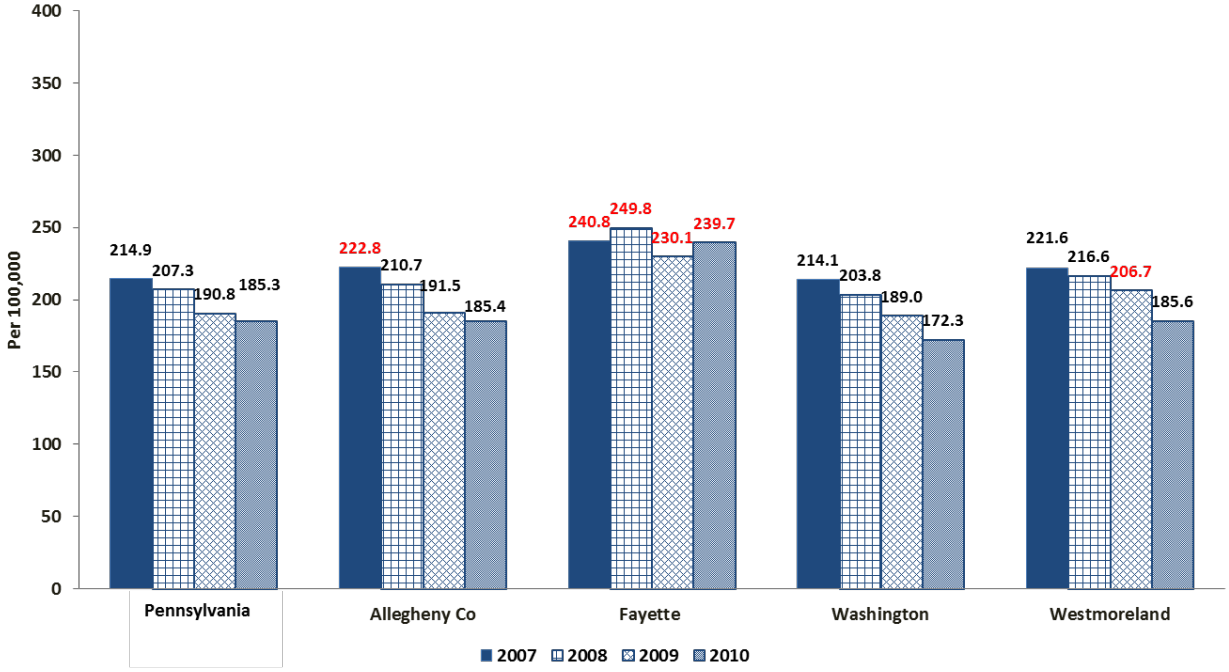
Figure 58: Heart attack, age GE 65



Source: Pennsylvania Department of Health

Figure 59 illustrates the heart disease mortality rates per 100,000 residents from the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. While the rates have been declining at the state level and across most of the counties of the service area during the past few years, the rate in Fayette County has been significantly higher and not declining.

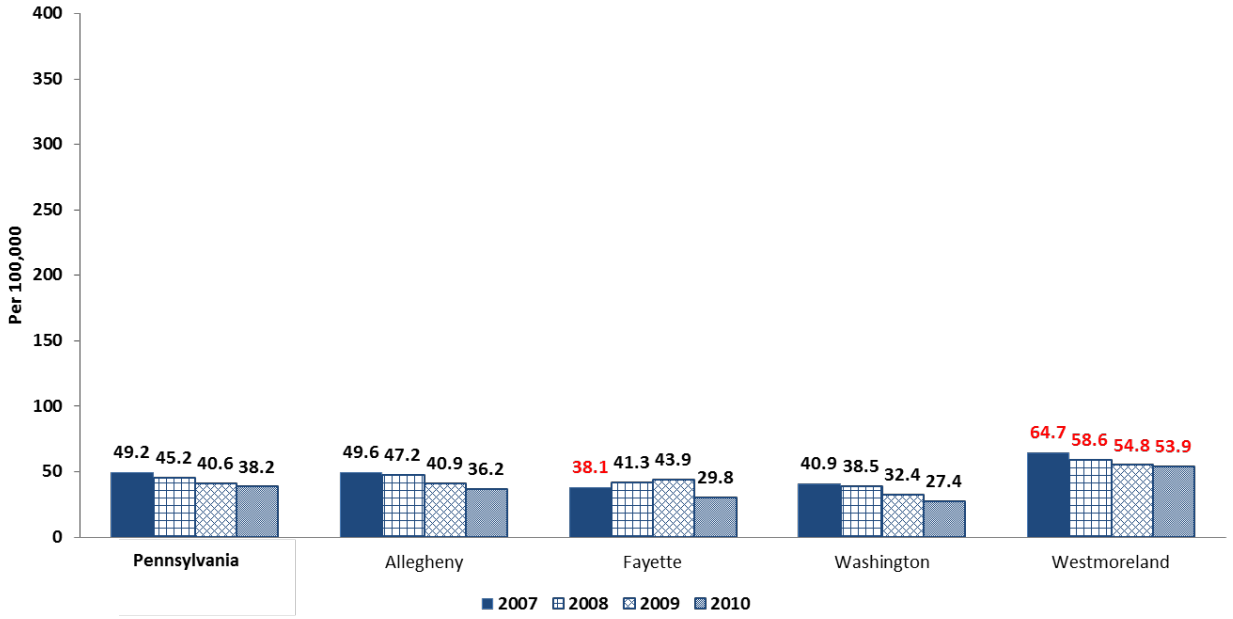
Figure 59: Heart disease mortality rate



Source: Pennsylvania Department of Health

Figure 60 illustrates myocardial infarction (heart attack) mortality rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington and Westmoreland counties from 2007 through 2010. While the rates have been declining across the state and within each of the counties of the service region, the rate in Westmoreland County is significantly higher than the state rates during the past four years. The Fayette County rate was also significantly higher in 2007.

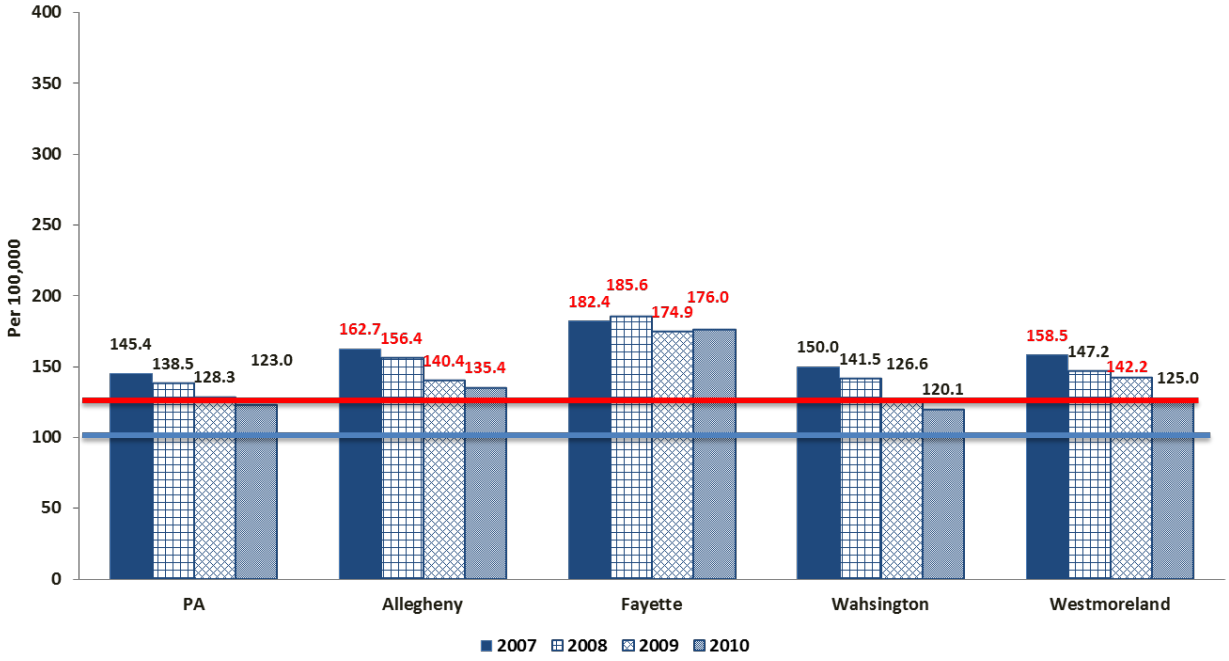
Figure 60: Myocardial infarction mortality rate



Source: Pennsylvania Department of Health

Figure 61 illustrates coronary heart disease mortality rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington and Westmoreland counties from 2007 through 2010. Although the state and all counties are trending downward, Allegheny and Fayette counties were significantly higher across the time period, as was Westmoreland County in 2007 and 2009.

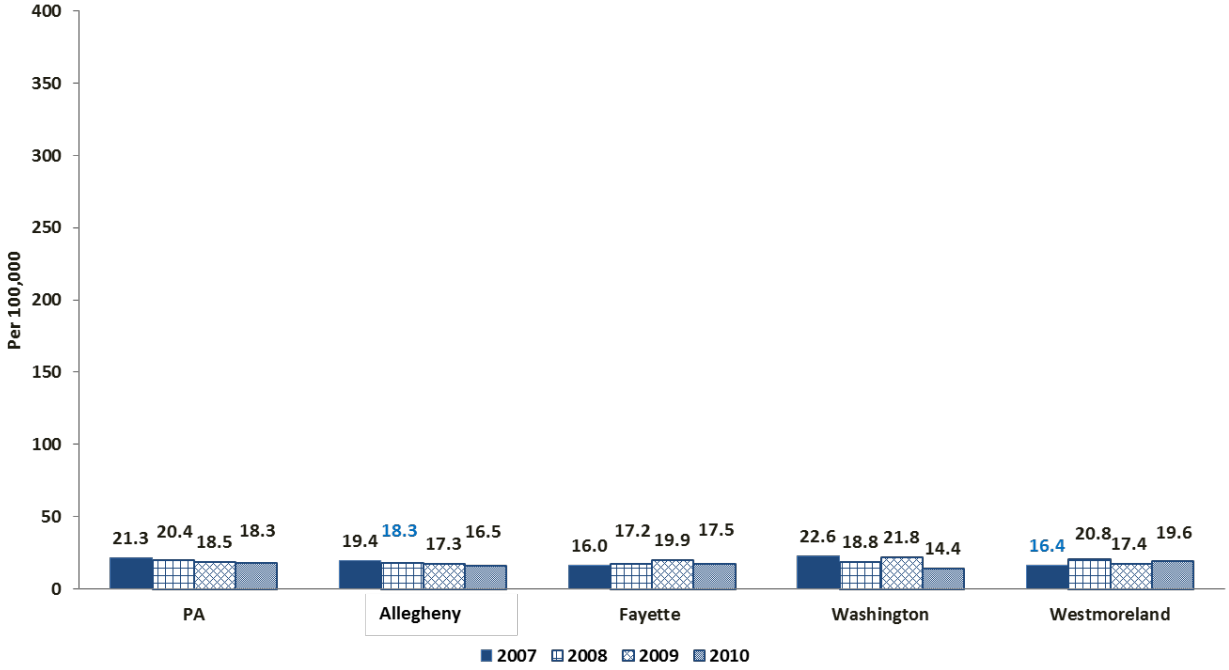
Figure 61: Coronary heart disease mortality rate



Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

Figure 62 illustrates heart failure mortality rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington and Westmoreland counties from 2007 through 2010. The rate between the state and counties are comparable, with Allegheny County in 2008 and Westmoreland County in 2007 being significantly lower.

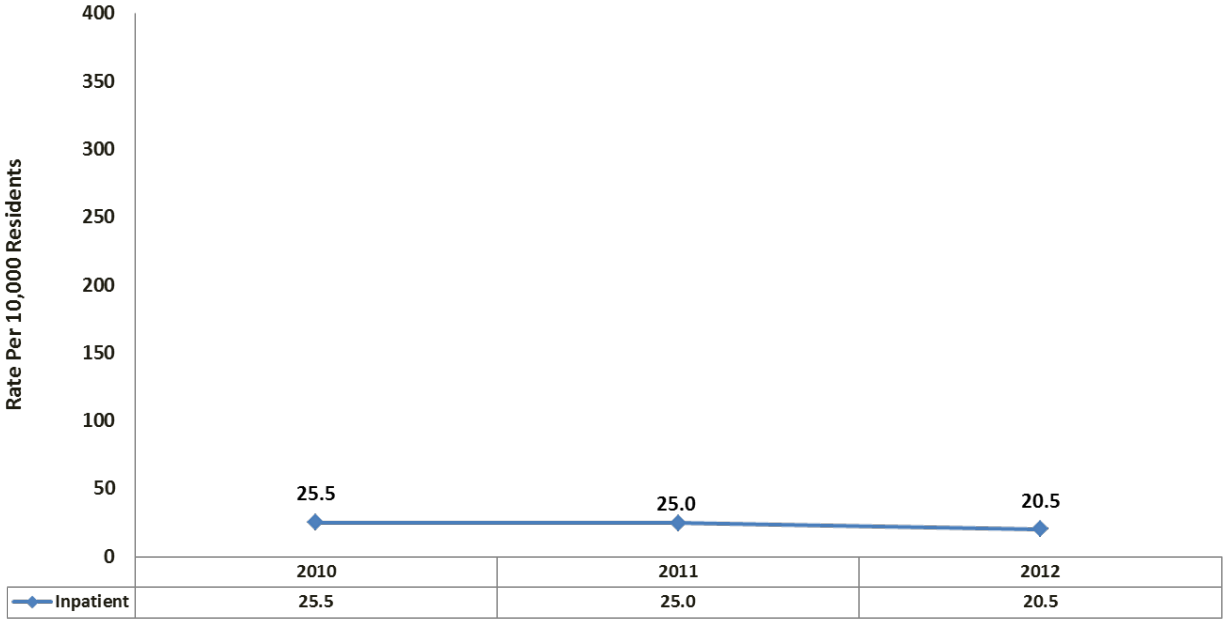
Figure 62: Heart failure mortality rate



Source: Pennsylvania Department of Health

Figure 63 illustrates the number of congestive heart failure inpatient discharges per 10,000 residents from the Jefferson Regional service territory from 2010 through 2012. Across the time period, the rate has decreased.

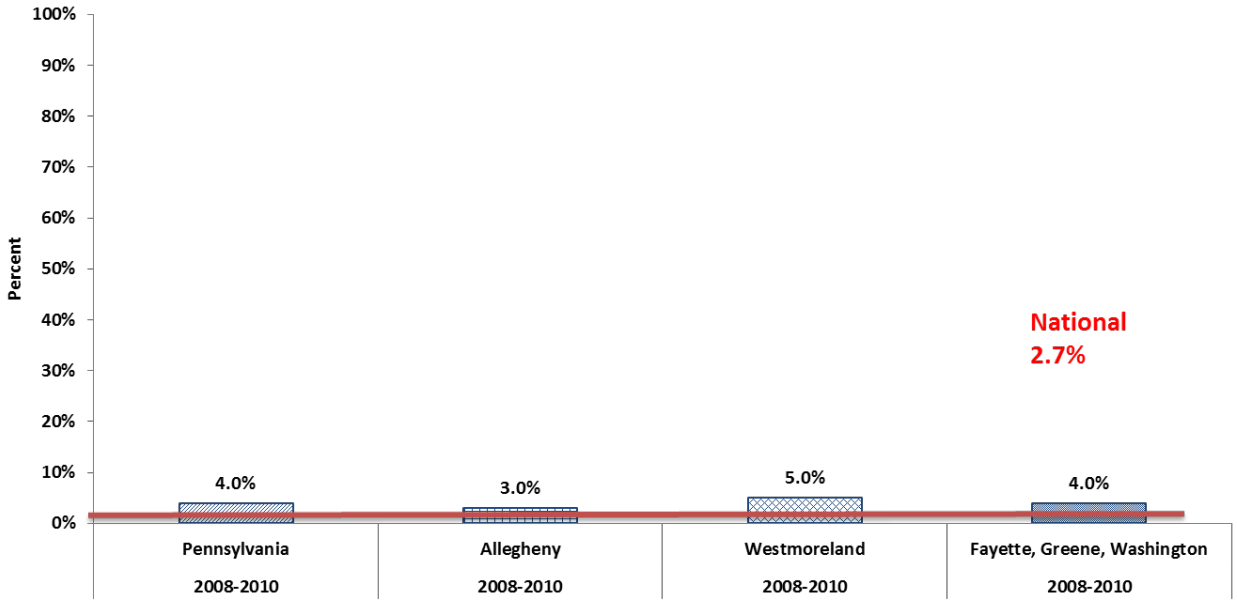
Figure 63: Congestive heart failure inpatient discharges



Source: Pennsylvania Health Care Cost Containment Council

Figure 64 illustrates the percentage of adults ever told they had a stroke in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. The state and county percentages were comparable and all above the national rate of 2.7 percent.

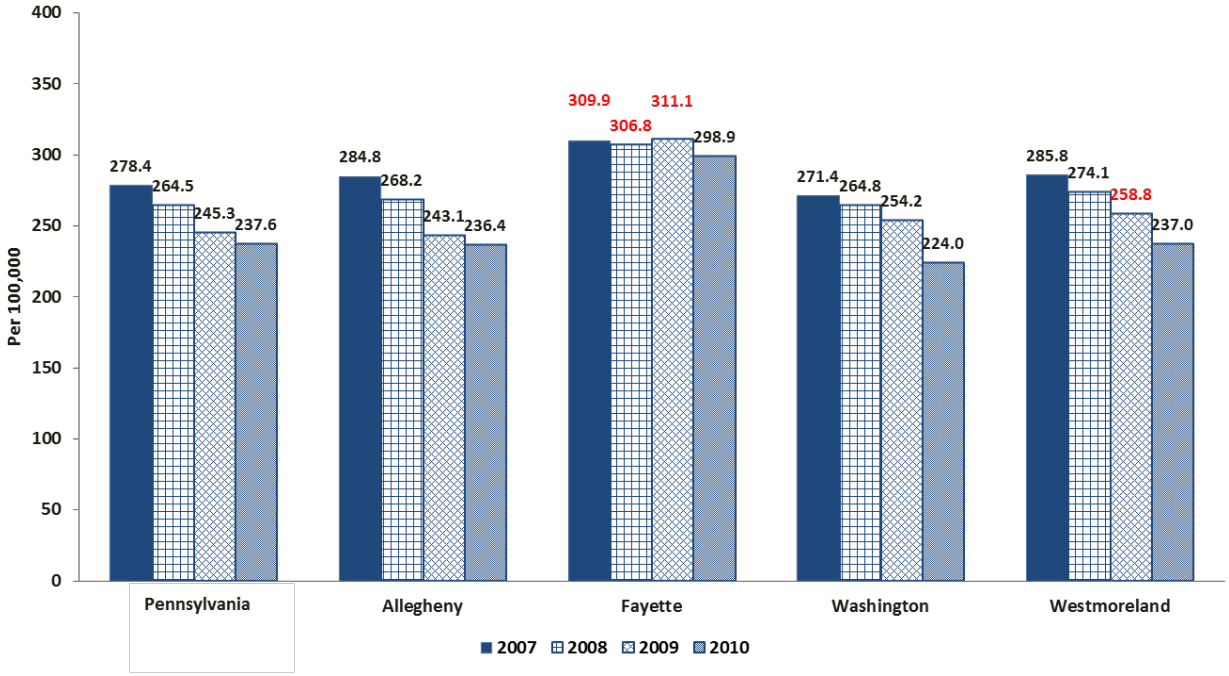
Figure 64: Ever told had a stroke



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 65 illustrates cardiovascular disease mortality rates per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington and Westmoreland counties from 2007 through 2010. While the state and all counties are trending downward, Fayette County was significantly higher in 2007, 2008, and 2009, and Westmoreland County in 2009.

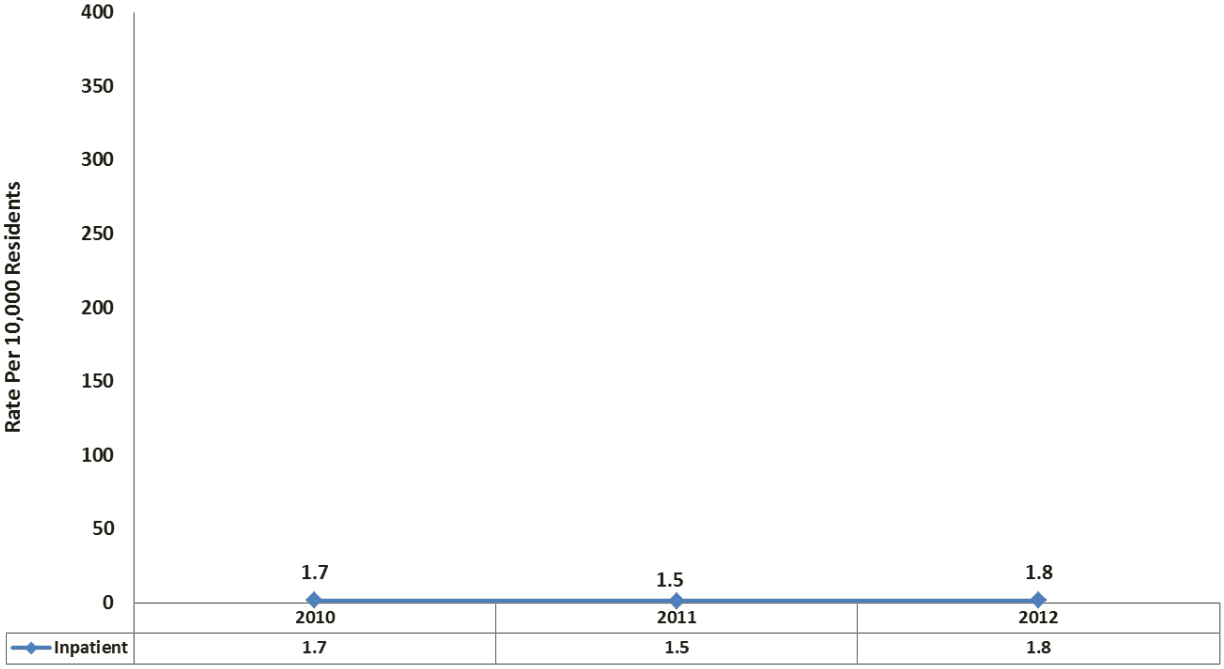
Figure 65: Cardiovascular disease mortality rate



Source: Pennsylvania Department of Health

Figure 66 illustrates the number of congestive heart failure inpatient discharges per 10,000 residents from the Jefferson Regional service territory from 2010 through 2012. Although the rates are low, they have increased slightly throughout the past three years.

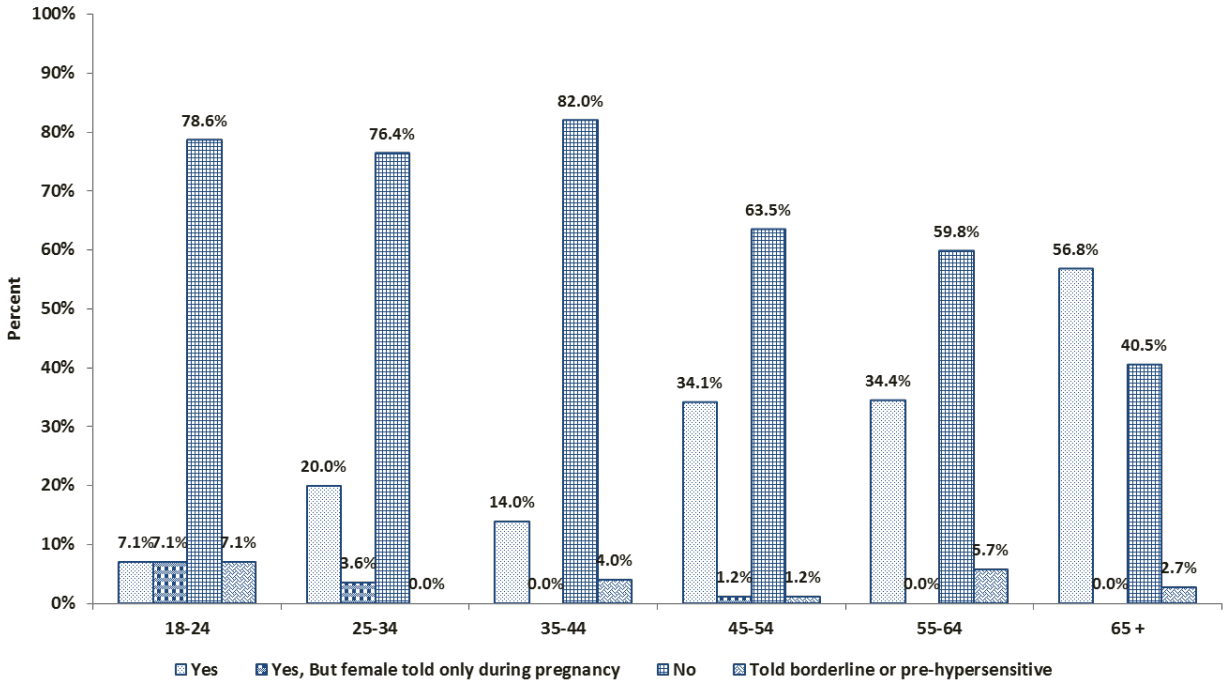
Figure 66: Hypertension inpatient discharges



Source: Pennsylvania Health Care Cost Containment Council

Figure 67 illustrates responses of respondents from the 2012 Service Area BRFSS by age told they have high blood pressure. The percentage of adults who have been told they have high blood pressure tends to increase with age, with more than (56.8 percent) over age 65 told that they have high blood pressure. Only 7.1 percent of those 18 to 24 have been told they have high blood pressure.

Figure 67: 2012 BRFSS: Told you have high blood pressure



Source: 2012 Jefferson Regional Medical Center BRFSS

Table 27 illustrates the responses from the 2012 Service Area BRFSS by age group when asked to identify how long it has been since the last time their blood pressure was taken. The majority (79 percent or more) of respondents across all age groups indicated that they have had their blood pressure taken within the last six months.

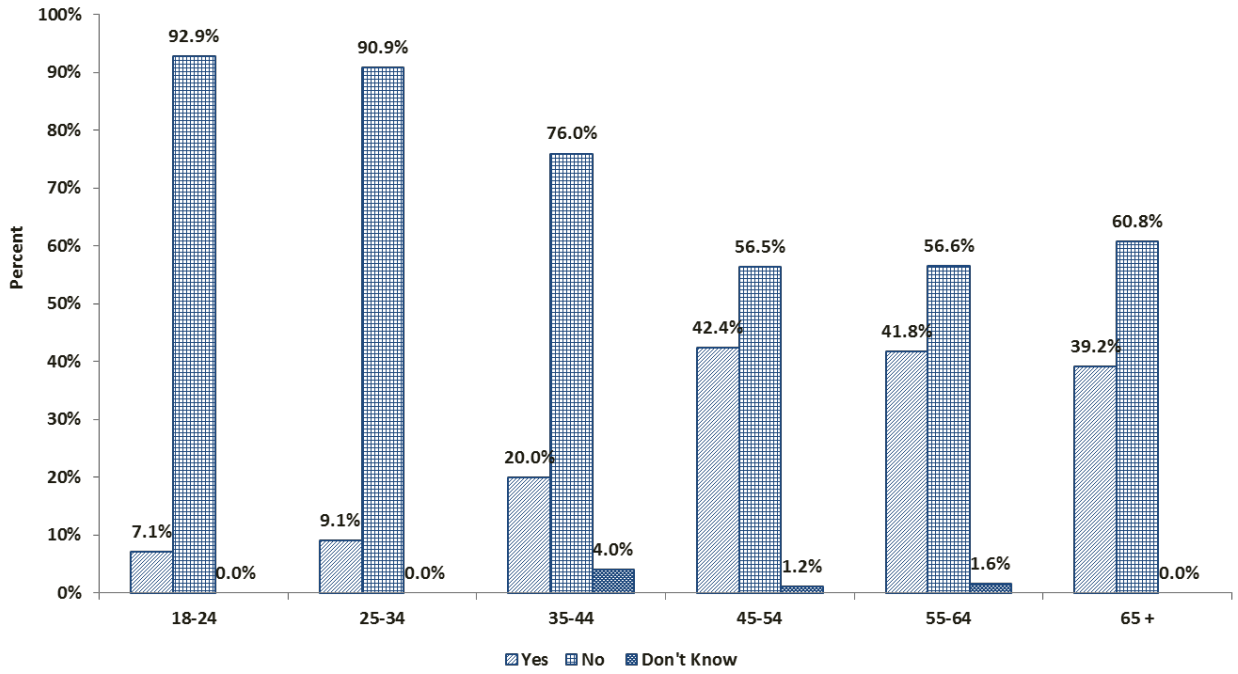
Table 27: 2012 BRFSS: Last time blood pressure taken

Age Category	Length of Time						
	<6 Months	7-12 Months	1-2 Years	2-5 Years	5+ Years	Don't Know	Never
18-24	79.0%	0.0%	14.0%	0.0%	7.0%	0.0%	0.0%
25-34	78.0%	9.0%	7.0%	0.0%	2.0%	2.0%	2.0%
35-44	88.0%	8.0%	0.0%	2.0%	2.0%	0.0%	0.0%
45-54	81.0%	8.0%	5.0%	1.0%	5.0%	0.0%	0.0%
55-64	84.0%	7.0%	2.0%	3.0%	4.0%	0.0%	0.0%
65 +	85.0%	6.0%	3.0%	2.0%	3.0%	0.0%	0.0%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 68 illustrates the responses from the 2012 Service Area BRFSS respondents when asked have they ever been told to reduce their cholesterol. Under age 34, less than 10 percent of respondents had been told to reduce their cholesterol. That number doubles to 20 percent among those 34 to 44 and then doubles again (to 42.4 percent) among those age 45 to 54 and older.

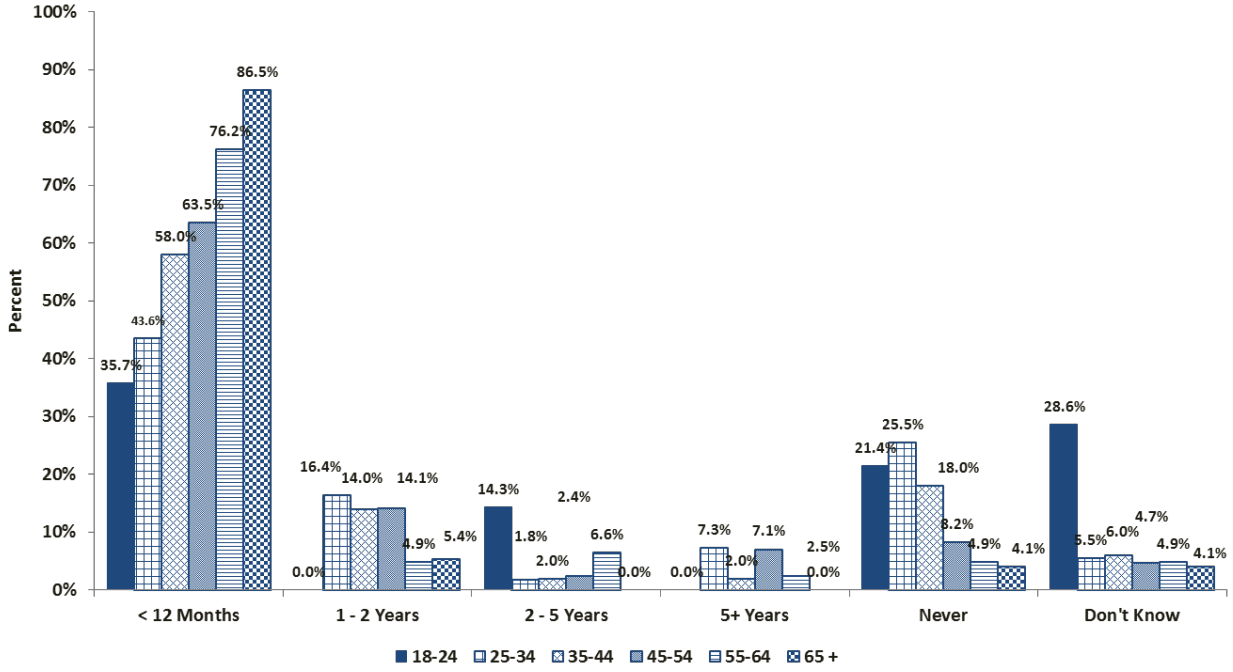
Figure 68: 2012 BRFSS: Ever been told to reduce cholesterol



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 69 illustrates the responses, by age group, from the 2012 Service Area BRFSS, when the last time their cholesterol was checked. The likelihood that their cholesterol has been checked in the last 6 months increases with age from about a third of those 18 to 24 having their cholesterol checked and almost all (86.5 percent) of those 65 and over.

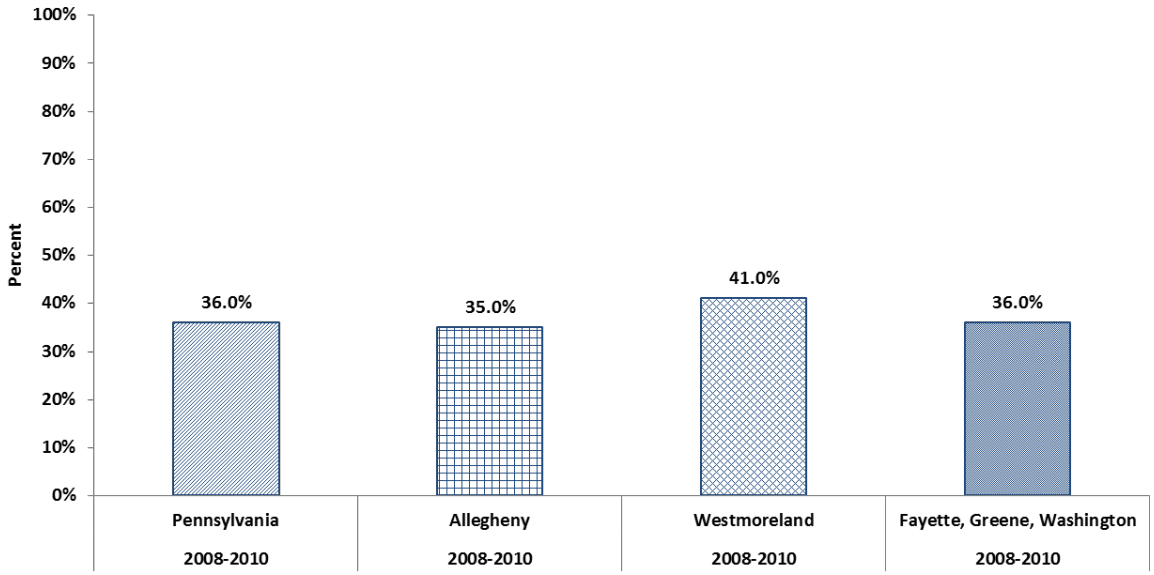
Figure 69. 2012 BRFSS: Last time cholesterol checked



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 70 illustrates the percentage of adults overweight from the Commonwealth of Pennsylvania Allegheny, Westmoreland and Fayette, Green and Washington counties for years 2008 through 2010. Individuals with a Body Mass Index (BMI) between 25 and 30 are considered to be overweight. Although the percentages are comparable between the state and counties, Westmoreland County was slightly higher at 41.0 percent.

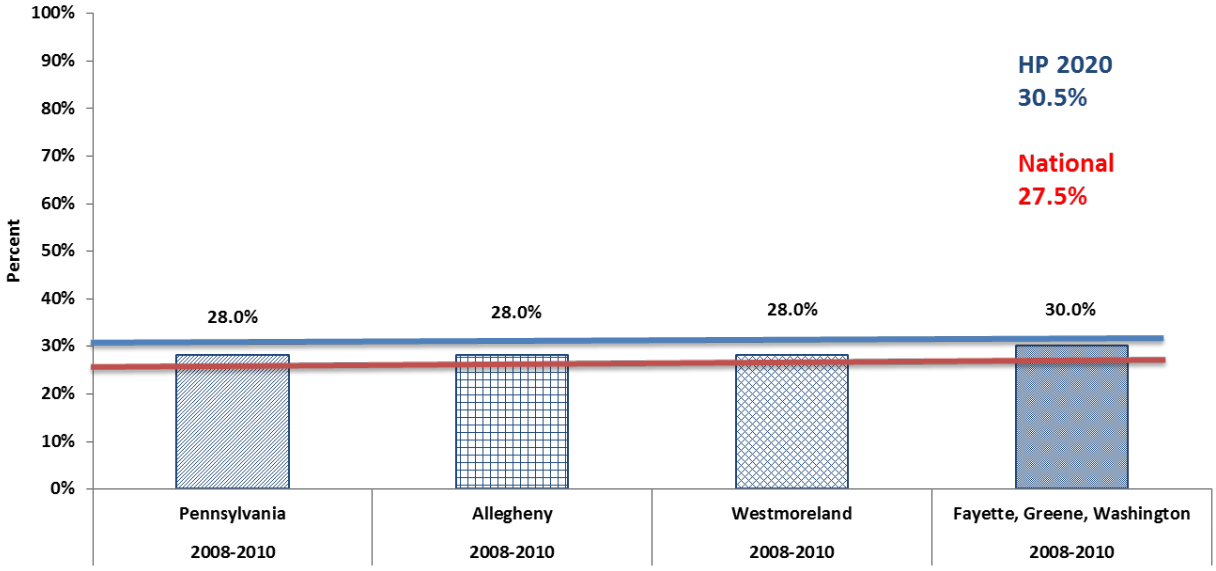
Figure 70: Adults overweight



Source: Pennsylvania Department of Health

Figure 71 illustrates the percentage of adults obese from the Commonwealth of Pennsylvania Allegheny, Westmoreland and Fayette, Greene and Washington counties for years 2008 through 2010. Individuals with a Body Mass Index (BMI) greater than 30 are considered to be obese. The percentages are comparable between the state and counties and all below the HP 2020 goal of 30.5 percent.

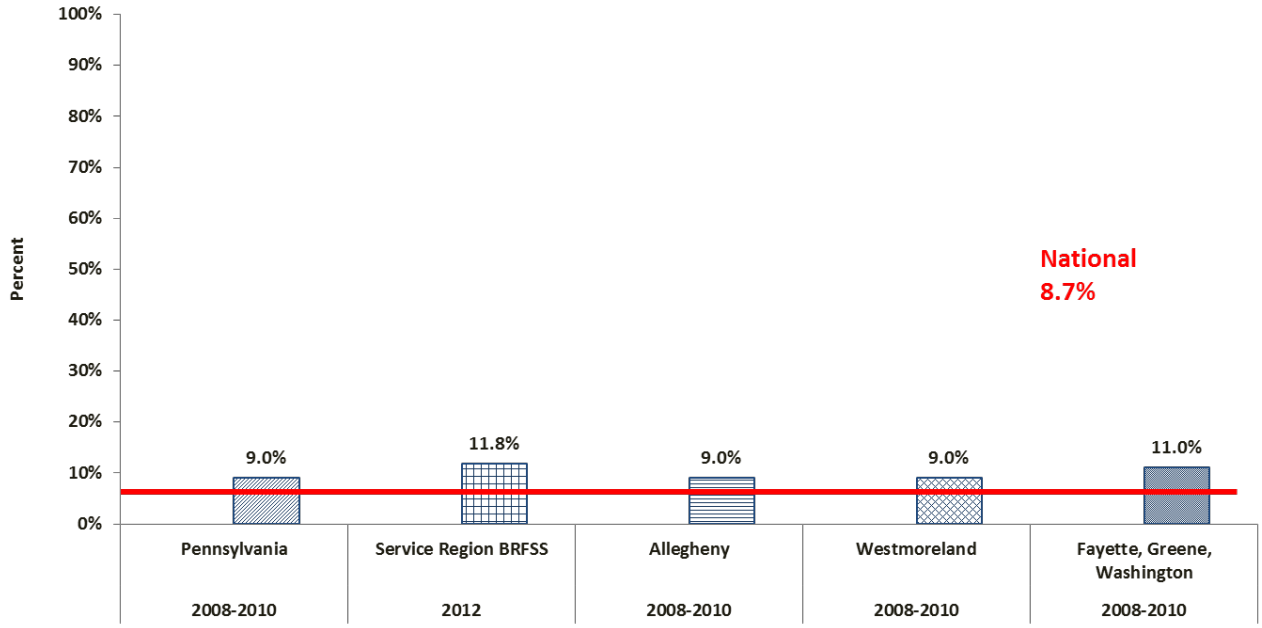
Figure 71: Adults obese



Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

Figure 72 illustrates the number of respondents from the Commonwealth of Pennsylvania and Allegheny, Westmoreland, Fayette, Greene and Washington counties for the years 2008 through 2010 and the service region BRFSS for the year 2012 who were told they have diabetes. The percentage of the service region population that has been told they have diabetes is 11.8 percent, which is slightly higher than the state and national rates.

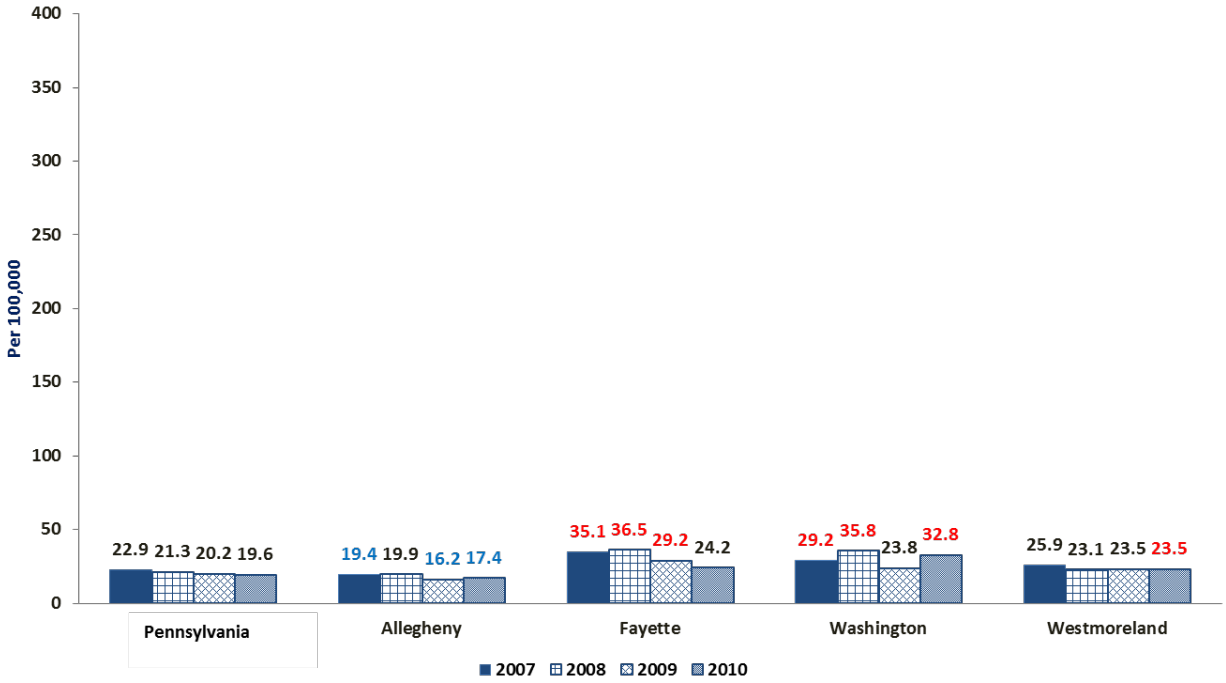
Figure 72: Ever told they have diabetes



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 73 illustrates the diabetes mortality rates, per 100,000, in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington and Westmoreland counties from 2007 through 2010. The rates have been declining across the state and in all counties of the service region except Washington County, where the rate is significantly higher than the state rate for three of the past four years. The Allegheny County rate was significantly lower than the state rate for three of the past four years.

Figure 73: Diabetes mortality rate



Source: Pennsylvania Department of Health

Table 28illustrates responses from the 2012 Service Area BRFSS when asked the number of times the participants have had an "A One C" test in the past 12 months. The majority (41.0 percent) of responses have not had the test done in the last 12 months, while 24.3 percent of respondents have had one "A One C" in the past 12 Months.

Table 28: 2012 BRFSS: "A One C" test in the past 12 months

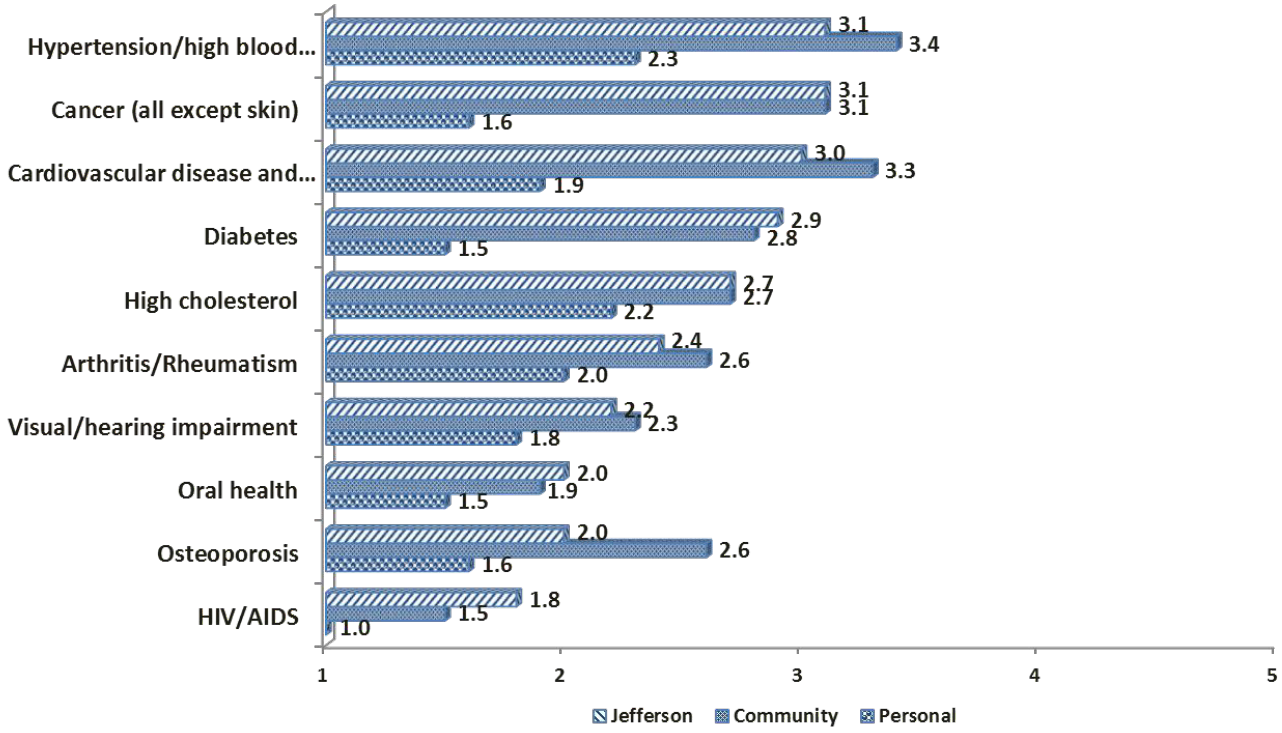
Number of Times	Number of Respondents	Percent
0	164	41.0%
1	97	24.3%
2	37	9.3%
3	12	3.0%
4	9	2.3%
5	1	0.3%
6	1	0.3%
8	2	0.5%
12	1	0.3%
20	1	0.3%
Never Heard of the Test	30	7.5%
Don't Know	44	11.0%

Source: 2012 Jefferson Regional Medical Center BRFSS

Focus Group Input

Focus Group participants were asked to rate the extent to which a number of issues are a problem in the community, in the Jefferson Regional service region overall and in their personal life. Items were rated based on a 5 point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 74 illustrates the rank ordering of the issues related to Chronic Diseases. Issues were rank ordered based on the average score of how much of a problem the issue is in the Jefferson Regional service region overall. Hypertension/High Blood Pressure was rated as the most serious chronic disease related issue in the service region. Cancer, Cardiovascular Disease and Diabetes were all rated as somewhat serious problems.

Figure 74: Focus Groups: Chronic Disease



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

Focus group participants had a lot of discussion regarding chronic diseases, both as drivers of community health status as well as top problems in the community. Some of the participants felt that there is a very high cancer rate in the service region, and some participants noted that there is a particularly high cancer rate in the northern part of Baldwin. The perception is that cancer is very prevalent in the community. If you are a woman, breast cancer is certainly a concern. Everybody knows someone who has cancer, and some expressed concern that the numbers are underreported.

The age of the population was mentioned as a factor contributing to the high incidence of chronic diseases, especially cardiovascular disease. Hypertension is a problem in the community because a lot of people are not aware that they have it. Some recognize that the high tobacco use rate in the community contributes to the cancer rate, although some noted that they feel genetics plays a role. Arthritis was mentioned by one of the groups as a top priority.

Stakeholder Interview Input

Stakeholders interviewed for this assessment identified heart disease, lung disease, and cancer as chronic conditions that exist in the Jefferson Regional service region. Some of these conditions are affected by environmental quality issues like poor air and water quality and tobacco use, which both contribute to diseases like asthma and Chronic Obstructive Pulmonary Condition (COPD). Comments documenting health concerns specifically driven by environmental factors such as air and water or tobacco use are further discussed in the sections titled Healthy Environment and Tobacco Use.

Heart and lung disease were top needs listed by stakeholders. Nearly all discussions surrounding heart and lung disease were in relation to disease causes, including environmental factors, and preventive care education. Diabetes education was listed as a top need by stakeholders in this process. Discussions surrounding diabetes were in relation to patient education and preventive care, physical activity and nutrition. Cancer was also listed by many interviewees as a concern. Oncology resources, especially for rising gynecological cancer rates, can be improved. There is question among some community members whether environmental factors like air quality could also be playing a role in these chronic conditions.

In regard to chronic disease, stakeholders mentioned that more emphasis should be placed on diabetes prevention and education, improved services for cardiovascular and pulmonary care as well as cancer care.

Chronic Disease Conclusions

There are a number of observations and conclusions that can be derived from the data related to Chronic Disease. They include:

- Breast cancer Incidence Rates trended upward in Pennsylvania and Westmoreland County, and was significantly higher in Allegheny County in 2008.
- Breast cancer incidence rates were comparable between the state and counties for the years 2007 through 2010.
- In 2011 and 2012 Pennsylvania had an increased percentage of adults who had a mammogram screening compared to the counties, which were comparable across the time period.
- The majority of 2012 BRFSS respondents (22.3 percent) had a mammogram in the past year. The age group 35-44 had the largest percentage (22.0) of women who never had a mammogram.
- Colorectal cancer incidence and mortality rates trended downward in the state, Allegheny, Washington, and Westmoreland Counties for years 2007 through 2009. In Fayette County the incidence and mortality rates trended upward across the time period and were significantly higher in 2009.
- From the 2012 BRFSS, 62 percent of respondents age 65 or older had a colonoscopy.
- Bronchus and Lung cancer incidence rates were significantly higher in Allegheny and Fayette counties in 2007 through 2009 compared to the state.
- Bronchus and Lung cancer mortality rates were significantly higher in Fayette County in 2007 and 2010, and Washington County in 2008.
- In the state and all counties, except Washington County, prostate cancer incidence rates trended downward for years 2007 through 2009 and were significantly lower in Fayette County in 2009 and significantly higher in Washington County in 2008.
- Ovarian cancer incidence rates were comparable between the state and all counties.
- From the 2012 BRFSS 74.0 percent of respondents age 65 or older had a PSA test.
- Ovarian cancer mortality rates were significantly higher in Washington County in 2008 and 2010.
- The majority of 2012 BRFSS respondents (23 percent) had a PAP test in the past year.
- The percentage of adults over the age of 35 told they have heart disease was comparable between the state and counties and all above the national percentage of 4.1.
- The percentage of adults over the age of 35 told they had a heart attack was comparable between the state and counties and all above the national percentage of 4.2. For adults aged 65 or older Westmoreland and Fayette Counties were significantly higher compared to the state.

- Heart disease mortality rates trended downward in the state and counties, although significantly higher for Allegheny County in 2009, Fayette County in 2007, 2008, and 2009, and Westmoreland County in 2009.
- Heart attack rates trended downward for the state and counties, although significantly higher for Allegheny County in 2007 and Westmoreland County 2007 through 2010.
- Coronary heart disease mortality rates trended downward for the state and counties, although significantly higher for Allegheny County for year 2007 through 2010, Fayette County 2007 through 2010, and Westmoreland County in years 2007 and 2009. The state and all counties were above the Healthy People 2020 goal of 100.8 for all years.
- Heart failure mortality rates were significantly lower in Allegheny County in 2008 and Westmoreland County in 2007.
- The percentage of adults who reported a stroke was comparable between the state and counties.
- Cardiovascular disease mortality rates trended downward for the state and all counties, although significantly higher in Fayette County for years 2007, 2008, and 2009, and Westmoreland County in 2009.
- From the 2012 BRFSS, 56.8 percent of adults aged 65 or older were told they have high blood pressure. However, 85 percent have had their blood pressure checked within the past 6 months.
- From the 2012 BRFSS, 42.4 percent of adults aged 45-54 were told they needed to reduce their cholesterol.
- The percentage of adults overweight was comparable across the counties with the highest percentage (41.0) in Westmoreland County.
- The percentage of obese adults was comparable across the counties with the highest percentage (30.0) in Fayette County.
- The percentage of adults told they had diabetes was comparable across the state and all counties, and all were above the national percentage of 8.7.
- Diabetes mortality rates trended downward in all counties except Washington County, and were significantly lower in Allegheny County for years 2007, 2009, and 2010 and significantly higher in Fayette County 2007, 2008, and 2009, significantly higher in Washington County 2007, 2008, 2010 and significantly higher in Westmoreland County in 2010.
- The majority of 2012 BRFSS respondents had an 'A One C' test within the past year.
- Focus Group respondents ranked hypertension high blood pressure as somewhat of a problem for the service area and community, followed by cancer and cardiovascular disease.

(This Page Intentionally Left Blank)

Healthy Environment

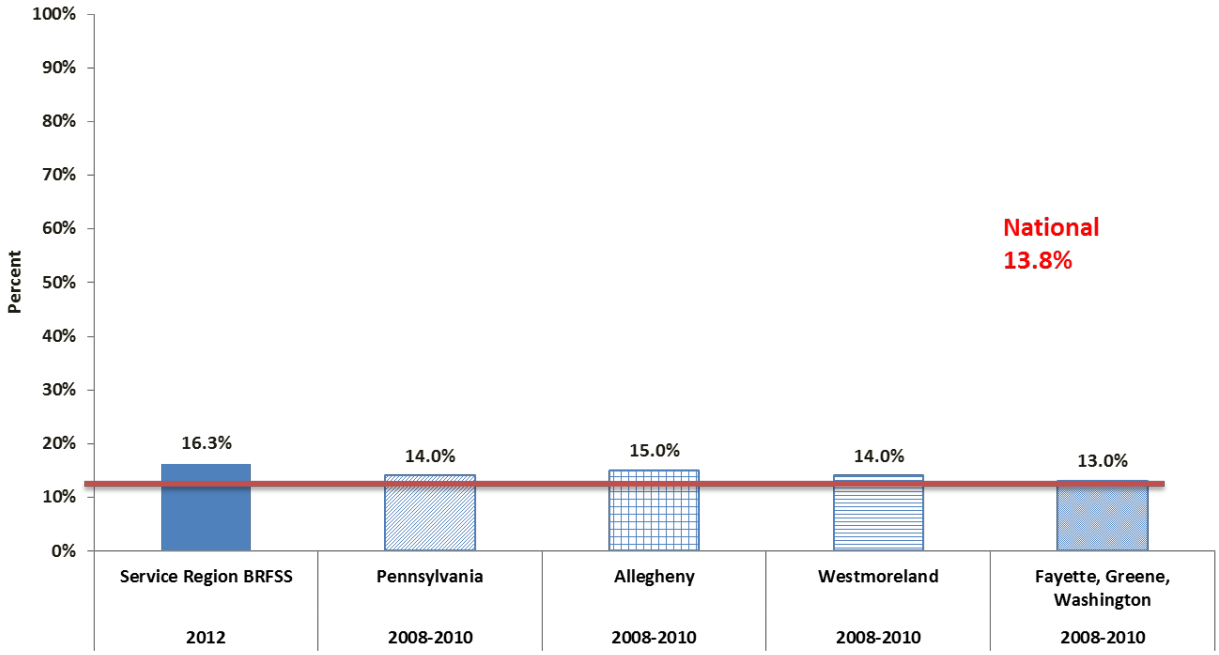
JEFFERSON
REGIONAL MEDICAL CENTER

Healthy Environment

Environmental quality is a general term which can refer to varied characteristics that relate to the natural environment, such as air and water quality, pollution and noise, weather and the potential effects which such characteristics may have on physical and mental health caused by human activities. However, environmental quality also refers to the socioeconomic characteristics of a given community or area, including economic status, education, crime and geographic information.

Figure 75 illustrates the responses when asked if the respondents have ever been told they have asthma, from the Commonwealth of Pennsylvania, BRFSS Service Region, Allegheny County, Westmoreland County, as well as Fayette, Greene, and Washington counties. The percentage of adults who have been told they have asthma in the service region is 16.3 percent.

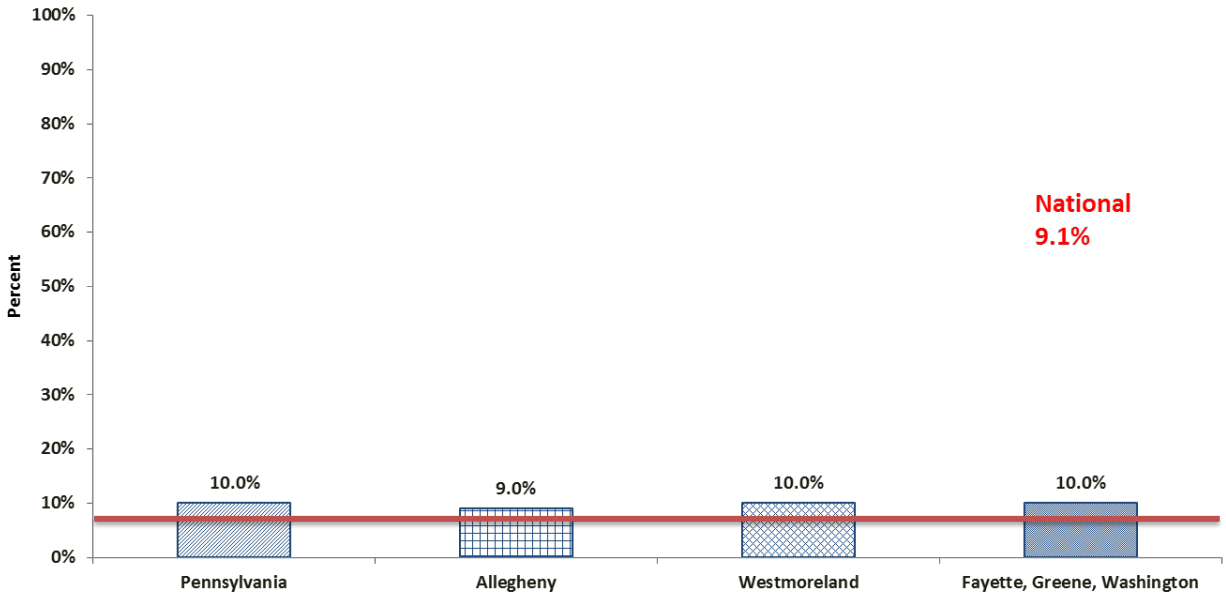
Figure 75: Ever told they have asthma



Source: Pennsylvania Department of Health, Centers for Disease Control 2012 Jefferson Regional BRFSS

Figure 76 illustrates adults who currently have asthma from the Commonwealth of Pennsylvania, and Allegheny, Westmoreland, Fayette, Greene, and Washington counties. The percentage of adults who currently have asthma in the service region counties is between 9 percent and 10 percent.

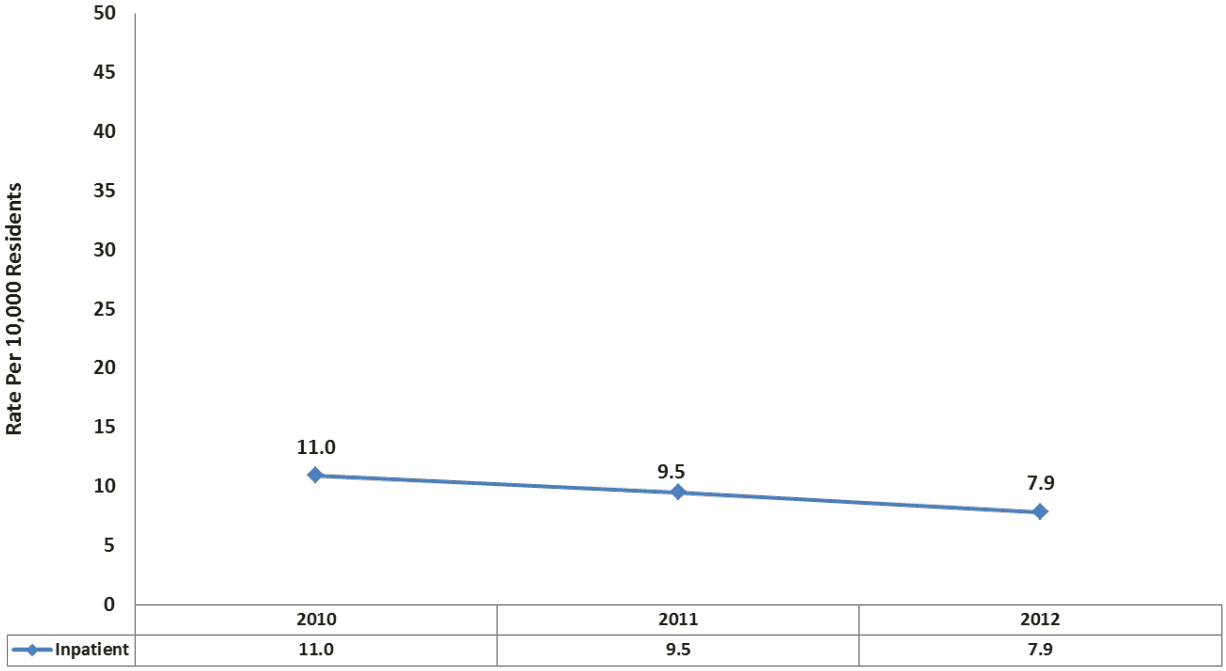
Figure 76: Currently have asthma



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 77 illustrates bronchitis and asthma inpatient discharges for years 2010 through 2012. Across the time period the rate has steadily decreased.

Figure 77: Bronchitis and asthma inpatient discharges



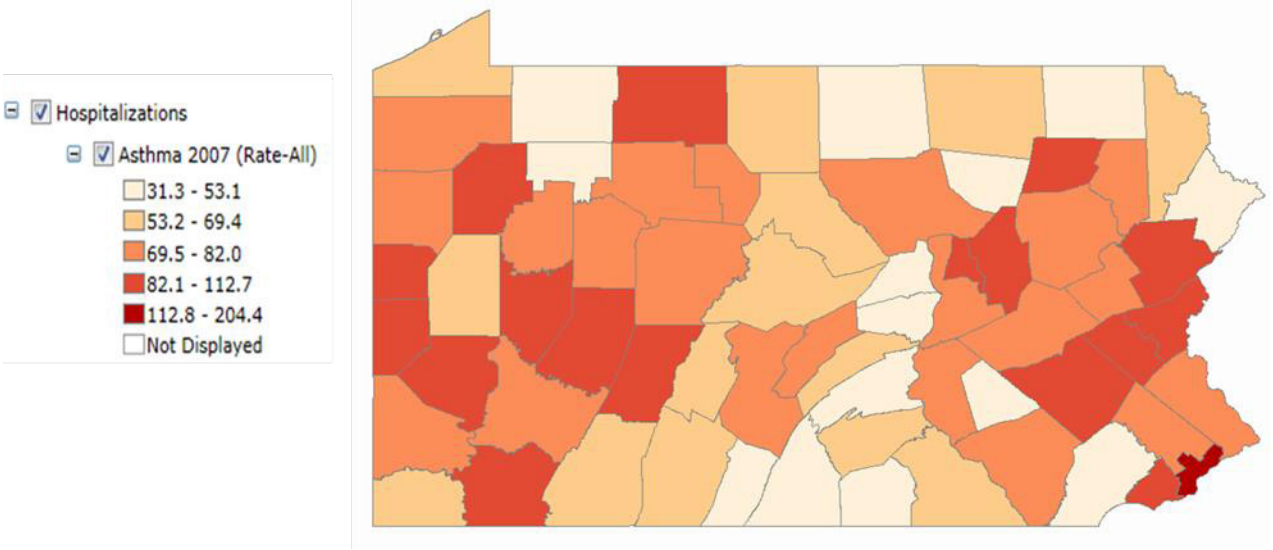
Source: Pennsylvania Health Care Cost Containment Council

In 1980, the CDC established the National Center for Environmental Health. In 2006, the Pennsylvania Department of Health began collection of environmental data associated with health. This is a fairly new process with limited national and state data available. Selected information from this dataset is included in this study to provide a graphical depiction of the service region compared to the state related to specific indicators. The cancer data also provides information on how rates have changed throughout the state over time.

- Asthma Hospitalization
- Ambient Air Quality Measures (Ozone, PM 2.5)
- Infant Mortality
- Cancer (over two decades)

Figure 78 illustrates the number of asthma hospitalizations in 2007. Allegheny and Fayette counties had the highest rate of hospitalizations in the region with a range of 112.8 through 204.4 in 2007.

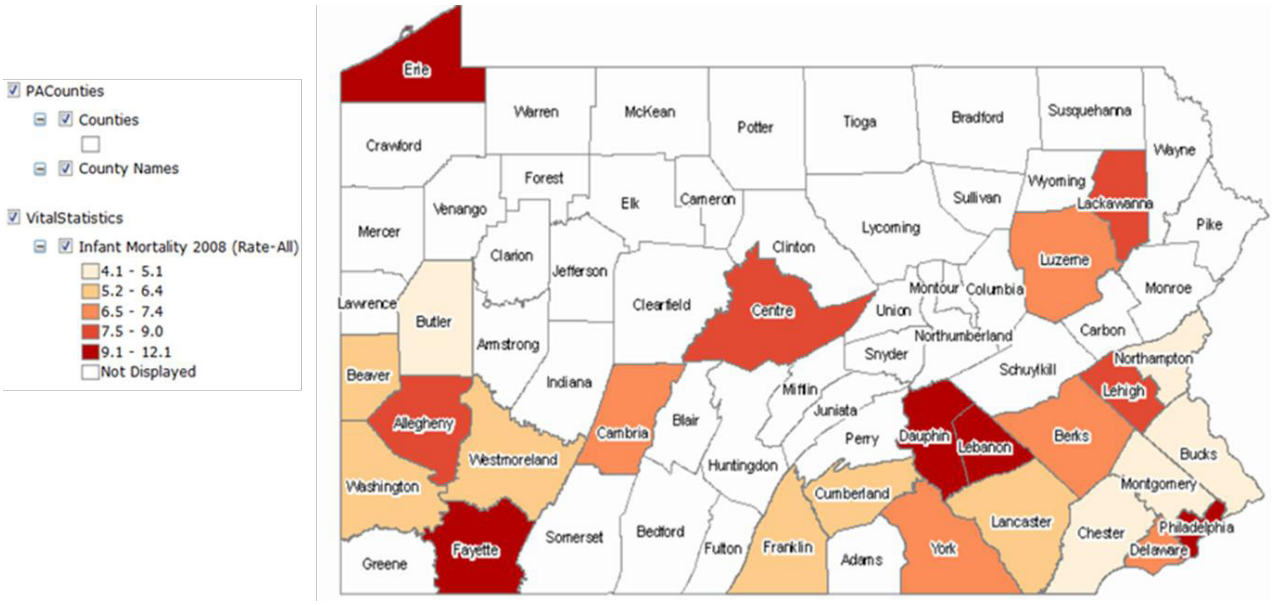
Figure 78: Asthma hospitalizations, 2007



Source: Pennsylvania Department of Health

Figure 79 illustrates infant mortality rates in the Commonwealth of Pennsylvania for 2008. The Allegheny County rate is between 7.5 and 9.0 per 1,000 births. The Fayette County rate is one of the highest in the state, between 9.1 and 12.1.

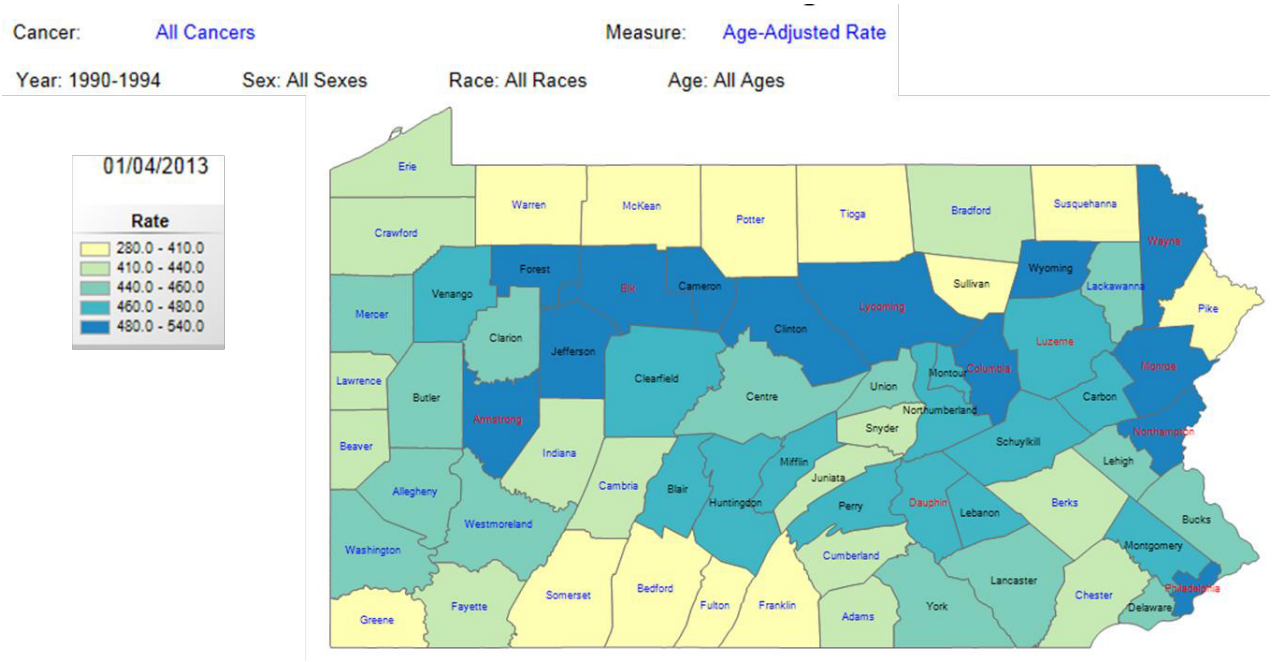
Figure 79: Infant mortality rate 2008



Source: Pennsylvania Department of Health

Figure 80 illustrates all cancers for the years 1990 through 1994.

Figure 80. All cancers 1990 through 1994

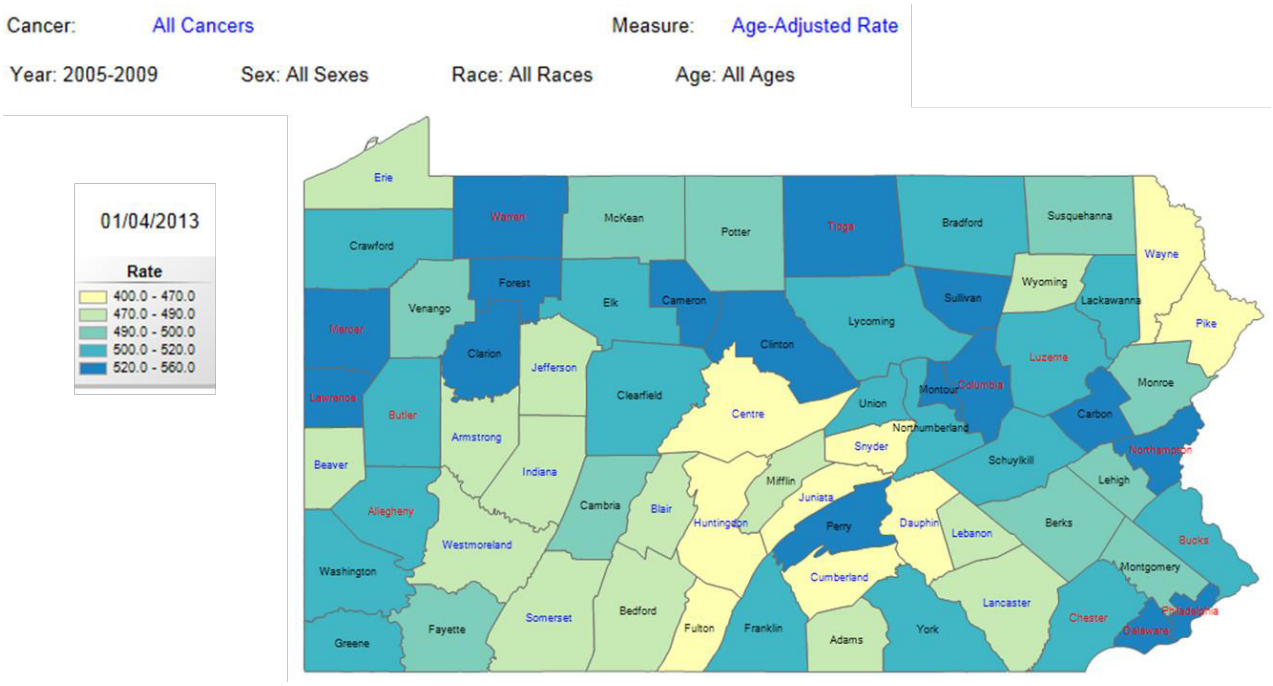


Notes: Age Adjusted Rate per 100,000 (Except age groups Under 15 & Under 20, which are per 1,000,000)
NA = Data Not Available is shown when either the Population or the Count variable is not available or a statistic cannot be calculated.
ND = Data Not Displayed is shown when the Count variable is > 0 but < 6, or statistics are based on < 10 events.
A county's name label shown in red is a significantly higher value than the state's corresponding rate statistic, while blue is a significantly lower value.
All counts exclude in situ cancer cases, except for urinary bladder.
* PI = Pacific Islander
Disclaimer: If you use any of the data provided by EPHTN, please include the following statement in any publication or release: These data were provided by the Bureau of Health Statistics and Research, Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations or conclusions.

Source: Pennsylvania Department of Health

Figure 81 illustrates all cancers from 2005 through 2009 in the Commonwealth of Pennsylvania.

Figure 81. All cancers 2005 through 2009

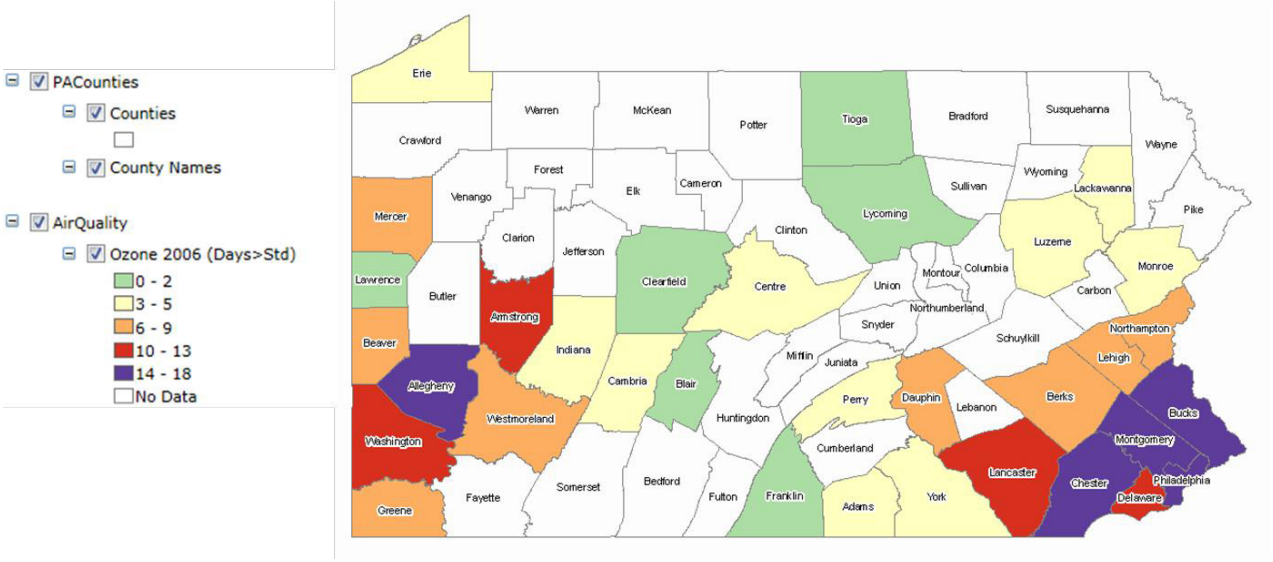


Notes: Age Adjusted Rate per 100,000 (Except age groups Under 15 & Under 20, which are per 1,000,000)
NA = Data Not Available is shown when either the Population or the Count variable is not available or a statistic cannot be calculated.
ND = Data Not Displayed is shown when the Count variable is > 0 but < 6, or statistics are based on < 10 events.
A county's name label shown in red is a significantly higher value than the state's corresponding rate statistic, while blue is a significantly lower value.
All counts exclude in situ cancer cases, except for urinary bladder.
* PI = Pacific Islander
Disclaimer: If you use any of the data provided by EPHTN, please include the following statement in any publication or release: These data were provided by the Bureau of Health Statistics and Research, Pennsylvania Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations or conclusions.
 Source: Pennsylvania Cancer Registry Dataset

Source: Pennsylvania Department of Health

Figure 82 illustrates greater than standard ozone days in the Commonwealth of Pennsylvania for 2006. The Allegheny County rate is among the highest in the state (14-18 days).

Figure 82. Air quality – greater than standard ozone days – 2006



Source: Pennsylvania Department of Health

Marcellus Shale Fracking

"Fracking," or hydraulic fracturing, is a widely used oil and gas drilling technique. Fracking involves injecting huge volumes of water mixed with sand and chemicals deep underground to fracture rock formations and release trapped gas. Potential concerns associated with fracking include impact on both water and air quality, including possible contamination of underground drinking water supplies, surface water contamination by the wastewater that is the byproduct of the drilling (including carcinogens and radioactive elements), and smog-forming pollutants. These effects could contribute to air pollution. In addition, methane is released after the well is producing natural gas and is considered a potential global warming pollutant.

There are few comprehensive studies that outline the net effects of these processes on the community or the environment. As a result, there are several psycho-social issues associated with Marcellus Shale and "fracking" that have been documented, including the stress associated with health concerns and community disruptions associated with the drilling processes themselves. The information included in this study provides relevant excerpts from the few comprehensive studies that have been published to date.

Although "real time" air quality data is available in selected areas, the compiled data is several years old (2007). Additionally, water quality data is only collected in municipalities that have public water systems and is not centrally reported and accessing it is a challenge. Outside of urban areas, water quality data is sporadic and dependent on individual owner testing; current testing standards do not include some of the substances of concern related to fracking.

One study, *"Drilling Down on Fracking Concerns: The Potential and Peril of Hydraulic Fracturing to Drill for Natural Gas"* by Tom Kenworthy and Daniel J. Weiss published in 2011 noted, "In 2008 and 2009, total dissolved solids (TDS) levels exceeded safe drinking standards in the Monongahela River, the source of drinking water for some residents of Pittsburgh. Pittsburgh's water treatment plants are not equipped to remove them from the water supplied to residents." The study also notes "….statistical analyses of post-drilling versus pre-drilling water chemistry did not suggest major influences from gas well drilling or hydro fracturing (fracking) on nearby water wells, when considering changes in potential pollutants that are most prominent in drilling waste fluids."

Another study "The Impact of Marcellus Gas Drilling on Rural Drinking Water Supplies," by Elizabeth W. Boyer, Ph.D.; Bryan R. Swistck, M.S.; James Clark, M.A.; Mark Madden, B.S.; and Dana E. Rizzo, M.S., of the Pennsylvania State University for the Center for Rural Pennsylvania published in March 2012 reported "when comparing dissolved methane concentrations in the 48 wells that were sampled both before and after drilling, the research found no statistically significant increases in methane levels after drilling and no significant correlation to distance from drilling.

However, the researchers suggest that more intensive research on the occurrence and sources of methane in water wells is needed."

According to the Pediatric Environmental Health Unit of the American Academy of Pediatrics, a study conducted in New York and Pennsylvania found that methane contamination of private drinking water wells was associated with proximity to active natural gas drilling." (Osborne SG, et al., 2011) "While many of the chemicals used in the drilling and fracking process are proprietary, the list includes benzene, toluene, ethyl benzene, xylene, ethylene glycol, glutaraldehyde and other substances with a broad range of potential toxic effects on humans ranging from cancer to adverse effects on the reproductive, neurological, and endocrine systems." (ATSDR, Colborn T., et al., U.S. EPA 2009). "Sources of air pollution around a drilling facility include diesel exhaust from the use of machinery and heavy trucks, and fugitive emissions from the drilling and NGE/HF practices….volatile organic compounds can escape capture from the wells and combine with nitrogen oxides to produce ground level ozone." (CDPHE 2008, 2010)

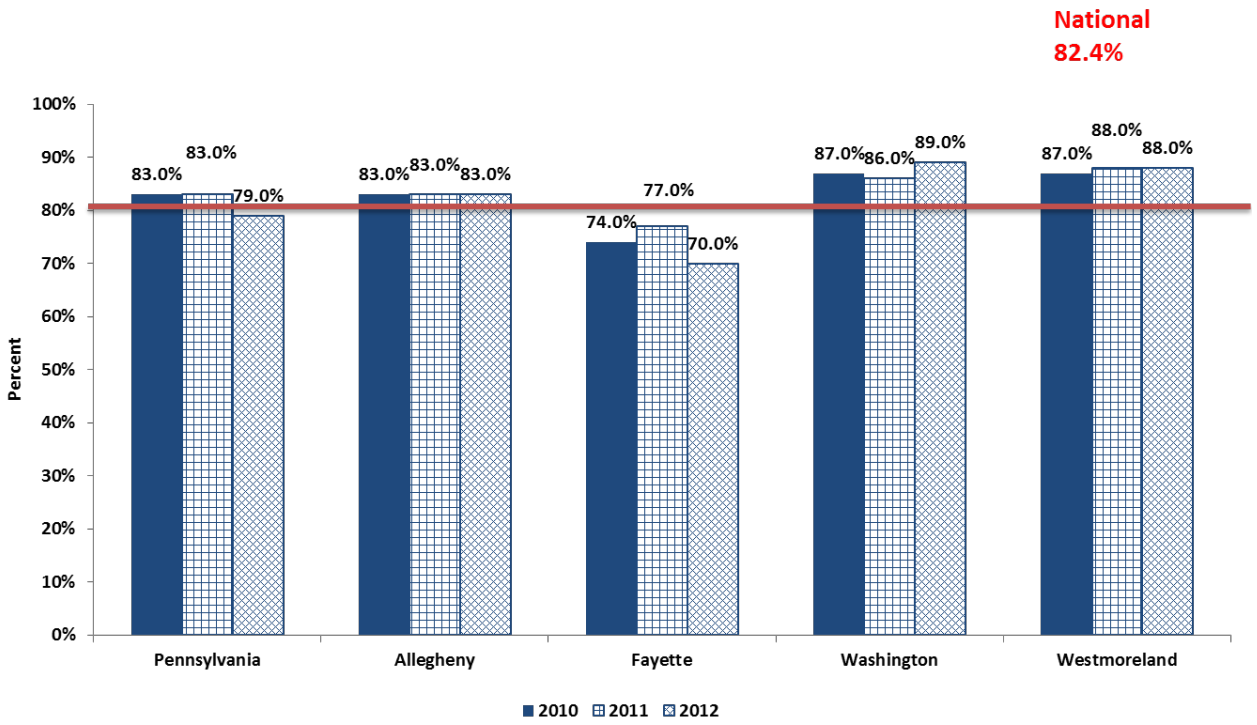
Recent research conducted by the RAND Corporation analyzed water quality, air quality and road damage. The results of the air quality and road damage are not yet published. An article titled "Estimation of regional air-quality damages from Marcellus Shale natural gas extraction in Pennsylvania," by RAND authors A. Litovitz, A. Curtright, S. Abramzon, N. Burger, and C. Samaras was recently published in "Environmental Research Letters." The full publication and video abstract are available, with open access, at: http://iopscience.iop.org/1748-9326/8/1/014017.

This paper provides an estimate of the conventional air pollutant emissions associated with the extraction of unconventional shale gas in Pennsylvania, as well as the monetary value of the associated regional environmental and health damages. The conclusions include:

- In 2011, the total monetary damages from conventional air pollution emissions from Pennsylvania-based shale gas extraction activities is estimated to have ranged from $7.2 to $32 million dollars. For comparison, the single largest coal-fired power plant alone caused $75 million in annual damages in 2008.
- This emissions burden is not evenly spread, and there are some important implications of when and where the emissions damages occur. In counties where extraction activity is concentrated, air pollution is equivalent to adding a major source of NO_x emissions, even though individual facilities are generally regulated separately as minor sources. The majority of emissions are related to the ongoing activities which will persist for many years into the future; compressor stations alone represent 60–75 percent of all emissions.
- Further study of the magnitude of emissions, including primary data collection, and development of appropriate regulations for emissions will both be important. This is because extraction-related emissions, under current industry practices, are virtually guaranteed and will be part of the cost of doing business.

Figure 83 illustrates high school graduation rates for the Commonwealth of Pennsylvania, and Allegheny, Westmoreland, Fayette, Greene, and Washington counties for years 2010 through 2012. Across the time period, Fayette County had lower high school graduation rates, while the state, Allegheny, Washington, and Westmoreland Counties were above the national percentage of 82.4.

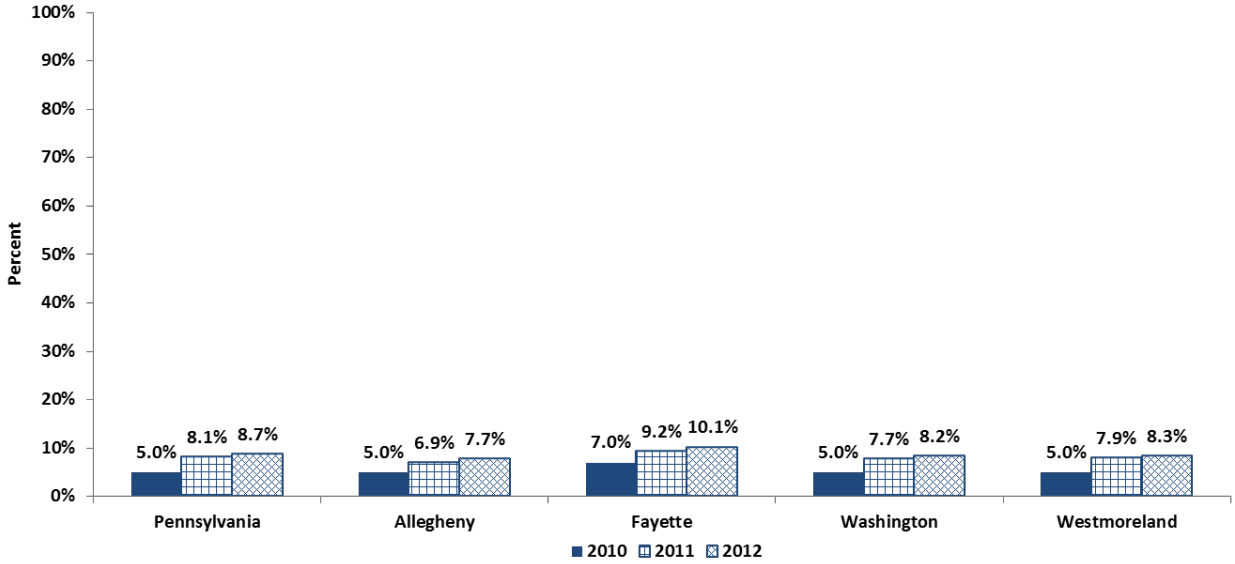
Figure 83: High school graduation rate



Source: www.countyhealthrankings.org

Figure 84 illustrates unemployment rates for the Commonwealth of Pennsylvania, and Allegheny, Westmoreland, Fayette, Greene, and Washington counties for years 2010 through 2012. For the state and counties, the rate steadily increased each year.

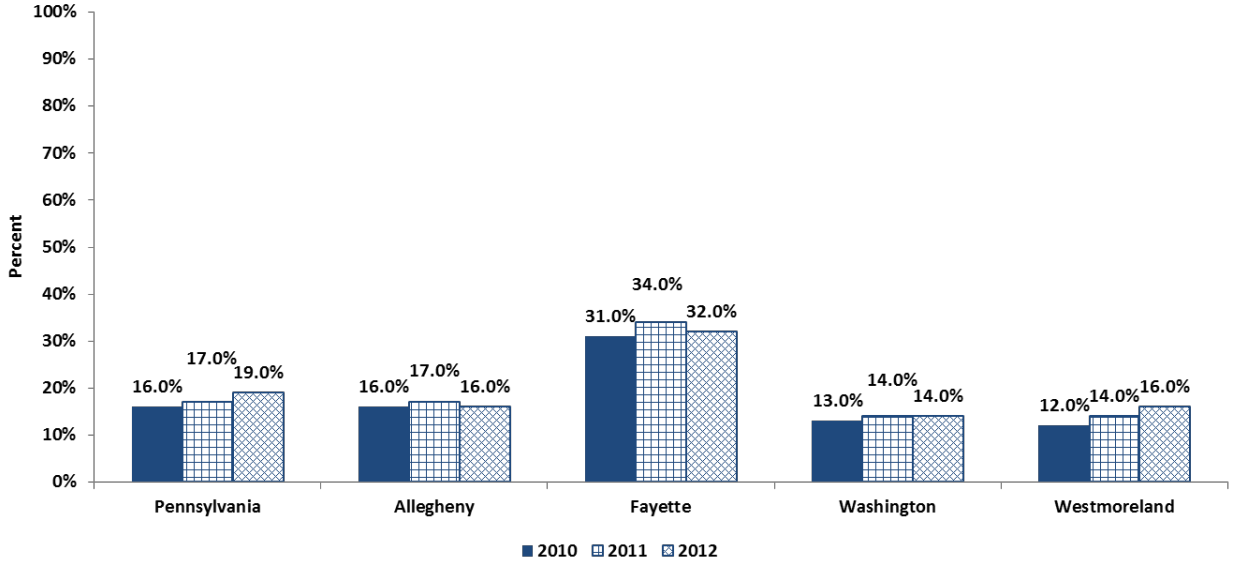
Figure 84: Unemployment rate



Source: www.countyhealthrankings.org

Figure 85 illustrates the percentage of children living in poverty for the Commonwealth of Pennsylvania, and Allegheny, Westmoreland, Fayette, Greene, and Washington counties for years 2010 through 2012. The County Health Rankings reports on children in poverty--the percent of children living in poverty, as defined by the federal poverty threshold--based on data from the Census' Small Area Income and Poverty Estimates (SAIPE).[1] Across the time period, Fayette County had the highest percentage of children living in poverty, while Allegheny, Washington, and Westmoreland counties were comparable to the state.

Figure 85: Children living in poverty

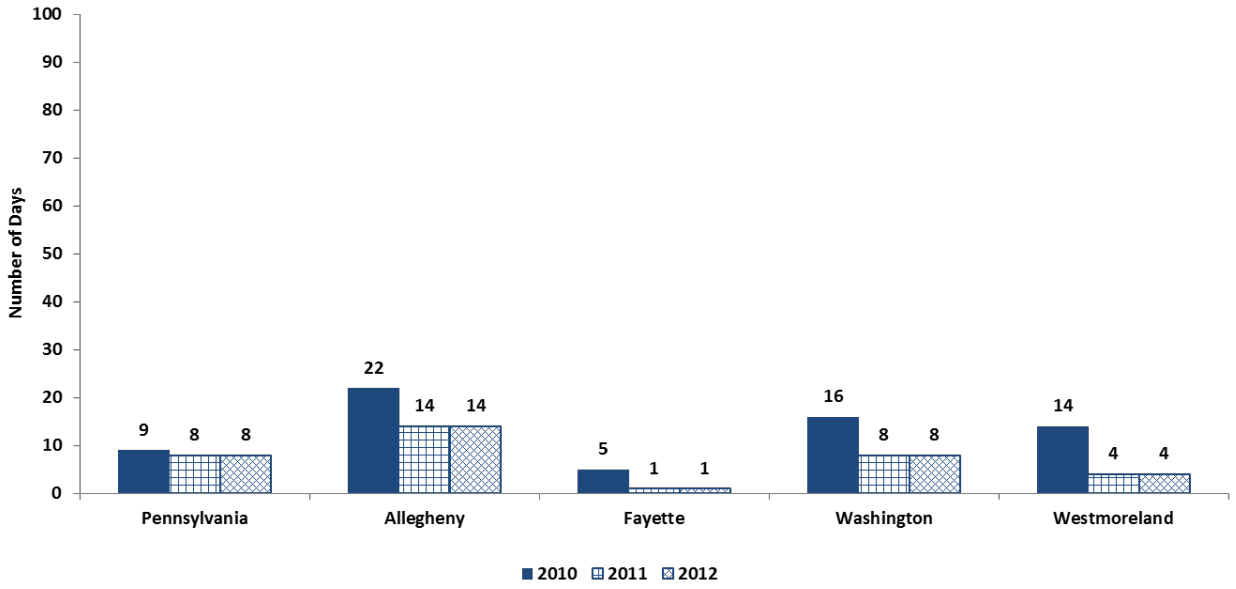


Source: www.countyhealthrankings.org

[1] N.A. (2013). Income: What is the County Health Rankings measurement strategy? County Health Rankings and Roadmap

Figure 86 illustrates the number of air pollution ozone days for the Commonwealth of Pennsylvania, and Allegheny, Westmoreland, Fayette, Greene, and Washington counties for years 2010 through 2012. Across the time period, Allegheny County had more air pollution ozone days compared to the state and other counties.

Figure 86: Air pollution ozone days



Source: www.countyhealthrankings.org

Table 29 illustrates the national air quality standards for Allegheny, Westmoreland, Fayette, Greene, and Washington Counties for years 2010 through 2012. The national air quality standards were met for each county.

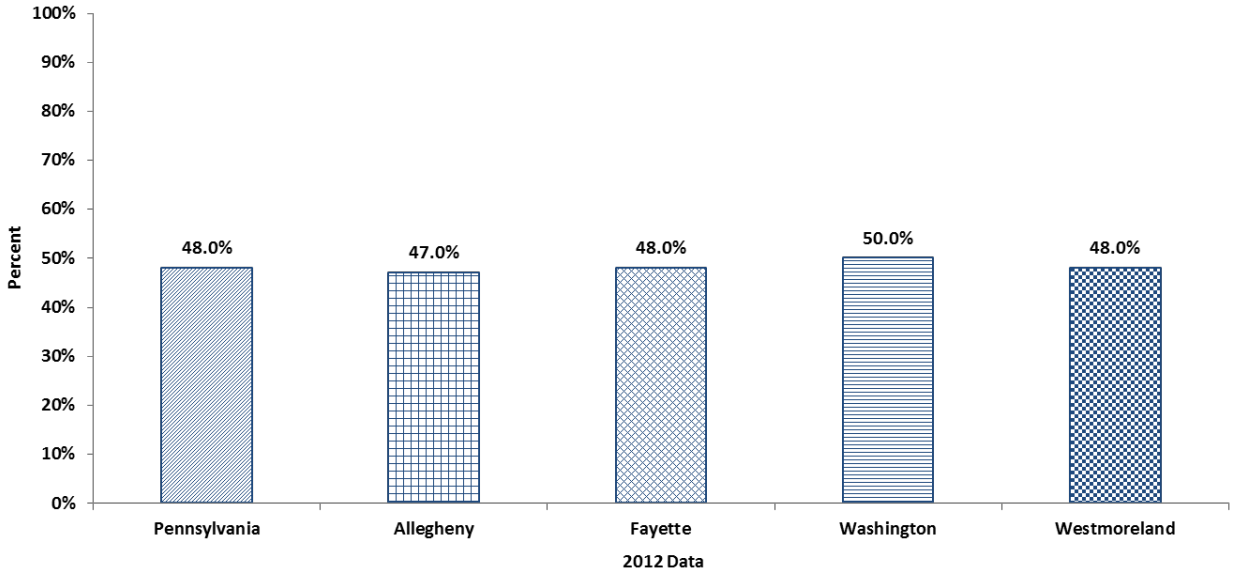
Table 29: Have the national air quality standards been met?

	Carbon Monoxide	Nitrogen Dioxide	Sulfur Dioxide	Ozone	Particulate Matter	Lead
Allegheny	Yes	Yes	Yes	Yes	Yes	Yes
Fayette	Yes	Yes	Yes	Yes	Yes	Yes
Washington	Yes	Yes	Yes	Yes	Yes	Yes
Westmoreland	Yes	Yes	Yes	Yes	Yes	Yes

Source: www.countyhealthrankings.org

Figure 87 illustrates the percentage of fast food restaurants for the Commonwealth of Pennsylvania, and Allegheny, Westmoreland, Fayette, Greene, and Washington counties for the year 2012. For the state and all counties, about half of all restaurants are fast food restaurants.

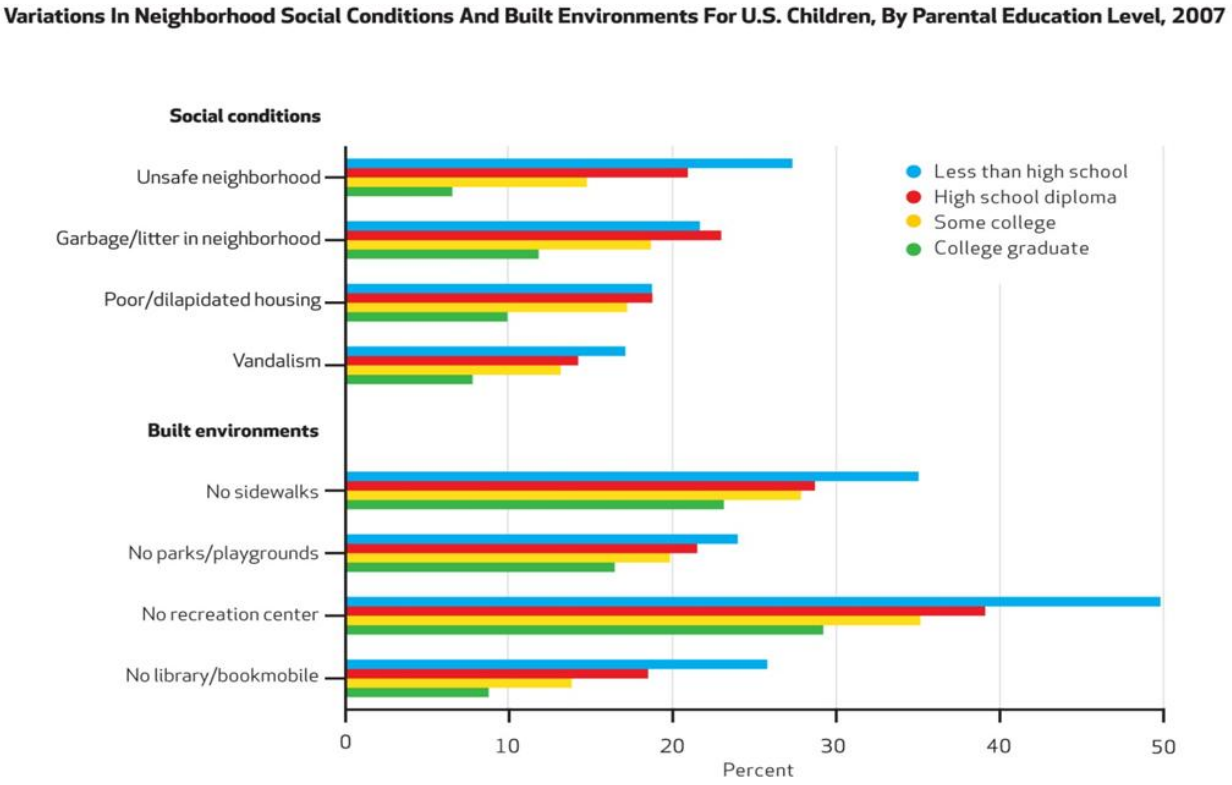
Figure 87: Fast food restaurants



Source: www.countyhealthrankings.org

Figure 88 illustrates variations in neighborhood social conditions and built environments by parent education level in 2007. Those with less than high school educations tend to live in unsafe neighborhoods and face higher levels of vandalism. These areas typically lack sidewalks, parks/playgrounds, recreational centers or library/bookmobiles.

Figure 88: Variations in neighborhood social conditions and built environments by parent education level



Source: National Survey on Childrens Health, 2007 (Note: N=90, 100)

Table 30 illustrates the percentage of BRFSS respondents who own pets. More than half of the respondents (57.0 percent) indicated that they own at least one pet. The largest percentage of respondents indicated that they own one dog (31.0 percent), one cat (12.8 percent), and one of another kind of pet (7.0 percent).

Table 30: 2012 BRFSS: Pets

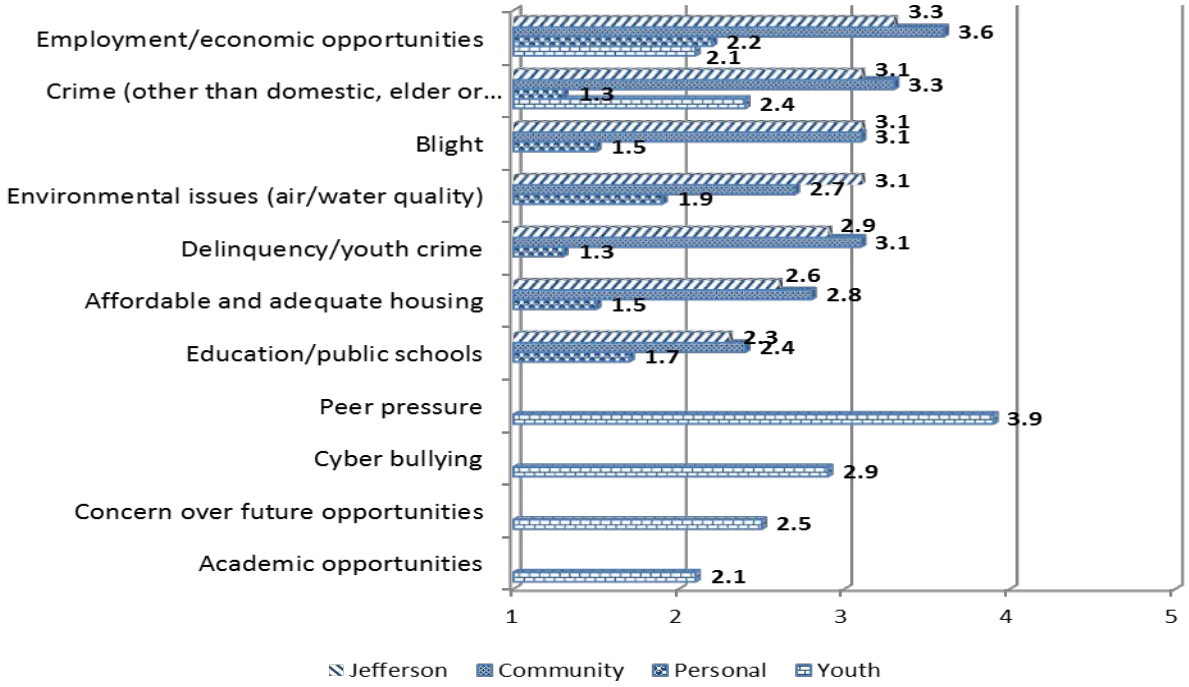
Respondents Who Own Pets (57%)					
Number of Dogs		Number of Cats		Number of Other Pets	
Number	Percent	Number	Percent	Number	Percent
1	31.0%	1	12.8%	1	7.0%
2	7.5%	2	9.5%	2	3.3%
3	1.0%	3	2.5%	3	1.3%
4	0.8%	4	1.3%	4	0
5	0.3%	5	0.3%	5	0.3%
		6-10	0.9%	6	0.9%

Source: 2012 Jefferson Regional Medical Center BRFSS

Focus Group Input

Focus Group participants were asked to rate the extent to which a number of issues perceived to be a problem in the community, in the Jefferson Regional Medical Center service region overall and in their personal life. Items were rated based on a 5-point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 89 illustrates the rank ordering of the issues related to Healthy Environment. Issues were rank- ordered based on the average score of how much of a problem the issue is in the Jefferson Regional service region overall. The most serious issue related to the Healthy Environment in the service region is Employment/Economic opportunities with a rating of 3.2, and the community rating Employment/Economic Opportunities a 3.1. The youth felt peer pressure was the most serious issue related to a Healthy Environment, with a score of 3.9.

Figure 89: Focus Groups: Healthy environment



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

There was a great deal of discussion regarding environmental issues in various focus groups, particularly in the ones that were held in Clairton and Homestead. Blight is a significant concern in parts of the service region. Crime is also a problem in a number of areas. Some participants made the distinction between crime and violence. Violence is an issue, particularly gun violence, and there is a perception that crime was rated higher because of the violence that exists in the community. Gang violence related to drugs is up; dealing is a crime which is part of the problem. There is also a high dropout rate in some school districts, and this impacts the crime rate.

Environmental pollution was identified as one of the top priorities in several of the groups. The rivers are polluted because of the mills. They have gotten cleaner throughout the years, but there are areas, including Elizabeth, where pollution is still a concern. Liberty Borough has one of the highest rates of air pollution in the country. There is a lot of uneasiness with the Marcellus Shale drilling, because of the lack of understanding of the potential impacts on the environment. Participants expressed concern that the environmental impact information would not be made public.

Participants also expressed the need for better employment opportunities, particularly since it is not possible to live and raise a family on a part-time job. Those jobs don't offer health care insurance either, which impacts access to care. Housing is also an issue in the region. There is a need for affordable housing for adults and seniors.

Stakeholder Interview Input

Some of the stakeholders interviewed for this process discussed air and water quality as a possible detriment to the Jefferson Regional service region. Crime and violence were also key concerns for the stakeholders. From steel mills to natural gas drilling, the areas around Jefferson Regional are affected by increased air and water pollution. Many of the stakeholders expressed concerns related to air quality and the environmental issues related to industrial plants and Marcellus Shale fracking; although one stakeholder indicated that they felt the air and water quality is good.

There is a perception among stakeholders that the local school districts are deficient with limited resources, and as a result, communities around Jefferson Regional struggle to support quality education.

School faculty members are overworked and understaffed; services have been cut, and jobs have merged. Overall lack of academic and social support exists, especially with student needs not being met at home. A few stakeholders commented that Duquesne is the worst school district in the state and that Clairton is one of the worst. Academically, students are not up to par, although they excel athletically. The local districts are trying to fix the problem but need support; the priority is not placed on academics.

Increased violence was a major concern among the stakeholders. Unemployment contributes to an increase in crime, and finding employment with a criminal background is very difficult. Violence is prevalent in the area and produces victims/emotional issues. When unemployment is high, people participate in the illegal economy. Most offenses stem from individuals "protecting their turf." After being released from prison, people need help reintegrating into the community—finding treatment options, and other critical services, housing and work.

Healthy Environment Conclusions

There are a number of observations and conclusions that can be derived from the data related to Healthy Environment. They include:

- The percentage of adults ever told they have asthma were comparable between the state, the service area BRFSS, and counties, and slightly below the national percentage (13.8).
- The percentages of adults who currently have asthma were comparable between the state and counties, and all above the national percentage of 9.1.
- High school graduation rates were lower in Fayette County for the years 2010 through 2012. Pennsylvania, Allegheny County, Washington County, and Westmoreland County were above the national percentage (82.4).
- Unemployment rates have steadily increased for the state and all counties for the years 2010 through 2012, as have the percentage of children living in poverty.
- The number of air pollution ozone days was highest in Allegheny County for years 2010 through 2012.
- All of the counties met the National Air Quality Standards.
- In Pennsylvania and all of the counties, about half of the restaurants are fast food restaurants.
- Focus Group participants ranked employment/economic opportunities as somewhat of a problem for the service area and community, followed by affordable and adequate housing, and crime.
- Stakeholders interviewed discussed that the air and water quality could be a possible detriment to the service area due to an increase in air and water pollution related to industrial plants and Marcellus Shale fracking.
- Stakeholders interviewed mentioned that there is a concern about the increase in violence and that unemployment contributes to an increase in crime and finding employment with a criminal background is difficult.
- Stakeholders interviewed also commented on the education system in the service area especially regarding that there is a perception among stakeholders that the local school districts are deficient with limited resources and there is a struggle to support quality education, that school faculty members are overworked and understaffed, that Duquesne is the worst school district in the state and that Clairton is one of the worst. There is also a concern that academically, the students are not up to par although they excel athletically.

(This Page Intentionally Left Blank)

Healthy Mothers, Babies, and Children

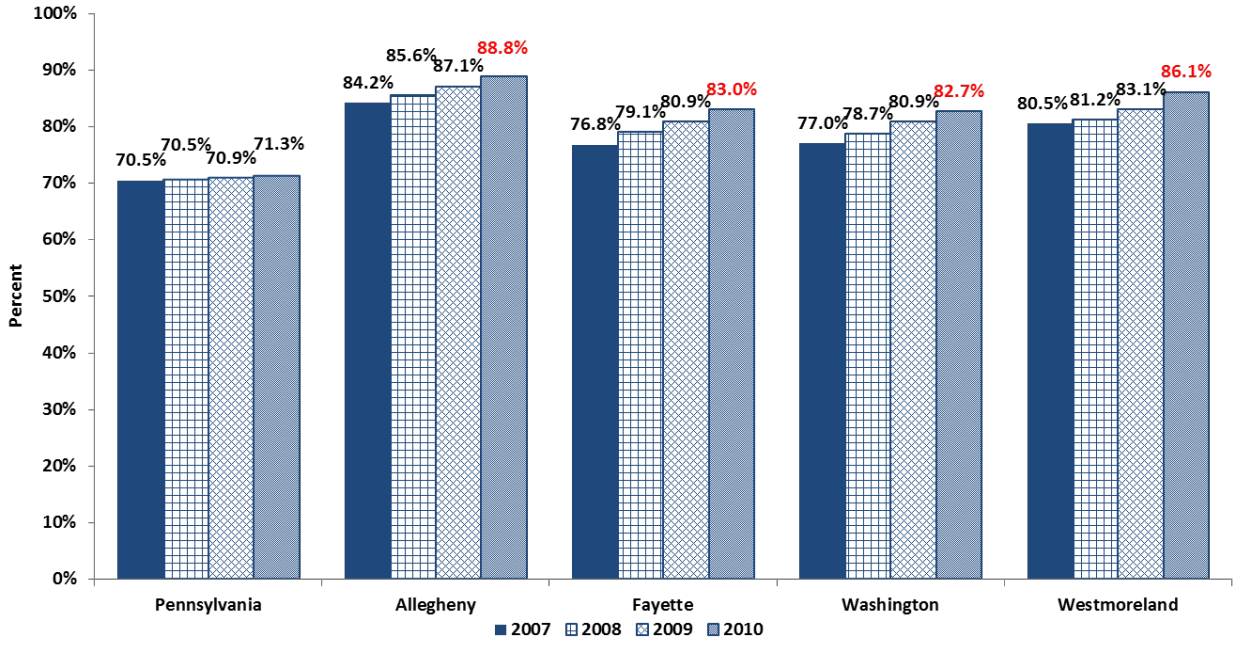
This page is intentionally blank

Healthy Mothers, Babies, and Children

Improving the well-being of mothers, babies and children is a critical and necessary community health need identified for the Jefferson Regional service region by focus group participants and stakeholders. The well-being of children determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The Healthy Mothers, Babies and Children topic area addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life for the entire community.

Figure 90 illustrates prenatal care during the first trimester of pregnancy in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Washington, and Westmoreland counties during 2007 through 2010. Over the time period, the state and all counties showed an upward trend. Compared to the state, Allegheny, Fayette, Washington, and Westmoreland counties were significantly higher in 2010.

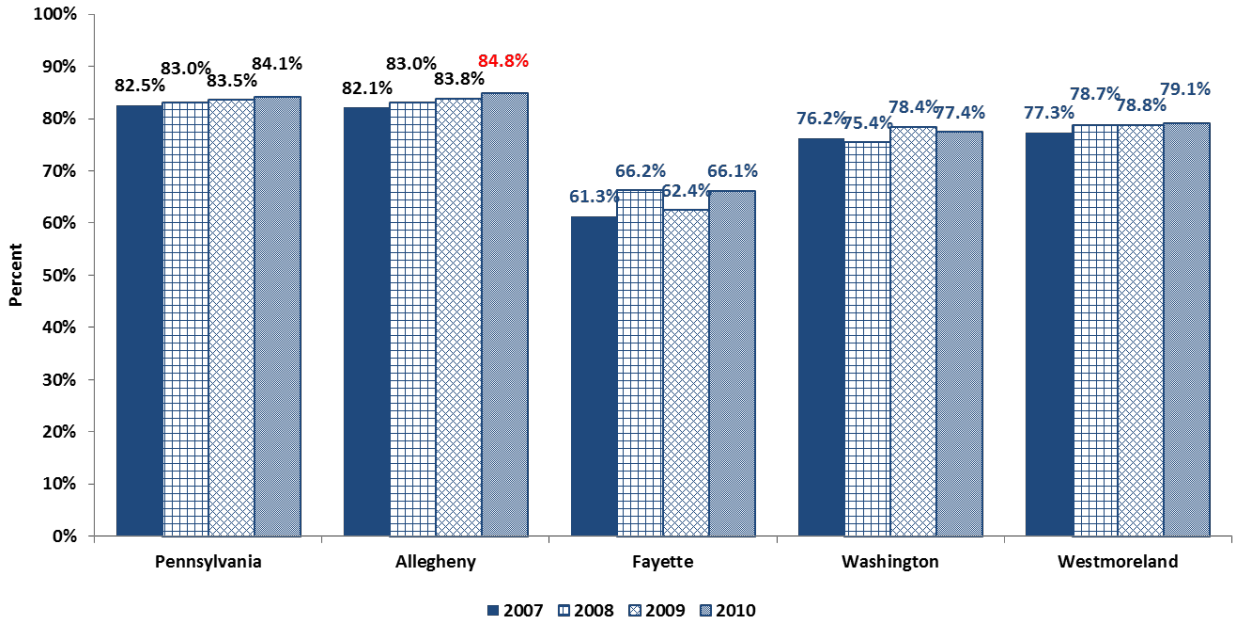
Figure 90: Prenatal care during the first trimester of pregnancy



Source: Pennsylvania Department of Health

Figure 91 illustrates mothers who did not smoke during pregnancy in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Washington, and Westmoreland counties during 2007 through 2010. Compared to the state, Allegheny County was significantly higher in 2010, while Fayette, Washington, and Westmoreland counties were significantly lower for all four years.

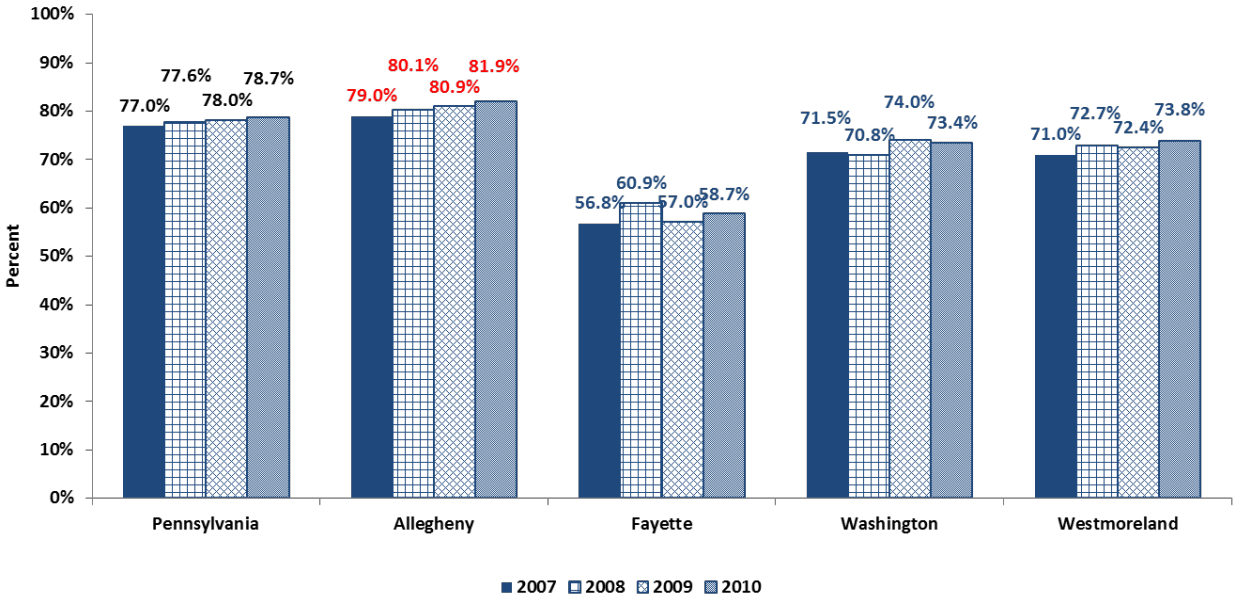
Figure 91: Mothers not smoking during pregnancy



Source: Pennsylvania Department of Health

Figure 92 illustrates mothers who did not smoke three months prior to pregnancy in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Washington, and Westmoreland counties during 2007 through 2010. Compared to the state, Allegheny County was significantly higher for years 2007 through 2010, while Fayette, Washington, and Westmoreland counties were significantly lower for all four years.

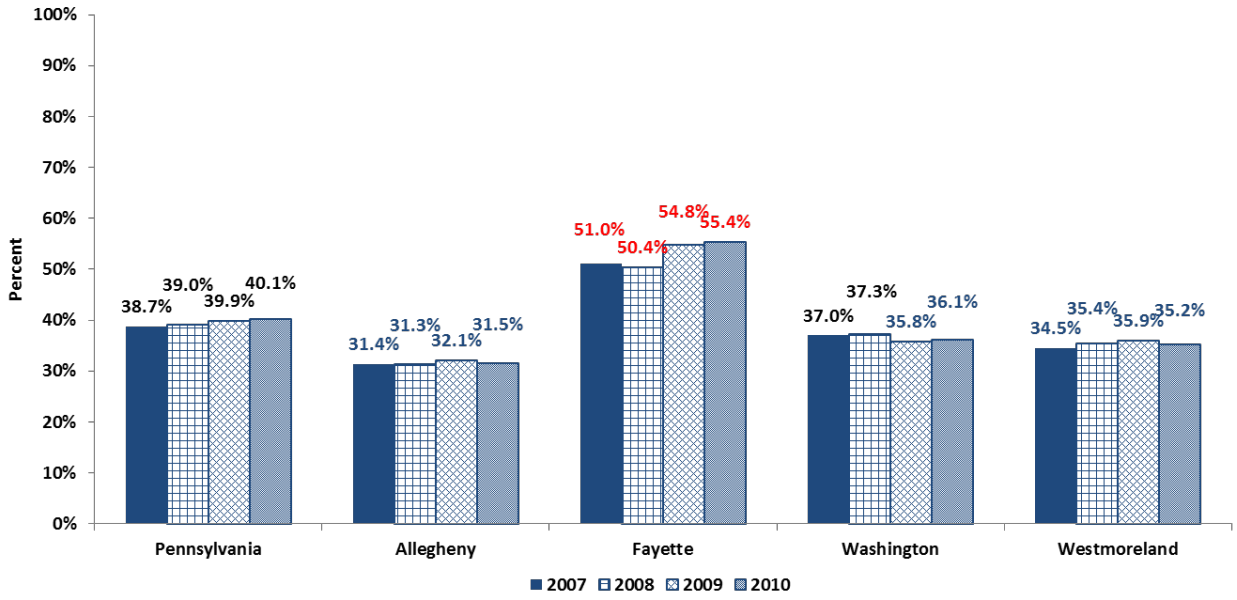
Figure 92: Mothers not smoking three months prior to pregnancy



Source: Pennsylvania Department of Health

Figure 93 illustrates mothers who received the special supplemental nutrition program for Women, Infants, and Children (WIC) in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Washington, and Westmoreland counties during 2007 through 2010. Compared to the state, Fayette County was significantly higher for years 2007 through 2010, while Allegheny and Westmoreland counties were significantly lower. For years 2009 and 2010, Washington County was significantly lower, compared to the state.

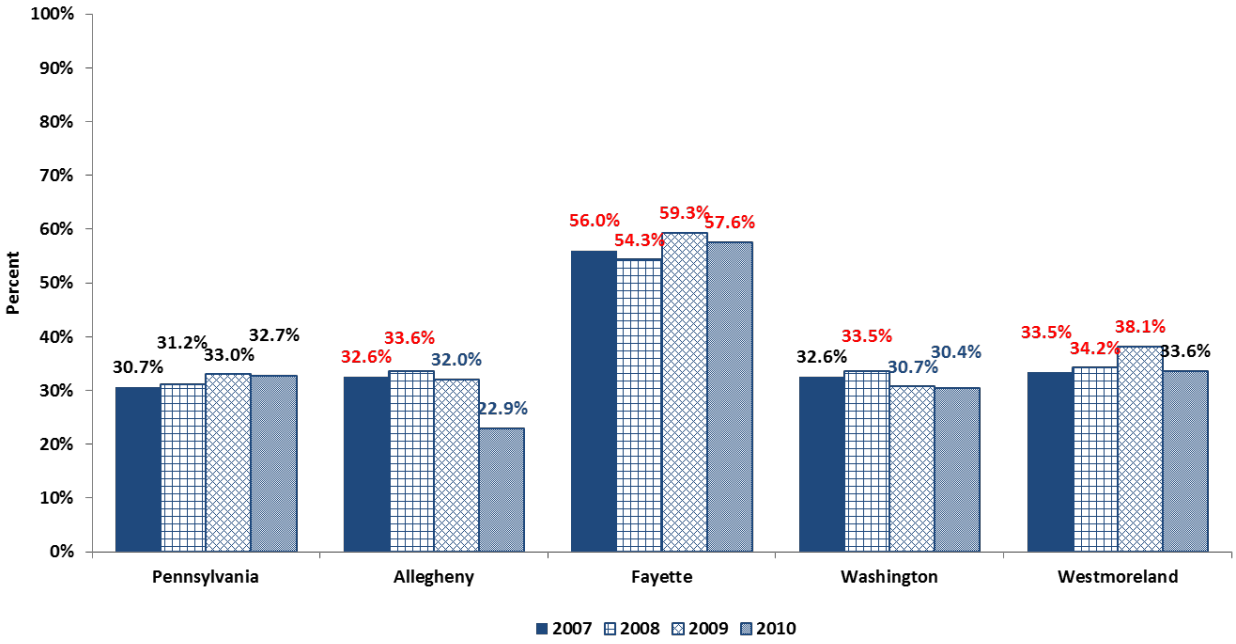
Figure 93: Mothers receiving WIC



Source: Pennsylvania Department of Health

Figure 94 illustrates mothers who received Medicaid in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Washington, and Westmoreland counties during 2007 through 2010. Compared to the state, Fayette County was significantly higher for years 2007 through 2010, as were Allegheny County in 2007 and 2008, Washington County in 2008, and Westmoreland County in 2007, 2008, and 2009. In Allegheny and Washington counties for years 2009 and 2010, the percentages were significantly lower compared to the state.

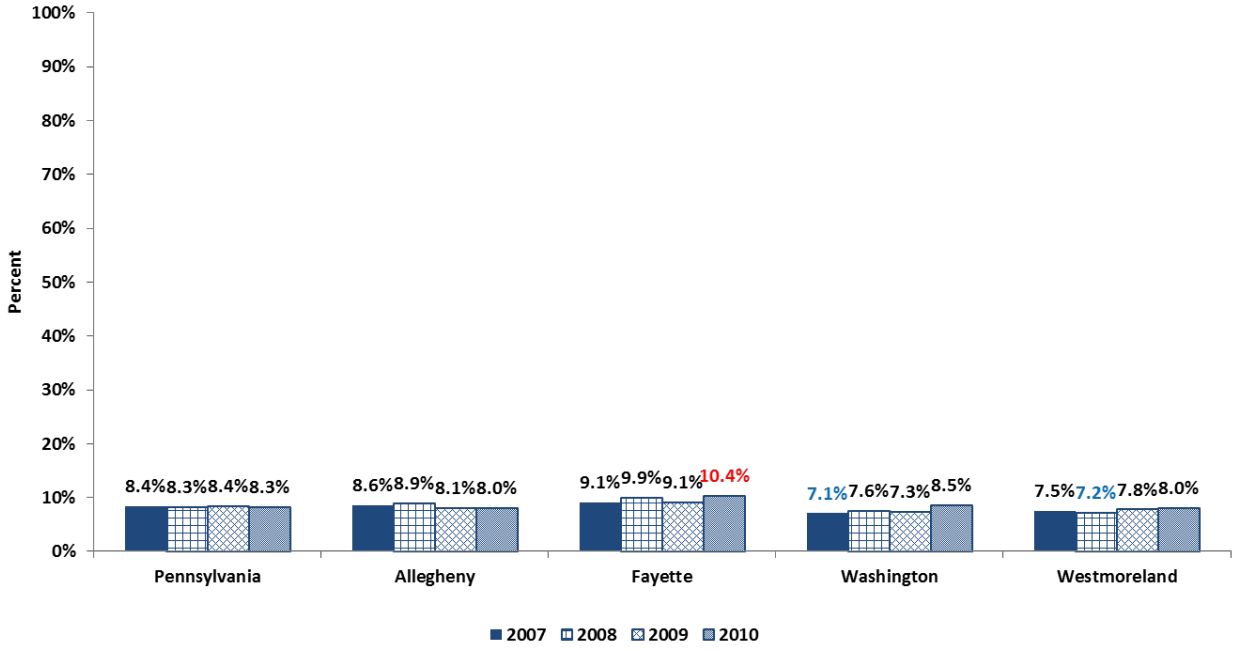
Figure 94: Mothers who received Medicaid



Source: Pennsylvania Department of Health

Figure 95 illustrates the percentage of low birth-weight babies born in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Washington, and Westmoreland counties during 2007 through 2010. Compared to the state, Allegheny County was significantly higher in 2008 and Fayette County in 2008 and 2010. Washington County was significantly lower in 2007 and Westmoreland County in 2008.

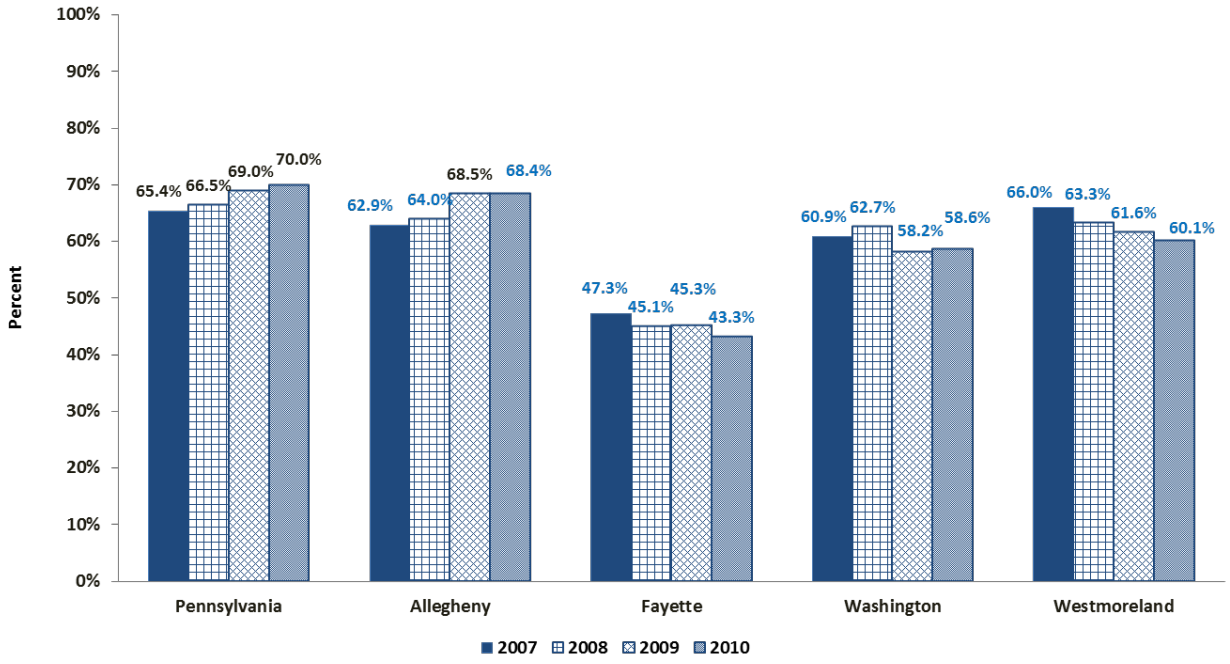
Figure 95: Low birth-weight babies born



Source: Pennsylvania Department of Health

Figure 96 illustrates the percentage of mothers who breastfed in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Washington, and Westmoreland counties during 2007 through 2010. Compared to the state, Fayette, Washington, and Westmoreland counties were significantly lower for years 2007 through 2010, while Allegheny County was significantly lower in 2007, 2008, and 2010.

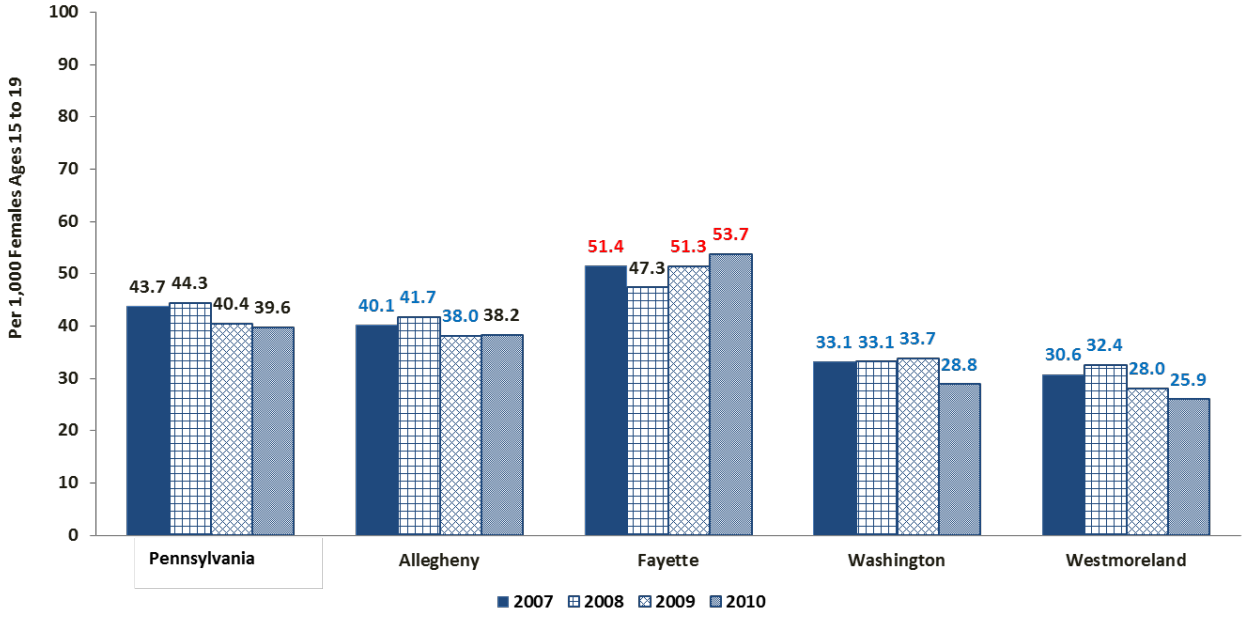
Figure 96: Breastfeeding



Source: Pennsylvania Department of Health

Figure 97 illustrates teen pregnancy rates per 1,000 females ages 15 to 19 in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. The teen pregnancy rate is significantly higher in Fayette County in years 2007, 2009, and 2010. The rates in Allegheny, Washington and Westmoreland counties are decreasing, and are significantly lower than the state rate (the one exception being Allegheny County in 2010, which was only slightly lower).

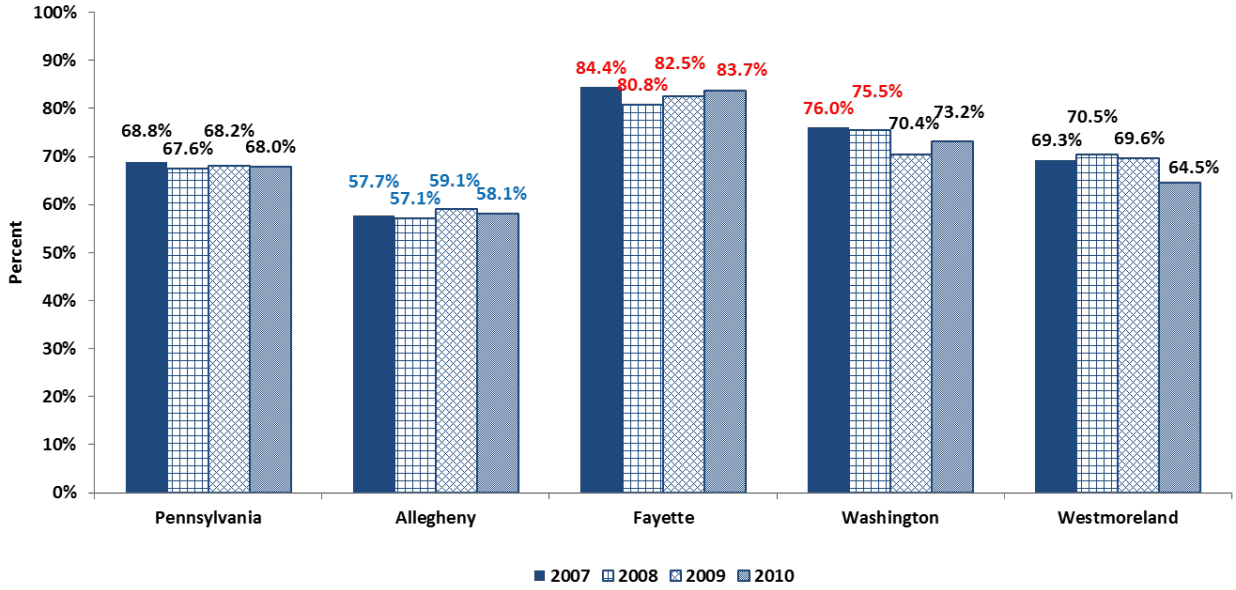
Figure 97: Teenage pregnancy



Source: Pennsylvania Department of Health

Figure 98 illustrates teen pregnancy rates per 1,000 females ages 15 to 19 that resulted in a live birth in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. Compared to the state, Fayette County was significantly higher for years 2007 through 2010 and Washington County for years 2007 and 2008. Allegheny County was significantly lower for years 2007 through 2010.

Figure 98: Teenage pregnancies that resulted in a live birth



Source: Pennsylvania Department of Health

According to the CDC, childhood obesity has more than tripled in the past 30 years. In 1980, 7.0 percent of 6 to 11 year olds and 5.0 percent of 12 to 19 year olds were obese. In 2008, 20.0 percent of 6 to 11 year olds and 18.0 percent of 12 to 19 year olds were obese. In a population based sample (2010), the CDC reported that 70.0 percent of obese youth had at least one risk factor for cardiovascular disease.

Table 31 illustrates childhood obesity by environment. Children who do not have access to certain environmental characteristics, such as sidewalks or walking paths, playgrounds, recreational centers, libraries and/or bookmobiles are more likely to be overweight or obese.

Table 31: Childhood obesity by environment

Prevalence Of Obesity And Overweight And Odds Of Being Obese Or Overweight (Adjusted For Age-Sex And Covariates), Among U.S. Children Ages 10–17, By Neighborhood Built Environmental Characteristics

	Obesity				Overweight			
Neighborhood characteristic	Weighted Percent	Weighted SE	Odds ratio, age-sex[a]	Odds ratio, covariate[b]	Weighted Percent	Weighted SE	Odds ratio, age-sex[a]	Odds ratio, covariate[b]
Index of neighborhood built environment (mean index score = 100; SD = 20)								
46.40–67.04 (low amenities)	19.72	1.79	1.44	1.34	37.38	2.10	1.41	1.29
67.05–81.39	18.60	1.35	1.36	1.44	32.92	1.44	1.17	1.18
81.40–104.99	17.20	0.86	1.22	1.21	32.31	1.01	1.13	1.09
105.00–116.40 (high amenities)	14.55	0.70	1.00	1.00	29.69	0.89	1.00	1.00
Neighborhood access to sidewalks or walking paths								
Yes	15.72	0.60	1.00	1.00	31.29	0.73	1.00	1.00
No	18.20	0.83	1.19	1.32	32.53	0.93	1.06	1.09
Neighborhood access to parks or playgrounds								
Yes	15.88	0.56	1.00	1.00	30.76	0.68	1.00	1.00
No	18.27	0.97	1.20	1.26	34.82	1.19	1.22	1.23
Neighborhood access to a recreation center, community center, or boys' and girls' club								
Yes	15.34	0.58	1.00	1.00	30.27	0.73	1.00	1.00
No	18.19	0.87	1.23	1.20	34.30	1.00	1.20	1.15
Neighborhood access to a library or bookmobile								
Yes	15.86	0.51	1.00	1.00	30.88	0.62	1.00	1.00
No	19.68	1.51	1.31	1.15	35.63	1.67	1.25	1.09

SOURCE National Survey of Children's Health, 2007. **NOTES** This exhibit has been abridged for presentation in print, and 95 percent confidence intervals have been omitted. The complete exhibit is available in the Online Appendix (see Note 25 in text). $N = 44,101$. Obesity denotes body mass index (BMI) at the ninety-fifth percentile and higher. Overweight denotes BMI in the eighty-fifth percentile and higher. The chi-square test for independence between each covariate and obesity or overweight prevalence was statistically significant at $p < 0.05$. SE is standard error. SD is standard deviation. [a]Adjusted by logistic regression for age and sex only. [b]Adjusted for age, sex, race/ethnicity, household composition, metropolitan/nonmetropolitan residence, household poverty or education levels, TV viewing time, recreational computer use, and physical activity. Neighborhood socioeconomic index and built environment index are independent of each other. Controlling for both indices simultaneously along with other individual-level covariates in the same model had no impact on the adjusted effects reported here.

Table 32 illustrates socioeconomic factors affecting obesity. Children who live in neighborhoods that are unsafe or have problems with garbage/litter, dilapidated or run down housing, or vandalism are more likely to be overweight or obese.

Table 32: Socioeconomic factors affecting obesity

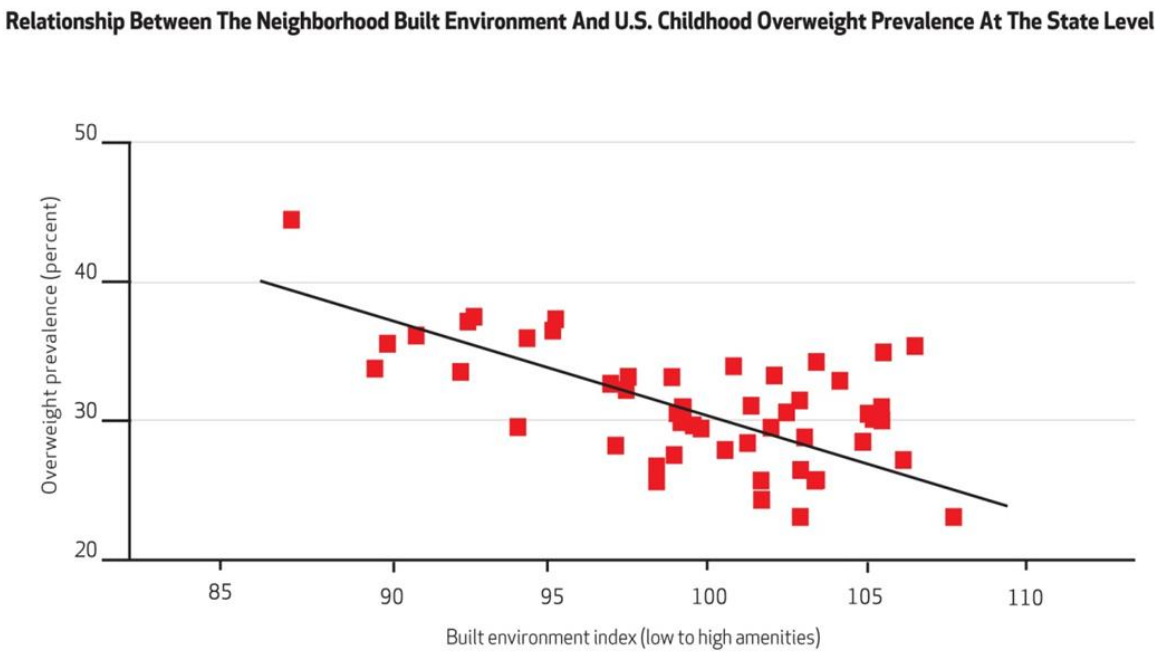
Prevalence Of Obesity And Overweight And Odds Of Being Obese Or Overweight (Adjusted For Age-Sex And Covariates), Among U.S. Children Ages 10–17, By Neighborhood Socioeconomic Conditions

	Obesity				Overweight			
	Weighted				Weighted			
Neighborhood characteristic	Percent	SE	Odds ratio, age-sex[a]	Odds ratio, covariate[b]	Percent	SE	Odds ratio, age-sex[a]	Odds ratio, covariate[b]
Total population	16.37	0.49			31.64	0.59		
Index of neighborhood socioeconomic conditions (mean index score = 100; SD = 20)								
20.78–67.09 (least favorable)	19.74	1.99	1.45	0.99	36.96	2.23	1.41	0.97
67.10–88.32	20.32	2.21	1.52	1.06	33.89	2.31	1.24	0.90
88.33–104.99	19.30	1.19	1.40	1.09	34.85	1.41	1.27	1.01
105.00–111.40 (most favorable)	14.74	0.56	1.00	1.00	29.79	0.71	1.00	1.00
Neighborhood safety								
Safe	15.53	0.51	1.00	1.00	30.64	0.62	1.00	1.00
Unsafe	22.27	1.61	1.61	1.05	38.24	1.82	1.43	0.96
Presence of garbage/litter in neighborhood								
Yes	20.74	1.41	1.44	1.10	36.43	1.54	1.31	1.01
No	15.56	0.51	1.00	1.00	30.70	0.64	1.00	1.00
Poorly kept or dilapidated/rundown housing in neighborhood								
Yes	19.63	1.50	1.31	1.04	36.32	1.65	1.29	1.04
No	15.86	0.51	1.00	1.00	30.85	0.63	1.00	1.00
Vandalism such as broken windows or graffiti in neighborhood								
Yes	17.28	1.65	1.09	0.84	33.65	1.95	1.13	0.87
No	16.27	0.51	1.00	1.00	31.38	0.62	1.00	1.00

SOURCE National Survey of Children's Health, 2007. **NOTES** This exhibit has been abridged for presentation in print, and 95 percent confidence intervals have been omitted. The complete exhibit is available in the Online Appendix (see Note 25 in text). $N = 44,101$. Obesity denotes body mass index (BMI) at the ninety-fifth percentile and higher. Overweight denotes BMI in the eighty-fifth percentile and higher. Chi-square test for independence between each covariate (except vandalism) and obesity or overweight prevalence was statistically significant at $p < 0.05$. SE is standard error. SD is standard deviation. [a]Adjusted by logistic regression for age and sex only. [b]Adjusted for age, sex, race/ethnicity, household composition, metropolitan/nonmetropolitan residence, household poverty or education levels, TV viewing time, recreational computer use, and physical activity. The neighborhood socioeconomic index and the built environment index are independent of each other. Controlling for both indices simultaneously along with other individual-level covariates in the same model had no impact on the adjusted effects reported here.

Figure 99 illustrates relationship between the neighborhood-built environment and U.S. childhood overweight prevalence at the state level. Mentioned also in the healthy environment chapter of this report, here, built environment is described as it relates to childhood obesity. As defined by a public report by Karen Roof, M.S. and Ngozi Oleru, Ph.D., "the built environment is the human-made space in which people live, work, and recreate on a day-to-day basis. It includes the buildings and spaces we create or modify. It can extend overhead in the form of electric transmission lines and underground in the form of landfills." The report goes on to mention that "the design of our built environment affects the possibility of injury related to pedestrian and vehicular accidents, and it also influences the possibility of exercise and healthy lifestyles." As built environment index increases, overweight prevalence shows a decreasing trend. In other words, children who have access to more neighborhood amenities are less likely to be overweight or obese. The red squares in the chart below represent the number of amenities in a built environment.

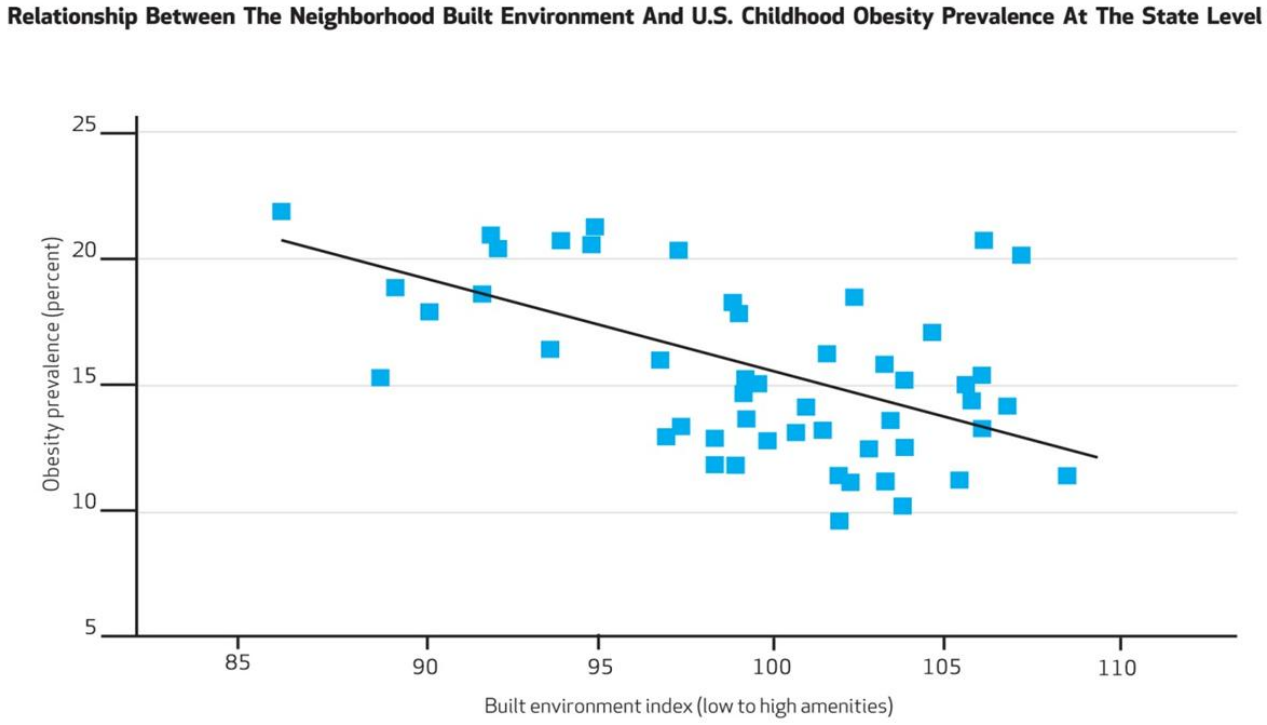
Figure 99: Neighborhood versus. U.S. childhood overweight prevalence



Source: National Survey on Children's Health, 2007

Figure 100 illustrates relationship between the neighborhood-built environment and U.S. childhood obesity prevalence at state level. As built environment index increases, obesity prevalence shows a decreasing trend. In other words, children who have access to more neighborhood amenities such as playgrounds, ball fields/courts, school crosswalks, and sidewalks are less likely to be overweight or obese. The blue squares in the chart below represent the number of amenities in a built environment.

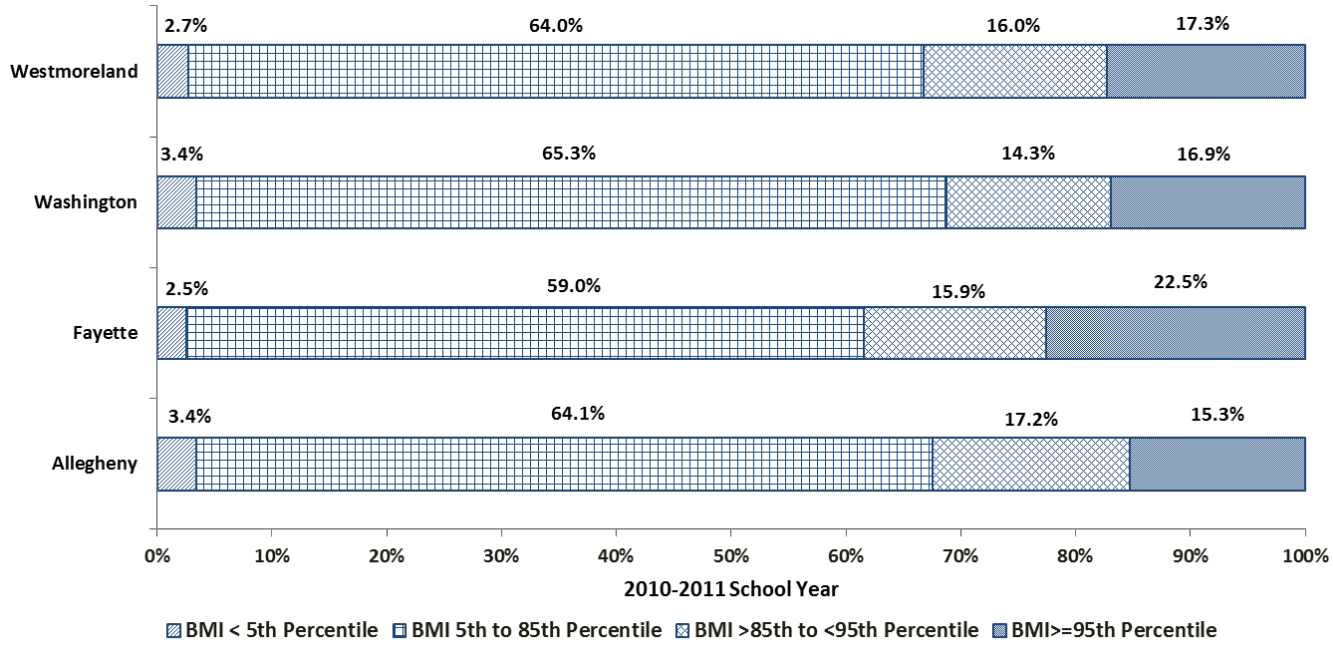
Figure 100: Neighborhood versus obesity prevalence



Source: National Survey of Children's Health, 2007

Figure 101 illustrates the Body Mass Index (BMI) percentiles for children in kindergarten through grade six throughout the service area counties for the 2010 through 2011 school year. BMI is classified into four categories: (i) underweight where a person's BMI is less than the 5th percentile; (ii) normal where the BMI is between the 5th percentile and the 85th percentile; (iii) overweight where a person's BMI is between the 85th percentile and 95th percentile; and (iv) a person is considered obese if their BMI is greater than the 95th percentile. Childhood obesity in grades kindergarten through grade six for the service area ranged 15.3 percent in Allegheny County to 22.5 percent in Fayette County.

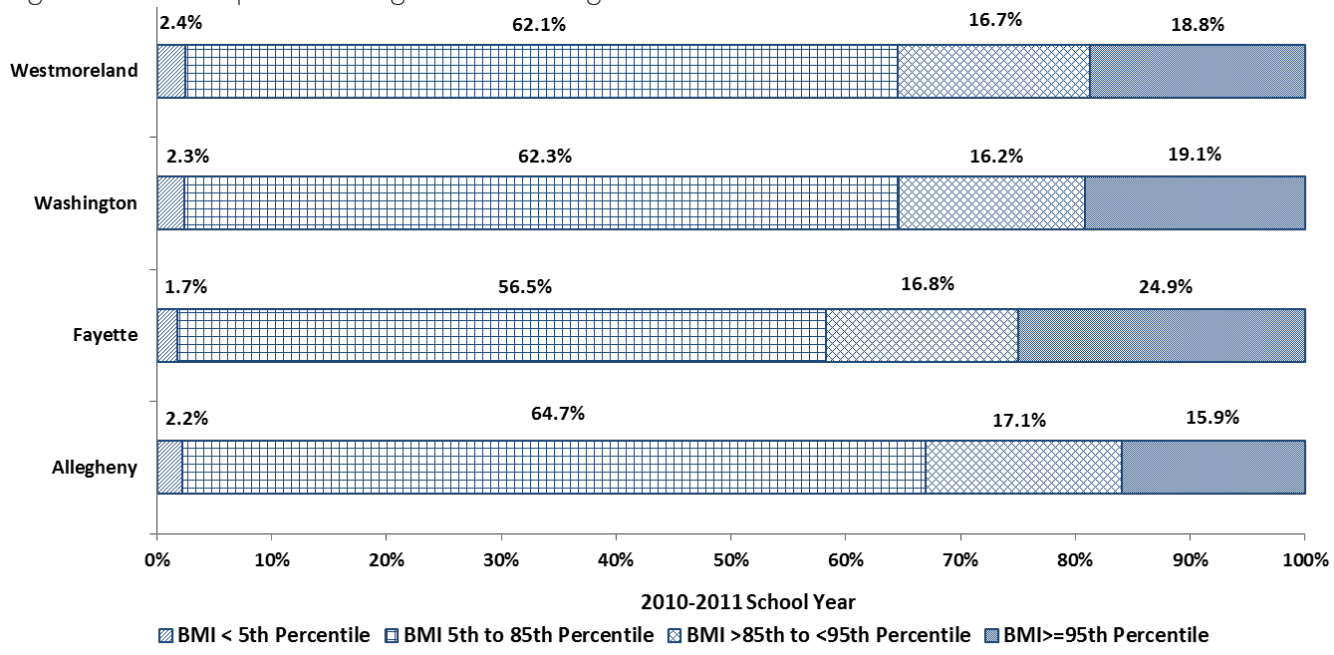
Figure 101: BMI Percentiles grades K through 6



Source: Pennsylvania Department of Health

Figure 102 illustrates the Body Mass Index (BMI) percentiles for children in grades seven through 12 throughout the service area counties for the 2010 through 2011 school year. BMI is classified into four categories: (i) underweight where a person's BMI is less than the 5th percentile; (ii) normal where the BMI is between the 5th percentile and the 85th percentile; (iii) overweight where a person's BMI is between the 85th percentile and 95th percentile; and (iv) a person is considered obese if their BMI is greater than the 95th percentile. Childhood obesity for grades seven through 12 in the service area ranged 15.9 percent in Allegheny County to 24.9 percent in Fayette County.

Figure 102: BMI percentiles grades 7 through 12

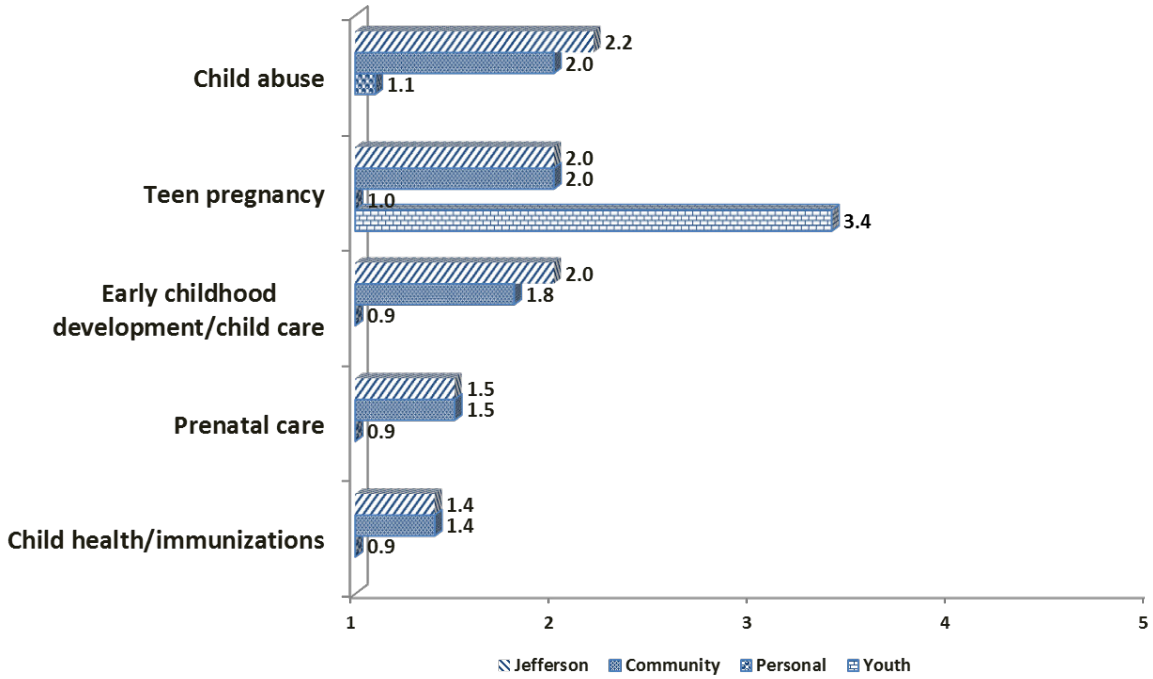


Source: Pennsylvania Department of Health

Focus group input

Focus group participants were asked to rate the extent to which a number of issues are a problem in the community, in the Jefferson Regional service region overall and in their personal life. Items were rated based on a 5-point scale, where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 103 illustrates the rank ordering of the issues related to Healthy Mothers, Babies and Children. Issues were rank ordered based on the average score of how much of a problem the issue is in the service region overall. Child abuse and teen pregnancy were ranked as small problems in the service region overall. However, youth rated teen pregnancy as a somewhat of a problem in the community.

Figure 103: Focus Groups: Healthy mothers, babies, and children



Source: 2012 Jefferson Regional Focus Groups, Strategy Solutions, Inc.

Focus group input

Participants of the youth focus group talked about young people who are much too young having sex and talking about it. Risk behaviors at younger ages (especially in middle school) are a concern. Some participants in the adult focus groups expressed a need for mental health services for children. Teen pregnancy was mentioned as a high priority in several of the groups. Although teen pregnancy rates are dropping, there are fewer intact families. The region has many single-parent households and teenagers having babies and then dropping out of high school. Some of them received a diploma but cannot read.

Focus group participants commented that there are not many services available for children. Children's Hospital is inconvenient and there are not many satellites. Some concerns were expressed specifically related to youth injury care. There is no youth sports medicine program locally. This is a concern with the number of kids that are involved in sports; if they get injured, they need to go to UPMC. This is something that should be provided in the community hospital.

Stakeholder Interview Input

The list of specific needs identified by interviewees included focus on the need for local obstetrics and gyn*ecological* care, local pediatric care, and improved education for children of all ages. The service region has a high population of teen pregnancy in high schools. There is a need for better access to women's healthcare and pediatrics; there is a general lack of providers in the area and some access issues regarding money/insurance plans that are not accepted. Obstetrics/gynecology and pediatrics are top priorities for Jefferson Regional.

Healthy Mothers, Babies and Children Conclusions

There are a number of observations and conclusions that can be derived from the data related to Healthy Mothers, Babies and Children. They include:

- The percentage of mothers who received prenatal care in the first trimester increased for the state and all counties each year between 2007 through 2010 and was significantly higher in 2010 for Allegheny, Fayette, Washington, and Westmoreland Counties.
- The percentage of mothers who reported not smoking during and three months prior to pregnancy was significantly higher for Allegheny County in 2010. For years 2007 through 2010, the percentages were significantly lower in Fayette, Washington, and Westmoreland Counties.
- The percentage of mothers who received WIC was significantly higher for Fayette County for years 2007 through 2010, while significantly lower in Allegheny and Westmoreland Counties for years 2007 through 2010, and Washington County in 2009 and 2010.
- The percentage of mothers who received Medicaid was significantly higher in Allegheny County in 2007 and 2008, but significantly lower in 2009 and 2010. Fayette County was significantly higher for years 2007 through 2010. Washington County was significantly higher in 2008, but lower in 2009 and 2010. Westmoreland County was significantly higher in 2007, 2008, and 2009.
- The percentage of low birth weight births was significantly higher in Allegheny County in 2008 and Fayette County in 2008 and 2010; the percentages were significantly lower for Washington County in 2007 and Westmoreland County in 2008.
- The percentage of mothers who breastfed were significantly lower in Allegheny County 2007, 2008, and 2010. The percentages were significantly lower for Fayette, Washington, and Westmoreland Counties for 2007 through 2010.
- Teenage pregnancy rates were significantly lower in Allegheny County in 2007, 2008, and 2009, and Washington and Westmoreland Counties 2007 through 2010. The rates were significantly higher in Fayette County in 2007, 2009, and 2010.
- The percentage of teen live birth outcomes was significantly lower in Allegheny County in 2007, 2008, and 2009, and Washington County in 2007 and 2008. The rates were significantly higher in Fayette County for years 2007 through 2010.
- Childhood obesity in grades K through 6 ranged from 15.3 percent in Allegheny County to 22.5 percent in Fayette County.
- Childhood obesity in grades 7 through 12 ranged from 15.9 percent in Allegheny County to 24.9 percent in Fayette County.
- Focus Group participants tended not to rate issues in this topic area as concern. However, youth Focus Group participants ranked teenage pregnancy as somewhat of a problem.

This page is intentionally blank

This page is intentionally blank

Infectious Disease

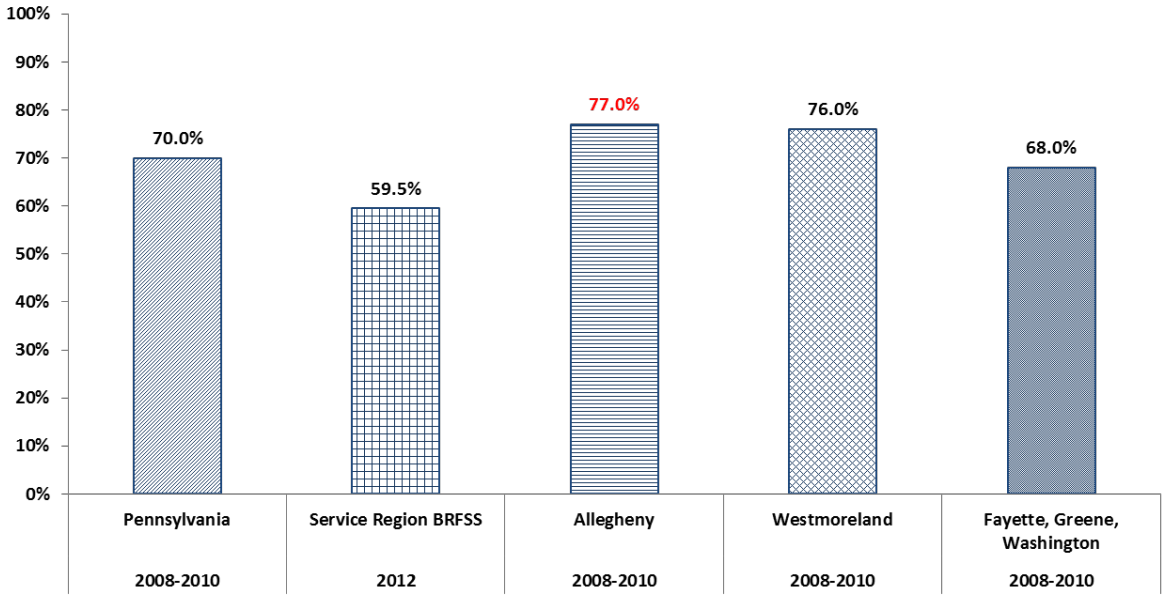
This page is intentionally blank

Infectious Diseases

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another. These diseases can be grouped in three categories: diseases which cause high levels of mortality; diseases which place on populations heavy burdens of disability; and diseases, which owing to the rapid and unexpected nature of their spread can have serious global repercussions (World Health Organization).

Figure 104 illustrates the percentage of BRFSS respondents who had a pneumonia shot aged 65 and older in the Commonwealth of Pennsylvania, the BRFSS Service Region, Allegheny, and Westmoreland counties, as well as Fayette, Greene and Washington counties. The percentage of adults age 65 and older who had a pneumonia shot in the service region is 59.5 percent and at 77.0 percent significantly higher in Allegheny County. The state, service region, and all counties are below the Healthy People 2020 goal of 90.0 percent.

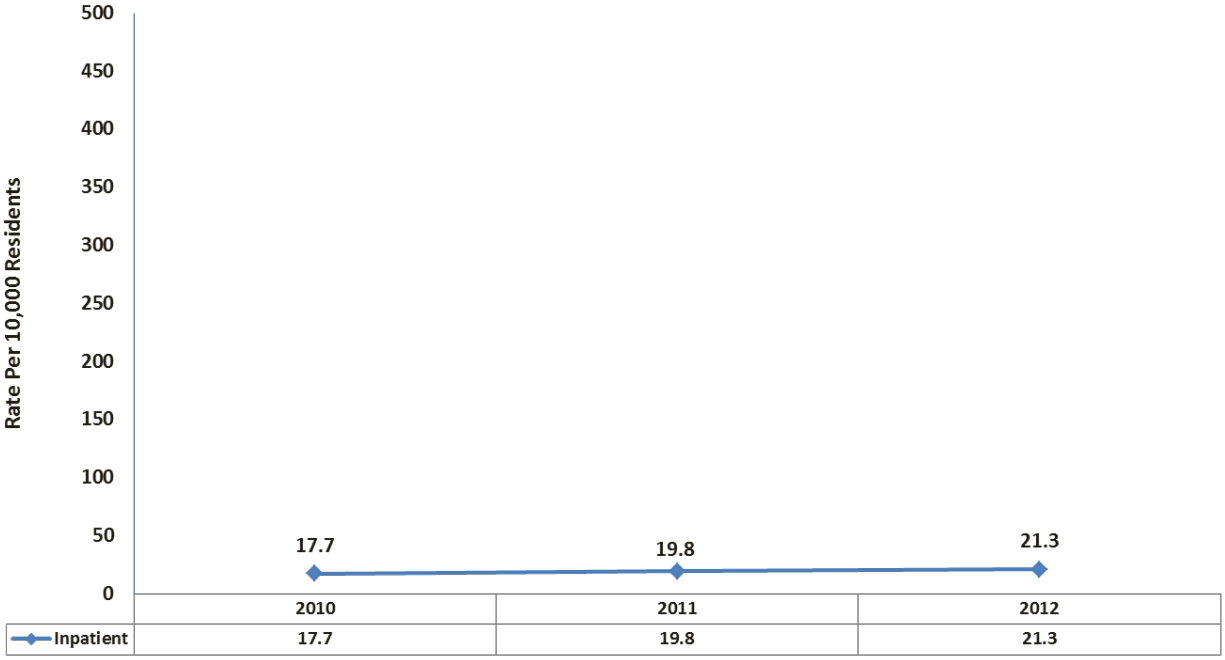
Figure 104: Pneumonia vaccine age GE 65



Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

Figure 105 illustrates the pneumonia inpatient discharge rate per 10,000 residents between the years 2010 through 2012. The rate of inpatient utilization for pneumonia has increased in the region during the time period.

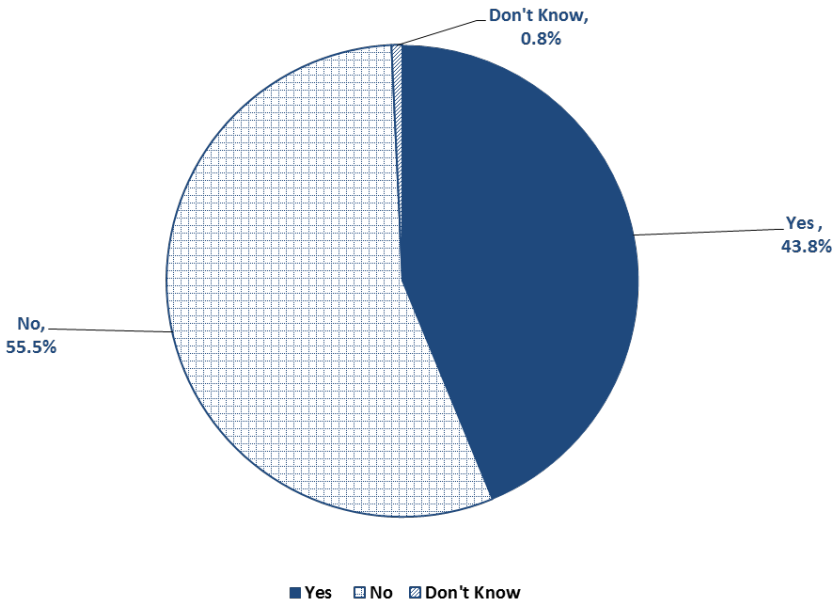
Figure 105: Pneumonia inpatient discharges



Source: Pennsylvania Health Care Cost Containment Council

Figure 106 illustrates the 2012 BRFSS responses when asked if they have received their seasonal flu vaccination. The majority (55.5 percent) responded no, while 43.8 percent have received their vaccination.

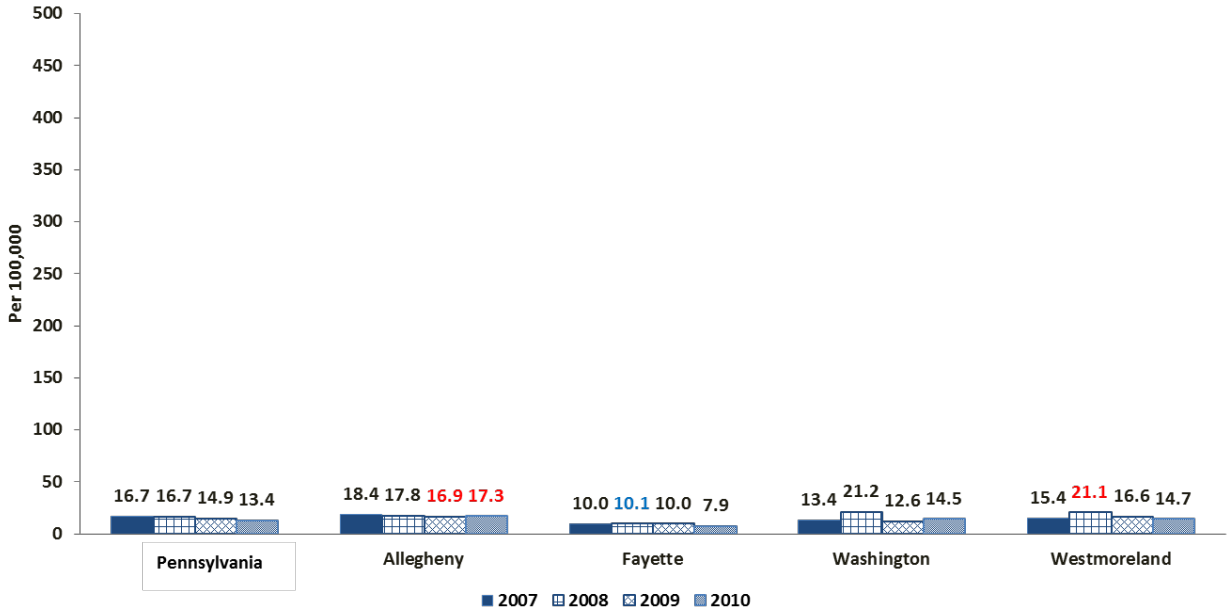
Figure 106: 2012 BRFSS: Seasonal flu vaccine



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 107 illustrates the influenza and pneumonia mortality rates per 100,000 in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. While the state rate is decreasing as are Allegheny, Fayette and Westmoreland counties, the rate in Washington County has increased slightly during the past four years. Allegheny County was significantly higher than the state rate in 2009 and 2010, while Fayette County was significantly lower in 2008.

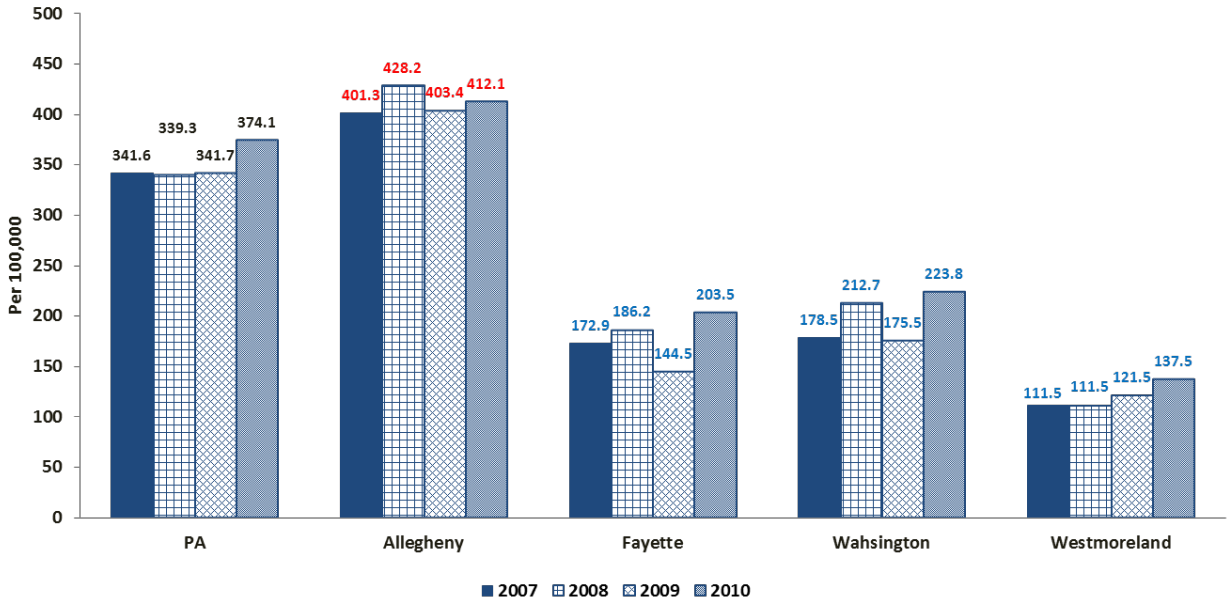
Figure 107: Influenza and pneumonia mortality



Source: Pennsylvania Department of Health

Figure 108 illustrates chlamydia rates per 100,000 in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. The rates in all four counties of the service region are increasing, as is the state rate. Allegheny County rate was significantly higher than the state rates for the time period, while the rates in the other counties of the service region are significantly lower.

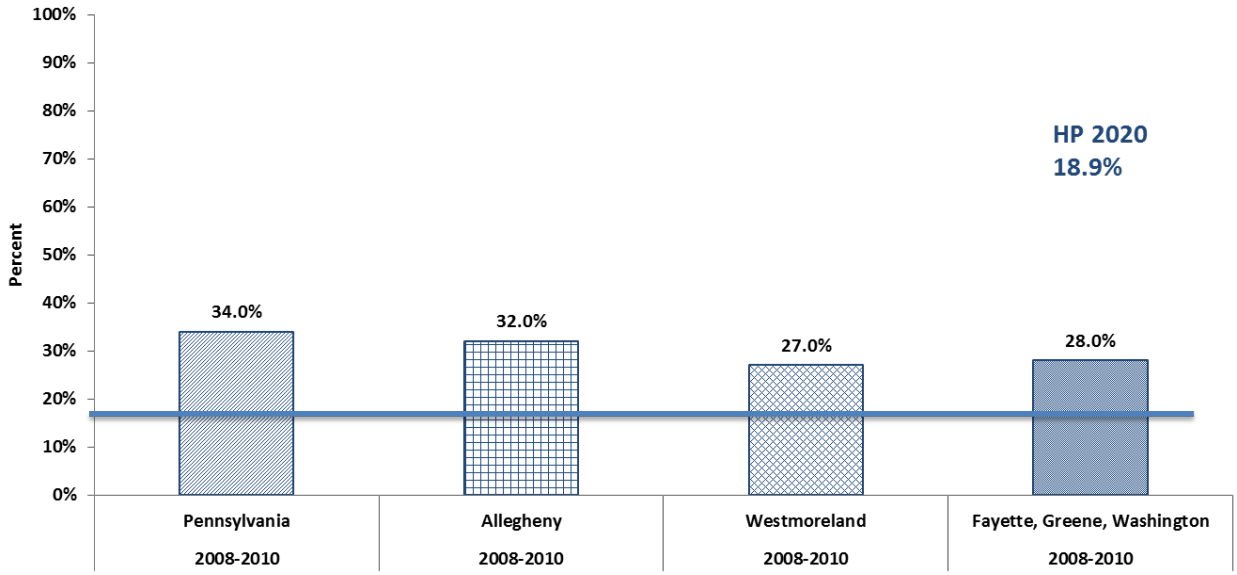
Figure 108: Chlamydia incidence



Source: Pennsylvania Department of Health

Figure 109 illustrates the percentage of adults aged 18 to 64 ever tested for HIV in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. There are no significant differences between the state and counties and all are above the Healthy People 2020 goal of 18.9 percent.

Figure 109: Adults ever tested for HIV



Source: Pennsylvania Department of Health, www.healthypeople.gov

Infectious disease was not a major concern discussed in the focus groups or by the stakeholders during their interviews. Therefore, there is no data or comments from focus groups to include in this report.

Stakeholder Interview Input

Among the concerns listed by stakeholders throughout the interview process were proper diagnosis and care for infectious diseases. Sexually transmitted diseases and MRSA were mentioned as specific cases. One stakeholder had concerns regarding patient experience. These concerns included a misdiagnosed infection, an overlooked diagnosis of MRSA and an overlooked diagnosis of a sexually transmitted disease.

Infectious Disease Conclusions

There are a number of observations and conclusions that can be derived from the data related to Infectious Disease. They include:

- The percentage of adults over the age of 65 who received a pneumonia vaccine was significantly higher in Allegheny County for years 2008 through 2010. The state and all counties were below the Healthy People 2020 goal of 90.0 percent.
- Pneumonia inpatient discharges have slightly increased for years 2010 through 2012.
- The majority of 2012 BRFSS respondents (55.5 percent) did not get a seasonal flu vaccine.
- Influenza and pneumonia mortality rates were significantly higher for Allegheny County in 2009 and 2010, and Westmoreland County in 2008. The rate was significantly lower in Fayette County in 2008.
- Chlamydia incidence rates were significantly higher in Allegheny County for years 2007 through 2010, while significantly lower for Fayette, Washington, and Westmoreland Counties for the same time period.
- The percentage of adults ever tested for HIV was comparable between the state and counties, and all above the Healthy People 2020 goal of 18.9 percent.

This page is intentionally blank

This page is intentionally blank

Mental Health and Substance Abuse

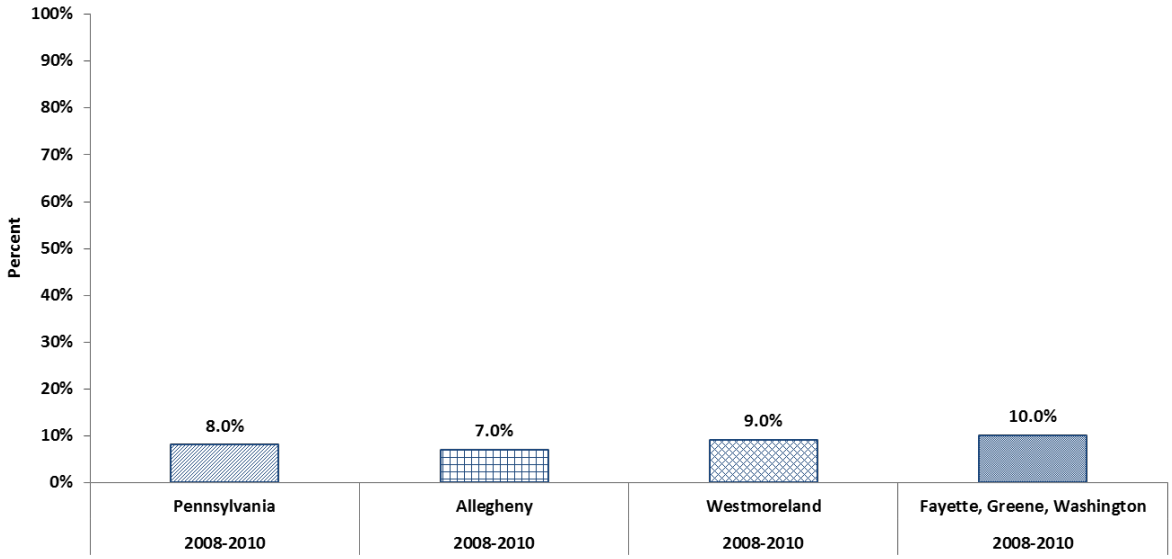
This page is intentionally blank

Mental Health and Substance Abuse

Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the World Health Organization's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease." It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders. According to the World Health Organization, substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome, a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

Figure 110 illustrates the percentages of all adults age 18 and older who rarely or never receive emotional support in the Commonwealth of Pennsylvania and Allegheny and Westmoreland counties, as well as Fayette, Greene, and Washington counties for years 2008 through 2010. The percentage in the service region ranges between 7.0 percent and 10.0 percent.

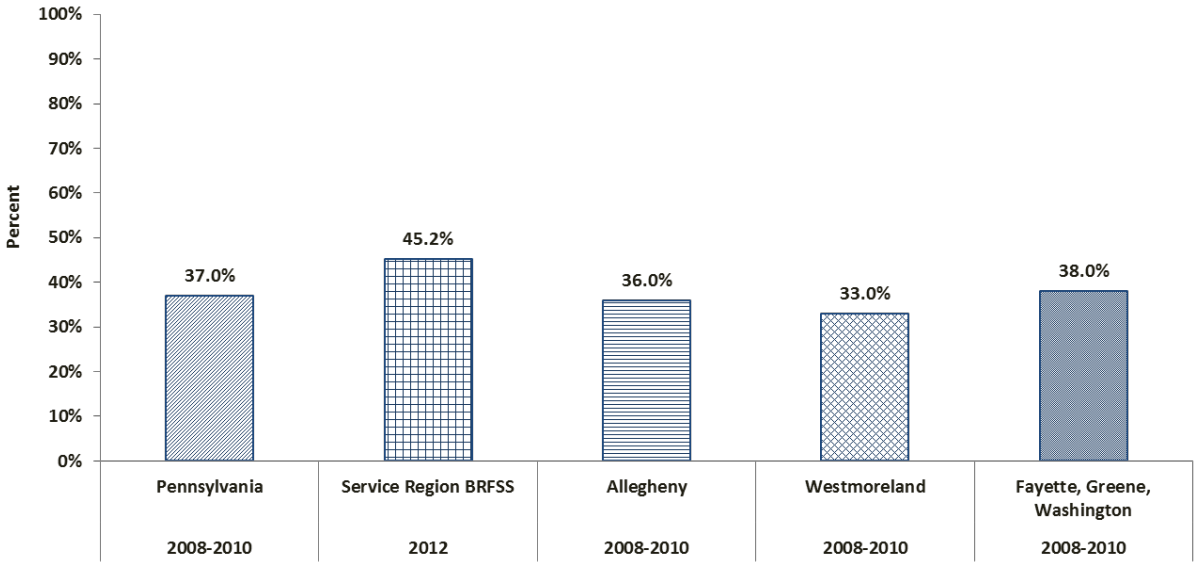
Figure 110: Adults age 18 and older who rarely or never getting emotional or social support



Source: Pennsylvania Department of Health

Figure 111 illustrates the percentages of respondents whose mental health was not good one or more days in the past 30 days in the Commonwealth of Pennsylvania, the service region and Allegheny and Westmoreland counties, as well as Fayette, Greene, and Washington counties. Almost half (45.2 percent) of respondents from the 2012 Service Region BRFSS indicated that their mental health was not good one or more days in the past month, which is higher than the state and county percentages.

Figure 111: Mental health not good 1+ days in the past month



Source: Pennsylvania Department of Health, 2012 Jefferson Regional Medical Center BRFSS

Table 33 illustrates the number of days per week or month that respondents have had at least one drink from the 2012 Service Region BRFSS. The majority of respondents have had at least one drink on at least one day during the past month. A small percentage of the respondents indicated that they drink every day or almost every day.

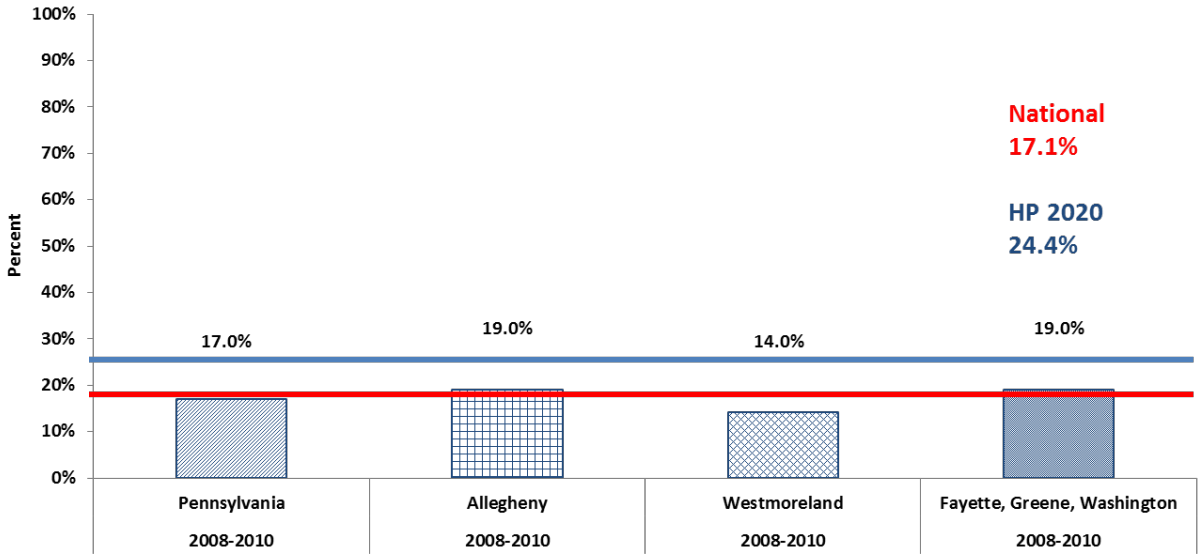
Table 33: 2012 BRFSS: Number of days per week and month at least one drink

Days	Per Week	Per Month
1	7.3%	7.3%
2	6.3%	8.5%
3	2.0%	3.8%
4	0.3%	3.8%
5	0.8%	1.5%
6		1.3%
7	5.3%	1.5%
8		0.5%
12		0.8%
14		0.8%
15		1.0%
20		0.3%
25		0.3%
27		0.3%
30		1.0%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 112 illustrates the percentage of adults who reported binge drinking (5+ drinks for men and 4+ drinks for women in one setting) in the Commonwealth of Pennsylvania and Allegheny, Westmoreland counties, as well as Fayette, Greene, and Washington counties. The percentage of the service region counties that reported binge drinking ranged between 14 percent and 19 percent and was below the Healthy People 2020 goal of 24.4 percent.

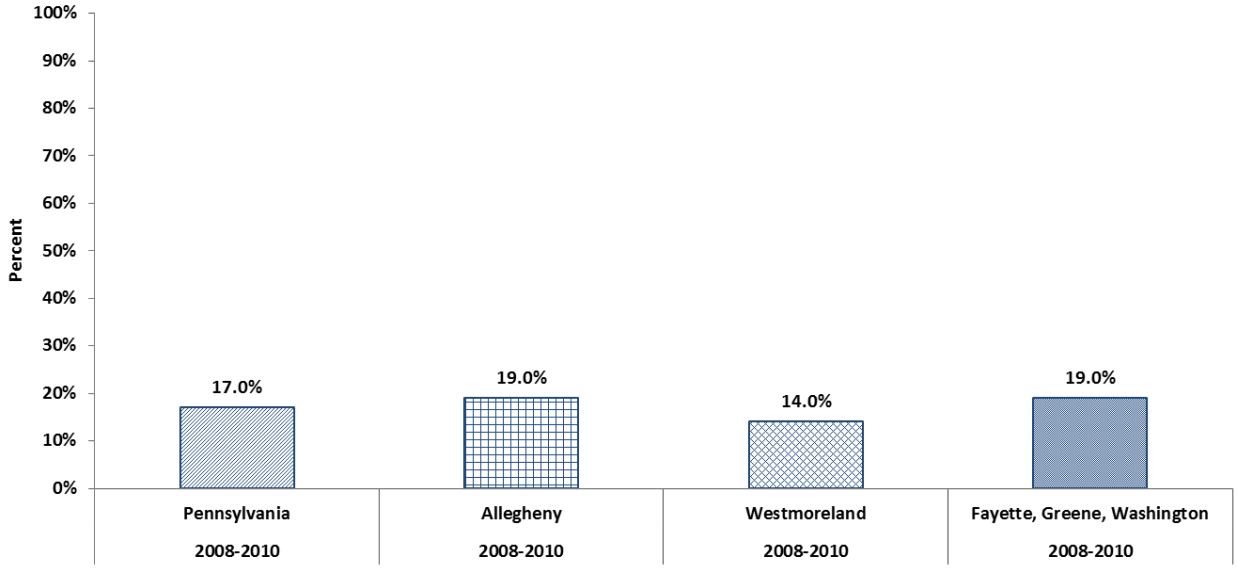
Figure 112: Binge drinking



Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

Figure 113 illustrates the percentage of adults who reported heavy drinking (2+ drinks for men and 1+ drinks for women daily) in the Commonwealth of Pennsylvania and Allegheny, Westmoreland County, as well as Fayette, Greene, and Washington counties. The percentage of the service region counties that reported heavy drinking ranged between 14.0 percent and 19.0 percent.

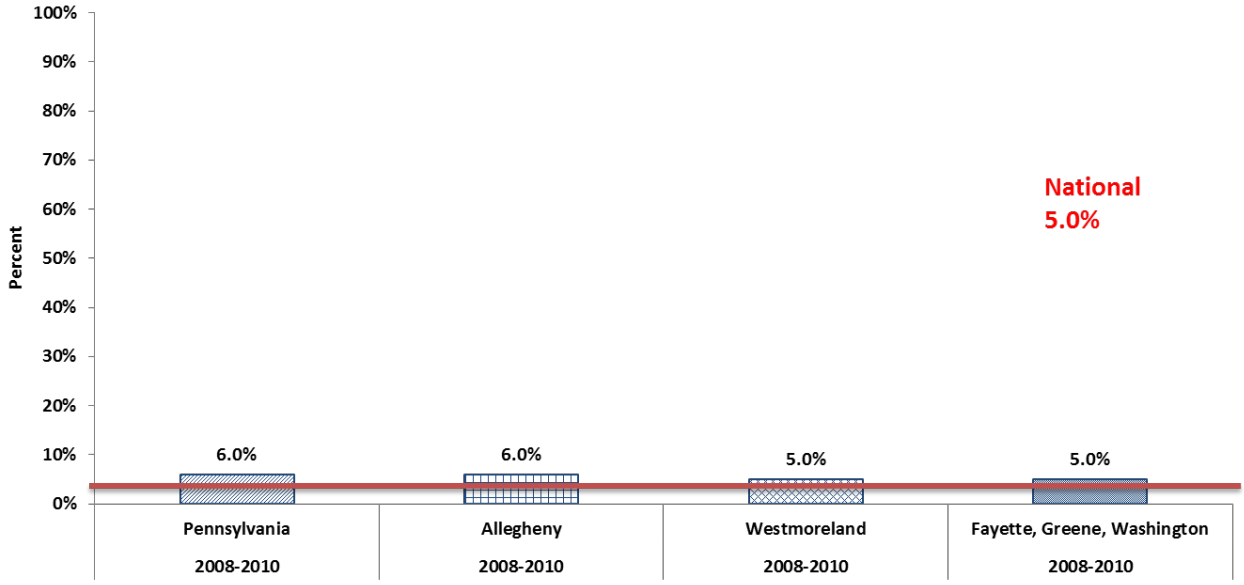
Figure 113: Heavy drinking



Source: Pennsylvania Department of Health

Figure 114 illustrates the percentage of adults who reported chronic drinking (2+ drinks every day for the past 30 days) in the Commonwealth of Pennsylvania and Allegheny and Westmoreland counties, as well as Fayette, Greene, and Washington counties. The percentage of the service region counties that reported chronic drinking ranged between 5.0 percent and 6.0 percent. Chronic drinking in the Commonwealth of Pennsylvania and Allegheny County was above the national percentage of 5.0 percent.

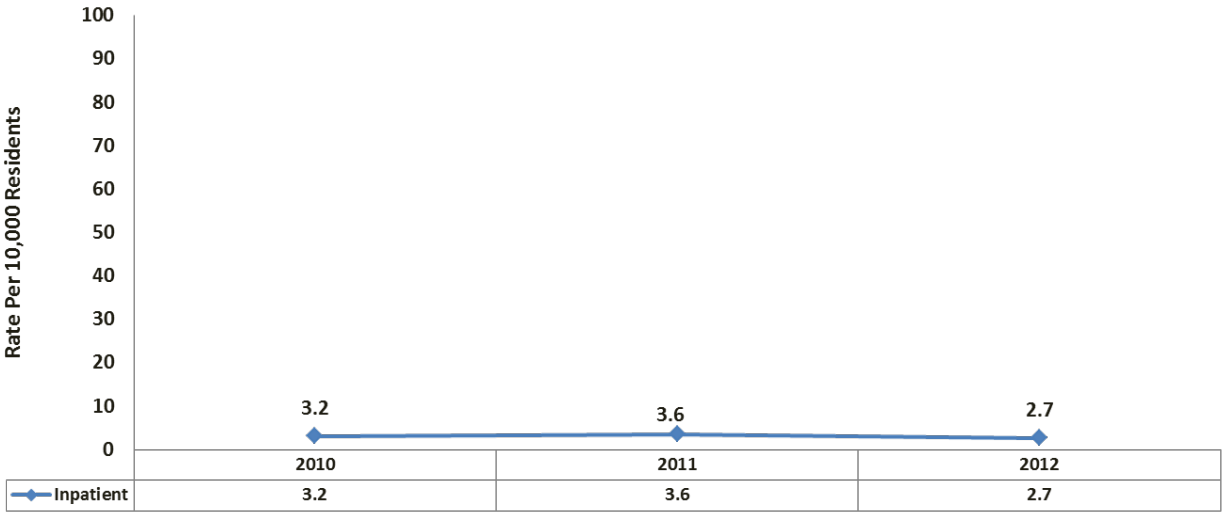
Figure 114: Chronic drinking



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 115 illustrates the alcohol and drug abuse inpatient discharge rate per 10,000 residents in the Jefferson Regional service territory from 2010 through 2012. The rate has fluctuated during the past three years, but was lower in 2012 than in 2010.

Figure 115: Alcohol and drug abuse inpatient discharges



Source: Pennsylvania Health Care Cost Containment Council

Table 34 illustrates the percentage of 2012 Service Region BRFSS responses to a series of mental health questions. A sizable portion (14.8 percent) of respondents indicated that they are now taking medicine or are receiving treatment for a mental health or emotional problem, and an additional 7.2 percent indicated that they have a family member who has mental health needs that are not currently being met. A smaller portion (4.0 percent) indicated that they or a family member have been affected by the use of drugs in the past 30 days or lived with someone who has abused drugs (3.8 percent) or have been threatened with physical violence (9.8 percent).

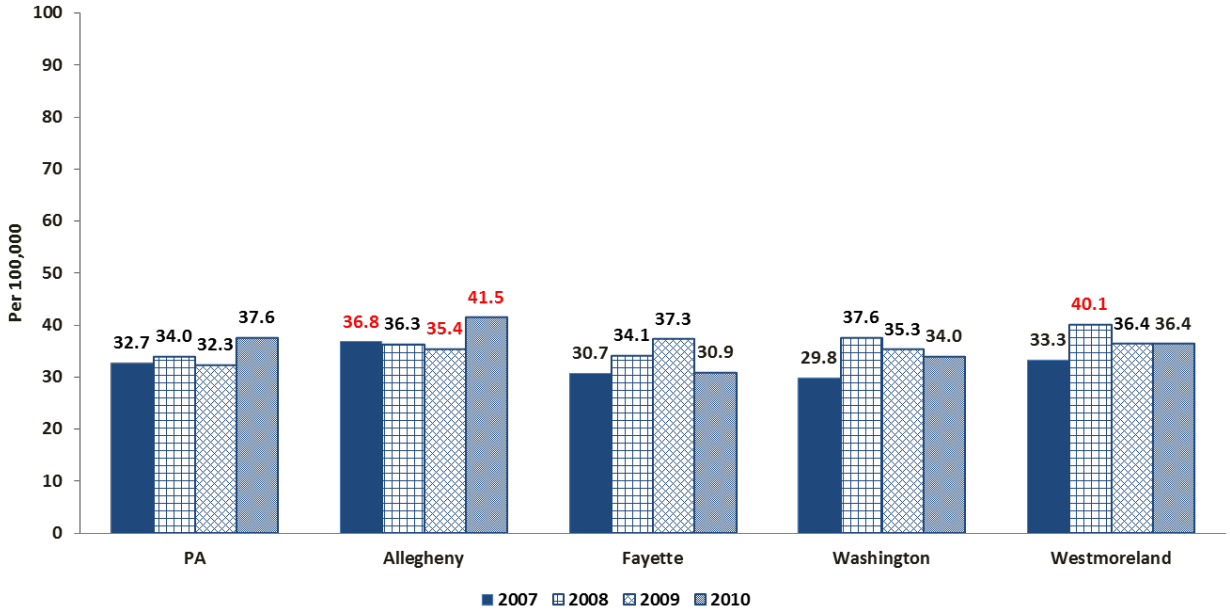
Table 34: 2012 BRFSS: Mental health

Question	Yes Response	No Response
Are you now taking medicine or receiving treatment from a doctor or other health care professional for any type of mental health condition or emotional problem?	14.8%	85.0%
Do you currently have a family member who has mental health needs that are not being met?	7.2%	91.8%
In the past 30 days, has you or your family been affected by the use of an illegal drug, prescription drug prescribed for someone else, or alcohol?	4.0%	96.0%
Do you live with anyone who used illegal street drugs or who abused prescription medications?	3.8%	95.8%
Has an intimate partner ever threatened you with physical violence?	9.3%	89.0%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 116 illustrates the mental and behavioral health disorder mortality rates per 100,000 in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. Compared to the state, Allegheny County was significantly higher in years 2007, 2009, and 2010, and Westmoreland County in 2008.

Figure 116: Mental and behavioral disorder mortality rate



Source: Pennsylvania Department of Health

Table 35 outlines the percentage of respondents indicating the number of days they have driven in the past 30 days while drinking from the Service Region BRFSS. The majority (96.3 percent) indicated that they have not driven in the past 30 days while drinking, while 2.0 percent have driven one day while drinking.

Table 35: 2012 BRFSS: Days driven in past 30 while drinking

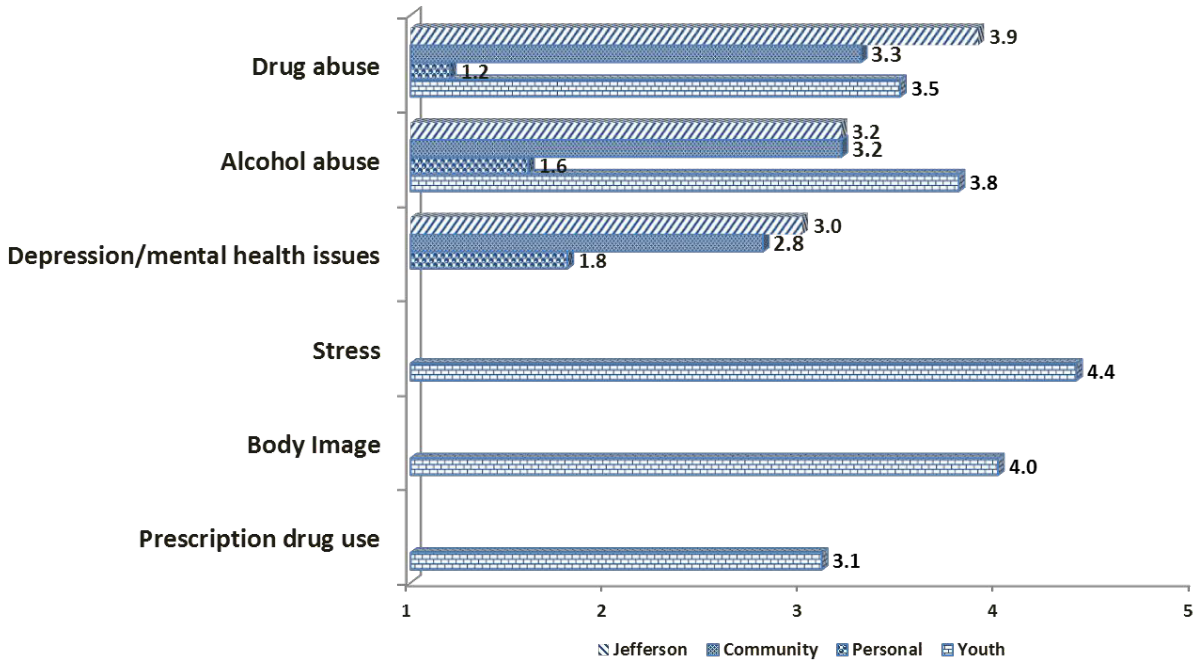
Days	Percent
None	96.3%
1 Day	2.0%
30 Days	0.8%
Refused	0.9%

Source: 2012 Jefferson Regional BRFSS

Focus Group Input

Focus Group participants were asked to rate the extent to which a number of issues are a problem in the community, in the Jefferson Regional Medical Center service region overall and in their personal life. Items were rated based on a 5-point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 117 illustrates the rank ordering of the issues related to mental health and substance abuse. Issues were rank ordered based on the average score of how much of a problem the issue is in the Jefferson Regional service region overall. Drug abuse was rated as a serious issue in the service region overall. Youth rated alcohol and drug abuse as well as stress and body image as serious issues in the community.

Figure 117: 2012 Focus Groups: Mental health and substance abuse



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

Mental health and drug and alcohol abuse issues received a great deal of discussion in the focus groups. Participants discussed the need for more mental health providers in the community. One participant noted the need for additional mental health services for children. The stress of living in communities that are considered unsafe creates anxiety and depression that are a concern as well, particularly for older persons.

Drug abuse is a significant concern because it affects the entire community. What was once seen as a youth-only problem is now impacting all ages. It is perceived that people are self-medicating and abusing prescription drugs and participants tied this to joblessness and hopelessness that exists in the community. There is a perception that there is a lot of marijuana use in the community, particularly among young people. It is also perceived that a number of the youth that are put on medications bring it to school and either give it or sell it to their friends. Drug and alcohol detox and rehabilitation programs are seen as a top priority in the community.

Participants also perceive that marijuana and cocaine have always been there but the police are now seeing a rise in drugs such as meth, heroin and prescription drugs. And these issues are happening in every community, not just in Clairton. Even in the wealthier communities, drugs are a problem. There have been several meth labs discovered in the area. There are no programs available in this area to address drug and alcohol use.

Stakeholder Interview Input

Adequate care for those with mental illnesses is a great need in the communities surrounding Jefferson Regional. The population with mental health needs continues to grow with unemployment, violence, and returning veterans; services must address these complex needs. The local community college has seen an increase in veterans who need mental health services; the college provides academic support for those with mental health issues, but does not have medical capabilities. There are also perceived gender-specific needs which include feelings of hopelessness and despair due to unemployment for males; and feelings of entrapment and a mentality that more children means a pressure for greater family income. Clairton desperately needs a mental health/drug and alcohol treatment facility.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse contribute to costly social, physical, mental, and public health problems. Substance abuse alters behaviors and decision-making and has negative health consequences for communities.

Many stakeholders discussed substance abuse as a major health need as well as a driving force of negative consequences on overall quality of life in the Jefferson Regional Medical Center service region. Alcohol, abuse of prescription drugs and illegal drug abuse were listed as concerns.

Mental Health and Substance Abuse Conclusions

There are a number of observations and conclusions that can be derived from the data related to Mental Health and Substance Abuse. They include:

- The percentage of adults who reported not getting social or emotional support was comparable between the state and counties.
- The percentage of adults who reported their mental health as not good one plus days in the month was comparable between the state and counties.
- From the 2012 BRFSS, 7.3 percent of respondents drank once a week or month.
- The percentage of adults who reported binge drinking was comparable between the state and counties and all below the Healthy People 2020 goal of 24.4 percent.
- The percentage of adults who reported heavy and chronic drinking was comparable between the state and counties.
- From the 2012 BRFSS, 14.8 percent of respondents reported taking medication or being in treatment for a mental health condition or emotional problems.
- Mental and behavioral disorder mortality rates were significantly higher for Allegheny County in 2007, 2008, and 2010, and Westmoreland County in 2008.
- From the 2012 BRFSS, 96.3 percent of respondents reported not drinking and driving in the past 30 days.
- Focus Group participants ranked alcohol, drug, and depression/mental health issues as somewhat of a problem for the service area and community. Youth Focus Group participants ranked stress and body image as serious problems.

This page is intentionally blank

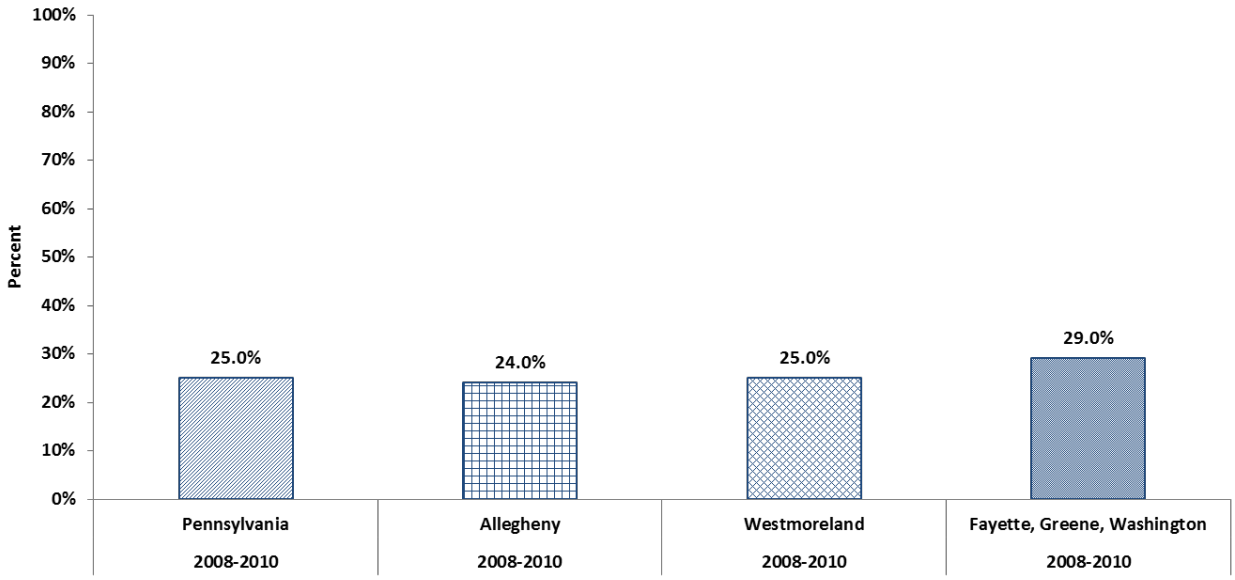
Physical Activity and Nutrition

Physical Activity and Nutrition

Regular physical activity reduces the risk for many diseases, helps control weight and strengthens muscles, bones and joints. Proper nutrition and maintaining a healthy weight are critical to good health. Physical activity and nutrition topics explored include: levels of physical activity, salt use, fruits, beans and green vegetables. When available for a given health indicator, Healthy People 2020 (HP 2020) goals and state and national rates were included.

Figure 118 illustrates the percentage of 2010 BRFSS respondents who have had no leisure time physical activity in the past 30 days in the Commonwealth of Pennsylvania and Allegheny, Westmoreland, Fayette, Greene, and Washington counties. The rate of no physical activity in the past 30 days in the service region counties ranged between 24.0 percent in Allegheny County and 29.0 percent in Fayette, Greene, and Washington counties.

Figure 118: No leisure time physical activity in the past 30 days



Source: Pennsylvania Department of Health

Table 36 illustrates the types of physical activities that the 2012 Service Region BRFSS respondents have participated in during the last 30 days. Respondents were given a list and asked to indicate all that apply, so that an individual had the opportunity to check multiple types of physical activity they participate in.

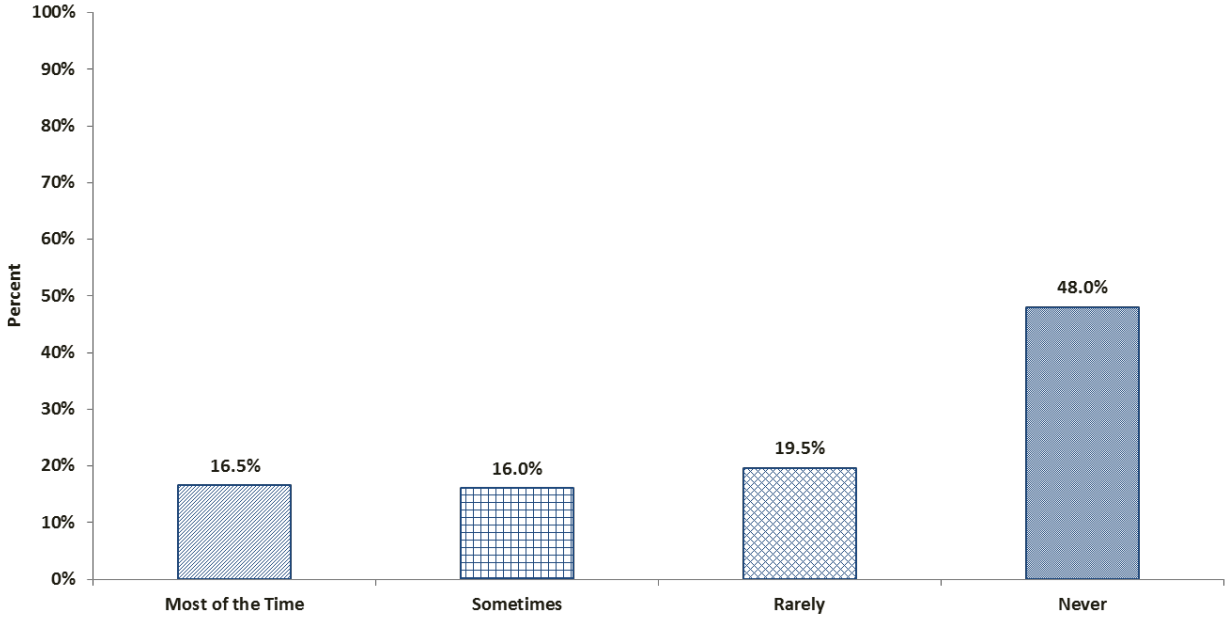
Table 36: 2012 BRFSS: Physical activity

Activity	Percent	Activity	Percent
Aerobics Class	4.0%	Martial Arts	0.8%
Back Packing	0.3%	Mowing Lawn	3.8%
Basketball	0.3%	House Painting	0.3%
Biking for Pleasure	4.3%	Racquetball	0.3%
Calisthenics	3.3%	Running	8.0%
Carpentry	1.0%	Soccer	0.8%
Dancing	0.5%	Softball	0.5%
Fishing	0.3%	Stair Climbing	1.8%
Gardening	6.0%	Swimming Laps	4.3%
Golf	2.0%	Tennis	0.3%
Health Club	3.0%	Volleyball	0.3%
Hiking	0.8%	Walking	56.8%
Home Exercise	2.5%	Water Skiing	0.3%
Jogging	1.5%	Weight Lifting	6.5%
		Yoga	0.8%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 119 illustrates the percentage of 2012 Service Region BRFSS responses regarding the frequency of adding salt to food. The majority (48.0 percent) never add salt to food, while 16.5 percent add salt to food most of the time.

Figure 119: 2012 BRFSS: Frequency of adding salt to food



Source: 2012 Jefferson Regional Medical Center BRFSS

Table 37 outlines the number of times per day, week, or month respondents eat fruit, according to the 2012 Service Region BRFSS. More than a third of the respondents eat fruit 1 time per day (34.8 percent), while a smaller percentage eats fruit 3 to 5 times per week (16.9 percent), and 1 to 10 times per month (7.9 percent). A small percentage (3.3 percent) of respondents indicated that they never eat fruit, and 0.5 percent of participants did not know.

Table 37: 2012 BRFSS: Number of fruits per day, week, and month

Nutrition	Times Per Day		Times Per Week		Times Per Month	
Fruits	1	34.8%	1-2	9.3%	1-10	7.9%
	2-4	20.3%	3-5	16.9%	11-20	3.4%
	5-7	1.5%	6-10	0.9%	21-30	2.2%
Never		3.3%				
Don't Know		0.5%				

Source: 2012 Jefferson Regional Medical Center BRFSS

Table 38 outlines the number of times per day, week, or month respondents eat beans, according to the 2012 Service Region BRFSS. The majority of respondents do not eat beans daily; the largest percentage indicated that they eat beans 1 to 5 times per month (31.9 percent). About a quarter (25.3 percent) of respondents never eat beans, and 0.8 percent of participants did not know.

Table 38: 2012 BRFSS: Servings of beans per day, week and month

Nutrition	Times Per Day		Times Per Week		Times Per Month	
Beans	1	4.8%	1-2	22.0%	1-5	31.9%
	2-4	1.8%	3-4	19.3%	5-10	2.7%
			5-7	2.3%	11-15	0.3%
Never		25.3%				
Don't Know		0.8%				

Source: 2012 Jefferson Regional Medical Center BRFSS

Table 39 illustrates the number of times per day, week, or month respondents eat green vegetables, according to the 2012 Service Region BRFSS. A little less than a quarter of the respondents indicated that they eat green vegetables daily; a larger percentage (about 40.0 percent) indicated that they eat green vegetables several times per week. A sizable portion (9.3 percent) of respondents indicated that they never eat green vegetables, and 1.0 percent of participants did not know.

Table 39: 2012 BRFSS: Servings of green vegetables per day, week or month

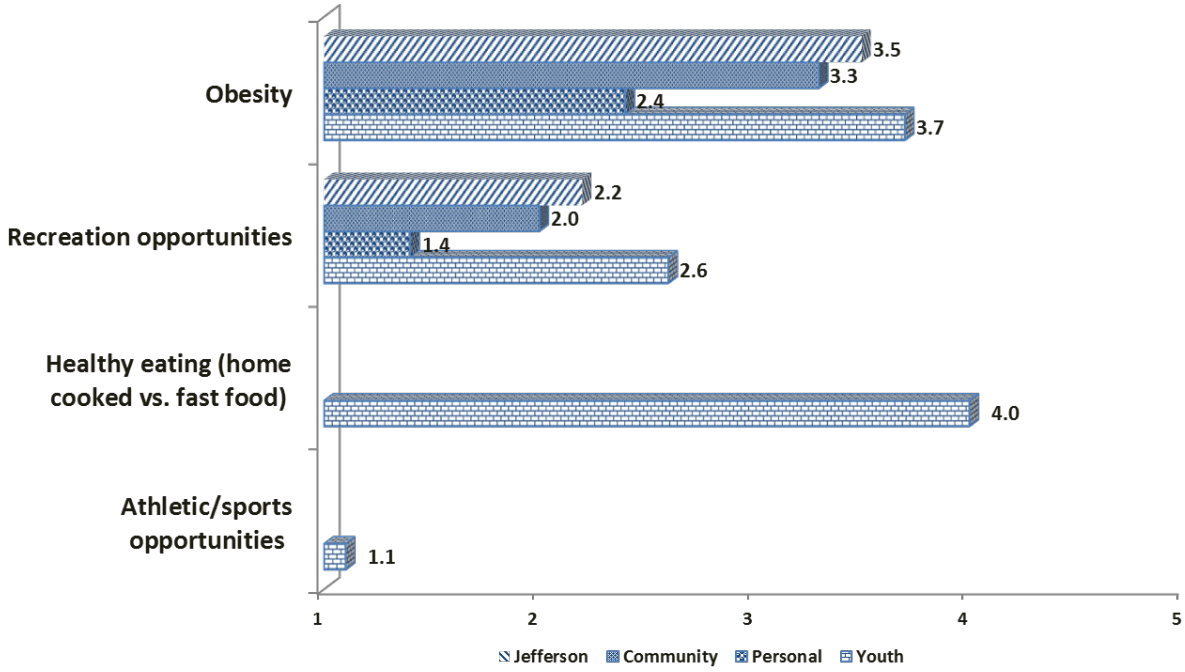
Nutrition	Times Per Day		Times Per Week		Times Per Month	
Green Vegetables	1-2	21.8%	1-2	18.3%	1-10	17.2%
	3-4	2.6%	3-5	20.4%	11-20	5.2%
	5-7	1.1%	6-14	2.1%	21-30	1.0%
Never		9.3%				
Don't Know		1.0%				

Source: 2012 Jefferson Regional BRFSS

Focus Group Input

Focus Group participants were asked to rate the extent to which a number of issues are a problem in the community, in the Jefferson Regional service region overall and in their personal life. Items were rated based on a 5-point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 120 illustrates the rank ordering of the issues related to physical activity and nutrition. Issues were rank ordered based on the average score of how much of a problem the issue is in the Jefferson Regional service region overall. Participants rated obesity as a serious problem in the service region. The youth rated obesity and healthy eating as serious problems in the community.

Figure 120: 2012 Focus Groups: Physical activity and nutrition



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

There was a great deal of discussion in the focus groups regarding physical activity and nutrition, especially related to obesity, which was identified as one of the top priority needs overall and in many of the individual groups. There is a perception that good nutrition comes with your level of education and income. Compared to other areas in the region, the hospital service area has easier access and more healthy options available. Some recognize that nutrition and diet play a big part in being healthy and people are becoming more interested in these areas, even younger children.

On the other hand, there are a lot of fast food restaurants in the area. Obesity can lead to other health problems like high cholesterol and diabetes and is also a growing problem for children. Focus group participants also noted that just because a person is obese, it does not necessarily mean they are not healthy, as weight gain can be a side effect to certain medications.

Access to healthy foods was a topic discussed during the focus groups. There are areas of the service region that do not have grocery stores. Many people buy food at the dollar store where there are no healthy food options. The lack of recreation facilities is a problem; there is nothing for children or youth to do. There are a few after-school programs but they need something to keep their interest.

Stakeholder Interview Input

Health needs within the topic area of physical activity and nutrition were listed as a top priority by nearly every stakeholder who was interviewed. Within this topic, issues like obesity and diabetes were specifically mentioned. Many see the barriers of physical wellness as being linked to access issues of education, awareness, and lack of healthy options. Individuals' ability to understand how wellness and nutrition affect their overall health and how and where to seek help to change unhealthy behaviors is a high priority.

Stakeholders expressed concern that there is a lack of resources and notably that there is no grocery store/farmer's market near Clairton. Transportation was noted as a barrier to access healthy diet options. Stakeholders identified a need for health education related to topic areas such as: lifestyle choices, eating habits, and exercise.

Physical Activity and Nutrition Conclusions

There are a number of observations and conclusions that can be derived from the data related to Physical Activity and Nutrition. They include:

- The percentage of adults who reported no leisure time physical activity in the past month was comparable between the state and counties.
- From the 2012 BRFSS, 56.8 percent of respondents reported walking for exercise.
- From the 2012 BRFSS, 16.5 percent of respondents reported adding salt to food most of the time, 48.0 percent reported never.
- From the 2012 BRFSS, 34.8 percent of respondents reported eating fruit once a day, 3.3 percent reported never.
- From the 2012 BRFSS, 4.8 percent of respondents reported eating beans once a day, 25.3 percent reported never.
- From the 2012 BRFSS, 21.8 percent of respondents reported eating green vegetables daily, 9.3 percent reported never.
- Focus Group participants ranked obesity as somewhat of a problem in the service area and community. Youth Focus Group participants ranked obesity and healthy eating as a serious problem.

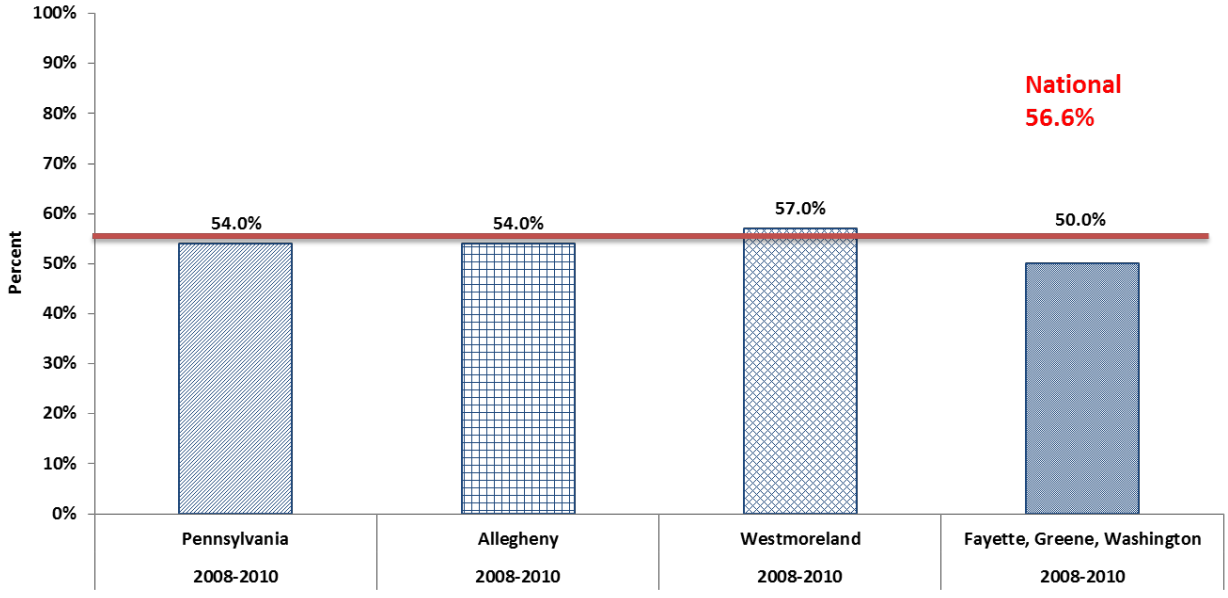
Tobacco Use

Tobacco Use

According to the Centers for Disease Control and Prevention, tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964. Tobacco use greatly increases health risks and in some cases may cause cancer, heart disease, lung diseases (including emphysema, bronchitis and chronic obstructive pulmonary disease), premature birth, low birth weight, stillbirth and infant death. There is no risk-free level of exposure to secondhand smoke. Like direct tobacco use, secondhand smoke greatly increases your risk for heart disease and lung cancer in adults and contributes to a number of health problems in infants and children, including severe asthma attacks, respiratory infections, ear infections and sudden infant death syndrome (SIDS). Tobacco use topics explored include: smoking, emphysema and smoking during pregnancy. When available for a given health indicator, Healthy People 2020 (HP 2020) goals and state and national rates were included.

Figure 121 illustrates adults who never smoked in the Commonwealth of Pennsylvania and Allegheny, Fayette, Greene, Washington, and Westmoreland counties from 2008 through 2010. Compared to the state, the counties were comparable with the percentage of adults who never smoked, with Fayette, Greene, and Washington Counties slightly lower. Westmoreland County was above the national percentage of 56.6 percent.

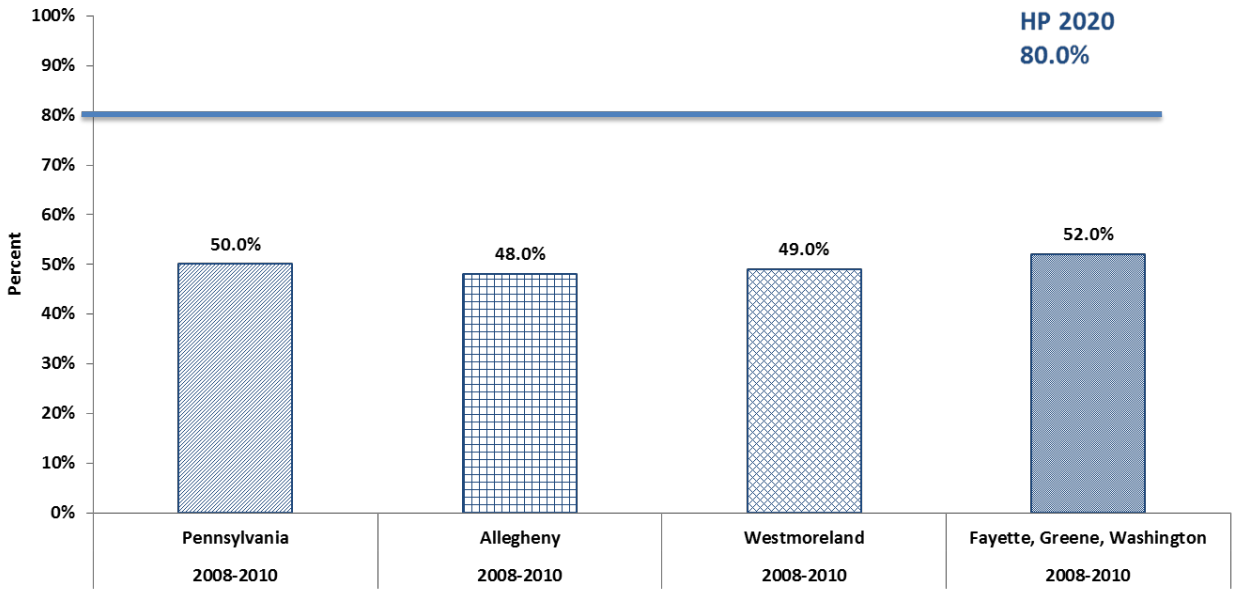
Figure 121: Adults who never smoked



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 122 illustrates adults who quit smoking at least one day in the past year (out of adults who smoke every day) in the Commonwealth of Pennsylvania and Allegheny, Fayette, Greene, Washington, and Westmoreland counties from 2008 through 2010. The percentage between the state and counties was comparable and all well below the Healthy People 2020 goal of 80.0 percent.

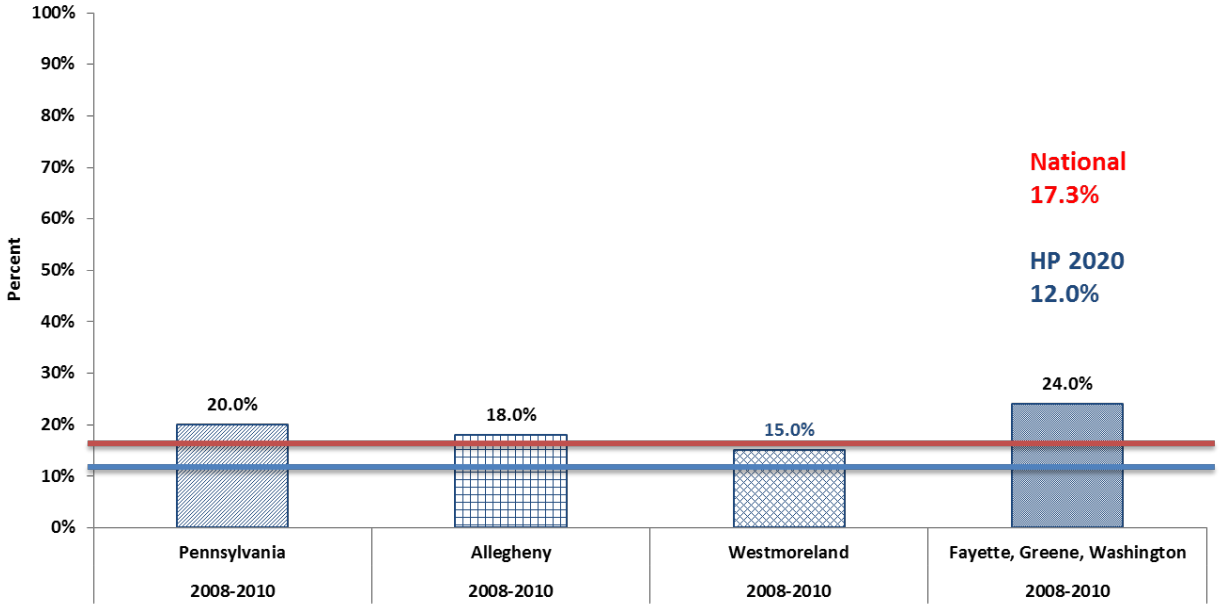
Figure 122: Adults who quit smoking at least one day in the past year (out of adults who smoke every day)



Source: Pennsylvania Department of Health, www.healthypeople.gov

Figure 123 illustrates adults who are current smokers in the Commonwealth of Pennsylvania and Allegheny, Fayette, Greene, Washington, and Westmoreland counties from 2008 through 2010. The percentage between the state and counties was comparable and all above the Healthy People 2020 goal of 12.0 percent. Westmoreland County was below the national percentage of 17.3 percent.

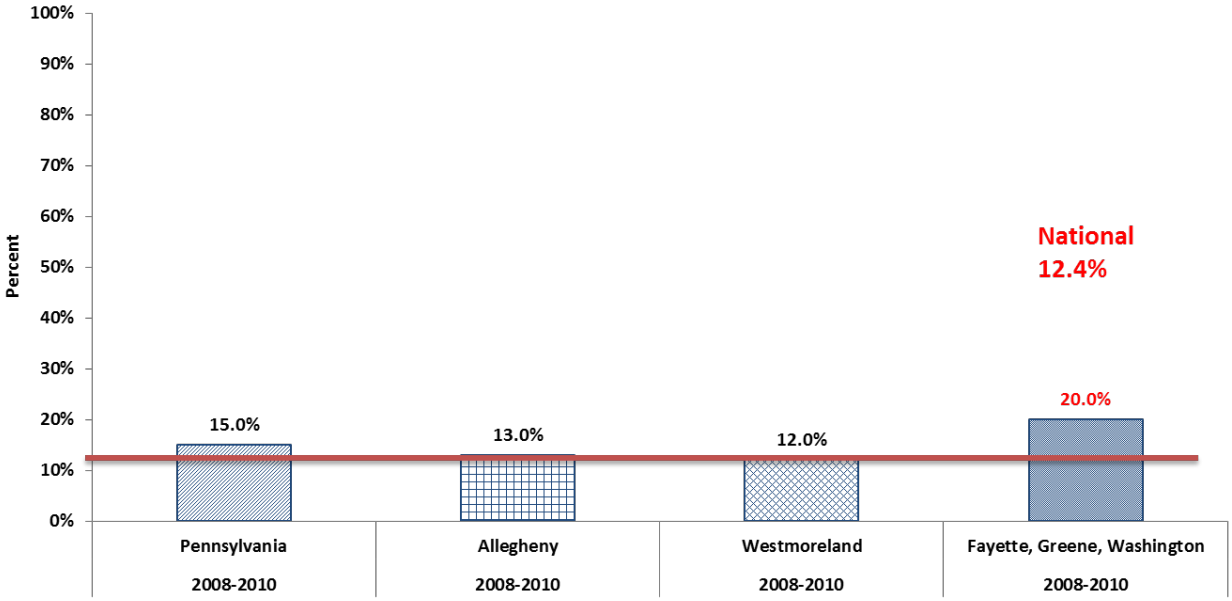
Figure 123: Adults who are current smokers



Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

Figure 124 illustrates adults who are everyday smokers in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Greene, Washington, and Westmoreland counties from 2008 through 2010. The percentage between the state and counties was comparable and significantly higher in Fayette, Greene, and Washington County. The Commonwealth of Pennsylvania, Allegheny, Fayette, Greene and Washington counties were above the national percentage of 12.4 percent.

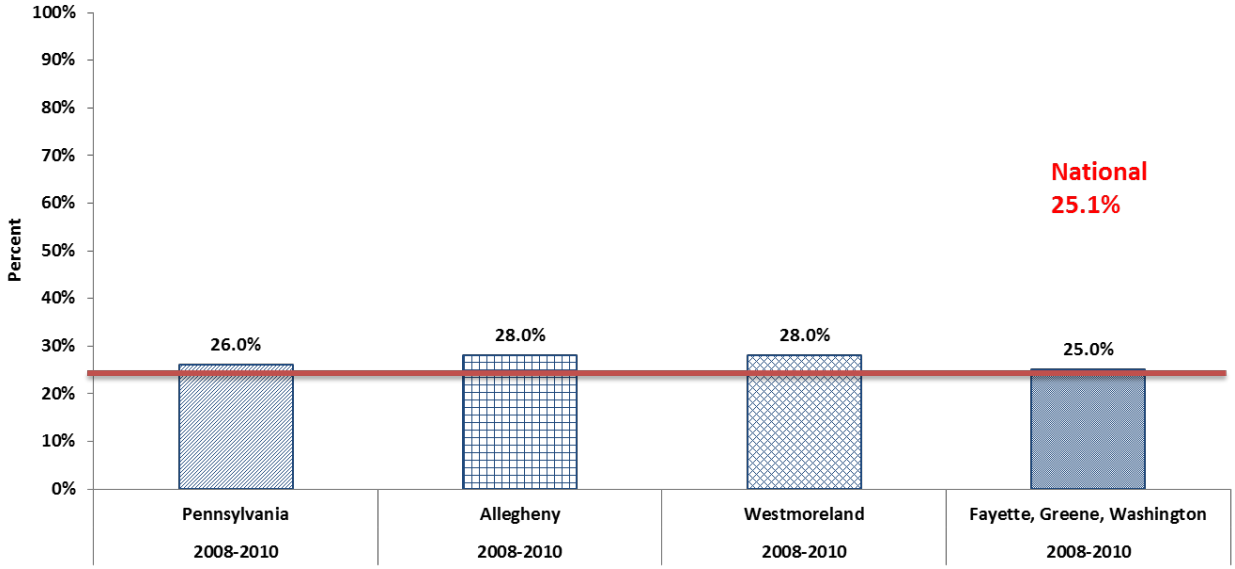
Figure 124: Adults who are everyday smokers



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 125 illustrates adults who are former smokers in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Greene, Washington, and Westmoreland counties from 2008 through 2010. The percentage between the state and counties was comparable. The Commonwealth of Pennsylvania, Allegheny and Westmoreland counties were above the national percentage of 25.1 percent.

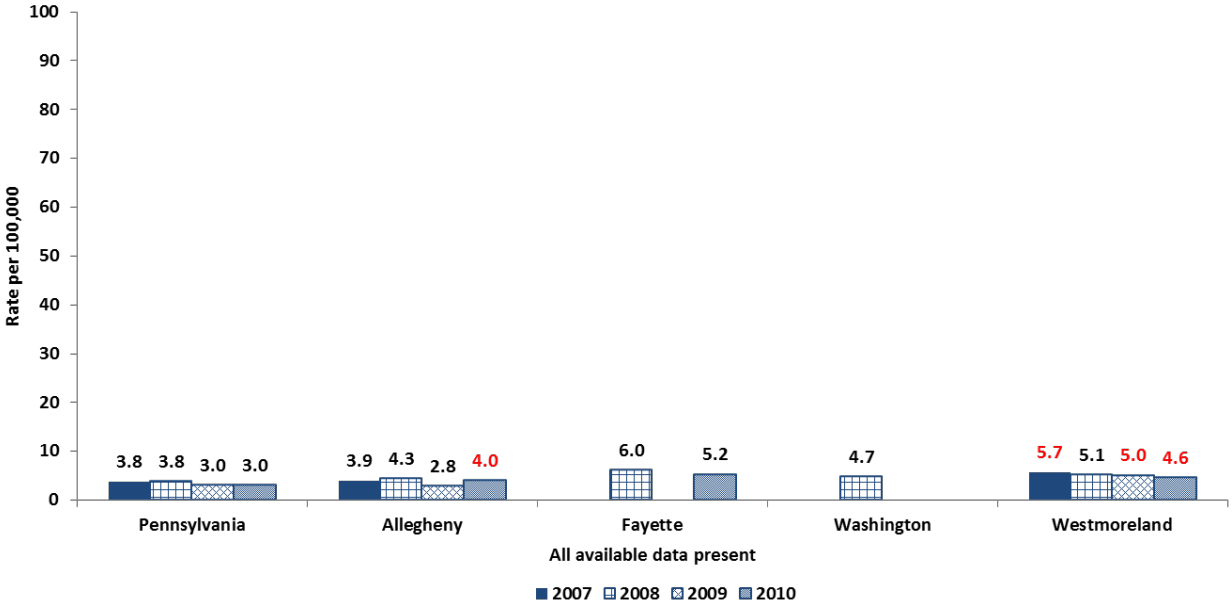
Figure 125: Adults who are former smokers



Source: Pennsylvania Department of Health, Centers for Disease Control

Figure 126 illustrates the emphysema mortality rate in the Commonwealth of Pennsylvania, and Allegheny, Fayette, Greene, Washington, and Westmoreland counties from 2007 through 2010. Compared to the state, Allegheny County had a significantly higher emphysema mortality rate in 2010, along with Westmoreland County in 2007, 2009, and 2010.

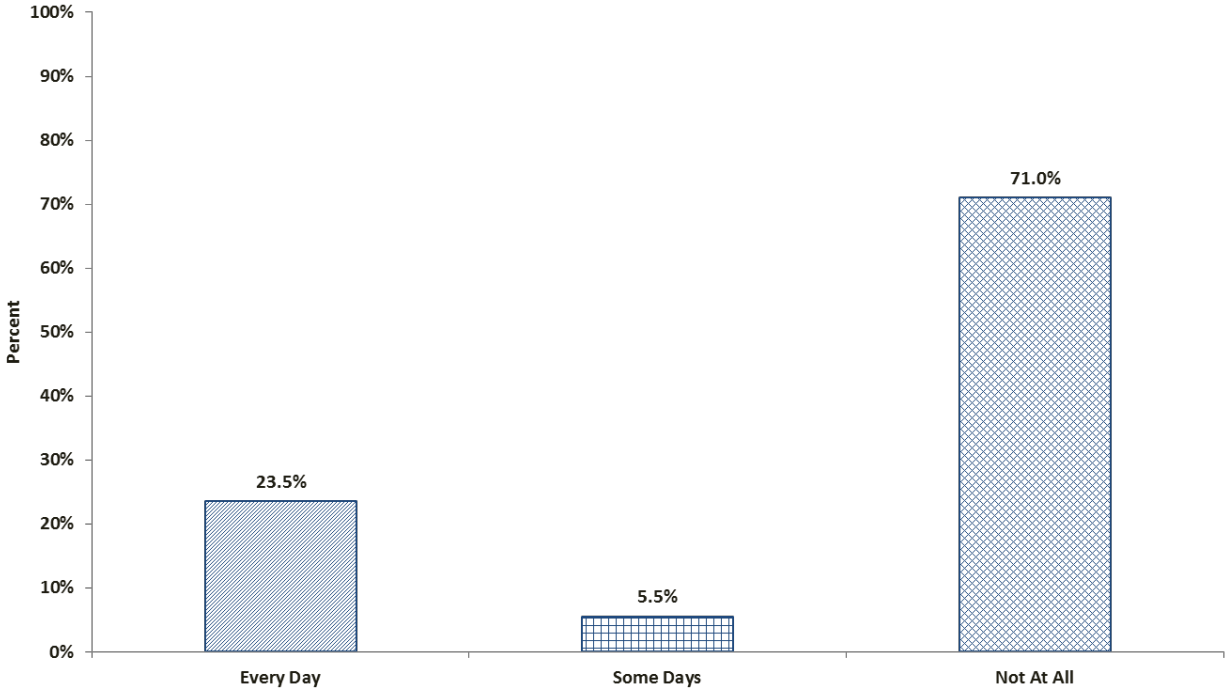
Figure 126: Emphysema mortality rate



Source: Pennsylvania Department of Health

Figure 127 illustrates the frequency of tobacco use by respondents of the 2012 Service Region BRFSS. The majority of respondents (71.0 percent) indicated that they do not use tobacco at all, while 23.5 percent use tobacco every day, and 5.5 percent of respondents use tobacco on some days.

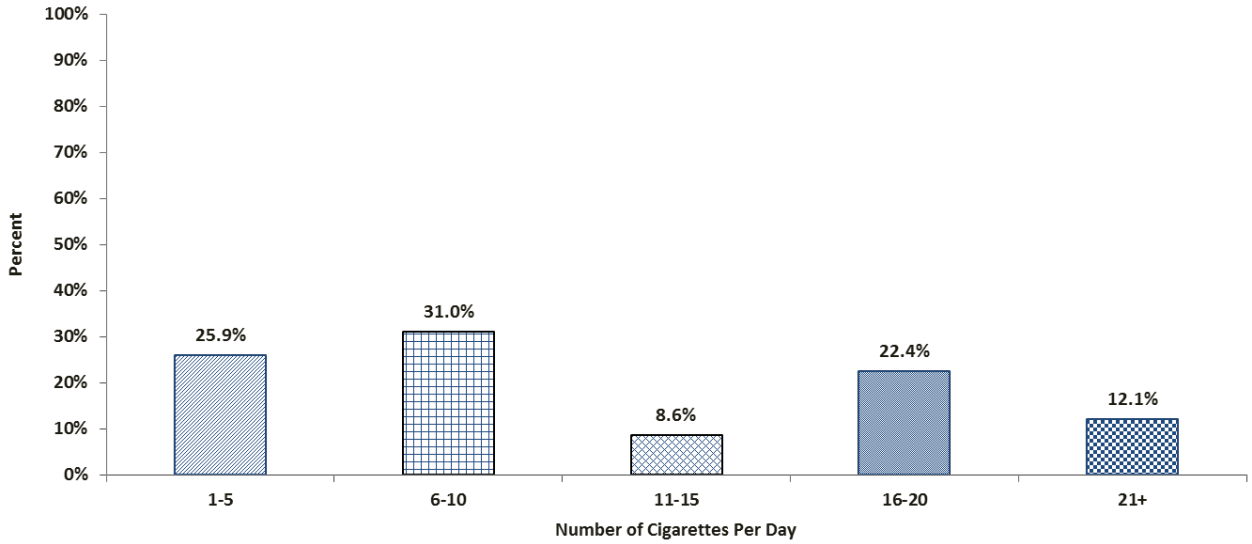
Figure 127: 2012 BRFSS: Tobacco use



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 128 illustrates the number of cigarettes smoked per day by current smokers from the 2012 Service Region BRFSS. The majority (31.0 percent) smoke 6 to 10 cigarettes per day, with 25.9 percent smoking 1 to 5 cigarettes per day.

Figure 128: 2012 BRFSS: Number of cigarettes per day (smokers only)



N=116

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 129 outlines the number of cigarettes smoked per day from the 2012 Service Region BRFSS. Table 40 if those smokers would like to quit. The majority of the current smokers would like to quit, regardless of the number of cigarettes that are currently smoked per day. For example, 27 of the 36 smokers who smoke 6 to 10 cigarettes per day would like to quit, while the majority (24) of smokers who smoked 1 to 5 cigarettes per day would also like to quit.

Figure 129: 2012 BRFSS: Number of cigarettes per day

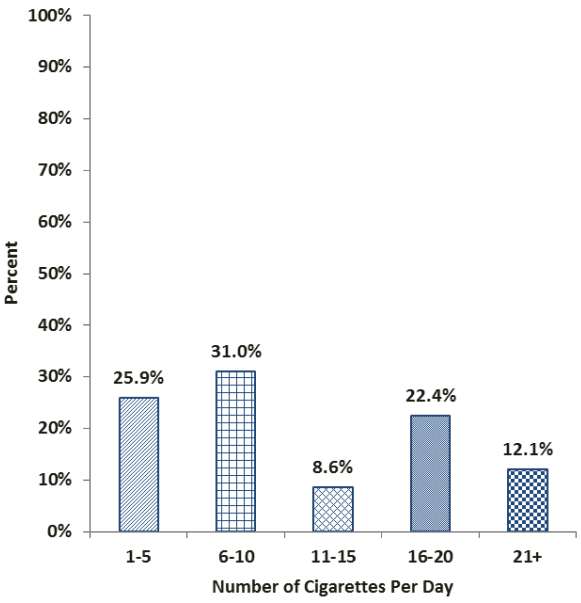


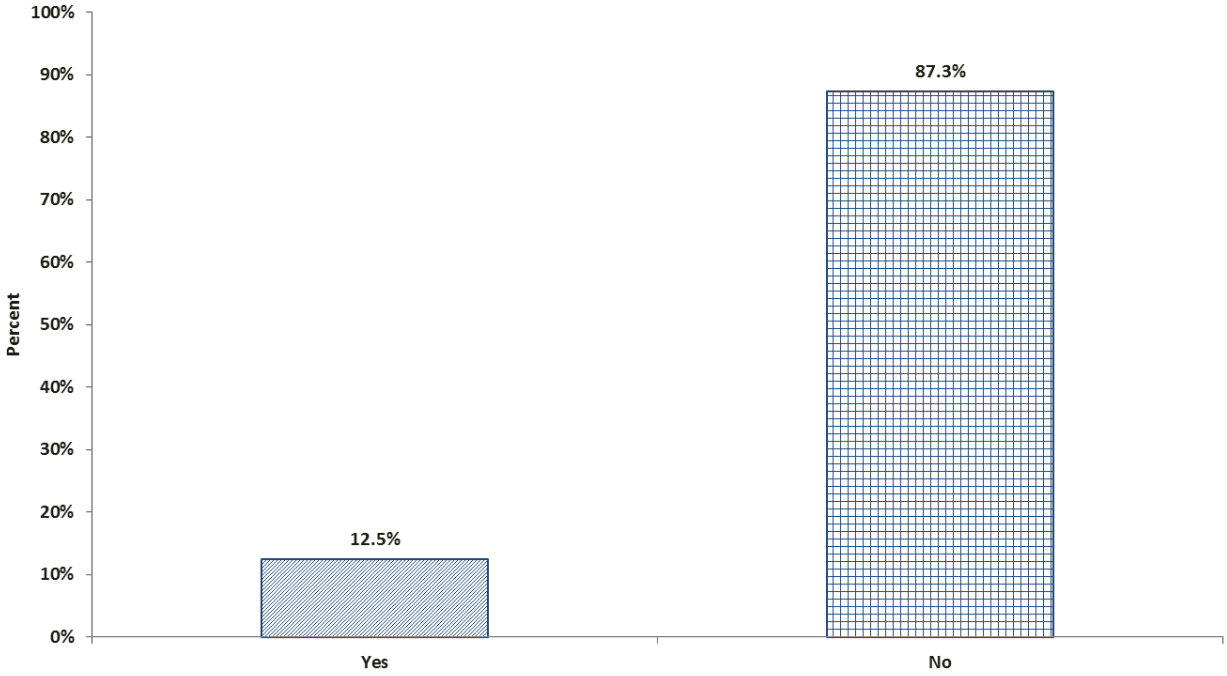
Table 40: 2012 BRFSS: Smoking cessation

Cigarettes Per Day	Smokers	YES	NO	Don't Know
1-5	30	24	5	1
6-10	36	27	7	2
11-15	10	5	3	2
16-20	26	14	10	2
21+	14	10	4	0
Total	116	80	29	7

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 130 illustrates the percentage of 2012 Service Region BRFSS respondents who were told they had COPD, emphysema or chronic bronchitis. A small portion (12.5 percent) of respondents had been told they had COPD, emphysema or chronic bronchitis, while 87.3 percent responded no.

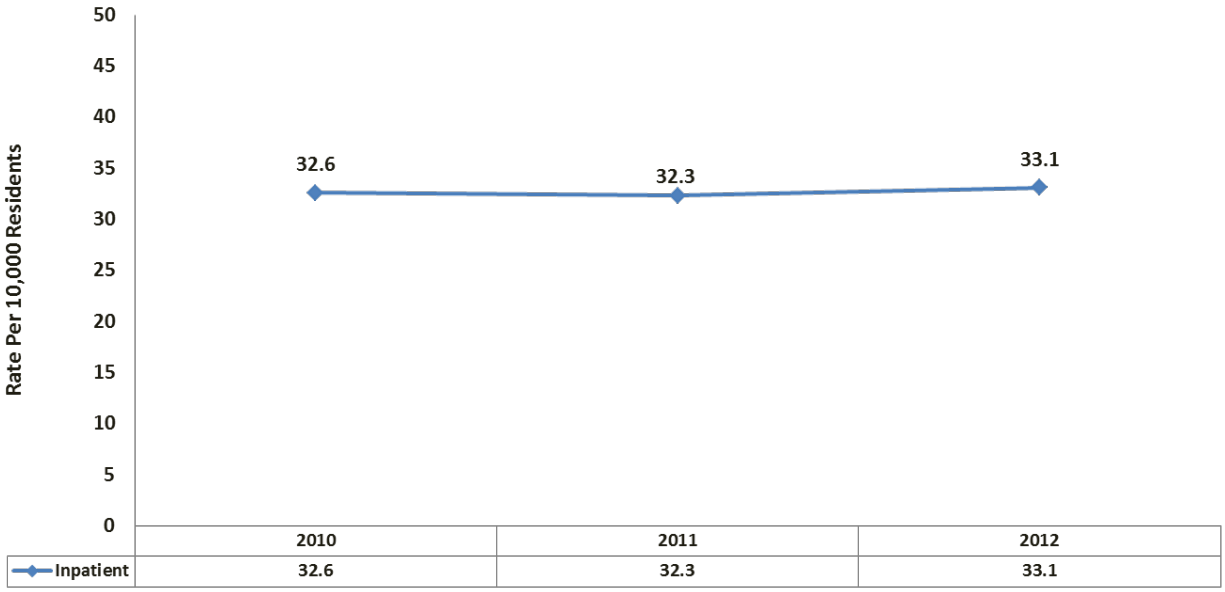
Figure 130: 2012 BRFSS: Told they have COPD, emphysema, or chronic bronchitis



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 131 illustrates the COPD inpatient discharges rate per 10,000 residents of the Jefferson Regional service territory from 2010 through 2012. The rate has increased slightly during the past three years.

Figure 131: COPD – inpatient discharges

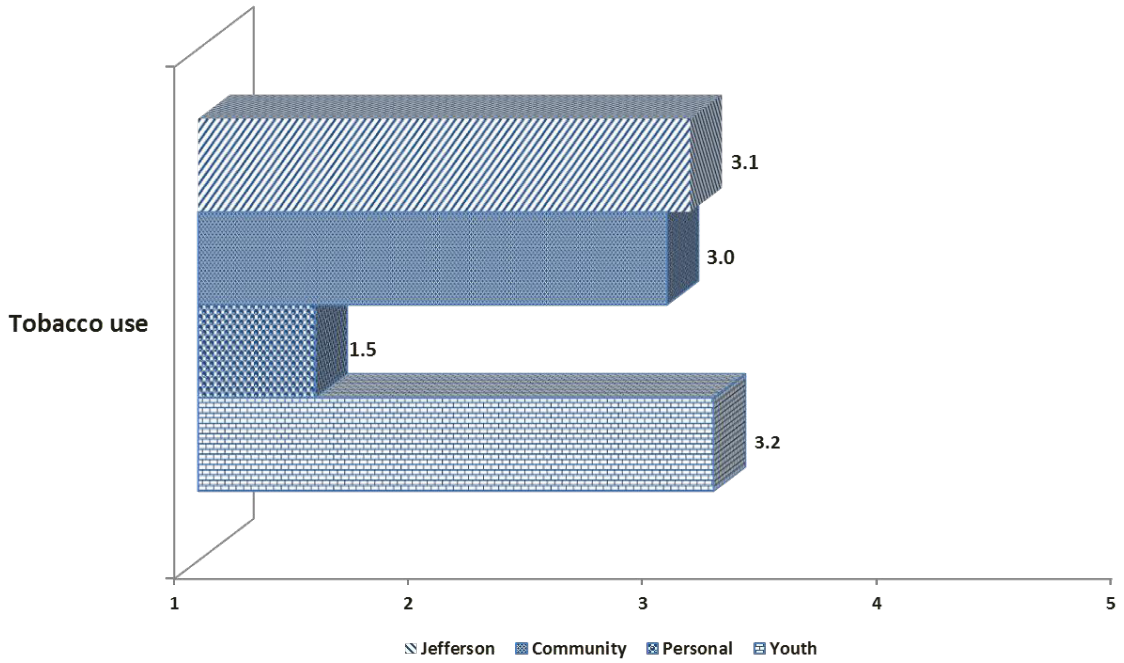


Source: Pennsylvania Health Care Cost Containment Council

Focus Group Input

Focus Group participants were asked to rate the extent to which a number of issues are a problem in the community, in the Jefferson Regional service region overall, and in their personal life. Items were rated based on a 5-point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 132 illustrates the rank ordering of the issues related to tobacco use. Issues were rank ordered based on the average score of how much of a problem the issue is in the Jefferson Regional service region overall. Focus group participants rated tobacco use as somewhat of a problem in the service region.

Figure 132: Focus Groups: Tobacco use



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

While tobacco use on its own was not a topic of significant discussion during the focus groups, a number of participants noted the connection between the high rates of tobacco use and cancer rates. They also expressed that there is a need for smoking cessation programs.

Stakeholder Interview Input

Tobacco use remains an issue in the Jefferson Regional service region. Smoking can lead to certain cancers, and chronic cardiac and pulmonary diseases. Smokeless tobacco also increases a person's chance of being diagnosed with certain cancers and chronic diseases. In the scope of the community, tobacco use poses dangerous health risks. Stakeholders expressed that there are still too many smokers; there is a higher than average number of smokers, and stakeholders cited the need for action related to smoking cessation.

Tobacco Conclusions

There are a number of observations and conclusions that can be derived from the data related to Tobacco Use. They include:

- The percentage of adults who reported never smoking is comparable between the state, counties, and national percentage (56.6).
- The percentage of everyday smokers who quit smoking at least one day in the past year was comparable between the state and counties, although well below the Healthy People 2020 goal of 80.0 percent.
- The percentage of adults who are current smokers was significantly lower in Westmoreland County. Pennsylvania, Allegheny County, and Fayette County were above the national percentage (17.3 percent) and Healthy People 2020 goal (12.0 percent).
- The percentage of everyday smokers in Fayette County (20.0 percent) was significantly higher compared to the state. Pennsylvania and Allegheny County were above the national percentage (12.4 percent).
- The percentage of former smokers was comparable between the state and counties and slightly higher than the national percentage (25.1 percent).
- Emphysema mortality rates were significantly higher in Allegheny County in 2010 and Westmoreland County in years 2007, 2008, and 2010, compared to the state.
- From the 2012 BRFSS, 71.0 percent reported never smoking, while 23.5 percent smoke daily.
- From the 2012 BRFSS, of respondents who smoke, 12.1 percent smoke at least a pack of cigarettes per day.
- From the 2012 BRFSS, 12.5 percent of smokers were told they have COPD, emphysema, or chronic bronchitis.
- Focus Group participants ranked tobacco use as somewhat of a problem.

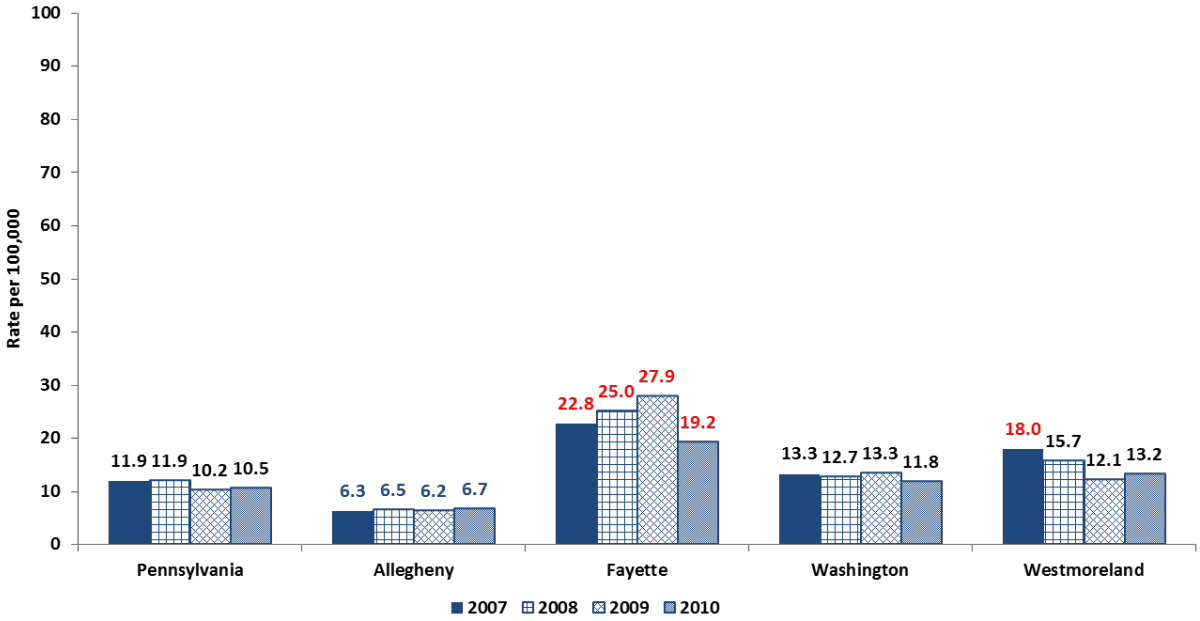
Unintentional/Intentional Injury

Unintentional/Intentional Injury

The topic of injury relates to any intentional or unintentional injuries that can be suffered by individuals. Injury topics explored include: auto accident mortality, seatbelt usage, fall mortality, fractures, suicide and firearm mortality. When available for a given health indicator, Healthy People 2020 (HP 2020) goals and state and national rates were included.

Figure 133 illustrates the motor vehicle mortality rate per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. Compared to the state, Fayette County had twice the mortality rate for years 2007 through 2010, and Westmoreland County in 2007. Allegheny County has a significantly lower motor vehicle mortality rate for the years 2007 through 2010 when compared to the state.

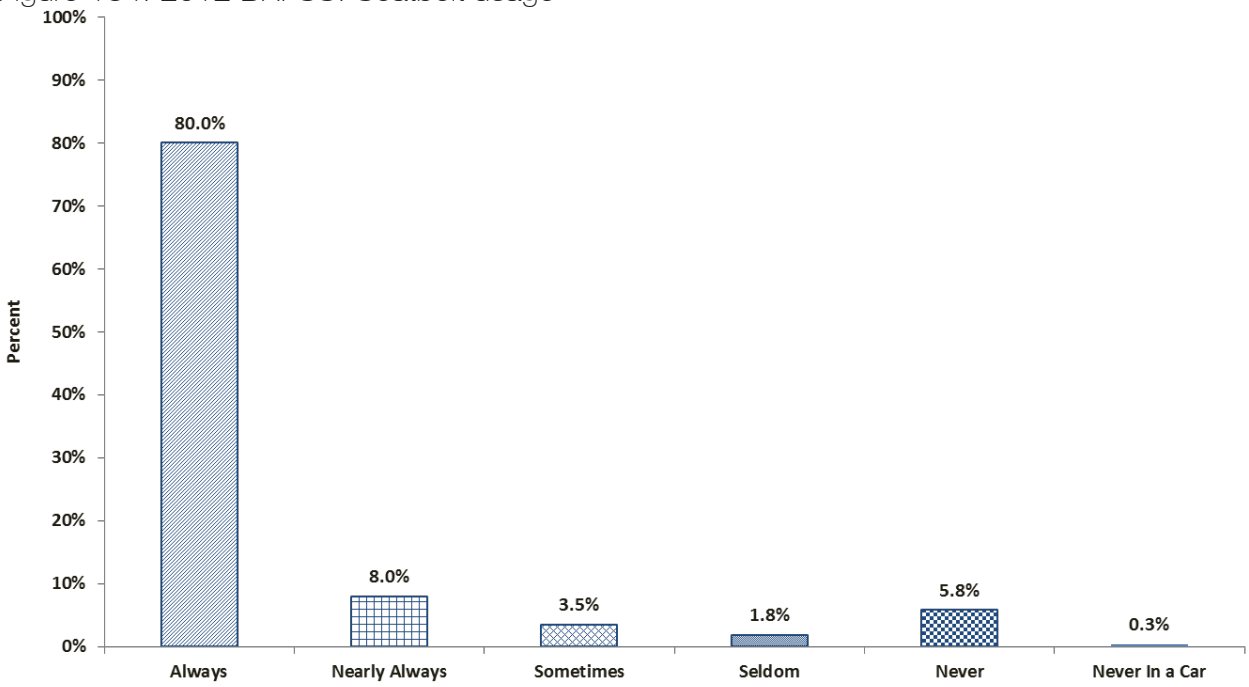
Figure 133: Motor vehicle mortality rate



Source: Pennsylvania Department of Health

Figure 134 illustrates the 2012 Service Region BRFSS frequency of seatbelt use. The majority (80.0 percent) of respondents always use their seatbelts, 8.0 percent nearly always wear their seatbelt, while 5.8 percent of respondents reported that they never wear their seatbelts.

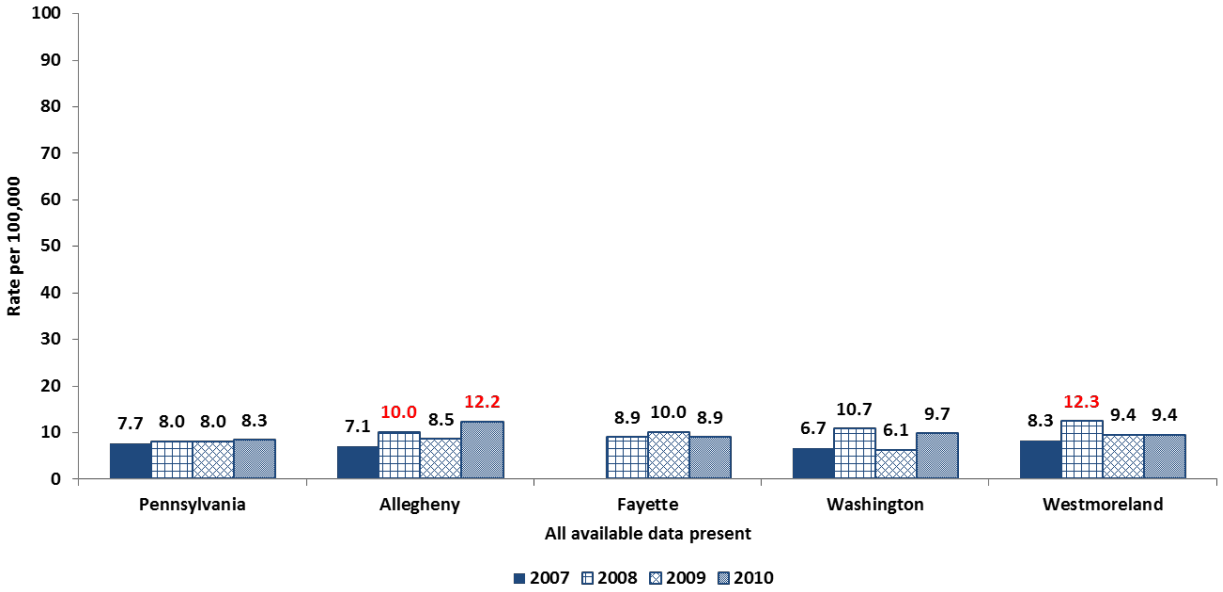
Figure 134: 2012 BRFSS: Seatbelt usage



Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 135 illustrates the fall mortality rate per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. Compared to the state, Allegheny County had a significantly higher fall mortality rate in 2008 and 2010, and Westmoreland County in 2008.

Figure 135: Fall mortality rate



Source: Pennsylvania Department of Health

Table 41 illustrates respondents who fell in the past 3 months, by age group from the 2012 Service Region BRFSS. A total of 88 respondents, or 22 percent of the sample, indicated they had experienced a fall in the past three months. The largest percentages of those who have fallen (27.3 percent) were between the ages of 55 through 64.

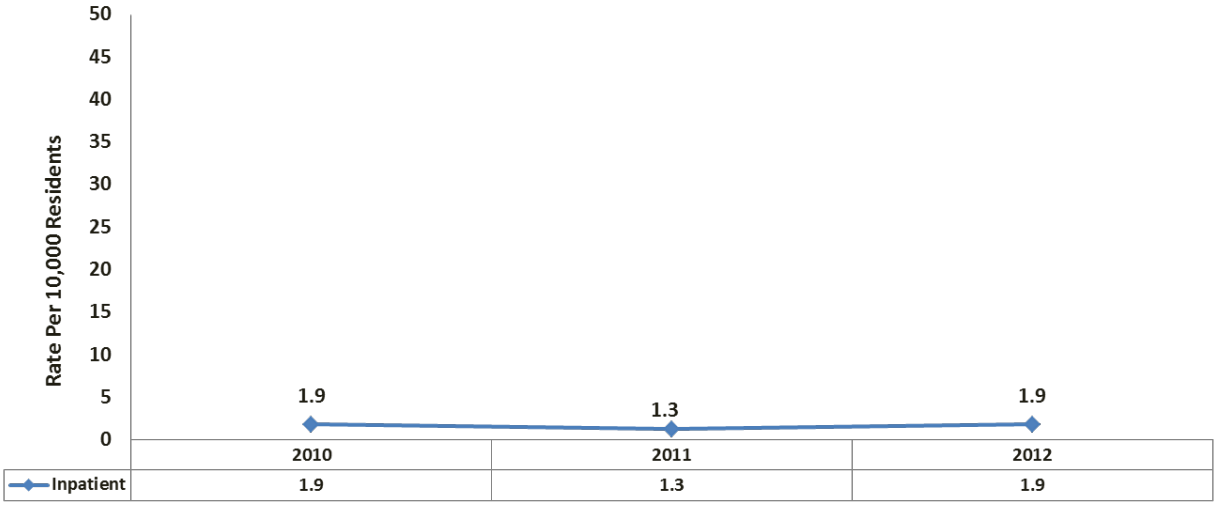
Table 41: 2012 BRFSS: Falls

Respondents Who Fell in the Past Three Months by Age Group		
Age	Number	Percent
18-24	5	5.7%
25-35	16	18.2%
35-44	7	8.0%
45-54	22	25.0%
55-64	24	27.3%
65+	14	15.9%

Source: 2012 Jefferson Regional Medical Center BRFSS

Figure 136 illustrates the fracture inpatient discharge rate per 10,000 residents of the Jefferson Regional service territory from 2010 through 2012. The utilization rate for fractures has varied slightly during the past three years.

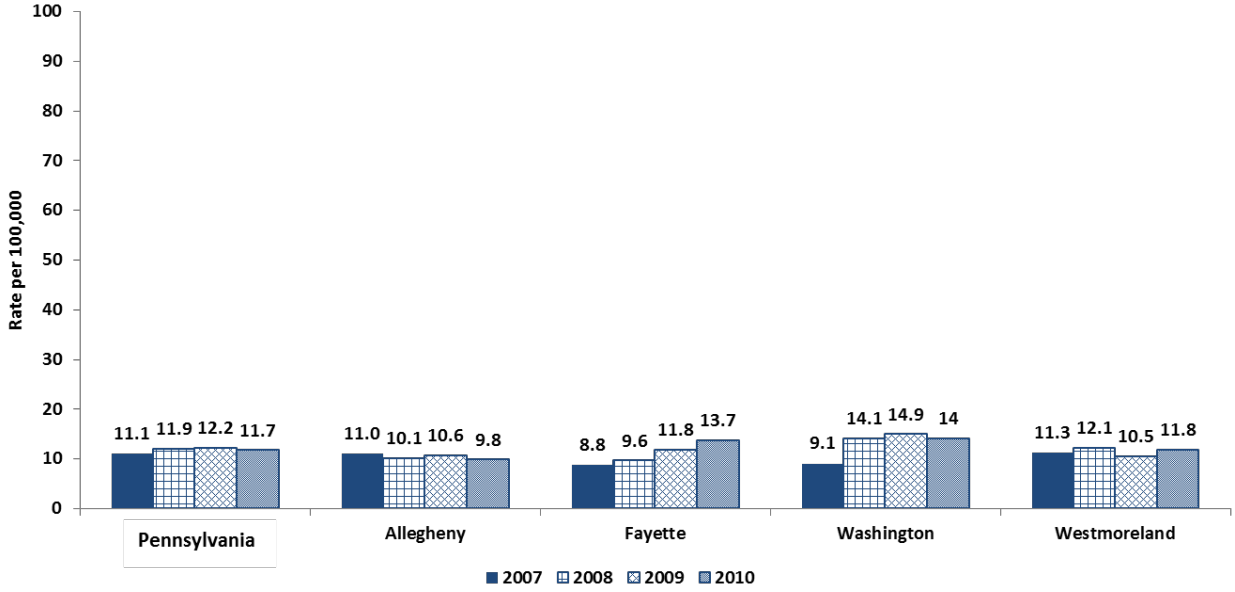
Figure 136: Fracture – inpatient discharges



Source: Pennsylvania Health Care Cost Containment Council

Figure 137 illustrates the suicide mortality rate per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. The suicide rate in Allegheny County has declined during the four year period, while the rates have increased across the other counties as well as the state.

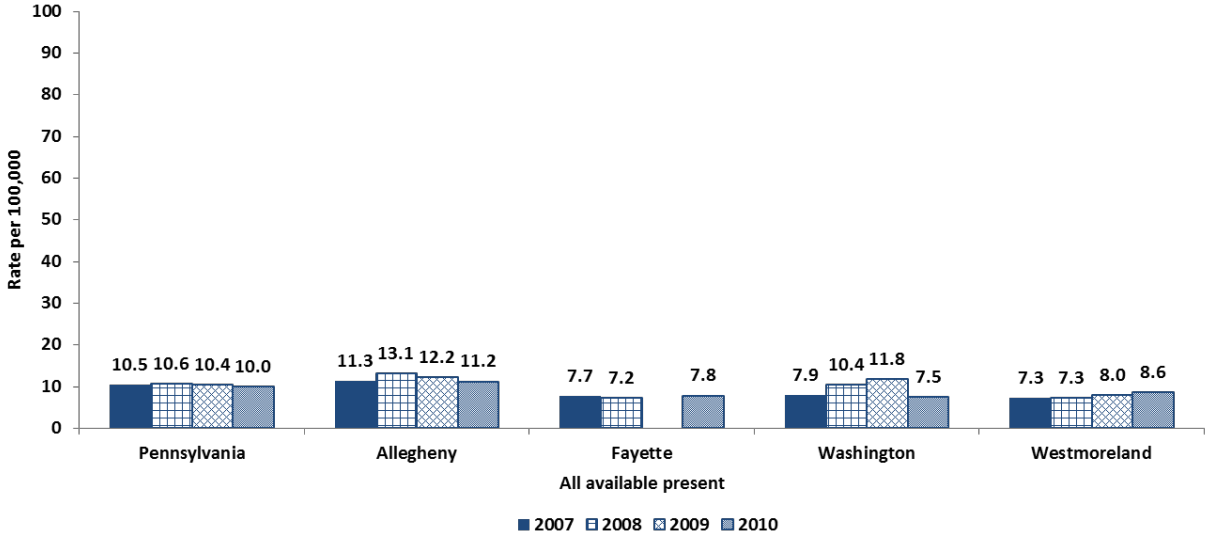
Figure 137: Suicide mortality rate



Source: Pennsylvania Department of Health

Figure 138 illustrates the firearm mortality rate per 100,000 residents in the Commonwealth of Pennsylvania and Allegheny, Fayette, Washington, and Westmoreland counties from 2007 through 2010. Although data is not available for all years in Fayette County, the rate between the state and counties is comparable.

Figure 138: Firearm mortality rate (accidental, suicide, homicide)

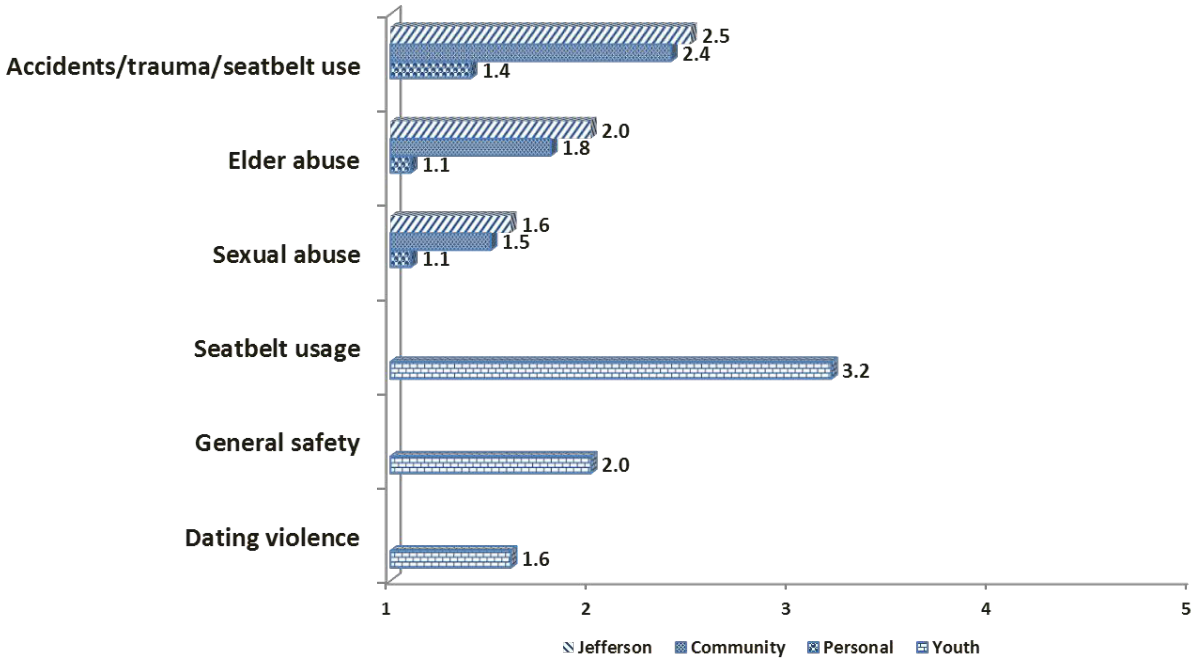


Source: Pennsylvania Department of Health

Focus Group Input

Focus Group participants were asked to rate the extent to which a number of issues are a problem in the community, in the Jefferson Regional Medical Center service region overall, and in their personal life. Items were rated based on a 5-point scale where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, 1=Not a Problem. Figure 139 illustrates the rank ordering of the issues related to Unintentional/Intentional Injury. Issues were rank ordered based on the average score of how much of a problem the issue is in the service region overall. Participants rated accidents/trauma/seatbelt use as somewhat of a problem in the service region. Youth identified seatbelt use a somewhat serious problem.

Figure 139: Focus Groups: Unintentional/Intentional injury



Source: 2012 Jefferson Regional Medical Center Focus Groups, Strategy Solutions, Inc.

Injury was discussed within the focus groups as it relates to crime and violence. Focus group participants expressed concerns related to the increase in violent activities in some of the local communities.

Stakeholder Interview Input

One pressing concern stakeholders discussed was increased violence. With increased violence, both unintentional and intentional injuries occur and have both mental and physical consequences for the surrounding community.

Unintentional/Intentional Injury Conclusions

There are a number of observations and conclusions that can be derived from the data related to Injury. They include:

- Motor Vehicle Mortality rates were significantly lower in Allegheny County for the years 2007 through 2010, significantly higher in Fayette County for the years 2007 through 2010, and significantly higher in Westmoreland County in 2007.
- From the 2012 BRFSS, 80.0 percent of respondents reported always wearing a seatbelt, while 5.8 percent never wear a seatbelt.
- In 2008 and 2010 fall mortality rates were significantly higher in Allegheny County, and also 2008 in Westmoreland County, compared to the state.
- From the 2012 BRFSS, 25.0 percent of respondent aged 45 to 54 had a fall in the past 3 months, 15.9 percent for respondents aged 65 and over.
- Suicide mortality rates were comparable between the state and all counties.
- Firearm mortality rates were comparable between the state and all counties
- Only 1.3 percent of 2012 BRFSS respondent reported knowledge of elder abuse.
- Focus Group participants ranked accidents/trauma/seatbelt usage as a small problem, followed by elder abuse and sexual abuse.

This page is intentionally blank

This page is intentionally blank

Conclusions

Conclusions

Demographic Conclusions

A number of conclusions can be drawn from the demographic data. They include:

- From the 1990 to 200 census the population of the Primary Service Area has steadily declined and the 2017 projection shows this trend continuing.
- The Primary Service Area and BRFSS respondents were very similar in terms of gender, with a slightly higher percentage of females.
- The majority, 40.4 percent for the service area, and 47.6 percent of the 2012 BRFSS respondents are between the ages of 25-54.
- The Primary Service Area and BRFSS respondents, while predominately white, had a similar population of African Americans at 10.8 percent and 8.3%, respectively.
- The Primary Service Area and BRFSS respondents were similar in terms of income, with 57.7 percent of the Service Area earning under $50,000 and 51.0 percent of the BRFSS respondents in the same earning category.
- The Primary Service Area and BRFSS respondents were similar in terms of education, with 39.6 percent of the Service Area having a high school education, and 22.3 percent having at least four years of college. For the BRFSS respondents, the percentages are 32.5 percent and 29.5 percent respectively.
- In the Primary Service Area, 47.0 percent were married, while the percentage for BRFSS respondents was 52.3 percent.
- In the Primary Service Area, 44.0 percent were employed, while the percentage for BRFSS respondents was 44.0 percent.
- For the majority (32.6 percent) of the service area population, average travel time to work was 15-29 minutes, while 8.4 percent needed to travel 60 minutes or more.

Access Conclusions

There are a number of observations and conclusions that can be derived from the data related to Access to quality health care. They include:

- In Pennsylvania, Allegheny County, and Westmoreland County, the percentage of adults who rated their general health as fair or poor was comparable; the percentage for Fayette County (22.0 percent) was significantly higher than the state percentage (15.0 percent).
- The Majority of BRFSS respondents (34.5 percent) rated their general health as good, while 24.5 percent rated it fair or poor.

- The percentage of adults not having a personal healthcare provider was lower than the Healthy People 2020 goal of 16.1 percent for the state and all counties; however, the age group 18 to 44 (24.0 percent) was significantly higher than the state (17.0 percent).

- Between the state, BRFSS Service Area, and counties, there were no significant differences for the percentage of adults who visited a doctor in the past two years for a routine check-up.
- The majority of BRFSS respondents (77.8 percent) had a routine check-up in the past year.
- The percentage of adults aged 18 to 64 with no health insurance was comparable between the state, BRFSS respondents, and counties, and all below the nation at 17.8 percent.
- BRFSS respondents reported the highest frequency of reasons for not having health insurance as a lost job or change in employment at 3.8 percent, followed by the inability to pay premiums at 2.8 percent.
- Although comparable, the state and counties were above the HP 2020 goal of 4.2 percent of adults who needed to see a doctor in the past year but could not due to cost.
- The majority of BRFSS respondents (71.0 percent) reported never needing to visit the emergency room in the past year, while 19.3 percent made one visit.
- Twenty-eight BRFSS respondents could not fill or take medication as directed because of cost in the past year.
- The majority of BRFSS respondents (50.8 percent) were able to make an appointment with a doctor within one week, while only 0.8 percent responded they did not get care because it took too long.
- The majority of BRFSS respondents (62.8 percent) saw a dentist in the past year, 1.5 percent reported never seeing a dentist.
- According to the county health rankings, between 55 percent and 60 percent of the women in the service area counties have appropriately had mammogram screenings.
- Somewhere between 15 percent and 17 percent of adults in the service area have low health literacy, depending on the definition used.
- Focus groups ranked transportation as the most serious problem to access to care for the Primary Service Area and community.

Chronic Disease Conclusions

There are a number of observations and conclusions that can be derived from the data related to Chronic Disease. They include:

- Breast cancer incidence rates trended upward in Pennsylvania and Westmoreland County, and was significantly higher in Allegheny County in 2008.
- Breast cancer incidence rates were comparable between the state and counties for the years 2007 through 2010.
- In 2011 and 2012 Pennsylvania had an increased percentage of adults who had a mammogram screening compared to the counties, which were comparable across the time period.

- The majority of 2012 BRFSS respondents (22.3 percent) had a mammogram in the past year. The age group 35-44 had the largest percentage (22.0) of women who never had a mammogram.
- Colorectal cancer incidence and mortality rates trended downward in the state, Allegheny, Washington, and Westmoreland Counties for years 2007 through 2009. In Fayette County the incidence and mortality rates trended upward across the time period and were significantly higher in 2009.
- From the 2012 BRFSS, 62 percent of respondents age 65 or older had a colonoscopy.
- Bronchus and Lung cancer incidence rates were significantly higher in Allegheny and Fayette counties in 2007 through 2009 compared to the state.
- Bronchus and Lung cancer mortality rates were significantly higher in Fayette County in 2007 and 2010, and Washington County in 2008.
- In the state and all counties, except Washington County, prostate cancer incidence rates trended downward for years 2007 through 2009 and were significantly lower in Fayette County in 2009 and significantly higher in Washington County in 2008.
- Prostate cancer mortality rates were comparable between the state and all counties.
- From the 2012 BRFSS 74.0 percent of respondents age 65 or older had a PSA test.
- Ovarian cancer incidence rates were comparable between the state and all counties.
- Ovarian cancer mortality rates were significantly higher in Washington County in 2008 and 2010.
- The majority of 2012 BRFSS respondents (23 percent) had a PAP test in the past year.
- The percentage of adults over the age of 35 ever told they have heart disease was comparable between the state and counties and all above the national percentage of 4.1.
- The percentage of adults over the age of 35 ever told they had a heart attack was comparable between the state and counties and all above the national percentage of 4.2. For adults aged 65 or older Westmoreland and Fayette Counties were significantly higher compared to the state.
- Heart disease mortality rates trended downward in the state and counties, although significantly higher for Allegheny County in 2009, Fayette County in 2007, 2008, and 2009, and Westmoreland County in 2009.
- Heart attack rates trended downward for the state and counties, although significantly higher for Allegheny County in 2007 and Westmoreland County 2007 through 2010.
- Coronary heart disease mortality rates trended downward for the state and counties, although significantly higher for Allegheny County for year 2007 through 2010, Fayette County 2007 through 2010, and Westmoreland County in years 2007 and 2009. The state and all counties were above the Healthy People 2020 goal of 100.8 for all years.
- Heart failure mortality rates were significantly lower in Allegheny County in 2008 and Westmoreland County in 2007.

- The percentage of adults who reported a stroke was comparable between the state and counties.
- Cardiovascular disease mortality rates trended downward for the state and all counties, although significantly higher in Fayette County for years 2007, 2008, and 2009, and Westmoreland County in 2009.
- From the 2012 BRFSS, 56.8 percent of adults aged 65 or older were told they have high blood pressure. However, 85 percent have had their blood pressure checked within the past 6 months.
- From the 2012 BRFSS, 42.4 percent of adults aged 45-54 were told they needed to reduce their cholesterol.
- The percentage of adults overweight was comparable across the counties with the highest percentage (41.0) in Westmoreland County.
- The percentage of adults obese was comparable across the counties with the highest percentage (30.0) in Fayette County.
- The percentage of adults ever told they had diabetes was comparable across the state and all counties, and all were above the national percentage of 8.7.
- Diabetes mortality rates trended downward in all counties except Washington County, and significantly lower in Allegheny County for years 2007, 2009, and 2010 and significantly higher in Fayette County 2007, 2008, and 2009, significantly higher in Washington County 2007, 2008, 2010 and significantly higher in Westmoreland County in 2010.
- The majority of 2012 BRFSS respondents had an 'A One C' test within the past year.
- Focus Group respondents ranked hypertension and high blood pressure as somewhat of a problem for the service area and community, followed by cancer and cardiovascular disease.

Healthy Environment Conclusions

There are a number of observations and conclusions that can be derived from the data related to Healthy Environment. They include:

- The percentage of adults ever told they have asthma were comparable between the state, the service area BRFSS, and counties, and slightly below the national percentage (13.8).
- The percentages of adults who currently have asthma were comparable between the state and counties, and all above the national percentage of 9.1.
- High school graduation rates were lower in Fayette County for the years 2010 through 2012. Pennsylvania, Allegheny County, Washington County, and Westmoreland County were above the national percentage (82.4).
- Unemployment rates have steadily increased for the state and all counties for the years 2010 through 2012, as have the percentage of children living in poverty.

- The number of air pollution ozone days was highest in Allegheny County for years 2010 through 2012.
- All of the counties met the National Air Quality Standards.
- In Pennsylvania and all of the counties, about half of the restaurants are fast food restaurants.
- Focus Group participants ranked employment/economic opportunities as somewhat of a problem for the service area and community, followed by affordable and adequate housing, and crime.

Healthy Mothers, Babies and Children Conclusions

There are a number of observations and conclusions that can be derived from the data related to Healthy Mothers, Babies and Children. They include:

- The percentage of mothers who received prenatal care in the first trimester increased for the state and all counties each year between 2007 through 2010 and was significantly higher in 2010 for Allegheny, Fayette, Washington, and Westmoreland Counties.
- The percentage of mothers who reported not smoking during and three months prior to pregnancy was significantly higher for Allegheny County in 2010. For years 2007 through 2010, the percentages were significantly lower in Fayette, Washington, and Westmoreland Counties.
- The percentage of mothers who received WIC was significantly higher for Fayette County for years 2007 through 2010, while significantly lower in Allegheny and Westmoreland Counties for years 2007 through 2010, and Washington County in 2009 and 2010.
- The percentage of mothers who received Medicaid was significantly higher in Allegheny County in 2007 and 2008, but significantly lower in 2009 and 2010. Fayette County was significantly higher for years 2007 through 2010. Washington County was significantly higher in 2008, but lower in 2009 and 2010. Westmoreland County was significantly higher in 2007, 2008, and 2009.
- The percentage of low birth weight births was significantly higher in Allegheny County in 2008 and Fayette County in 2008 and 2010; the percentages were significantly lower for Washington County in 2007 and Westmoreland County in 2008.
- The percentage of mothers who breastfed were significantly lower in Allegheny County 2007, 2008, and 2010. The percentages were significantly lower for Fayette, Washington, and Westmoreland Counties for 2007 through 2010.
- Teenage pregnancy rates were significantly lower in Allegheny County in 2007, 2008, and 2009, and Washington and Westmoreland Counties 2007 through 2010. The rates were significantly higher in Fayette County in 2007, 2009, and 2010.

- The percentage of teen live birth outcome was significantly lower in Allegheny County in 2007, 2008, and 2009, and Washington County in 2007 and 2008. The rates were significantly higher in Fayette County for years 2007 through 2010.
- Childhood obesity in grades K through 6 ranged from 15.3 percent in Allegheny County to 22.5 percent in Fayette County.
- Childhood obesity in grades 7 through 12 ranged from 15.9 percent in Allegheny County to 24.9 percent in Fayette County.
- Focus Group participants tended not to rate issues in this topic area as concern. However, youth Focus Group participants ranked teenage pregnancy as somewhat of a problem.

Infectious Disease Conclusions

There are a number of observations and conclusions that can be derived from the data related to Infectious Disease. They include:

- The percentage of adults over the age of 65 who received a pneumonia vaccine was significantly higher in Allegheny County for years 2008 through 2010. The state and all counties were below the Healthy People 2020 goal of 90.0 percent.
- Pneumonia inpatient discharges have slightly increased for years 2010 through 2012.
- The majority of 2012 BRFSS respondents (55.5 percent) did not get a seasonal flu vaccine.
- Influenza and pneumonia mortality rates were significantly higher for Allegheny County in 2009 and 2010, and Westmoreland County in 2008. The rate was significantly lower in Fayette County in 2008.
- Chlamydia incidence rates were significantly higher in Allegheny County for years 2007 through 2010, while significantly lower for Fayette, Washington, and Westmoreland Counties for the same time period.
- The percentage of adults ever tested for HIV was comparable between the state and counties, and all above the Healthy People 2020 goal of 18.9 percent.

Mental Health and Substance Abuse Conclusions

There are a number of observations and conclusions that can be derived from the data related to Mental Health and Substance Abuse. They include:

- The percentage of adults who reported not getting social or emotional support was comparable between the state and counties.
- The percentage of adults who reported their mental health as not good one plus days in the month was comparable between the state and counties.
- From the 2012 BRFSS, 7.3 percent of respondents drank once a week or month.
- The percentage of adults who reported binge drinking was comparable between the state and counties and all below the Healthy People 2020 goal of 24.4 percent.
- The percentage of adults who reported heavy and chronic drinking was comparable between the state and counties.
- From the 2012 BRFSS, 14.8 percent of respondents reported taking medication or being in treatment for a mental health condition or emotional problems.
- Mental and behavioral disorder mortality rates were significantly higher for Allegheny County in 2007, 2008, and 2010, and Westmoreland County in 2008.
- From the 2012 BRFSS, 96.3 percent of respondents reported not drinking and driving in the past 30 days.
- Focus Group participants ranked alcohol, drug, and depression/mental health issues as somewhat of a problem for the service area and community. Youth Focus Group participants ranked stress and body image as a serious problem.

Physical Activity and Nutrition Conclusions

There are a number of observations and conclusions that can be derived from the data related to Physical Activity and Nutrition. They include:

- The percentage of adults who reported no leisure time physical activity in the past month was comparable between the state and counties.
- From the 2012 BRFSS, 56.8 percent of respondents reported walking for exercise.
- From the 2012 BRFSS, 16.5 percent of respondents reported adding salt to food most of the time, 48.0 percent reported never.
- From the 2012 BRFSS, 34.8 percent of respondents reported eating fruit once a day, 3.3 percent reported never.
- From the 2012 BRFSS, 4.8 percent of respondents reported eating beans once a day, 25.3 percent reported never.

- From the 2012 BRFSS, 21.8 percent of respondents reported eating green vegetables daily, 9.3 percent reported never.
- Focus Group participants ranked obesity as somewhat of a problem in the service area and community. Youth Focus Group participants ranked obesity and healthy eating as a serious problem.

Tobacco Conclusions

There are a number of observations and conclusions that can be derived from the data related to Tobacco Use. They include:

- The percentage of adults who reported never smoking is comparable between the state, counties, and national percentage (56.6).
- The percentage of everyday smokers who quit smoking at least one day in the past year was comparable between the state and counties, although well below the Healthy People 2020 goal of 80.0 percent.
- The percentage of adults who are current smokers was significantly lower in Westmoreland County. Pennsylvania, Allegheny County, and Fayette County were above the national percentage (17.3 percent) and Healthy People 2020 goal (12.0 percent).
- The percentage of everyday smokers in Fayette County (20.0 percent) was significantly higher compared to the state. Pennsylvania and Allegheny County were above the national percentage (12.4 percent).
- The percentage of former smokers was comparable between the state and counties and slightly higher than the national percentage (25.1 percent).
- Emphysema mortality rates were significantly higher in Allegheny County in 2010 and Westmoreland County in years 2007, 2008, and 2010, compared to the state.
- From the 2012 BRFSS, 71.0 percent reported never smoking, while 23.5 percent smoke daily.
- From the 2012 BRFSS, of respondents who smoke, 12.1 percent smoke at least a pack of cigarettes per day.
- From the 2012 BRFSS, 12.5 percent of smokers were told they have COPD, emphysema, or chronic bronchitis.
- Focus Group participants ranked tobacco use as somewhat of a problem.

Unintentional/Intentional Injury Conclusions

There are a number of observations and conclusions that can be derived from the data related to Injury. They include:

- Motor Vehicle Mortality rates were significantly lower in Allegheny County for the years 2007 through 2010, significantly higher in Fayette County for the years 2007 through 2010, and significantly higher in Westmoreland County in 2007.
- From the 2012 BRFSS, 80.0 percent of respondents reported always wearing a seatbelt, while 5.8 percent never wear a seatbelt.
- In 2008 and 2010 fall mortality rates were significantly higher in Allegheny County, and also 2008 in Westmoreland County, compared to the state.
- From the 2012 BRFSS, 25.0 percent of respondent aged 45 to 54 had a fall in the past 3 months, 15.9 percent for respondents aged 65 and over.
- Suicide mortality rates were comparable between the state and all counties.
- Firearm mortality rates were comparable between the state and all counties
- Only 1.3 percent of 2012 BRFSS respondent reported knowledge of elder abuse.
- Focus Group participants ranked accidents/trauma/seatbelt usage as a small problem, followed by elder abuse and sexual abuse.

This page is intentionally blank

This page is intentionally blank

Prioritization

JEFFERSON
REGIONAL MEDICAL CENTER

Prioritization Process

At the end of the data presentation and discussion, a list of 39 needs, issues and potential priorities were identified.

Access to Quality Health Services - Transportation to/from Medical Services	Social Environment - Violence
Access to Quality Health Services - Affordability of health care/insurance costs/copays	Healthy Mothers, Babies & Children - Tobacco Use During Pregnancy
Access to Quality Health Services - Perception of quality of local care	Healthy Mothers, Babies & Children - Low Birthweight Babies
Access to Quality Health Services - Availability of Broader Community Based Services	Healthy Mothers, Babies & Children - Breastfeeding
Access to Quality Health Services - Early Screening	Healthy Mothers, Babies & Children - Teen Pregnancy
Access to Quality Health Services - Eldercare	Healthy Mothers, Babies & Children - Lack of Children's Services/Youth Development
Access to Quality Health Services - Access to Women's Health/OB Services	Infectious Disease - Flu & Pneumonia
Access to Quality Health Services - Access to Mental Health Services	Infectious Disease - STDs
Chronic Disease - Cardiovascular Disease (Heart Disease, Cholesterol, etc.)	Mental Health/Substance Abuse - Alcohol & Drugs
Chronic Disease - Hypertension	Mental Health/Substance Abuse - Domestic Violence
Chronic Disease - Cerebrovascular Disease (Stroke)	Mental Health/Substance Abuse - Lack of support systems for Veterans
Chronic Disease - Diabetes	Mental Health/Substance Abuse - Stress Management
Chronic Disease - Lung Cancer	Physical Activity/Nutrition: Lack of Physical Activity
Chronic Disease - Other Cancers	Physical Activity/Nutrition: Eating Habits
Chronic Disease - Obesity	Tobacco Use
Healthy Environment - air and water quality/Asthma/COPD related issues	Injury - Homicide due to firearms
Social Environment - availability and location of day care centers	Injury - Falls
Social Environment - Affordable Housing for Seniors	Injury - Seat Belt use
Social Environment - Crime	Injury - Suicide
Social Environment - Lack of Jobs/unemployment	

During the prioritization process, the Steering Committee rated each of the issues that were identified in the data collection process on a 1 to 10 scale for each criterion using the OptionFinder audience response polling system.

Prioritization Criteria

Item	Definition	Scoring		
		Low (1)	Medium	High (10)
Accountable Entity	Extent to which the issue is an important priority to address in this action planning effort for either the health system or the community	This is an important priority for the community to address	This is important but is not for this action planning effort	This is an importantpriorityforthe hospital/health system to address
Magnitude of the problem	Degree to which the problem leads to death, disability or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers of people affected; no risk for epidemic	Moderate numbers/ % of people affected and/or moderate risk	High numbers/ % of people affected and/or risk for epidemic
Variance against benchmarks or goals	This would include variance with selected benchmarks, state standards or state data, Healthy People 2010 goals and/or other prevention agenda standard or state data	Local/regional rates meet or exceed the goal or standard	Local/regional rates are somewhat worse than the goal or standard	Local/regional rates are significantly worse than the goal or standard
Capacity (systems and resources) to implement evidence -based solutions	This would include the capacity to and ease of implementing evidence-based solutions	There is little or no capacity (systems and resources) to implementevidence based solutions	Some capacity (system and resources) exist to implement evidence based solutions	There is solid capacity (system and resources) to implement evidence based solutions in this area

The results of the ratings for the magnitude, variance and capacity criteria were added together and then sorted high to low. Those items that had "high" total scores on the 3 criteria as well as high averages scores on the Accountable Entity criterion (average score of 7 or higher) were identified as the highest priorities for the health system.

Those items that had high total scores on the three criteria and low average scores on the Accountable Entity criterion were identified as high priorities for the community. The outcome of the rating process was a prioritized list. The highest priorities are as follows:

Prioritization Results

Issue	Discussion/Rationale	Accountability Criterion	Magnitude of the problem Criterion	Variance against bench Criterion	Capacity Criterion	Combined
Access to Quality Health Services - Transportation to/from Medical Services	Overall lack of transportation - bus stop is at bottom of hill as opposed to stopping at the hospital, bus routes continue to be cut which limits access, people are not satisfied with current Access transportation noting long waits, having to call night before, etc.	7.5	7.0	8.1	4.9	20.0
Access to Quality Health Services - Availability of Broader Community Based	There are areas that are lacking providers (medical, dental, mental health, etc.) suggesting need for additional satellite offices	7.9	7.2	5.7	6.9	19.8
Access to Quality Health Services - Access to Women's Health/OB Services	General lack of services in area	8.1	6.6	6.1	6.9	19.6
Access to Quality Health Services - Perception of quality of local care	Feeling for many in Pittsburgh area that UPMC is place to go for care - perception that we can't get anything good in our community	8.6	6.9	4.7	7.8	19.4
Access to Quality Health Services - Affordability of health care/insurance	Insurance is costly, many employers do not offer or people can't afford, many people make just enough that they do not qualify for assistance programs	4.8	6.4	5.4	3.0	14.8
Physical Activity/ Nutrition: Lack of Physical Activity	Sedentary lifestyle and need for people to have more opportunities (especially affordable opportunities) for recreation - also need for education on what is available and importance of it	4.8	6.4	4.9	3.4	14.7
Healthy Environment - air and water quality/ Asthma/COPD related issues	Concerns over pollution related to industry, etc. in the area and the impact that has on health - sense that there are increased rates of asthma and COPD as result of historic impact of industry	2.7	5.9	6.4	2.1	14.4

Implementation Strategies and Action Plan

The implementation strategies and action plan to address the priorities is designed to focus on increasing access to women's health services in Jefferson Regional Medical Center's service area. The hospital will expand women's health services in its service area, add access to pre- and post-natal care and obstetrical care in the service area, add additional women's subspecialists to the service area, expand office hours and services in the southern part of the service area and expand women's health services in the Clairton area. It is expected that, over time, by increasing access to education and women's health services, various other health needs of women and families will be addressed, as women are the primary gatekeepers to health care for families. The following table outlines Jefferson Regional Medical Center's implementation strategies and action plan.

Review and Approval

The 2013 Community Health Needs Assessment and Action Plan was presented and approved by the Jefferson Regional Medical Center's Board of Directors on May 20, 2013.

JEFFERSON REGIONAL MEDICAL CENTER
COMMUNITY ACTION PLAN 2013

GOAL 1: Increase access to Women's Health Services in the Jefferson Regional Medical Center Service Area					
Objectives		Action Steps	Accountability / Organization Responsible for	Time Frame	Evaluation Metrics / Measures
A.	*Expand Women's Health Services in Jefferson Regional Medical service area*	• Add women's midlife gynecology specialist, three days per week • Add women's behavioral health & other wellness programs • Expand mammography services • Add additional women's health specialists • Support at least two women's health education events	Marcie Caplan/ Rosanne Saunders	12/30/13	Number of sessions, number of women served, events offered, physicians present. Develop baseline.
B.	*Add access to Pre & Post Natal Care Obstetrical Care in our service area*	• Appoint Site Director for Obstetrics at Jefferson Regional Medical Center • Increase visibility and access to other obstetricians in the market • Add additional obstetricians/gynecologists to the market • Support at least two pregnancy related educational events in the market	Marcie Caplan/Rosanne Saunders/Debbi Linhart	3/30/14	Number of events held and attendance, number of women served.
C.	*Add additional Women's Subspecialists to Jefferson Regional service area*	Recruit the following specialists: • Gynecology-Oncology • Urology-Gynecologist • Maternal Fetal Medicine/High Risk Obstetrician Specialist	Marcie Caplan/Debbi Linhart	12/30/13	Presence in the marketplace, number of women served.
D.	*Expand office hours & services in southern part of service area*	• Add more hours of gynecology services • Increase awareness of women's services in the southern part of the service area.	Dr. Anthony Gentile/Marcie Caplan/Debbi Linhart	6/30/14	Number of women served.
E.	*Expand Women's Health Services in the Clairton area*	• Identify and implement Outreach Team • Identify under-served population in the area • Establish Gynecology presence in the Clairton area	Marcie Caplan/Debbi Linhart	6/30/14	Number of women served.

This page is intentionally blank

This page is intentionally blank

Appendix

Appendix A
BRFSS Questionnaire

Jefferson Regional Medical Center BRFSS

August 2012

Hi, this is _____ from Moore Research. We are asking general health and exercise questions that will benefit the health programs in your area. This project is supported and endorsed by Jefferson Regional Medical Center located in your community.

1. **Could I speak to the youngest male available that is 18 or older?**
   - ❑ ***Male 18+ available***
   - ❑ ***Male 18+ NOT available [ASK FOR YOUNGEST FEMALE AVAILABLE 18 OR OLDER]***
   - ❑ ***No male 18+ living in household [ASK FOR YOUNGEST FEMALE AVAILABLE 18 OR OLDER]***
   - ❑ ***No adult available [THANK AND END INTERVIEW]***

2. **INTERVIEWER, PLEASE INDICATE GENDER OF RESPONDENT**
   - ❑ ***Male***
   - ❑ ***Female***

3. **What is your age?**
   - ❑ ***18-24***
   - ❑ ***25-34***
   - ❑ ***35-44***
   - ❑ ***45-54***
   - ❑ ***55-64***
   - ❑ ***65 +***

4. **Would you say in general your health is:**
   - ❑ ***Excellent***
   - ❑ ***Very Good***
   - ❑ ***Good***
   - ❑ ***Fair***
   - ❑ ***Poor***
   - ❑ ***DK/NS***
   - ❑ ***Refused***

5. **Now, thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the last 30 days was your mental health not good?**
   ENTER NUMBER OF DAYS
   88 = NONE
   77 = DK/NS
   99 = REFUSAL

6. About how much do you weigh without shoes?

IF RESPONDENT ANSWERS IN METRICS, PUT "9" BEFORE WEIGHT
ROUND FRACTIONS UP
7777 = DK/NS
9999 = Refused

_____

7. INTERVIEWER: You indicated the respondent's weight was (Q#). Is this correct?

- ❑ *Yes*
- ❑ *No (Use the back button BELOW to re-enter weight at Q6)*

8. About how tall are you without shoes?

IF RESPONDENT ANSWERS IN METRICS, PUT "9" BEFORE WEIGHT
ROUND FRACTIONS UP .

Separate feet and inches with "/" (Ex. 5'6' = 5/6)
7777 = DK/NS
9999 = Refused

_____

9. How many children less than 18 years of age live in your household?
ENTER NUMBER OF CHILDREN
88 = None
99 = REFUSAL

_____

10. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a physical exam, not an exam for a specific injury, illness, or condition.

- ❑ *Within the past year (anytime less than 12 months ago)*
- ❑ *Within the past 2 years (1 year but less than 2 years ago)*
- ❑ *Within the past 5 years (2 years, but less than 5 years ago)*
- ❑ *5 or more years ago*
- ❑ *DK/NS*
- ❑ *Never*
- ❑ *Refused*

11. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMO's, or government plans such as Medicare?

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

IF "YES" GO TO QUESTION 12. IF "NO" GO TO QUESTION 13

12. **What was the main reason you were without health care coverage during the past 12 months?**

- ❑ *Lost job or changed employers*
- ❑ *Spouse or parent lost job or changed employers*
- ❑ *Became divorced or separated*
- ❑ *Spouse or parent died*
- ❑ *Became ineligible because of age or because left school*
- ❑ *Employer Doesn't offer or stopped offering coverage*
- ❑ *Cut back to part-time or became a temporary employee*
- ❑ *Benefits from employer or former employer ran out*
- ❑ *Couldn't afford to pay the premiums*
- ❑ *Insurance company refused coverage*
- ❑ *Lost Medicaid or Medical Assistance eligibility*
- ❑ *Other*
- ❑ *DK/NS*
- ❑ *Refused*

13. **In the past 12 months, how many times did you go to an emergency room to get care for yourself?**

ENTER NUMBER OF TIMES
88 = NONE
77 = DK/NS
99 = REFUSAL

_____

14. **The last time you phoned your doctor's office to get an appointment for care you needed right away, how long did it take you to get an appointment?**

- ❑ *Same day*
- ❑ *Within a week*
- ❑ *Other*
- ❑ *Too long; I went somewhere else*
- ❑ *Too long; I didn't get care*
- ❑ *DK/NS*
- ❑ *Refused*

Other, please specify _____
_____
_____

15. **In the last 12 months, when you made an appointment for a check-up or routine care with your doctor, how long did it take for you to get an appointment?**

- ❑ *Same day*
- ❑ *Within a week*
- ❑ *Other*
- ❑ *Too long; I went somewhere else*
- ❑ *Too long; I didn't get care*
- ❑ *DK/NS*

- ❑ *Refused*

Other, please specify _____
_____
_____

16. **Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?**
    - ❑ *Yes*
    - ❑ *No*
    - ❑ *DK/NS*
    - ❑ *Refused*

17. **Was there a time in the past 12 months when you needed to fill a prescription but could not because of the cost?**
    - ❑ *Yes*
    - ❑ *No*
    - ❑ *DK/NS*
    - ❑ *Refused*

18. **Sometimes people are unable to take medications as prescribed due to the cost associated with the prescription. As a result, some people share prescription medication with others or they take less than was prescribed to make the medication last a longer period of time. At any time during the last 12 months, were you unable to take any prescription medication as it was prescribed to you because of costs?**
    - ❑ *Yes*
    - ❑ *No*
    - ❑ *DK/NS*
    - ❑ *Refused*

19. **About how long has it been since you last had your blood pressure checked by a doctor, nurse, or other health professional? READ ONLY IF NECESSARY: "by other health professional, we mean a nurse practitioner, a physicians assistant, or some other licensed health professional.**
    - ❑ *Within the past 6 months (1 to 6 months ago)*
    - ❑ *Within the past year (7 to 12 months ago)*
    - ❑ *Within the past 2 years (1 year but less than 2 years ago)*
    - ❑ *Within the past 5 years (2 years but less than 5 years ago)*
    - ❑ *5 or more years ago*
    - ❑ *DK/NS*
    - ❑ *Never*
    - ❑ *Refused*

20. **Have you ever been told by a doctor, nurse, or other health care professional that you have high blood pressure? (If "Yes" and respondent is female, ask "Was this only when you were pregnant?"**

- ❑ *Yes*
- ❑ *Yes, But female told only during pregnancy*
- ❑ *No*
- ❑ *Told borderline or pre-hypersensitive*
- ❑ *DK/NS*
- ❑ *Refused*

21. **About how long has it been since you last had your blood cholesterol checked, if ever? READ ONLY IF NECESSARY**

- ❑ *Within the past year (Anytime less than 12 months ago)*
- ❑ *Within the past 2 years (1 year but less than 2 years ago)*
- ❑ *Within the past 5 years (2 years but less than 5 years ago)*
- ❑ *5 or more years ago*
- ❑ *Never*
- ❑ *DK/NS*
- ❑ *Refused*

22. **Have you EVER been told by a doctor, nurse or other health professional to reduce your blood cholesterol or blood fat level?**

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

23. **A mammogram is an X-ray of each breast to look for breast cancer. How long has it been since you had your last mammogram? (ASK ONLY IF FEMALE)**

- ❑ *Within the past year (Anytime less than 12 months ago)*
- ❑ *Within the past 2 years (1 year but less than 2 years ago)*
- ❑ *Within the past 3 years (2 years but less than 3 years ago)*
- ❑ *Within the past 5 years (3 years but less than 5 years ago)*
- ❑ *5 or more years ago*
- ❑ *Never*
- ❑ *DK/NS*
- ❑ *Refused*

24. **A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test? (ASK ONLY IF FEMALE)**

- ❑ *Within the past year (Anytime less than 12 months ago)*
- ❑ *Within the past 2 years (1 year but less than 2 years ago)*
- ❑ *Within the past 3 years (2 years but less than 3 years ago)*
- ❑ *Within the past 5 years (3 years but less than 5 years ago)*
- ❑ *5 or more years ago*
- ❑ *Never*
- ❑ *DK/NS*

- ❑ *Refused*

25. **A Prostate-Specific Antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. Have you ever had a PSA test?** (ASK ONLY IF MALE)

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

26. **Sigmoidoscopy and colonoscopy exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. Have you ever had either of these exams?**

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

27. **Has a doctor, nurse, or other health care professional EVER told you that you have asthma?**

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

28. **Has a doctor, nurse, or other health care professional ever told you that you have Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Chronis Bronchitis?**

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

29. **A test "A one C" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health care professional checked you for "A one C"?**

ENTER NUMBER OF TIMES
88 = NONE
66 = Never heard of test
77 = DK/NS
99 = REFUSAL

_____

30. **Has a doctor, nurse or other health professional EVER told you that you have diabetes? (If "Yes" and the respondent is female, ask "Was this only when you were pregnant?)**

- ❑ *Yes*

- ❑ *Yes, but female told only during pregnancy*
- ❑ *No*
- ❑ *No, pre-diabetes or borderline diabetes*
- ❑ *DK/NS*
- ❑ *Refused*

31. Do you now smoke cigarettes every day, some days, or not at all?

- ❑ *Every day*
- ❑ *Some days*
- ❑ *Not at all (skip to question 33)*
- ❑ *DK/NS*
- ❑ *Refused*

32. On the average, about how many cigarettes a day do you now smoke?

ENTER NUMBER PER DAY
77 = DK/NS
99 = Refused

_____

33. Would you like to stop smoking?

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

34. How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as Orthodontists.

- ❑ *Within the past year (anytime less than 12 months ago)*
- ❑ *Within the past 2 years (1 year but less than 2 years ago)*
- ❑ *Within the past 5 years (2 years, but less than 5 years ago)*
- ❑ *5 or more years ago*
- ❑ *Never*
- ❑ *DK/NS*
- ❑ *Refused*

35. Which one or more of the following would you say is your race? CHECK ALL THAT APPLY

- ❑ *White*
- ❑ *Black or African American*
- ❑ *Asian*
- ❑ *Native Hawaiian or other Pacific Islander*
- ❑ *American Indian, Alaska Native*
- ❑ *Other (specify below)*
- ❑ *DK/NS*
- ❑ *Refused*

Other, please specify _____
_____
_____

36. Are you Hispanic or Latino?

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

37. Are you... (Please read)

- ❑ *Married*
- ❑ *Divorced*
- ❑ *Widowed*
- ❑ *Separated*
- ❑ *Never Married*
- ❑ *A member of an unmarried couple*
- ❑ *Refused*

38. What is the highest grade or year of school you completed?

- ❑ *Never attended school or only attended kindergarten*
- ❑ *Grades 1 through 8 (Elementary)*
- ❑ *Grades 9 through 11 (Some high school)*
- ❑ *Grade 12 or GED (High school graduate)*
- ❑ *College, 1 year to 3 years (Some college or technical school)*
- ❑ *College, 4 years or more (College graduate)*
- ❑ *Refused*

39. Are you currently.... (Please read)

- ❑ *Employed for wages*
- ❑ *Self-employed*
- ❑ *Out of work for more than one year*
- ❑ *Out of work for less than one year*
- ❑ *A homemaker*
- ❑ *A student*
- ❑ *Retired*
- ❑ *Unable to work*
- ❑ *Refused*

40. Is your annual household income from all sources less than $25,000?

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

41. Is it less than $20,000? (if answer to Q# is yes)

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

42. Is it less than $15,000? (if answer to Q# is yes)

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

43. Is it less than $10,000? (if answer to Q# is yes)

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

44. Is it less than $35,000 (if answer to Q# is no)

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

45. Is it less than $50,000 (if answer to Q# is no)

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

46. Is it less than $75,000 (if answer to Q# is no)

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

47. To confirm, your household income level is (read from above). Is that correct?

- ❑ *Less than $10,000*
- ❑ *Between $10,000 and $15,000*
- ❑ *Between $15,000 and $20,000*
- ❑ *Between $20,000 and $25,000*
- ❑ *Between $25,000 and $35,000*
- ❑ *Between $35,000 and $50,000*
- ❑ *Between $50,000 and $75,000*
- ❑ *More than $75,000*
- ❑ *DK/NS*
- ❑ *Refused*

RESPONDENT MUST CONFIRM INCOME LEVEL. If respondent disagrees with the figure above, click back to question 39 and re-ask income questions.

48. **What is the zip code where you live?**
77777 = DK/NS
99999 = REFUSAL

_____

49. **What is the name of the city, town, township or borough where you live?**
77777 = DK/NS
99999 = Refused

_____

50. **During the past month, what type of physical activity or exercise did you spend the most time doing?**

- ❑ ***Aerobics Class***
- ❑ ***Back Packing***
- ❑ ***Badminton***
- ❑ ***Basketball***
- ❑ ***Bicycling for pleasure***
- ❑ ***Boating or canoeing, rowing, sailing for pleasure or camping***
- ❑ ***Bowling***
- ❑ ***Boxing***
- ❑ ***Calisthenics***
- ❑ ***Canoeing/rowing in competition***
- ❑ ***Carpentry***
- ❑ ***Dancing - Aerobics/Ballet***
- ❑ ***Fishing from river bank or boat***
- ❑ ***Gardening (spading, weeding, digging, filling)***
- ❑ ***Golf***
- ❑ ***Handball***
- ❑ ***Health club exercise***
- ❑ ***Hiking - cross country***
- ❑ ***Home exercise***
- ❑ ***Horseback riding***
- ❑ ***Hunting large game - deer, elk***
- ❑ ***Jogging***
- ❑ ***Judo/Karate***
- ❑ ***Mountain climbing***
- ❑ ***Mowing lawn***
- ❑ ***Paddleball***
- ❑ ***Painting/papering house***
- ❑ ***Racquetball***
- ❑ ***Raking lawn***
- ❑ ***Running***
- ❑ ***Rope skipping***
- ❑ ***Scuba diving***
- ❑ ***Skating - ice or roller***
- ❑ ***Sledding, tobogganing***
- ❑ ***Snorkelling***

- ❑ *Snow shoeing*
- ❑ *Snow shoveling*
- ❑ *Snow blowing*
- ❑ *Snow skiing*
- ❑ *Soccer*
- ❑ *Softball*
- ❑ *Squash*
- ❑ *Stair Climbing*
- ❑ *Stream fishing in waders*
- ❑ *Surfing*
- ❑ *Swimming laps*
- ❑ *Table Tennis*
- ❑ *Tennis*
- ❑ *Touch football*
- ❑ *Volleyball*
- ❑ *Walking*
- ❑ *Water skiing*
- ❑ *Weight lifting*
- ❑ *Yoga*
- ❑ *Other*

51. **During the past month, not counting juice, how many times per day, week, or month did you eat fruit? (Count fresh, frozen or canned fruit)**

1_ _ Times per day
2_ _ Times per week
3 _ _ Times per month
555 = NEVER
777 = DK/NS
999 = Refused

_____

READ ONLY IF NECESSARY: Your best guess is fine. Includes apples, bananas, applesauce, oranges, grapefruit, fruit salad, watermelon, cantaloupe or musk melon, papaya, lychees, star fruit, pomegranates, mangos, grapes, and berries such as blueberries and strawberries.

INTERVIEWER NOTE: Do not count fruit jam, jelly, or fruit preserves. Not not include dried fruit in ready-to-eat cereals. Do not include dried raisins, cran-raisins if respondent tells you - but due to their small serving size they are not included in the prompt. Do include cut up fresh, frozen, or canned fruit added to yogurt, cereal, jello or other meal items.

52. **During the past month, how many times per day, week, or month did you eat cooked or canned beans, such as refried, baked, black, garbanzo beans, beans in soup, soybeans, edamame, tofu, or lentils. (Do NOT include long green beans)**

1 _ _ Times per day
2 _ _ Times per week
3 _ _ Times per month
555 = NEVER
777 = DK/NS
999 = Refused

_____

READ ONLY IF NECESSARY: Include round or oval beans or peas such as navy, pinto, split peas, cow peas, hummus, lentils, soy beans and tofu. Do NOT include long green beans such as string beans, broad or winged beans, or pole beans.

INTERVIEWER NOTE: Include soybeans also called edamame, tofu (bean curd from soybeans), kidney, pinto, hummus, lentils, black, black-eyed peas, cow peas, lima beans and white beans. Include bean burgers including garden burgers and veggie burgers. Include falafel and tempeh

53. **During the past month, how many times per day, week, or month did you eat dark green vegetables for example broccoli or leafy greens including romaine, chard, collard greens, or spinach?**

1 _ _ Times per day
2 _ _ Times per week
3 _ _ Times per month
555 = NEVER 777 = DK/NS999 =

_____

INTERVIEWER NOTE: Each time a vegetable is eaten it counts as one time

INTERVIEWER NOTE: Include all raw leafy green salads including spinach, mesclun, romaine lettuce, bok choy, dark green leafy lettuce, dandelions, komatsuna, watercress, and arugula. Do not include iceberg (head) lettuce if specifically told type of lettuce. Include all cooked greens including kale, collard greens, choys, turnip greens, mustard greens.

54. **How often do you usually add salt to your food at the table?**

- ❑ ***Most of the time***
- ❑ ***Sometimes***
- ❑ ***Rarely***
- ❑ ***Never***
- ❑ ***DK/NS***
- ❑ ***Refused***

55. **Do you live with anyone who used illegal street drugs or who abused prescription medications?**

- ❑ ***Yes***
- ❑ ***No***
- ❑ ***DK/NS***
- ❑ ***Refused***

56. **Has an intimate partner EVER THREATENED you with physical violence? This includes threatening to hit, slap, push, kick, or physically hurt you in any way.**

- ❑ ***Yes***
- ❑ ***No***
- ❑ ***DK/NS***
- ❑ ***Refused***

57. **Now I will ask you questions about seasonal flu vaccine. There are two ways to get the seasonal flu vaccine. One is a shot in the arm and the other is a spray, mist, or drop in the nose called FluMist. During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?**

- ❑ ***Yes***

- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

58. A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

59. A drink of alcohol is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail or 1 shot of liquor. During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor?

1_ _ Days per week
2 _ _Days per month
ENTER NUMBER OF TIMES
88 = None
77 = DK/NS
99 = Refused

_____

60. Are you now taking medicine or receiving treatment from a doctor or other health care professional for any type of mental health condition or emotional problem?

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

61. Do you currently have a family member who has mental health needs that are not being met?

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

62. How often do you use seat belts when you drive or ride in a car? Would you say:

- ❑ *Always*
- ❑ *Nearly always*
- ❑ *Sometimes*
- ❑ *Seldom*
- ❑ *Never*
- ❑ *DK/NS*
- ❑ *Never drive or ride in a car*

- ❑ *Refused*

63. **The next question is about drinking and driving. During the past 30 days how many times have you driven when you've had perhaps too much to drink?**
Enter number of times.
88 = None
77 = DK/NS
99 = Refused
_____

64. **The next question is about recent falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level. In the past 3 months, how many times have you fallen?**
Enter number of times.
88 = None
77 = DK/NS
99 = Refused
_____

65. **Do you know or suspect that an older person you know is or might be being abused?**
- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

66. **How do you usually find health related information?** **DO NOT READ RESPONSES**
- ❑ *Physician, nurse or other health care professional*
- ❑ *Pharmacist*
- ❑ *Community agency*
- ❑ *Local hospital or clinic (including Ask -A-Nurse)*
- ❑ *Internet*
- ❑ *Television or radio advertising*
- ❑ *Newspaper or magazines including advertisements*
- ❑ *Health related newsletter*
- ❑ *Direct mail including circulars, flyers and coupons*
- ❑ *Health insurance provider*
- ❑ *Friend*
- ❑ *Family member*
- ❑ *Other*

Please Specify _____
_____
_____

67. **During the past 30 days, have you or your family been affected by the use of an illegal drug, prescription drug prescribed for someone else, or alcohol?**

- ❑ *Yes*
- ❑ *No*
- ❑ *DK/NS*
- ❑ *Refused*

Thank respondent and end interview
DO NOT CLICK SUBMIT

68. Interviewer Initials

_____

69. Today's Date: M/D

_____

70. Respondent Name:

_____

71. Phone Number:

_____

Appendix B
Focus Group Interview Guide

JEFFERSON
REGIONAL MEDICAL CENTER

Community Health Assessment
Focus Group Topic Guide – Rev. 8-1-12

I. Introduction

Hello, my name is _____ and we're going to be talking about community health. We are attempting to conduct a community health assessment by asking diverse members of the community to come together and talk to us about community health problems, services that are available in the community, barriers to people using those services, and what kinds of things that could or should be done to improve the health of the community.

Before we get started, we would like to collect some data from everyone in the room on a few questions using the OptionFinder Technology (or survey). It will also help us understand if there are any differences in how people think based on where they live or other things about them.

Does anyone have any initial questions?

Stop and conduct OptionFinder questions

Let's get started with the discussion. As I stated earlier, we will be discussing different aspects of community health. First, I have a couple of requests. One is that you speak up and only one person speaks at a time.

The other thing is, please say exactly what you think. There are no right or wrong answers in this. We're just as interested in your concerns as well as your support for any of the ideas that are brought up, so feel free to express your true opinions, even if you disagree with an idea that is being discussed.

I would also ask that you do some self-monitoring. If you have a tendency to be quiet, force yourself to speak and participate. If you like to talk, please offer everyone a chance to participate. Also, please don't be offended if I think you are going on too long about a topic and ask to keep the discussion moving. At the end, we will vote on each of the topic areas brought up and rank them according to how important they are to the health status of the community.

Also, we have an outline of the topics that we would like to discuss before the end of our meeting. If someone brings up an idea or topic that is part of our later questions, I may ask you to "hold that thought" until we get to that part of our discussion.

Now, to get started, perhaps it would be best to introduce ourselves. Let's go around the table one at a time and I'll start. Please tell your name, a current community initiative or project that you are currently involved in (or a community health issue that is important to you) and your favorite flavor of ice cream.

II. Overall Community Health Status

A. Overall, how would you rate the health status of the community? (show the graph)
NOTE: If someone asks how we define community, ask, "How would you define it?"

B. Why do you say that?

C. What are the things that you think are impacting the health of the community?

D. Why do you say that?

E. How do you think a person's individual health affects the health of the community? Do you think there's a link between individual health and the health of the community?

F. Why do you say that?

III. Community Health Needs

Using a 5 point scale where 5 equals a Very Serious Problem and 1 equals Not a Problem at All, Individuals are asked to rate each health care issue in terms of how much the identified problem is an issue for the community, for the individual's family and how much of an issue the problem is for the participant.

How much of a problem is this community health need/issue in this community?
How much of a problem is this community health need/issue for you or your family?
How much of a problem is this community health need/issue in this (hospital service territory) region?

5=Very Serious Problem
4=Serious Problem
3=Somewhat of a Problem
2=Small Problem
1=Not a Problem

Needs/Issues	**Behavioral/Health Conditions**
Health Care Access	*Conditions*
Access to mental health services	Obesity
Access to dental care	Depression/mental health issues
Access to medical care providers	Diabetes
Availability of specialists	Arthritis – Rheumatism
Prescription drug availability and access (can people get the prescriptions they need and pay for them)	Visual/hearing impairment
Affordable healthcare (related to copays and deductibles)	High Cholesterol
Insurance coverage	Cardiovascular Disease and stroke
Care for Special Populations	Asthma – COPD
Prenatal care	Cancer (all except skin)
Elder care	Hypertension/High blood pressure

JEFFERSON
REGIONAL MEDICAL CENTER

Community Health Assessment
Focus Group Topic Guide – Rev. 8-1-12

Needs/Issues	Behavioral/Health Conditions
Services for Disabled	Osteoporosis
Child health/immunizations	Oral Health
Other	HIV/AIDS
Transportation	*Violence/Crime*
Affordable and adequate housing	Domestic violence (intimate partners)
Employment/economic opportunities	Elder abuse
Early childhood development/child care	Child abuse
Education/public schools	Sexual abuse
Recreation opportunities	Crime (other than domestic, elder or child abuse)
Environmental issues (air and water quality)	Delinquency/youth crime
	Substance Use/Abuse
	Tobacco use
	Alcohol abuse
	Drug abuse
	Other
	Blight
	Teen pregnancy
	Accidents/trauma/seatbelt use

A. When you completed the survey, you ranked the list of possible community health needs and issues. Based on your experience in your neighborhood and community, what do you think the single biggest community health need is? (list on flip chart) OR you are saying that _____(based on the graph) is the greatest community health need

B. Why do you say that?

C. What are some of the other problems that are impacting the health of the community? Are there other indicators that weren't listed on the survey?

D. Why do you say that?

Show graphs for community issues list and discuss top 3 (why is #1 first, #2 next and #3 next?)

E. What is the one problem in the community that you would change and what would you do?

Show the top health issue results with no discussion with consumers.

Community (professionals) discuss top 3 (why is #1 first, #2 next and #3 next?)

Access to Services

A. What solutions to these problems are currently available in the community? What are you aware of? Are you aware of community agencies and organizations who are working on these?

B. To what extent do people use these services/solutions? Why?

C. What are the things/barriers that prevent people from using these services?

D. Why do you say that?

IV. Potential Solutions

A. What should the community be doing to improve community health? (List on the flipchart – round robin)

B. How important is each of these things to you personally? (dot voting if enough people are present and there are enough priorities to choose from)

(community) How likely would you be to work on any of these initiatives?

- Are there topics that you might be interested in?
- Why?
- What would need to happen to make you change your mind?

C. Why do you say that?

D. What advice would you give those of us who are working on this community assessment?

Appendix C
Stakeholder Interview Guide

Jefferson Regional Medical Center
Community Health Assessment
Individual Interview Questions

Thank you for taking the time to talk with us to support the Jefferson Regional Medical Center Community Health Assessment.

1. First of all, could you tell me a little bit about yourself and your background/experience with community health related issues.

2. What, in your opinion, are the top 3 community health needs for the Jefferson area?	**3. What, in your opinion are the issues and the environmental factors that are driving these community health needs?**

4. Check to see if the area they were selected to represent is one of the top priorities identified above. If not mentioned, say….

Our records indicate that you were selected to participate in these individual interviews because you have specific background/experience/ knowledge regarding _____. What do you feel are the key issues related to this topic area?

What, in your opinion are the issues and the environmental factors that are driving the needs in this topic area?

5. What activities/initiatives are currently underway in the community to address the needs within this topic area?

6. What more, in your opinion, still needs to be done in order to address this community health topic area.

7. What advice do you have for the project steering committee who is implementing this community health assessment process?

Glossary

A

Access to Health Care

The timely use of personal health services to achieve the best possible outcomes." It can include, but is not limited to, availability of information, care, public or private insurance coverage, transportation, culturally and linguistically competent care, and other factors that affect personal and cultural decisions related to seeking health care services.

Actual Causes of Death

While the leading causes of death are heart disease, cancer, stroke, and respiratory disease, the actual causes of death are defined as lifestyle and behavioral factors such as smoking and physical inactivity that contribute to this nation's leading killers. Physical inactivity and poor nutrition is catching up to tobacco at the top of the list of actual causes of death. In 2000, the most common actual causes of death in the United States were tobacco (435,000), poor diet and physical inactivity (400,000), alcohol consumption (85,000), microbial agents (e.g., influenza and pneumonia, 75,000), toxic agents (e.g., pollutants, asbestos, etc., 55,000), motor vehicle accidents (43,000), firearms (29,000), sexual behavior (20,000) and illicit use of drugs (17,000).

Adjusted Rates

Adjusted rates are summary rates constructed to permit fair comparison between groups differing in some important characteristic such as age, sex or race. When comparing the rate of disease between two or more counties, adjusted rates standardize the composition of their populations so that the influence of ethnic, racial, or age differences is minimized. Adjusted rates are also referred to as standardized rates and can be contrasted with "crude rates" where there have been no adjustments to the data.

Age

The number of complete years an individual has lived. The age classification is based on the age of the person at his or her last birthday.

Age Adjusted Rate

Age-adjustment is a statistical process applied to rates of disease, death, injuries or other health outcomes which allows communities with different age structures to be compared.

Assessment

One of public health's three core functions, the others are policy development and assurance. It is the regular collection, analysis and sharing of information about health conditions, risks and resources in a community. Assessment is needed to identify health problems and priorities and the resources available to address the priorities.

Asset Mapping

A tool for mobilizing community resources. It is the process by which the capacities of individuals, civic associations, and local institutions are inventoried.

Attributable Risk

The arithmetic or absolute difference in incidence rates between an exposed and non-exposed group.

B

Behavioral Risk Factors

Behaviors which are believed to cause, or to be contributing factors to, accidents, injuries, disease, and death during youth and adolescence and significant morbidity and mortality in later life.

Benchmarks

Indicators of progress that tell us whether elements of a long-term strategic plan are being achieved.

Best Available Evidence

Conclusive evidence of the links between, for example, socio-environmental factors and health or the effectiveness of interventions is not always available. In such cases, the best available evidence – that which is judged to be the most reliable and compelling – can be used, but with caution.

Bias

In statistics, bias is the difference between this estimator's expected value and the true value of the parameter being estimated. Although the term bias sounds pejorative, bias is tolerated and sometimes even welcome in statistics.

Birth Rate

The average annual number of births during a year per 1,000 population. Also known as the crude birth rate.

Board of Health

A legally designated governing body whose members are appointed or elected to provide advisory functions and/or governing oversight of public health activities, including assessment, assurance, and policy development, for the protection and promotion of health in their community.

BRFSS

Behavioral Risk Factor Surveillance Survey. A national survey of behavioral risk factors conducted by states with CDC support.

C

Capacity

The ability of an individual, organization or system to effectively complete specific tasks over time and across issues.

Case-Control Study

A study in which people diagnosed as having a disease (cases) are compared with persons who do not have the disease (controls). Also referred to as a retrospective study.

Cause of Death

Any condition that leads to or contributes to death and is classifiable according to the International Classification of Diseases.

Cause-Specific Death Rate

A rate which approximates the risk of death from a specific condition; differences in the magnitude of this measure in subgroups and by time and place suggest etiologic hypotheses and document the need for control measures.

CDC

The Centers for Disease Control and Prevention.

Coalition

A group of individuals and/or organizations that join together for a common purpose.

Community

The aggregate of persons with common characteristics such as geographic, professional, cultural, racial, religious, or socio-economic similarities; communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other common bonds.

Community Assets

Contributions made by individuals, citizen associations, and local institutions that individually and/or collectively build the community's capacity to assure the health, wellbeing, and quality of life for the community and all its members.

Community Collaboration

A relationship of working together cooperatively toward a common goal. Such relationships may include a range of levels of participation by organizations and members of the community. These levels are determined by: the degree of partnership between community residents and organizations, the frequency of regular communication, the equity of decision making, access to information, and the skills and resources of residents. Community collaboration is a dynamic, ongoing process of working together, whereby the community is engaged as a partner in public health action.

Community Health

A perspective on public health that assumes community to be an essential determinant of health and the indispensable ingredient for effective public health practice. It takes into account the tangible and intangible characteristics of the community, its formal and informal networks and support systems, its norms and cultural nuances, and its institutions, politics, and belief systems.

Community Health Needs Assessment (CHNA)

The Department of Health (DOH) requests that each county prepare a community health needs assessment on a regular basis, usually every four years. The community health needs assessment, or CHNA, identifies those health issues of most concern in the county. Among those issues, a smaller number usually are selected as priority health issues. For those priority health issues, additional detail is provided, additional data collection occurs, stakeholders are identified and invited to participate, and action items are formulated. Progress is charted over the next four years and reported on in the next CHNA document.

Community Health Improvement Process

The community health improvement process involves an ongoing collaborative, community wide effort to identify, analyze, and address health problems; assess applicable data; develop measurable health objectives and indicators; inventory community health assets and resources; identify community

perceptions; develop and implement coordinated strategies; identify accountable entities; and cultivate community ownership of the entire process.

Community Health Needs

Traditionally defined as the gaps and deficiencies identified through a community health assessment that needs to be addressed. However, there is increasing recognition that gaps and deficiencies must be balanced with recognition of building on strengths identified in the community.

Community Health Profile

A comprehensive compilation of measures representing multiple categories that contributes to a description of health status at a community level and the resources available to address health needs.

Community Health Status

Health status in a community is measured in terms of mortality (rates of death within a population) and morbidity (the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates; by degree of premature death (Years of Productive Life Lost); and by cause (disease--cancer and non-cancer or injury--intentional, unintentional). Morbidity may be represented by age-adjusted incidence of disease.

Community Partnerships

A continuum of relationships that foster the sharing of resources, responsibility and accountability in undertaking activities within a community. A cooperative relationship formed between two or more organizations to achieve a shared goal or pursue a common interest.

Community Support

Actions undertaken by those who live in the community that demonstrate the need for and value of a healthy community and an effective local public health system. Community support often consists of, but is not limited to, participation in the design and provision of services, active advocacy for expanded services, participation at board meetings, support for services that are threatened to be curtailed or eliminated, and other activities that demonstrate that the community values a healthy community and an effective local public health system.

Contributing Factors

Those factors that directly or indirectly influence a risk factor's influence on a specific health problem (also referred to as a causative factors, risk factors, or determinants).

Crude Rate

A summary rate based on the actual number of events (e.g., birth or deaths) in a total population over a given time period. A rate that has not been “adjusted” or “standardized” for any other factor, such as age.

D

Death, Illness, and Injury

Health status in a community is measured in terms of mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates; by degree of premature death (Years of Productive Life Lost); and by cause (disease - cancer and non-cancer or injury - intentional, unintentional). Morbidity may be represented by age-adjusted incidence of cancer and chronic disease. This is a category of data recommended for collection within the Community Health Status Assessment.

Demographic Characteristics

Demographic characteristics include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub-populations are located, and the rate of change in population density over time, due to births, deaths and migration patterns. This is a category of data recommended for collection within the Community Health Status Assessment. Characteristic data such as size, growth, density, distribution, and vital statistics that are used to study human population. Demographic characteristics of your jurisdiction include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub populations are located, and the rate of change in population density over time, due to births, deaths and migration patterns.

Determinants (or Risk Factors)

Direct causes and risk factors which, based on scientific evidence or theory, are thought to influence directly the level of a specific health problem. Broad causal factors involved in influencing health and illness, including social, economic, genetic, perinatal, nutritional, behavioral, and environmental characteristics. A primary risk factor (causative factor) associated with the level of health problem.

Disadvantaged Groups

Disadvantaged (or vulnerable or marginalized) applies to groups of people who, due to factors usually considered outside their control, do not have the same opportunities as other, more fortunate groups in society. Examples might include unemployed people, refugees and others who are socially excluded.

E

Economic Impact Assessment

Economic impact assessment involves exploring and identifying the ways in which the economy in general, or local economic circumstances in particular, will be affected by a policy, program or project.

Evidence Based

The evidence base refers to a body of information, drawn from routine statistical analyses, published studies and "grey" literature, which tells us something about what is already known about factors affecting health. For example, in the field of housing and health there are a number of studies which demonstrate the links between damp and cold housing and respiratory disease and, increasingly, the links between high quality housing and quality of life.

F

Family

A group of two or more people who reside together and who are related by birth, marriage, or adoption.

Family Household

A family household consists of a householder and one or more people living together in the same household who are related to the householder by birth, marriage, or adoption. All people in a household who are related to the householder are regarded as members of his or her family. People not related to the householder are not included as part of the householder's family in census tabulations. In 1950 and 1960, a household enumerated in the census could contain more than one family. Thus, there were more families than family households.

G

Geocode

Addresses matched and assigned to a corresponding latitude and longitude. The process of assigning geographic location information to attribute data that are to be used for analytic purposes.

Geographic Information System (GIS)

GIS combines modern computer and supercomputing digital technology with data management systems to provide tools for the capture, storage, manipulation, analysis, and visualization of spatial data. Spatial data contains information, usually in the form of a geographic coordinate system that gives data location relative to the earth's surface. These spatial attributes enable previously disparate data sets to be integrated into a digital mapping environment. Geographic information systems that are computer based processes for capturing, lining, summarizing, and analyzing data containing geographical location information. These systems are particularly useful in supporting visual analysis and communication of data using maps that display the geographic distribution of data.

H

Health

A dynamic state of complete physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity. The state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending on the cultural milieu and on the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms of morbidity and mortality.

Health Care

The prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.

Health Disparity

A statistically significant difference in a health indicator between groups that persists over time.

Health Equity

Distribution of disease, disability and death in such a way as to not create a disproportionate burden on one population; the absence of persistent health differences over time, between racial and ethnic groups.

Health Gain

Improvement in health status.

Health Impact

A health impact can be positive or negative. A positive health impact is an effect which contributes to good health or to improving health. For example, having a sense of control over one's life and having choices is known to have a beneficial effect on mental health and wellbeing, making people feel "healthier". A negative health impact has the opposite effect, causing or contributing to ill health. For example, working in unhygienic or unsafe conditions or spending a lot of time in an area with poor air quality is likely to have an adverse effect on physical health status.

Health Indicator

A health indicator is numeric value for a specific health-related occurrence, such as the percentage of smokers or the number of people diagnosed with cancer within a given population. Health indicators are documented over-time to assess trends and compare values in the local population to state and national averages. While health indicators are important for understanding the depth and breadth of a health problem, data alone cannot solve health problems. Solutions require health experts and community stakeholders working together to understand the context and influences on the problem, including the demographic, social, environmental, and economic characteristics within the population.

Health Issues

Health issues summarize or categorize the health indicators of most concern within a population. A health issue can be a particular disease such as chronic or infectious disease. A health issue also can be the social, economic, or behavioral conditions that are causing or exacerbating a disease. For example, tobacco use, poor diet and lack of physical fitness are health issues because they are known to directly contribute to diseases of the heart, lungs, and circulatory system. Health issues usually are comprised of multiple health indicators and efforts to address and improve a health issue require broad-based community attention and support.

Health Insurance Coverage

A person is considered covered by health insurance at some time during the year if he or she was covered by at least one type of coverage.

Health Promotion

Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities. An intervention strategy that seeks to eliminate or reduce exposures to harmful factors by modifying human behaviors. Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. This process enables individuals and communities to control and improve their own health. Health promotion approaches provide opportunities for people to identify problems, develop solutions, and work in partnerships that build on existing skills and strengths. Any combination of educational, organizational, environmental, and economic interventions designed to encourage behavior and conditions of living that are conducive to health.

Healthy People 2010

A national health promotion and disease prevention initiative that brings together national, state, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life. In Healthy People 2010, 467 health promotion and disease prevention objectives are identified for achievement by the year 2010. There will be a Health People 2020 initiative.

Household

One person or a group of people living in a housing unit.

Housing Unit

A housing unit is a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied or intended for occupancy, as separate living quarters. Separate living quarters are those in which the occupant(s) live separately from any other people in the building and which have direct access from outside the building or through a common hall.

I

Impact Assessment

Impact assessment is about judging the effect that a policy or activity will have on people or places. It has been defined as the prediction or estimation of the consequences of a current or proposed action.

Impact Objective

A short term (less than three years) and measurable. The object of interest is on knowledge, attitudes, or behavior.

Incidence

A measure of the health condition in the population; generally the number of new cases occurring during a specified time period.

Indicator

A measurement that reflects the status of a system. Indicators reveal the direction of a system (a community, the economy, and the environment), whether it is going forward or backward, increasing or decreasing, improving or deteriorating, or staying the same. A measure of health status or a health outcome. An element used to measure health status, risk, or outcome. See also “Health Indicator”

Inequalities Audit or Equity Audit

A review of inequalities within an area or of the coverage of inequalities issues in a policy, program or project, usually with recommendations as to how they can be addressed.

Infrastructure

The resources (e.g., personnel, information, monetary, and organizational) used by the public health system to provide the capacity to perform its duties.

Integrated Impact Assessment

Integrated impact assessment brings together components of environmental, health, social and other forms of impact assessment in an attempt to incorporate an exploration of all the different ways in which policies, programs, or projects may affect the physical, social and economic environment.

Intervention

A public health program intended to improve the health of a specific population or the overall population. The focus of a public health intervention is to prevent rather than treat a disease through

surveillance of cases and the promotion of healthy behaviors. Interventions can be used to create change in different settings, including: communities, work sites, schools, health care organizations, faith-based organizations or at home. Interventions may be most effective when they include multiple settings.

Injury

Injuries can be classified by the intent or purposefulness of occurrence in two categories, intentional and unintentional injuries. Intentional injuries are ones that are purposely inflicted and often associated with violence. These include child abuse, domestic violence, sexual assault, aggravated assault, homicide, and suicide. Unintentional injuries include only those injuries that occur without intent of harm and are not purposely inflicted.

International Classification of Disease (ICD-10-CM)

The ICD-10 is used to code mortality data. Its purpose is to provide a common language, specifically number and letter codes, for identifying illnesses, injuries and causes of death. This enables communities, health care organizations, insurance companies, regulatory agencies, etc. to compare rates of disease and injury, as well as allowing comparison of cost and pricing practices.

L

Latent Period

The interval of time from exposure to chemical agents and the onset of signs and symptoms of the illness.

Local Health Department

An administrative or service unit of local or state government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than the state. Functionally, a local (county, multicounty, municipal, town, other) health agency, operated by local government, often with oversight and direction from a local board of health, that carries out public health's core functions throughout a defined geographic area. A more traditional definition is an agency serving less than an entire state that carries some responsibility for health and has at least one full time employee and a specific budget.

M

Mean

The measure of central location commonly called the average. It is calculated by adding together all the individual values in a group of measurements and dividing by the number of values in the group.

Median

The measure of central location which divides a set of data into two equal parts.

Median Age

The median divides the age distribution into two equal parts, one-half of the population falling below the median age and one-half above the median.

Mental Health

A term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined.

Morbidity

The condition of being sick or diseased, the prevalence of a disease in a population.

Mortality Rate

The number of deaths from a given condition in a defined population in a specified time period, the ratio of deaths in an area to the population of that area, can be crude or age-adjusted.

N

Natality

Natality is another term for births.

Neonatal Death Rate

The number of deaths among infants under 28 days of age in a defined population and time period divided by the number of live births in that population and time period.

O

Outcome Objective

The level to which a health problem is to be reduced as a result of an intervention, usually measured in terms of mortality, morbidity, or disability. An outcome objective usually is long term (greater than 3 years) and measurable.

P

Per Capita Income

The per capita income for an area is defined as the total personal income in an area, divided by the number of people in that area. The Census Bureau derived per capita income by dividing the total income of a particular group by the total population in that group (excluding patients or inmates in institutional quarters).

Policy Development

One of public health's three core functions, the others are assessment and assurance. Processes by which public health organizations formulate policies and plans to address priority health issues for the populations they serve, and advocate for the adoption and implementation of these policies by legislative and regulatory bodies and by private sector institutions. The means by which problem identification, technical knowledge of possible solutions, and societal values converge to set a course of action. Policy development processes typically involve planning and priority-setting efforts that include broad participation by community members as well as health-related professionals and institutions. Policy development is not synonymous with the development of laws, rules, and regulations. Laws, rules, and regulations may be adopted as tools among others to implement policy. Policy development is a process that enables informed decisions to be made concerning issues related to the public's health. Policy development involves serving the public interest in the development of comprehensive public health policies by promoting the use of the scientific knowledge base in decision making and by leading in developing public health policy.

Population Health

An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.

Population Projections

A calculation of population size derived for future dates using assumptions about future trends and data from population censuses, administrative records, sample surveys, and/or other sources.

Prevalence

The number of cases of a disease, infected people or people with some other attribute present during a particular interval of time. It often is expressed as a rate.

Prevention

An active process that promotes the personal, physical and social well-being of individuals and families to reinforce positive health behaviors and lifestyles that minimize morbidity and maximize the overall quality of life. Primary care can be viewed as a form of prevention as its proper use can result in fewer hospitalizations for conditions such as asthma, diabetes, chronic obstructive pulmonary disease, and congestive heart failure, which are affected by the level of care given on an outpatient basis.

Preventive Care

A set of measures taken in advance of symptoms to prevent illness or injury. This type of care is best exemplified by routine physical examinations and immunizations. The emphasis is on preventing illnesses before they occur.

Process Objective

A process objective is short term and measurable. The object of interest is the level of professional practice in the completion of the methods established in a Community Health Plan. Process objectives may be evaluated by audit, peer review, accreditation, certification, or administrative surveillance. Objects of evaluation may include adherence to projected timetables, production, distribution, and utilization of products, and financial audits.

Proportional Mortality

The relative importance of a specific cause of death in relation to all deaths in a population group. The two measures in the proportional mortality rate are measured over the same period of time.

Public Health

The mission of public health is to fulfill society's desire to create conditions so that people can be healthy. Activities that society undertakes to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, and counter threats to the health of the public.

Public Health Leadership

This is demonstrated by both individuals and organizations that are committed to the health of the community. Leadership defines key values and guides action; participates in scanning the environment both internal and external for information critical to implementing the public health mission; keeps the public health mission in focus and articulates it clearly; and facilitates the creation of a vision of excellence, a compelling scenario of a preferred future. Through shared information and decision making, public health leadership facilitates the empowerment of others to create and implement plans to enact the shared vision and to participate actively in the process of community health improvement.

Public Health Mission

To fulfill society's interest in assuring conditions in which people can make choices to be healthy in their communities. Public health carries out its mission through organized, interdisciplinary efforts that help prevent and treat the physical, mental and environmental health concerns of communities and populations.

Public Health System

The network of organizations and professionals that participate in producing public health services for a defined population or community. This network includes governmental public health agencies as well as relevant health care and social service providers, community based organizations, and private institutions with an interest in population health.

Q

Quality of Life

A construct that connotes an overall sense of well-being when applied to an individual and a supportive environment when applied to a community. While some dimensions of quality of life can be quantified using indicators that research has shown to be related to determinants of health and community wellbeing, other valid dimensions include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life.

R

Race/Ethnicity

Race and ethnicity are social, not biological constructs, referring to social groups often sharing cultural heritage and ancestry. Race and ethnicity are not valid biological or genetic categories. As per the U.S. Census, prior to 1980, race was determined either solely by the observation of the enumerator or by a combination of enumerator observation and self-identification. These categories reflect social usage and should not be interpreted as being scientific or anthropological in nature. Furthermore, the race categories include both racial and national-origin groups.

Random

Chance used to refer to the type of error that results from fluctuations around a value because of sampling variability.

Rate

A measure of some event, disease or condition in relation to a unit of population where time and place are stated. A true rate can be determined only if the numerator is included as part of the denominator if the denominator represents the entire population at risk and a unit of time is specified.

Ratio

A relative number expressing the magnitude of one occurrence or condition in relation to another.

Relative Risk

The ratio of the incidence rate of those exposed to a factor to the incidence rate of those not exposed.

Resource Allocation

The process of deciding what is needed to carry out an activity and providing for those needs. This can include making provision for financial resources (money), capital resources (such as buildings and computer hardware) and staff resources (including the number of staff needed and the skill mix required).

Risk Assessment

The scientific process of evaluating adverse effects caused by a substance, activity, lifestyle, or natural phenomenon. Risk assessment is the means by which currently available information about public health problems arising in the environment is organized and understood. A systematic approach to quantifying the risks posed to individuals and populations by environmental pollutants and other potentially harmful exposures.

Root Causes

Root causes are primary causes of health problems that underlie the more obvious causes. Social problems are often root causes that result in health inequalities through complex pathways. For example, racism is a root cause because it results in income inequality, lack of power, residential and occupational segregation, and stress in marginalized groups. These things in turn cause things like inadequate health care, working in dangerous environments, living in cramped conditions where infections spread easily, smoking, and the inability to afford nutritious food. These things, in turn, are related to a host of health problems like injury, infectious and chronic disease, and mental illness. While addressing root causes will not eliminate disease and death, it will reduce health disparities between populations.

S

Social Impact Assessment

Social impact assessment is the process of assessing or estimating, in advance, the social consequences that are likely to follow from specific policy actions or project development, particularly in the context of appropriate national, state or provisional policy legislation. It is based on the assumption that the way in which the environment is structured can have a profound effect on people's ability to interact socially with other people and to develop networks of support. For example, a major road cutting across a residential area can have the effect of dividing a community with implications for social cohesion.

Socioeconomic Characteristics

Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables.

Specificity

The ability to identify correctly those who do not have a given disease.

Standard Population

The age distribution of a population for a given period of time

Strategic Planning

A disciplined effort to produce fundamental decisions and actions that shape and guide what an organization (or other entity) is, what it does, and why it does it. Strategic planning requires broad scale information gathering, an exploration of alternatives, and an emphasis on the future implications of present decisions. It can facilitate communication and participation, accommodate divergent interests and values, and foster orderly decision making and successful implementation.

Strategies

Patterns of action, decisions, and policies that guide a group toward a vision or goals. Strategies are broad statements that set a direction. They are pursued through specific actions (i.e., those carried out in programs and services of individual components of the local public health system).

Statistical Significance

In statistics "significant" means a finding is probably true and reliable and not due to chance. Significance levels show how likely a result is due to chance. The most common level, used to mean something is good enough to be believed, is 95%. This means that the finding has a 95% chance of being true. When quantitative differences found between populations are labeled as statistically significant, it means the differences are considered highly likely to be real and are not due to mere coincidence (random error). For example, if the diabetes rate for Hispanics is higher than the rate for other racial/ethnic groups and those differences are statistically significant, it means the rates probably reflect true disparities between groups.

Surveillance

The systematic collection, analysis, interpretation, and dissemination of health data to assist in the planning, implementation, and evaluation of public health interventions and programs. Systematic monitoring of the health status of a population. The process of collecting health related data that are representative of a population of interest, for use in assessing trends in disease and other health conditions, measuring the prevalence of health risk factors and health behaviors, and monitoring the use of health services.

Sustainability

The long-term health and vitality - cultural, economic, environmental, and social - of a community. Sustainable thinking considers the connections between various elements of a healthy society, and implies a longer time span (i.e., in decades, instead of years).

Systems Change

The process of improving the capacity of the public health system to work with many sectors to improve the health status of all people in a community.

T

Teen Pregnancy Rate

Annual number of pregnancies to women aged 15-19 per 1,000 female population aged 15-19.

U

Underlying Cause of Death

The disease or injury that initiated the sequence of events leading directly to death, or the circumstances of the accident or violence that produced the fatal injury.

V

Values

The fundamental principles and beliefs that guide a community driven process. These are the central concepts that define how community members aspire to interact. The values provide a basis for action and communicate expectations for community participation.

Vision

A compelling and inspiring image of a desired and possible future that a community seeks to achieve. A health vision states the ideal, establishes a stretch linked explicitly to strategies, inspires commitment, and draws out community values. A vision expresses goals that are worth striving for and appeals to ideals and values that are shared throughout the local public health system.

Vital Events

Live births, deaths, fetal deaths, marriages, divorces, and induced terminations of pregnancy, together with any change in civil status that may occur during an individual's lifetime.

Vital Statistics

Data derived from certificates and reports of birth, death, fetal death, induced termination of pregnancy, marriage, (divorce, dissolution of marriage, or annulment) and related reports. Information compiled by state health agencies concerning births, deaths, marriages, divorces, fetal deaths, and abortions.

Y

Years of Life Lost

A measure of premature mortality. The measure subtracts the person's age at death from the life expectancy for someone that age in a standard population. The younger the age at death, the greater the Years of Life Lost. Since many younger deaths could be prevented or postponed this measure has implications for prevention efforts.

Years of Potential Life Lost

This measure of premature mortality is the number of years between the age at death and age 65 or 75, that is, the number of years which are "lost" by persons who die before one of those ages. This approach places additional value on deaths that occur at earlier ages.

This page is intentionally blank