Implementation Strategy Plan 2022

AHN JEFFERSON

Report

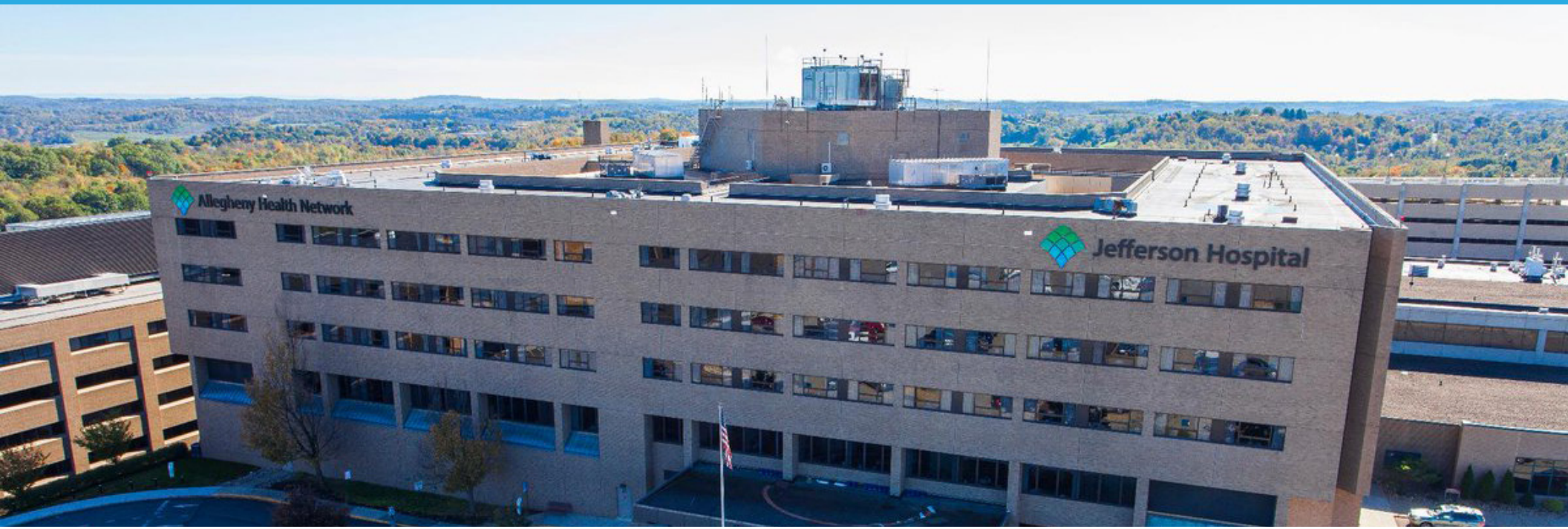
About Allegheny Health Network (AHN)

The hospitals of Allegheny Health Network, as they have for decades, provide exceptional health care to help people live healthy lives and continue to extend their reach, offering a broad spectrum of care and services. The tradition continues by using the latest medical innovations to treat patients. Gaining knowledge through research to constantly improve how to prevent, diagnose, and treat illness, AHN staffs each hospital with experienced, expert, and compassionate physicians, nurses, and other health care professionals dedicated to medicine, people, and healing.

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

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

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



About AHN Jefferson

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

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

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

Mission

To create a remarkable health experience, freeing people to be their best.

Vision

A world where everyone embraces health.

Values

People matter

Every person contributes to our success. We strive for an inclusive culture, regarding people as professionals, and respecting individual differences while focusing on the collective whole.

Stewardship

Working to improve the health of the communities we serve and wisely managing the assets that have been entrusted to our care.

Trust

Earning trust by delivering on our commitments and leading by example.

Integrity

Committing to the highest standards encompassing every aspect of our behavior including high moral character, respect, honesty, and personal responsibility.

Customer-focused collaboration

Because no one person has all the answers, we actively seek to collaborate with each other to achieve the right outcomes for our customers.

Courage

Empowering each other to act in a principled manner and to take appropriate risks to do what is right to fulfill our mission.

Innovation

Committing to continuous learning and exploring new, better, and creative ways to achieve our vision.

Excellence

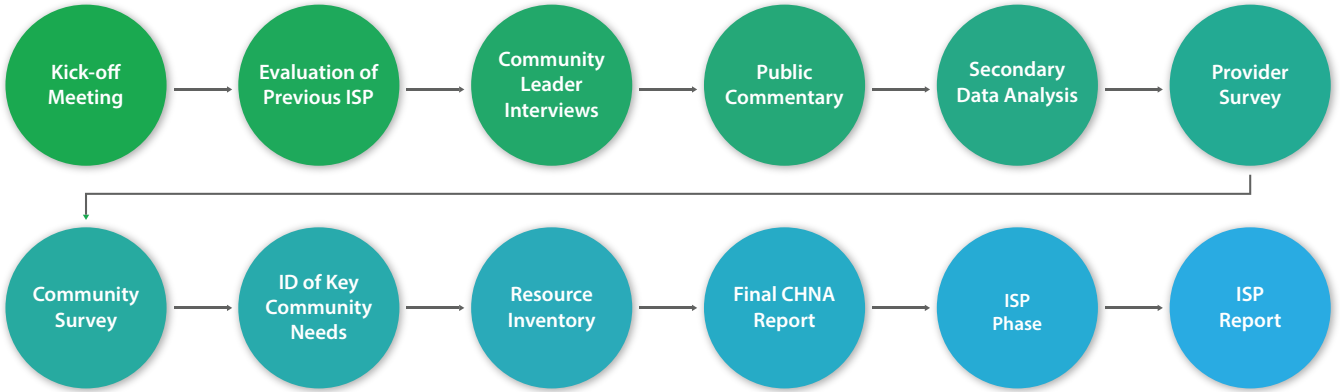
Being accountable for consistently exceeding the expectations of those we serve.

Introduction

Serving the communities of the South Hills and lower Mon Valley since 1977, Jefferson Hospital has evolved into a 341 licensed bed hospital with more than 500 physicians and 1,700 staff members. The leadership and staff are dedicated to providing patients with innovative treatments, pioneering research discoveries, and personalized medical care.

In 2022, AHN joined together with Tripp Umbach to conduct a comprehensive community health needs assessment for AHN Jefferson's service area of Allegheny, Fayette, Washington, and Westmoreland counties. The CHNA process included input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of public health issues and representatives of vulnerable populations. The overall CHNA involved multiple steps that are depicted in the below flow chart.

Figure 1: Overall CHNA and Implementation Strategy Plan (ISP) Process Flow Chart



The CHNA and implementation strategy plan meets the requirements of the Patient Protection and Affordable Care Act. The act has changed how individuals are obtaining care and promotes reduced healthcare costs, greater care coordination, and better care and services. Health care organizations and systems are striving to improve the health and social needs of the community they serve through collaboration with local, state and national partners. The implementation strategy plan outlines the needs identified in the CHNA and documents how AHN Jefferson will be addressing the needs over the next three years.

CHNA Needs not Being Further Addressed

Efforts related to behavioral health (in particular mental health services) and diabetes will no longer be addressed in AHN Jefferson's planning efforts. However, AHN Jefferson will continue to make diabetes services and behavioral health care (mental health services) available through its hospital-based focus to assist patients and families to manage and prevent chronic diseases, including diabetes, and to ensure access to behavioral health care and services through the Allegheny Clinic.

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

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

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

A) Social Determinants of Health

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

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

Cost of Care

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

SDOH: Cost of Care				
Goal: Reduce costs that may have a direct benefit to reducing patients' out-of-pocket and risk adjusted per member per month insurance healthcare expenses.				
Impact: (1) Eliminated inefficient prescribing process; (2) decreased out-of-pocket costs for patients' medication; (3) reduced readmission rates; and (4) reduced emergency department (ED) visits due to negative side effects or ineffective antibiotic treatment.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Patients presenting at Jefferson Hospital.	Implement at least one project(s) aimed at reducing medical prescription (Rx) expenditures.	• Introduce Real-Time Prescription Benefit (RTPB) tool. • Educate providers on new technology. • Demonstrate how to use the platform to providers/staff for optimal outcomes.	• The cost savings of moving the patients to the lower cost medications. • Number of patients benefitting from services.	• Primary Care Physicians (PCPs) • Clinicians • Hospital staff
	Reduce incidence of negative side-effects or ineffective antibiotic treatment for infection.	• Involve pharmacists in culture follow-up process for Emergency Department (ED) visits for urinary tract infections (UTIs), wound infections, throat cultures, and sexually transmitted diseases (STDs). • Develop an algorithm or a standardized protocol that pharmacists can make recommendations. • Review culture alerts received after discharge from ED and when appropriate.	• Percent of appropriate antibiotic based on bacteria. • Percent of appropriate duration of treatment based on type of infection. • Percent of readmissions return visits to ED for same issue of side-effect from treatment.	• Pharmacists • ED
	Implement a project to address medication needs of discharged patients.	• Develop Meds to Bed program to improve patient outcomes with medication adherence through upfront education, clarification of questions and resolution of insurance issues.	• Number of patients utilizing the Meds to Beds program. • Number of patients utilizing Meds to Beds with medication related admissions.	• Meds to Bed staff • Hospital staff

SDOH: Cost of Care				
Goal: Increase access to appropriate primary and specialist care.				
Impact: (1) Patients more connected to PCP and additional resources.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
ED patients	Address health care needs of Front Door Initiative patients discharged from ED.	• Connect patients without a PCP with a primary care office. • Support patients who would like to change their PCP to identify a new provider. • Connect patients with additional resources if they have barriers for reaching their PCP. • Connect patients with case managers or social workers for their insurance providers for further support.	• Number of patients without a PCP who have been connected to a PCP. • Number of patients connected with additional resources to overcome barriers that prevent them from accessing health care. • Number of patients connected with insurance providers; social worker/case manager.	• Area Agency on Aging

Food Insecurity, Diet, and Nutrition

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

SDOH: Food Insecurity				
Goal: Identify and address food insecurity for AHN Jefferson patients.				
Impact: (1) Number of patients referred to food distribution sites; (2) patient consultations at AHN Jefferson Healthy food center; (3) patients receive food bags through inpatient or Emergency Department (ED).				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
ED patients	Connect food insecure patients to Health Food Center and other regional food resources.	• Identify food insecure patients. • Partner with the Healthy Food Center, food distribution sites, and Greater Pittsburgh Area Food Bank. • Refer patients who screen positive for food insecurity to Health Food Center or food distribution sites through the Greater Pittsburgh Area Food Bank.	• Number of patients referred to the Healthy Food Center through the Front Door Initiative. • Number of patients referred to food distribution sites. • Number of patients who receive food bags through the ED.	• Center for Inclusion Health (CIH) • Healthy Food Center • Food distribution sites • Greater Pittsburgh Area Food Bank
AHN patients (inpatient/outpatient) Community members and community-based organizations (CBO) members.	Increase utilization of food screenings and referral process.	• Educate providers and CBOs on food insecurity screening and referral process. • Identify food insecure patients and community members through SDOH screening tool. • Screen patients for food insecurity. • Refer patients to Health Food Center who screen positive. • Assess needs of population served (food access, transportation, utensils, education, recipes, other SDOH needs). • Provide healthy foods based on individual needs (chronic disease/preference/cultural, education, community resources, SNAP, WIC).	• Number of patients referred to Health Food Center. • Number of patients who complete referral process and visits new vs. follow up. • Number of people served. • Number of meals provided.	• Highmark Health • Greater Pittsburgh community Food Bank • Highmark Whole Care • Traveler's Aid • The Food Trust • 412 Food Rescue

Transportation

Access to health care services has a significant impact on health, including improved overall physical, social, and mental health status, prevention of disease and disability, and better quality of life. Transportation affects residents in rural and urban communities. Having adequate transportation is often a barrier to accessing services and can significantly affect the quality of people's lives. The lack of vehicle access, cost, long distances, and lengthy times to reach needed services impact travel for residents.

SDOH: Transportation				
Goal: increase patient access to available transportation resources in region.				
Impact: (1) Number of Emergency Department (ED) patients connected with Medical Assistance Transportation Program (through Allegheny County) (MATP); (2) Number of patients connected with MATP and ACCESS; and (3) Number of patients supported by Outpatient Transportation Program.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
ED patients	Increase access to MATP and ACCESS services.	• Provide transportation for rides home from ED d by Allegheny County MATP contract holder Traveler's Aid. • Track every patient who receives a ride home from the ED to receive and MATP application and enroll all eligible patients. • Refer patients with transportation needs to Front Door Initiative (FDI) for further MATP. • enrollment and ACCESS referrals.	• Number of patients receiving Z-trip or bus pass vouchers in the ED due to lack of transportation. • Number of FDI patients referred to MATP and ACCESS. • Number of patients enrolled in ACCESS or MATP.	• Traveler's Aid of Pittsburgh • Z-trip
Outpatients	Increase transportation for already established AHN Jefferson patients unable to utilize any other forms of transportation (i.e., public transportation, ACCESS, MATP, family, friends).	• Gain approval through application and review process. • Provide rides for AHN Jefferson Hospital service at the hospital, Medical Office Building (MOB), Jefferson Medical Arts Building (JMA), Behavioral Health or Aquatics Center.	• Number of free round-trip rides provided.	• Z-Trip

Workforce Development

Being employed and having a steady livable income enables one to have choices and options for a healthy lifestyle. Having a comfortable income can provide a safe home environment, food, transportation, health care, and much more.

SDOH: Workforce Development				
Goal: Provide support and career opportunities to prospective and current JH employees.				
Impact: (1) Number of environmental services (EVS) employees and supervisors participating in English as a Second Language (ESL) classes; (2) results of pre-and post-evaluation for ESL classes; (3) Engaged current and potential talent.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Community members, current, and future employees.	Increase internal outreach efforts to increase allied health career paths.	• Conduct internal meetings for AHN Jefferson Hospital employees. • Implement community events.	• Number of community events. • Number of internal meetings. • Number of participants.	• Community members
AHN Jefferson Hospital employees who speak English as a second language.	Partner with Literacy Pittsburgh to implement ESL courses for the Environmental Services Department.	• Determine level of English for current employees who are non-English speakers. • Establish curriculum and class cadence. • Establish class start date and timing.	• Number of EVS employees enrolled in courses. • Number of supervisors participating in ESL cultural competency trainings. • Number of classes held throughout the year.	• Literacy Pittsburgh

SDOH – ALL

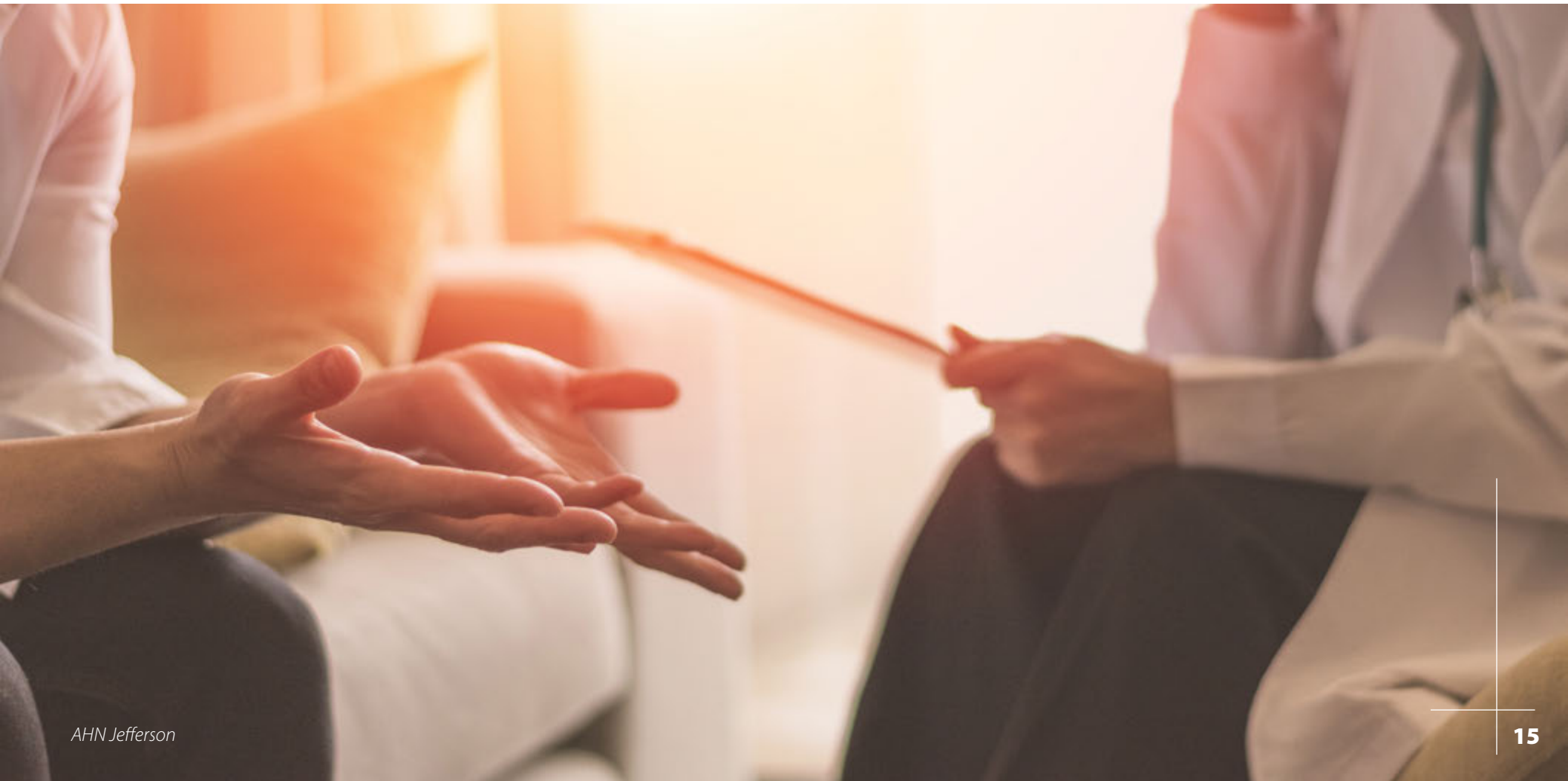
Goal: Identify and connect patients with SDOH needs to community resources at Front Door Imitative.

Impact: (1) Referrals to community resources; (2) decreased readmission rates; (3) increased community referrals; (4) increased number of food packages provided; (5) improved adherence to medical appts and follow-up appts; (6) improved quality of life.

Target Population	Strategies	Action Steps	Measure	Partners
ED Patients	Through the Front Door Initiative, assess and address social determinants of health (SDOH) needs for patients in the ED by connecting them to community resources to help them meet their needs.	• Screen and assess social factors impacting patient health and acute physical emergencies. • Connect with organizations to understand what resources are available for patients with a multiplicity of needs. • Follow-up with patients for 3 to 4 months post-discharge • Document demographic, referral, and closed loop data for patients referred to the Front Door Initiative. • Increase opportunities for ED staff to engage with FDI and learn about SDOH. • Implement staff training on cultural competency, social determinants of health, Emergency Nursing Pediatric Course (ENCP). • Integrate SDOH screening tool in EPIC for ED patients.	• Number of patients screened for SDOH in the ED. • Number of referrals to FDI from various sources (iPad self-assessment, nurses, physicians, social work, case management). • Number of referrals to community resources. • Documented Healthy Days measures for patients across FDI touchpoints. • Comparison of per member per month (PMPM) costs of patients engaged with FDI to those who are not engaged in similar populations. • Closed loop data for patient connections with community resources.	• Front Door Initiative • Nurses • Community resources

B) Behavioral Health

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



AHN Jefferson

Substance Use Disorder

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

Behavioral Health: Substance Use Disorder				
Goal: Improve awareness of substance use disorder and treatment options.				
Impact: (1) Number of patients referred to MAT at Squirrel Hill Health Center (SHHC); (2) Number of patients referred to a PCP with a BHC; and (3) Number of patients referred to other behavioral health resources in the community.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Patients presenting at AHN Jefferson Hospital who have substance use disorder or other behavioral health.	Improve patient connections to behavioral health resources.	• Determine pathways for treatment for patients including referrals to the Center for Excellence. • Continue MAT program at SHHC. • Connect patients with primary care when possible. • Identify patients with substance use disorder who come to the ED. • Connect patients who have behavioral health concerns and Highmark insurance to primary care providers with a Behavioral Health Center (BHC). • Identify other community resources such as Steel Smiling or Auberle Behavioral Health where patients can receive behavioral health services.	• Number of patients referred to Squirrel Hill Health Center for MAT. • Number of patients referred to primary care practices with a BHC. • Number of patients referred to other behavioral health resources in the community.	• Squirrel Hill Health Center

C) Chronic Diseases

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

AHN Jefferson

Chronic Diseases: Cancer

Goal: Reduce the number of cancer related deaths.

Impact: (1) increased number of education events at AHN hospitals; (2) increased number of hospital employees trained on tobacco cessation counseling; (3) increased number of trained community partners; (4) increased number of cancer screenings; and (5) increased number of early cancer diagnoses.

Target Population	Strategies	Action Steps	Measure	Partners
General population	Provide resources to help individuals stop the use of tobacco products.	• Collaborate with Adagio Health to provide pathways for patients to access tobacco cessation workshops. • Train hospital employees on motivational interviewing for tobacco cessation. • Offer workshops at Jefferson Hospital.	• Number of educational events. • Number of participants in tobacco cessation programs. • Number of participants in tobacco cessation programs with Adagio (inside and outside the hospital)	• Adagio Health
	Increase the number of adults who receive timely age-appropriate cancer screenings based on the most recent guidelines.	• Plan free cancer screenings for prostate, breast, skin, cervical, colon/rectal, and lung cancer. • Distribute booklet on Age-Appropriate Cancer Screenings.	• Number of screenings performed. • Number of abnormal screenings identified and referred for additional testing. • Number of individuals screened for at least one cancer.	• AHN Cancer Institute
Goal: Improve the life of those diagnosed with cancer.				
Patients presenting at AHN Jefferson and/or affiliates.	Increase the volume of patients participating in programs that help people dealing with a cancer diagnosis and the challenges related to treatment.	• Promote Cancer Bridges Cancer Support Group. • Promote Cancer Bridges Living Life Post Cancer Treatment program. • Promote The AHN Care and Cosmetics Program. • Promote AHN Cancer Institute pre-chemo treatment visits for all patients undergoing chemotherapy at AHN Jefferson. • Partner with EBeauty to provide a Free Wig Salon. • Provide Satchels of Caring for cancer patients. • Provide free nutrition consultation to oncology patients. • Engage an oncology social worker to offer free assistance to oncology patients with their SDOH of need. • Utilize a nurse navigator to provide coordination of their care as patients go through their cancer journey.	• Number of programs. • Number of participants.	• Cancer Bridges Cancer Support group • AHN Care and Cosmetics Program • EBeauty • Social workers • Nurse navigators

Chronic Diseases: Obesity				
Goal: Reduce rate of obesity in the service area.				
Impact: (1) Increased number of children educated on physical activity; (2) increased number of people enrolled in physical activity programs; (3) increased number of community events; and (4) increased opportunities for physical activity and nutrition.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Patients presenting at Jefferson Hospital and/or affiliates.	Offer nutrition education seminars to metabolic institute patients.	• Nutritionist will have a one-on-one session (in person, phone or virtual) with each patient at first visit.	• Number of medical weight loss patients educated. • Number of surgical weight loss patients educated.	• Nutrition education seminars • Nutritionists
	Offer support to individuals working on weight management.	• Offer a monthly support group for people to share personal experiences, feelings, and coping strategies on weight management.	• Number of programs provided. • Number of participants.	• Support group staff

D) Health Equity

Diversity, Equity, & Inclusion (DEI)

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

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

Health Equity: Diversity, Equity, and Inclusion (DEI)

Goal: Increased cultural competency for a more equitable and inclusive workplace at AHN Jefferson.

Impact: Patients will feel more relaxed, understood, and represented.

Target Population	Strategies	Action Steps	Measure	Partners
ED staff and patients	Increase cultural competency training for ED staff.	• Require cultural competency myLearning module for all incoming ED staff. • Include SDOH and cultural competency training segment in annual Training Days for ED staff. • Provide guidance for appropriate greetings for different immigrant and refugee groups.	• Number of ED staff trained in cultural competency course on myLearning. • Number of staff included in SDOH trainings during annual training days. • Number of signs and informational flyers that are provided to staff for different greeting customs in the inpatient and ED settings.	• BCAP • Center for Inclusion Health
Impact: (1) viable career pathways; (2) higher employee retention rates.				
AHN Jefferson employees Underserved community members	Implement Talent Attraction Program at AHN Jefferson.	• Identify barriers in education and hiring practices. • Collaborate with allied health training partners and community organizations to provide educational opportunities. • Seek candidates for the program. • Identify continued career advancement pathways for diverse students, and current employees of color. • Implement regular diversity and inclusion trainings.	• Number of program participants. • Amount of increase in minority workforce. • Rate of increase in minority retention.	• Allied health training partners • Community organizations

E) Conclusion

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

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

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

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