COMMUNITY HEALTH NEEDS ASSESSMENT

AHN WESTFIELD

Report

April 2022

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Mission

AHN Westfield is committed to compassion and excellence in the delivery of care that appropriately addresses the health needs of our community.

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

About Allegheny Health Network (AHN)

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

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

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

AHN can extend its reach to more people as a health network by offering a broad spectrum of care and services. AHN has 14 hospitals and more than 200 primary- and specialty-care practices. AHN has approximately 2,400 physicians in every clinical specialty, 21,000 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.

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

About AHN Westfield

Westfield Memorial Hospital was founded in 1942 with funds raised by local Rotarians. A major building and renovation project resulted in the addition of 17,720 square feet and renovated facilities in cardiac rehab, physical therapy, radiology, emergency care, surgery, and laboratory services. In January 1999, the affiliation with Saint Vincent Health System was restructured, providing a mechanism to share medical services and resources otherwise unavailable to a small rural hospital.

In 2013, Saint Vincent Hospital and Westfield Memorial Hospital joined the Allegheny Health Network, further expanding the care available to the community. The communities that AHN Westfield serves are Westfield, Ripley, Brocton, Sherman, Clymer, Bemus Point, Mayville, Chautauqua, Stockton, Portland, Dewittville, Hartfield, and Ashville.

At AHN Westfield, our skilled, local doctors, nurses, and technicians are known for going the extra mile, such as giving a ride home or running to the store for a forgotten necessity. AHN Westfield offers access to a range of top specialists, including many who visit us from AHN Saint Vincent. We continue to invest in new medical technology and additional health care services, thanks to our affiliation with AHN Saint Vincent and Allegheny Health Network.

Westfield Memorial Hospital offers patients a comprehensive network of specialty care:

- Cardiac Rehab
- Cataract and Glaucoma Treatment
- Chautauqua Primary Care Clinic
- Colonoscopy
- Diabetes Education
- Emergency Department
- Imaging
- IV Infusions
- Laboratory
- Orthopaedic Clinic
- Physical Therapy
- Sleep Lab
- Surgery
- Urology Clinic
- Women's Wellness Suite
- Wound Clinic

For more than 75 years, AHN Westfield has provided quality care that meets the needs of the people of western New York.

For more information about AHN Westfield Hospital please click here.

Frequently Asked Questions

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)?

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

WHY WAS A CHNA PERFORMED?

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

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

HOW WAS DATA FOR THE CHNA REPORT COLLECTED?

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

Internal Revenue Service (IRS) Requirements

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

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

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

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

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

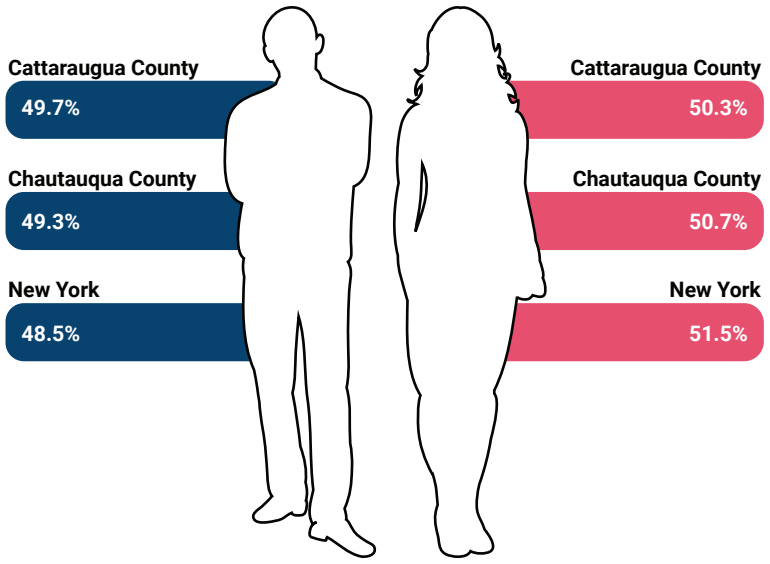
AHN WESTFIELD

Community Profile

Population

Cattaraugua County	Chautauqua County	New York
77,121	128,496	19,572,319
-4.08% from 2010-2020	**-5.37%** from 2010-2020	**4.25%** from 2010-2020

Gender



Age	0-4	5-17	18-24	25-34	35-44	45-54	55-64	65+	Median
Cattaraugua County	5.7%	16.6%	9.2%	10.9%	10.7%	13.1%	15.1%	18.7%	42.0
Chautauqua County	5.5%	15.0%	9.9%	11.7%	10.5%	12.8%	15.1%	19.6%	42.6
New York	5.9%	15.1%	9.4%	14.6%	12.4%	13.4%	13.2%	16.1%	38.8

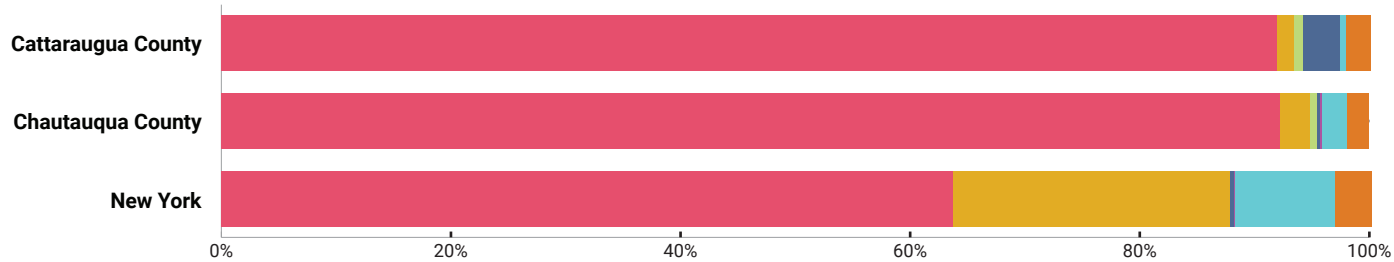
Limited English Proficiency

Cattaraugua County	Chautauqua County	New York
2.0%	2.9%	8.4%

Uninsured Population

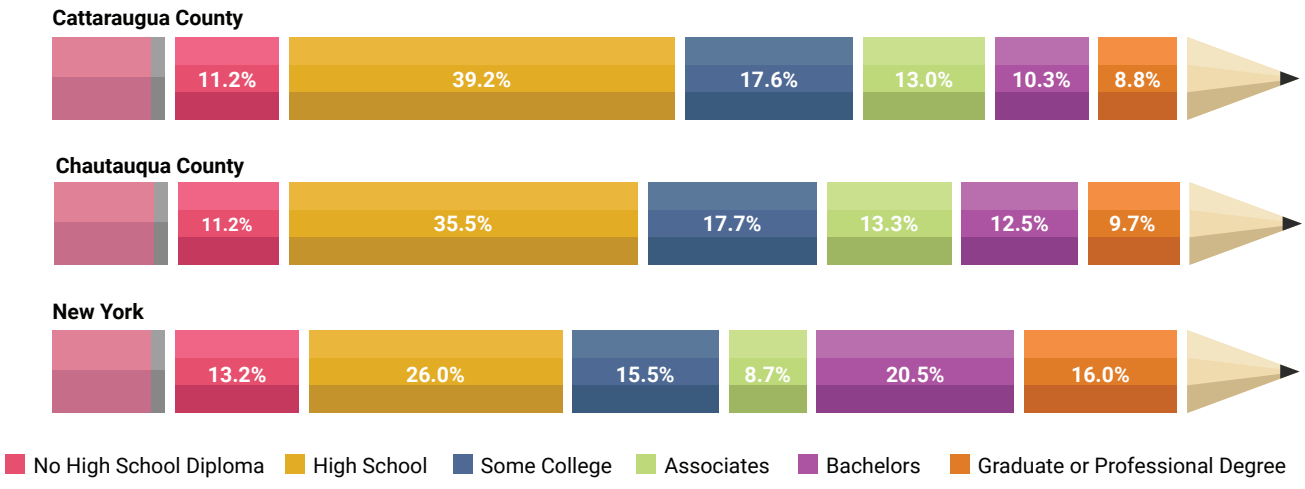
Cattaraugua County	Chautauqua County	New York
6.9%	5.4%	5.8%

Race



	White	Black	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Cattaraugua County	91.9%	1.5%	3.2%	0.8%	0.0%	0.6%	2.1%
Chautauqua County	92.2%	2.6%	0.3%	0.6%	0.1%	2.2%	2.0%
New York	63.7%	15.7%	0.4%	8.4%	0.1%	8.7%	3.2%

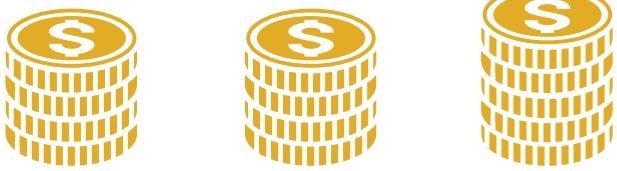
Education



Unemployment Rate

4.3%	4.7%	6.0%
Cattaraugua County	Chautauqua County	New York

Median Household Income



$48,703	$46,820	$68,486
Cattaraugua County	Chautauqua County	New York

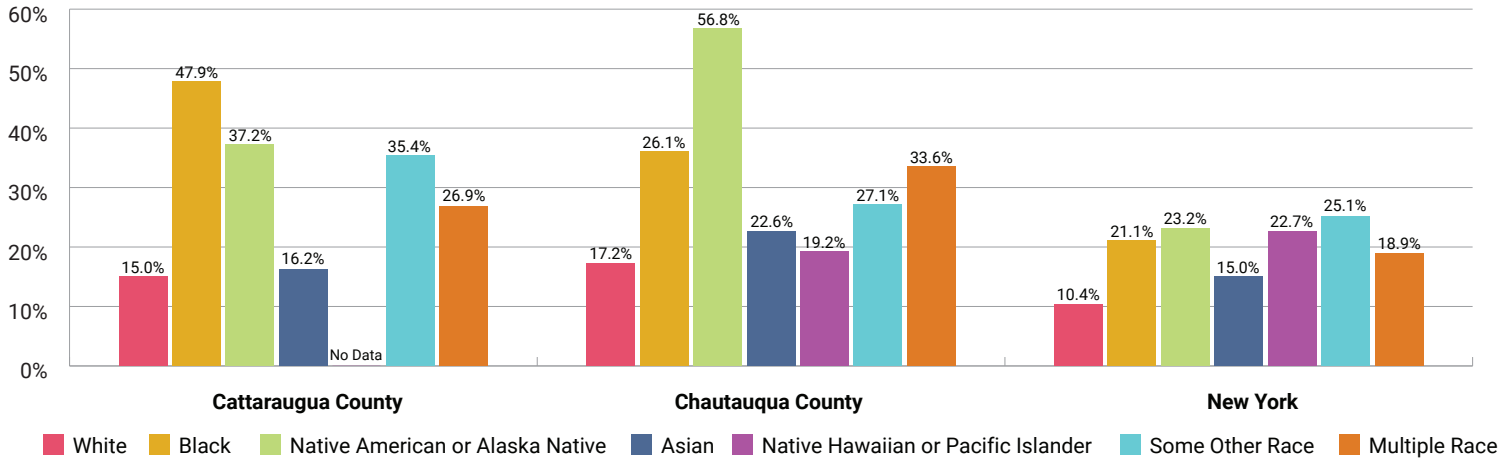
Population Below 100% FPL

Cattaraugua County	16.5%
Chautauqua County	18.2%
New York	14.1%

Population Below 200% FPL

Cattaraugua County	38.6%
Chautauqua County	38.8%
New York	29.7%

Population in Poverty by Race Alone



Executive Summary

Project Overview

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

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

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

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

An internal planning meeting was held with the AHN Steering Committee to discuss and finalize the CHNA needs for 2021 based on primary and secondary data results. AHN Westfield recognized its needs from the previous assessment and will build upon those issues. Based on collective information from the previous implementation strategy plan along with the needs identified in the current cycle, AHN Westfield will reinforce and create new strategies to bridge the gap and address the needs of the underserved in their service area.

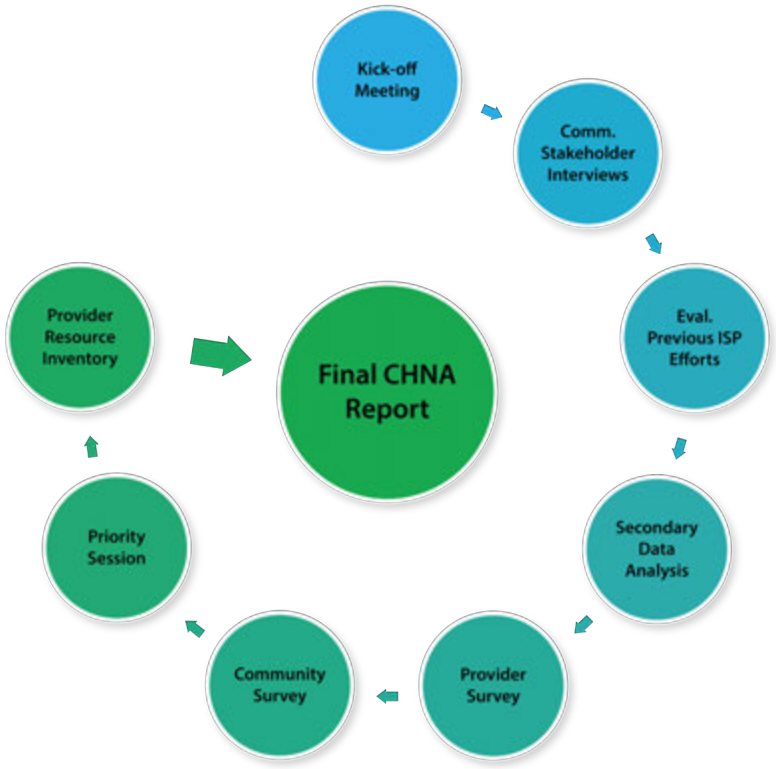
A resource inventory was generated to highlight available programs, services, organizations, and agencies within each of the priority needs in the service area. A significant component of the CHNA was compiling a regional profile (secondary data analysis). The regional profile was composed utilizing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

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

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

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

Figure 1: Overall CHNA Process Flow Chart[2]



2021 Allegheny Health Network Prioritized Findings

AHN Westfield

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

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

AHN Westfield

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

Table 1: 2021 Prioritized Needs

Allegheny Health Network (AHN)	2021 Prioritized Findings													
	Social Determinants of Health					Behavioral Health			Chronic Disease					Health Equity
	Transportation	Workforce Development	Cost of Care	Access to care*	Food Insecurity, Diet, and Nutrition	Substance Use Disorder	Mental Health Services	Postpartum Depression	Diabetes	Heart Disease	Cancer	COPD	Obesity	Diversity, Equity, and Inclusion**
Allegheny General Hospital	X	X			X	X			X	X	X			X
Allegheny Valley Hospital	X					X	X		X	X				X
Canonsburg Hospital	X			X		X			X	X				X
Forbes Hospital	X					X	X		X	X		X		X
Grove City Medical Center				X			X		X	X			X	X
Jefferson Hospital	X	X	X		X	X					X		X	X
Saint Vincent Hospital	X	X		X	X	X	X	X	X		X		X	X
West Penn Hospital		X			X			X	X		X		X	X
Westfield Memorial Hospital						X	X		X	X	X			X
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) 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.[4]

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.

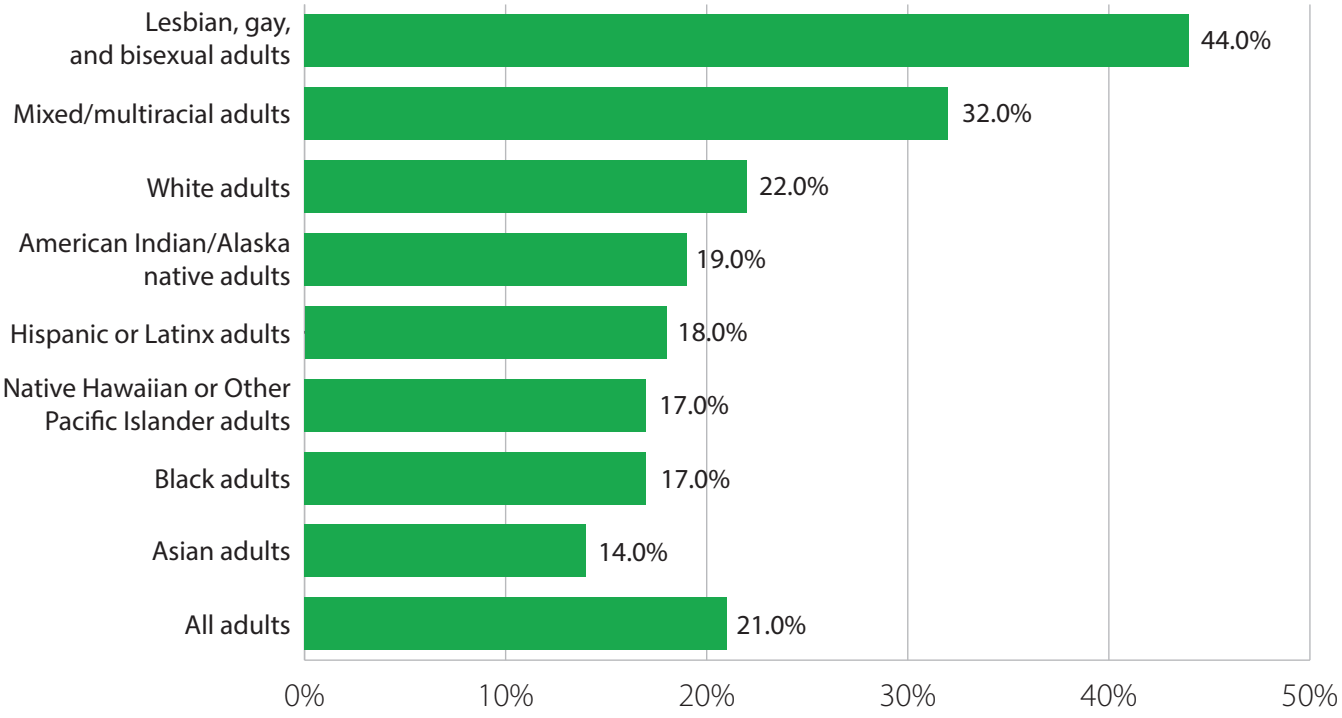
- Cattaraugus County has ten mental health facilities that provide mental health services and Chautauqua County has eight.
- In 2019, the CDC estimated 14.0% (34.1 million) of U.S. adults smoke cigarettes.
- The provider survey reported that behavioral health was the top persistent health problem in the community. The mentally ill were reported as being the most vulnerable population in the community.
- The provider survey also found that 82.7% of respondents cited mental health and 60.2% identified suicide prevention as a 4/5 rating on a rating scale of 1-5, where 1 equals less of a concern and 5 equals more of a concern.
- The top responses from the provider survey showed that access to behavioral health services, mental health services, and substance use support would have the greatest impact on the quality of life for residents in the community.
- Community stakeholders cited drug/alcohol and behavioral/mental health as top health problems in their communities. They also reported substance use as being the top high-risk behavior and having access to behavioral health services as the top choice to improve the quality of life for residents.
- The community survey also found that drug/alcohol use (47.2%) was a top health problem in the community and that access to drug/alcohol and mental health services is needed to improve residents' quality of life and health.

Mental Health Services

The prevalence of mental illness in American is vast and continues to grow yearly. According to the National Alliance on Mental Health, one in five U.S. adults experiences a mental illness, one in 20 U.S. adults experience serious mental illness, and 17% of youth (6-17 years old) experience a mental health disorder.[5]

The figure below reports U.S. adults who have experienced any mental illness within the past 12-months, broken out by population.6 The figure shows that more than one-third of American adults who are lesbian, gay, and bisexual have a mental illness followed by individuals who are mixed/multiracial (32.0%).

Figure 2: 12-Month Prevalence of Any Mental Illness



Source: National Alliance on Mental Health

While COVID-19 has intensified and heightened mental health conditions, barriers to receiving mental health services have been problematic for years. One central issue is the availability of mental health professionals.

County Health Rankings & Roadmaps in 2021 reveals that Chautauqua County (176.0 per 100,000 per population) has a high number of mental health providers when compared to Cattaraugus (142.0 per 100,000 per population) County. The availability of mental health providers allows one to have access to care and services and enables those suffering from the disease appropriate care and treatment when sought. While individuals face mental health challenges and struggle, people who seek regular treatment can improve their symptoms and live a better, prosperous, and higher quality of life.

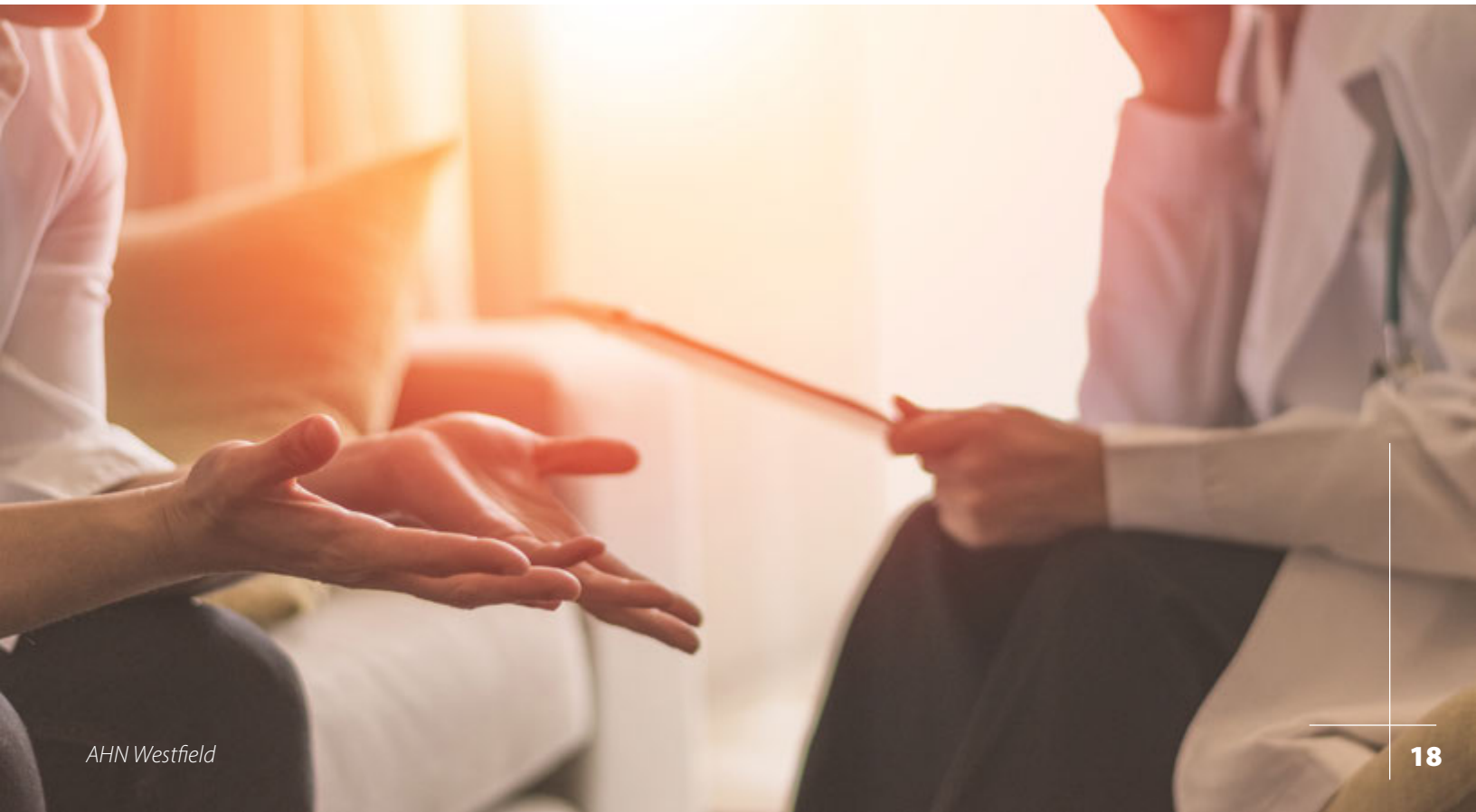
Postpartum Depression

Postpartum depression, maternal depression, or the "baby blues" are emotions often experienced by mothers as they prepare for and welcome a new member into their family. After birth, many mothers experience anxiety, depression, guilt, isolation, sadness, hopelessness, emptiness, or overwhelmed emotions. The CDC reports about 1 in 8 women experience symptoms of postpartum depression. Additionally, a recent analysis found the rate of depression diagnosed at delivery was roughly seven times higher in 2015 than in 2000.[7]

Common risk factors associated with maternal depression include race/ethnicity, age, socioeconomic status, history of depression, health problems of the baby, having multiple babies during birth, difficulty breast-feeding, and unwanted or unplanned pregnancy.[8] Depression in mothers can disrupt the bonding experience in infancy. This phase, which is critical for child development, creates a healthy, nurturing, and empathetic relationship between child and mother. Unfortunately, when the mother is depressed, she is less likely to engage and participate in a healthy and loving parent experience.

Maternal depression is a community and public health problem often having a ripple effect, taking a toll on the well-being and livelihood of mothers and their families. Addressing postpartum depression requires a community commitment of those who share a common interest and desire to support the health of all mothers and families who seek and require help.

Fortunately, postpartum depression is treatable and AHN Westfield will address the community issue to raise awareness and engage women and families in need of help.



B) Chronic Disease

Chronic diseases are a significant cause of disability and death in New York and the United States. The seven leading causes of death nationwide are heart disease, cancer, accidents, chronic lower respiratory diseases, stroke, Alzheimer's disease, and diabetes.[9] According to the CDC, the top leading cause of death in New York is heart disease.[10] With New York'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.

Diabetes

- An estimated 1.7 million New Yorkers (11%) have diabetes. The percentage of New York adults who have diabetes increased from 6.3% in 2000 to 11% in 2018.[11] Estimates show that one of every three children born in the United States will be directly affected by diabetes.
- According to the CDC, in 2017, Cattaraugus County (11.8%) reported a higher number of adults who have diabetes when compared to residents in Chautauqua County (10.5%).
- In 2017, 16.8 per 100,000 per population reported death from diabetes in New York.[12]

Heart Disease

- Heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups in the United States.[13]
- For deaths from heart disease per 100,000 population in 2015-2019, the CDC reported 154.8 deaths in Cattaraugus and 116.5 in Chautauqua. These rates are higher than the national rate of 92.6.

Cancer

- In 2015-2019, 157.4 per 100,000 population in Cattaraugus and 165.6 in Chautauqua died from cancer. These rates are higher than the state rate of 141.5 and the national rate of 152.3. The Healthy People 2030 target is less than or equal to 122.7 per 100,000 population.
- The leading cause of death in 2017 in New York, according to the CDC National Center for Health Statistics, was heart disease (44,092 deaths), followed by cancer (34,956).[14]
- The provider survey identified diabetes, cancers, and heart disease as the top persistent health problems in the community.
- The provider survey also found that 58.1% of respondents listed cancer and 67.0% listed heart disease as a 4/5 rating on a rating scale of 1-5, where 1 equals less of a concern and 5 equals more of a concern.
- Community stakeholders reported cancers and heart disease as top health problems in their communities.

D) Health Equity

Diversity, Equity, & Inclusion

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

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

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

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

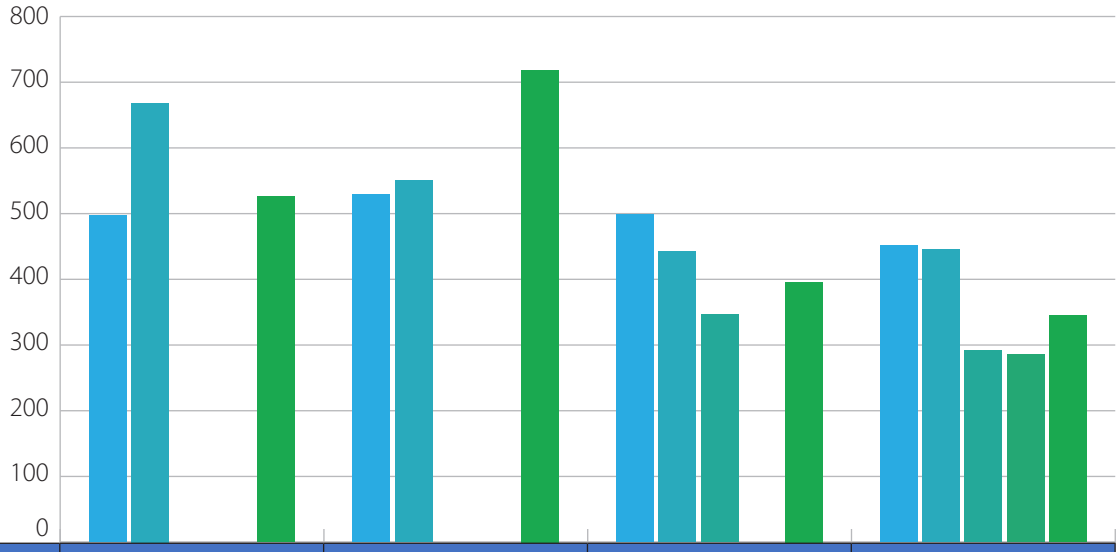
Therefore, interventions to improve health equity and reduce health disparities must be systematic as an organization gains greater understanding and appreciation for diverse cultures and enhances the organization's ability to serve all patients effectively and efficiently. Health equity is realized when all people have the opportunity to be as healthy as possible and no one is limited in achieving good health because of their social and economic status.

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

Recognition is increasing across the health care environment. Improving health and achieving health equity demands a broad, multi-pronged approach and requires community engagement and addressing economic, social, and environmental factors that influence health. For example, prejudice and discrimination can lead to delays in medical diagnosis and treatment. The New England Journal of Medicine published a study reporting that women were seven times more likely than men to be misdiagnosed and discharged in the middle of having a heart attack due to the medical concepts of most diseases being based on understandings of male physiology and women having different heart attack symptoms than men.[15]

Health inequities unveil startling contrasts in health among different populations. Data reviewed for Cattaraugus and Chautauqua counties reveal the vast differences among their residents. Publication data from 2014-2018 reveal that Blacks and Latino in Cattaraugus and Chautauqua counties have higher cancer incidence rates when compared to whites.[16]

Figure 3: Cancer Incidence Rates by Race/Ethnicity (per 100,000 population)



	Cattaraugua County	Chautauqua County	New York	US
White	497.0	529.6	498.2	451.0
Black	668.3	550.1	442.6	444.9
Asian/Pacific Islander			346.4	291.4
American Indian or Alaskan Native				285.8
Hispanic/Latino	525.9	718.8	395.8	345.0

Note: Empty cells indicated that data was not supplied/available or suppressed.

Between years 2013-2019 the table revealed the seven-year average percentage of live births with low birthweight (< 2,500 grams) by ethnicity. Non-Hispanic Black and Hispanic/Latino residents in Cattaraugus and Chautauqua counties have higher percentages of residents who have low-birth weight babies.

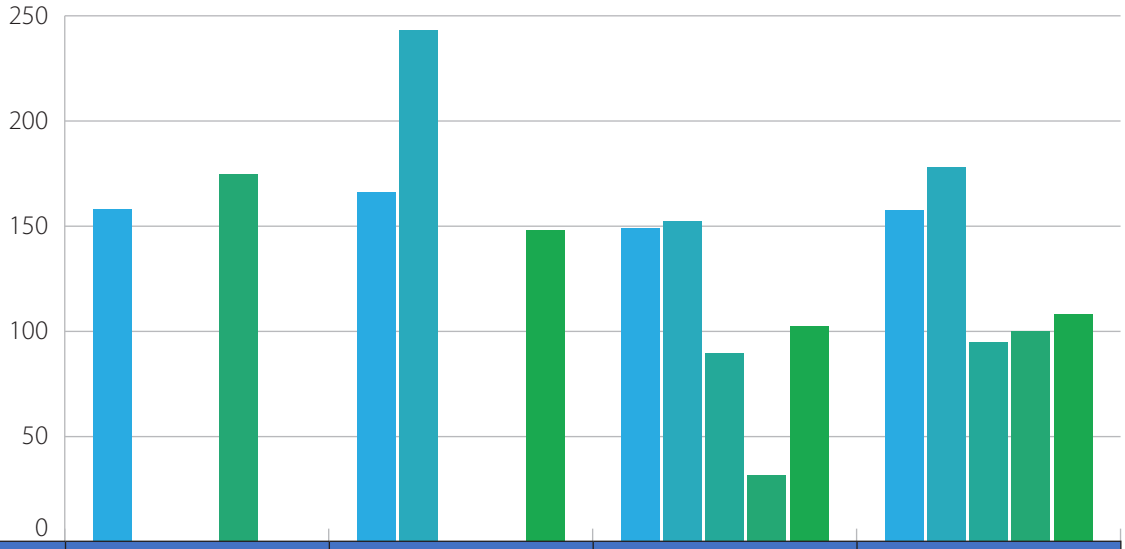
Table 2: Low Birth Weight by Ethnicity

	Non-Hispanic White (percent)	Non-Hispanic Black (percent)	Hispanic/Latino (percent)
Cattaraugus County	7.8	11.4	8.5
Chautauqua County	7.4	10.4	9.1
New York	6.4	12.4	8.0
US	6.8	13.5	7.3

AHN Westfield

Data from 2015-2019 reveal that Blacks in Chautauqua County and American Indian or Alaskan Native in Cattaraugus County have higher cancer mortality rates when compared to whites.[17]

Figure 4: Cancer Incidence Rates by Race/Ethnicity (per 100,000 population)



	Cattaraugua County	Chautauqua County	New York	US
White	158.1	165.9	148.8	157.5
Black		243.3	152.2	178.0
Asian/Pacific Islander			89.5	94.7
American Indian or Alaskan Native	174.5		31.5	100.1
Hispanic/Latino		147.9	102.2	108.2

Note: Empty cells indicated that data was not supplied/available or suppressed.

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

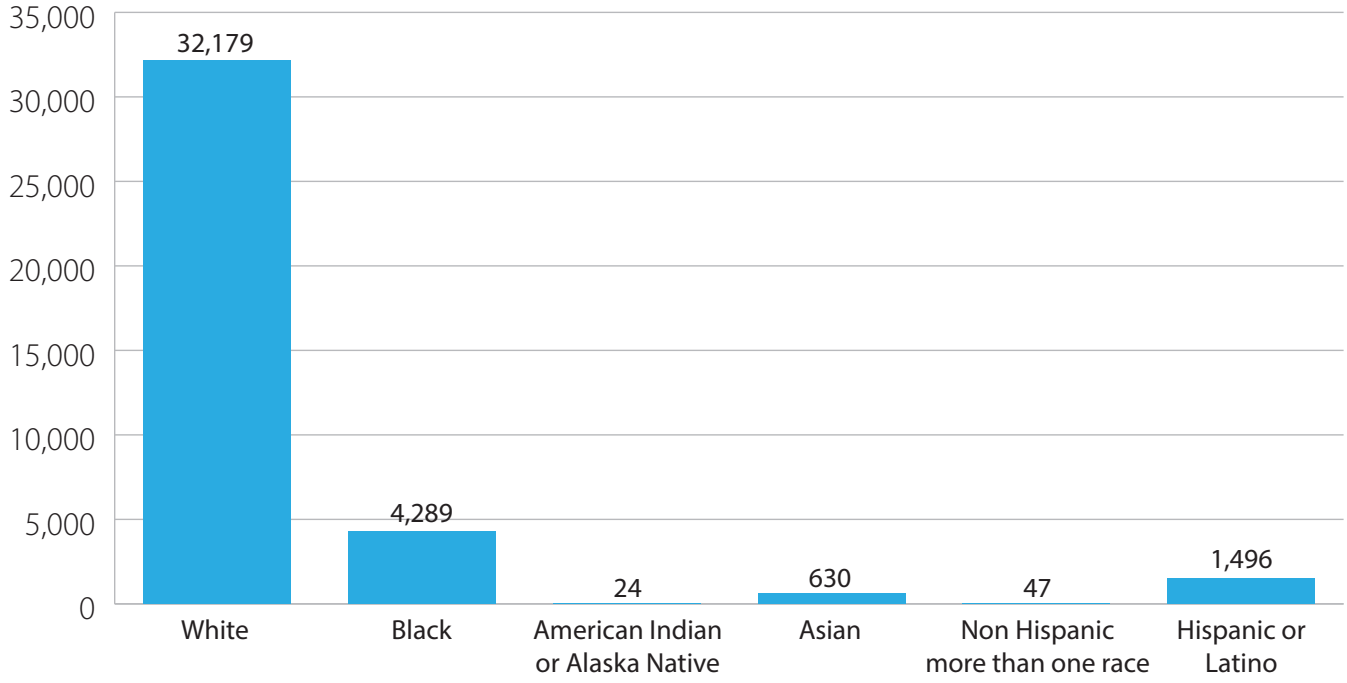
Improving health equity engages all community sectors and partners to promote health equity and sustainability through job creation and economic development, transportation access and mobility, access to foods and nutrition, physically active and safe neighborhoods, and improved educational status. Most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

Impact of COVID-19 on Health Equity

The effects of COVID-19 have been far-reaching and long-lasting. The Centers for Diseases Control and Prevention (CDC) reported that essential employees (those in health care, food services, and transportation) — were much more likely to die than other workers. Hispanics were nearly two times as likely to contract the disease as Whites. Blacks were hospitalized at three times the rate of Whites and American Indian/Alaska Natives have lost loved ones at more than double the rate of Whites.

Figure 5 shows the distribution of COVID-19 deaths is disproportionally higher among Blacks when compared to American Indian/Alaska Native, Asian, Non- Hispanic more than one race, and Hispanic or Latino. The graph reports the number of COVID-19 deaths for each race and Hispanic group.

Figure 5: Pennsylvania COVID-19 Death by Race and Hispanic Origin in 2020-2022
(updated as of January 2022)



Source: Centers for Diseases Control and Prevention 2020

Race and ethnicity are also markers for other underlying conditions that affect health, including socioeconomic status, access to health care, and exposure to the virus related to occupation. Health and social inequities placed individuals from different racial and ethnic minority groups at increased risk of death from COVID-19 (CDC).

There are multiple factors that continue to contribute to poor health outcomes social and health inequalities in marginalized communities. Unfortunately, the COVID-19 pandemic has further exacerbated existing inequalities with many people suffering from chronic illnesses and other conditions that increase their risk of severe illness. Underserved communities continue to feel the brunt and the lack of investment in addressing barriers to health and productive lives in marginalized communities leads to many other health and social consequences.

It has been reported that independent drivers of disease inequalities and a multi-sectorial approach are needed to reduce the impact of COVID-19 and other health issues among marginalized, disenfranchised, vulnerable, and underserved communities.

Figure 6: COVID-19 is a Health Equity Issue: Key Drivers of Disease Inequities

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

LIMITED ACCESS TO ESSENTIAL SERVICES AND RESOURCES
Barriers towards health insurance, childcare, sick leave, paid leave, or access to PPE, make some demographics more prone to COVID-19 inequities.

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

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

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

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

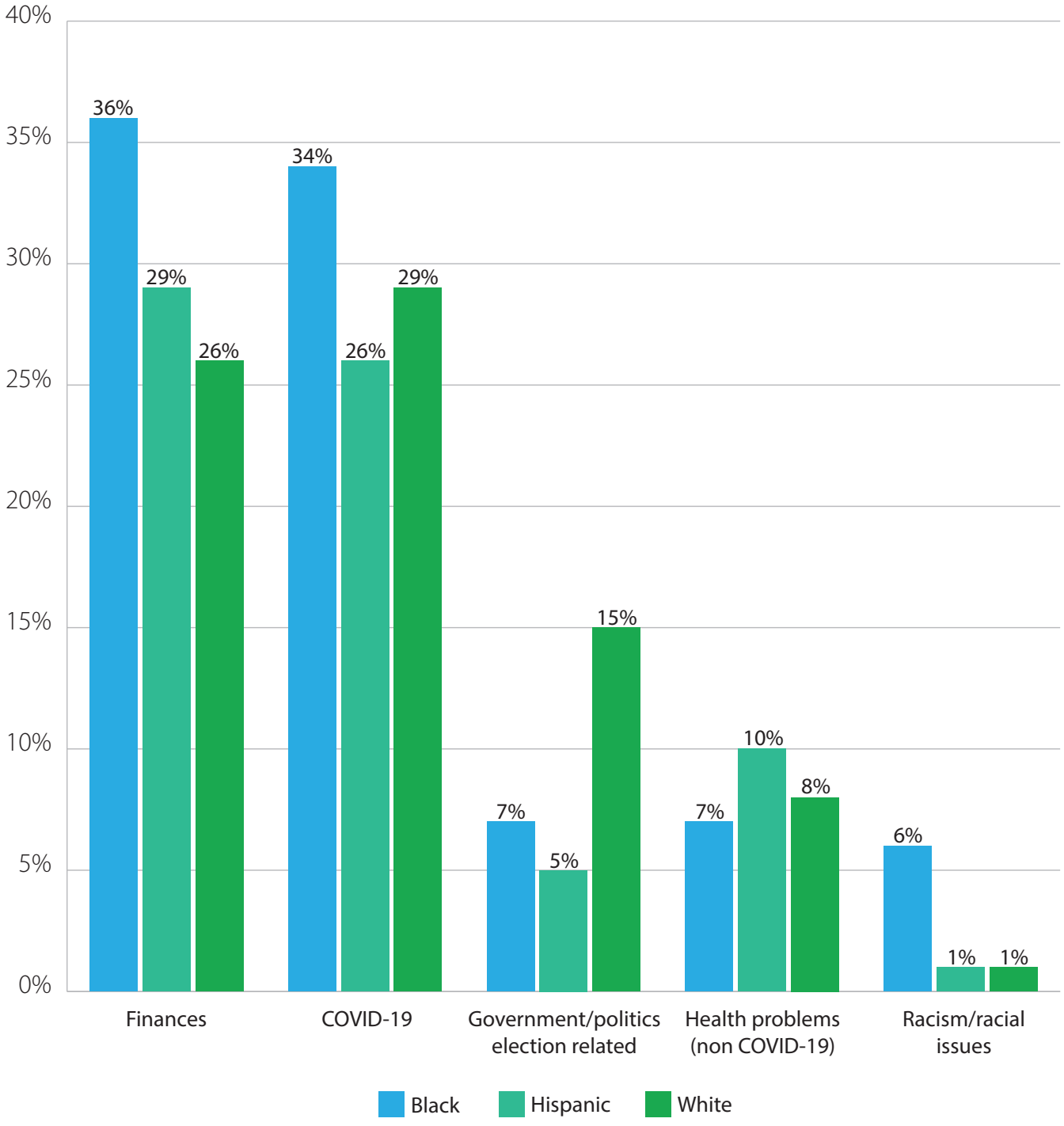
CHRONIC STRESS
Stress can impact physical health, inducing conditions such as heart disease or high blood pressure, which could lead to COVID-19 complications.

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

Source: The Health Equality Initiative 2020

Figure 7 depicts the largest concerns families face broken down by race. More than one-third of Black adults cite financial issues and a similar share (34%) cite concerns related to the COVID-19 pandemic. These are also the top two concerns mentioned by White and Hispanic adults, though Black adults are 10 percentage points more likely than White adults to name financial challenges among their top concerns (36% vs. 26%). Notably, six percent of Black adults cite issues related to racism as being among their top concerns.

Figure 7: Biggest Concerns Facing Individuals & Families 2020
(Open Ended)



Source: The Health Equality Initiative 2020

Conclusion

AHN Allegheny General 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 Allegheny General 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 Allegheny General aims to heighten overall community health status and to improve quality of life for the diverse communities they serve. The health system may provide a plethora of recognized physicians, best practice services, noteworthy programs and services but if residents lack transportation and insurance, access to care can be difficult. There is a direct correlation between the ease of accessing health care and the overall health of a community.

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

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

AHN Allegheny General 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 Allegheny General communities will be resolved.

Defined Community

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

The defined community (or primary service area, or PSA) of AHN Westfield encompasses 26 ZIP codes located in Chautauqua and Cattaraugus counties. Map 1 shows AHN Westfield's defined community.

Map 1: 2021 CHNA Study Area/Counties

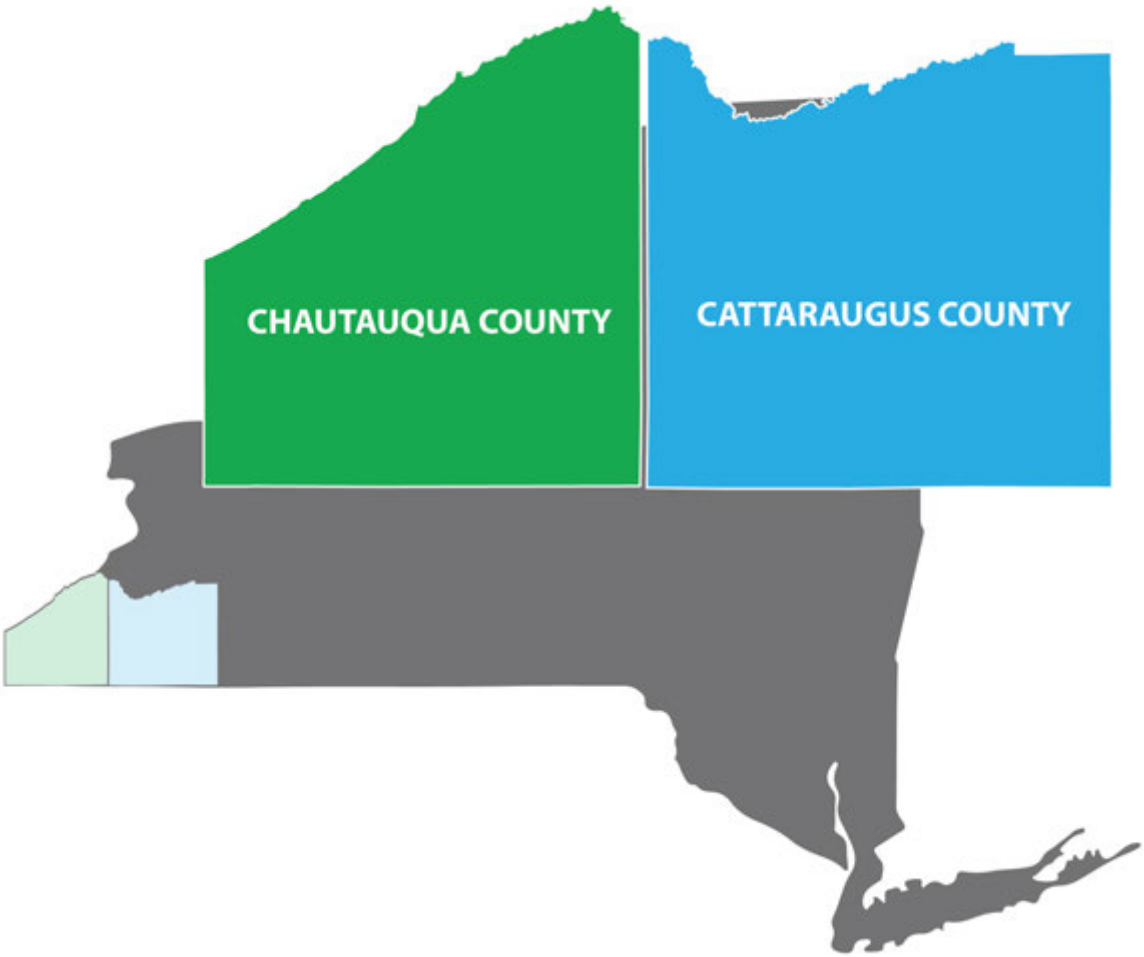


Table 3: Primary Service Area ZIP Codes

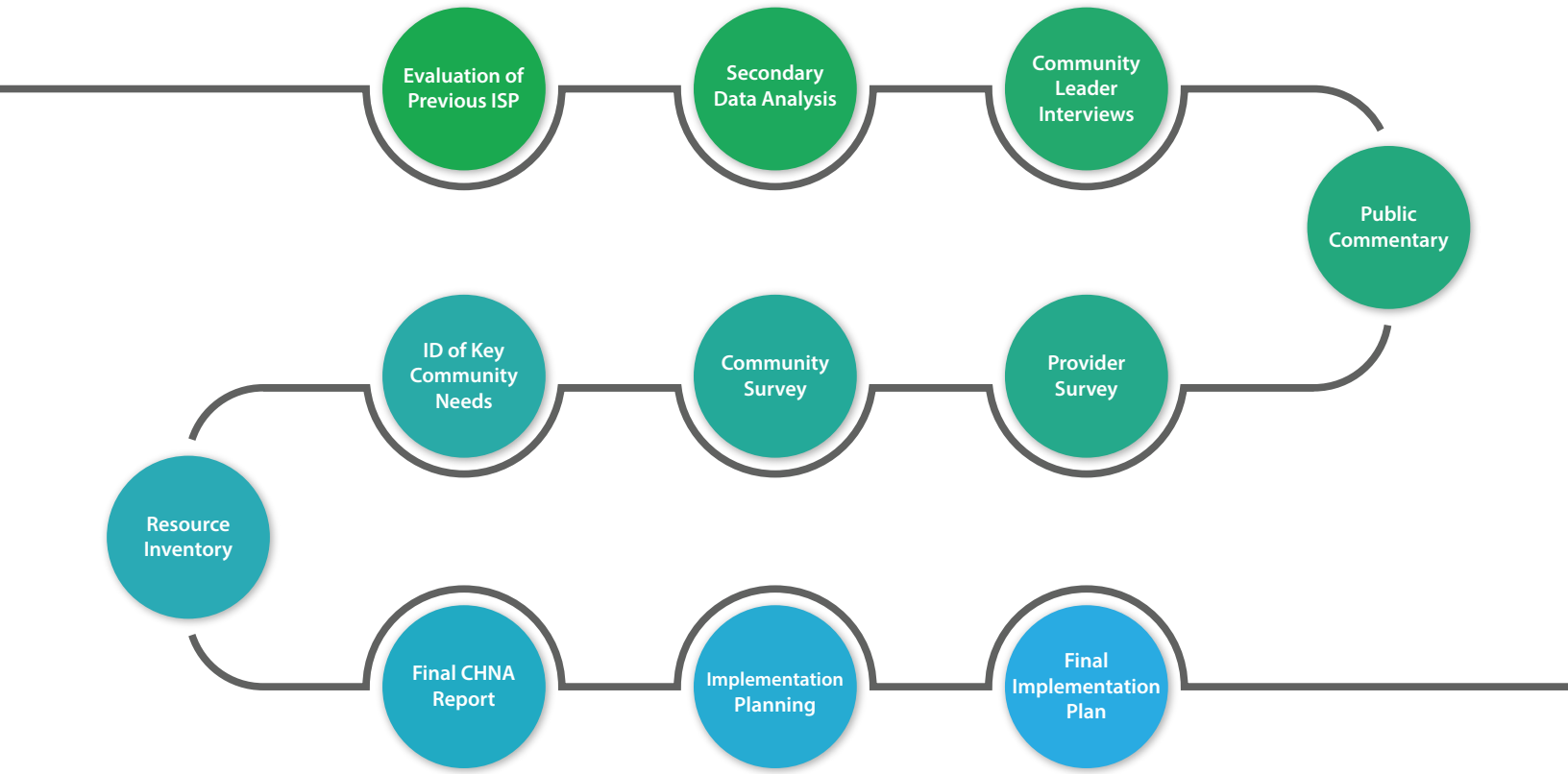
ZIPS	Town	County
14726	Dunkirk	Cattaraugus
14048	Dunkirk	Chautauqua
14063	Dunkirk	Chautauqua
14712	Bemus Point	Chautauqua
14718	Dunkirk	Chautauqua
14728	Westfield	Chautauqua
14738	Jamestown	Chautauqua
14740	Jamestown	Chautauqua
14769	Westfield	Chautauqua
14784	Stockton	Chautauqua
14736	Jamestown	Chautauqua
14750	Lakewood	Chautauqua
14787	Westfield	Chautauqua
14716	Brocton	Chautauqua
14733	Jamestown	Chautauqua
14724	Jamestown	Chautauqua
14775	Westfield	Chautauqua
14747	Jamestown	Chautauqua
14757	Westfield	Chautauqua
14782	Jamestown	Chautauqua
14710	Jamestown	Chautauqua
14767	Jamestown	Chautauqua
14062	Dunkirk	Chautauqua
14138	Dunkirk	Chautauqua
14701	Jamestown	Chautauqua
14702	Jamestown	Chautauqua

Methodology

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

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

Figure 8: Data Collection Roadmap

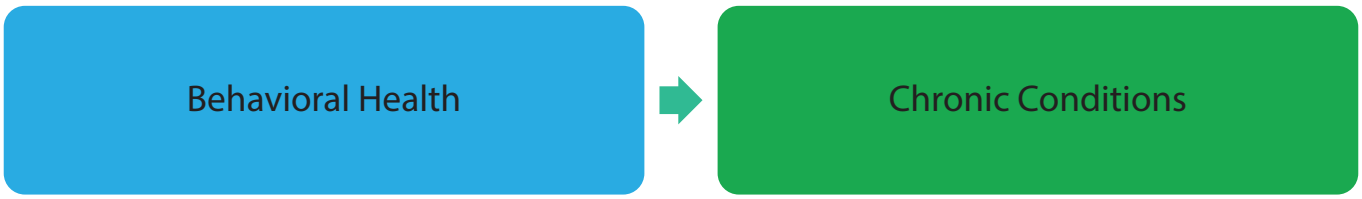


Community Health Needs Assessment Data Collection

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

Evaluation of 2018 Implementation Strategy Plan

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



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

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

It is important to note, due to the impact of COVID-19 and staffing changes, several programs, initiatives, and strategies were not pursued as priorities shifted from the 2019 implementation cycle. The implementation planning phase in 2022 will continue to identify and complete plans to address the needs of the community that were identified in the 2021 CHNA.

Health Priority: Chronic Conditions

Goal: To improve quality outcomes associated with diabetes.

Impact: Increased participation in children's camp; and Increased education for campers.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Promote diabetes prevention in the community.	Host screening and education events.			X	Number of community events – one, in 2021 Number of at-risk patients identified through biometric screenings - 138 Number of social media education topics posted.
	Identify at risk patients through biometric screenings.			X	138 patients identified
	Present at schools and community group on healthy living.			X	Completed in 2021
Partner with local children's diabetic camp.	Provide subject matter support to children at the camp.			X	Staff hours for planning and presenting at the camp - 75 Number of campers educated - 10
	Educate campers on diabetes management strategies.			X	We were able to impact several children in our 2021 camp. The 2020 camp had to be cancelled due to COVID-19

Goal: Increase the number of adults who receive age-appropriate screenings.

Impact: Increased number of lung screenings; and increased number of early lung cancer detections.

Strategies	Action Steps	2019	2020	2021	Metrics per year
Develop CT lung cancer screening program.	Implement Lung Cancer Screening protocols.			X	The start of a lung cancer screening program was started using our CT scanner in 2021
	Educate referring providers of service.			X	Education was provided to primary care providers with referrals to Saint Vincent as needed

Secondary Data Analysis

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

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

The secondary quantitative data collection process included:

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

Community Stakeholder Interviews

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

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

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

Community Stakeholder Interviews Common Themes

Community Problems

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

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

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

Community

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

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

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

Information

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

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

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

1. AHN Westfield Board
2. Erie County Executive
3. Erie County Health Department
4. Martin Luther King Center
5. Mayor of Erie
6. Mercy Center for Women
7. Saint Mary's Home of Erie
8. Second Harvest Food Bank of Northwest Pennsylvania
9. United Way
10. Westfield Area Central School Board
11. Westfield Memorial Hospital Foundation

Public Commentary

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

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

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

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

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

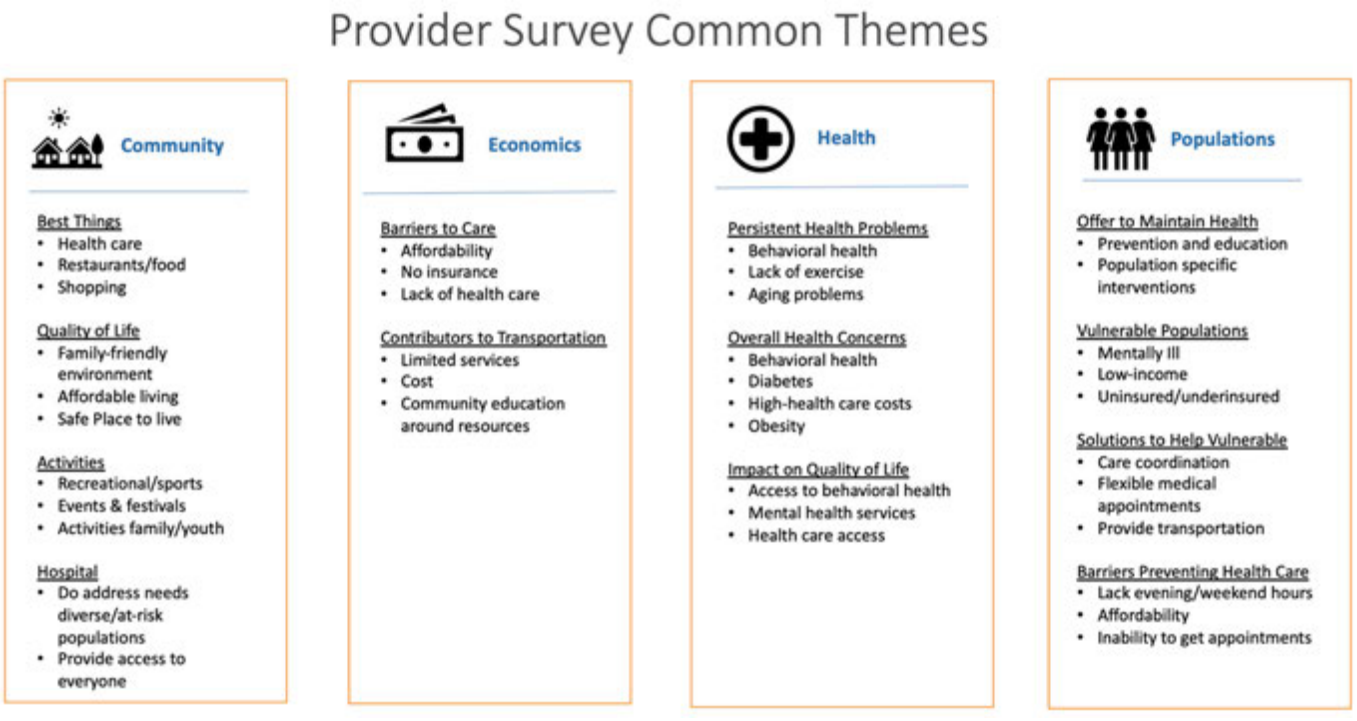
- Once CHNA/implementation plans are completed, bring back interviewees to review/discuss results.
- Allowing agencies like this to think outside the box and think like a client.
- Helping communities understand what it means and the overall impact.
- Focus on changing regional demographics. There is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

Provider Survey

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

A survey instrument was developed and used to obtain vital information through the lens of local providers. Collecting data through the provider survey will allow more appropriate care to populations most in need. The provider audience is also essential to gauge how patients and residents have adjusted their health needs during the COVID-19 pandemic and how providers assisted them.

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



Community Survey

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

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

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

Community Survey Common Themes

Community

Top 3 Health Problems in Community

English Speakers

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

Non-English Speakers

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

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

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

Community

Needed to Improve Quality of Life and Health

English Speakers

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

Non-English Speakers

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

Information

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

1. Physician offices

Health Screenings Needed to Stay Healthy

English Speakers

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

Non-English Speakers

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

Community Survey Common Themes

Information

Top 3 Behaviors People Need more Information About:

English Speakers

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

Non-English Speakers

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

Personal Health

Describe One's Overall Health

English Speakers

1. Excellent/very good – 35.2%

Non-English Speakers

1. Excellent/very good – 66.7%

Top 3 Health Personal Challenges

English Speakers

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

Non-English Speakers

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

Personal Health

Preventative Procedure in past 12 months:

English Speakers

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

Non-English Speakers

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

COVID-19

Received COVID-19 Vaccination

English Speakers

- Yes- 84.9%

Non-English Speakers

- Yes - 100.0%

Top 3 Areas Impacted by COVID-19

English Speakers

1. Social
2. Emotional
3. Quality of life

Non-English Speakers

1. Emotional
2. Fear of sickness
3. Social

Identification of Key Community Needs

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

Resource Inventory

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

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

Data Limitations

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

Steering Committee Members

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

Additional Information

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

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

Endnotes

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

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

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

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

[5] National Alliance on Mental Health: www.nami.org/mhstats

[6] Ibid.

[7] Centers for Diseases Control and Prevention: www.cdc.gov/reproductivehealth/features/maternal-depression/index.html

[8] Mayo Clinic: www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617

[9] Centers for Diseases Control and Prevention: www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

[10] Centers for Diseases Control and Prevention: www.cdc.gov/nchs/pressroom/states/newyork/newyork.htm

[11] New York Department of Health: www.health.ny.gov/diseases/conditions/diabetes/

[12] Centers for Disease Control and Prevention: www.cdc.gov/nchs/pressroom/states/newyork/newyork.htm

[13] Centers for Disease Control and Prevention. www.cdc.gov/heartdisease/facts.htm

[14] Centers for Disease Control and Prevention: www.cdc.gov/nchs/pressroom/states/newyork/newyork.htm

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

[16] National Vital Statistics: www.cdc.gov/nchs/nvss/index.htm

[17] National Vital Statistics: www.cdc.gov/nchs/nvss/index.htm

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