Allegheny Health Network — AHN Canonsburg Hospital

Community Health Needs Assessment

2024 Report

AHN CANONSBURG Hospital

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A Message From Our Presidents

A Healthier Future: Community Health Needs Assessment Results

Dear Valued Members of our Community,

Earlier this year, we embarked on a journey to understand the health needs of our community through the Community Health Needs Assessment (CHNA). This comprehensive process involved gathering valuable insight from thousands of residents, hundreds of health care providers, community organizations, and local leaders. This collective effort has provided us with a clear picture of the health priorities that matter most to our community.

The CHNA identified several key areas of focus, and AHN Canonsburg Hospital is committed to taking action. We are developing a strategic plan that will address the priorities, as summarized below:

- **Social Determinants of Health:** Many residents face challenges accessing affordable health care, particularly in underserved areas. In addition, community members are searching for family sustaining employment while the health care system is looking for qualified and dedicated team members.
- **Health Equity:** We believe that everyone in our community deserves access to quality health care and the opportunity to live a healthy life. We must ensure that all residents have equal access to quality, culturally appropriate health care, regardless of background, primary language or socioeconomic status.

This is not just a hospital initiative; it's a community-wide effort. We invite you to join us in building a healthier future for our community. Together, we can make a difference.

Sincerely,

Jim Benedict, JD, CPA, MAFIS, FACHE
President, Allegheny Health Network

Chong Park, MD, FACS
President, AHN Canonsburg Hospital

About This Report

Community Health Needs Assessment Overview

As a nonprofit organization, Allegheny Health Network (AHN) Canonsburg Hospital (AHN Canonsburg) is mandated by the Internal Revenue Service (IRS) to conduct a Community Health Needs Assessment (CHNA) every three years. The CHNA report from AHN Canonsburg complies with the guidelines set forth by the Affordable Care Act (ACA) and meets IRS requirements. This document comprehensively analyzes primary and secondary data, examining socioeconomic, public health, and demographic information at the local, state, and national levels. AHN Canonsburg Hospital proudly presents its 2024 CHNA report and findings to the community.

The community health needs assessment is vital for AHN Canonsburg as it provides a thorough understanding of the health needs and challenges faced by the local population. The hospital can identify key concerns and prioritize resource allocation effectively by systematically collecting and analyzing data on socioeconomic factors, public health trends, and demographic information. This process highlights critical health issues and reveals social and environmental barriers that affect health outcomes. For AHN Canonsburg, conducting a CHNA is essential for developing targeted strategies to enhance health services, improve patient care, and address the needs of underserved and vulnerable communities. By engaging stakeholders, including community-based organizations (CBOs) and public health experts, AHN Canonsburg fosters a collaborative approach to health improvement, promoting a healthier, more resilient community.

AHN Canonsburg's CHNA utilized a systematic method to identify and address the needs of underserved and marginalized communities within the hospital's service area. The CHNA report and the subsequent Implementation Strategy Planning (ISP) report outline strategies to improve health outcomes for those affected by diseases and social and environmental barriers.

The community needs assessment process involved significant engagement and input collection from community-based organizations, establishments, and institutions. The CHNA spanned multiple counties in Pennsylvania and New York and encompassed 261 ZIP codes. Managed and consulted by Tripp Umbach, the CHNA process incorporated insights from community representatives, particularly those with specialized knowledge of public health issues and data concerning underserved, hard-to-reach, and vulnerable populations.

AHN Canonsburg expresses gratitude to the region's stakeholders, community providers, and community-based organizations participating in this assessment and appreciates their valuable contributions throughout the CHNA process.

IRS Mandate

The CHNA report thoroughly analyzes primary and secondary data, exploring local, state, and national demographic, health, and socioeconomic factors. This report fulfills the requirements of Internal Revenue Code 501(r)(3), as stipulated by the Patient Protection and Affordable Care Act (PPACA), which mandates that nonprofit hospitals conduct CHNAs every three years. AHN Canonsburg's CHNA report aligns with the guidelines established by the Affordable Care Act and adheres to Internal Revenue Service (IRS) regulations, ensuring a comprehensive assessment of community health needs and guiding effective strategies to address them.

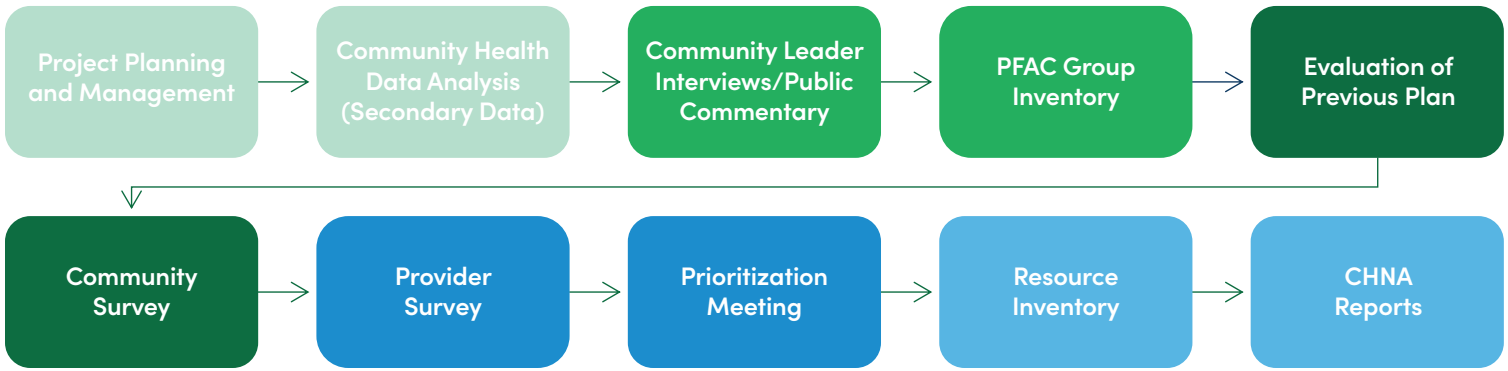
CHNA Methodology

AHN and AHN Canonsburg partnered with Tripp Umbach to carry out the 2024 CHNA for AHN Canonsburg. This assessment complies with IRS regulations for 501(c)(3) nonprofit hospitals and includes input from a range of stakeholders who reflect the varied needs of the communities served by AHN Canonsburg. To meet IRS requirements related to the ACA, the study methodology included qualitative and quantitative data methods to identify the needs of underserved and disenfranchised populations. While multiple steps made up the overall CHNA process, Tripp Umbach worked closely with members of the CHNA working group to collect, analyze, and identify the results to complete AHN Canonsburg Hospital's assessment.

CHNA Process

The CHNA roadmap was crafted to involve every segment of the community, including residents, community-based organizations, health and business leaders, educators, policymakers, and health care providers. Its purpose is to pinpoint health care needs and propose viable solutions to the identified health issues.

Figure 1: Roadmap for the Community Health Needs Assessment



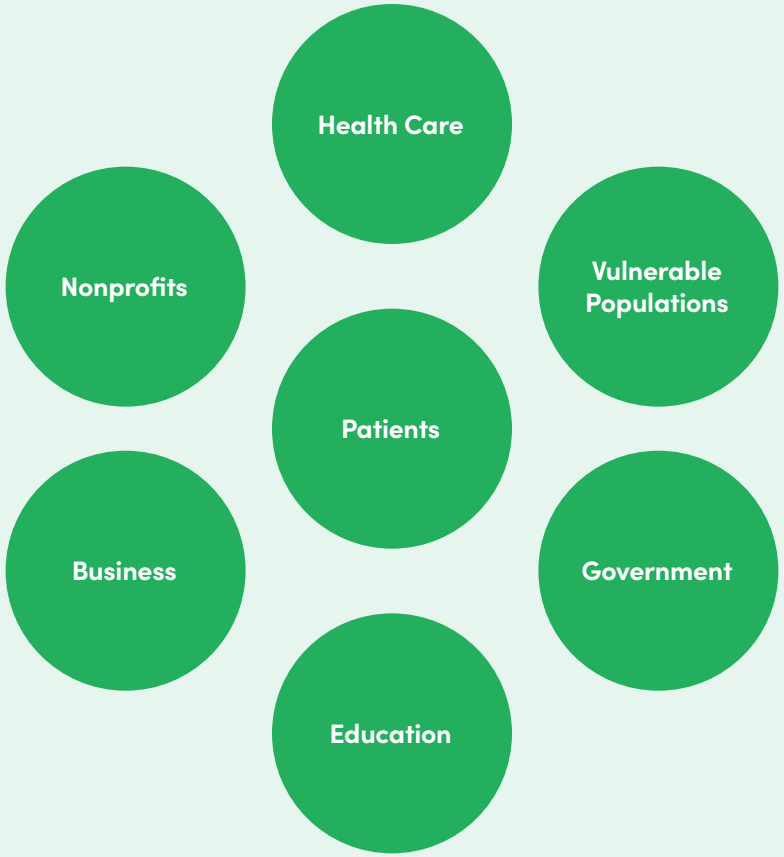
Community Engagement

The CHNA process commenced in April 2024, with the collection of quantitative and qualitative data concluding in October 2024. During this needs assessment, a diverse group of residents, educators, government and health care professionals, and leaders in health and human services from AHN Canonsburg's service area participated in the study. Feedback from these leaders offered valuable insights into community issues, factors related to health equity, and overall community needs. AHN Canonsburg gathered data through stakeholder interviews, group interviews, community surveys, and provider surveys to capture the community's perspectives.

County demographics and chronic disease prevalence data were obtained from local, state, and federal databases to compile secondary data. Surveys and interviews with stakeholders and providers were conducted to encourage participation from everyone living or working in the primary service area. The information collected helped identify needs, high-risk behaviors, barriers, social issues, and concerns affecting underserved and vulnerable populations.

Although the CHNA process consisted of multiple steps, Tripp Umbach collaborated closely with a working group and steering group to collect, analyze, and identify the findings necessary to complete the hospital's assessment.

Figure 2: Key Stakeholders



About Allegheny Health Network and AHN Canonsburg Hospital

Allegheny Health Network

Allegheny Health Network is a leading nonprofit health system based in Pittsburgh, Pennsylvania, dedicated to providing high-quality, comprehensive health care services to the communities it serves. AHN, part of the Highmark Health enterprise, operates 14 hospitals, employs over 22,000 people, and has more than 250 locations providing care. AHN is an integrated health system dedicated to providing exceptional care to people in the local communities. Serving 12 Pennsylvania counties and two counties in New York, AHN brings together the services of AHN Allegheny General Hospital, AHN Allegheny Valley Hospital, AHN Canonsburg, AHN Forbes Hospital, AHN Grove City, AHN Jefferson Hospital, AHN Saint Vincent Hospital, AHN West Penn Hospital, AHN Westfield Memorial Hospital, AHN Wexford Hospital, and AHN Neighborhood Hospitals (AHN Brentwood Neighborhood Hospital, AHN Harmar Neighborhood Hospital, AHN Hempfield Neighborhood Hospital, and AHN McCandless Neighborhood Hospital).

AHN provides exceptional quality care to the region. AHN employs diverse health care professionals, including physicians, nurses, allied health staff, and support personnel. Its staff includes over 3,000 physicians, residents, and fellows; 6,000 nurses; and 22,000 employees. The facilities have nine surgical centers, six regional cancer centers, and six health and wellness pavilions.

AHN encompasses a wide range of health care services, including acute care, outpatient services, rehabilitation, emergency care, and specialty programs. AHN is also recognized for its cutting-edge technology and research initiatives, focusing on advancing medical science and enhancing patient care.

Allegheny Health Network is a vital component of the health care landscape focused on delivering high-quality, patient-centered care. Through its extensive services, community engagement, and commitment to health equity, AHN strives to improve the health and well-being of the communities it serves. With a dedication to innovation and excellence, AHN continues to play a crucial role in shaping the future of health care in the region.

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

Vision Statement: A world where everyone embraces health.

Figure 3: Allegheny Health Network Primary Service Area (PSA)

- Allegheny County, PA
- Armstrong County, PA
- Beaver County, PA
- Butler County, PA
- Crawford County, PA
- Erie County, PA
- Lawrence County, PA
- Mercer County, PA
- Venango County, PA
- Warren County, PA
- Washington County, PA
- Westmoreland County, PA
- Cattaraugus County, NY
- Chautauqua County, NY

AHN Canonsburg Hospital

AHN Canonsburg is a community hospital with 104 beds, 25 miles southwest of Pittsburgh in Strabane Township. Established in 1904, it primarily serves residents from Washington counties. The hospital employs over 400 local community members and boasts a medical staff of 592 physicians.[2]

With a steadfast commitment to delivering high-quality medical care, the physicians and staff at AHN Canonsburg prioritize the well-being of their patients and families. For over a century, AHN Canonsburg has earned the community's trust by consistently providing exceptional patient care.

As part of the Allegheny Health Network, AHN Canonsburg connects patients with top medical experts and the latest technology right in their neighborhood. The hospital is recognized as a leading provider of comprehensive medical services, offering exceptional health care in a friendly and intimate environment.

AHN Canonsburg caters to a wide array of health needs, from a specialized sleep lab to surgical care for heart conditions. It utilizes advanced diagnostic and treatment technologies to ensure patients achieve their best health. Residents can access diverse medical specialties at AHN Canonsburg, including critical care, emergency medicine, general surgery, neurology, rehabilitation, and more.

[2] Allegheny Health Network

Defined Community

In the context of a CHNA, the "defined community" refers to the specific population or geographic area that the assessment targets. This community can be identified based on geographic boundaries (such as counties, cities, or neighborhoods), demographic factors (age, race, or socioeconomic status), or the population served by a health care provider or organization. Accurately defining the community is crucial for assessing health needs effectively, as it ensures that the collected and analyzed data accurately reflects that particular population's unique characteristics and health challenges.

By concentrating on a well-defined community, the CHNA delivers detailed and actionable insights, aiding in the creation of targeted health interventions, policies, and programs tailored to the residents' needs. This approach ensures that health resources are allocated efficiently and that efforts to improve health outcomes are focused where they are most needed, ultimately enhancing the overall well-being of the community.

For AHN Canonsburg, the defined community is the geographic area from which a substantial number of patients accessing hospital services come. Although the CHNA considers other health care providers, AHN Canonsburg is the primary provider of acute care services in the region. Therefore, using hospital service data offers the most accurate representation of the community.

In 2024, 10 ZIP codes were identified as the primary service area for AHN Canonsburg. The following table highlights the study area focus for AHN Canonsburg Hospital's 2024 CHNA.

Figure 4: 2024 AHN Canonsburg's Primary Service Area

ZIP Code	Town	County
15019	Bulger	Washington
15317	Canonsburg	Washington
15342	Houston	Washington
15057	McDonald	Washington
15330	Eighty-Four	Washington
15367	Venetia	Washington
15055	Lawrence	Washington
15363	Strabane	Washington
15321	Cecil	Washington
15060	Midway	Washington

AHN Canonsburg Hospital Awards and Recognitions

First in western Pennsylvania to achieve Pathway to Excellence® designation from the American Nurses Credentialing Center. This designation recognizes health care organizations for their commitment to creating a healthy and positive work environment that empowers nurses.

Get With The Guidelines® - Heart Failure GOLD PLUS with Target: Heart Failure Honor Roll for providing quality care to heart failure patients.

Blue Distinction Center+ designation for efficiency in delivering high-quality care and better overall outcomes for knee and hip replacement.

Shortest average emergency room wait times in the South Hills according to Hospital Compare.

Blue Distinction® Center+ designation for efficiency in delivering high-quality care and better overall outcomes for knee and hip replacement.

Get with the Guidelines® — Heart Failure GOLD PLUS with Target: Heart Failure Honor Roll.

The Hospital and Healthsystem Association of Pennsylvania Donate Life Hospital Challenge Titanium Award, 2022

Primary Data Analysis

Community Stakeholder Interviews

Community stakeholder interviews are essential in a CHNA as they provide valuable insights into the local population's unique challenges, priorities, and strengths. These interviews capture the perspectives of key leaders and service providers who have firsthand knowledge of health disparities, barriers to care, and available resources. Engaging stakeholders fosters collaboration, builds trust, and ensures the assessment reflects the community's needs and priorities. Their input informs the development of targeted strategies and promotes more effective and sustainable solutions, leading to improved health outcomes and stronger community partnerships.

For the CHNA, telephone interviews were conducted with community stakeholders in the service area to gain a deeper understanding of the changing environment. These conversations provided an opportunity for community leaders to offer feedback on local needs, recommend secondary data sources for review, and share other relevant insights for the study. The interviews with stakeholders took place from July to September 2024 and involved individuals from the below organizations.

1. AHN Cancer Institute
2. Allegheny County Health Department
3. Allegheny Family Network
4. Allen Place Community Services, Inc.
5. Alliance for Nonprofit Resources, Inc.
6. Canonsburg Borough
7. Chautauqua Health Department
8. City Mission, Hope for the Homeless
9. Community Health Clinic Inc. – Greensburg
10. Erie County Health Department
11. Grove City Area United Way
12. Grove City Chamber of Commerce
13. Grove City Police Department
14. Grove City School District
15. Jeannette City Schools
16. Jefferson Regional Foundation
17. Life Options Pittsburgh
18. Municipality of Monroeville
19. Neighborhood Resilience Project
20. North Side/Shore Chamber
21. Sheep Health Care Center
22. The Monroeville Foundation
23. Westfield Memorial Hospital Board
24. Westfield Memorial Hospital Foundation
25. Westmoreland Chamber of Commerce
26. Westmoreland Transit

As part of the assessment, 30 interviews were conducted with community leaders and stakeholders.[3] The qualitative data collected from these interviews captured the opinions, perceptions, and insights of the CHNA participants, offering valuable perspectives that enriched the qualitative analysis. Through these discussions, key health needs, themes, and concerns were identified. Each broad theme included several specific issues. Below are the primary themes highlighted by community stakeholders as the most significant health concerns in their area.

1. Affordability
2. Behavioral health (mental health and substance abuse)
3. Transportation issues
4. Health literacy
5. Insurance coverage/issues
6. Health care coordination (lack of health care coordination services)
7. Chronic conditions/diseases (heart disease, diabetes, cancers, etc.)
8. Affordable housing
9. Lifestyle and health habits (unhealthy eating habits and inadequate physical activity)
10. Aging problems

Figure 5: Community Stakeholder Summary Analysis

Community Stakeholder Summary Analysis: Community Residents				
Significant Health Problems (Top 5)	**Risky Behaviors (Top 5)**	**Health Factors Contributing to Healthy Community (Top 3)**	**Social Factors Contributing to Healthy Community (Top 3)**	**Factors that Improve Quality of Life in the Community (Top 5)**
1. Overweight/Obesity/ Diabetes 2. Heart disease/stroke/ high blood pressure 3. Behavioral Health 4. Substance use disorder/ addiction 5. Aging problems	1. Substance use/drug/ alcohol/smoking/ tobacco 2. Lack of exercise/physical activity 3. Poor eating habits 4. Unsafe driving 5. Unmanaged stress or anxiety	1. Access to preventive screenings and vaccinations 2. Access to affordable prescription and OTC medication 3. Access to affordable healthy food options	1. Overall feeling of safety/ security 2. Safe places to walk/play 3. Affordable, safe, quality housing/utilities	1. Safe places to walk/ play and accessible, affordable community activities 2. Access to affordable prescription and OTC medication 3. Access to affordable healthy food options 4. Affordable, quality child and/or senior care options 5. Access to mental health resources

[3] It is important to note that while 26 organizations are listed, multiple individuals were interviewed representing the same organization.

Public Commentary

As part of the CHNA, Tripp Umbach gathered feedback on the 2021 CHNA and Implementation Strategy Plan on behalf of AHN Canonsburg Hospital. Input was requested from community stakeholders identified by the working group. This process allowed community representatives to respond to the methods, findings, and actions taken as a result of the 2021 CHNA and ISP. Stakeholders addressed questions developed by Tripp Umbach. The public comments below summarize the feedback provided by stakeholders regarding the previous documents. The study's data collection took place from July to September 2024.

In the assessment, 54.5% of respondents confirmed that input from community members or organizations was included. Additionally, 33.3% indicated that the report did not exclude relevant community members or organizations. When asked about unrepresented health needs in the community, 42.8% stated no such needs.

Respondents identified several benefits of the CHNA and ISP for their community. They highlighted improved care quality, which enhances patient outcomes and reduces provider biases, as a significant advantage. There was also an expanded understanding of social determinants of health and behavioral health services. Data provided by the CHNA supported funding and planning efforts, though some felt the initiatives did not achieve their intended impact. Participants noted consistent perceptions of health care needs across organizations and appreciated engagement in community meetings and support for events through AHN. While new initiatives, such as a café and a more diverse staff, were introduced, respondents emphasized the need for increased collaboration and follow-through, particularly regarding pediatric and mental health services. Additionally, there were concerns about the lack of implementation of proposed initiatives. Overall, respondents recognized the CHNA as a valuable tool for hospitals to better understand the root causes of health issues and to serve as a useful framework for future planning.

Group Interviews

Group interviews were conducted to gather diverse perspectives and foster collaborative dialogue among key stakeholders. This approach encourages participants to share insights, identify common challenges, and explore potential solutions in a collective setting.

The group interviews allowed more stakeholders to actively participate in the CHNA by creating a collaborative environment where multiple voices could be heard simultaneously. This format encouraged open dialogue, allowing participants to share their experiences, insights, and concerns freely. It also allowed individuals who might not have engaged in one-on-one interviews to contribute their perspectives, fostering inclusivity. This collective input enriched the CHNA, ensuring a more well-rounded and representative understanding of the community's health priorities.

Qualitative data was collected from two group interviews representing the Patient Family Advisory Council (PFAC) at AHN. The group interviews had seven participants. Feedback from the PFAC interviews provided information through the lens of representatives who provide services and directly interact with community residents.

PFAC Group 1

The PFAC group identified the following as the most significant barriers and issues for people not receiving care:

- Continuity of care, especially for older people with multiple providers and little coordination. This led in part to the opioid crisis.
- Obtaining appointments promptly — need more providers.
- Management of chronic illnesses such as diabetes and hypertension must be improved.
- Reimbursement and insurance issues, including cost of care and copay.
- Domestic violence with an increase in elder abuse.
- Food insecurity in children and elderly population.
- Transportation is a significant barrier, especially in rural communities, leading to less preventive care access.
- Need for an integrated technology system that brings all providers and care — not just medical — to coordinate care and health maintenance.
- Housing insecurity, transportation, and food insecurity.
- They ask SDOH questions upon intake but don't follow up. It feels more like a "check the box" with no intention of doing anything. There are not enough community health and social workers to follow up.
- Behavioral health services that integrate with medical and wellness services are needed; the systems are separate and not coordinated.
- Staffing issues and lack of workforce have resulted in experienced providers who provide poor care.
- The staffing of health care workers who provide care navigation and health coordination must be increased.
- Must take services to where people are and expand public health models that work to provide services much earlier.
- More church food banks where education and screenings are provided where folks are picking up food.
- Mobile vans that bring care into the community regularly.
- The economic design of health care must change from the old model of investing billions in health care facilities and expensive equipment to using the money for prevention and wellness.
- It sends a mixed message in the community that hospitals invest billions in facilities for sick care when the community needs population health investment.

- Health fairs, health literacy classes, and care coordination with patient engagement through technology are more often controlled by the patients

PFAC Group 2

The PFAC group identified the following as the most significant barriers and issues for people not receiving care:

- Lack of clear communication with patients.
- Health literacy and issues with patients using technology.
- Poor navigation between insurance and care delivery throughout the entire health care system.
- Not enough specialists cause impossibly long wait times that impact care and health.
- Long wait times for care and even to talk with someone to help patients know what to do.
- Impossible to navigate the system.
- Solutions for staying healthy include focusing the health care system on chronic conditions, especially with older patients.
- Better health care coordination is essential.
- Education on treatments, medication, how to pay, and how to work with insurance companies.
- Health improvement and maintenance are overlooked in a sick care-focused system, and they must become a priority, as in other countries.
- There is a need for patient health coordinators who prioritize preventative care, but there is a power struggle between what is suitable for patients and what is best for the health care system's bottom line.
- The health care system must move from passiveness to a proactive health-first organization that fights for patients' health, not their dollars.
- The system must be accountable and look at inefficiencies and waste, like building new buildings.
- There is a need to advocate for better public policy that promotes collaboration among health care systems and does not promote competition.
- Focusing on telehealth can be a beneficial, cost-effective model of care, but the government and payers need to support this financially.
- The ability for patients to finally see their medical reports represents a massive change for good. The patient must drive the entire system, not the provider or insurance company.

Community Survey

A community survey was conducted to collect data from residents within AHN's service area and the broader region. The survey highlighted specific health needs and concerns, including those of vulnerable populations that may not be apparent through other methods. By obtaining detailed input from community members and stakeholders, organizations can make more informed decisions on resource allocation and develop targeted interventions. Ultimately, the community survey ensures that health and social initiatives align with the community's needs, leading to more effective and efficient health care delivery.

Working with the CHNA working group, a quality-of-life survey instrument was created and distributed to patients and community residents using AHN services.

The community survey was active from July to September 2024, and 3,437 surveys were collected and used for analysis. Below are the top "health problems" AHN Canonsburg Hospital residents reported in their community, descending from the most to the least identified.

1. Overweight/obesity/diabetes
2. Heart disease, stroke, high blood pressure
3. Behavioral health (anxiety, depression, post-traumatic stress disorder, suicide, etc.)
4. Substance use disorder/addiction
5. Aging problems (hearing or vision loss, memory loss)

Below are the top "risky behaviors" AHN Canonsburg Hospital residents reported in their community, descending from the most to the least identified.

1. Substance use/drug/alcohol/smoking/tobacco
2. Lack of exercise/physical activity
3. Poor eating habits
4. Unsafe driving
5. Unmanaged stress or anxiety

Figure 6: Community Survey Summary Analysis

Community Stakeholder Summary Analysis: Community Residents				
Significant Health Problems (Top 5)	**Risky Behaviors (Top 5)**	**Health Factors Contributing to Healthy Community (Top 3)**	**Social Factors Contributing to Healthy Community (Top 3)**	**Factors that Improve Quality of Life in the Community (Top 5)**
1. Overweight/Obesity/ Diabetes 2. Behavioral Health 3. Cancer 4. Heart disease/stroke/ high blood pressure 5. Substance use disorder/ addiction	1. Substance use/drug/ alcohol/smoking/tobacco 2. Lack of exercise/physical activity 3. Poor eating habits 4. Unsafe driving 5. Unmanaged stress or anxiety	1. Access to preventive screenings and vaccinations 2. Access to affordable prescription and OTC medication 3. Access to affordable healthy food options	1. Safe places to walk/play 2. Affordable, safe, quality housing/utilities 3. Overall feeling of safety/security	1. Access to affordable healthy food options 2. Affordable, safe, quality housing/utilities 3. Access to mental health resources 4. Safe places to walk/ play and accessible, affordable community activities 5. Access to affordable prescription and OTC medication

Provider Survey

A provider survey was employed to capture health care professionals' unique insights and experiences interacting directly with the community. Providers offer perspectives on emerging health trends, service gaps, barriers to care, and population health challenges. Their input helps identify both unmet needs and existing resources, guiding the development of targeted strategies to improve health outcomes. Additionally, provider surveys enhance the credibility of the CHNA by incorporating expert opinions, ensuring that recommendations align with the realities of health care delivery and the population's specific needs.

The provider survey was conducted from September 4 through September 15, 2024, during which time 232 surveys were collected for analysis. The responses below summarize the key results from the survey.

Figure 7: Provider Survey Summary Analysis

Provider Survey Summary Analysis			
Community	**Economics**	**Health**	**Population**
Most Important Health Factors (Top 3) 1. Access to affordable prescription and OTC medication 2. Access to mental health resources 3. Access to healthy food options **Most Important Social Factors (Top 3)** 1. Affordable, safe, quality housing 2. Adequate employment 3. Overall feeling of safety and security **AHN Hospitals** 1. Address the needs of diverse and at-risk populations 2. Ensure access to care for everyone, regardless of race, gender, education, and economic status	**Barriers to Care (Top 5)** 1. Affordability 2. Availability of services 3. No insurance coverage 4. Lack of transportation 5. Lack of health care coordination services **What is needed to improve quality of life and health** 1. Access to affordable prescription and OTC medication 2. Access to mental health resources 3. Access to affordable healthy food options 4. Affordable, safe, quality housing 5. Affordable, quality child and/or senior care options	**Most Significant Health Problems** 1. Behavioral Health 2. Overweight/obesity/diabetes 3. Substance use disorder/addiction (tie) 4. Heart disease/stroke/high blood pressure (tie) **Overall health concerns** 1. Behavioral Health 2. Overweight/obesity/diabetes 3. Substance use disorder/addiction 4. Heart disease/stroke/high blood pressure 5. Cancer	**Vulnerable Populations** 1. Seniors 2. Mentally ill 3. Low-income **Top solution to health vulnerable populations meet health needs:** 1. Community outreach services

Evaluation of Previous Community Health Needs Assessment and Implementation Strategy Plan

Over the past three years, representatives from AHN Canonsburg have focused on developing and implementing strategies to address the health needs and concerns in the study area. Additionally, AHN Canonsburg has evaluated the effectiveness of these strategies in meeting its goals and tackling health challenges within the community. This review of the previous implementation strategy aimed to assess how well the methods and approaches from the prior ISP were executed. The working group reviewed each goal, objective, and strategy to identify ways to enhance their effectiveness. Internal self-assessments were used to track progress and refine each strategy and action step over the next three years. AHN Canonsburg has addressed the following strategies.

Social Determinants of Health

Health Priority: Transportation

Goal: Improve transportation services for the community.

Figure 8: SDOH Transportation Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022 – June 30, 2024
To demonstrate the importance of our transportation services for community members to and from the hospital (Medi-Van)	• Partner with the Medi-Van team for data collection	X	X	X	• Number of patients using the Medi-Van per month • Types of patients using the Medi-Van per month	• Completed 2,658 Medi-Van trips during 2023

Health Priority: Access to Care

Goal: Improve access to primary care physicians (PCPs).

Figure 9: SDOH Access to Care Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022-June 30, 2024
Enhance PCP availability	• Expand PCP office hours to include weekends. • Move hospital-based PCPs back to office base only. • Utilize CRNPs	X	X	X	• Number of Office visits with PCP • Number of certified registered Nurse Practitioner (CRNP) visits	• Conducted 89,970 Office Visits with PCP • Served 9,812 +Tele Visits

Behavioral Health

Health Priority: Substance Use Disorder

Goal: Strengthen ED patient access to drug and alcohol resources.

Figure 10: Behavioral Health, Substance Use Disorder Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022-June 30, 2024
Strengthen access to drugs and alcohol to ED patients	• Provide access from the ED to appropriate inpatient or outpatient treatment programs. • Collaborate with Washington Drug & Alcohol Center (WDAC) to have drug and alcohol counselors available to the ED or offsite.	X	X	X	• Number of patients seen on-site • Number of patients referred offsite • Number of Narcan kits issued • Number of return overdose patients in the ED • Number of return patients showing symptoms of drug use in the ED • The number referred to WDAC	• Served 203 BH patients on site • Referred 64 patients off-site to appropriate BH care • 109 Overdose patients returned to the ED • Three Narcan kits issued • 37 Return patients showing symptoms of drug use in the ED

Chronic Disease

Health Priority: Diabetes

Goal: Increase access to diabetes education and resources.

Figure 11: Chronic Disease, Diabetes Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022-June 30, 2024
Provide education on-site and in the community on the health risks of diabetes	• Partner with the community to provide diabetes education classes. • Conduct Health Fairs	X	X	X	• The number of education classes provided • The number of health fairs • Number of communities and patients reached	• Held 48 Diabetes Education sessions • Held one (Trunk & Treat) Event • AHA Goes Red Health Fair
Reduce the number of hypoglycemic episodes due to the use of older diabetes medications	• Screen home medications list to identify patients for use of first-generation (older) anti-diabetic medications. • Conduct interviews with eligible patients regarding hypoglycemic episodes. • When appropriate, convert diabetic medications that have a lower potential for hypoglycemia.	X	X	X	• Number of diabetes patients screened and interviewed • Number of patients interviewed regarding hypoglycemic episodes • Number of patients educated on medication	• Served and educated 524 diabetes patients regarding their medication • Served and educated 317 hypoglycemic patients on their medication

Health Priority: Heart Disease

Goal: Increase access to heart disease education and resources.

Figure 12: Chronic Disease, Heart Disease Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022-June 30, 2024
Provide education on-site and in the community on the health risks of heart disease	• Partner with the community to provide heart disease education classes • Conduct health fairs	X	X	X	• Number of education classes provided • Number of attendees • The number of health fairs.	• Provided education on heart disease and risks to 8,973 patients • Hosted one Trunk & Treat community event • Participated in the AHA Go Red Health Fair

Health Equity

Health Priority: Diversity, Equity, and Inclusion

Goal: To increase health needs/services/resources to minority community members.

Figure 13: Health Equity Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022-June 30, 2024
In support of the AHN DEI initiative, want to determine the health needs of our local minority community members	• Work closely with a local community church to help determine the health needs. • Conduct assessments to identify SDOH needs • Prioritize health needs • Connect with community resources to address needs.	X	X	X	• Number of needs/ types of needs identified • Number of people to connect with resources • The number of community partners served • Number of referrals and connections to community agencies and resources	• Hosted expansive health fair and outreach to 100+ diverse attendees in collaboration with local churches; featured over 25 vendors, preventive screenings and health education. • Conducted DEI needs survey and continuing to build partnership with local ministerium. • Held a Diversity Fair for the staff and visitors. The local Latino group and AHN DEI were represented — around 100 participants.

Secondary Data Analysis

A robust secondary data compilation provided a comprehensive and objective foundation for understanding the community's health status. The data included credible information such as public health records, census data, and behavioral health information, which offer insights into trends such as chronic disease prevalence, mortality rates, and social determinants of health. Utilizing secondary data complements findings from the primary data (e.g., interviews and surveys) and allows for comparisons with regional, state, or national benchmarks.

Information was gathered to create a regional community health profile based on the location and service areas of AHN Canonsburg. The main data source was Community Commons, a publicly available dashboard aggregating health indicators from national data sources. This enabled the analysis of historical trends and changes in demographics, health, social, and economic factors. Additional data sources included County Health Rankings and the U.S. Census Bureau. The data is also peer-reviewed and validated, ensuring high credibility. This data compilation identifies key health priorities, informs evidence-based decision-making, and ensures the CHNA reflects a broader, data-driven understanding of the community's needs.

The comprehensive community profile generated a deeper understanding of regional issues, particularly in identifying regional and local health and socioeconomic challenges. The secondary quantitative data collection process included the following:

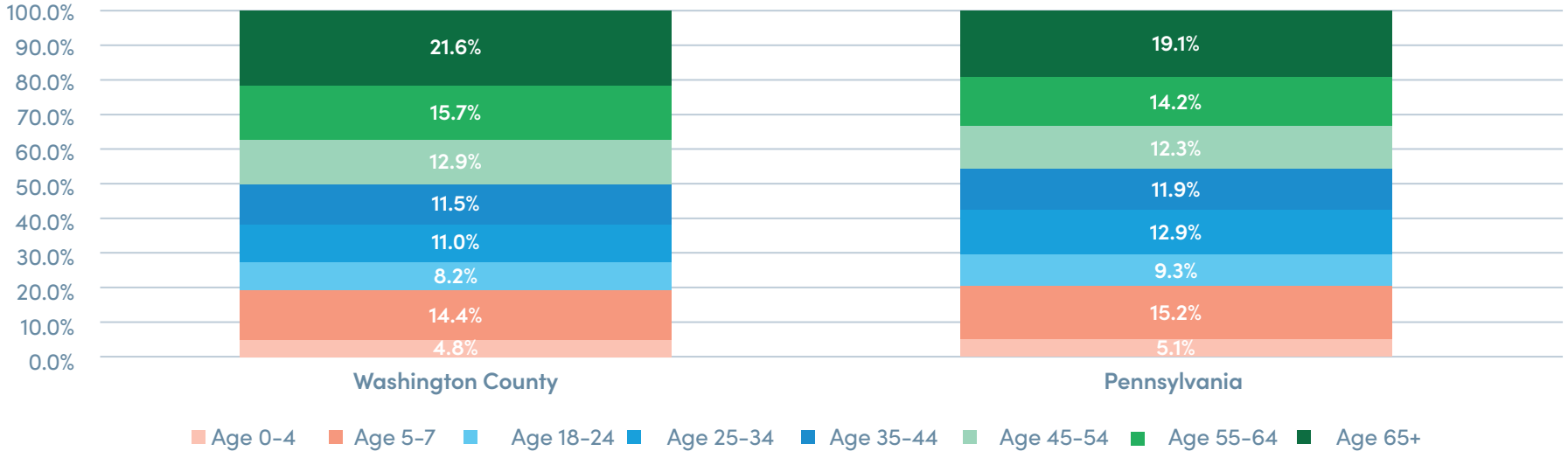
1. America's Health Rankings
2. Centers for Disease Control and Prevention (CDC)
3. Centers for Medicare and Medicaid Services
4. Community Commons Data
5. County Health Rankings
6. Dartmouth College Institute for Health Policy & Clinical Practice
7. Federal Bureau of Investigation
8. Feeding America
9. Kids Count Data Center
10. National Center for Education Statistics
11. Pennsylvania Department of Health
12. U.S. Department of Agriculture
13. U.S. Census Bureau
14. U.S. Department of Health & Human Services
15. U.S. Department of Housing and Urban Development
16. U.S. Department of Labor

AHN Canonsburg Community at a Glance

Figure 14: Population

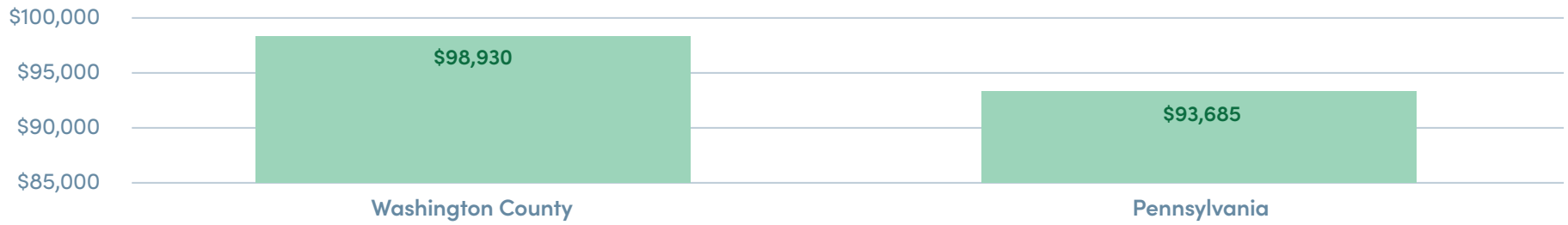
	Total Population	Males	Females
Washington County	209,631	103,708	105,923
Pennsylvania	12,989,208	6,410,766	6,578,442

Figure 15: Age Distribution



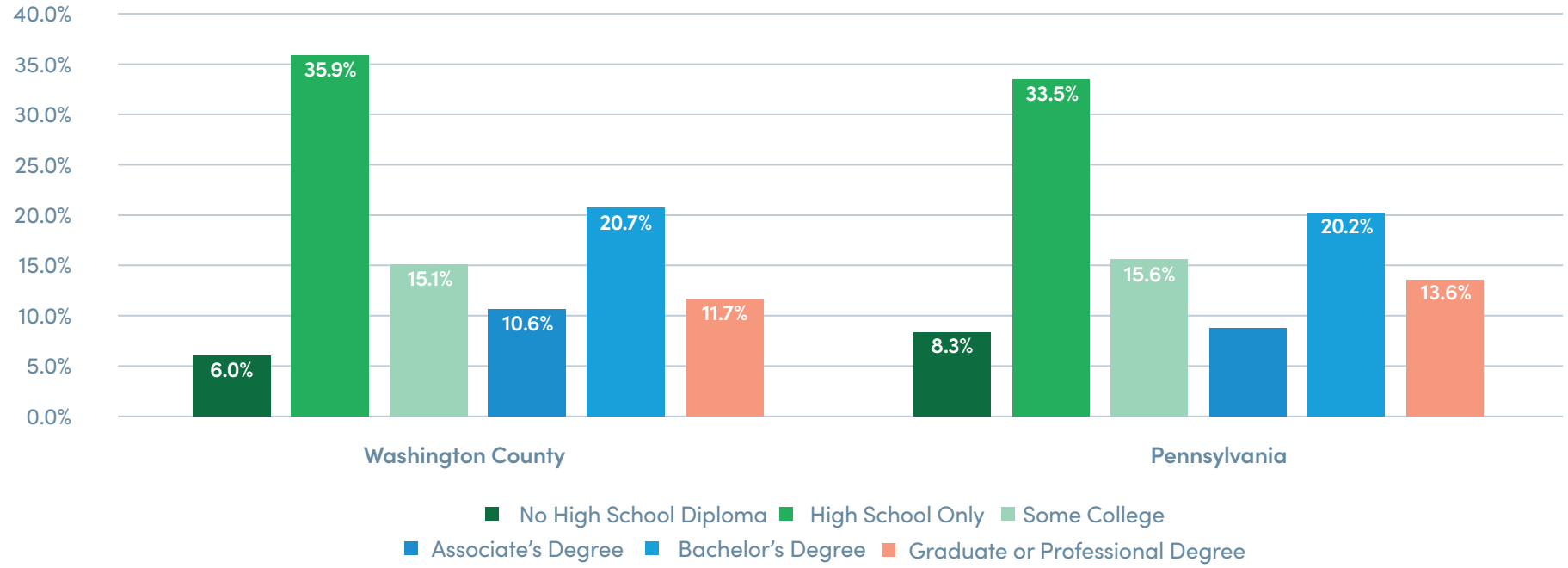
Source: Census Bureau, American Community Survey 2020

Figure 16: Median Household Income



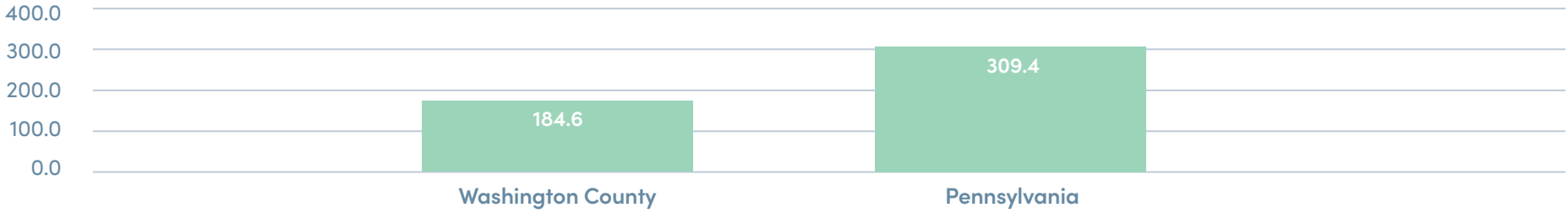
Source: Census Bureau, American Community Survey 2018 – 2022

Figure 17: Education



Source: Census Bureau, American Community Survey 2020

Figure 18: Violent Crime
(per 100,000 population)



Source: U.S. Census Bureau, American Community Survey 2020

Figure 19 below reports the number and percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%.

Figure 19: Substandard Conditions

Report Area	No Conditions	One Condition	Two or Three Conditions	Four Conditions
Washington County	79.20%	19.86%	0.94%	0.00%
Pennsylvania	72.77%	26.16%	1.07%	0.01%

Source: U.S. Census Bureau, American Community Survey 2018 – 2020

County Health Rankings

It is important to review rankings as they provide a clear and concise way to compare performances across different entities, helping identify areas of strength and weakness for targeted improvements. Pennsylvania's score of 1 in the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps represents the "healthiest" county in a given measure. Figure 20 reveals that Washington County's social and economic factor score was the only score that worsened from 2020 to 2023, going from 13 to a ranking of 20.

Examining social and economic factors is essential because they greatly impact health outcomes and disparities, shaping access to key resources such as education, employment, and health care.[4] Understanding these factors allows for the identification of root causes and the development of targeted interventions to enhance community health. Social and economic conditions play a pivotal role in influencing our health and life expectancy. These determinants emphasize the deep connection between socioeconomic conditions and health, underscoring the need to address them to improve overall well-being and achieve better health outcomes across populations.[5]

Figure 20: County Health Rankings: (67 Counties in PA) (1=Healthiest)

	Year	Health Outcomes	Health Factors	Mortality	Morbidity	Health Behaviors	Clinical Care	Social & Economic Factor	Physical Environment
Washington County	2023	30	15	50	12	14	23	**20**	13
	2020	33	15	53	14	17	24	13	33

Note: Figures in bold and highlighted in yellow indicate a value worse in 2023 than in 2020.

County Health Rankings are critical in shaping public health strategies and improving community well-being. These rankings serve as a vital benchmark, allowing counties to measure their health outcomes and contributing factors against those of other regions. This comparative analysis provides valuable insights into a county's strengths and weaknesses, helping to highlight areas where public health initiatives are successful and where improvements are needed. By identifying gaps in care or specific health challenges, counties can implement more focused and effective interventions to improve overall health outcomes.

[4] Social and economic factors include income, education, employment, community safety, injury and death rates, social support, and the prevalence of children in poverty.
[5] County Health Rankings & Roadmaps

Moreover, rankings play a significant role in the distribution of resources. Counties with lower rankings often face greater health disparities and may qualify for additional state or federal funding. This targeted financial assistance can be instrumental in addressing critical issues such as access to health care, economic instability, or social determinants of health that disproportionately affect vulnerable populations. As a result, poorer-ranked counties can prioritize investments in areas like health care access, nutrition programs, or housing improvements, directly contributing to health equity and long-term community development.

Publicizing county health rankings guides funding and intervention efforts and increases community awareness of health issues. When residents and stakeholders are informed about their county's standing in relation to others, it sparks greater public engagement and mobilizes support for health improvement programs. Community members, leaders, and advocacy groups are more likely to collaborate when they see where their county excels or lags, driving collective action and accountability.

Health departments, hospitals, and organizations rely heavily on rankings to shape strategic health improvement plans. These plans often include setting measurable goals, identifying priority areas such as chronic disease prevention, maternal health, or mental health services, and tracking progress. Rankings offer a quantifiable means of assessing whether health outcomes are improving, stagnating, or declining, and they allow for the adjustment of strategies to meet the community's evolving needs better.

Furthermore, health rankings highlight disparities among counties, underscoring inequalities that must be addressed. For instance, counties with better access to health care, higher income levels, and robust public health infrastructure often outperform counties that lack these advantages. Highlighting these inequities encourages policy changes and concerted efforts to reduce gaps in health outcomes across regions, ensuring that all residents, regardless of where they live, have equal opportunities to achieve good health.

County Health Rankings are indispensable tools in public health. They enable effective monitoring of health outcomes, facilitate community engagement, and provide a foundation for evidence-based decision-making. By identifying areas for improvement, guiding resource allocation, and raising awareness of health issues, rankings are crucial in driving health equity, improving overall well-being, and ensuring that all communities can thrive.

Identifying and Prioritizing Significant Health Needs

Identification and Prioritization Planning Session

Tripp Umbach conducted an internal hospital identification and prioritization session with steering group members to present the community health need findings and to gather input on the community's overall needs and concerns. A 90-minute virtual meeting took place to rank, target, and align resources while focusing on achievable goals and strategies to address community needs. The community health needs were identified by examining data and overarching themes from the community input process and secondary data analyses.

Criteria for Identification and Prioritization

The following decision-making criteria were used to guide prioritization processes for the assessment cycle.

- Consider the CHNA needs from the previous assessment. Were those needs addressed? Or are they still being addressed?
- What were the top needs/issues from the community stakeholder's data?
- What were the top needs/issues from the community surveys?
- What were the top needs/issues from the secondary data?
- What is the magnitude/severity of the problem?
- What are the needs of vulnerable populations?
- What is the community's capacity and willingness to act on the issue?
- What is the hospital's ability to have a measurable impact on the issue?
- What hospital and community resources are available?

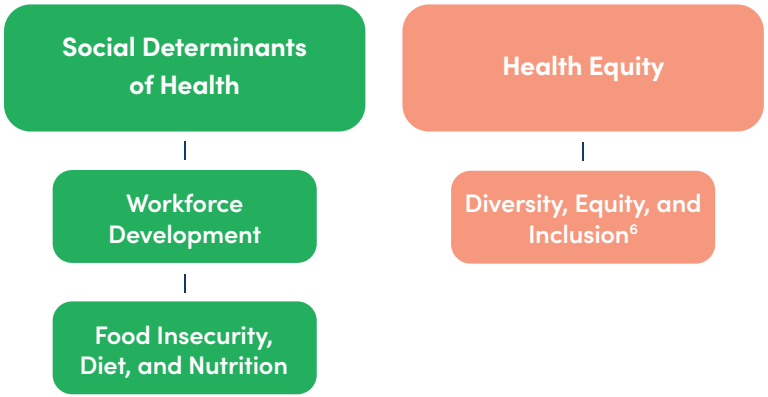
Identification and Prioritization Process

The identification and prioritization process was designed to endorse inclusivity, participation, and a data-driven approach. Participants were encouraged to review and discuss data, share narratives relevant to each community's needs, and offer their perspectives on the most pressing issues. Following an in-depth group analysis of the data, consensus was reached, and the group identified key health needs for the CHNA. This collaborative approach ensured that diverse viewpoints were considered, leading to a comprehensive understanding of the community's health priorities. The agreed-upon needs reflect the shared commitment to addressing the most urgent health concerns within the AHN community.

2024 Community Health Needs Assessment Final Identified and Prioritized Needs

AHN hospitals are dedicated to serving the residents of Pennsylvania and southwestern New York, as a nonprofit, community-focused organization. As a comprehensive health care provider, the 14 hospitals in AHN serve a 14-county area and employ more than 22,000 people. The 2024 CHNA for AHN Canonsburg Hospital highlighted the following community needs:

Figure 21: AHN Canonsburg 2024 CHNA Needs



[6] Diversity, Equity, & Inclusion includes LGBTQ+, cultural competency, and Culturally and Linguistically Appropriate Services (CLAS).

A.) Social Determinants of Health

Social determinants of health (SDOH) was identified as a community need in the stakeholder interviews, community survey, and provider survey. In addition to those three data points, SDOH was identified in the secondary data analysis. Social determinants of health (SDOH) are the conditions in which individuals are born, grow, live, work, and age, and they significantly influence a person's health and well-being. These determinants encompass a wide array of factors, including socioeconomic status, education, employment, social support networks, and access to health care. These elements play a crucial role in shaping individual and community health outcomes. For example, a person's socioeconomic background can dictate their ability to afford essential resources such as nutritious food, safe housing, and quality health care services. Without these basic necessities, individuals are more susceptible to health issues, both physical and mental. Therefore, understanding and addressing SDOH is critical in promoting health equity and improving overall population health.

Economic stability is one of the most significant factors influencing health. Individuals with steady employment and higher income levels generally enjoy greater financial security, allowing them access to critical resources. These resources include the basics like food and shelter and the ability to afford health care services, including preventive care, which helps maintain long-term health. Financial stability also reduces stress levels, directly linked to better mental health. Those who experience financial hardship, on the other hand, are often at greater risk of developing chronic stress and mental health issues such as anxiety and depression. The stress of economic instability can exacerbate existing health problems and create barriers to seeking timely medical care, further contributing to poor health outcomes. Moreover, economic stability influences access to safe neighborhoods and clean environments, which are essential for preventing illnesses and promoting well-being.

Education is another fundamental determinant of health. It is pivotal in improving health outcomes by empowering individuals with the knowledge and skills necessary to make informed health decisions. Higher levels of education increase health literacy, enabling people to understand health care information, navigate the health care system more effectively, and adopt healthier behaviors. Education also opens doors to better job opportunities, improving economic stability and access to employer-sponsored health care benefits. Furthermore, educational institutions often serve as platforms for social interaction, developing community engagement and emotional support, and contributing to better mental health. In contrast, individuals with limited education may face challenges understanding health information or accessing job opportunities that offer sufficient income and health benefits. As a result, education influences individual health choices and impacts long-term health trajectories by shaping economic opportunities and social standing.

The physical environment in which individuals live is equally important. Safe housing, clean air, and access to recreational spaces influence physical health and quality of life. Living in a safe and clean environment can prevent respiratory diseases, accidents, and other health risks. For example, exposure to pollution in urban areas or hazardous living conditions in poorly maintained housing can lead to chronic respiratory problems, allergies, or other serious health issues. Additionally, access to parks, walking paths, and recreational facilities promotes physical activity, essential for preventing chronic conditions

such as obesity, diabetes, and heart disease. Conversely, individuals living in environments that lack these resources are more likely to lead sedentary lifestyles, increasing their risk of developing these conditions. Improving the physical environment by ensuring access to clean air, safe housing, and recreational facilities can greatly enhance the overall health of communities, especially in underserved or marginalized areas. Access to health care, including preventive services and timely medical interventions, ensures that health issues are addressed before they escalate, promoting better long-term health outcomes.

Equally important is the social and community context in which individuals find themselves. Strong social connections and support networks are crucial for maintaining mental and physical health. A sense of belonging within a community and access to emotional support during times of stress or hardship can significantly mitigate the impact of life's challenges. Social support has been shown to reduce the risks of mental health issues such as depression and anxiety, as well as to encourage healthy behaviors, such as regular physical activity and adherence to medical advice. On the other hand, experiences of social exclusion, discrimination, or isolation can have devastating effects on health. Discrimination and exclusion, whether based on race, gender, socioeconomic status, or other factors, can lead to chronic stress, which has been linked to a range of negative health outcomes, including cardiovascular disease, mental health disorders, and weakened immune function. Thus, creating inclusive communities and addressing social inequities is critical to reducing health disparities and ensuring all individuals have the support they need to thrive.

Access to health care is perhaps the most direct determinant of health. Obtaining timely and appropriate medical care, including preventive services such as vaccinations and screenings, is critical to maintaining good health and preventing the escalation of health problems. Individuals with regular access to health care providers are more likely to receive early diagnoses and interventions, reducing the need for costly emergency care or hospitalizations. However, many people, especially those in low-income or rural areas, face significant barriers to accessing health care, whether because of financial constraints, lack of insurance, or geographic isolation. Addressing these barriers is essential for improving health outcomes and reducing disparities. Expanding health care access through policy changes, community health initiatives, and telemedicine can help ensure that everyone, regardless of their background, has the opportunity to receive the care they need.

Ultimately, the complex interplay of these social determinants — economic stability, education, social support, the physical environment, and health care access — shapes our health and well-being. Addressing these factors is critical to promoting health equity, improving population health, and reducing community disparities. By recognizing and addressing these underlying social drivers, we can create a more equitable health care system that ensures everyone has the opportunity to achieve optimal health. Collaborative efforts among health care providers, policymakers, and community organizations are essential to tackle these determinants effectively. By recognizing and addressing the broader social factors that influence health, we can create healthier, more resilient communities and work toward reducing health disparities for future generations.

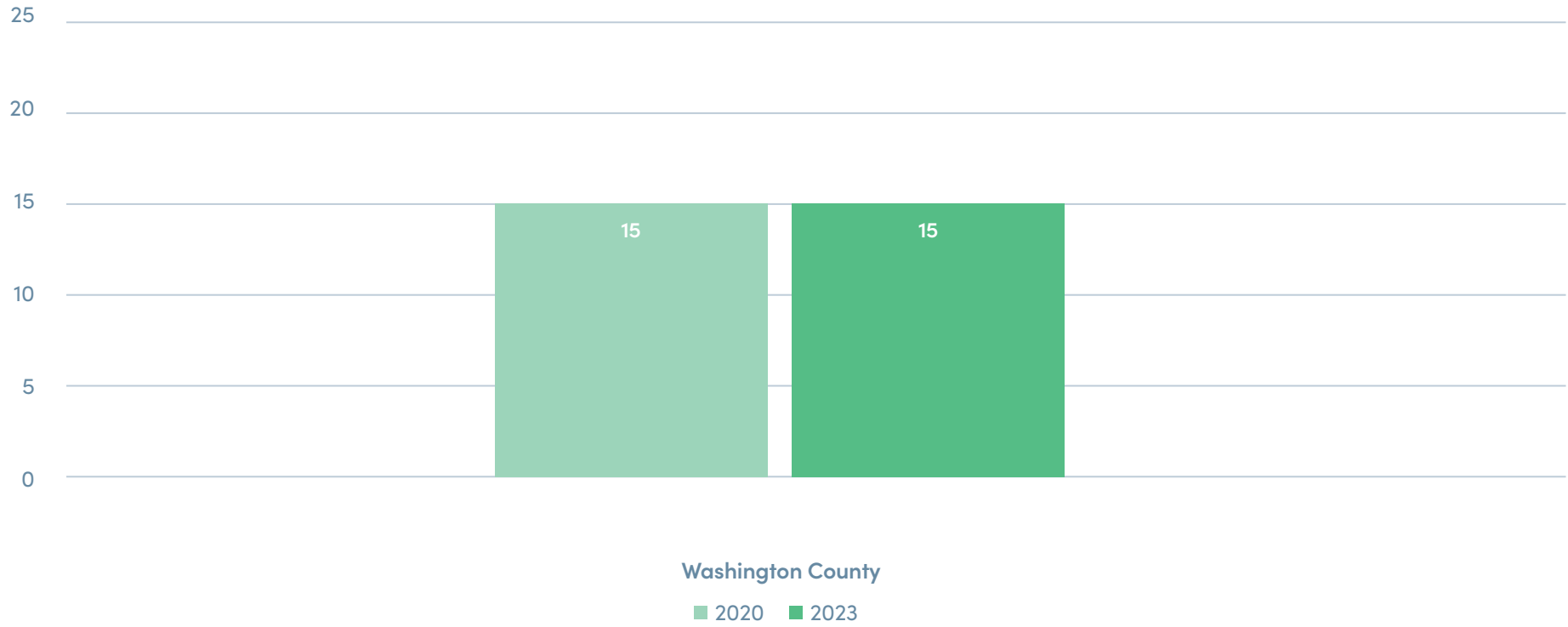
Figure 22: Social Determinants of Health

The key themes identified across stakeholder groups — through stakeholder interviews, Patient and Family Advisory Council (PFAC) group interviews, community surveys, and provider surveys — reveal several significant barriers to accessing health care. These barriers include affordability challenges, such as high out-of-pocket costs and deductibles, lack of insurance coverage, and the cost of services. Other common issues include transportation difficulties, food and housing insecurity, and a shortage of health care providers and specialists.

Additionally, gaps in health care coordination services and health literacy were highlighted, as many individuals struggle to navigate the health care system or comprehend the information provided. Access to mental health and substance use resources, affordable medications, and preventative screenings are also prominent concerns. Long waiting times, inconvenient appointment schedules, and a lack of culturally appropriate care were issues noted in the community surveys. These findings point to significant socioeconomic and systemic barriers affecting access to quality health care services.

Health factors are based on weighted scores of health behaviors, clinical care, social and economic factors, and physical environment. Those having high ranks, e.g., 1 or 2, are considered the “healthiest.” Figure 23 below shows that Washington County stayed the same in regard to the health factor rankings from 2020 to 2023.

Figure 23: Health Factors Rankings



Source: County Health Rankings

Figure 24 delineates the responses from the community leader stakeholder interviews, PFAC group interviews, community surveys, and providers regarding the community's needs and health care barriers.

Figure 24: Engaging the Community Through Primary Data Collection

Stakeholder Interviews	PFAC Group Interviews	Community Surveys	Provider Survey
• Affordability (i.e., out-of-pocket costs/high deductibles/copay) • Lack of transportation • Health literacy (i.e., inability to comprehend the information provided) • No insurance coverage (uninsured/underinsured) • Lack of health care coordination services (i.e., not being able to navigate the health care system) • Access to substance use/drug/ alcohol resources • Access to behavioral health resources • Access to affordable prescription and over-the-counter medication • Affordable, quality childcare	• Health care navigation and health care coordination • Lack of providers • Food insecurity • Transportation • Housing insecurity • Not enough specialists • Cost of services	• Access to preventative screenings and vaccinations • Access to affordable prescription and over-the-counter medication • Access to affordable healthy food options • Safe places to walk/play • Affordable, safe, quality housing/ utilities • The overall feeling of safety/ security	• Affordability • Availability of services • No insurance coverage • Lack of transportation • Lack of health care coordination services

Workforce Development

Workforce Development was identified as a prioritized health need for AHN Canonsburg based on the provider survey results and AHN Canonsburg Hospital's capacity to implement a workforce development program. Workforce development is vital in shaping SDOH by improving access to economic opportunities, enhancing job skills, and promoting overall economic stability. By providing individuals with the education, training, and support necessary to obtain quality jobs, workforce development helps secure stable employment closely tied to better health outcomes. Employment offers financial resources and access to employer-sponsored health benefits, which can significantly reduce barriers to health care. Research shows that individuals with steady, well-paying jobs are more likely to access preventive care and engage in healthy behaviors, reducing the risk of chronic illnesses.

Additionally, workforce development initiatives contribute to SDOH by promoting a skilled labor force, which ensures that health care systems and other industries have the workforce necessary to provide quality services. For example, efforts to train health care workers, especially in underserved areas, can help alleviate provider shortages and improve access to medical care. In rural communities or economically disadvantaged urban areas, workforce training programs focusing on building local health care capacity can lead to more health care professionals working in these regions, helping close the health care access gap and outcomes.

Moreover, workforce development has a broader societal impact by addressing systemic inequities. Vulnerable populations often face barriers to obtaining high-quality education and job opportunities. Workforce development programs that focus on equity, such as those providing vocational training, mentorship, or job placement services, can help break the cycle of poverty and reduce health disparities. When more individuals from these communities have access to stable employment and financial security, they are better positioned to afford housing, transportation, and other key health determinants.

In the long term, investing in workforce development strengthens the economy and reduces societal costs associated with poor health outcomes. When individuals have access to jobs that pay a living wage and offer health benefits, they are less reliant on public assistance programs and emergency health care services, which reduces the strain on public resources. Additionally, by building a workforce that can adapt to changing economic demands, communities become more resilient, and individuals are better prepared to weather economic downturns, further supporting long-term health and well-being.

Figure 25: Percentage of Unemployed Population >16 but Seeking Work

	Year	Unemployment
Washington County	2022	4.6%
	2021	6.6%
Pennsylvania	2022	4.4%
	2021	6.3%

Source: County Health Rankings

Figure 26 below shows the household income ratio at the 80th percentile to income at the 20th percentile. This means when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates a greater division between the top and bottom ends of the income spectrum.

Figure 26: Income Inequality

	Unemployment
Washington County	4.6
Pennsylvania	4.8

Source: County Health Rankings, 2018 – 2022

Access to Care

Access to care was identified as a prioritized health need for AHN Canonsburg based on the stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN Canonsburg considered their capacity to implement programming to improve access to care. Access to health care is a critical factor in achieving positive health outcomes and reducing health disparities. When individuals can easily access medical services, they are more likely to receive preventive care, early diagnoses, and appropriate treatments, which l ead to better overall health.

The lack of access to health care disproportionately affects vulnerable populations. A study by the Kaiser Family Foundation found that 27.5 million people in the United States were uninsured in 2022, with low-income individuals, racial and ethnic minorities, and rural residents being the most affected.[7] Expanding access to affordable health care can significantly reduce these disparities, improve population health, and lower long-term health care costs by reducing reliance on emergency care and addressing health issues before they become more severe.

[7] Kaiser Family Foundation

According to the Association of American Medical Colleges (AAMC), a shortage of 86,000 physicians by 2036 is predicted across the United States because of a growing older patient population and physicians retiring.[8] The Robert Graham Center reports that to maintain current utilization rates, Pennsylvania will need an additional 1,039 primary care physicians by 2030, an 11% increase compared to the state's (as of 2010) 9,096 PCP workforce.[9]

Access to health care not only affects physical health but also has broader social and economic implications. When people have reliable access to care, they are more likely to remain productive, continue working, and avoid disability. The economic costs of untreated illness are significant; for example, the CDC estimates that chronic diseases cost the U.S. health care system $4.5 trillion annually.[10] By ensuring that individuals can access preventive care and timely treatment, health care systems can reduce the long-term financial burden on both individuals and society, improve quality of life, and promote a healthier, more equitable population.

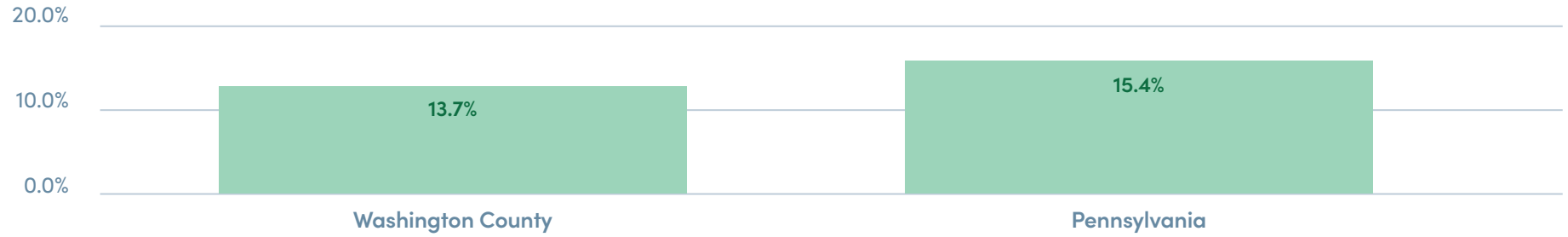
Specialty services are vital for ensuring comprehensive and effective health care. Specialty services provide targeted and advanced medical attention that general practitioners may not be equipped to offer. Access to specialized care enables early detection, precise diagnosis, and personalized treatment plans that can significantly improve patients' survival rates and quality of life. Specialty services are critical for managing specific health conditions, reducing risks, and promoting overall well-being. Without such specialized care, individuals may face delayed diagnoses, inadequate treatment, and poorer health outcomes. Therefore, ensuring the availability and accessibility of specialty services like cancer care and women's care is essential for addressing complex health needs, enhancing patient outcomes, and nurturing a healthier community.

Ensuring access to care is fundamental to promoting health and well-being within a community. Improving access to care is essential for promoting health equity, enhancing the quality of life, and building a healthier population. It is vital for vulnerable groups, such as low-income individuals and those living in rural areas, who are often disproportionately affected by these barriers. Ensuring necessary health care services is fundamental to achieving overall community well-being and sustainable health improvements.

[8] Association of American Medical Colleges
[9] The Robert Graham Center
[10] Centers for Disease Control and Prevention

Figure 27 reports the percentage of adults aged 18 and older who self-report their general health status as “fair” or “poor.”

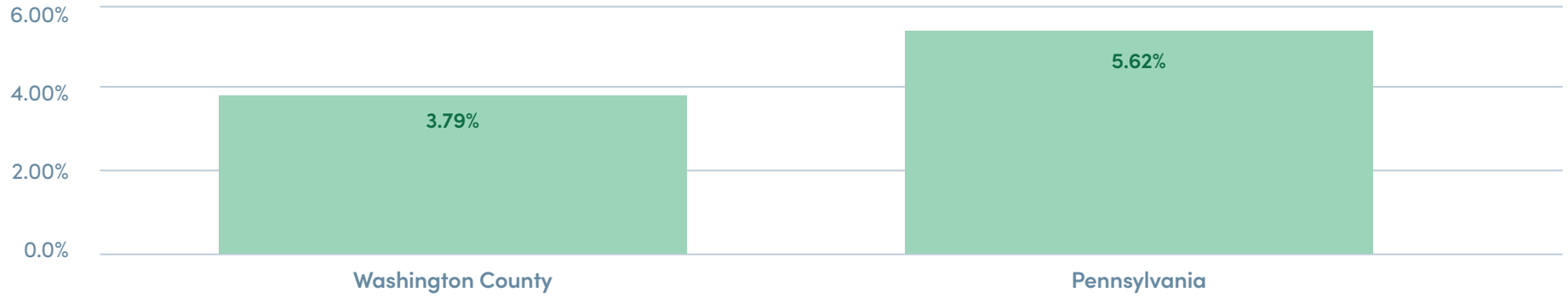
Figure 27: Health Status of Adults >18



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2021

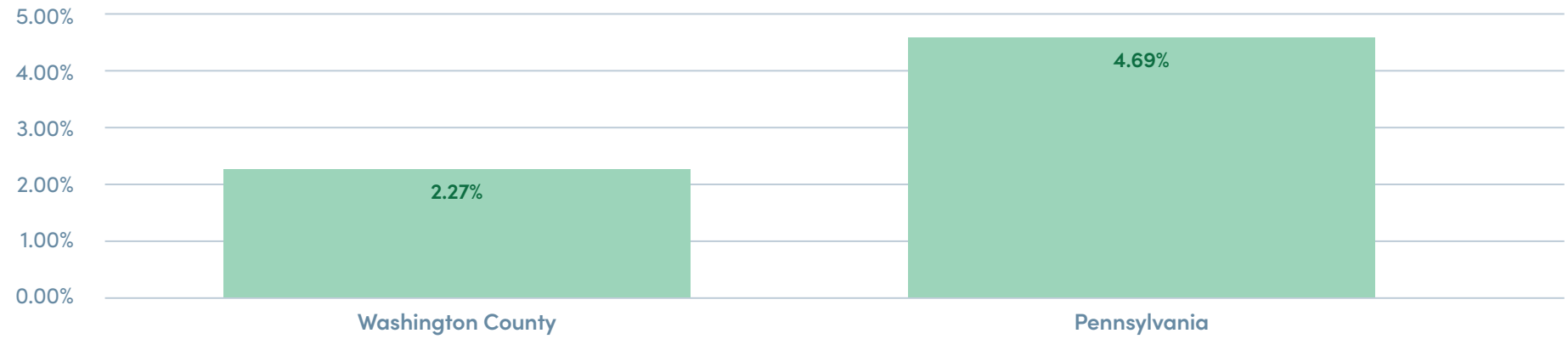
Lack of health insurance is considered a key driver of health status. Figure 28 below reports the lack of health insurance as a primary barrier to health care access, contributing to poor health status.

Figure 28: Uninsured Population



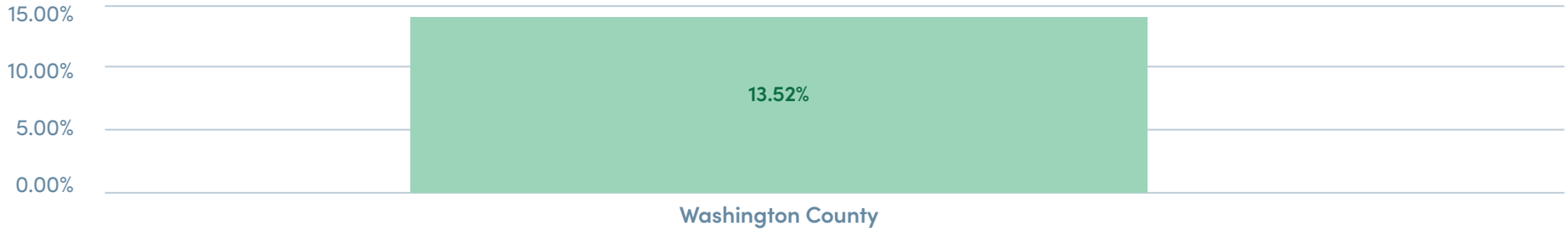
Source: U.S. Census Bureau, American Community Survey 2018 – 2022

Figure 29: Uninsured Children



Source: U.S. Census Bureau, American Community Survey 2018 – 2022

Figure 30: Public Assistance Income or Food Stamps/SNAP



Source: U.S. Census Bureau, American Community Survey 2020

Figure 31: Health Professional Shortage Areas (HPSAs) by County

HPSAs	Dental Health	Mental Health	Primary Care	Total HPSAs
Washington County	1	1	2	4
Pennsylvania	148	119	130	397

Source: Health Resources and Services Administration

B.) Health Equity

Health equity was identified as a prioritized health need for AHN Canonsburg based upon it being an enterprise-wide priority. In addition, AHN Canonsburg Hospital considered their capacity to implement health equity programming. Health equity is a crucial aspect of public health that aims to ensure that all individuals, regardless of socioeconomic status, race, ethnicity, or geographic location, have equal access to health care resources and opportunities for optimal health. The importance of health equity lies in its potential to reduce health disparities, improve health outcomes, and enhance overall community well-being.

Disparities in health outcomes are often linked to social determinants of health, including income, education, and environmental factors, which disproportionately affect marginalized populations. We can work toward a more just health care system that benefits everyone by addressing these inequities. When health disparities are reduced, it leads to healthier populations, which can result in decreased health care costs and increased productivity.

The World Health Organization (WHO) emphasizes that reducing inequities in health can lead to improved social and economic outcomes, as healthier individuals are more capable of contributing to their communities. Health equity is achieved when everyone can attain their full potential for health and well-being. Moreover, equitable access to health care develops a sense of trust and engagement among community members, encouraging them to seek necessary care and adhere to preventive measures.

Health equity is essential for creating a fair and effective health care system that serves all individuals. Addressing the root causes of health disparities and promoting equitable access to care can improve health outcomes and advance a healthier, more resilient society.

The key themes identified from stakeholder interviews, PFAC group interviews, community surveys, and provider surveys reveal a strong emphasis on improving access to preventative health care services and education about navigating the health care system. Preventative services such as health screenings, mental health and substance abuse services, and behavioral health support are consistently highlighted as critical needs.

There is also a focus on improving community engagement through health promotion and education, community-based health programs, and services that address the social determinants of health (SDOH), such as transportation assistance, access to affordable healthy food, and safe spaces for recreation. Additionally, respondents stressed the importance of having affordable, quality care for children and seniors, as well as access to affordable housing and utilities.

Many stakeholders also called for increased access to mental health resources and education on how to utilize available health care services effectively. Health literacy classes, health coordinators, and community outreach services are seen as key components in addressing these gaps, ultimately aiming to improve overall health outcomes within the community.

Figure 32 delineates the responses from the community leader stakeholder interviews, community surveys, and provider surveys regarding equitable care and maintaining optimal health.

Figure 32: Engaging the Community Through Primary Data Collection

Stakeholder Interviews	PFAC Group Interviews	Community Surveys	Provider Surveys
Preventative health care services (health screenings)		Access to affordable healthy food options	Access to affordable prescription and over-the-counter medication
Health promotion and education		Affordable, safe, quality housing/ utilities	Access to mental health resources
Behavioral health/stress management	Education on how to navigate the health care system	Access to mental health resources	Access to affordable healthy food options
Community engagement and support	Health coordinators	Safe places to walk/play and accessible, affordable community activities (parks, trails, community centers)	Affordable, safe, quality housing and utilities
Access to healthy foods	Behavioral health services — education on resources	Affordable, quality child and/or senior care options	Affordable, quality child and/or senior care options
Mental health and substance abuse services	Health literacy classes	Access to affordable prescription and over-the-counter medication	Community outreach services
Transportation assistance	Preventative services		
Community-based health programs			
Address SDOH			

Diversity, Equity, and Inclusion

Diversity, equity, and inclusion was identified as a prioritized health need for AHN Canonsburg based upon it being an enterprise-wide priority. In addition, AHN Canonsburg considered their capacity to implement diversity, equity, and inclusion programming. Diversity, equity, and inclusion (DEI) in health care are essential for creating a system that addresses the needs of all patients and communities effectively. A diverse health care workforce brings perspectives, experiences, and cultural understandings that can enhance patient care and improve health outcomes. Research has shown that when health care providers reflect the diversity of their communities, patients are more likely to feel understood and receive culturally competent care.[11] This representation can lead to better communication, increased trust, and better adherence to medical recommendations. Diversity in health care also benefits financial performance and employee retention, as it emphasizes the importance of addressing bias for better patient care and employee relations. Addressing health disparities, particularly those affecting people of color and LGBTQ+ communities, can significantly reduce excess medical costs, as much as $93 billion annually.[12]

Equity in health care involves ensuring that all individuals have access to the resources they need to achieve optimal health. This includes addressing systemic barriers that disproportionately affect marginalized groups, such as racial and ethnic minorities, the LGBTQ+ community, and individuals with disabilities. By promoting equity, health care organizations can work to eliminate disparities in health outcomes and ensure that every patient receives the quality care they deserve, regardless of their background. Implementing DEI initiatives can significantly reduce disparities in treatment, diagnosis, and overall health outcomes.

Inclusion in health care focuses on representation and creating an environment where everyone feels valued and respected. Inclusive practices encourage patients to share their concerns and experiences, leading to more personalized and effective care. Health care organizations prioritizing inclusion will likely improve employee satisfaction and retention, as staff members feel empowered to contribute their unique perspectives.

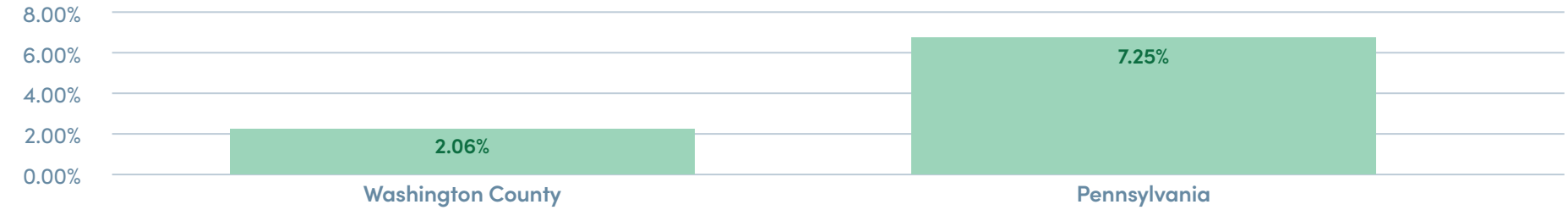
Moreover, stimulating an inclusive environment helps create a culture of safety where patients can communicate openly about their health needs without fear of discrimination or bias.

Diversity, equity, and inclusion are vital to a successful health care system. By prioritizing DEI, health care organizations can enhance patient care, reduce health disparities, and create a more supportive and effective environment for patients and health care providers.

[11] National Library of Medicine
[12] Newsweek

Figure 33 below reports the percentage of the population that is foreign-born. The foreign-born population includes anyone who was not a US citizen or a US national.

Figure 33: Foreign-Birth Population, Percent of Total Population

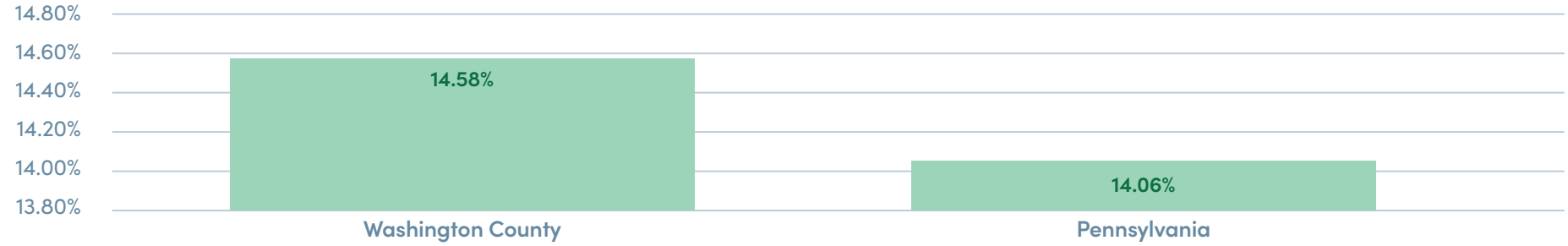


Source: US Census Bureau, 2018 – 2022

Figure 34: Population with Limited English Proficiency (age 5+)

Source: US Census Bureau, 2018 – 2022

Figure 35: Percentage of Population with a Disability



Source: US Census Bureau, 2018 – 2022

Community Resources Available to Address Identified Needs

In addition to the programs and services offered to the community through AHN Canonsburg, there are various existing community resources available throughout the community that have additional programs and services tailored to meet all the identified needs. The following is a list of community agencies that address the identified needs.

Figure 36: Community Resources

Identified Significant Health Needs	Local Community Resources Available to Address Needs
Social Determinants of Health — Workforce Development	Arc Human Services, AARP Foundation Work Resource Hotline, Washington County Dept. of Human Services
Social Determinants of Health — Access to Care	Rx Outreach, Southwestern PA Area Agency on Aging, Catholic Charities of the Diocese of Pittsburgh
Health Equity — Diversity, Equity, and Inclusion	Immigration Equality, Easterseals — Western & Central Pennsylvania, LGBTQ Freedom Fund

AHN Community Resource Inventory

AHN created a comprehensive inventory of programs and services available in the region. The inventory highlights programs and services within the service areas corresponding to each priority need area. It identified the organizations and agencies serving the target populations within these priority needs, provided detailed program descriptions, and gathered information on the potential for coordinating community activities and establishing linkages among agencies. The interactive community resource can be directly accessed at ahn.findhelp.com.

Conclusion

Achieving health equity is a multifaceted challenge that exceeds the traditional boundaries of health care and requires the collaboration of various sectors within the community. Realizing that health outcomes are shaped by social, economic, and environmental factors has prompted a growing recognition that true health equity cannot be reached through medical interventions alone. It necessitates a comprehensive approach that addresses broader systemic issues such as transportation, housing, education, and employment — all of which are integral to an individual's overall well-being. The limitations of public transportation, for example, highlight how access to health care, employment, and nutritious food are interconnected and essential to bolstering health equity.

AHN Canonsburg's commitment, through developing its CHNA and forthcoming implementation strategy plan, demonstrates a forward-thinking approach that values community engagement and collaboration. By incorporating feedback from stakeholder interviews, group interviews, community surveys, and provider surveys, AHN Canonsburg ensures that the voices of the community are heard and reflected in its health strategies. Partnering with community organizations allows AHN Canonsburg to address not only the medical needs of the population but also the underlying social determinants of health, laying the foundation for sustainable and impactful change. This collaborative effort is essential for reducing health disparities and promoting equitable access to health care and other critical resources.

The path to achieving health equity is long and requires persistent effort, but initiatives such as those undertaken by AHN Canonsburg Hospital serve as a blueprint for how health care institutions can lead the charge in building healthier, more equitable communities. By embracing a multi-sector approach and addressing the root causes of health disparities, we can move closer to a future where everyone has the opportunity to achieve optimal health, regardless of their socioeconomic status, geographic location, or background. Health equity is not just a matter of fairness but a fundamental requirement for building strong, resilient communities that can thrive for generations.

AHN Canonsburg is taking steps toward supporting health equity by engaging with the communities it serves. Recognizing that solutions must be informed by the lived experiences and needs of the community, AHN Canonsburg has committed to gathering insights through methods including surveys and interviews. These tools allow community members to share their perspectives, identify barriers to care, and suggest areas for improvement. By listening to community voices, AHN Canonsburg aims to ensure that its strategies are aligned with the real needs of the population. This participatory approach helps identify the root causes of health disparities and encourages trust and collaboration between health care institutions and the community. It shifts the dynamic from a top-down approach to one that empowers community members to be active partners in shaping the future of health care and health equity.

Building on the insights gathered through community engagement, AHN Canonsburg is preparing to develop its CHNA Implementation Strategy Plan. This plan represents a strategic roadmap for addressing the health disparities identified in the assessment phase. The CHNA Implementation Strategy Plan will be developed in close partnership with community organizations, ensuring it is grounded in the data collected and the population's unique needs. These partnerships are critical to the success of any health equity initiative, as community organizations often have deep connections with underserved populations and a nuanced understanding of the barriers these groups face. By collaborating with these organizations, AHN Canonsburg can create more targeted and effective interventions that address health care needs and the broader social determinants of health. The plan will likely include strategies to improve access to health care, enhance transportation services, promote food security, and strengthen social support networks — key areas that contribute to overall health and well-being.

AHN Canonsburg's commitment to developing the CHNA Implementation Strategy Plan reflects a broader dedication to improving health outcomes and advancing health equity. The focus is on treating illness and creating conditions that prevent illness and promote long-term well-being. By addressing health's social, economic, and environmental drivers, AHN Canonsburg and its community partners are working to reduce health disparities and ensure that all individuals can achieve optimal health, regardless of their background or circumstances. This forward-thinking approach acknowledges that achieving health equity requires sustained efforts, ongoing collaboration, and a willingness to adapt as new challenges arise. It also underscores the importance of continuous dialogue between health care providers and their communities, ensuring that health equity is not a distant goal but a reality for everyone.

Additional Information

AHN will create implementation plans that utilize the organization's strengths and resources to effectively meet the health needs of their communities and enhance the overall health and well-being of community members. For more details and to share feedback, please visit the CHNA landing page at ahn.org/about/caring-for-our-community/community-health-needs-assessment.

Appendix

Data Limitations

It is important to acknowledge that the data collected for the 2024 CHNA has certain limitations. The secondary data used in the report covers a broader geographic area and is not specifically focused on AHN Canonsburg's primary service area. Additionally, the primary data gathered through stakeholder interviews, group interviews, community surveys, and provider surveys are limited in their representation of AHN Canonsburg's service area, as it was collected using convenience sampling.

CHNA Needs Reevaluated as Priorities are Met

The transition from the 2021 cycle to the 2024 cycle has led to a reevaluation of priorities in the CHNA, particularly in the areas of transportation, substance use disorder, diabetes, and heart disease for AHN Canonsburg. In terms of transportation, the reliance on Medi-Van statistics has raised concerns about the long-term sustainability of this service. While the Medi-Van will continue for now, uncertainties surrounding budget constraints have made it difficult to commit to this program for the next three years. As funding becomes more competitive, prioritizing transportation initiatives may not be feasible, especially when the immediate impact on community health outcomes is uncertain. This necessitates a shift in focus to more reliable programs that can demonstrate a clear and sustainable benefit to the community.

Similarly, the focus on substance use disorder has shifted due to the realization that previous metrics, such as emergency department statistics and Narcan usage, were not reflective of a cohesive community program. AHN Canonsburg's collaboration with the Washington Drug & Alcohol Center did not materialize, underscoring the need for more strategic partnerships that yield tangible community benefits. This highlights the importance of fostering collaborative efforts that address substance use in a more structured manner rather than relying on individual statistics that may not represent a comprehensive community approach.

Diabetes and heart disease also face a shift in prioritization as AHN Canonsburg recognizes that previous reporting metrics, such as outpatient diabetes classes and education on heart disease, were focused primarily on patient encounters within clinical settings rather than community-wide initiatives. While these services are essential, they should not be presented as community programs when they are more accurately characterized as standard care practices for individuals seeking treatment.

The shift in priorities reflects a commitment to developing more impactful, sustainable health programs that directly benefit the community. By re-evaluating the metrics used to assess needs and focusing on initiatives that engage the broader population, AHN Canonsburg aims to align its resources more effectively with the health challenges facing the community today.

About Tripp Umbach

Tripp Umbach, a private consulting company, is a nationally renowned firm with extensive experience in conducting CHNAs across diverse regions and populations. In fact, more than one in five Americans lives in a community where our firm has worked. With a deep understanding of health care dynamics, Tripp Umbach employs a comprehensive approach combining quantitative and qualitative data collection methods. This enables them to capture a holistic view of community health needs, including the perspectives of medically underserved and vulnerable populations. Tripp Umbach's methodology ensures that regional stakeholders, from local health care providers to community leaders, are engaged, ensuring that the CHNA reflects a broad spectrum of community insights and priorities.

Over the years, Tripp Umbach has completed numerous CHNAs for hospitals and health care systems, nonprofit organizations, and state entities. Tripp Umbach leverages expertise in identifying pressing health needs and assists organizations in developing targeted strategies to address these issues effectively. Tripp Umbach's CHNAs comply with IRS guidelines for charitable 501(c)(3) tax-exempt hospitals, ensuring that health care providers meet regulatory requirements while improving community health outcomes. Through its rigorous and inclusive process, Tripp Umbach has consistently enabled communities to enhance their health care services, address disparities, and improve overall public health.

Tripp Umbach