Allegheny Health Network — AHN Westfield Memorial Hospital

Community Health Needs Assessment

2024 Report

AHN WESTFIELD MEMORIAL
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 Westfield Memorial 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 and healthy foods, particularly in underserved areas. These concerns affect individuals and families of all backgrounds, impacting their health, well-being, and overall quality of life.
- **Behavioral Health and Substance Use:** We believe that everyone deserves access to comprehensive and compassionate care for their mental health, postpartum, and substance use needs. However, we recognize many individuals continue to struggle in silence.
- **Chronic Disease Management:** Chronic diseases, such as diabetes, heart disease, and cancer, are a growing concern in our community. These conditions not only impact individual health and well-being, but also place a significant strain on our loved ones, health care system, and local economy.
- **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

Christopher Clark, DO, MHA
President, AHN Westfield Memorial Hospital

About This Report

Community Health Needs Assessment Overview

As a nonprofit organization, Allegheny Health Network (AHN) Westfield Memorial Hospital (AHN Westfield Memorial Hospital) is mandated by the Internal Revenue Service (IRS) to conduct a Community Health Needs Assessment (CHNA) every three years. The CHNA report from AHN Westfield Memorial Hospital 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 Westfield Memorial Hospital proudly presents its 2024 CHNA report and findings to the community.

The community health needs assessment is vital for AHN Westfield Memorial Hospital 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 Westfield Memorial Hospital, 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 Westfield Memorial Hospital fosters a collaborative approach to health improvement, promoting a healthier, more resilient community.

AHN Westfield Memorial Hospital'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 Westfield Memorial Hospital 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 Westfield Memorial Hospital'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.

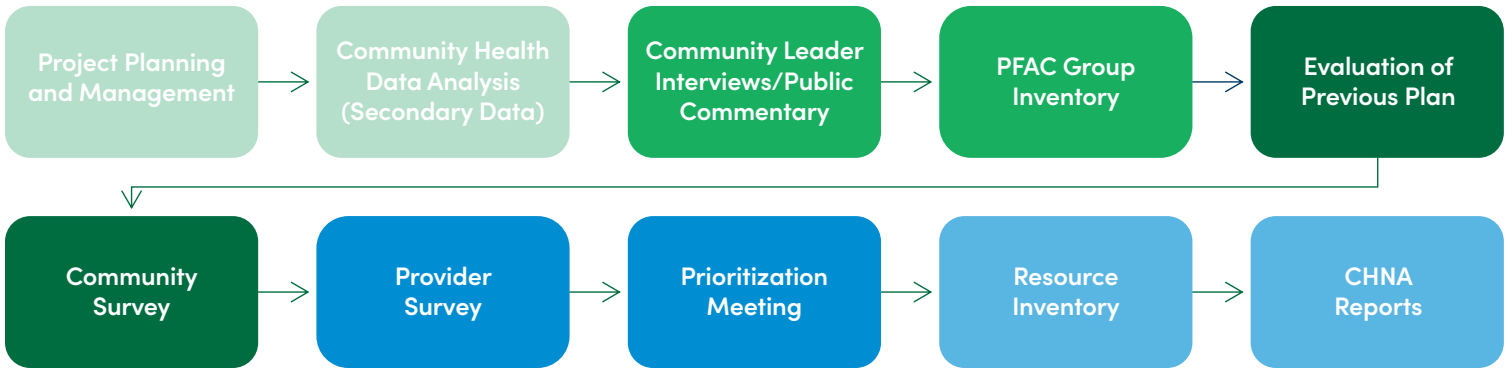
CHNA Methodology

AHN and AHN Westfield Memorial Hospital partnered with Tripp Umbach to carry out the 2024 CHNA for AHN Westfield Memorial Hospital. 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 Westfield Memorial Hospital. 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 Westfield Memorial 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



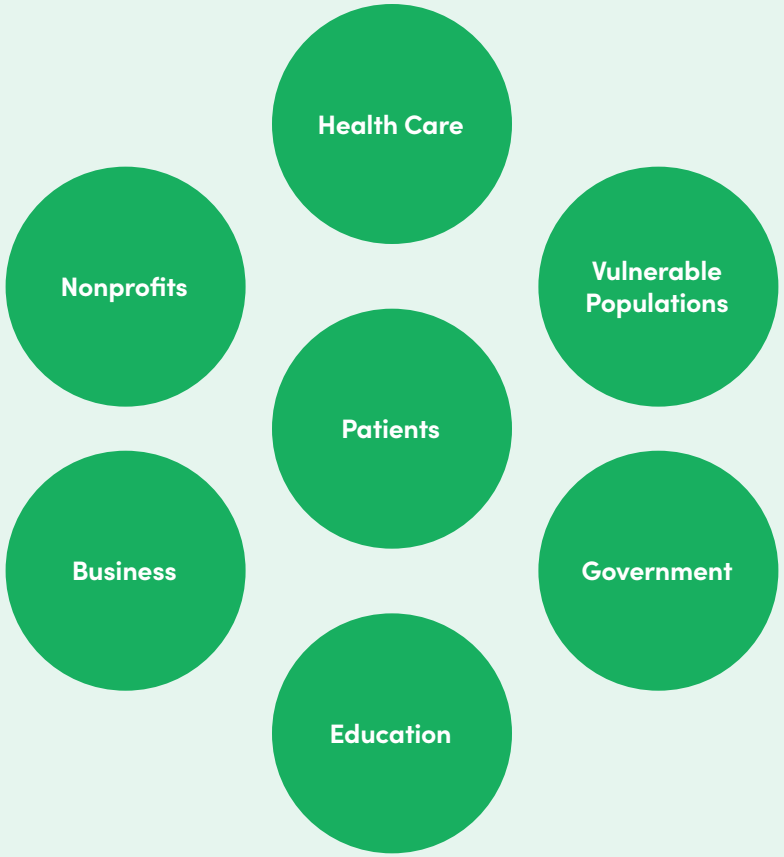
Community Engagement

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 Westfield Memorial Hospital'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 Westfield Memorial Hospital 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 Westfield Memorial 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, which is 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 Hospital, AHN Forbes Hospital, AHN Grove City Hospital, 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.[1] 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.

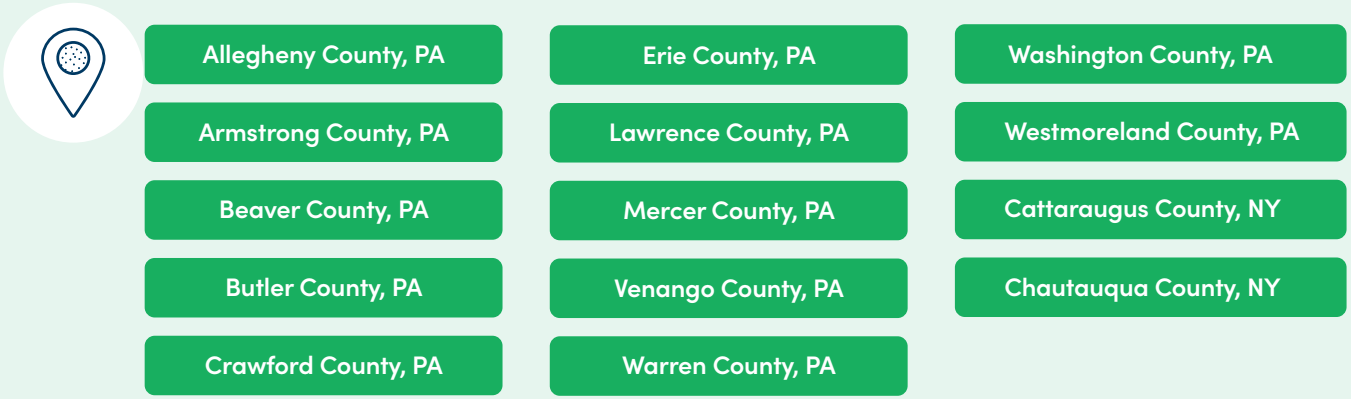
Allegheny Health Network is a vital component of the health care landscape focused on delivering high-quality, patient-centered care. Through its extensive services, community engagement, and commitment to health equity, AHN strives to improve the health and well-being of the communities it serves. With 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.

1 Allegheny Health Network

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



Allegheny Health Network Westfield Memorial Hospital

AHN Westfield Memorial Hospital is a full-service health care facility dedicated to providing top-tier, patient-centered care to communities in and around New York. The hospital is committed to upholding the Allegheny Health Network's mission of delivering high-quality, compassionate care and advancing medical excellence in the region. AHN Westfield Memorial Hospital offers a broad range of medical services, including emergency care, surgical procedures, and advanced diagnostic testing, with the goal of meeting the unique needs of each patient and ensuring accessible, comprehensive care close to home.

Equipped with state-of-the-art technology and staffed by a team of about 180 highly trained physicians, AHN Westfield Memorial Hospital prioritizes the safety, comfort, and well-being of every individual it serves.[2] The hospital's specialized services extend beyond general medicine to include areas such as orthopedics, cardiology, oncology, and women's health, providing patients with seamless access to expert care and personalized treatment plans. AHN Westfield Memorial Hospital is also actively engaged in community health initiatives, working to enhance wellness and promote healthy living within its service area. Through its commitment to innovation, empathy, and community partnerships, AHN Westfield Memorial Hospital remains a trusted health care provider in the region.

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 Westfield Memorial Hospital, 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 Westfield Memorial Hospital 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, 42 ZIP codes were identified as the primary service area for AHN Westfield Memorial Hospital. The following table highlights the study area focus for AHN Westfield Memorial Hospital's 2024 CHNA.

2 Allegheny Health Network

Figure 4: 2024 AHN Westfield Memorial Hospital's Primary Service Area

Zip Code	Town	County
14048	Dunkirk	Chautauqua
14063	Fredonia	Chautauqua
14712	Bemus Point	Chautauqua
14718	Cassadaga	Chautauqua
14726	Dunkirk	Cattaraugus
14728	Westfield	Chautauqua
14738	Frewsburg	Chautauqua
14740	Jamestown	Chautauqua
14769	Portland	Chautauqua
14784	Stockton	Chautauqua
14736	Findley Lake	Chautauqua
14750	Lakewood	Chautauqua
14787	Westfield	Chautauqua
14716	Brocton	Chautauqua
14733	Falconer	Chautauqua
14724	Jamestown	Chautauqua
14775	Westfield	Chautauqua
14747	Jamestown	Chautauqua
14757	Westfield	Chautauqua
14782	Sinclairville	Chautauqua
14710	Jamestown	Chautauqua
14767	Jamestown	Chautauqua
14062	Dunkirk	Chautauqua

Zip Code	Town	County
14138	South Dayton	Chautauqua
14701	Jamestown	Chautauqua
14702	Jamestown	Chautauqua
14757	Mayville	Chautauqua
14781	Sherman	Chautauqua
14789	Sherman	Chautauqua
14703	Jamestown	Chautauqua
14704	Jamestown	Chautauqua
14720	Celoron	Chautauqua
14722	Chautauqua	Chautauqua
14723	Cherry Creek	Chautauqua
14730	East Randolph	Cattaraugus
14732	Ellington	Chautauqua
14742	Greenhurst	Chautauqua
14756	Maple Springs	Chautauqua
14758	Niobe	Chautauqua
14772	Randolph	Cattaraugus
14783	Steamburg	Cattaraugus
14785	Stow	Chautauqua

AHN Westfield Memorial Hospital Awards and Recognitions

Allegheny Health Network is rated among the Top 10% of health systems in the nation for Medical Excellence in Stroke Care.

Allegheny Health Network is rated among the Top 10% of health systems in the region for Patient Safety in Overall Surgical Care.

Allegheny Health Network Westfield Memorial Hospital recognized as #1 in market for medical excellence in Cardiac Care.

[3] The Baby-Friendly designation is a global initiative sponsored by the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) and promoted by the Colorado Department of Public Health and Environment (CDPHE). The rigorous designation requires birth centers to have policies that enhance mother-baby bonding, offer optimal care for infant feeding, and ensure a baby's nutritional needs are adequately met, regardless of whether a mother chooses to breastfeed or formula feed.

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 capture 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 Westfield Memorial 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 copays.
- 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.
- 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 preventive 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 Westfield Memorial 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. Cancer
4. Behavioral health (anxiety, depression, post-traumatic stress disorder, suicide, etc.)
5. Substance use disorder/addiction

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

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

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. Heart disease/stroke/ high blood pressure 3. Cancer 4. Behavioral Health 5. Substance use disorder/ addiction	1. Substance use/drug/ alcohol/smoking/tobacco 2. Poor eating habits 3. Lack of exercise/physical activity 4. Unmanaged stress or anxiety 5. Unsafe driving	1. Access to culturally appropriate primary care services 2. Access to preventive screenings and vaccinations 3. Access to affordable healthy food options	1. Overall feeling of safety/ security 2. Affordable, safe, quality housing/utilities 3. Safe places to walk/play	1. Access to mental health resources 2. Affordable, safe, quality housing/utlities 3. Adequate employment 4. Affordable, quality child and/or senior care options 5. Access to affordable healthy food options

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 population 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 CHNA and ISP

Over the past three years, representatives from AHN Westfield Memorial Hospital have focused on developing and implementing strategies to address the health needs and concerns in the study area. Additionally, AHN Westfield Memorial Hospital 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 Westfield Memorial Hospital has addressed the following strategies.

Behavioral Health

Health Priority: Substance Use Disorder

Goal: Establish protocol to treat eligible overdose patients with Medication Assisted Therapy (MAT).

Figure 8: SDOH Cost of Care Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
Begin medicating patients that meet criteria with first dose of Buprenorphine and transition to Medication Assisted Treatment (MAT) for detox.	• Introduce Real-Time Prescription Benefit (RTPB) tool. • Educate providers on new technology. • Demonstrate how to use the platform to providers/staff for optimal outcomes.		X	X	• Number of patients screened for eligibility for MAT. • Number of patients that participate in MAT program.	• Served five patients eligible for MAT

Health Priority: Mental Health Services

Goal: Increase referrals from emergency department (ED) to outpatient treatment options.

Figure 9: Behavioral Health, Mental Health Services Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
Provide patients presenting to the ED with local options for follow-up care.	• Develop partnerships with area behavioral health providers. • Develop a referral pathway for post-ED follow-up care of addiction and other mental health issues.	X	X	X	• Number of patients referred to mobile crisis services. • Number of local services identified.	• Referred seven patients to mobile crisis services • Increased meetings with Chautauqua County Office of Mental Healh to provide resources for BH patents in the ED

Health Priority: Postpartum Depression

Goal: Increase knowledge and access to postpartum depression resources.

Figure 10: Behavioral Health, Postpartum Depression Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
Increase community knowledge of postpartum depression program.	• Partner with OB group to establish a referral pattern for postpartum depression services	X	X	X	• Number of patients referred to postpartum depression program • Number of patients that attend a postpartum depression program • Number of postpartum depression programs	

Chronic Disease

Health Priority: Diabetes

Goal: To improve quality outcomes associated with diabetes.

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
Promote diabetes prevention in the community.	• Host screening and education events. • Identify at-risk patients through biometric screenings. • Present at schools and community groups on healthy living.	X	X	X	• Number of community events • Number of at-risk patients identified through biometric screenings. • Number of community events. • Number of at-risk patients identified through biometric screenings.	• Held seven community events reaching 102 patients regarding diabetes risk, high blood pressure, and BMI
Partner with local children's diabetic camp.	• Provide subject matter support to children at the camp. • Educate campers on diabetes management strategies.	X	X	X	• Staff hours for planning and presenting at the camp. • Number of campers educated.	• Conducted diabetes camp annually with a total of 51 diabetic children attending

Health Priority: Heart Disease

Goal: Improve quality outcomes associated with heart disease.

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
Begin offering consistent cardiac ECHO services WMH.	• Use inpatient care pathways established by the network. • Educate PCPs and patients on heart disease management.	X	X	X	• Number of inpatient order sets used to require an ECHO • Number PCP referrals for outpatient ECHO	• Completed 1,415 ECHO studies/ exams

Health Priority: Cancer

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

Figure 13: Chronic Disease, Cancer Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
Lung cancer screening program.	• Continue Lung Cancer Screening protocols. • Educate referring providers of service. • Begin community lung cancer screening.	X	X	X	• Number of studies performed • Number of patients screened at community events	• Completed 314 cancer screenings and follow-ups • Completed 739 cancer screenings; 67 had significant findings; two cancer findings

Health Equity

Goal: Identify community leaders to improve preventive care for the Amish population.

Figure 14: Health Equity Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
Identify community leaders	• Provide opportunity for preventive health screenings	X	X	X	• Number of population health screenings	• Held five screening events serving 114 individuals

Challenges Impacting CHNA Objectives, Path Forward Strategy

AHN Westfield Memorial Hospital has faced challenges in meeting critical health care goals in recent years, including objectives related to substance use disorder, postpartum depression, and health equity. In 2022, the hospital aimed to improve outcomes for patients struggling with substance use disorders but encountered barriers. However, these limitations only occurred for one year as the goal was met for 2023 and 2024 at AHN Westfield Memorial Hospital.

Postpartum depression was another area where AHN Westfield Memorial Hospital fell short of its goals across multiple years, including 2022, 2023, and 2024. While the hospital planned to enhance education and support services, AHN Westfield Memorial Hospital did not have the resources to address postpartum depression effectively. This situation has led to a continuation of unmet needs for maternal mental health services, with many new mothers lacking the necessary support during a crucial period of their lives.

Health equity also presented challenges for AHN Westfield Memorial Hospital, especially in 2022, as the hospital struggled to address disparities in access to care for marginalized groups in its service area. The hospital's commitment to delivering equitable health care to the Amish population were fulfilled in 2023 and 2024.

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 Westfield Memorial Hospital. 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

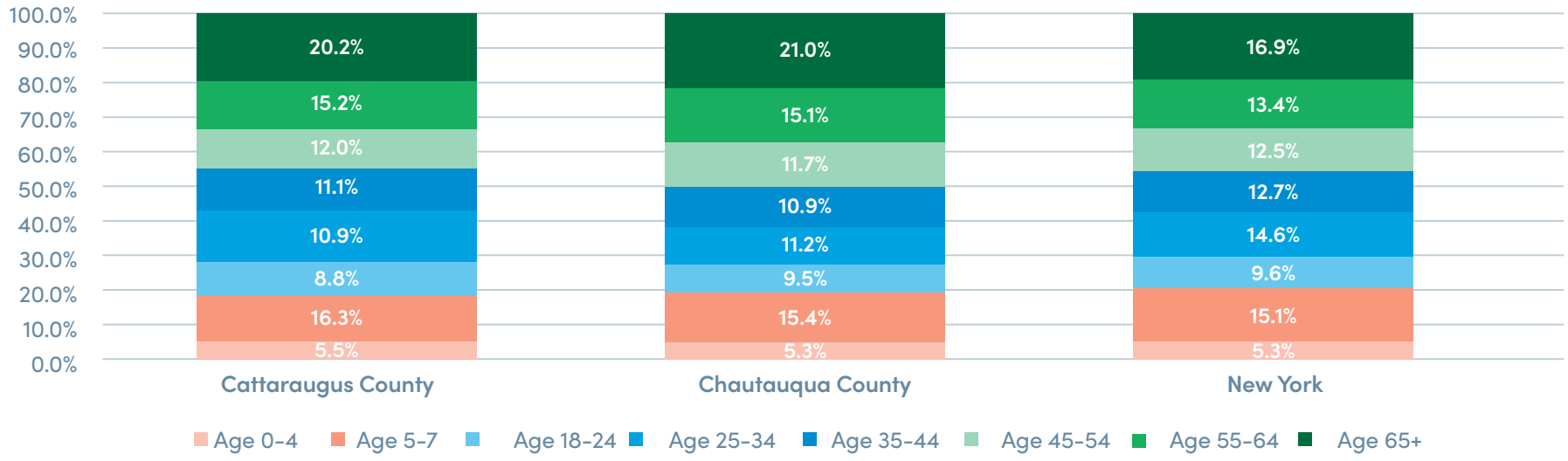
AHN Westfield Memorial Hospital Community At-A-Glance

Figure 15: Population

	Total Population	Males	Females
Cattaraugus County, NY	77,000	38,652	38,348
Chautauqua County, NY	127,440	63,496	63,944
New York	19,994,379	9,781,286	10,213,093

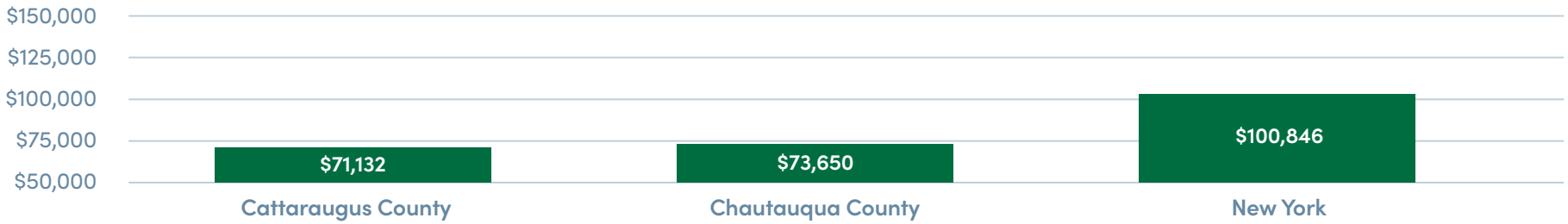
Source: U.S. Census Bureau, American Community Survey 2018-2022

Figure 16: Age Distribution



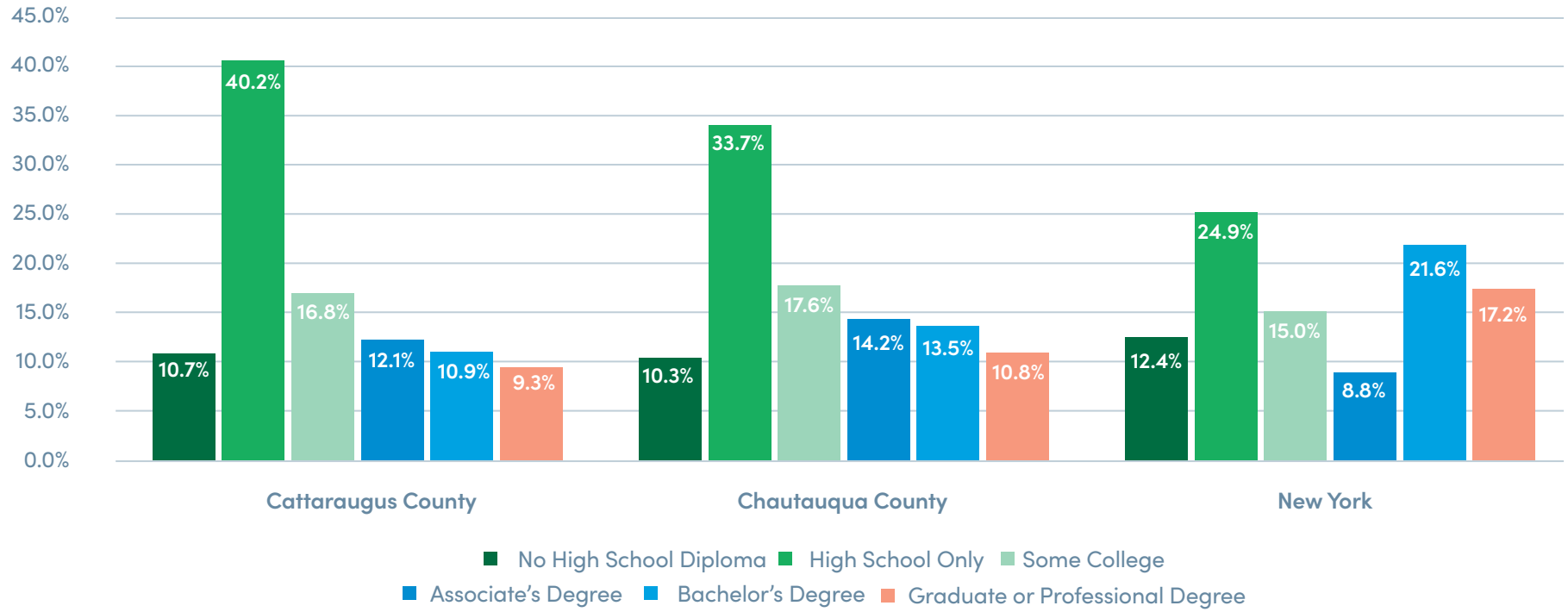
Source: U.S. Census Bureau, American Community Survey 2020

Figure 17: Median Household Income



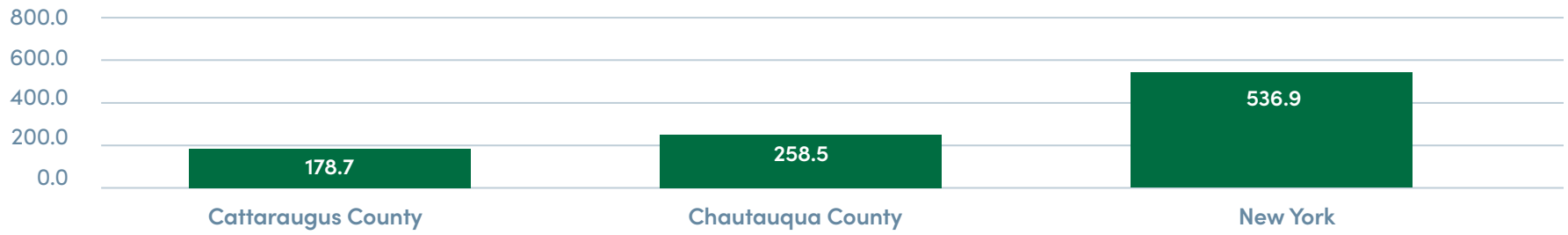
Source: U.S. Census Bureau, American Community Survey 2018-2022

Figure 18: Education



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

Figure 19: Violent Crime
(per 100,000 population)



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

Figure 20 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 20: Substandard Condition

Report Area	No Conditions	One Condition	Two or Three Conditions	Four Conditions
Cattaraugus County	74.49%	23.57%	1.85%	0.09%
Chautauqua County	72.81%	25.69%	1.46%	0.04%
New York	61.31%	35.95%	2.73%	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. A score of 1 in the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps represents the "healthiest" county in a given measure. Figure 21 reveals that in 2023, the clinical care ranking for both counties in AHN Westfield Memorial Hospital's primary service area worsened. Cattaraugus County worsened their scores from 2020 to 2023 in five of the eight categories.

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 21: County Health Rankings: (62 Counties in NY) (1=Healthiest)

	Year	Health Outcomes	Health Factors	Mortality	Morbidity	Health Behaviors	Clinical Care	Social & Economic Factor	Physical Environment
Cattaraugus County	2023	61	59	58	61	58	61	49	24
	2020	57	59	47	60	49	58	55	52
Chautauqua County	2023	56	49	51	59	53	25	54	1
	2020	61	54	60	61	55	20	56	56

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

[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

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.

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?

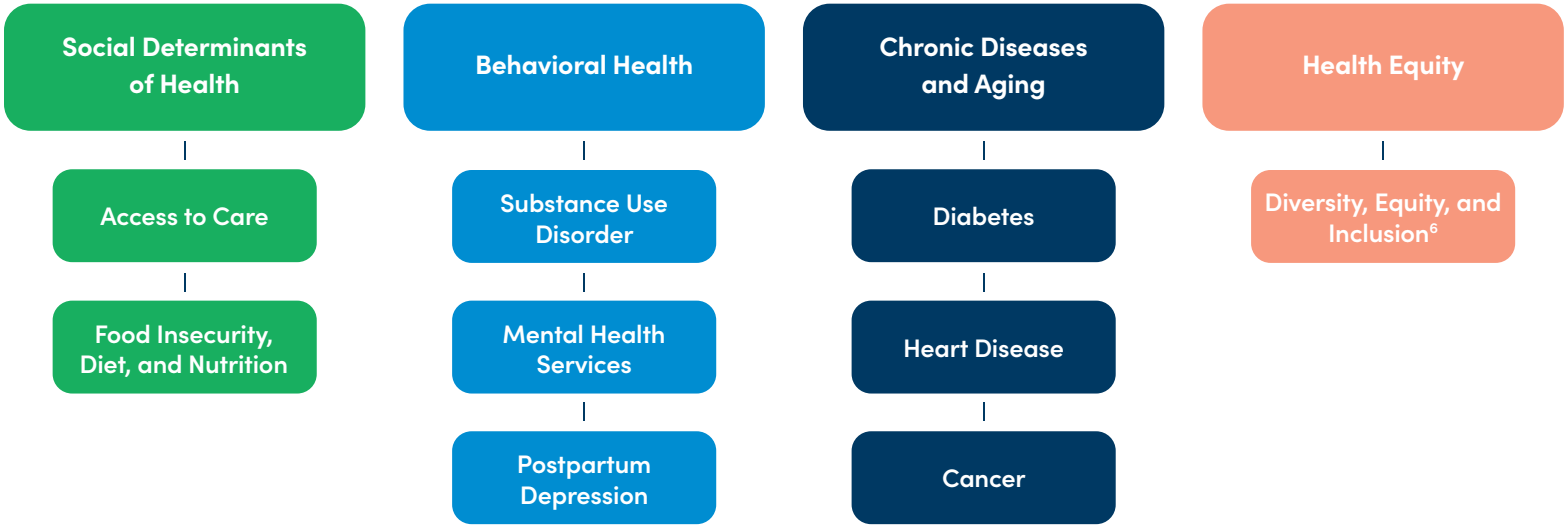
Identification and Prioritization Process

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 Allegheny Health Network community.

2024 CHNA 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 Westfield Memorial Hospital highlighted the following community needs:

Figure 22: AHN Westfield Memorial Hospital 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 —e conomic 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 23: Social Determinants of Health

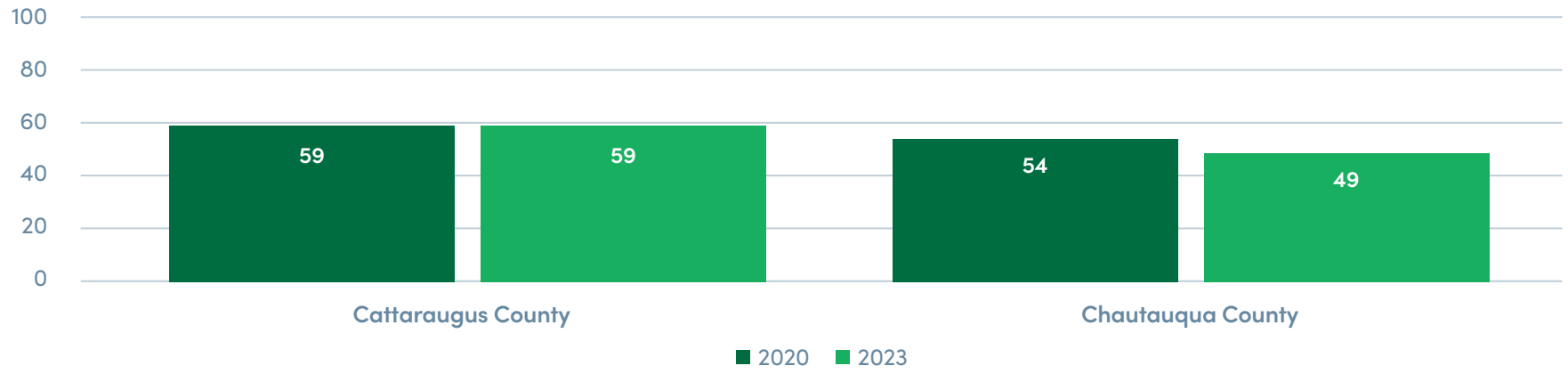
The key themes identified across stakeholder groups — through stakeholder interviews, Patient and Family Advisory Council (PFAC) group interviews, community surveys, and provider surveys — reveal several significant barriers to accessing health care. These barriers include affordability challenges, such 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 preventive 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 24 below shows that Chautauqua County improved their health factor rankings from 2020 to 2023, although Cattaraugus County stayed the same.

Figure 24: Health Factors Rankings



Source: County Health Rankings

Figure 25 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 25: Engaging the Community Through Primary Data Collection

Stakeholder Interviews	PFAC Group Interviews	Community Survey	Provider Survey
• Affordability (i.e., out-of-pocket costs/high deductibles/copays) • 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 culturally appropriate primary care services • Access to preventive screenings and vaccinations • Access to affordable healthy food options • Access to mental health resources • Access to affordable prescription and over-the-counter medication • Overall feeling of safety/security • Affordable, safe, quality housing/ utilities • Safe places to walk/play	• Affordability • Availability of services • No insurance coverage • Lack of transportation • Lack of health care coordination services

Access to Care

Access to care was identified as a prioritized health need for AHN Westfield Memorial Hospital 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 Westfield Memorial Hospital 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 lead 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.

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, New York will need an additional 1,220 primary care physicians by 2030, an 8% increase compared to the state's (as of 2010) 14,858 PCP workforce.[9]

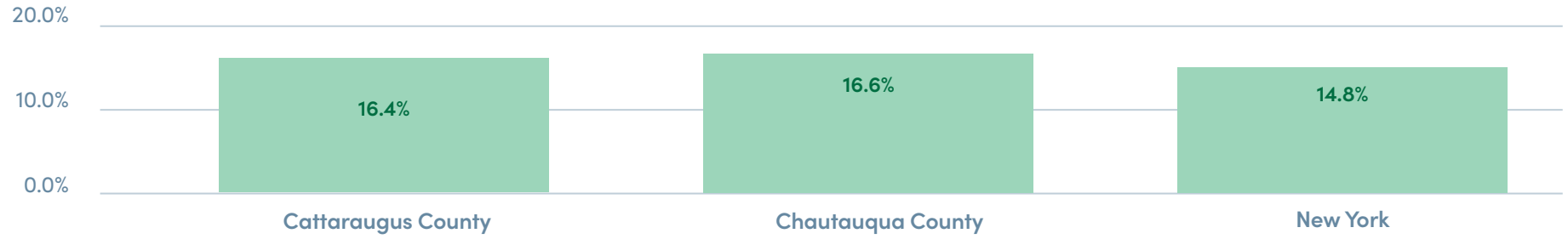
Access to health care not only affects physical health but also has broader social and economic implications. When people have reliable access to care, they are more likely to remain productive, continue working, and avoid disability. The economic costs of untreated illness are significant; for example, 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.

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

Figure 26 reports the percentage of adults aged 18 and older who self-report their general health status as “fair” or “poor.”

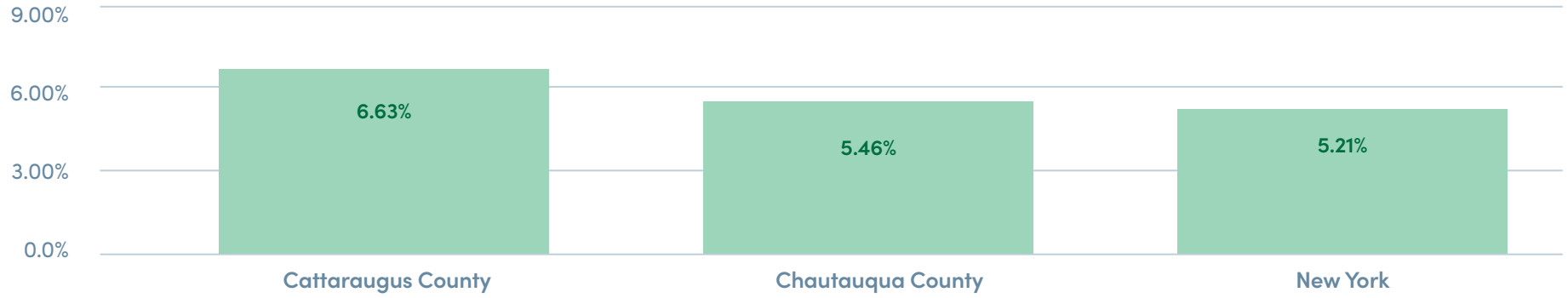
Figure 26: Adults >18 with “fair” or “poor” health status



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

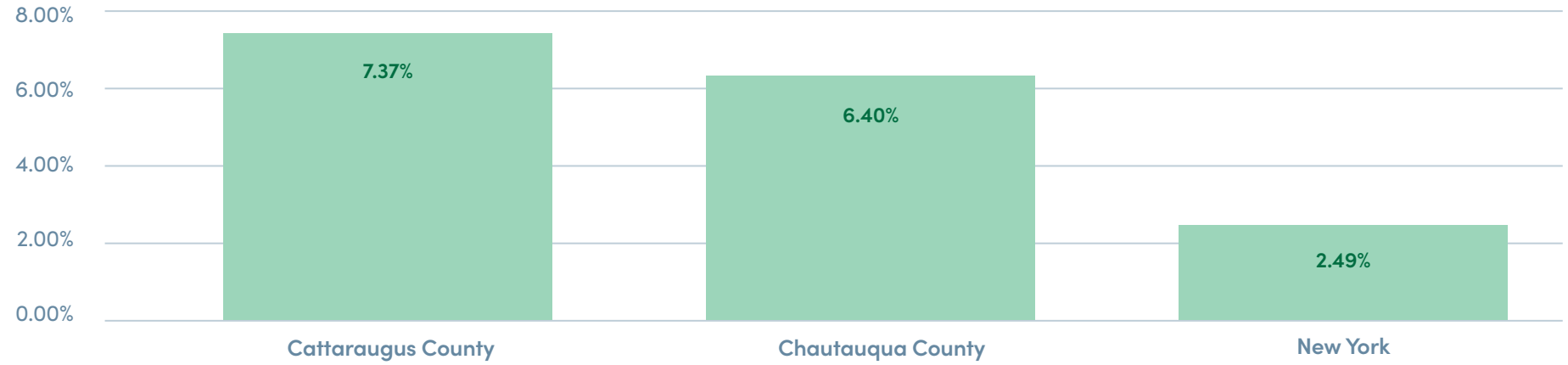
Lack of health insurance is considered a key driver of health status. Figure 27 below reports the lack of health insurance as a primary barrier to health care access, contributing to poor health status.

Figure 27: Uninsured Population



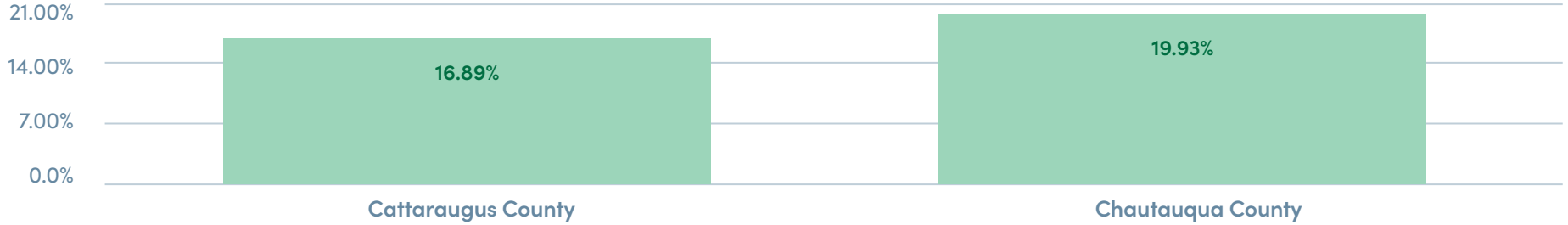
Source: U.S. Census Bureau, American Community Survey 2018-2022

Figure 28: Uninsured Children



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

Figure 29: Public Assistance Income or Food Stamps/SNAP



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

Figure 30: Health Professional Shortage Areas (HPSAs) by County

HPSAs	Dental Health	Mental Health	Primary Care	Total HPSAs
Cattaraugus County	3	3	3	9
Chautauqua County	3	3	3	9
New York	156	192	184	532

Source: Health Resources and Services Administration

Food Insecurity, Diet, and Nutrition

Food insecurity, diet, and nutrition was identified as a prioritized health need for AHN Westfield Memorial Hospital based on the community survey and provider survey results as well as the secondary data analysis. In addition to those data points, AHN Westfield Memorial Hospital considered their capacity to implement food insecurity, diet, and nutrition programming. Food insecurity, poor diet, and inadequate nutrition are critical social determinants of health that profoundly impact individual and population health outcomes. Food insecurity refers to the lack of reliable access to sufficient, safe, and nutritious food necessary for an active and healthy life. The United States Department of Agriculture (USDA) reported that 33.2% of low-income individuals in the U.S. lived in food deserts, and 10.2% of households were food insecure for at least a portion of time during 2021.[11] When individuals or families face food insecurity, they are often forced to trade between purchasing food and meeting other basic needs, such as health care or housing, which directly impacts their health. According to the United States Department of Agriculture (USDA), more than 47 million people in the United States, including one in five children, are food insecure.[12] People who are food-insecure often turn to cheaper, calorie-dense, but nutritionally poor food options, leading to increased risks of chronic diseases such as obesity, diabetes, and heart disease.

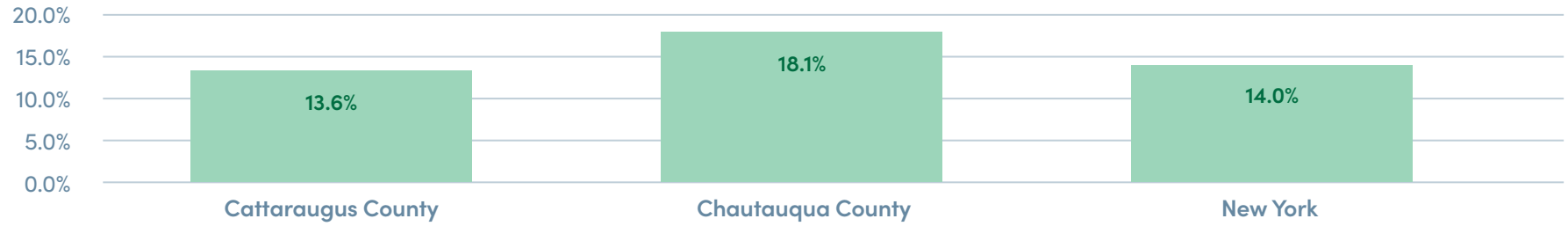
Diet and nutrition are key health factors, influencing everything from physical health to cognitive development. A diet lacking in essential nutrients can impair immune function, reduce energy levels, and increase susceptibility to illness. Furthermore, poor nutrition in early childhood has long-term consequences, including developmental delays, learning difficulties, and higher risks of chronic diseases later in life. Chronic conditions are disproportionately prevalent in low-income communities where access to healthy foods is limited because of food deserts, a term used to describe areas where residents have little access to affordable, nutritious food.

Socioeconomic disparities deepen the issue of food insecurity and poor nutrition. Low-income families are more likely to live in neighborhoods without grocery stores that offer fresh produce, relying instead on convenience stores or fast-food outlets where unhealthy, processed foods are more accessible. This imbalance perpetuates health disparities, as individuals in these communities are at greater risk for poor diet-related health outcomes. Addressing food insecurity and improving access to nutritious foods are essential to promoting health equity. By improving diet and nutrition, society can work toward reducing chronic disease rates and cultivating healthier communities, narrowing health disparities linked to food insecurity.

The Supplemental Nutrition Assistance Program (SNAP) benefits are crucial because they enhance food security for low-income individuals and families, ensuring access to nutritious food and reducing hunger. On average, 41.2 million people in 21.6 million households received monthly SNAP benefits in the 2022 fiscal year, which ran from October 2021 through September 2022.[13] By improving dietary quality, SNAP contributes to better health outcomes, lowering the incidence of chronic diseases. The program also supports economic stability by freeing up household resources for other essential needs and stimulates local economies through food purchases. SNAP is vital for children's proper growth and cognitive development, contributing to better academic performance and overall well-being. Ultimately, SNAP plays a key role in alleviating poverty and promoting a healthier, more stable society.

[11] The National Library of Medicine
[12] U.S. Department of Agriculture
[13] Pew Research Center

Figure 31: Population Receiving Supplemental Nutrition Assistance Program (SNAP)



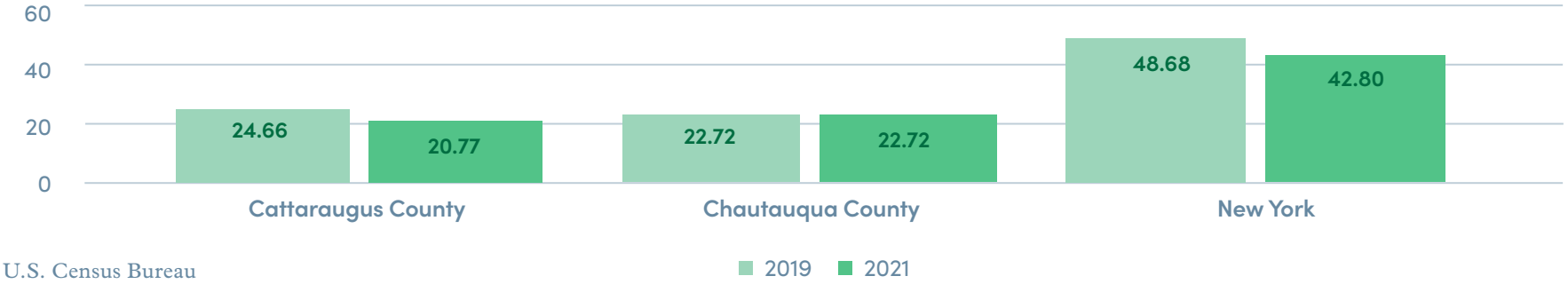
Source: U.S. Census Bureau, 2021

Figure 32: Unmarried Partner Households Receiving SNAP Benefits

Source: The Agency for Health care Research and Quality, 2020

Access to healthy foods supports healthy dietary behaviors, and grocery stores are a major provider of these foods. Grocery stores are defined as supermarkets and smaller grocery stores primarily retailing a general line of food, such as canned/frozen foods, fresh fruits/vegetables, and fresh/prepared meats, fish, and poultry. Delicatessen-type establishments are also included. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded.

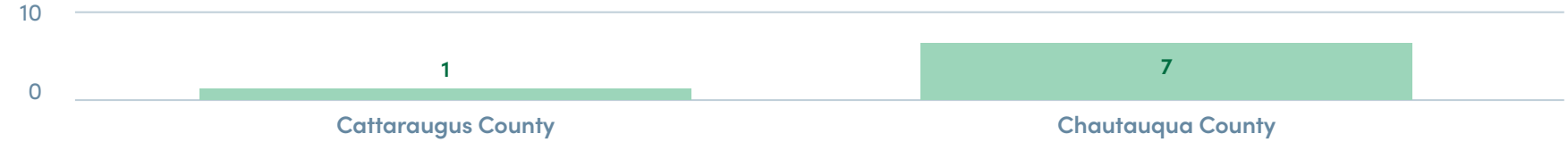
Figure 33: Food Environment – Grocery Stores (per 10,000 population)



Source: U.S. Census Bureau

The USDA Food Access Research Atlas defines a food desert as any neighborhood that lacks healthy food sources because of income level, distance to supermarkets, or vehicle access.

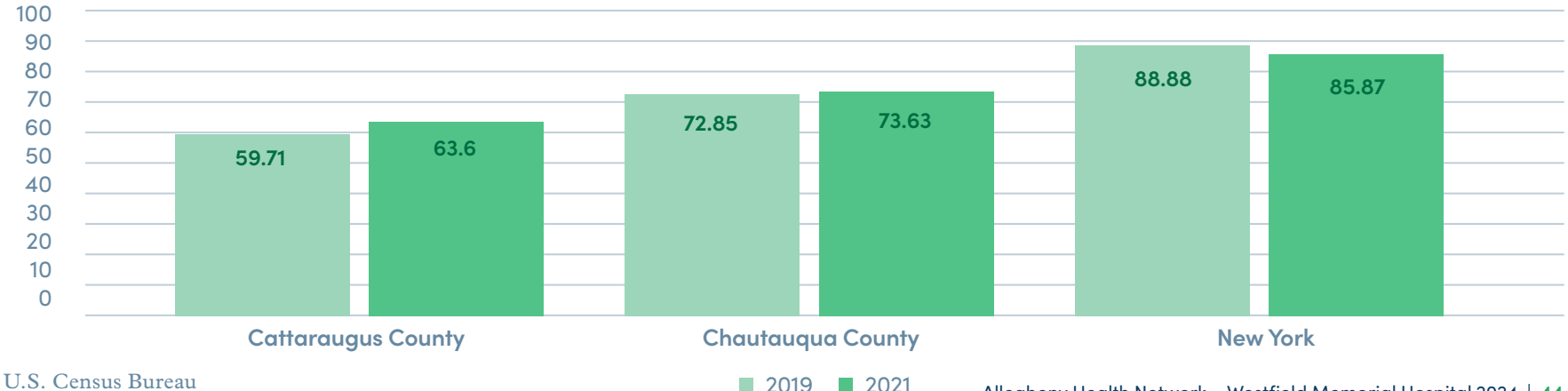
Figure 34: Food Environment – Food Desert Census Tracts



Source: U.S. Census Bureau, 2019

The prevalence of fast-food restaurants provides a measure of access to healthy food and environmental influences on dietary behaviors. Fast-food restaurants are limited-service establishments primarily providing food services (except snack and non-alcoholic beverage bars) where patrons generally order or select items and pay before eating.

Figure 35: Food Environment – Fast Food Restaurants (per 10,000 population)



Source: U.S. Census Bureau

B.) Behavioral Health

Behavioral health was identified as a prioritized health need for AHN Westfield Memorial Hospital based on stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN Westfield Memorial Hospital considered their capacity to implement behavioral health programming. Behavioral health is a critical issue in New York, as the state faces rising challenges related to mental health and substance use disorders. In the 2021-2022 period, federal data estimated 21.1% of adult New Yorkers – fully 3.2 million people had a mental illness. Incidence is particularly pronounced for those ages 18 to 25, for whom fully 30 percent were estimated to have a mental illness. This increased need is reflected in a 23% increase in the number of individuals served by the State's public mental health system over the last 10 years, with 900,000 New Yorkers utilizing services.[14]

In particular, cases of severe mental illness – which may result in serious functional impairment or interference with major life activities – which were already growing prior to the pandemic afflicted nearly 5.1 percent of New York's adults in 2021-2022, or about 783,000 individuals.[15] These individuals may require intensive treatment or hospitalization; however, inpatient psychiatric capacity – defined as beds in the acute care units of general hospitals and stand-alone psychiatric hospitals (collectively referred to as "community hospitals"), as well as beds in State-operated psychiatric centers (PC) – has been in a nearly steady decline since 2014.

Including behavioral health in the CHNA allows communities to gain deeper insights into the prevalence and impact of mental health and substance use issues. This data-driven approach enables targeted interventions and strategically allocating resources to address these challenges effectively. By incorporating behavioral health, communities can identify obstacles to accessing care, such as stigma, lack of insurance coverage, and limited provider availability, often preventing individuals from seeking the help they need.

The shortage of mental health professionals, particularly in rural areas, amplifies access challenges. The CHNA process highlights these disparities, allowing communities to advocate for increased funding, policy reforms, and implementing programs that expand access to behavioral health services. These actions improve individual health outcomes and strengthen the community's resilience and well-being. Addressing behavioral health concerns requires a collaborative approach, engaging healthcare providers, policymakers, community organizations, and residents to develop effective solutions that enhance mental health care across the region.

[14-15] New York State Comptroller, 2024

Figure 36: Behavioral Health Measures, New York State Rankings

Measure	2020	2023
Depression	74.49%	23.57%
Excessive Drinking	72.81%	25.69%
Frequent Mental Distress	61.31%	35.95%
Smoking	74.49%	23.57%
Suicide	72.81%	25.69%

Source: America's Health Rankings

Substance Use Disorder

Substance use disorder was identified as a prioritized health need for AHN Westfield Memorial Hospital based on stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN Westfield Memorial Hospital considered their capacity to implement substance use disorder programming. New York, along with the rest of the United States, has been grappling with a persistent opioid crisis since the federal government declared a public health emergency in October 2017. This emergency has been renewed multiple times, underscoring the ongoing severity of the epidemic. By 2020, opioid overdose deaths had spiked significantly across the nation, with a 38 percent increase.[16] In New York, the numbers were even more alarming, with a 44 percent rise in overdose deaths that year. This troubling trend continued into 2021, when overdose fatalities in New York grew by an additional 17 percent, reaching nearly 5,000 deaths, a 68 percent increase in just two years.[17]

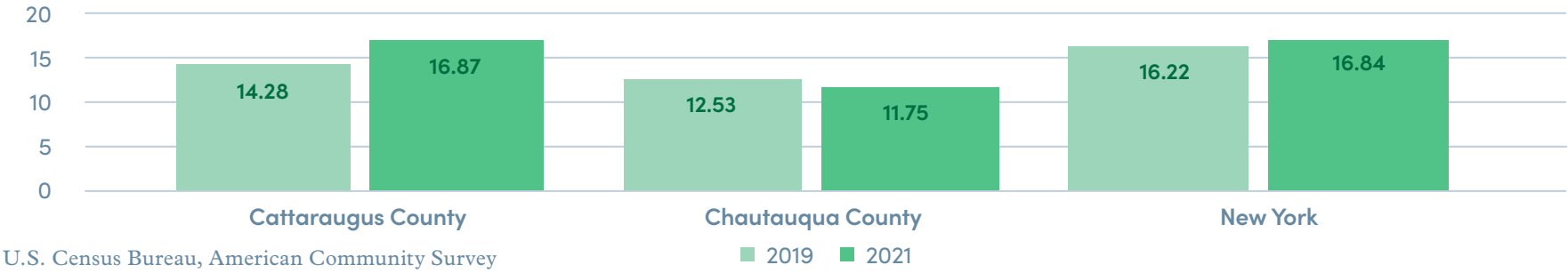
The proportion of drug overdose deaths in New York involving opioids has also risen sharply over the past decade. In 2010, opioids were involved in 69 percent of overdose deaths, but by 2020 and 2021, that share had surged to 85 percent. This escalation reflects both the widespread availability of opioids and the rise in the potency of illicit opioids like fentanyl. In 2021, 30 out of every 100,000 New Yorkers died from a drug overdose, with opioid overdoses accounting for 25 of those deaths—a drastic increase from only 5 opioid-related deaths per 100,000 in 2010. Notably, New York's opioid overdose death rate surpassed the national average during both 2020 and 2021.[18]

[16-18] New York State Comptroller, 2022

The opioid crisis has impacted New Yorkers across the state, with some counties experiencing particularly high rates of fatal overdoses. In 2020, 10 of the 15 counties with available data reported overdose death rates above the state average of 25.4 per 100,000 people, with Dutchess County suffering the highest rate, at over 43 per 100,000. The crisis has also affected all racial and ethnic groups in New York, though its impact has been disproportionately severe among minority communities. From 2010 to 2020, overdose death rates for Black New Yorkers increased nearly five-fold, while rates for Hispanic or Latino New Yorkers quadrupled and rates for white New Yorkers tripled. In 2020, white New Yorkers had the highest death rate, at 28.7 per 100,000.[19]

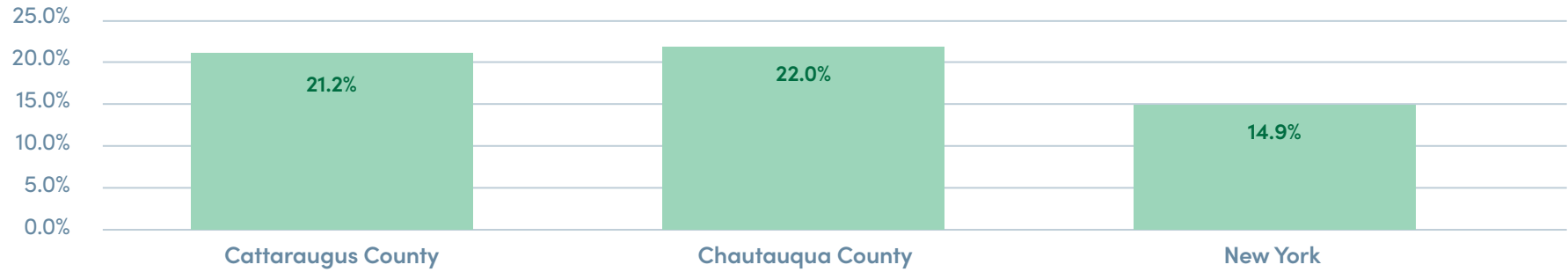
By prioritizing substance use disorder within the health care framework, New York can work toward reducing the prevalence of addiction and its associated consequences. Collaborative efforts that include education, outreach, and support can help create healthier communities and aid resilience among individuals and families affected by substance use disorder.

Figure 37: Built Environment – Liquor Stores (per 10,000 population)



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

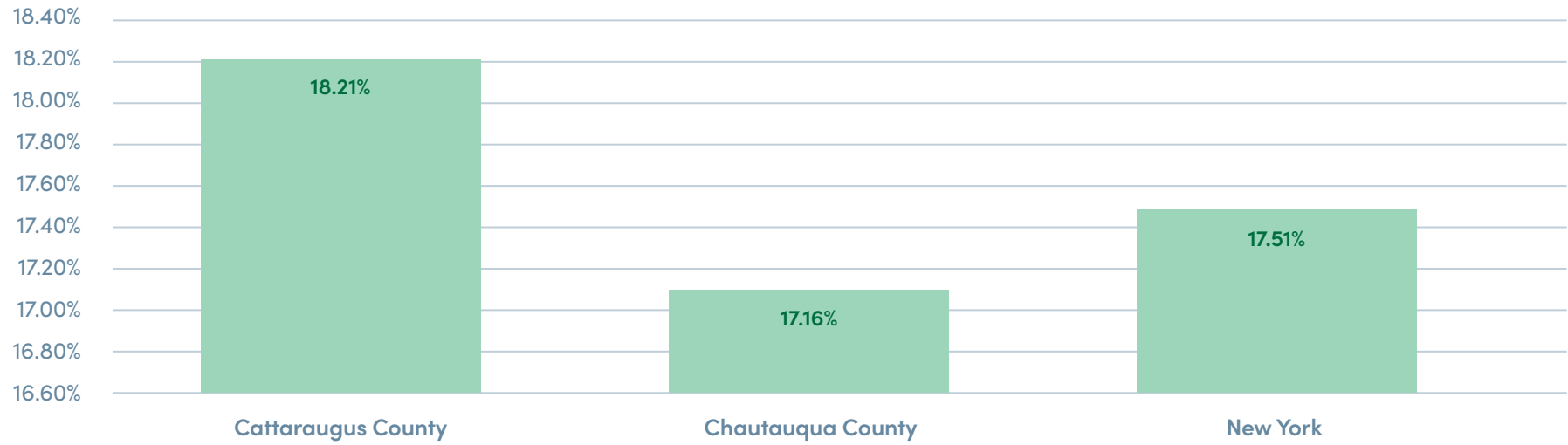
Figure 38: Current Smokers



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

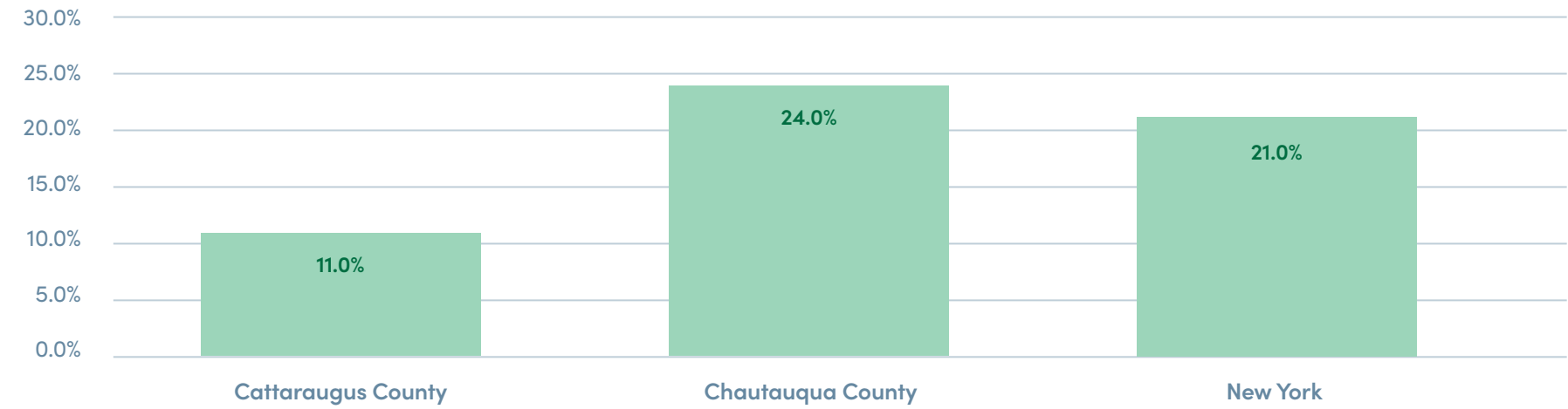
[19] New York State Comptroller, 2022

Figure 39: Adults Reporting Excessive Drinking



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

Figure 40: Alcohol-Impaired Driving Deaths



Source: County Health Rankings, 2017-2021

Mental Health Services

Mental health services was identified as a prioritized health need for AHN Westfield Memorial Hospital based on stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN Westfield Memorial Hospital considered their capacity to implement mental health programming. The demand for mental health services has surged in recent years, worsened by the COVID-19 pandemic, which led to increases in anxiety, depression, and stress-related conditions among the population.

In a 2023 survey of New York City teens, 24% said they needed or wanted mental health care but did not get it over the past 12 months. Among these teens who needed or wanted but did not receive mental health care, the most common reasons were feeling that they could handle their mental health without treatment (55%), not wanting to share with family that they needed mental health care (53%), and worrying that if they received mental health care, people would think badly of them (27%). Teens were least likely to report having problems using telehealth services (2%) and being unable to find a provider who spoke their language or understood their culture (1%).[20]

Unmet need for mental health treatment includes people's perception of not receiving as much treatment as they would have wanted, not receiving it as soon as they wish they had, or not easily accessing it at any point when they wanted it. Among NYC adults with a diagnosed mental illness, 34% have had an unmet need for mental health treatment in the past year.[21]

Because unmet need is self-reported, it is tied to factors that influence which groups of people want to pursue mental health treatment. It is, therefore, possible that some groups report higher levels of treatment and unmet need. An unmet need may be due to cost or stigma. Many barriers to receiving mental health treatment disproportionately affect adults with low incomes and communities facing structural discrimination. In 2023, 14%, or about 945,000, of all adult New Yorkers reported an unmet need for mental health treatment in the past 12 months.[22]

Expanding access to mental health services, ensuring adequate insurance coverage, and addressing barriers such as provider shortages are essential to tackling mental health challenges. Additionally, targeted interventions are required for underserved populations, including those facing socioeconomic hardships and specific demographic groups disproportionately affected by mental health issues, such as minorities and the LGBTQ+ community.

[20] NYC Teen Mental Health Survey, 2023
[21] NYC Neighborhood Wellness Survey, 2023
[22] NYC Neighborhood Wellness Survey, 2023

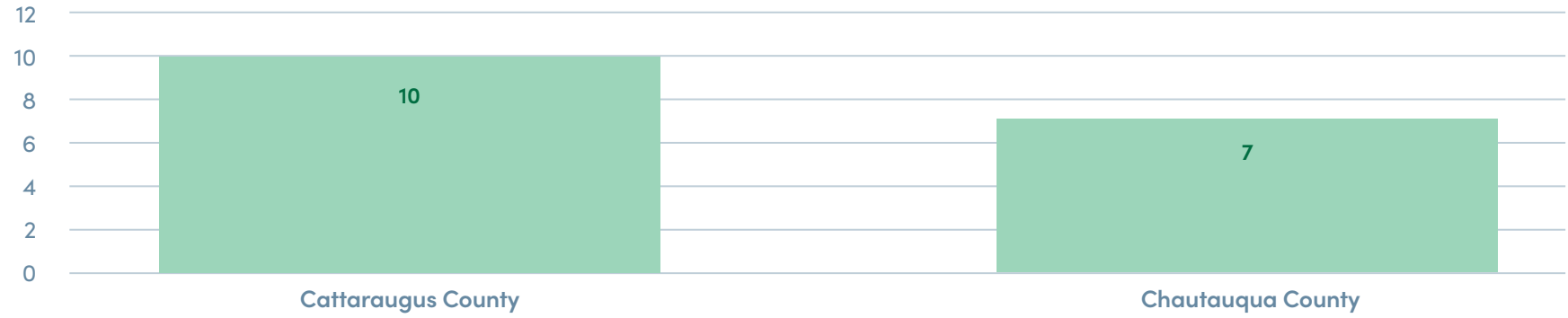
Figure 41 below shows the average number of mentally unhealthy days reported in the past 30 days (age-adjusted).

Figure 41: Poor Mental Health Days

	Average Number of Mentally Unhealthy Days in the Past 30 Days
Cattaraugus County	5.3
Chautauqua County	5.2
New York	4.2

Source: County Health Rankings, 2021

Figure 42: Facilities That Provide Mental Health Services



Source: The Agency for Health care Research and Quality (AHRQ), 2020

Mental health providers is the ratio of the population to mental health providers. The ratio represents the number of individuals served by one mental health provider in a county if providers were equally distributed across the population.

Figure 43: Ratio of Population to Mental Health Providers

	Mental Health Providers Rate (per 100,000 population)
Cattaraugus County	570:1
Chautauqua County	530:1
New York	280:1

Source: County Health Rankings, 2023

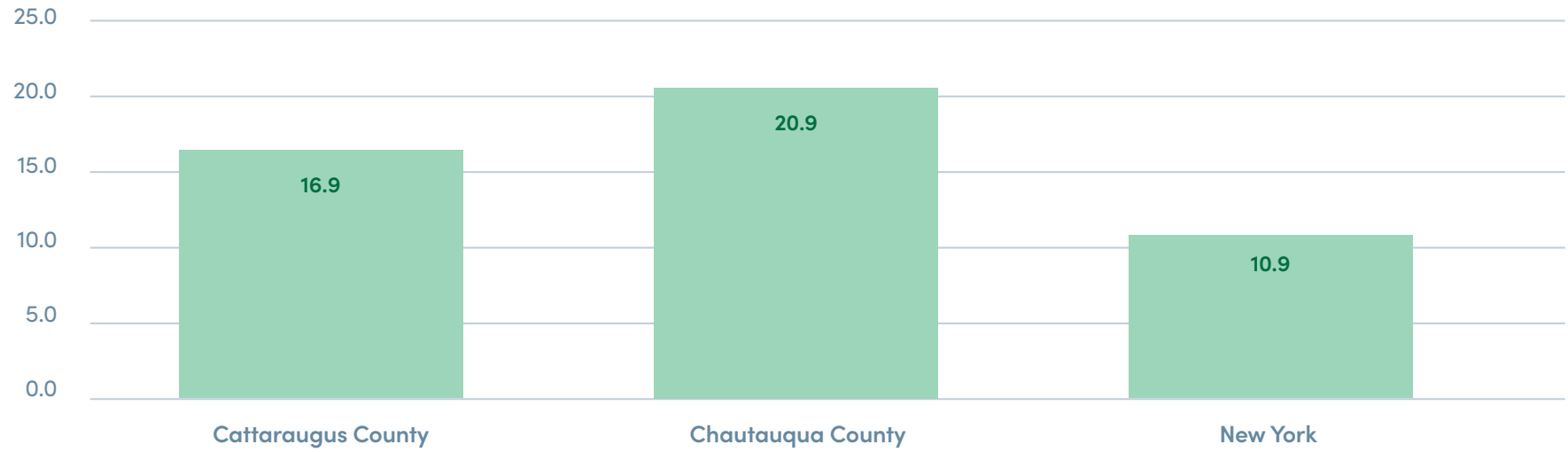
Postpartum Depression

Postpartum depression was identified as a prioritized health need for AHN Westfield Memorial Hospital based on the introduction of providing OB-GYN services in the region, as well as the secondary data analysis. In addition to those data points, AHN Westfield Memorial Hospital considered their capacity to implement postpartum depression programming. Postpartum depression (PPD) is a significant mental health issue that affects many new mothers, impacting their emotional well-being and overall behavioral health. It is characterized by feelings of sadness, anxiety, and exhaustion that can interfere with a mother's ability to care for herself and her baby. Research indicates that approximately one in 10 women experience PPD, with some estimates suggesting that rates can be even higher among women with a history of mental health issues or those facing social and economic challenges.[23]

To effectively combat PPD, early identification and intervention are essential. Screening for depression during prenatal visits and postpartum check-ups can help health care providers recognize at-risk individuals. Furthermore, providing access to mental health resources, including counseling, support groups, and peer support programs, can empower mothers to seek help and alleviate symptoms. Communities can play a pivotal role in supporting mothers by creating environments that promote mental health, reducing stigma associated with seeking help, and ensuring that adequate resources are available for those in need.

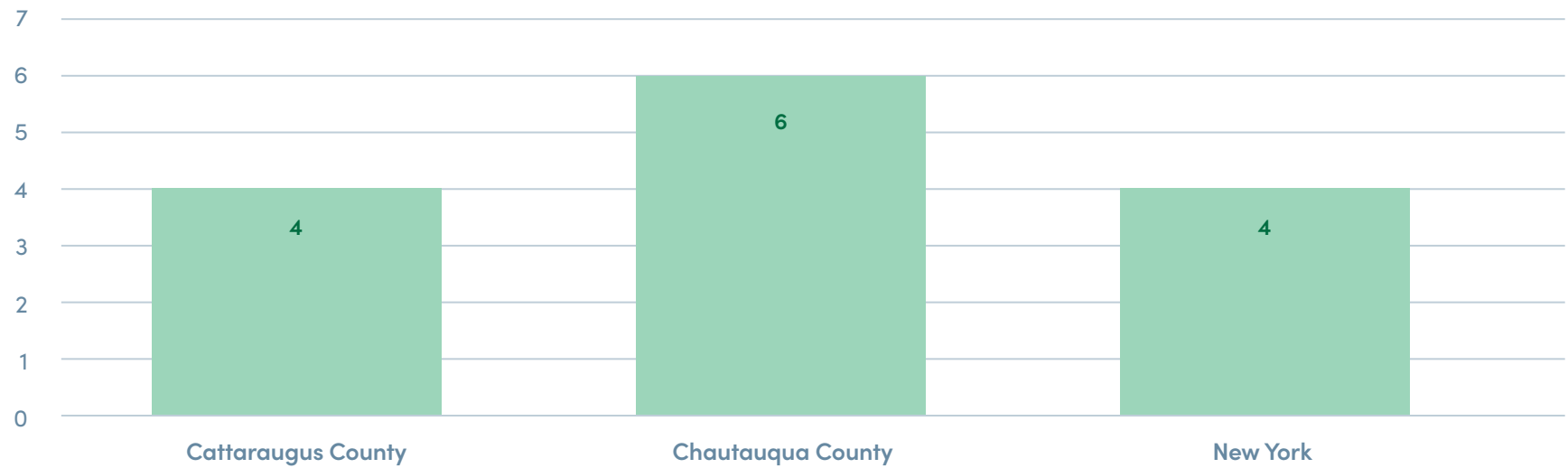
[23] BMC Public Health

Figure 44: Teen Births, Rate per 1,000 Female Population (age 15-19)



Source: Centers for Disease Control and Prevention, 2016-2020

Figure 45: Infant Mortality (under age 1 per 1,000 live births)



Source: County Health Rankings, 2015-2021

C.) Chronic Diseases and Aging

Chronic diseases and aging was identified as a prioritized health need for AHN Westfield Memorial Hospital 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 Westfield Memorial Hospital considered their capacity to implement chronic disease and aging programming. Chronic diseases and the effects of aging pose significant health challenges and have far-reaching impacts on individuals and society. Defined as long-lasting conditions that often require ongoing medical attention, chronic diseases include conditions such as diabetes, heart disease, and cancer (plus aging). These diseases can lead to severe health complications, reduced quality of life, and increased health care costs. An estimated 129 million people in the United States have at least one major chronic disease, according to the U.S. Department of Health and Human Services.[24] Addressing these risk factors is crucial for prevention and management strategies.

According to the Centers for Disease Control and Prevention (CDC), 90% of the nation's $4.5 trillion in annual health care expenditures are for people with chronic and mental health conditions.[25] Chronic care costs are often higher because of the increased risk of patients ending up in an emergency room or hospital. Patients with chronic conditions and "highly fragmented care" were 13% to 14% more likely to visit the ER.[26] Additionally, chronic diseases contributed to 60% of all ER visits, and 4.3 million visits were likely preventable. Avoiding these preventable visits would save $8.3 billion yearly in health care costs.[27] This financial strain affects health care systems, businesses, and communities through increased insurance premiums, lost productivity, and disability costs. Moreover, individuals suffering from chronic diseases often face limitations in daily activities, leading to diminished work capacity and economic stability.

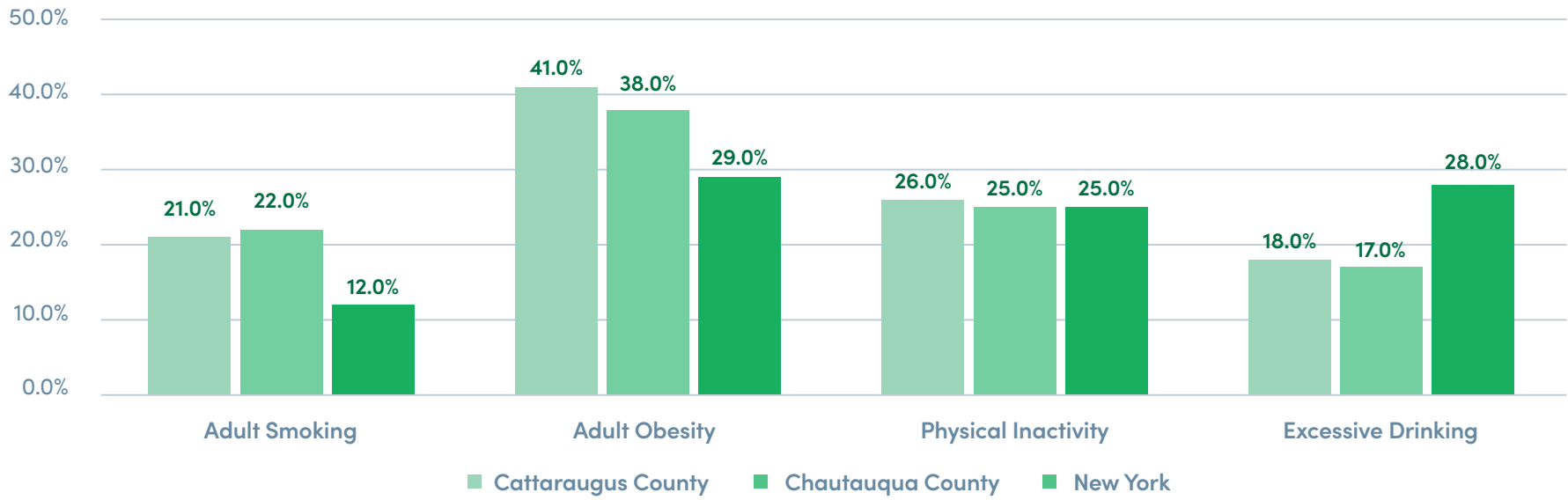
The impacts of chronic diseases extend beyond physical health; they also significantly affect mental and emotional well-being. People living with chronic illnesses frequently experience anxiety, depression, and social isolation. This interplay between physical and mental health can complicate treatment and management strategies, necessitating an integrated approach that addresses both aspects.

Adopting healthy behaviors and positive habits, including regular exercise, sufficient sleep, a nutritious diet, and avoiding tobacco and excessive alcohol, can greatly lower the risk of disease and enhance overall quality of life. Maintaining a healthy lifestyle is crucial for managing specific health issues, ensuring general well-being, and decreasing the chances of being diagnosed with chronic illnesses.

[24] Centers for Disease Control and Prevention
[25] Centers for Disease Control and Prevention
[26] Fragmented care often means lack of continuity in care and treatment plans. These people may not have a primary care provider to coordinate care and monitor their health over time.
[27] Highmark Blue Cross Blue Shield

Chronic diseases, though prevalent, are among the most preventable health problems. Proper management of chronic diseases involves a combination of regular screenings, routine checkups, and vigilant monitoring of treatment plans. These proactive measures help in early detection and effective management of conditions, thereby improving patient outcomes. Patient education is also crucial, as it empowers individuals to manage their conditions better, adhere to prescribed treatments, and make lifestyle changes that promote overall well-being. Multiple chronic conditions may involve or cause a person's immune system to not function properly.

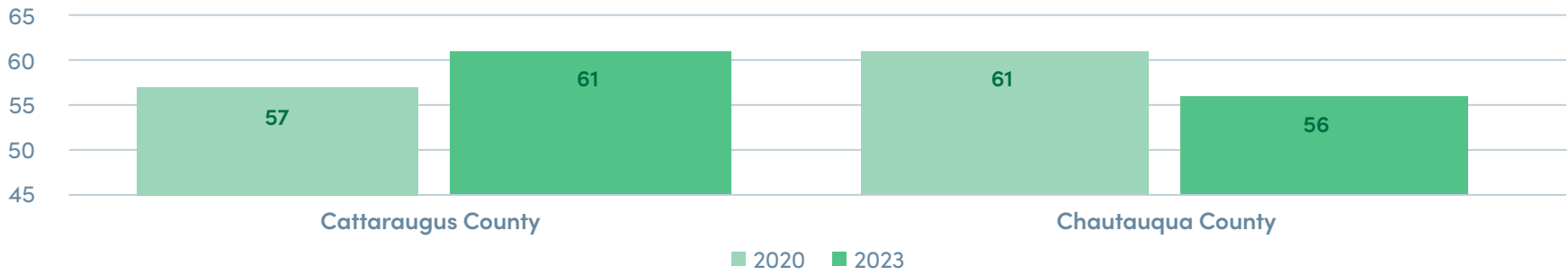
Figure 46: Behaviors Leading to Chronic Conditions



Source: County Health Rankings, 2021

Rankings for health outcomes are based on equal weighting of one length of life (mortality) measure, and four quality of life (morbidity) measures. Those having high ranks, e.g., 1 or 2, are considered the "healthiest." A ranking of Figure 47 below shows that Cattaraugus County's health outcomes rankings got worse from 57 in 2020 to 61 in 2023, while Chautauqua County improved their ranking from 61 to 56.

Figure 47: Health Outcomes Rankings



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

The data collected from stakeholder interviews, PFAC group interviews, community surveys, and provider surveys highlight several major health concerns within the community. Behavioral health issues, such as anxiety, depression, post-traumatic stress disorder, and suicide, are consistently emphasized across all sources. Other prevalent concerns include chronic conditions such as heart disease, stroke, diabetes, and cancer and issues related to substance use disorders, including opioid abuse and alcohol addiction.

Being overweight and obese, often tied to poor eating habits, lack of physical activity, and unmanaged stress, are recurring themes. Aging-related problems such as memory loss, vision or hearing loss, and mobility challenges are also significant. Additionally, some groups highlighted the dangers of unsafe driving practices (e.g., DUI, speeding) as a public health concern. Overall, the findings reflect a broad spectrum of health issues, from mental and behavioral health to chronic disease management and lifestyle-related challenges.

Figure 48 delineates the responses from the community leader stakeholder interviews, PFAC group interviews, community surveys, and provider surveys regarding the top health problems the community is facing.

Figure 48: Engaging the Community Through Primary Data Collection

Stakeholder Interviews	PFAC Group Interviews	Community Survey	Provider Survey
• Behavioral health (anxiety, depression, post-traumatic stress disorder, suicide, etc.) • Heart disease and stroke • Being overweight/obesity (lack of exercise/physical inactivity) • Diabetes • Substance use disorder/addiction (including alcohol abuse) • Aging problems (i.e., hearing or vision loss, memory loss, etc.) • Cancer • Poor eating habits	• Opioid abuse • Chronic illnesses (diabetes, cancer, heart disease) • Behavioral health	• Overweight/obesity/diabetes • Substance use disorder/addiction • Behavioral health (anxiety, depression, post-traumatic stress disorder, suicide, etc.) • Heart disease, stroke, high blood pressure • Aging problems • Poor eating habits • Lack of physical activity • Bullying (including online) • Risky/excessive social media use	• Behavioral health • Overweight/obesity/diabetes • Substance use disorder/addiction • Heart disease/stroke/high blood pressure • Cancer

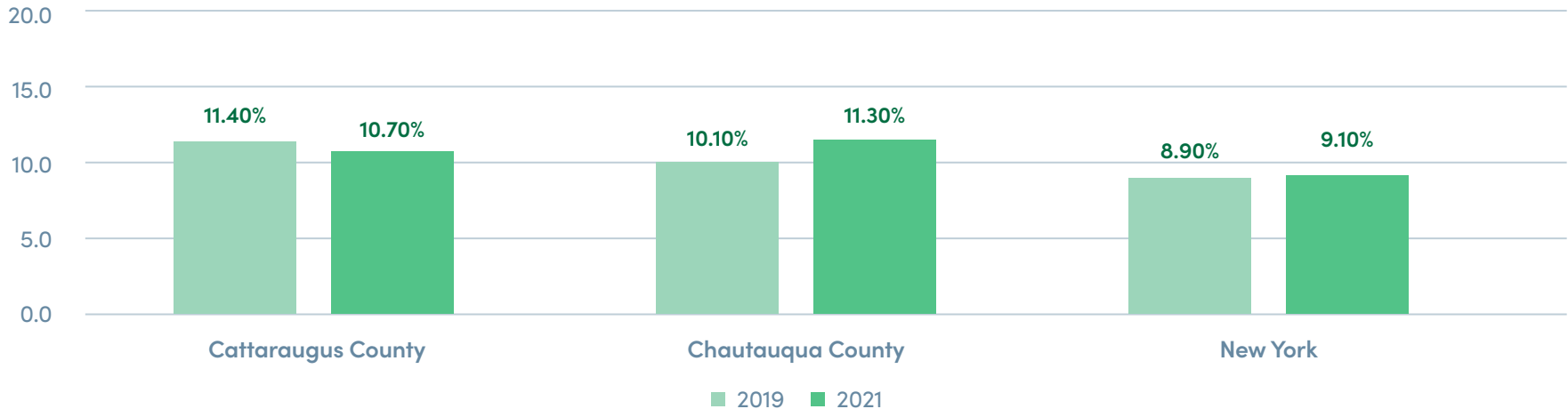
Diabetes

Diabetes was identified as a prioritized health need for AHN Westfield Memorial Hospital 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 Westfield Memorial Hospital considered their capacity to implement diabetes programming. Diabetes is an epidemic in the United States. According to the Centers for Disease Control and Prevention, more than 38 million Americans have diabetes and face its devastating consequences. The prevalence of diabetes has been steadily increasing, reflecting national trends influenced by factors such as obesity, sedentary lifestyles, and aging populations. Among those diagnosed, many suffer from type 2 diabetes, which is often associated with lifestyle choices and can lead to serious complications if not managed effectively.

Around one in three (34.5%) adults in the United States have prediabetes, a condition that can lead to type 2 diabetes if left unaddressed. In New York, this prevalence translates to as many as 5.3 million adults potentially living with prediabetes. However, awareness of this condition remains low. In 2021, only 11.5% of adults in New York reported that their health care provider had informed them they had prediabetes. This lack of diagnosis means that most New Yorkers with prediabetes are unaware of their risk, underscoring the need for increased screening and public health initiatives to prevent the progression of diabetes.[28]

Efforts to combat diabetes include public health initiatives to raise awareness about prevention, encourage healthier lifestyle choices, and increase access to medical care. Programs focusing on nutrition education, physical activity, and regular health screenings are essential to these initiatives. Additionally, community organizations are working to provide resources and support for individuals with diabetes, helping them to manage their condition effectively and reduce the risk of complications.

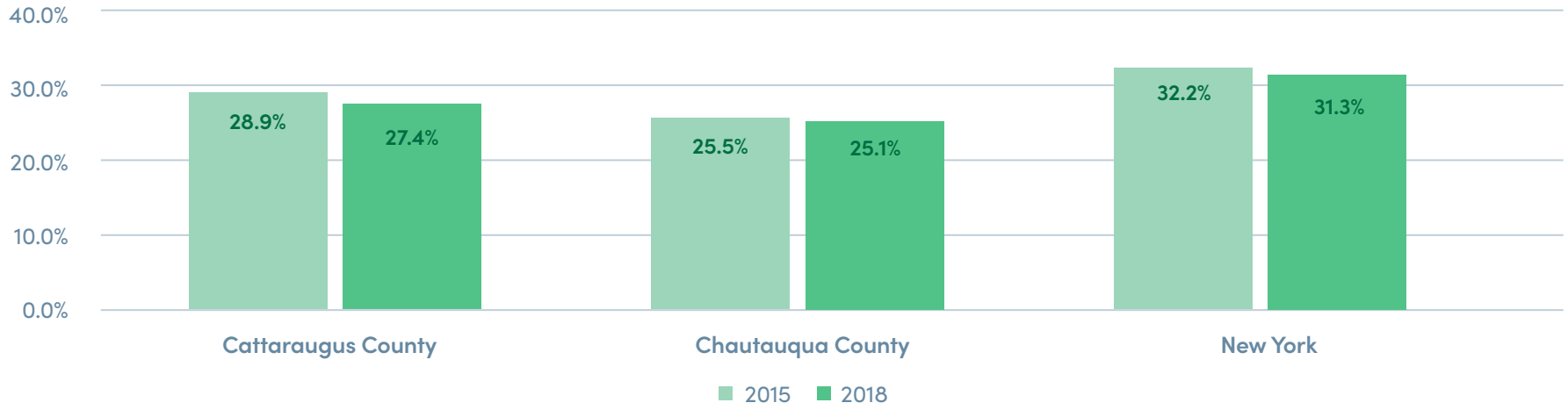
Figure 49: Adults with Diabetes



Source: Centers for Disease Control and Prevention

[28] New York State Department of Health

Figure 50: Diabetes Prevalence (Medicare Population)



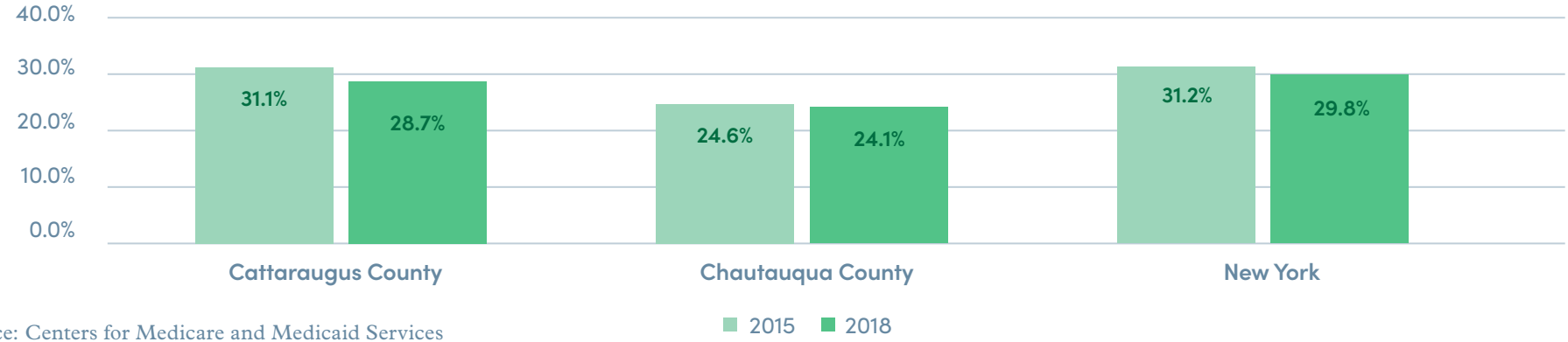
Source: Centers for Medicare and Medicaid Services

Heart Disease

Heart disease was identified as a prioritized health need for AHN Westfield Memorial Hospital 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 Westfield Memorial Hospital considered their capacity to implement heart disease programming. In 2021, an estimated 7.4% of adults in New York reported experiencing a heart attack, angina, coronary heart disease, or stroke.[29] This statistic highlights the significant impact of cardiovascular disease on New Yorkers, reflecting the ongoing public health challenge of managing and preventing heart-related conditions. Such cardiovascular events are often linked to risk factors like high blood pressure, high cholesterol, obesity, and smoking, which continue to affect many residents. The prevalence underscores the importance of regular screenings, preventive measures, and lifestyle changes to reduce the risk of these serious health events and improve overall community health.

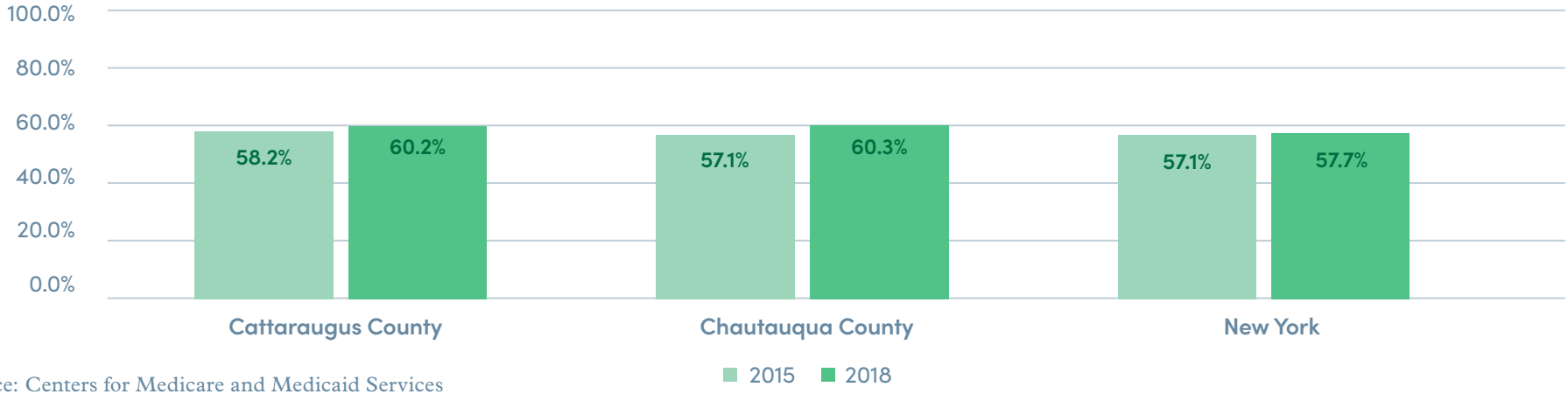
[29] New York State Department of Health, 2021

Figure 51: Heart Disease Prevalence (Medicare Population)



Source: Centers for Medicare and Medicaid Services

Figure 52: High Blood Pressure (Medicare Population)

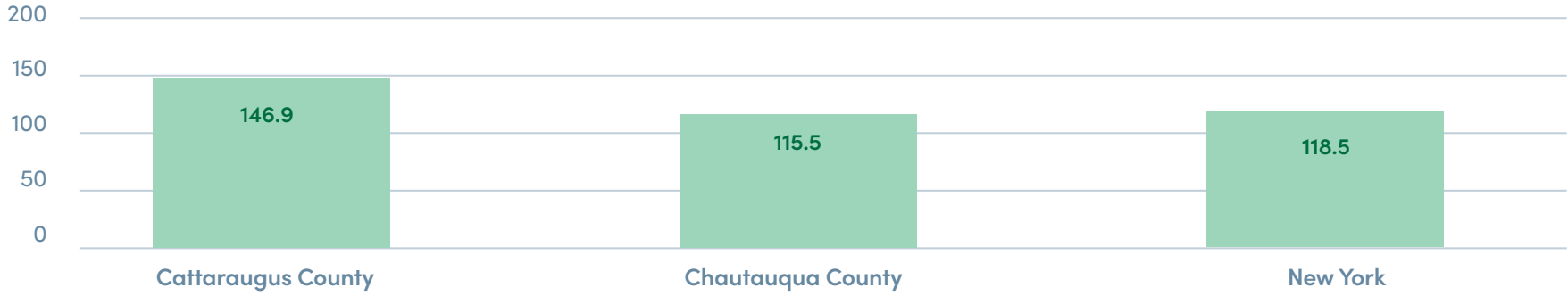


Source: Centers for Medicare and Medicaid Services

Heart disease is a broad term that encompasses various types of heart conditions that affect the heart's structure and function. The most common type of heart disease is coronary heart disease. Coronary heart disease is often referred to as "heart disease," although it is not the only type of heart disease. In America, nearly 650,000 people die from heart disease each year, and about 366,000 Americans die from coronary heart disease each year.

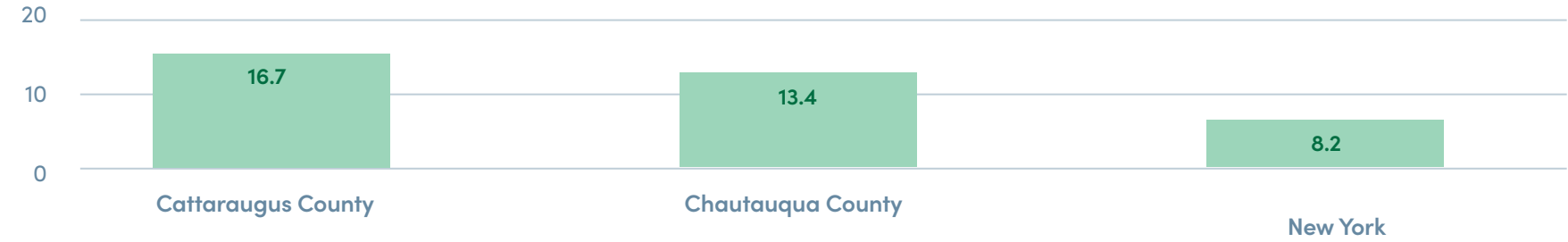
[30] National Heart, Lung, and Blood Institute

Figure 53: Coronary Heart Disease Mortality Rate (Per 100,000 Population)



Source: Centers for Disease Control and Prevention, 2016-2020

Figure 54: Stroke Mortality Rate (Per 100,000 Population)

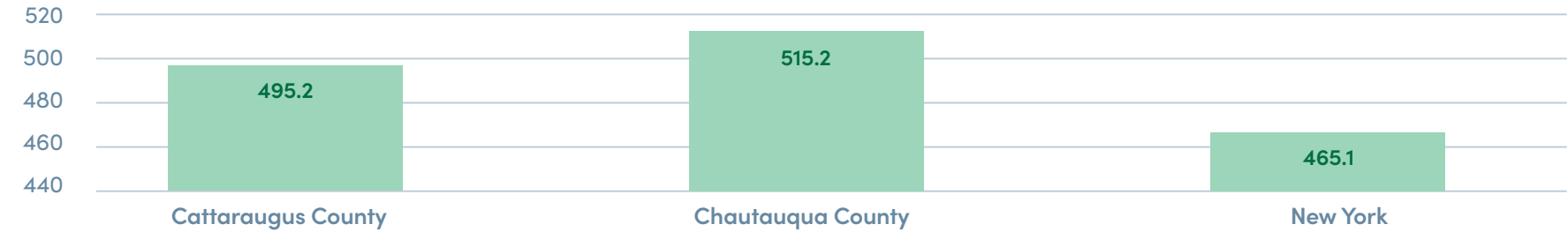


Source: Centers for Disease Control and Prevention, 2016-2020

Cancer

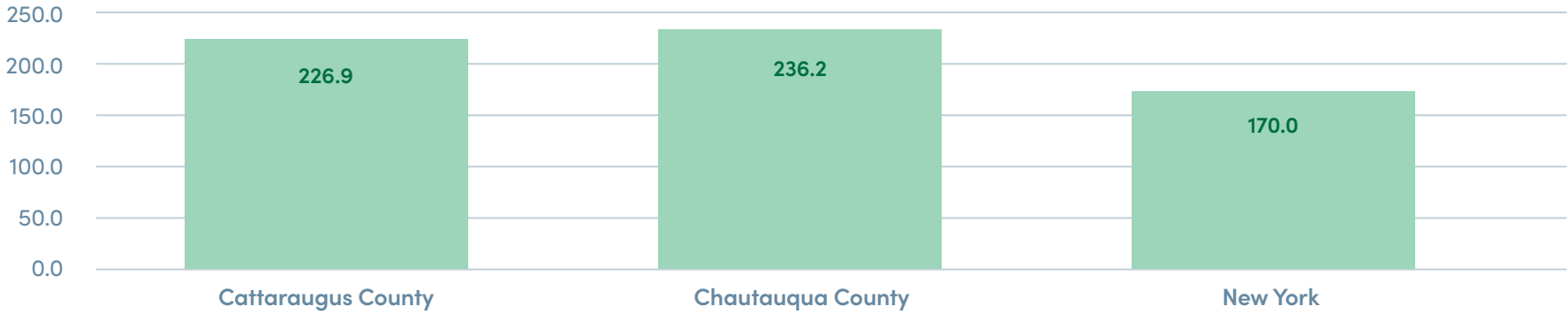
Cancer was identified as a prioritized health need for AHN Westfield Memorial Hospital based on the community survey results as well as the secondary data analysis. In addition to those data points, AHN Westfield Memorial Hospital considered their capacity to implement cancer-related programming. Cancer is one of the most common chronic diseases in New York and is second only to heart disease as the leading cause of death. Each year, over 116,000 New Yorkers are diagnosed with cancer.[31] Every year, thousands of New Yorkers receive a cancer diagnosis, with common types including breast, lung, prostate, and colorectal cancer. Factors influencing cancer prevalence in New York include population density, high rates of smoking and alcohol use, environmental exposures, and disparities in access to health care. While advances in early detection and treatment have improved survival rates, cancer incidence remains high, particularly in underserved communities. Public health efforts focus on screening, lifestyle modification programs, and initiatives to improve health care accessibility, aiming to lower cancer rates and address the significant health care burden in the state.

Figure 55: Cancer Incidence Rate (Per 100,000 Population)



Source: Centers for Disease Control and Prevention, 2016-2020

Figure 56: Cancer Mortality Rate (Per 100,000 Population)

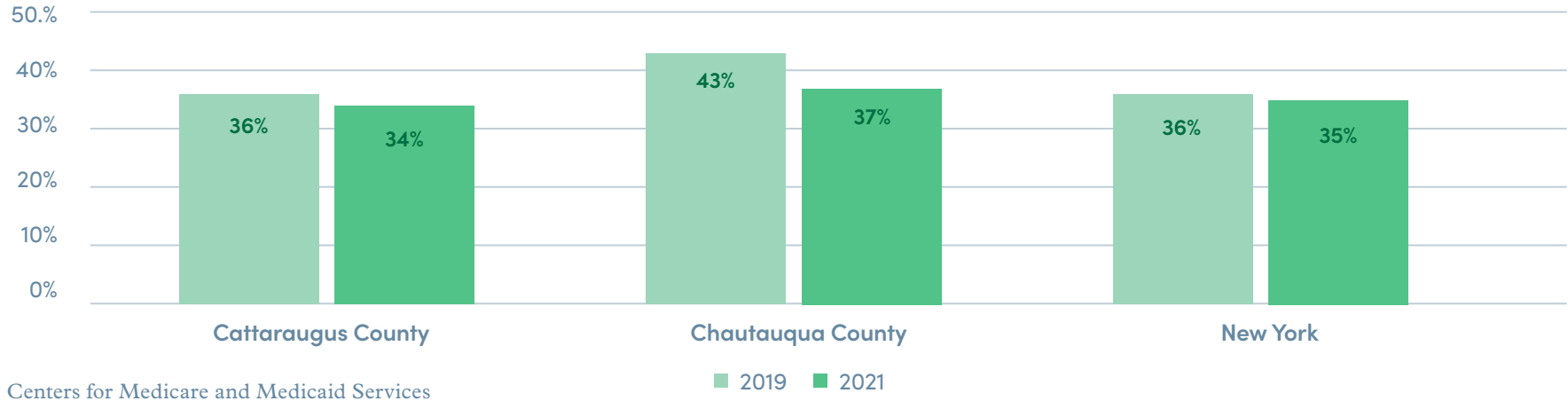


Source: Centers for Disease Control and Prevention, CDC, 2018-2022

[31] New York State Department of Health

Figure 57 below reports the percentage of female Medicare beneficiaries aged 35 and older who had a mammogram in the most recent reporting year. The American Cancer Society recommends that women aged 45 to 54 should get a mammogram every year, and women aged 55 and older should get a mammogram every other year.

Figure 57: Mammogram Screenings



Source: Centers for Medicare and Medicaid Services

D.) Health Equity

Health equity was identified as a prioritized health need for AHN Westfield Memorial Hospital based upon it being an enterprise-wide priority. In addition, AHN Westfield Memorial 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 preventive health care services and education about navigating the health care system. Preventive 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 58 delineates the responses from the community leader stakeholder interviews, community surveys, and provider surveys regarding equitable care and maintaining optimal health

Figure 58: Engaging the Community Through Primary Data Collection

Stakeholder Interviews	PFAC Group Interviews	Community Survey	Provider Survey
• Preventive health care services (health screenings) • Health promotion and education • Behavioral health/stress management • Community engagement and support • Access to healthy foods • Mental health and substance abuse services • Transportation assistance • Community-based health programs • Address SDOH	• Education on how to navigate the health care system • Health coordinators • Behavioral health services — education on resources • Health literacy classes • Preventive services	• Access to mental health resources • Affordable, safe, quality housing and utilities • Adequate employment • Affordable, quality child and/or senior care options • Access to affordable healthy food options	• Access to affordable prescription and over-the-counter medication • Access to mental health resources • Access to affordable healthy food options • Affordable, safe, quality housing and utilities • Affordable, quality child and/or senior care options • Community outreach services

Diversity, Equity, and Inclusion

Diversity, equity, and inclusion was identified as a prioritized health need for AHN Westfield Memorial Hospital based upon it being an enterprise-wide priority. In addition, AHN Westfield Memorial Hospital 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.[32] 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.[33]

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.

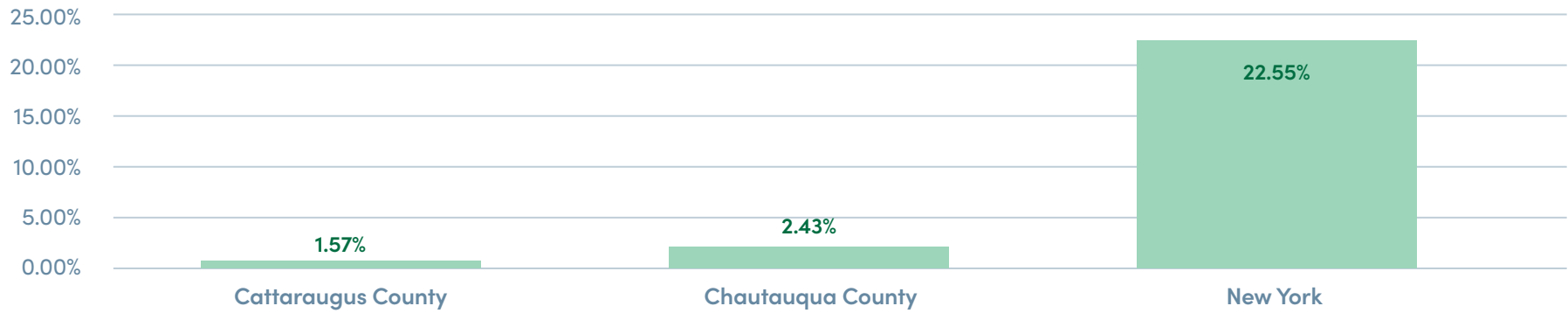
Moreover, stimulating an inclusive environment helps create a culture of safety where patients can communicate openly about their health needs without fear of discrimination or bias.

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.

[32] National Library of Medicine
[33] Newsweek

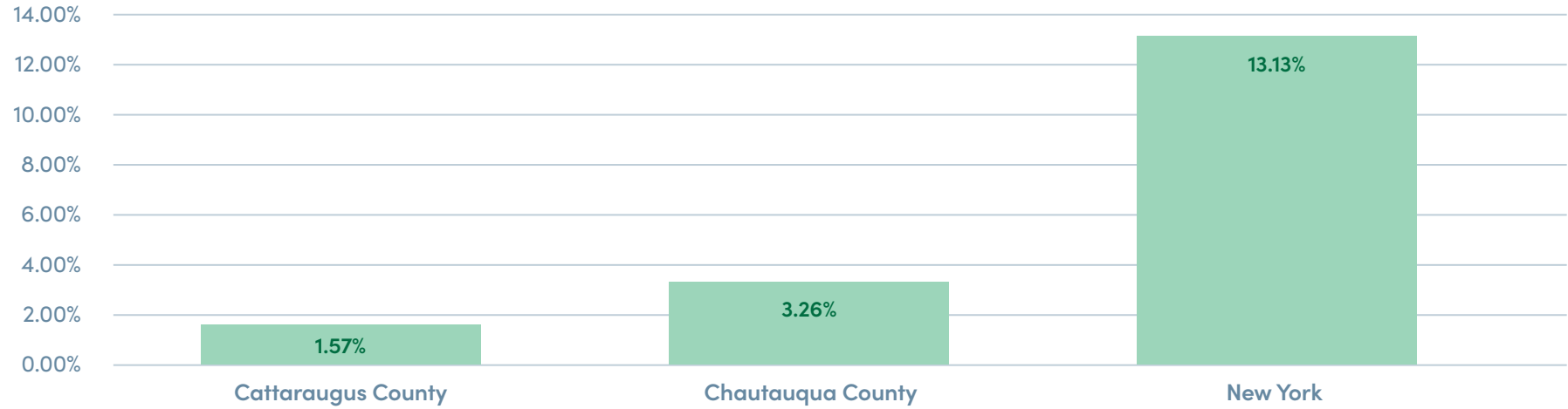
Figure 59 below reports the percentage of the population that is foreign-born. The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national.

Figure 59: Foreign-Birth Population, Percent of Total Population



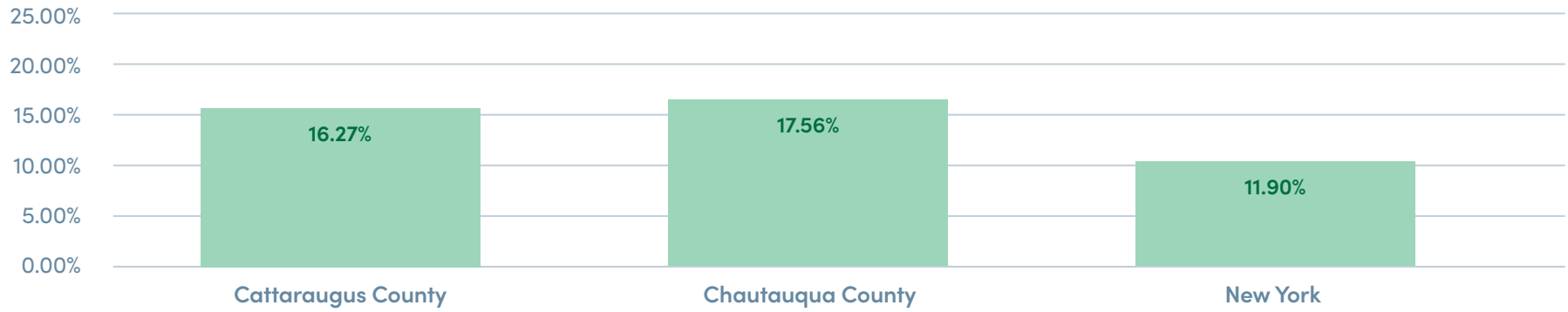
Source: US Census Bureau, 2018-2022

Figure 60: Population with Limited English Proficiency (age 5+)



Source: US Census Bureau, 2018-2022

Figure 61: 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 Westfield Memorial Hospital, 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 62: Community Resources

Identified Significant Health Needs	Local Community Resources Available to Address Needs
Social Determinants of Health – Access to Care	Rx Outreach, Care Guide Services, Chautauqua County Office for the Aging
Social Determinants of Health – Food Insecurity, Diet, and Nutrition	First United Methodist Church of Westfield Food Pantry, FeedMore WNY, Forestville Food Pantry
Behavioral Health – Substance Use Disorder	Unity Recovery, Evergreen Health, Prevention Works
Behavioral Health – Mental Health Services	New York State Office of Mental Health (OMH), Charlie Health, Child Mind Institute, Inc.
Behavioral Health – Postpartum Depression	Postpartum Support International (PSI), Postpartum Resource Center of New York, Depression and Bipolar Support Alliance (DBSA)
Chronic Diseases and Aging – Diabetes	American Diabetes Association, CR3 Diabetes Association
Chronic Diseases and Aging – Heart Disease	Mended Hearts, Walk with a Doc
Chronic Diseases and Aging – Cancer	For Pete's Sake Cancer Respite Foundation, Colorectal Cancer Alliance, National Pancreatic Cancer Foundation (NPCF)
Health Equity - Diversity, Equity, and Inclusion	WNY Heroes – Pawsitive for Heroes Program, Seneca Nation of Indians

AHN Community Resource Inventory

AHN created a comprehensive inventory of programs and services available in the region. The inventory includes 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 gathers 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 Westfield Memorial Hospital'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 Westfield Memorial Hospital ensures that the voices of the community are heard and reflected in its health strategies. Partnering with community organizations allows AHN Westfield Memorial Hospital 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 Westfield Memorial 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 Westfield Memorial Hospital 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 Westfield Memorial Hospital 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 Westfield Memorial Hospital 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 Westfield Memorial Hospital 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 Westfield Memorial Hospital 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 Westfield Memorial Hospital'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 Westfield Memorial Hospital and its community partners are working to reduce health disparities and ensure that all individuals can achieve optimal health, regardless of 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 Westfield Memorial Hospital'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 Westfield Memorial Hospital's service area, as it was collected using convenience sampling.

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