Allegheny Health Network — AHN Allegheny Valley Hospital

Community Health Needs Assessment

2024 Report

AHN ALLEGHENY VALLEY Hospital

Table of Contents

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 Allegheny Valley Hospital is committed to taking action. We are developing a strategic plan that will address the priorities, as summarized below:

- **Social Determinants of Health:** Access to healthy foods and is crucial, but for many in our community, transportation presents a significant challenge. Lack of reliable transportation can create barriers to receiving timely care and purchasing healthy foods which impacts health outcomes and overall well-being.
- **Behavioral Health and Substance Abuse:** We believe that everyone deserves access to comprehensive and compassionate care for their mental health and substance use needs. However, many individuals continue to struggle in silence.
- **Chronic Disease Management:** Chronic diseases, such as heart disease and diabetes, 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

Mark A. Rubino, MD, MMM, FACOG
President, AHN Allegheny Valley Hospital

About This Report

Community Health Needs Assessment Overview

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

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

AHN AVH'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 AVH 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 AVH'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.

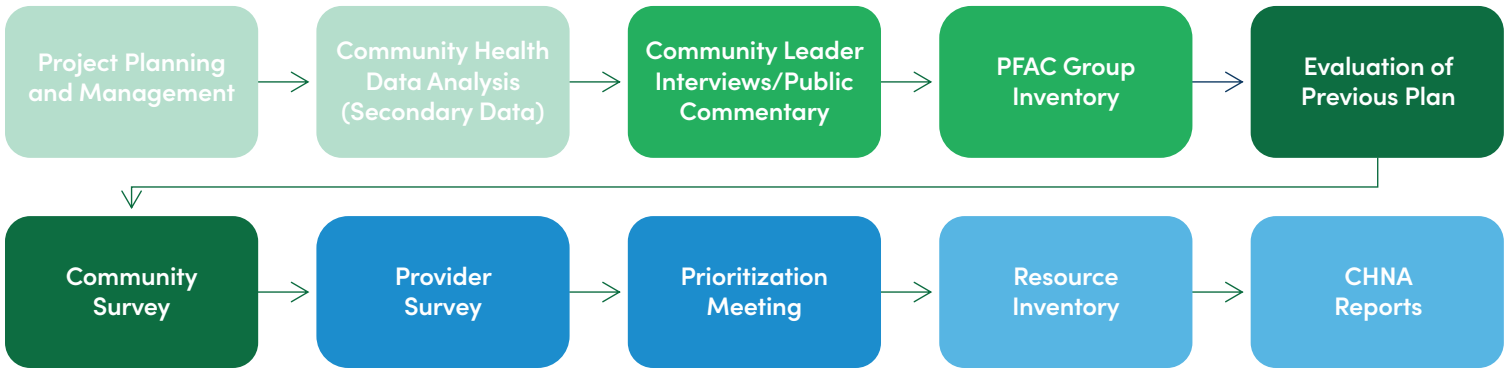
CHNA Methodology

AHN and AHN AVH partnered with Tripp Umbach to carry out the 2024 CHNA for AHN AVH. 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 AVH. 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 AVH'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



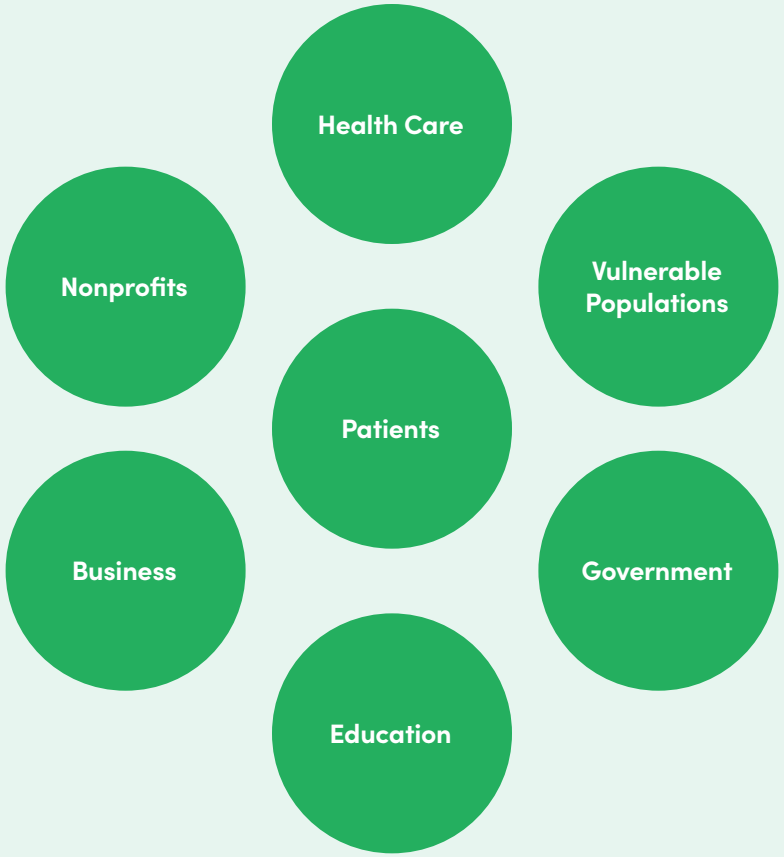
Community Engagement

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 AVH'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 AVH 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 Allegheny Valley 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.

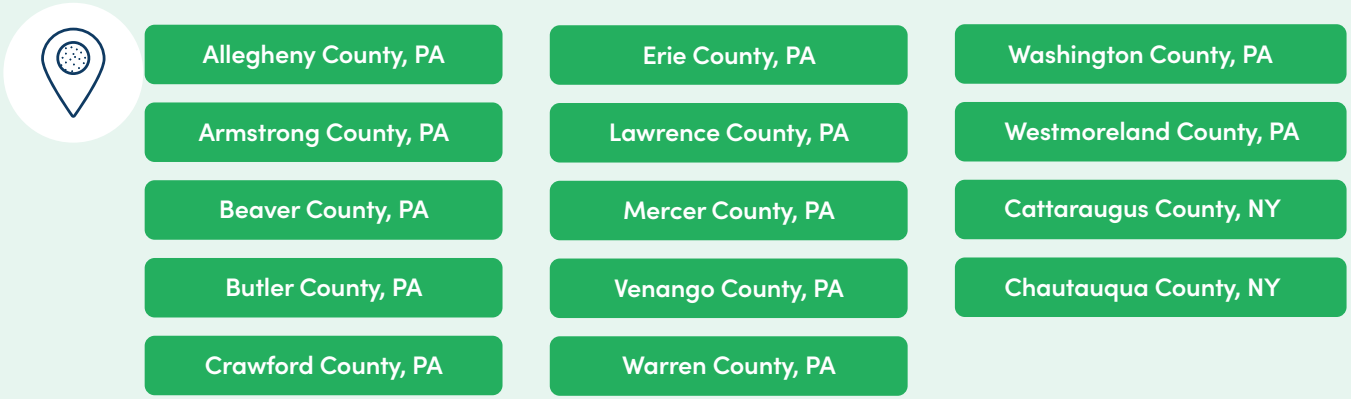
AHN is a vital component of the health care landscape focused on delivering high-quality, patient-centered care. Through its extensive services, community engagement, and commitment to health equity, AHN strives to improve the health and well-being of the communities it serves. With a dedication to innovation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



AHN Allegheny Valley Hospital

AHN AVH has been serving Allegheny Valley and Kiski Valley residents with comprehensive, expert care for over 100 years. AHN AVH provides health care services, education, and support to more than 160,000 residents in portions of Allegheny, Butler, Westmoreland, and Armstrong counties.[2] The 188-bed hospital delivers a broad spectrum of specialty services including primary care, cancer center, heart disease care, emergency medicine, geriatric health, orthopedic care, physical therapy and rehabilitation services, surgery, women's health, neurology, and stroke care.

With a dedicated team of 686 skilled physicians, nurses, and support staff, AVH continues to prioritize patient safety, cutting-edge technology, and a holistic approach to health care.[3] Its mission remains focused on enhancing the health and well-being of the communities it serves, making it a trusted and respected health care provider in western Pennsylvania.

The hospital has set itself apart in various areas, consistently recognized locally and nationally for delivering exceptional care and ranking among the nation's top performers.

[2] Allegheny Health Network

[3] Allegheny Health Network

Defined Community

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

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

For AHN AVH, 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 AVH 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, 46 ZIP codes were identified as the primary service area for AHN AVH. The following table highlights the study area focus for AHN AVH's 2024 CHNA.

Figure 4: 2024 AHN AVH's Primary Service Area

Zip Code	Town	County
15014	Brackenridge	Allegheny
15024	Cheswick	Allegheny
15030	Creighton	Allegheny
15049	Harwick	Allegheny
15051	Indianola	Allegheny
15065	Natrona Heights	Allegheny
15068	New Kensington	Westmoreland
15076	Russellton	Allegheny
15084	Tarentum	Allegheny
15139	Oakmont	Allegheny
15144	Springdale	Allegheny
15613	Apollo	Armstrong
15618	Avonmore	Westmoreland
15641	Hyde Park	Westmoreland
15656	Leechburg	Armstrong
15686	Spring Church	Armstrong
15690	Vandergrift	Westmoreland
16023	Cabot	Butler
16055	Sarver	Butler
16056	Saxonburg	Butler
16201	Kittanning	Armstrong
16212	Cadogan	Armstrong
16226	Ford City	Armstrong

Zip Code	Town	County
16228	Ford Cliff	Armstrong
16229	Freeport	Armstrong
16238	Manorville	Armstrong
16262	Worthington	Armstrong
15065	Natrona	Allegheny
15068	Arnold	Westmoreland
15068	Lower Burrell	Westmoreland
15068	Upper Burrell	Westmoreland
15075	Rural Ridge	Allegheny
15084	Frazer Township	Allegheny
15147	Verona	Allegheny
15238	Pittsburgh (Harmar & O'Hara)	Allegheny
15613	Oklahoma Borough	Armstrong
15613	Washington & North Washington Twp.	Armstrong
15656	West Leechburg	Armstrong
15681	Saltsburg	Westmoreland
15686	Spring Church	Armstrong
15690	North Vandergrift	Westmoreland
16023	Winfield Township	Butler
16201	North Buffalo Township	Armstrong
16229	South Buffalo Township	Armstrong
15084	Fawn Township	Allegheny
15065	Fawn Township	Allegheny

AHN Allegheny Valley Hospital Awards and Recognitions

American Heart and American Stroke Association's Gold Plus status for both Get With The Guidelines® heart failure and stroke programs.

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

AHN Allegheny Valley Hospital is rated among the Top 10% of hospitals in the region for Medical Excellence in Overall Hospital Care.

AHN Allegheny Valley Hospital is rated among the Top 10% of hospitals in the nation for Patient Safety in Overall Surgical Care and Overall Hospital Care.

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

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

Figure 5: Community Stakeholder Summary Analysis

Community Stakeholder Summary Analysis				
Largest Barriers (Top 5) 1. Affordability 2. Lack of transportation 3. Health literacy 4. No Insurance coverage 5. Lack of health care coordination services **Vulnerable Populations (Top 3)** 1. Older adults 2. People living with mental illness 3. Low-income	**Persistant Health Problems (Top 5)** 1. Behavioral/Mental Health 2. Heart Disease/Stroke 3. Obesity 4. Diabetes 5. Substance Use Disorder/ Addiction	**Significant Barriers to Improving Health & Quality of Life (Top 5)** 1. Access to substance use/ drug/alcohol resources 2. Access to behavioral health resources 3. Access to affordable prescription and OTC medication 4. Affordable, quality child care 5. Affordable, quality housing/utilities	**Persistant High-Risk Behaviors (Top 5)** 1. Being overweight/obese 2. Drug abuse 3. Poor eating habits 4. Lack of exercise/physical inactivity 5. Alcohol abuse	**What Should Be Offered to Maintain Optimal Health (Top 5)** 1. Preventive health care services 2. Health promotion and education 3. Behavioral health/ stress management 4. Community engagement and support 5. Access to healthy foods

[4] 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 AVH. 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.

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 AVH 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 AVH 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				
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 affordable prescription/OTC medication 2. Access to preventive screenings and vaccinations 3. Access to culturally appropriate primary care services	1. Overall feeling of safety/ security 2. Adequate employment 3. Affordable, safe, quality housing/utilities	1. Adequate employment 2. Access to affordable prescriptions/OTC medication 3. Access to affordable, quality child and/or senior care options 4. Affordable, safe, quality housing/utilities 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 and utilities 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 help vulnerable populations meet health needs:** 1. Community outreach services

Evaluation of Previous Community Health Needs Assessment and Implementation Strategy Plan

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

Social Determinants of Health

Health Priority: Transportation

Goal: To develop an improved transportation system for AVH patients and families.

Figure 8: SDOH Transportation Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
Improve access to transportation services for patients and families.	• Assess current transportation services. • Collaborate with Prehospital Care Services to utilize a centralized coordination center. • Educate primary care physicians (PCPs) and patients on transportation services. • Implement transportation protocol with community partners • Continue to work to improve connectivity with One Call System. • Collaborate with discharge planning team.	X	X	X	• Amount of current known transportation services. • Percentage of increased community-based transportation provided. • Number of patients that utilize transportation resources. • Number of patients that have identified they need transportation during 2x daily discharge huddle.	• Completed 1,541 transports, community benefit value of $203,453 • Provided 9,709 zTrip hours @ annual cost of $546,040

Health Priority: Food Insecurity, Diet, and Nutrition (new goal added 2023)

Goal: To reduce food insecurity for AVH patients and the community.

Figure 9: SDOH Food Insecurity, Diet, and Nutrition Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
Open AVH Healthy Food Center (HFC) in June 2023.	• Identify and address food insecurity for AVH patients • Educate providers and CBOs on food insecurity screening and referral process • Identify food-insecure patients and community members through the SDOH screening tool		X	X	• Number of HFC referrals, new clients, and follow-ups • Number of clients served • Number of meals served	• Opened AVH HFC June 2023 • Served 450 referrals, 108 new clients and 288 follow-ups • Served 834 clients • Provided total of 8,340 meals

Behavioral Health

Health Priority: Substance Use Disorder

Goal: Increase knowledge and access to substance use disorder programs and services.

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

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
To increase access to services in the ED for post-overdose management.	• Consult with needs assessment counselors to discuss treatment options for ED patients. • Use ED pathway for initiation of MAT and warm handoff program. • Educate ED providers on substance use disorder and medication-assisted therapy (MAT) as an effective treatment for post-overdose management. • Provide warm handoff to MAT treatment services.	X	X	X	• The number of trainings for hospital staff. • Number of patients screened for eligibility for MAT.	• Treated 129 SUD patients; Discharged 100 patients with resources; Transferred 33 for detox • Administered 1,007 MAT (Medication Assisted Treatment) related drugs with 274 given in the ED • Served 379 MAT patients

Health Priority: Mental Health Services

Goal: Transform the treatment and care continuum for mental health services at AHN AVH.

Figure 11: Behavioral Health, Mental Health Services Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year
Improve quality outcomes for mental health domain.	• Utilize needs assessment counselors/social services to monitor patient encounters in the emergency department (ED).	X	X	X	• Number of patients referred to inpatient or outpatient facilities.
Collaborate with AHN Behavioral Health Consultants (BHC) in the primary care practices.	• Identify patients who may need behavioral health support. • Utilize the BHC to provide support for patients with mental health issues.	X	X	X	• Number of patients referred to inpatient or outpatient facilities. • Number of trainings for staff. • Number of staff trained. • Number of BHC consultations.

Summary of outcomes 2022 – June 30, 2024
• Had 2,952 NAC encounters • Served 2,142 adults and 238 minors; Transferred 408 • Discharged 1,042 BH adults and 128 minors from the ED • Conducted total of 61 D&A Consults • The Mobile Chill Bus served Martin Elementary School in New Kensington for three weeks. Martin is a kindergarten-only school serving 201 students and 10 staff members • The Chill Mobile Bus made three stops at the East Union Intermediate Center which serves preteen students • Career observation — hosted students from Chatham University, Pitt, and local high schools (17 in total)
• Center for Inclusion provided AHN Intimate Partner Violence education • Working with community partner, Alle-Kiski HOPE Center to provide a medical advocate for patients who express domestic violence concerns, 1/1/2024. Will provide info on safety planning, safe shelter, permanent housing, PFAs/legal advocacy, trauma-informed counseling, transport services

Chronic Disease

Health Priority: Diabetes

Goal: To improve quality outcomes associated with diabetes.

Figure 12: 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
Educate community members on the prevention, diagnosis, and treatment (management) of diabetes.	• Provide education program(s) at hospital and in community. • Collaborate with AHN service line to promote awareness of and participation in diabetes education classes (virtual and in-person)	X	X	X	• Number of participants. • The number of community events.	• Reporting for this was moved to AVH's Food Insecurity section.
Offer blood sugar screenings to participants at local health fairs and community events.	• Identify opportunities to participate in community events and focus on diabetes awareness. • Participate in local state rep's community health day. • Link participants with appropriate care resources (PCP, etc.).	X	X	X	• The number of community events. • Number of participants.	• Reporting for this was moved to AVH's Food Insecurity section.
Provide education and resource information on healthy eating as a tool to manage diabetes.	• Coordinate education opportunities with AVH's diabetes support group, the local Center for Endocrinology & Diabetes, and the Diabetes Navigator assigned to AVH.	X	X	X	• The number of community programs. • Performance on diabetes measures. • Results of screenings for food insecurities.	• Reporting for this was moved to AVH's Food Insecurity section.

Health Priority: Heart Disease

Goal: Improve quality outcomes associated with heart disease.

Figure 13: 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
Improve quality outcomes associated with heart disease.	• Collaborate with the Stroke Team to provide stroke awareness community events. • Extend provision of current CHF at home scale for Community Care Network (CCN) patients. • Partner with CHF Navigation Team's 30 post-discharge follow-up program.	X	X	X	• The number of community events. • Number of participants. • Number of CCN CHF patients that utilize a scale. • Readmissions for CHF patients. • The number of patients served via the navigation team 30-day follow-up.	• Hosted three Stroke Awareness events: *AVH Quality Fair; Senior Expo sponsored by Reps Abby Major and Jill Cooper, and Sen. Joe Pittman; provided awareness on sepsis and colorectal cancer; conducted glucose and cholesterol screenings; *Gateway High School: Teacher Wellness Day, approx. 275-300 attendees. • Held/participated in two heart disease prevention community events with 225+ attendees. • Stroke nurse navigator provided community education at multiple community events. • AVH's readmission rate dropped from 16.6% to 13.3%. • *CMS reports national readmission rates average 25%. The overall rate for AHN is 13.8%. • % of eligible patients with a follow-up visit scheduled within 7 days or less from time of hospital discharge averaged 75.9% in 2024. • % of heart failure patients who had a follow-up visit or phone call scheduled within 72 hours or less of hospital discharge in 2024 was 92%.

Health Equity

Goal: Improved access to care for underserved, at-risk populations.

Figure 14: Health Equity Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year
Incorporate into each priority need actions.	• Evaluate each priority need for focus on reaching at-risk and underserved populations.	X	X	X	• Number of at-risk or underserved populations included.

Summary of outcomes for this chart appears on the following page.

Health Equity Summary of Outcomes

Summary of outcomes 2022 – June 30, 2024	
• Participated in community health fair, serving a majority African American Church. • Provided health education and free transport to seniors on stroke awareness, sepsis, colorectal cancer; provided glucose and cholesterol screening. • AVH employees donated over 500 food items to the AV Assoc. of Churches who serve a marginalized, homeless populations as their food bank, community action center, other ministries. • AVH participated in Freeport Area Schools Student Adv. Council regarding career support, job shadowing, internships, mentoring; also shared info about TAP program, volunteer and shadow opportunities. • Targeted seniors, ethnic, and disenfranchised groups with health education, preventive screenings. • Provided over 500 food item donations to the homeless. • Introduced TAP program to 50+ students. • **Freeport Middle School Career Day** - Professionals from nursing, occupational therapy and biomedical engineering met with 6 individual class groups to share their career choice, preparation, and experience. The professionals were able to share why they chose their careers and discuss with students related coursework and tuition. Total students served 138. • **Apollo Ridge High School Career Day** - Professionals from nursing, physical therapy, and biomedical engineering shared their experience 135 students.	• **Freeport Senior High School, Career Day** - Health care professionals from nursing and biomedical engineering shared (about 125 students). Students came from a variety of economic backgrounds • Highlands Partnership Network participation. Monthly meeting x3. Local agencies serving families in AVH service provide updates on services available, access to services, and processes to procure needed services. • The Intimate Partner Violence (IPV) program launched at AVH in December 2023. No referrals were received in Q1. The IPV program is a collaboration between AHN's Center for Inclusion Health and the Alle-Kiski HOPE Center (local domestic violence service & shelter). • **Apollo-Ridge High School Career Day** - Professionals from nursing, biomedical engineering, and physical therapy met with multiple class groups to discuss career paths, preparation, and job satisfaction experienced. (140 students participated.) • **Freeport High School Career Day** - Nursing, biomedical engineering, and occupational therapy presented. Nursing was joined by CORE to increase organ donor awareness. (128 students participated.) • **Apollo Ridge High School's senior career portfolio presentation** - Professionals from multiple disciplines observed students' compilation presentation of possible career explored and were able to "interview" students about this learning experience. Each group of professionals (group of 3), including a teacher, met with 4 individual students. (80 students participated.) • AHN's Center for Inclusion Health and the Alle-Kiski HOPE Center met to increase awareness of this initiative and related resources.

Challenges Impacting CHNA Objectives, Path Forward Strategy

In 2023, AHN AVH set a new goal to tackle food insecurity and promote better diet and nutrition among its patients and the wider community. This shift in focus arises from recognizing the growing impact of food-related challenges on overall health outcomes, particularly in light of social determinants of health. While AHN AVH made strides in various other health initiatives in 2022, addressing food insecurity became a more targeted approach. By prioritizing nutrition and access to healthy food options in 2023 and 2024, AHN AVH aimed to establish comprehensive programs that not only identify food-insecure patients but also connect them with resources and education to improve their dietary habits. This new goal reflected AHN AVH's commitment to enhancing the well-being of the community it serves and addressing the underlying factors that contribute to health disparities.

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

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

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

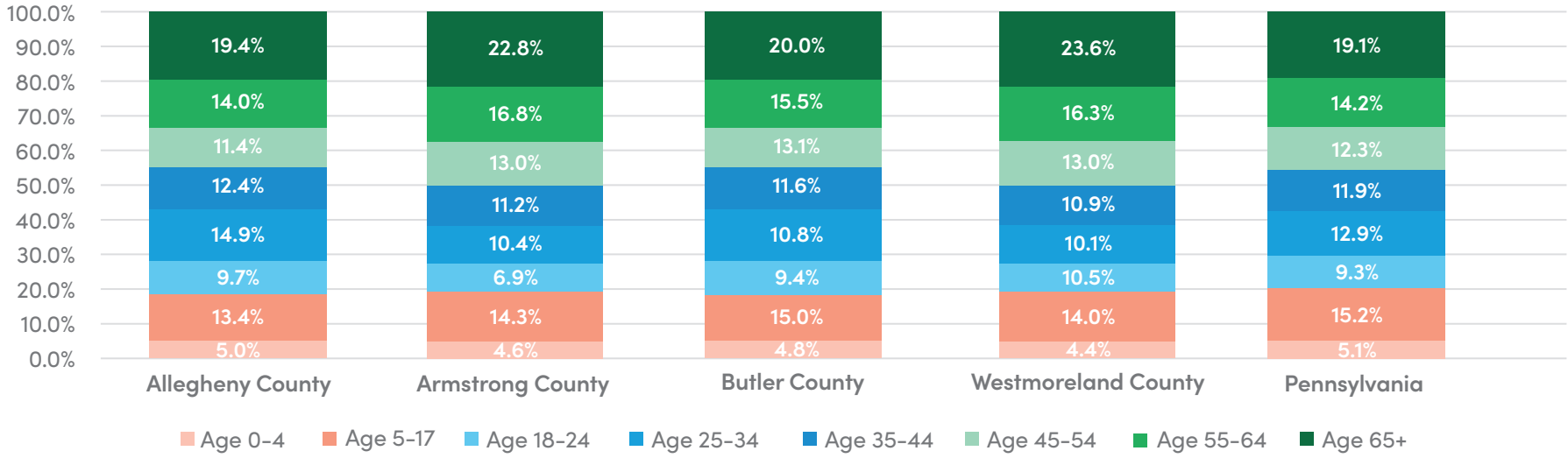
AHN Allegheny Valley Hospital Community at a Glance

Figure 15: Population

	Total Population	Males	Females
Allegheny County	1,245,310	607,557	637,753
Armstrong County	65,538	32,862	32,676
Butler County	194,562	97,055	97,507
Westmoreland County	354,414	175,081	179,333
Pennsylvania	12,989,208	6,410,766	6,578,442

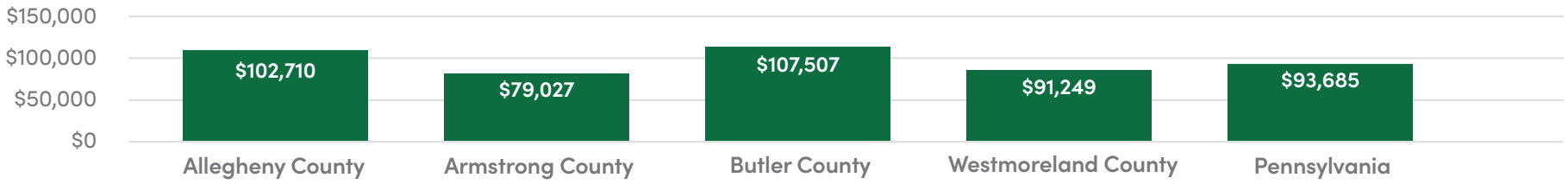
Source: U.S. Census Bureau, American Community Survey 2018-2022

Figure 16: Age Distribution



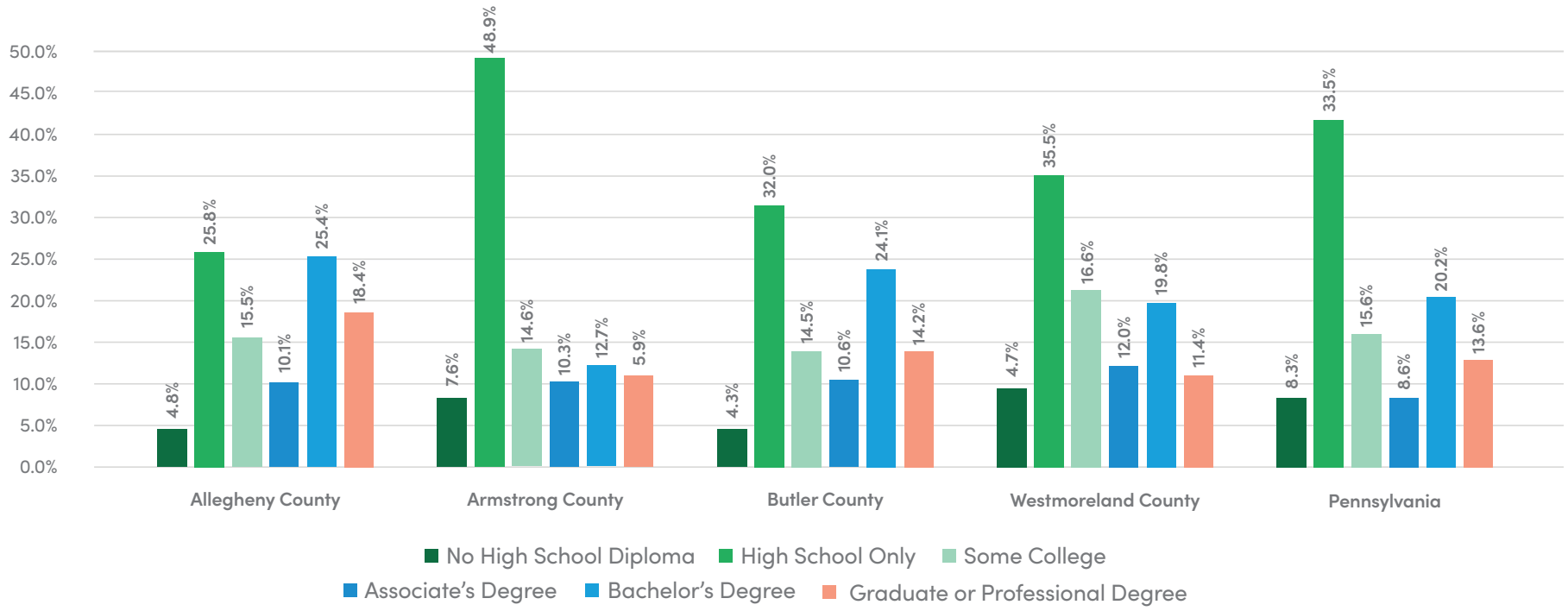
Source: Census Bureau, American Community Survey 2020

Figure 17: Median Household Income



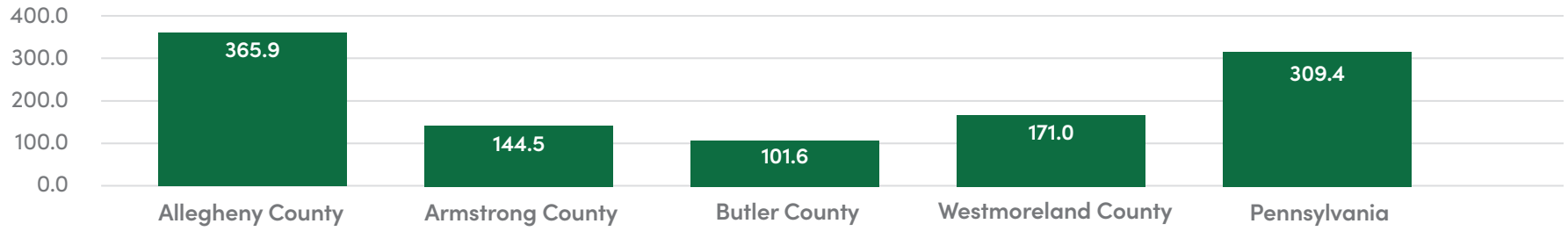
Source: Census Bureau, American Community Survey, 2018-2022

Figure 18: Education Attainment



Source: Census Bureau, American Community Survey, 2020

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



Source: 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 Conditions

Report Area	No Conditions	One Condition	Two or Three Conditions	Four Conditions
Allegheny County	74.76%	24.40%	0.83%	0.01%
Armstrong County	80.91%	17.37%	1.71%	0.01%
Butler County	78.62%	20.66%	0.72%	0.00%
Westmoreland County	79.65%	19.68%	0.65%	0.01%
Pennsylvania	72.77%	26.16%	1.07%	0.01%

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

County Health Rankings

It is important to review rankings as they provide a clear and concise way to compare performances across different entities, helping identify areas of strength and weakness for targeted improvements. Pennsylvania's score of 1 in the Robert Wood Johnson Foundation's County Health Rankings & Roadmaps represents the "healthiest" county in a given measure. Figure 21 shows that from 2020 to 2023, all counties in AHN AVH's primary service area improved in their mortality ranking. The health behaviors ranking also improved from 2020 to 2023 for Allegheny, Butler, and Westmoreland Counties, and stayed level for Armstrong County.

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.[5] 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.[6]

Figure 21: County Health Rankings: (67 Counties in PA) (1=Healthiest)

	Year	Health Outcomes	Health Factors	Mortality	Morbidity	Health Behaviors	Clinical Care	Social & Economic Factor	Physical Environment
Allegheny County	2023	**27**	13	37	**20**	9	12	17	**67**
	2020	14	20	39	6	19	14	20	64
Armstrong County	2023	57	**58**	56	**46**	62	**50**	**45**	35
	2020	58	55	61	31	62	36	36	61
Butler County	2023	6	6	10	**3**	7	4	5	60
	2020	6	7	16	1	8	10	6	63
Westmoreland County	2023	20	14	43	10	19	**20**	**19**	3
	2020	49	18	48	40	37	17	14	25

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

[5] Social and economic factors include income, education, employment, community safety, injury and death rates, social support, and the prevalence of children in poverty.
[6] 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?

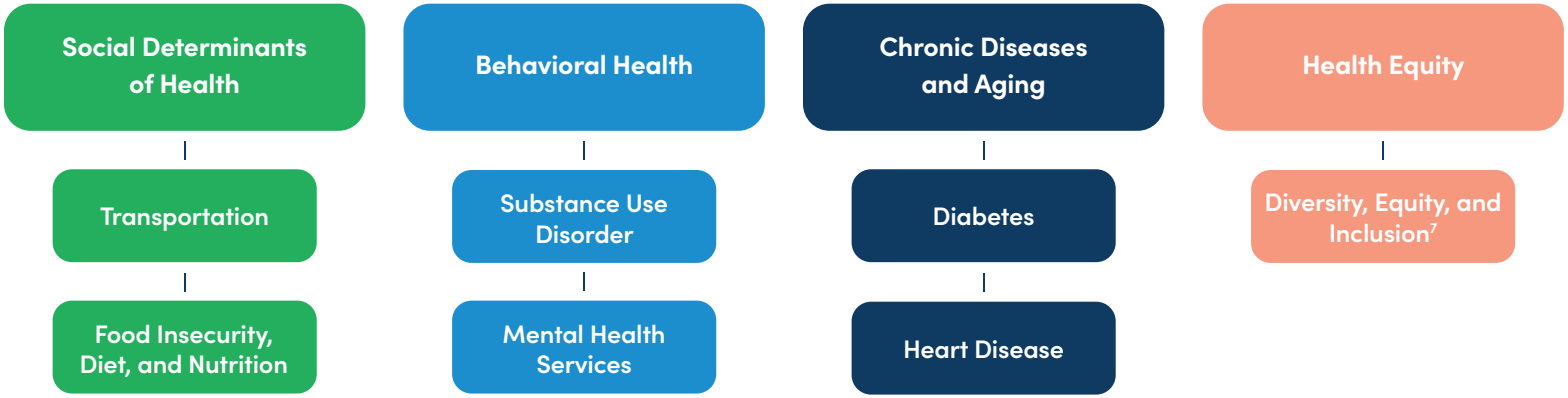
Identification and Prioritization Process

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 Community Health Needs Assessment Final Identified and Prioritized Needs

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

Figure 22: AHN AVH 2024 CHNA Needs



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

A.) Social Determinants of Health

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

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

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

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

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

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

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

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

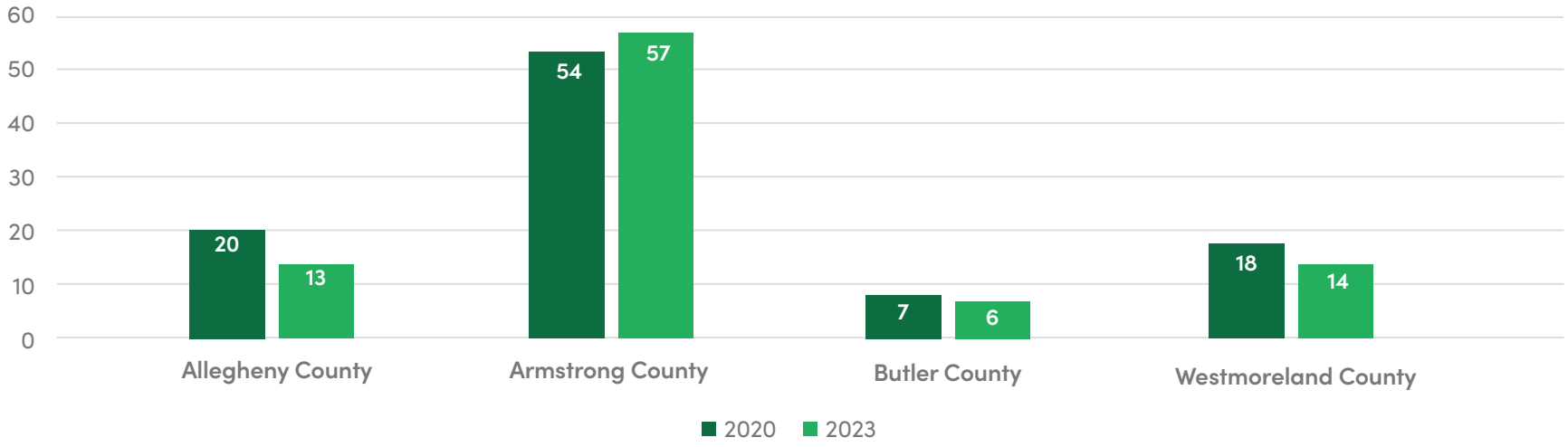
Figure 23: Social Determinants of Health

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 Allegheny, Butler, and Westmoreland County improved their health factor rankings from 2020 to 2023.

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 affordable prescription and over-the-counter medication • Access to preventive screenings and vaccinations • Access to culturally appropriate primary care services • Overall feeling of safety/security • Adequate employment • Affordable, safe, quality housing/utilities	• Affordability • Availability of services • No insurance coverage • Lack of transportation • Lack of health care coordination services

Transportation

Transportation was identified as a prioritized health need for AHN AVH based on the stakeholder interviews and provider survey results as well as the secondary data analysis. In addition to those data points, AHN AVH considered their capacity to implement transportation programming. Transportation is a critical component of social determinants of health because it directly affects individuals' ability to access essential resources like health care, employment, and nutritious food. Reliable transportation enables people to attend medical appointments, engage in preventive care, and access emergency services. Without it, individuals, especially those in rural or underserved areas, are more likely to delay or skip medical visits, leading to worse health outcomes.

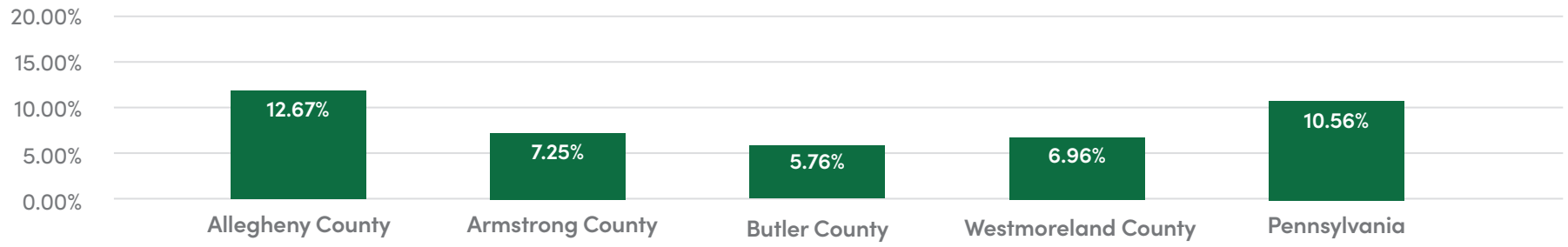
The relationship between transportation and health is evident in the correlation as transportation barriers are often linked to missed medical appointments, increasing the likelihood of emergency room visits and hospitalizations.[8] When individuals are unable to travel to their health care providers, they are more likely to resort to emergency room visits or require hospitalizations for issues that could have been managed earlier. These emergency visits strain health care systems and place a significant financial burden on individuals and families. Additionally, the absence of reliable transportation disproportionately affects vulnerable populations, such as low-income families, seniors, and individuals with disabilities, intensifying existing health disparities. These groups often have limited resources and face greater challenges in securing transportation, leading to heightened risks of untreated health conditions and poorer overall health.

The absence of public transit and the long distances to health care facilities create substantial obstacles to receiving timely medical care. Traveling to a doctor's office or hospital can be a significant undertaking for many residents in these regions, often requiring long journeys or reliance on inconsistent transportation options. This inaccessibility can lead to neglect of health care needs, as the effort and cost involved in traveling can deter individuals from seeking necessary care. Without reliable transportation, individuals may find it difficult to travel to grocery stores that offer fresh produce and other healthy options, contributing to food insecurity and related health problems such as obesity and diabetes.

Lack of transportation also disproportionately affects low-income populations, seniors, and people with disabilities, exposing health disparities. In rural areas, for example, the absence of public transit or long travel distances to health care facilities often prevents residents from receiving timely care. Moreover, poor transportation options can limit access to healthy food, contributing to food insecurity and related health problems such as obesity and diabetes. Addressing transportation barriers is essential for improving health equity, as it enables more consistent access to care and the essential resources needed to maintain a healthy lifestyle. Individuals can gain more consistent access to the resources and services they need to maintain a healthy lifestyle by improving transportation options. Through expanded public transit, community-based transportation programs, or other innovative solutions, removing transportation barriers can lead to better health outcomes for vulnerable populations. This, in turn, reduces health care costs, improves quality of life, and helps bridge the gap in health disparities across different communities. Transportation, therefore, is not just a logistical issue but a fundamental component of ensuring equitable access to health care and promoting overall well-being.

[8] National Library of Medicine

Figure 26: Households with No Motor Vehicle



Source: The Agency for Healthcare Research and Quality, 2020

Food Insecurity, Diet, and Nutrition

Food insecurity, diet, and nutrition was identified as a prioritized health need for AHN AVH based on the community survey and provider survey results as well as the secondary data analysis. In addition to those data points, AHN AVH 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.[9] 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.[10] 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.

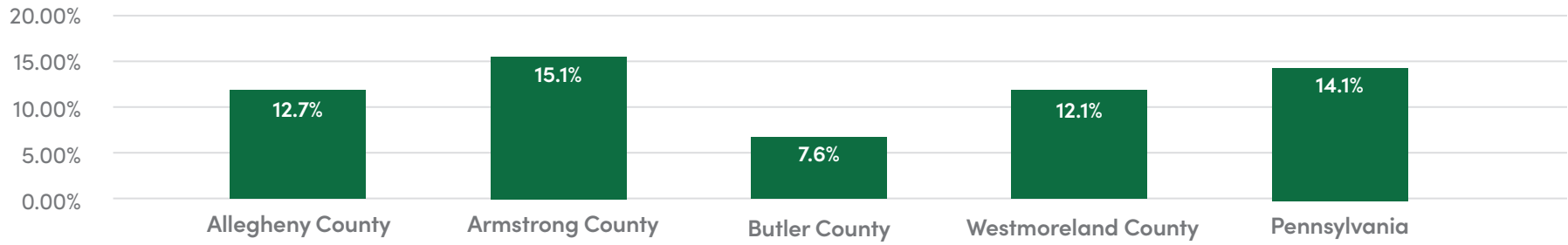
The Supplemental Nutrition Assistance Program (SNAP) benefits are crucial because they enhance food security for low-income individuals and families, ensuring access to nutritious food and reducing hunger. On average, 41.2 million people in 21.6 million households received monthly SNAP benefits in the 2022 fiscal year, which ran from October 2021 through September 2022.[11] 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.

[9] The National Library of Medicine

[10] U.S. Department of Agriculture

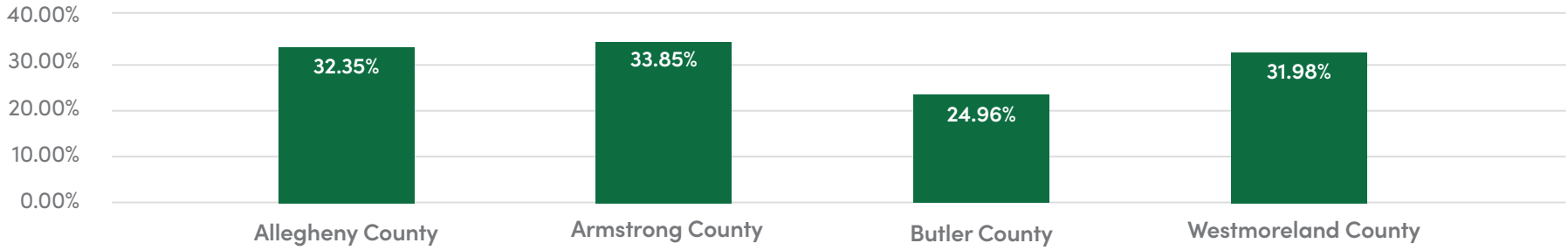
[10] Pew Research Center

Figure 27: Population Receiving Supplemental Nutrition Assistance Program (SNAP)



Source: U.S. Census Bureau, 2021

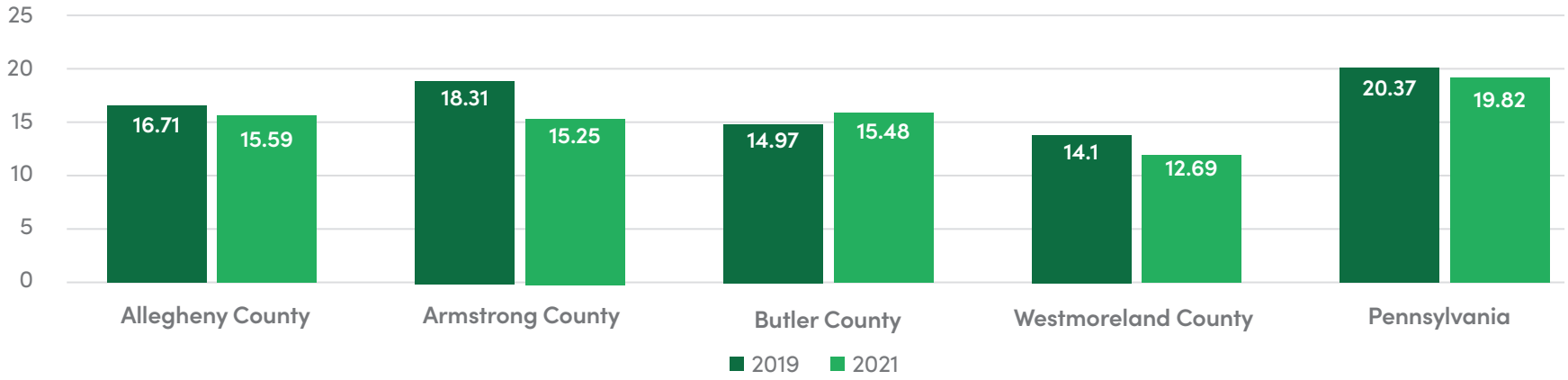
Figure 28: Unmarried Partner Households Receiving SNAP Benefits



Source: The Agency for Healthcare 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.

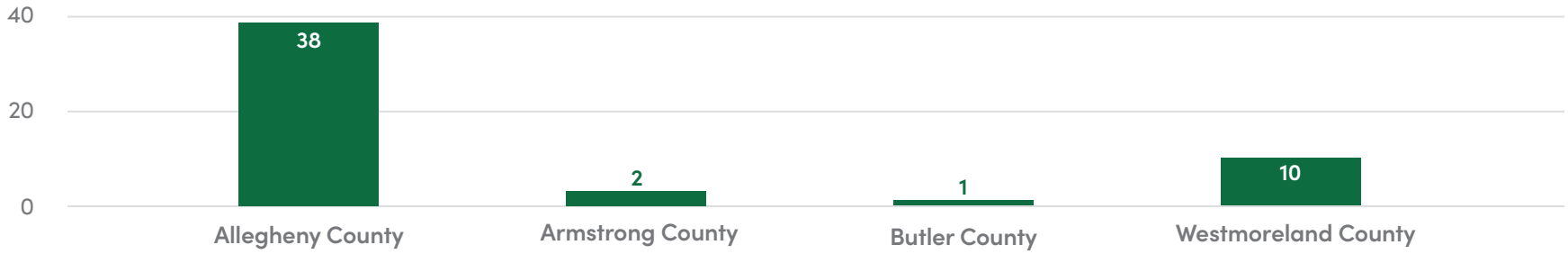
Figure 29: Food Environment – Grocery Stores (per 10,000 population)



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.

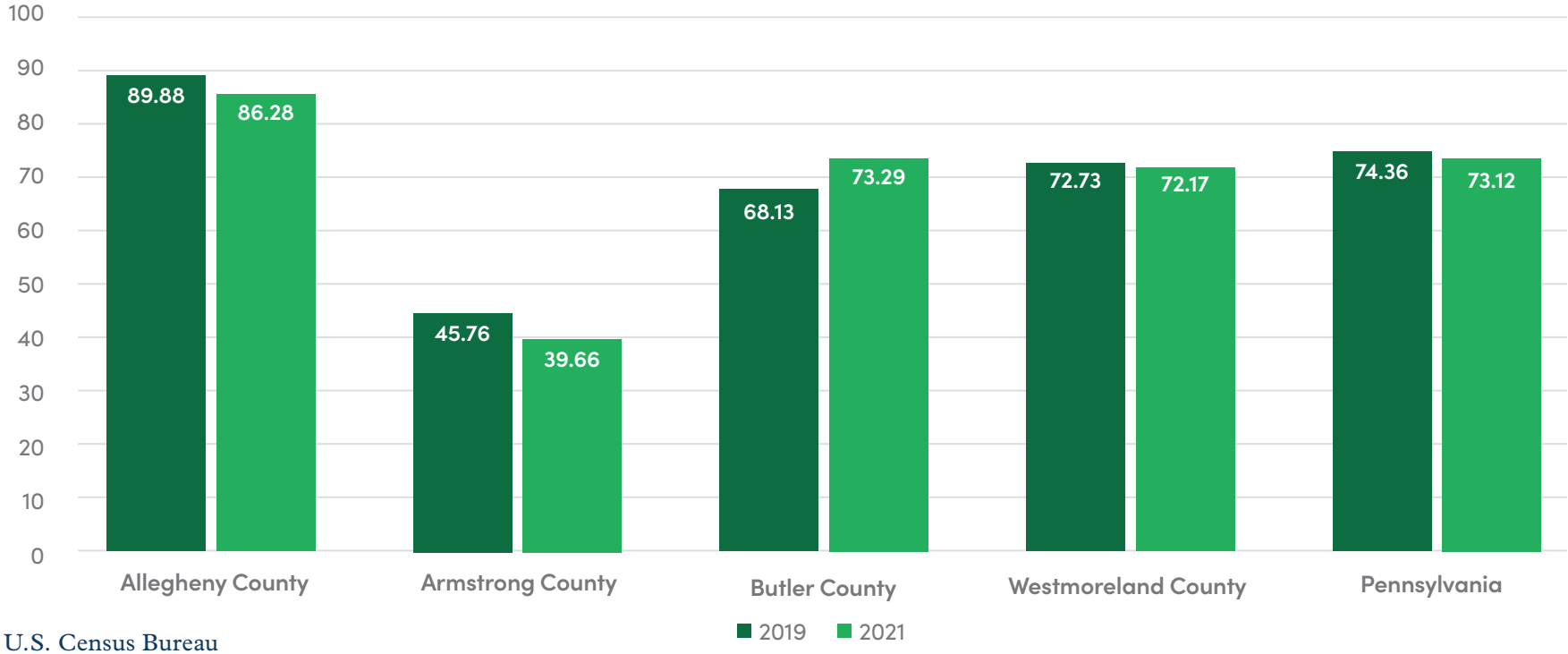
Figure 30: Food Environment – Food Desert Census Tracts



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 31: 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 AVH based on stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN AVH considered their capacity to implement behavioral health programming. Behavioral health is a critical issue in Pennsylvania, as the state faces rising challenges related to mental health and substance use disorders. Behavioral health encompasses mental health and substance use conditions, and Pennsylvania has taken significant steps to address the growing demand for services in these areas. According to the Pennsylvania Department of Health, nearly 20% of adults in Pennsylvania reported experiencing a mental illness in the past year; while, in 2021, there were 4,081 opioid overdose deaths in Pennsylvania, which accounted for 75% of all drug overdose deaths in the state.[12] Mental health is an important part of Pennsylvanians' overall health and well-being, and the prevalence of mental health-related issues is increasing. Access to adequate behavioral health care remains a significant concern, especially in rural areas of the state, where provider shortages and transportation barriers further limit care options.

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 the strategic allocation of 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.

In Pennsylvania, 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 overall resilience and well-being. Addressing behavioral health concerns requires a collaborative approach, engaging health care providers, policymakers, community organizations, and residents to develop effective solutions that enhance mental health care across the region.

[12] Kaiser Family Foundation

Figure 32: Behavioral Health Measures, Pennsylvania State Rankings

Measure	2020	2023
Depression	24	25
Excessive Drinking	19	25
Frequent Mental Distress	24	16
Smoking	32	31
Suicide	19	13

Source: America's Health Rankings

Substance Use Disorder

Substance use disorder was identified as a prioritized health need for AHN AVH based on stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN AVH considered their capacity to implement substance use disorder programming. The opioid crisis has been particularly devastating in Pennsylvania, one of the states hardest hit by the epidemic. In 2022, Pennsylvania had one of the highest opioid overdose death rates in the country, with 5,146 drug overdose deaths were reported.[13] An average of 14 Pennsylvanians die every day from overdose, and based on available data, the death toll will only continue to rise.[14]

Besides opioids, other substances, including alcohol and methamphetamines, contribute to the state's substance use issues. Recent data indicate that alcohol use disorders affect a significant portion of the population, escalating health problems and leading to higher rates of hospitalization and emergency room visits. Moreover, the emergence of methamphetamines as a prevalent substance in Pennsylvania has raised concerns among communities.

Addressing substance use disorder requires a comprehensive approach that encompasses prevention, treatment, and recovery support. Pennsylvania has made strides in expanding access to treatment services, including medication-assisted treatment (MAT) and behavioral therapies, to meet the needs of individuals struggling with addiction. However, barriers remain, such as stigma, lack of insurance coverage, and insufficient provider availability, especially in rural areas. To combat these challenges, the state has implemented initiatives aimed at improving access to care, promoting public awareness, and enhancing coordination among health care providers, community organizations, and law enforcement agencies.

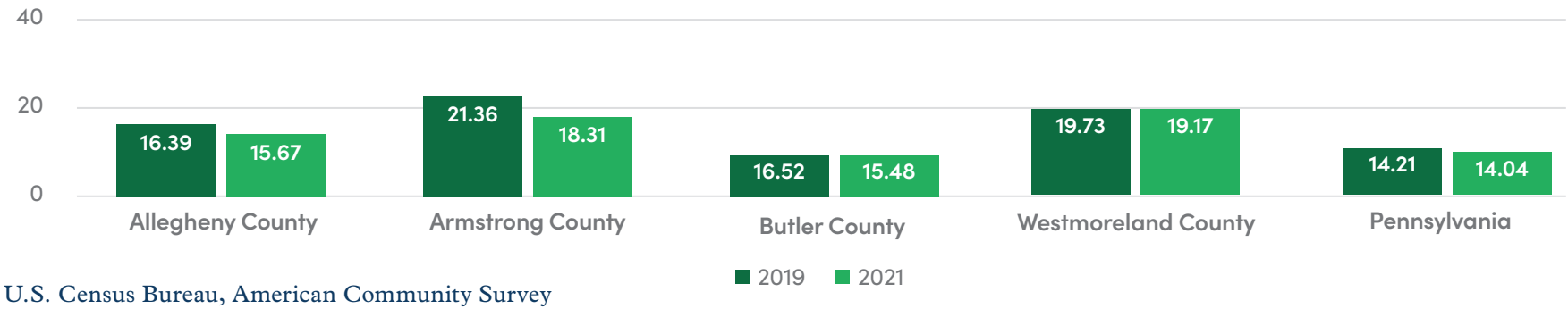
By prioritizing substance use disorder within the health care framework, Pennsylvania can work toward reducing the prevalence of addiction and its associated consequences. Collaborative efforts that include education, outreach, and support can help create healthier communities and aid resilience

[13] Pennsylvania Department of Health
[14] Pennsylvania Office of the Attorney General

among individuals and families affected by substance use disorder.

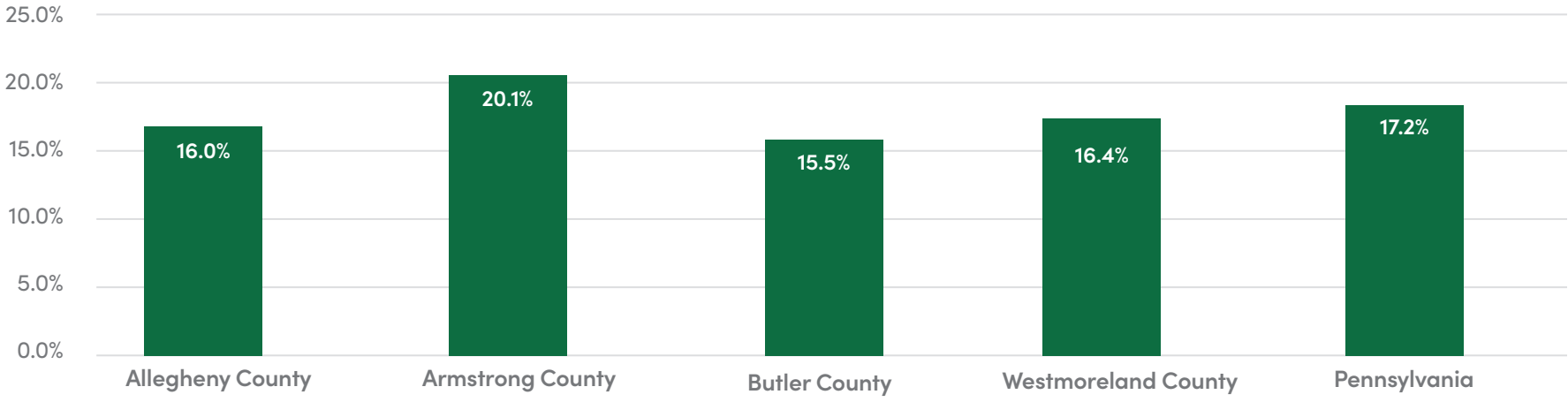
Alcohol and tobacco use are root causes and can aggravate behavioral health conditions. In Pennsylvania, alcohol and tobacco use pose significant health risks. The number of liquor stores per 10,000 population provides a measure of environmental influences on dietary behaviors and the accessibility of healthy foods. Note this data excludes establishments preparing and serving alcohol for consumption on premises (including bars and restaurants) or which sell alcohol as a secondary retail product (including gas stations and grocery stores).

Figure 33: Built Environment – Liquor Stores (per 10,000 population)



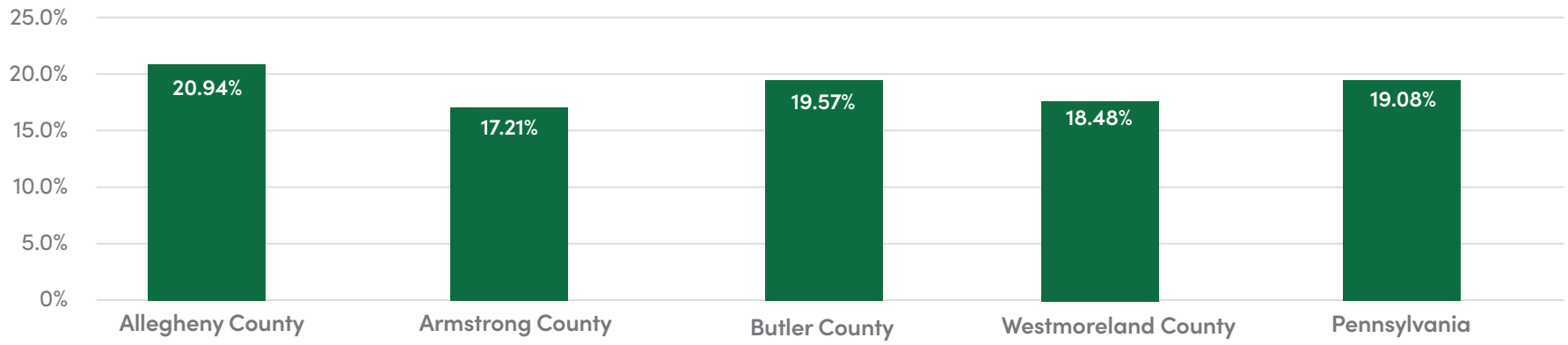
Source: U.S. Census Bureau, American Community Survey

Figure 34: Current Smokers, Percentage



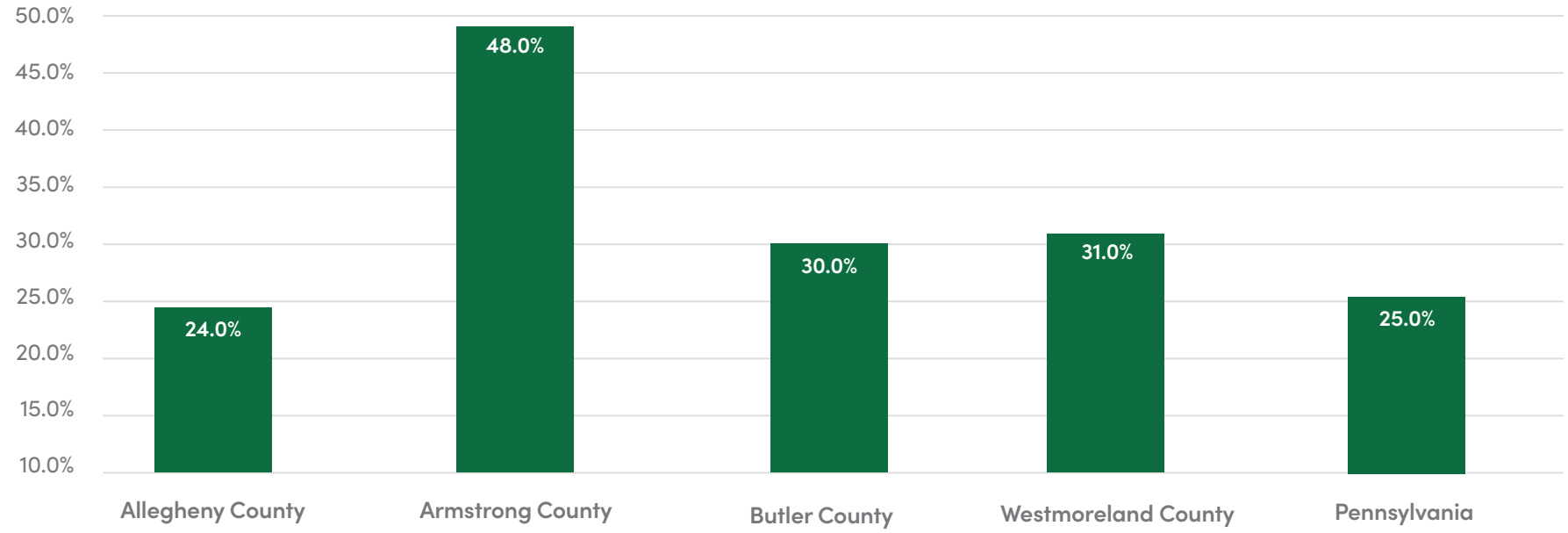
Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2021

Figure 35: Adults Reporting Excessive Drinking



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

Figure 36: 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 AVH based on stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN AVH considered their capacity to implement mental health programming. The mental health care landscape in Pennsylvania is similarly complex. 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. Around 19.7% of adults, nearly 2 million people, experience some form of mental illness, placing Pennsylvania 17th in the nation for mental illness prevalence. In Pennsylvania, 51.9% of adults with mental illness do not receive the treatment they need, impacting more than 1 million Pennsylvanians. This issue is even more critical considering the state's suicide rate, which includes 482,000 adults suffering from suicidal thoughts.[15]

In September 2023, the Pennsylvania Department of Human Services (DHS) announced its intent to increase rates paid in its Behavioral HealthChoices program, which provides access to mental health, substance use disorder, and other behavioral health services for Medicaid recipients. "Access to mental and behavioral health care is essential to our overall health and well-being. If we cannot get the care we need, our ability to participate in and engage fully in our responsibilities like work, school, and family will not be possible," said DHS Secretary Val Arkoosh.[16]

Expanding access to mental health services, ensuring adequate insurance coverage, and addressing barriers such as provider shortages are essential to tackling these 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.

Figure 37 below shows the average number of mentally unhealthy days reported in the past 30 days (age-adjusted).

Figure 37: Poor Mental Health Days

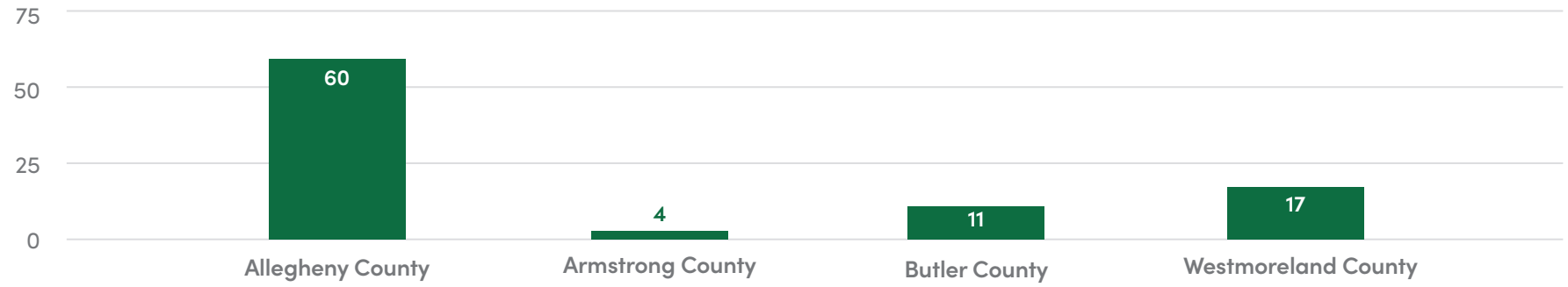
	Average Number of Mentally Unhealthy Days in the Past 30 Days
Allegheny County	5.1
Armstrong County	5.1
Butler County	4.4
Westmoreland County	5.2
Pennsylvania	4.7

Source: County Health Rankings, 2021

[15] Commonwealth of Pennsylvania

[16] Commonwealth of Pennsylvania

Figure 38: Facilities That Provide Mental Health Services



Source: County Health Rankings, 2017-2021

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 39: Ratio of Population to Mental Health Providers

	Mental Health Providers Rate (per 100,000 population)
Allegheny County	220:1
Armstrong County	650:1
Butler County	470:1
Westmoreland County	490:1
Pennsylvania	370:1

Source: County Health Rankings, 2023

C.) Chronic Diseases and Aging

Chronic diseases and aging was identified as a prioritized health need for AHN AVH 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 AVH 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.[17] 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.[18] 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.[19] 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.[20] 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.

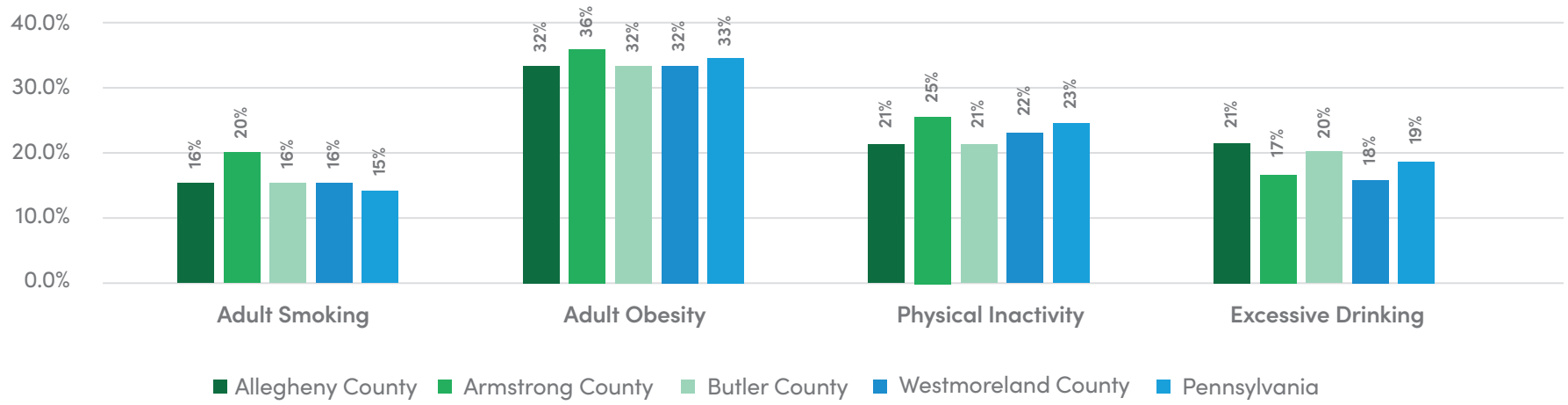
The impacts of chronic diseases extend beyond physical health; they also significantly affect mental and emotional well-being. People living with chronic illnesses frequently experience anxiety, depression, and social isolation. This interplay between physical and mental health can complicate treatment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

[17] Centers for Disease Control and Prevention
[18] Centers for Disease Control and Prevention
[19] 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.
[20] Highmark Blue Cross Blue Shield

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.

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.

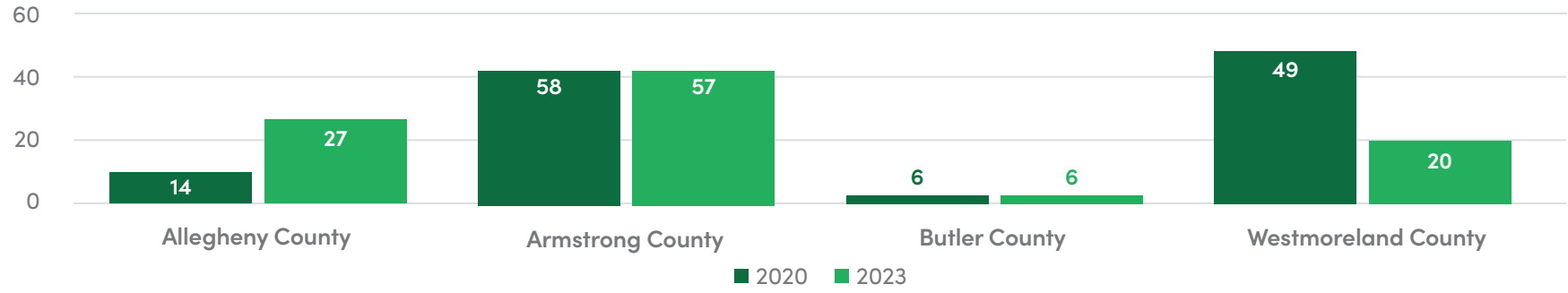
Figure 40: Behaviors Leading to Chronic Conditions



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 41 below shows that Allegheny County's health outcomes rankings got worse from 14 in 2020 to 27 in 2023, while Armstrong, Butler, and Westmoreland counties all improved their ranking or stayed the same.

Figure 41: Health Outcomes Rankings



Source: County Health Rankings

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 42 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 42: 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 • Heart disease, stroke, high blood pressure • Cancer • Behavioral health (anxiety, depression, post-traumatic stress disorder, suicide, etc.) • Substance use disorder/addiction • Poor eating habits • Lack of physical activity • Unmanaged stress or anxiety • Unsafe driving (DUI, speeding, road rage)	• Behavioral health • Overweight/obesity/diabetes • Substance use disorder/addiction • Heart disease/stroke/high blood pressure • Cancer

Diabetes

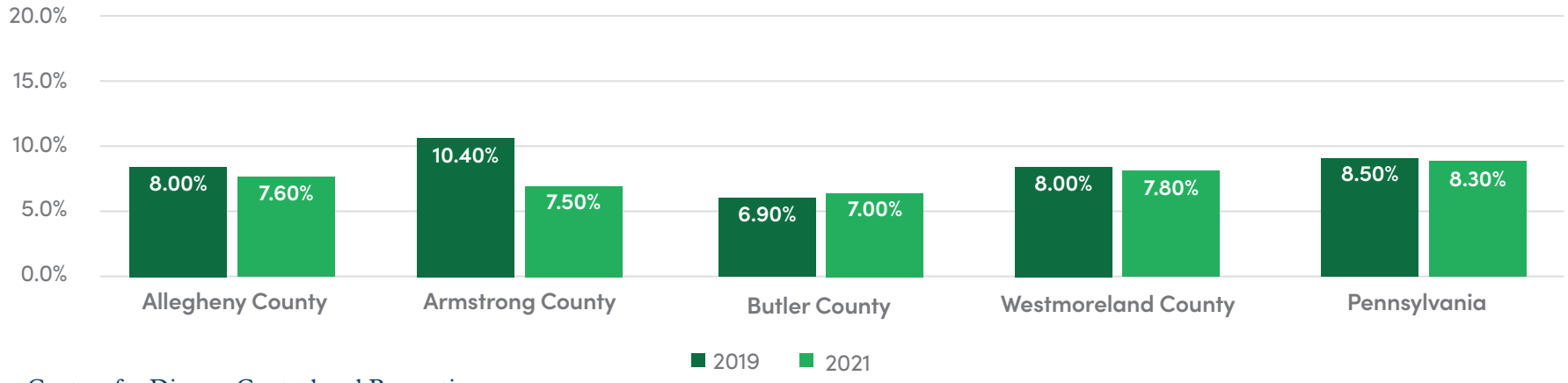
Diabetes was identified as a prioritized health need for AHN AVH based on the stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN AVH considered their capacity to implement diabetes programming. Diabetes is 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. Diabetes is a significant public health concern in Pennsylvania; 1.1 million adults in the state, or 11.1% of the adult population, have been diagnosed with diabetes.

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.

The impact of diabetes on individuals and the health care system in Pennsylvania is profound. People living with diabetes face a higher risk of developing serious health complications, including heart disease, kidney failure, and vision loss. According to the Pennsylvania Department of Health, diabetes and its complications are among the leading causes of death in the state, underscoring the urgent need for effective prevention and management strategies.

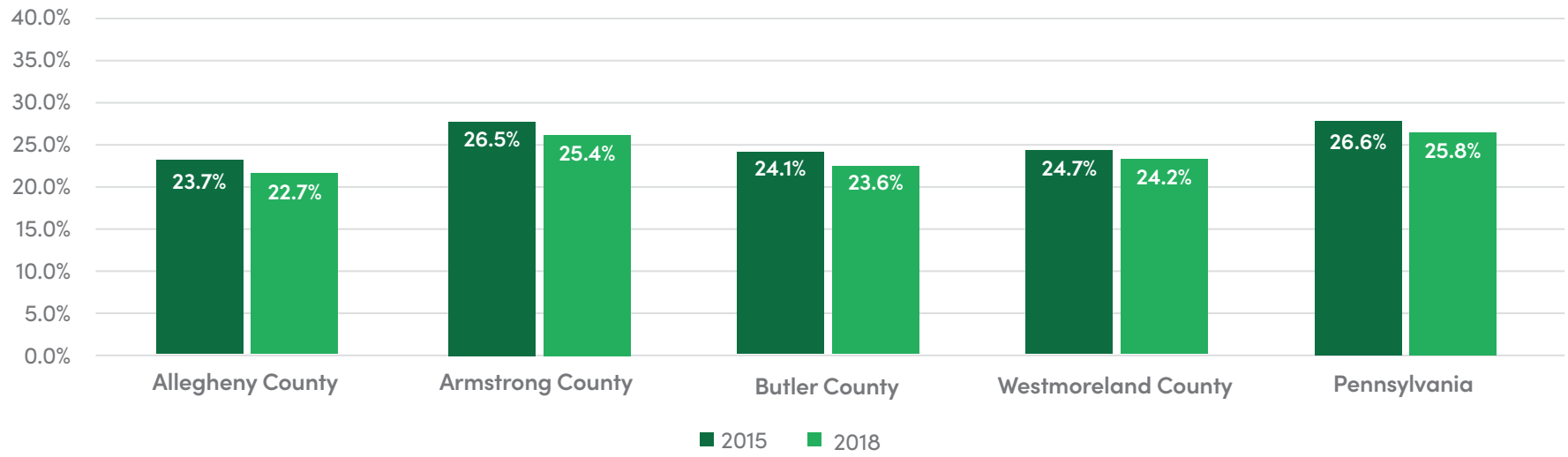
Efforts to combat diabetes in Pennsylvania include public health initiatives aimed at raising awareness about prevention, encouraging healthier lifestyle choices, and increasing access to medical care. Programs focusing on nutrition education, physical activity, and regular health screenings are essential components of 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 43: Adults with Diabetes



Source: Centers for Disease Control and Prevention

Figure 44: Diabetes (Medicare Population)



Source: Centers for Medicare and Medicaid Services

Figure 45: Diabetes Death Rates (Age-Adjusted)

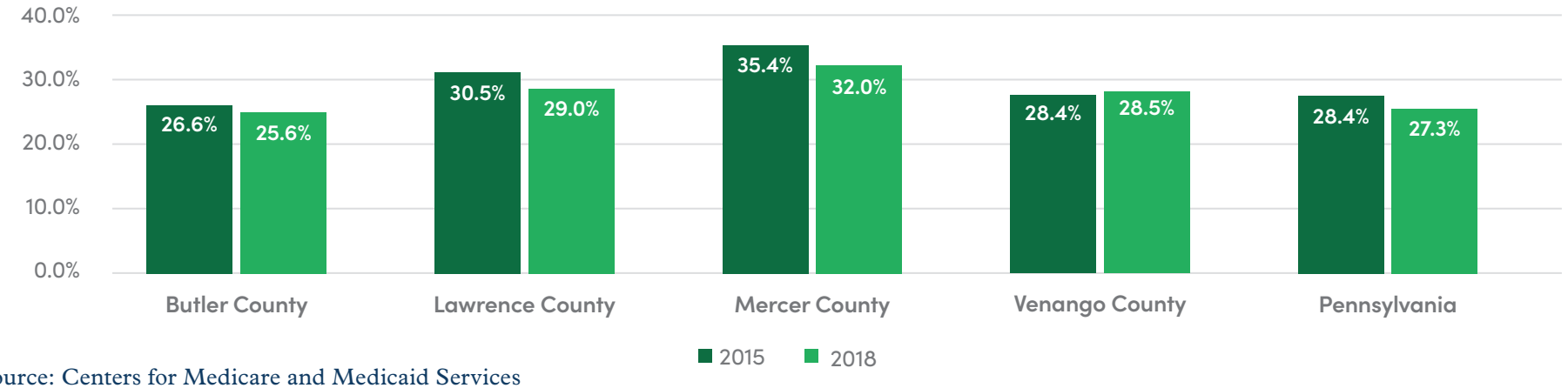
	Diabetes Mellitus Death Rate
Allegheny County	18.5
Armstrong County	30.4
Butler County	22.9
Westmoreland County	22.7
Pennsylvania	22.1

Source: Pennsylvania Department of Health, 2018-2022

Heart Disease

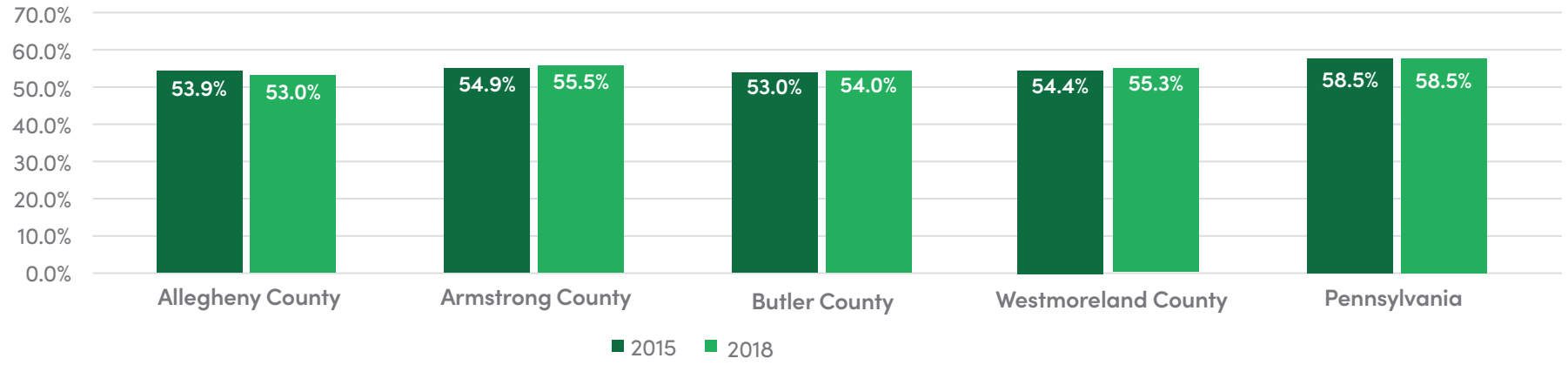
Heart disease was identified as a prioritized health need for AHN AVH based on the stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN AVH considered their capacity to implement heart disease programming. Heart disease is a leading chronic condition in Pennsylvania, significantly impacting the health and well-being of its residents. It encompasses a range of cardiovascular conditions, including coronary artery disease, heart failure, and arrhythmias. According to the Pennsylvania Department of Health, heart disease is the leading cause of death in Pennsylvania.

Figure 46: Heart Disease (Medicare Population)



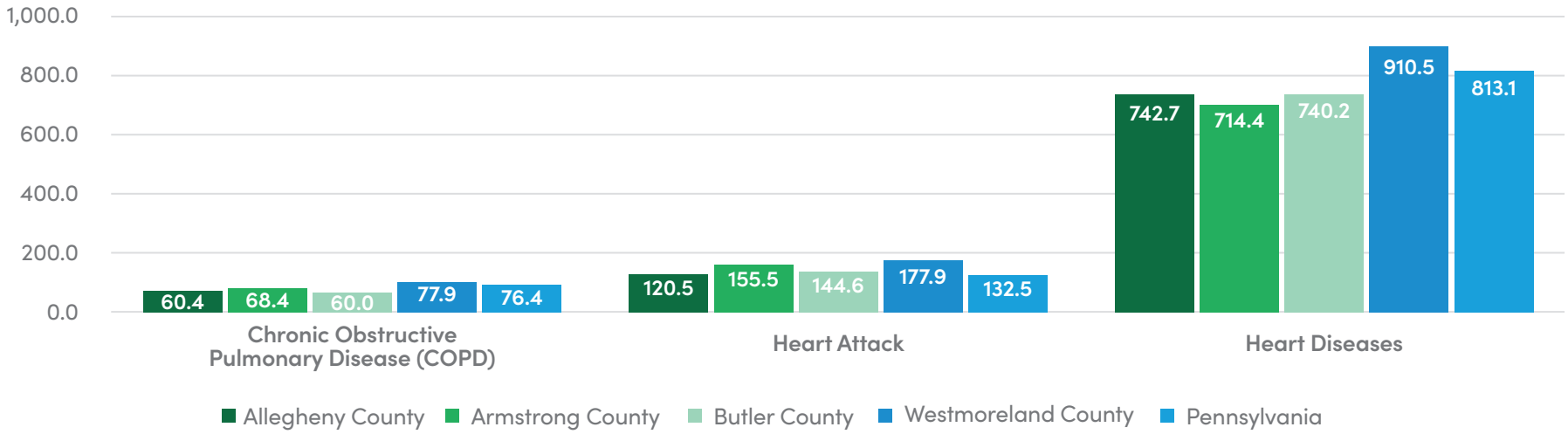
Source: Centers for Medicare and Medicaid Services

Figure 47: High Blood Pressure (Medicare Population)



Source: Centers for Medicare and Medicaid Services

Figure 48: Hospitalizations Discharge Rates



Source: Pennsylvania Department of Health, 2022

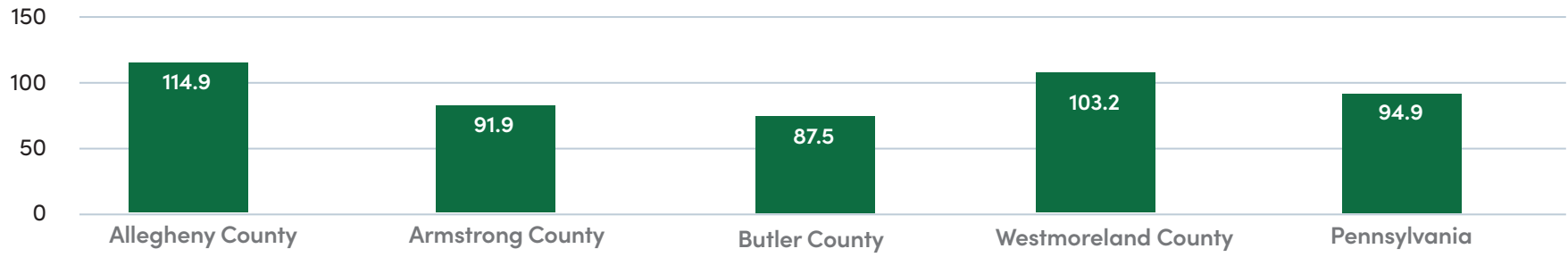
Figure 49: Heart Disease Death Rates

	Heart Disease Death Rate per 100,000 People
Allegheny County	191.5
Armstrong County	181.4
Butler County	171.8
Westmoreland County	185.7
Pennsylvania	176.4

Source: Pennsylvania Department of Health, 2018-2022

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.

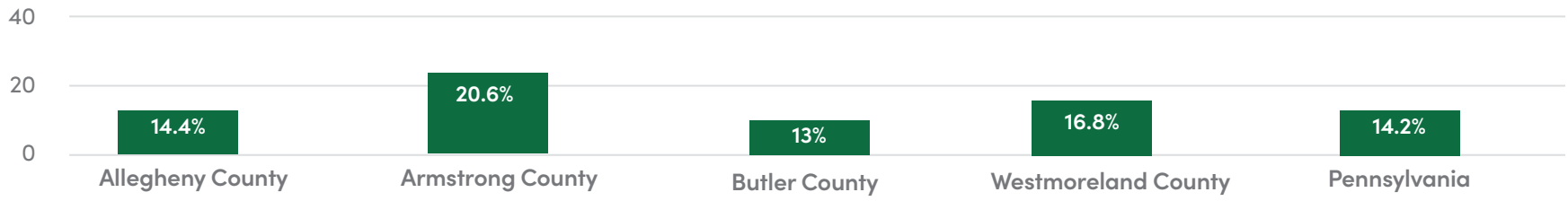
Figure 50: Coronary Heart Disease Mortality Rate (Per 100,000 Population)



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

[22] National Heart, Lung, and Blood Institute

Figure 51: Stroke Mortality Rate (Per 100,000 Population)



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

D.) Health Equity

Health equity was identified as a prioritized health need for AHN AVH based upon it being an enterprise-wide priority. In addition, AHN AVH 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 52 delineates the responses from the community leader stakeholder interviews, community surveys, and provider surveys regarding equitable care and maintaining optimal health.

Figure 52: 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	• Adequate employment • Access to affordable prescription and over-the-counter medication • Affordable, quality child and/or senior care options • Affordable, safe, quality housing and utilities • Safe places to walk/play and accessible, affordable community activities (parks, trails, community centers) • Access to affordable healthy food options • Access to mental health resources	• 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 AVH based upon it being an enterprise-wide priority. In addition, AHN AVH 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.[23] 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.[24]

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.

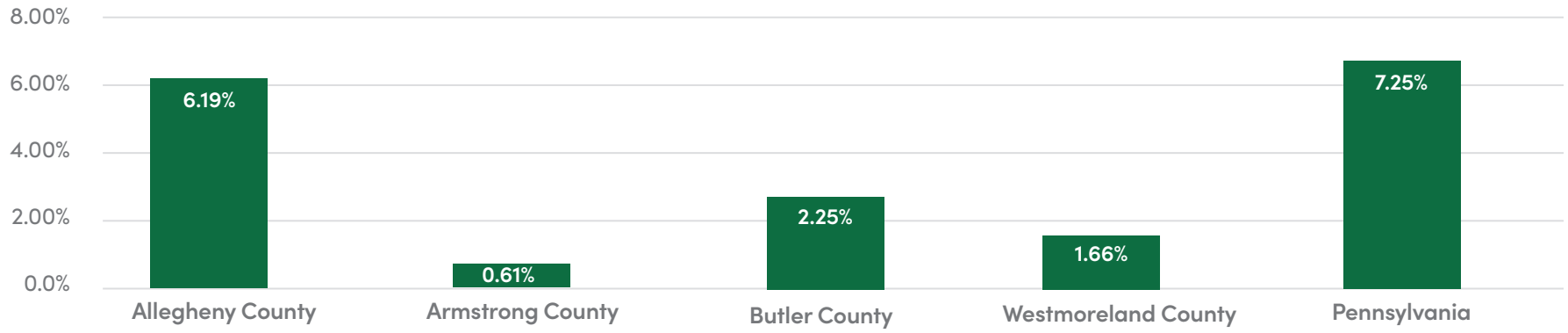
Moreover, stimulating an inclusive environment helps create a culture of safety where patients can communicate openly about their health needs without fear of discrimination or bias.

[23] National Library of Medicine
[24] Newsweek

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.

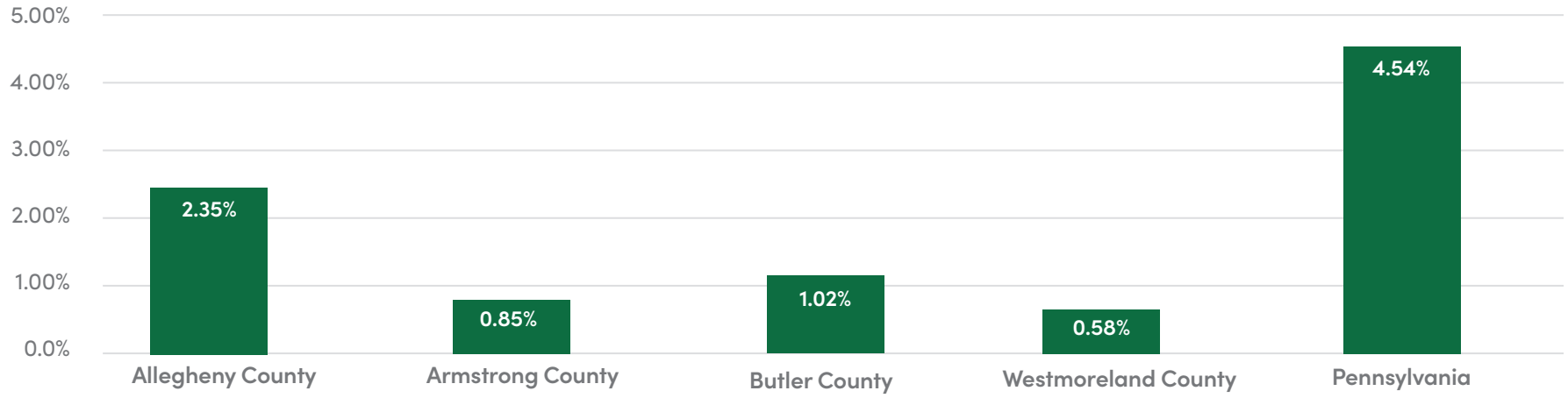
Figure 53 below reports the percentage of the population that is foreign-born. The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national.

Figure 53: Foreign-Birth Population, Percent of Total Population



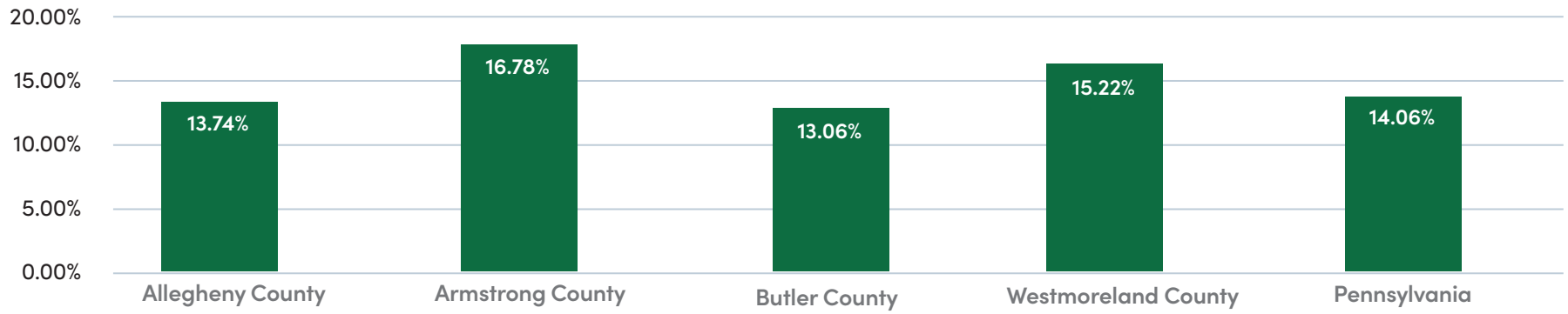
Source: U.S. Census Bureau, 2018-2022

Figure 54: Population with Limited English Proficiency (age 5+)



Source: U.S. Census Bureau, 2018-2022

Figure 55: Percentage of Population with a Disability



Source: U.S. Census Bureau, 2018-2022

Community Resources Available to Address Identified Needs

In addition to the programs and services offered to the community through AHN AVH, 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 56: Community Resources

Identified Significant Health Needs	Local Community Resources Available to Address Needs
Social Determinants of Health – Transportation	Allegheny Valley Association of Churches (AVAC) Transportation Assistance, Mercy Medical Angels (MMA), Port Authority of Allegheny County
Social Determinants of Health – Food Insecurity, Diet, and Nutrition	Allegheny Valley Association of Churches (AVAC), The Building Block of Natrona, The Lighthouse Foundation
Behavioral Health – Substance Use Disorder	Adagio Health, Unity Recovery
Behavioral Health – Mental Health Services	Wesley Family Services, Erika's Lighthouse, Alle-Kiski Area Hope Center, Inc.
Chronic Diseases and Aging – Diabetes	Affordable Diabetic, American Diabetes Association, Nutrition for Longevity
Chronic Diseases and Aging – Heart Disease	YMCA of Greater Pittsburgh, Mended Hearts
Health Equity – Diversity, Equity, and Inclusion	United Disabilities Services (UDS), Pennsylvania Immigration Resource Center (PIRC)

AHN Community Resource Inventory

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

Conclusion

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

AHN AVH'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 AVH ensures that the voices of the community are heard and reflected in its health strategies. Partnering with community organizations allows AHN AVH 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 AVH 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 AVH 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 AVH 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 AVH 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 AVH 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 AVH 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 AVH'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 AVH 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 AVH'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 AVH's service area, as it was collected using convenience sampling.

Tripp Umbach

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.