Allegheny Health Network — AHN West Penn Hospital

Community Health Needs Assessment

2024 Report

AHN WEST PENN Hospital

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A Message From Our Presidents

A Healthier Future: Community Health Needs Assessment Results

Dear Valued Members of Our Community,

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

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

- **Social Determinants of Health:** Many residents face challenges accessing affordable health care and healthy foods, particularly in underserved areas. These issues affect individuals and families of all backgrounds, impacting their health, well-being, and overall quality of life.
- **Chronic Disease Management:** Chronic diseases, such as obesity, 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. 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

Brian Johnson, MD
President, AHN West Penn Hospital

About This Report

Community Health Needs Assessment Overview

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

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

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

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

AHN West Penn 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 West Penn Hospital's CHNA report aligns with the guidelines established by the Affordable Care Act and adheres to Internal Revenue Service (IRS) regulations, ensuring a comprehensive assessment of community health needs and guiding effective strategies to address them.

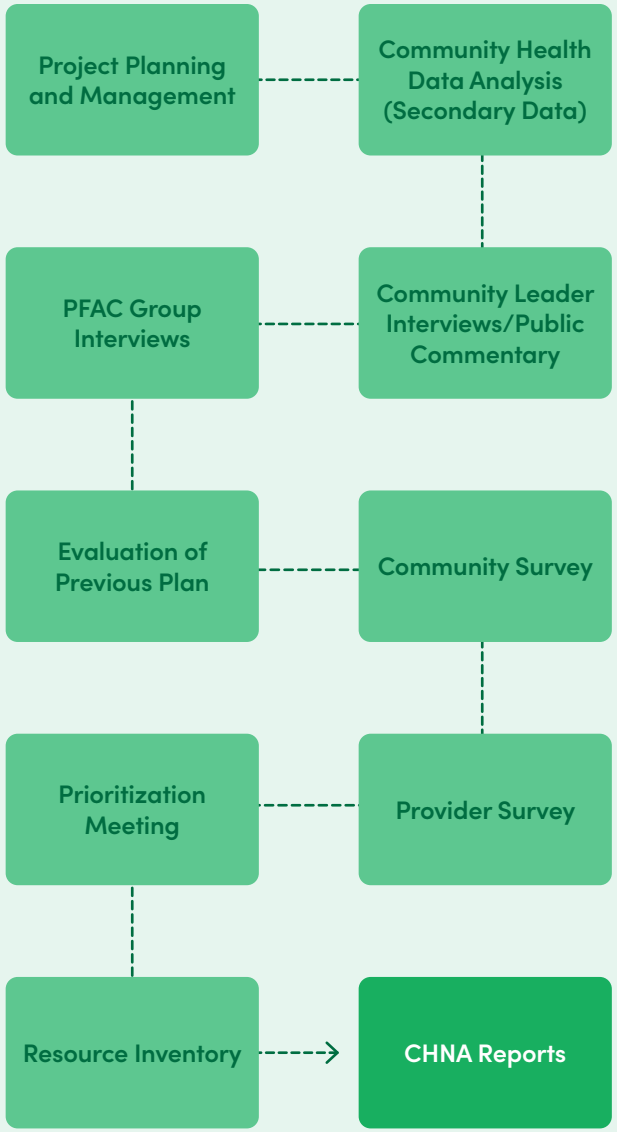
CHNA Methodology

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

CHNA Process

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

Figure 1: Roadmap for the Community Health Needs Assessment



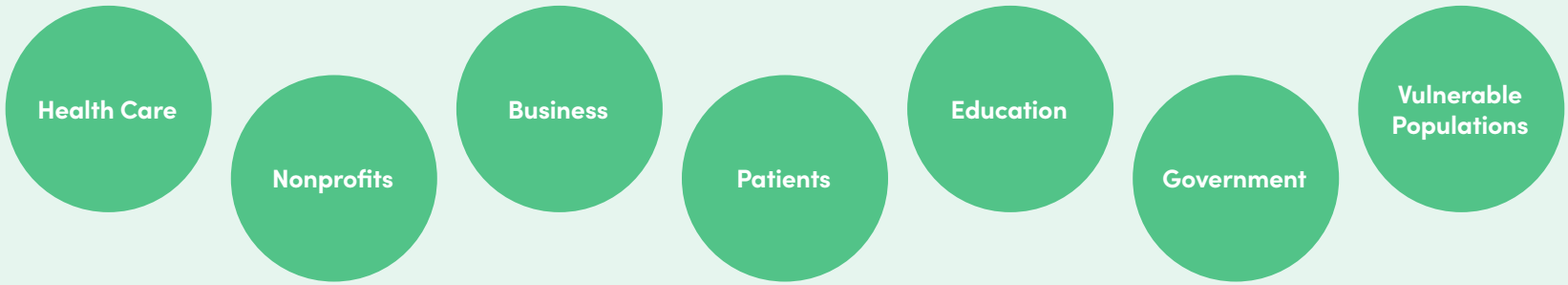
Community Engagement

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

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

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

Figure 2: Key Stakeholders



About Allegheny Health Network and AHN West Penn Hospital

Allegheny Health Network

Allegheny Health Network is a leading nonprofit health system based in Pittsburgh, Pennsylvania, dedicated to providing high-quality, comprehensive health care services to the communities it serves. AHN, part of the Highmark Health enterprise, operates 14 hospitals, employs over 22,000 people, and has more than 250 locations providing care. AHN is an integrated health system dedicated to providing exceptional care to people in the local communities. Serving 12 Pennsylvania counties and two counties in New York, AHN brings together the services of AHN Allegheny General Hospital, AHN Allegheny Valley Hospital, AHN Canonsburg 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.

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

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

1 Allegheny Health Network

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.

AHN West Penn Hospital

Founded in 1848, AHN West Penn Hospital has established itself as a premier health care institution in Pittsburgh, Pennsylvania, and serves as a cornerstone of health and wellness for the western Pennsylvania community. With 356 beds, AHN West Penn is renowned for its commitment to excellence in patient care, education, and research.[2] Over the years, AHN West Penn has garnered an international reputation for its innovative approaches and high-quality services across a wide range of medical specialties.

AHN West Penn is recognized as a national leader in oncology, surgery, and women's health, providing advanced treatment options for conditions such as cancer, heart disease, severe burns, autoimmune diseases, and neurological disorders. The hospital's extensive medical staff includes 1,246 physicians who collaborate with experienced nursing teams to deliver comprehensive care.[3]

With a rich history and a forward-thinking approach, AHN West Penn Hospital remains committed to meeting the evolving health care needs of its community while striving to achieve the best possible outcomes through compassionate care and advanced medical technology.

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

In 2024, 18 ZIP codes were identified as the primary service area for AHN West Penn Hospital. The following table highlights the study area focus for AHN West Penn Hospital's 2024 CHNA.

Figure 4: 2024 AHN West Penn Hospital's Primary Service Area

Zip Code	Town	County
15139	Oakmont	Allegheny
15147	Verona	Allegheny
15201	Pittsburgh	Allegheny
15206	Pittsburgh	Allegheny
15208	Pittsburgh	Allegheny
15213	Pittsburgh	Allegheny
15215	Pittsburgh	Allegheny
15217	Pittsburgh	Allegheny
15218	Pittsburgh	Allegheny
15219	Pittsburgh	Allegheny
15221	Pittsburgh	Allegheny
15222	Pittsburgh	Allegheny
15223	Pittsburgh	Allegheny
15224	Pittsburgh	Allegheny
15232	Pittsburgh	Allegheny
15235	Pittsburgh	Allegheny
15238	Pittsburgh	Allegheny
15260	Pittsburgh	Allegheny

AHN West Penn Hospital Awards and Recognitions

- AHN West Penn Hospital is rated the No. 1 hospital in southwestern PA for Medical Excellence in Cancer Care.
- Rated among the Top 100 Hospitals in the nation for Patient Safety in Cancer Care
- Rated among the Top 100 Hospitals in the nation for Medical Excellence in Women's Health
- Rated among the Top 10% of hospitals in the Nation for Medical Excellence in Heart Attack Treatment
- Rated among the Top 10% of hospitals in the nation for Patient Safety in Overall Hospital Care
- Blue Distinction® Center+ designation for efficiency in delivering high-quality care and better overall outcomes for bariatric care, cardiac care, and maternity care
- American Heart Association's Silver Plus status for Get With The Guidelines® heart failure program
- The AHN Comprehensive Hypertension Center at AHN West Penn Hospital is American Heart Association-certified** (the only such center in the region), thanks to the wide array of multispecialty resources patients can access to diagnose and care for difficult-to-treat high blood pressure.
- **Four Time Magnet® Recognition:** West Penn Hospital is Southwest Pennsylvania's only 4-time Magnet-recognized hospital. The Magnet® designation from the American Nurses Credentialing Center recognizes health care organizations that provide nursing excellence.
- **American Heart Association® Gold Plus:** This designation is for hospitals that deliver the highest quality of heart failure treatment.
- **International Board of Lactation Consultants Care Award:** This award is reserved for hospitals and community-based facilities that promote, protect, and support breastfeeding.
- **U.S. News and World Report:** West Penn Hospital is ranked in the nation's top 50 hospitals for OB-GYN care.
- Keystone 10 designation for Quality Improvement in Breastfeeding.
- **American Heart Association® Certified Comprehensive Hypertension Center:** Certified hospitals must perform extensive exams, treatments, diagnostic evaluations, and interventions for complex or resistant-to-treatment hypertension.
- **West Penn Burn Center:** For more than 20 years, the West Penn Burn Center has been the only pediatric burn center in western Pennsylvania to be verified by the American Burn Association and the American College of Surgeons.
- **Blue Distinction Center for Bariatric Surgery:** A recognition from Blue Cross Blue Shield for health care facilities and providers with expertise and efficiency in delivering this specialty care.
- **Bariatric Surgery Center of Excellence Accreditation:** This accreditation from the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP®) is reserved for bariatric surgical centers that undergo a rigorous review process.
- **Blue Distinction Center+:** A recognition from Blue Cross Blue Shield for hospitals that demonstrate more affordable care in addition to quality care, treatment expertise, and better overall patient results.

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

Key Stakeholders					
Largest Barriers (Top 5)	**Persistent Health Problems (Top 5)**	**Significant Barriers to Improving Health & Quality of Life (Top 5)**	**Persistent High-Risk Behaviors (Top 5)**	**Vulnerable Populations (Top 3)**	**What Should Be Offered to Maintain Optimal Health (Top 5)**
1. Affordability 2. Lack of transportation 3. Health literacy 4. No insurance coverage 5. Lack of health care coordination services	1. Behavioral/ Mental Health 2. Heart Disease/ Stroke 3. Obesity 4. Diabetes 5. Substance Use Disorder/Addiction	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 childcare 5. Affordable, quality housing/utilities	1. Being overweight/ obese 2. Drug abuse 3. Poor eating habits 4. Lack of exercise/ physical inactivity 5. Alcohol abuse	1. Older adults 2. People living with mental illness 3. Low-income	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 West Penn Hospital. Input was requested from community stakeholders identified by the working group. This process allowed community representatives to respond to the methods, findings, and actions taken as a result of the 2021 CHNA and ISP. Stakeholders addressed questions developed by Tripp Umbach. The public comments below summarize the feedback provided by stakeholders regarding the previous documents. The study's data collection took place from July to September 2024.

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

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

Group Interviews

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

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

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

PFAC Group 1

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

- Continuity of care, especially for older people with multiple providers and little coordination. This led in part to the opioid crisis.
- Obtaining appointments promptly — need more providers.
- Management of chronic illnesses such as diabetes and hypertension must be improved.
- Reimbursement and insurance issues, including cost of care and copays.
- Domestic violence with an increase in elder abuse.
- Food insecurity in children and elderly population.
- Transportation is a significant barrier, especially in rural communities, leading to less preventive care access.
- Need for an integrated technology system that brings all providers and care — not just medical — to coordinate care and health maintenance.
- Housing insecurity, transportation, 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 West Penn Hospital residents reported in their community, descending from the most to the least identified.

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

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

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

Figure 6: Community Survey Summary Analysis

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

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

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

Evaluation of Previous Community Health Needs Assessment and Implementation Strategy Plan

Over the past three years, representatives from AHN West Penn Hospital have focused on developing and implementing strategies to address the health needs and concerns in the study area. Additionally, AHN West Penn Hospital has evaluated the effectiveness of these strategies in meeting its goals and tackling health challenges within the community. This review of the previous implementation strategy aimed to assess how well the methods and approaches from the prior ISP were executed.

The working group reviewed each goal, objective, and strategy to identify ways to enhance their effectiveness. Internal self-assessments were used to track progress and refine each strategy and action step over the next three years. AHN West Penn Hospital has addressed the following strategies.

SOCIAL DETERMINANTS OF HEALTH

Health Priority: Workforce Development

Goal: (1) Establish a system with local groups to recruit for open positions; and
(2) develop opportunities/programs for high school students to career paths in health care.

Figure 8: SDOH Workforce Development Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year
Partner with local community groups to develop ongoing recruitment and hiring at WPH. Develop programs for high school students for a career path in health care.	• Identify/continue to advance relationships with community partners/schools. • Perform monthly and/or quarterly meetings to establish process flow with all local community groups.	X	X	X	• Communication of open positions • Number of formal meetings • Number of hires • Number of students in programs • Number of students shadowing • Number of educational events
Summary of Outcomes 2022 – June 30, 2024					
• Held 36 formal NLA meetings with 29 student participants • Hosted 30 students and 38 Shadow/Observers within various clinical departments • Provided career development and training to 128 students and interns					• Participated in Health & Wellness fair for Woolslair Elementary students and parents in conjunction with Highmark community affairs; Approx 75 attendees • Provided career development training, tours, and careers fairs with 329 interns and student attendees

SOCIAL DETERMINANTS OF HEALTH

Health Priority: Food Insecurity, Diet, and Nutrition

Goal: Strengthen access to specialty provider services and increase utilization of services.

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

Strategies	Action Steps	2022	2023	2024	Metrics Per Year
Increase access to The Healthy Food Center (HFC).	• Utilize the Healthy Food Center to educate on chronic diseases. • Partner with The Healthy Food Center to provide education on healthy choices. • Partner with PCP offices to utilize the Social Determinants of Health screening tool for food insecurities. • Refer patients to HFC.	X	X	X	• Number of referrals from PCP offices. • Number of referrals that utilize the Healthy Food Center.
Summary of Outcomes 2022 – June 30, 2024					
• 2,109 visits • Served 5,019 people • Provided 50,190 meals • Provided patient education: Shopping Healthy on a Budget – 135 patients					• Nutrition counseling – 13 patients • Two (2) Community presentations: West Penn Patient & Family Advisory Council (PFAC) and the Immigrant and Refugee Health Conference on Nutrition, Diet, and Overcoming Barriers of Food Insecurity

BEHAVIORAL HEALTH

Health Priority: Postpartum Depression

Goal: Increase utilization of outpatient behavioral health services for women.

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

Strategies	Action Steps	2022	2023	2024	Metrics Per Year
Identify women at risk for perinatal or postpartum depression and anxiety disorders.	• Conduct early screenings for perinatal and postpartum depression. • Conduct behavioral health assessment prior to discharge. • Provide access to appropriate level care. • Destigmatize postpartum depression and anxiety disorders. • Conduct behavioral health assessment at follow-up visits.	X	X	X	• Number of women screened. • Number of women referred to Alexis Joy D'Achille Center for Perinatal Mental Health. • Number of behavioral health assessments.
Summary of Outcomes 2022 – June 30, 2024					
• Held 3x Mother of All Baby Showers with 972 +/- attendees • Served 12,152 unique patients • Referred 7,983 behavioral health patients					• Conducted a total of 57,776 appointments • Participated in PA Black Maternal Health Caucus in Harrisburg • Partnered with Highmark's First Steps & Beyond Program

CHRONIC DISEASE

Health Priority: Diabetes

Goal: Improve quality outcomes associated with diabetes.

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

Strategies	Action Steps	2022	2023	2024	Metrics Per Year
Develop a chronic disease specialty center at West Penn Hospital.	• Educate PCPs and patients on diabetes management. • Promote lifestyle change interventions and intensive case management to the target population.	X	X	X	• A1C levels for the target population. • Number of education programs for providers. • Number of education programs for patients. • Number of attendees to education programs.
Summary of Outcomes 2022 – June 30, 2024					
A1C tracking of 4 HFC pts: • PT#1-Highest decrease in A1C was 7.1 • PT#2- Decrease in A1C of 6.7 • PT#3- 7.6 decreased to 6.5 • PT#4-7.5 decreased to 6.9	A1C tracking demonstrates an average decrease in A1C of 3.0				

CHRONIC DISEASE

Health Priority: Cancer

Goal: Reduce the number of cancer-related deaths.

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

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022-June 30, 2024
Increase the number of adults who receive timely age-appropriate cancer screenings based on the most recent guidelines.	• Plan free cancer screenings for prostate, breast, skin, cervical, colon/rectal, and lung cancer. • Distribute a booklet on age-appropriate cancer screenings.	X	X	X	• Number of screenings performed • Number of abnormal screenings identified and referred for additional testing • Number of individuals screened for at least one cancer	• Screened 967 during annual events • Held "Survivor's" picnic with 200 in attendance • Held "Ahead of Cancer" virtual lecture series and WPH's Dr. Lister and Dr. Edington served on the panel
Educate adults on the importance of early detection.	• Collaborate with community partners to enhance community outreach and education. • Collaborate with Breath PA, American Lung Association, and Consumer Health Coalition on smoking cessation. • Work with PCPs on smoking cessation education and counseling. • Educate PCPs on recommending home colon/rectal screening kits.	X	X	X	• Number of educational events • Number of participants • Number of collaborations • Number of programs • Number of educations and counseling	• Counseled, increased awareness by holding several educational events totaling roughly 110 attendees

CHRONIC DISEASE

Health Priority: Obesity

Goal: Reduce the rate of obesity in the service area.

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

Strategies	Action Steps	2022	2023	2024	Metrics Per Year
Implement programs to reduce obesity in adults.	• Offer meal planning and nutrition counseling. • Offer medical weight loss programs. • Provide a comprehensive multidisciplinary approach to surgical intervention. • Provide education sessions on surgical interventions. • Provide support groups. • Provide web-based education and cooking classes.	X	X	X	• Number of community-based education events. • Number of participants medical weight loss . • Number of patients with surgical interventions. • Number of support group meetings. • Number of attendees.
Summary of Outcomes 2022 – June 30, 2024					
• Provided 224 info sessions • Served 2,763 new medical weight loss visits • 8,748 established patients • Conducted 969 stapling and 70 non-stapling interventions • Held 27 support group sessions					• Had WPH tent during Bloomfield Saturday Market (12 weeks), over 45,000 attended; conducted numerous medical screenings and provided a plethora of health education to approx. 15,000 attendees • Conducted health screenings at Little Italy Days, provided 250+ screenings, over 100,000 in attendance

HEALTH EQUITY

Goal: Increase access to care for women.

Figure 14: Health Equity Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of outcomes 2022-June 30, 2024
Working with women's institute on access to care and to evaluate barriers. Opportunities to decrease barriers to care.	• Partner with Mobile Moms — part of Travelers Aid Medical Assistance Transportation Program. • Provide support to patients one day per week from a social worker at OB-GYN residency program. • Train staff quarterly on transgender sensitivity.	X	X	X	• Number of clients who use Mobile Moms • Different types of support the social worker provides • Number of staff training • Number of staff who attend training	• Enrolled 179 clients into Mobile Moms program • With 1,072 visits, assessed for SDOH; provided care coordination, nutrition education, and referrals; and connected clients to community resources through the WPH HFC

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

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

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

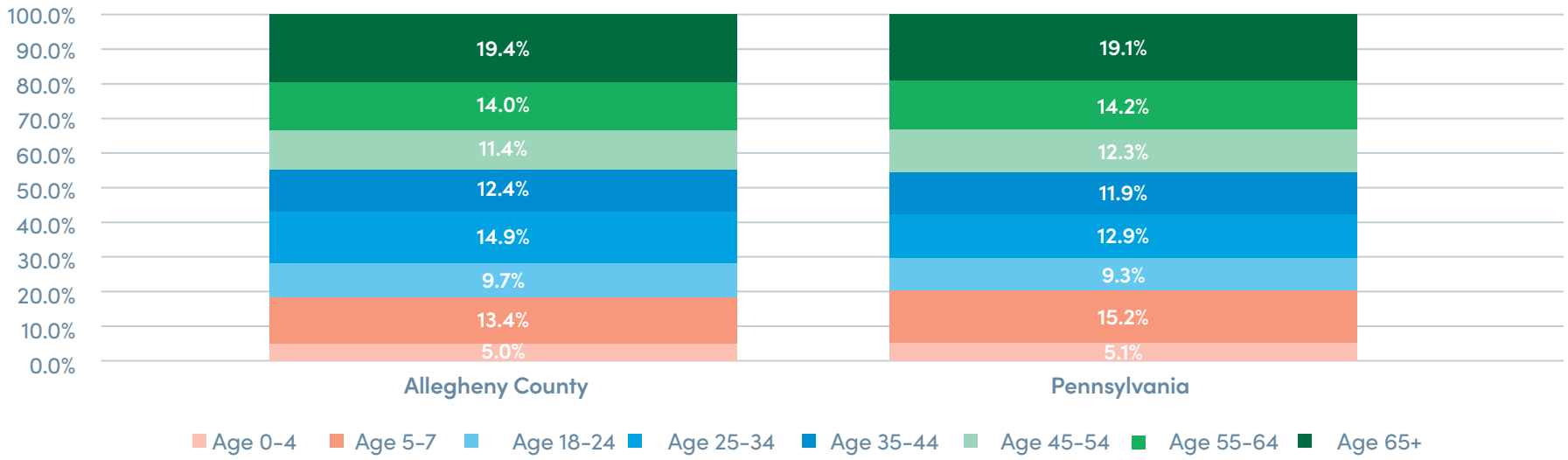
AHN West Penn Community at a Glance

Figure 15: Population

	Total Population	Males	Females
Allegheny County	1,245,310	607,557	637,753
Pennsylvania	12,989,208	6,410,766	6,578,442

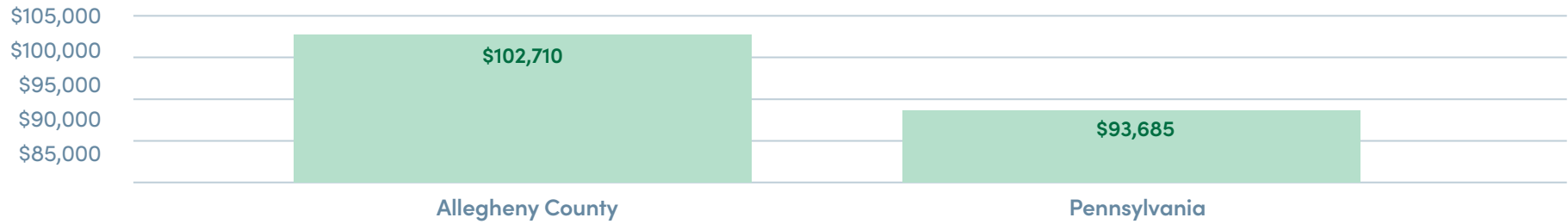
Source: U.S. Census Bureau, American Community Survey 2018-2022

Figure 16: Age Distribution



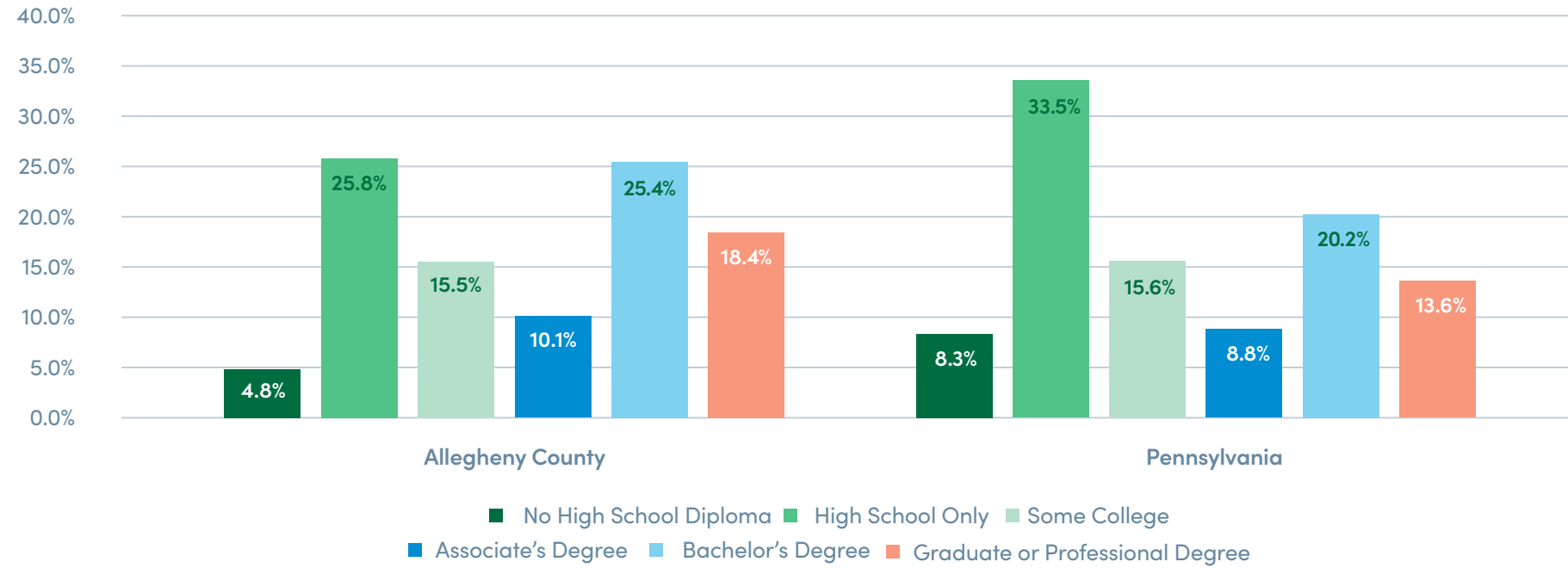
Source: Census Bureau, American Community Survey 2020

Figure 17: Median Household Income



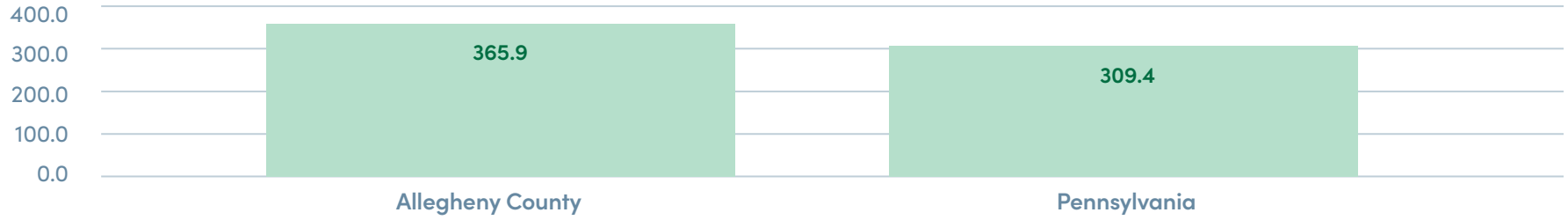
Source: Census Bureau, American Community Survey 2018-2022

Figure 18: Education



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%
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 reveals that in 2023, Allegheny County's health outcomes score worsened, from 14 in 2020 to 27. Additionally, Allegheny County's morbidity score dramatically shifted from 2020 to 2023, going from 6 to a ranking of 20.

Examining social and economic factors is essential because they greatly impact health outcomes and disparities, shaping access to key resources such as education, employment, and health care.[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

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?

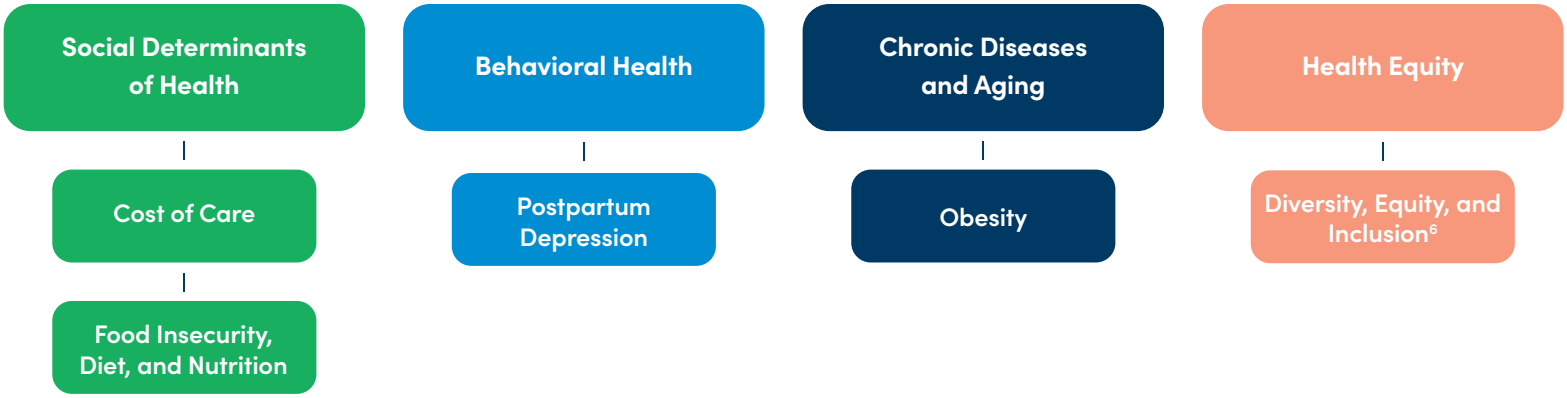
Identification and Prioritization Process

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 West Penn Hospital highlighted the following community needs:

Figure 22: AHN West Penn Hospital 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 based on the stakeholder interviews, community survey, and provider survey results. 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, 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.

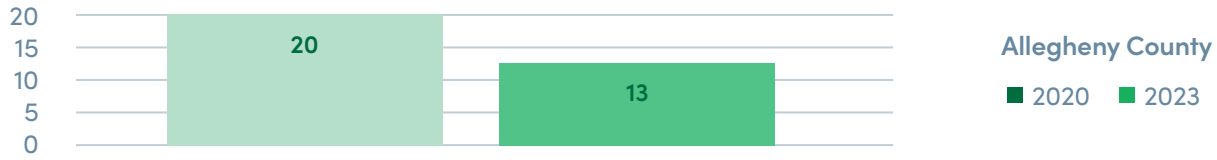
Figure 23: Social Determinants of Health

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 County improved its health factor rankings from 20 in 2020 to 13 in 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 Surveys	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 healthy food options • Access to preventive screenings and vaccinations • Access to affordable prescription and over-the-counter medication • Access to culturally appropriate primary care services • Affordable, safe, quality housing/ utilities • Safe places to walk/play • Overall feeling of safety/security	• Affordability • Availability of services • No insurance coverage • Lack of transportation • Lack of health care coordination services

Cost of Care

Cost of care was identified as a prioritized health need for AHN West Penn Hospital based on the stakeholder interviews and provider survey results as well as the secondary data analysis. In addition to those data points, AHN West Penn Hospital considered their capacity to implement programming to reduce cost of care. The cost of health care is a major factor in shaping SDOH because it directly influences individuals' ability to access necessary medical services. When the cost of care is prohibitively high, people may delay or forgo medical treatments, leading to worse health outcomes. This issue is especially pronounced among uninsured or underinsured individuals, who often face higher out-of-pocket expenses. According to a West Health-Gallup Affordability Index Survey, an estimated 72.2 million (or nearly one in three) American adults did not seek needed health care because of cost, which significantly impacts their ability to seek preventive care, manage chronic conditions, or receive timely treatments.[8]

High health care costs also contribute to financial stress and insecurity, magnifying other social determinants of health, such as housing and food insecurity. When individuals have to choose between paying for medical bills or basic needs like rent and groceries, their overall health and well-being are compromised. Research shows that medical debt is one of the leading causes of bankruptcy in the United States, and it disproportionately affects low-income households.[9] This financial burden not only impacts physical health but also mental health, as the stress of managing medical expenses can lead to anxiety, depression, and other psychological issues.

Cost barriers to health care disproportionately affect vulnerable populations, including racial and ethnic minorities, rural residents, and the elderly. These groups are often more likely to face higher health care expenses because of systemic barriers such as lack of insurance coverage, lower incomes, or limited access to affordable care. For example, people living in rural areas may need to travel long distances to receive specialized care, incurring additional costs in transportation, missed work, or overnight stays. These compounded expenses contribute to widening health disparities and worsen existing inequalities.

Addressing the high cost of health care is essential for improving health equity and reducing the long-term societal costs of poor health outcomes. By tackling the cost of care, society can take a significant step toward reducing health disparities and improving the overall well-being of populations.

Figure 26: Affordability State of Pennsylvania Rankings

	2020	2023
Avoided Care Because of Cost	9	13
Economic Hardship Index	18	20

Source: America's Health Rankings

8 West Health-Gallup Affordability Index
9 Marketplace.org

Figure 27: Federal Poverty Line (FPL)

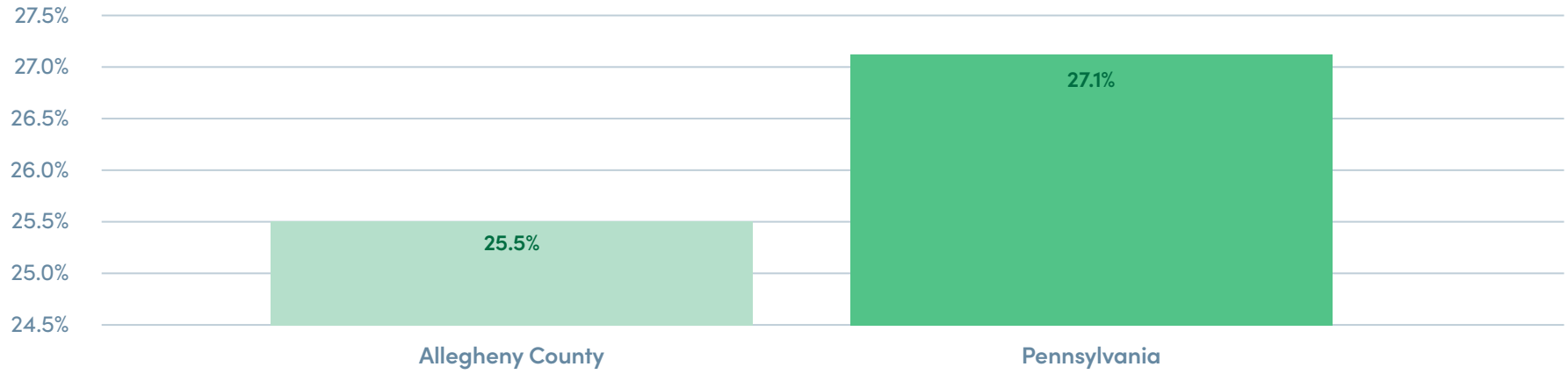
	Children Below 100% FPL	Children Below 200% FPL	Population Below 100% FPL	Population Below 200% FPL
Allegheny County	14.54%	29.81%	11.1%	24.5%
Pennsylvania	16.15%	35.03%	11.8%	26.9%

Note: The FPL in 2022 was $13,590 for an individual and $26,500 for a family of four.

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

Figure 28 below reports the percentage of households where housing costs are 30% or more of total household income.

Figure 28: Cost-Burdened Households



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

Food Insecurity, Diet, and Nutrition

Food insecurity, diet, and nutrition was identified as a prioritized health need for AHN West Penn Hospital based on the community survey and provider survey results as well as the secondary data analysis. In addition to those data points, AHN West Penn Hospital considered their capacity to implement food insecurity, diet, and nutrition programming. Food insecurity, poor diet, and inadequate nutrition are critical social determinants of health that profoundly impact individual and population health outcomes. Food insecurity refers to the lack of reliable access to sufficient, safe, and nutritious food necessary for an active and healthy life. The United States Department of Agriculture (USDA) reported that 33.2% of low-income individuals in the U.S. lived in food deserts, and 10.2% of households were food insecure for at least a portion of time during 2021.[10] 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.[11] 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.

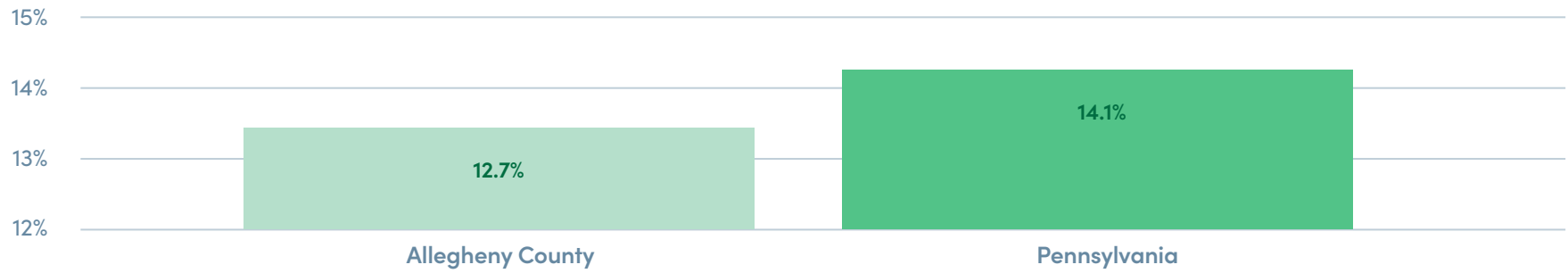
Diet and nutrition are key health factors, influencing everything from physical health to cognitive development. A diet lacking in essential nutrients can impair immune function, reduce energy levels, and increase susceptibility to illness. Furthermore, poor nutrition in early childhood has long-term 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.[12] 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.

10 The National Library of Medicine
11 U.S. Department of Agriculture
12 Pew Research Center

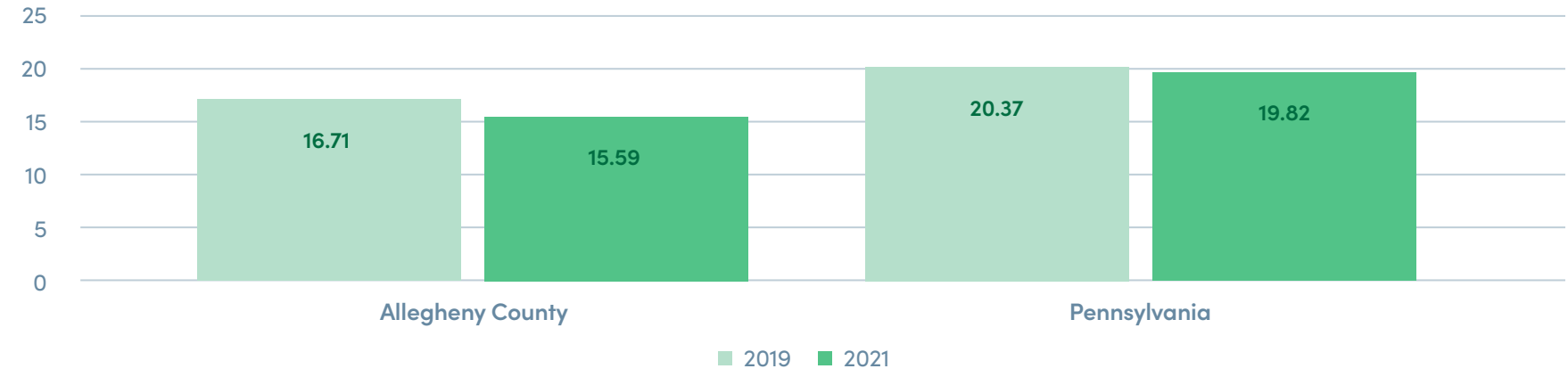
Figure 29: Population Receiving Supplemental Nutrition Assistance Program (SNAP)



Source: U.S. Census Bureau, 2021

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.

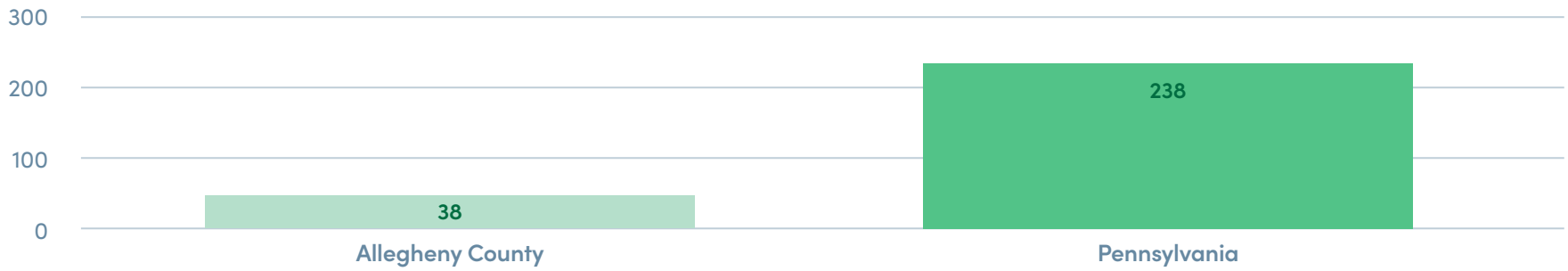
Figure 30: Food Environment – Grocery Stores (per 10,000 population)



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.

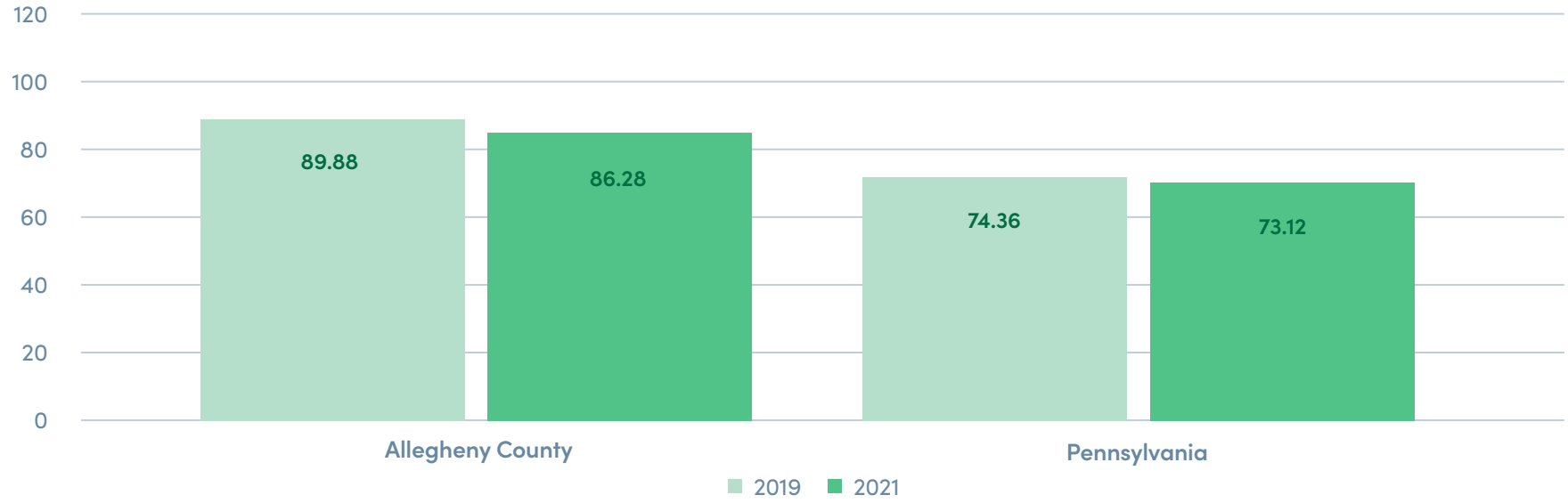
Figure 31: Food Environment – Food Desert Census Tracts



Source: US Department of Agriculture, 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 32: 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 West Penn Hospital based on the stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN West Penn Hospital 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. 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 healthcare providers, policymakers, community organizations, and residents to develop effective solutions that enhance mental health care across the region.

1 Kaiser Family Foundation

Figure 33: 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

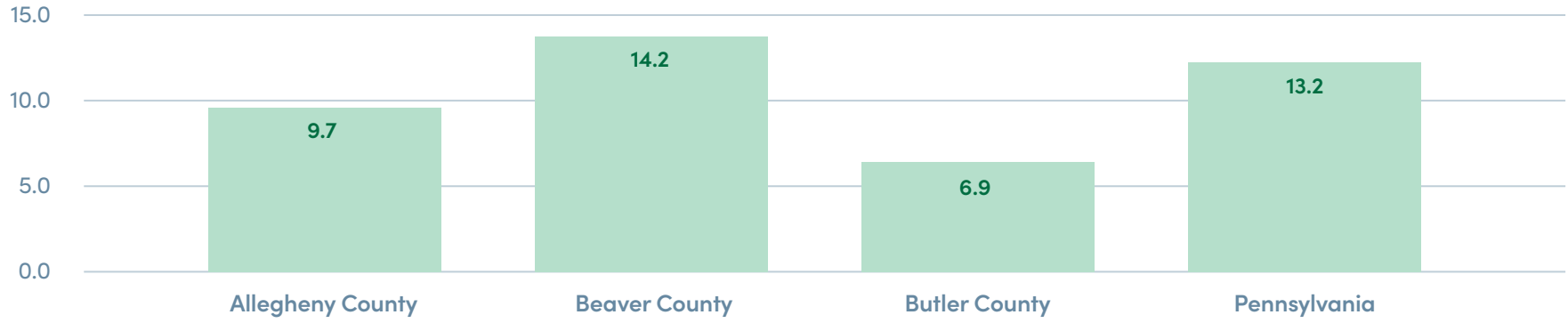
Source: America's Health Rankings

Postpartum Depression

Postpartum depression (PPD) was identified as a prioritized health need because AHN West Penn Hospital has taken the lead in offering services to address this growing issue. AHN West Penn Women's Behavioral Health offers services such as cognitive behavioral therapy (CBT), interpersonal therapy (IPT), dialectical behavior therapy, group therapy, and medication management. PPD is a substantial community issue, and AHN West Penn Hospital will continue to bring awareness and address the effects of untreated maternal depression to continue to engage women and families in need of help. In addition, AHN West Penn Hospital considered their capacity to implement PPD programming through the Alexis Joy D'Achille Center for Perinatal Mental Health. PPD is a significant mental health issue that affects many new mothers, impacting their emotional well-being and overall behavioral health. It is characterized by feelings of sadness, anxiety, and exhaustion that can interfere with a mother's ability to care for herself and her baby. Research indicates that approximately one in 10 women experience PPD, with some estimates suggesting that rates can be even higher among women with a history of mental health issues or those facing social and economic challenges.

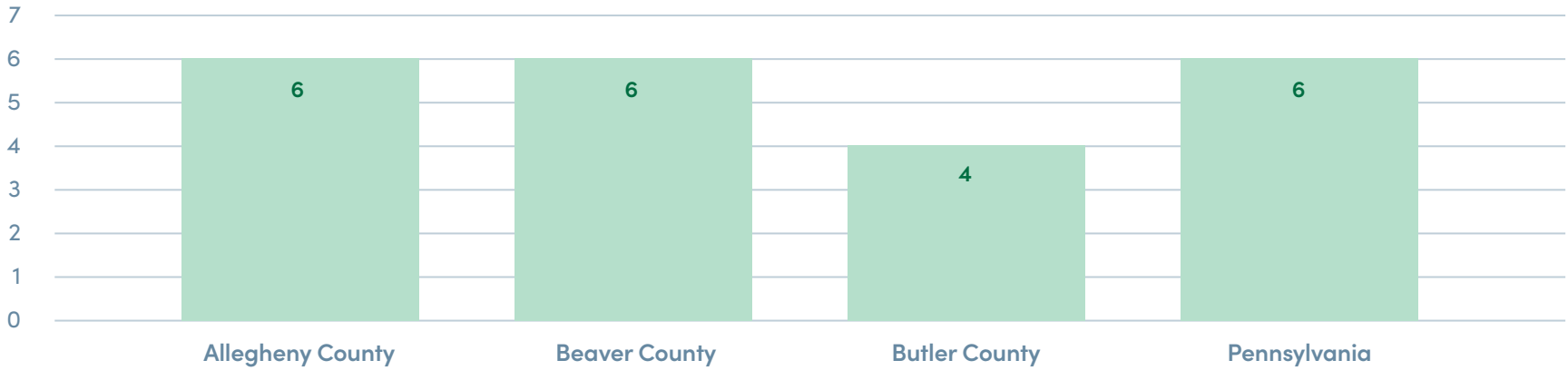
To effectively combat PPD, early identification and intervention are essential. Screening for depression during prenatal visits and postpartum check-ups can help healthcare providers recognize at-risk individuals. Furthermore, providing access to mental health resources, including counseling, support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

Figure 34: Teen Births, Rate per 1,000 Female Population (age 15-19)



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

Figure 35: Infant Mortality (under age 1 per 1,000 live births)



Source: County Health Rankings, 2015-2021

C.) Chronic Diseases and Aging

Chronic diseases and aging was identified as a prioritized health need for AHN West Penn Hospital based on the stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN West Penn Hospital considered their capacity to implement chronic diseases 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.[13] 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.[14] 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.[15] 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.[16] This financial strain affects health care systems, businesses, and communities through increased insurance premiums, lost productivity, and disability costs. Moreover, individuals suffering from chronic diseases often face limitations in daily activities, leading to diminished work capacity and economic stability.

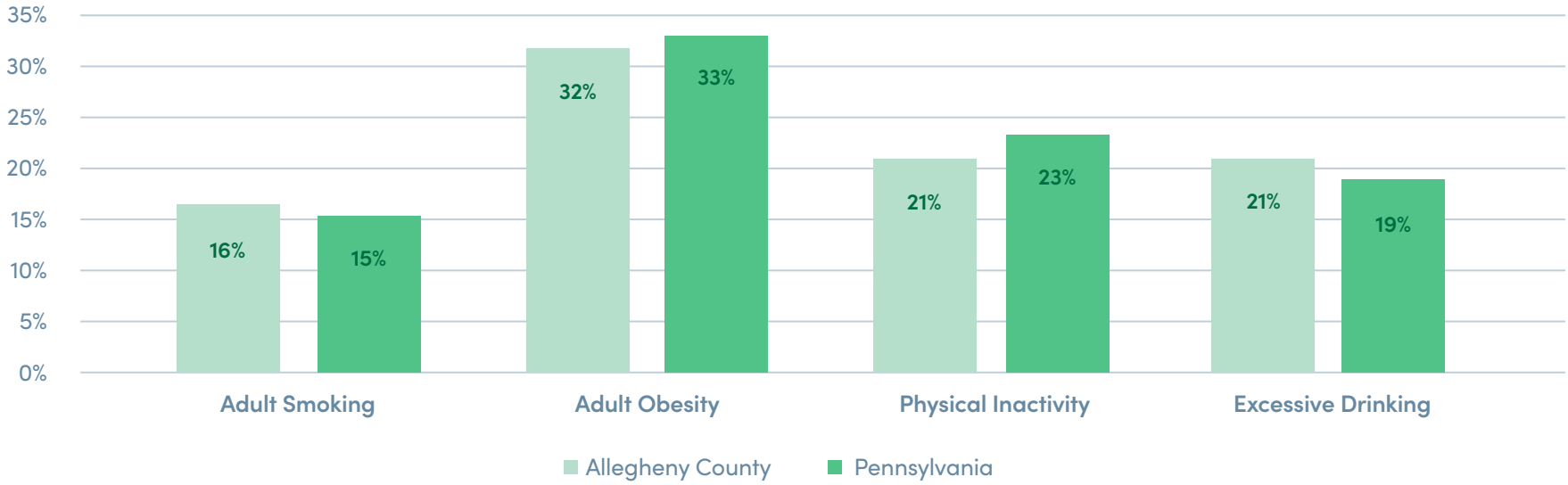
The impacts of chronic diseases extend beyond physical health; they also significantly affect mental and emotional well-being. People living with chronic illnesses frequently experience anxiety, depression, and social isolation. This interplay between physical and mental health can complicate treatment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

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

13 Centers for Disease Control and Prevention
14 Centers for Disease Control and Prevention
15 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.
16 Highmark Blue Cross Blue Shield

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

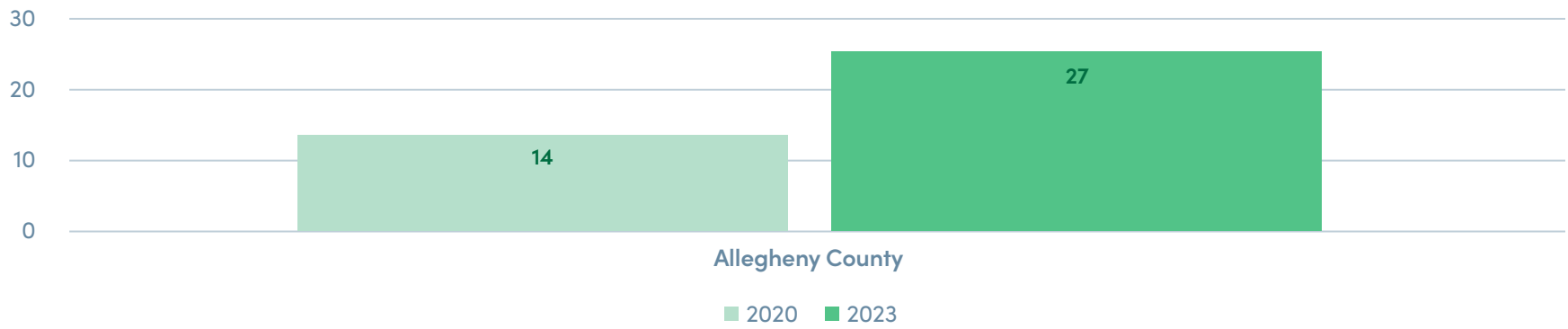
Figure 33: Behaviors Leading to Chronic Conditions



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 35 below shows that Allegheny County's health outcomes rankings got worse from 14 in 2020 to 27 in 2023.

Figure 34: 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 35 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 35: 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 • Behavioral health (anxiety, depression, post-traumatic stress disorder, suicide, etc.) • Heart disease, stroke, high blood pressure • Substance use disorder/addiction • Cancer • Lack of physical activity • Unmanaged stress or anxiety • Unstable housing	• Behavioral Health • Overweight/obesity/diabetes • Substance use disorder/addiction • Heart disease/stroke/high blood pressure • Cancer

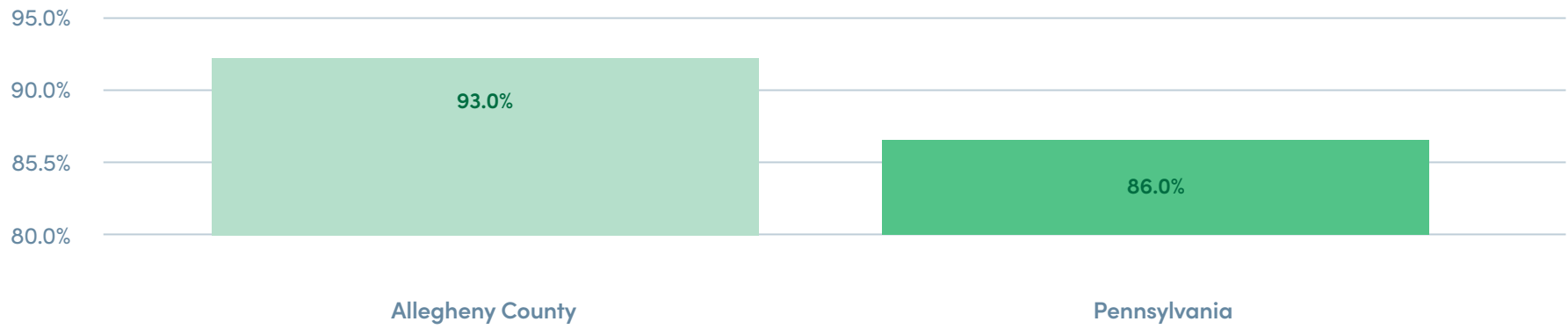
Obesity

Obesity was identified as a prioritized health need for AHN West Penn Hospital based on the stakeholder interviews, community survey, and provider survey results as well as the secondary data analysis. In addition to those data points, AHN West Penn Hospital considered their capacity to implement obesity-related programming. Obesity is a significant public health concern in Pennsylvania, affecting more than 3.4 million adults in the state, which translates to about 33.4% of the adult population, have obesity.

Regular physical activity can help people live longer and reduce the risk of serious health problems such as heart disease, type 2 diabetes, obesity, and certain cancers. For those already living with chronic diseases, physical activity can aid in managing these conditions and preventing complications. However, only one in four U.S. adults meets the physical activity guidelines for aerobic and muscle-strengthening activities. Insufficient physical activity carries high health and financial costs, totaling $117 billion nationally in annually related health care expenses.[17]

Figure 36 below shows the percentage of the population with adequate access to locations for physical activity. Individuals are considered to have adequate access to exercise opportunities if they 1) reside in a census block that is within a half mile of a park or 2) reside in a census block that is within one mile of a recreational facility in an urban area, or 3) reside in a census block that is within three miles of a recreational facility in a rural area.

Figure 36: Access to Exercise Opportunities

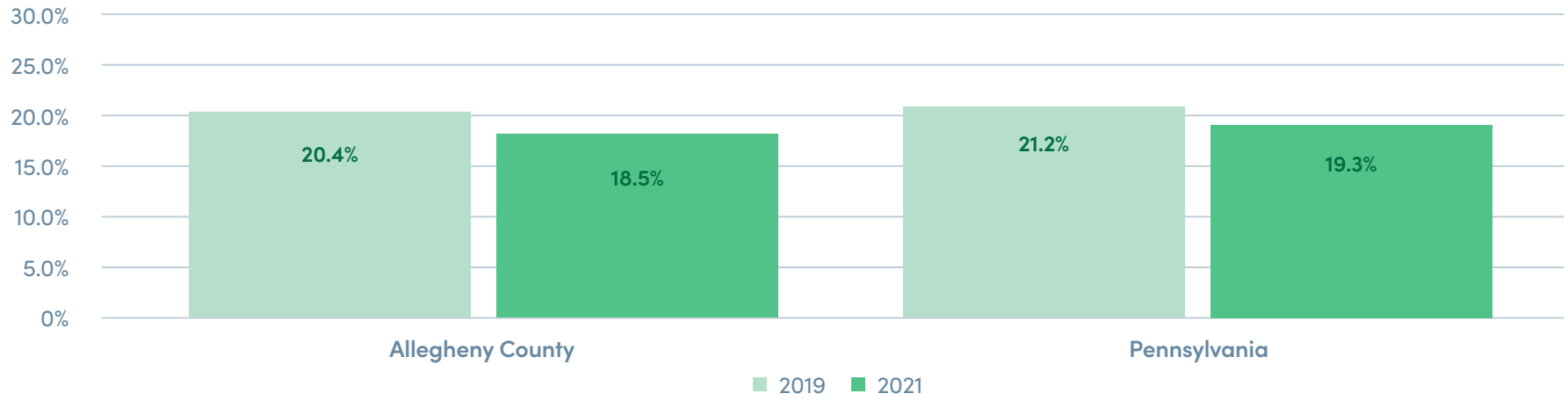


Source: County Health Rankings, 2020-2023

17 Centers for Disease Control and Prevention

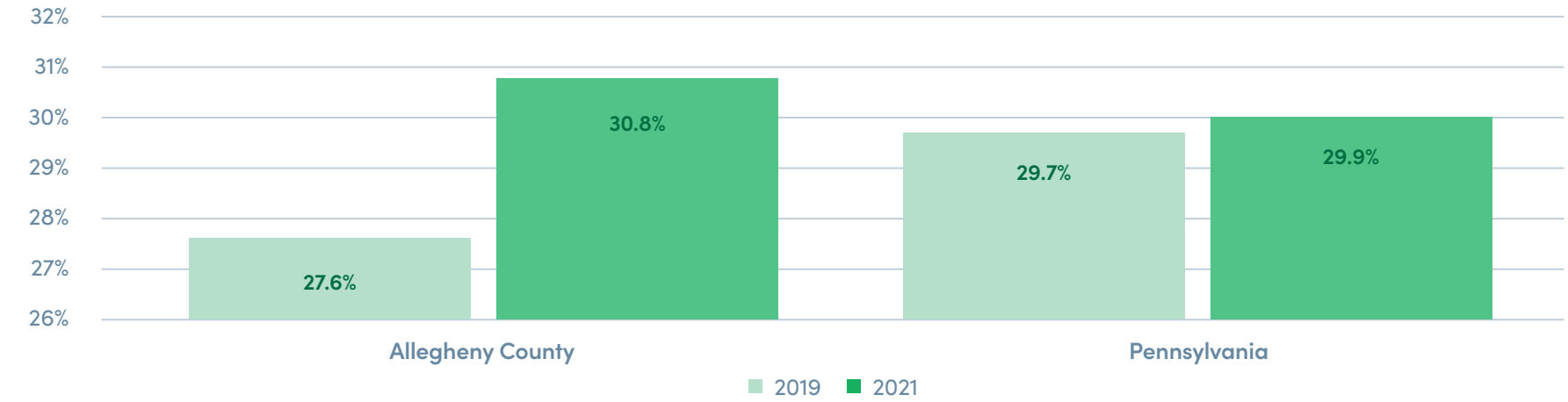
Current determinants of future health and physical inactivity may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health. Figure 37 below shows the percentage of adults aged 20 and older self-reporting no active leisure time from 2019 to 2021.

Figure 37: Physical Inactivity



Source: Centers for Disease Control and Prevention

Figure 38: Obesity – Adults with BMI Exceeding 30.0%



Source: Centers for Disease Control and Prevention

D.) Health Equity

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

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

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

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

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

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

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

Figure 39 delineates the responses from the community leader stakeholder interviews, community surveys, and provider surveys regarding equitable care and maintaining optimal health.

Figure 39: 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	• Affordable, safe, quality housing/ utilities • Access to mental health resources • Access to affordable healthy food options • Environmental issues (air/water pollution) • Safe places to walk/play and accessible, affordable community activities (parks, trails, community centers)	• 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 West Penn Hospital based upon it being an enterprise-wide priority. In addition, AHN West Penn Hospital considered their capacity to implement diversity, equity, and inclusion programming. Diversity, equity, and inclusion (DEI) in health care are essential for creating a system that addresses the needs of all patients and communities effectively. A diverse health care workforce brings perspectives, experiences, and cultural understandings that can enhance patient care and improve health outcomes. Research has shown that when health care providers reflect the diversity of their communities, patients are more likely to feel understood and receive culturally competent care.[18] 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.[19]

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

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

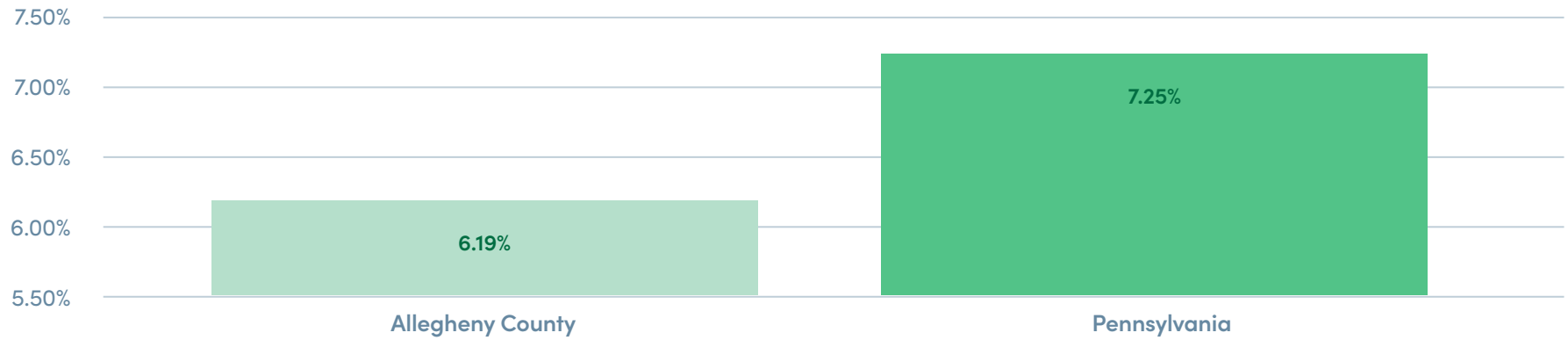
Moreover, stimulating an inclusive environment helps create a culture of safety where patients can communicate openly about their health needs without fear of discrimination or bias.

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

18 National Library of Medicine
19 Newsweek

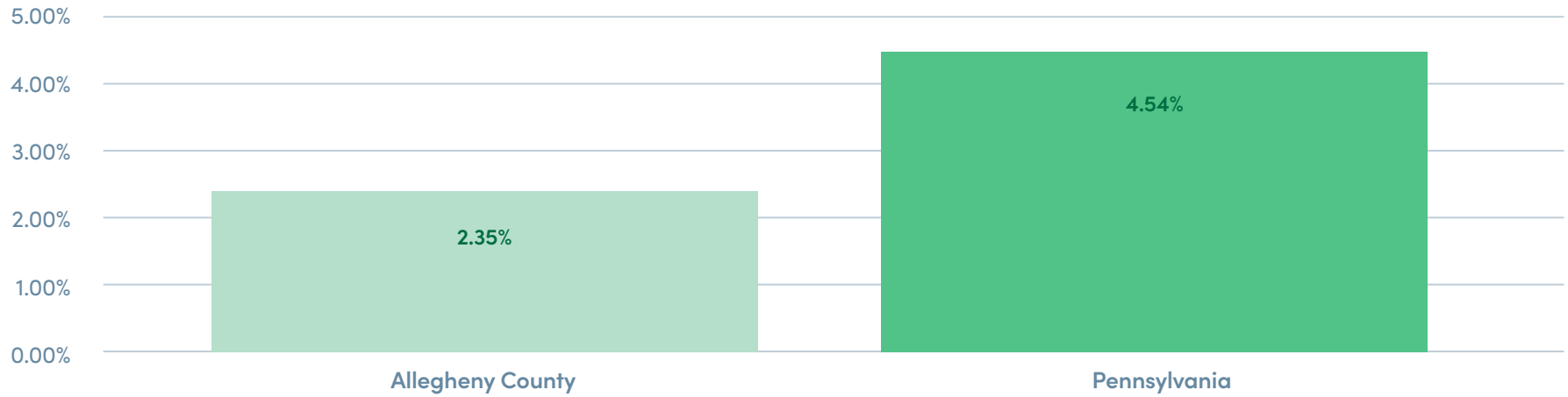
Figure 40 below reports the percentage of the population that is foreign-born. The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national.

Figure 40: Foreign-Birth Population, Percent of Total Population



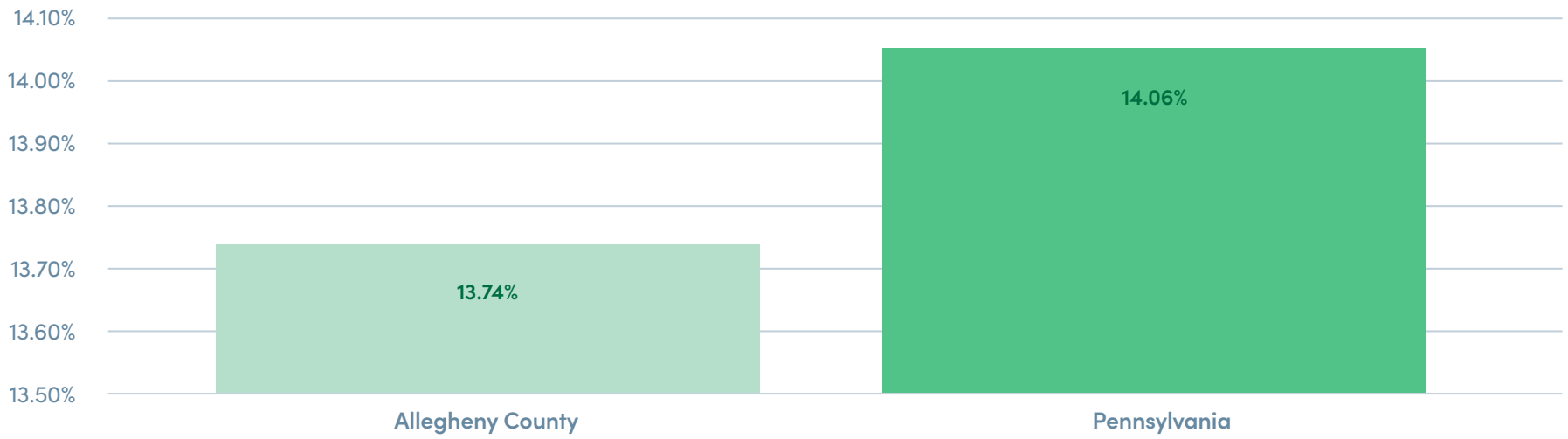
Source: US Census Bureau, 2018-2022

Figure 41: Population with Limited English Proficiency (age 5+)



Source: US Census Bureau, 2018-2022

Figure 42: Percentage of Population with a Disability



Source: US Census Bureau, 2018-2022

Community Resources Available to Address Identified Needs

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

Figure 43: Community Resources

Identified Significant Health Needs	Local Community Resources Available to Address Needs
Social Determinants of Health – Cost of Care	PA Dept. of Human Services, Children of Restaurant Employees (CORE) – Financial Assistance Program, Multiple Sclerosis Association of America – MRI Access Program
Social Determinants of Health – Food Insecurity, Diet, and Nutrition	Greater Pittsburgh Community Food Bank, Community Human Services, East End Cooperative Ministry
Behavioral Health – Postpartum Depression	Maya Organization, Jewish Family and Community Services (JFCS) – Counseling Services, Thriveworks – Pennsylvania
Chronic Diseases and Aging – Obesity	US Dept. of Veterans Affairs – MOVE! Weight Management Program, YMCA of Greater Pittsburgh
Health Equity – Diversity, Equity, and Inclusion	Persad Center, Macedonia Family and Community Enrichment Center (FACE), Veterans Leadership Program of Western PA

AHN Community Resource Inventory

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

Conclusion

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

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

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

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

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

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

Additional Information

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

Appendix

Data Limitations

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

CHNA Needs Reevaluated as Priorities are Met

In looking forward to the current CHNA cycle, AHN West Penn Hospital has chosen to deprioritize certain health needs based on progress made and community feedback. Regarding workforce development, the hospital has successfully established strong partnerships with community organizations and implemented programs for underserved youth, facilitating over 120 shadow experiences annually. With these initiatives well-established and ongoing, the hospital has deemed its goals met.

For diabetes management, the Bariatric and Metabolic Institute, particularly its endocrinology services, has experienced significant growth, with high patient satisfaction and increased referrals. While diabetes care remains important, the hospital has prioritized obesity for the 2024 CHNA, which intersects with diabetes management, allowing for integrated health strategies.

Lastly, although AHN West Penn Hospital collaborates with the Cancer Institute to provide annual screenings, community surveys indicated that cancer was not a high-ranking priority. Consequently, the hospital will continue to offer localized resources but will not prioritize this area in the upcoming CHNA cycle. Overall, AHN West Penn Hospital's decision to shift its priorities reflects a commitment to building on established successes while responding to community needs as identified.

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.