December 2018

Westfield Memorial Hospital Community Health Needs Assessment - 2018

Conducted by: Tripp Umbach

Table of Contents

Contents

Section 1. Executive Summary....2

Introduction....2

Objectives and Methodology....3

Key Prioritized Needs....5

Section 2. Community Definition....6

Section 3. Key Findings of CHNA Process....7

Priority #1: Behavioral Health....7

Priority #2: Chronic Conditions....10

Appendix A. Primary Data Summary....16

Appendix B. Secondary Data Analysis Highlights....19

Appendix C. 2015 Implementation Planning Update and Evaluation....30

Appendix D. About Tripp Umbach....34

Section 1. **Executive Summary**

Introduction

For decades, the hospitals of Allegheny Health Network (AHN) have been providing people with exceptional healthcare to help people live healthy lives and have extended their reach to more people than ever offering a broad spectrum of care and services. AHN boasts eight hospitals: Allegheny General, Allegheny Valley, Canonsburg, Forbes, Jefferson, Saint Vincent, Westfield Memorial and West Penn; and more than 200 primary- and specialty-care practices. They have approximately 2,400 physicians in every clinical specialty, 19,000 employees and 2,000 volunteers. Together, AHN provides world-class medicine to patients in their communities, across the country and around the world.

AHN has proudly received accolades from numerous organizations, including Thomson Reuters, AARP, Healthgrades, and Consumer Reports.

As an affiliate of Saint Vincent Hospital, Westfield Hospital has served the community since 1942 and through technology, services, and partnerships, offers patients direct access to highly specialized care including cardiac rehabilitation, an orthopedic clinic, outpatient surgery services, physical therapy services, sleep labs, sports medicine services, a wound clinic, and an array of diagnostic services.

As a true community hospital dedicated to wellness and health improvement, Westfield Hospital maintains a strong focus on providing access to specialty care and on-site physician specialists. The hospital continues to offer advanced medical technology and access to the most qualified medical staff that are close to home

In 2018, AHN joined Tripp Umbach to conduct a comprehensive community health needs assessment for the Westfield Hospital service area of Chautauqua County. The following report documents each project step as well as the key findings.

Objectives and Methodology

With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals are required to conduct a community health needs assessment (CHNA) and adopt implementation strategies to actively improve the health of the communities they serve. The findings of the CHNA provide hospitals and with the necessary information to develop and implement strategies that address the specific health needs of their communities. Coordination and management of strategies based upon the outcomes of a CHNA and implementation strategies improves health outcomes of the communities this hospital serves.

To adhere to the requirements imposed by the IRS, tax-exempt hospitals and health systems among other things, must:

1. Conduct a CHNA every three years.
2. Adopt an implementation strategy to meet the community health needs identified through the assessment.
3. Report how they are addressing the needs identified in the CHNA.

The following report fulfills the CHNA and implementation strategies requirements for tax-exempt hospitals and health systems.

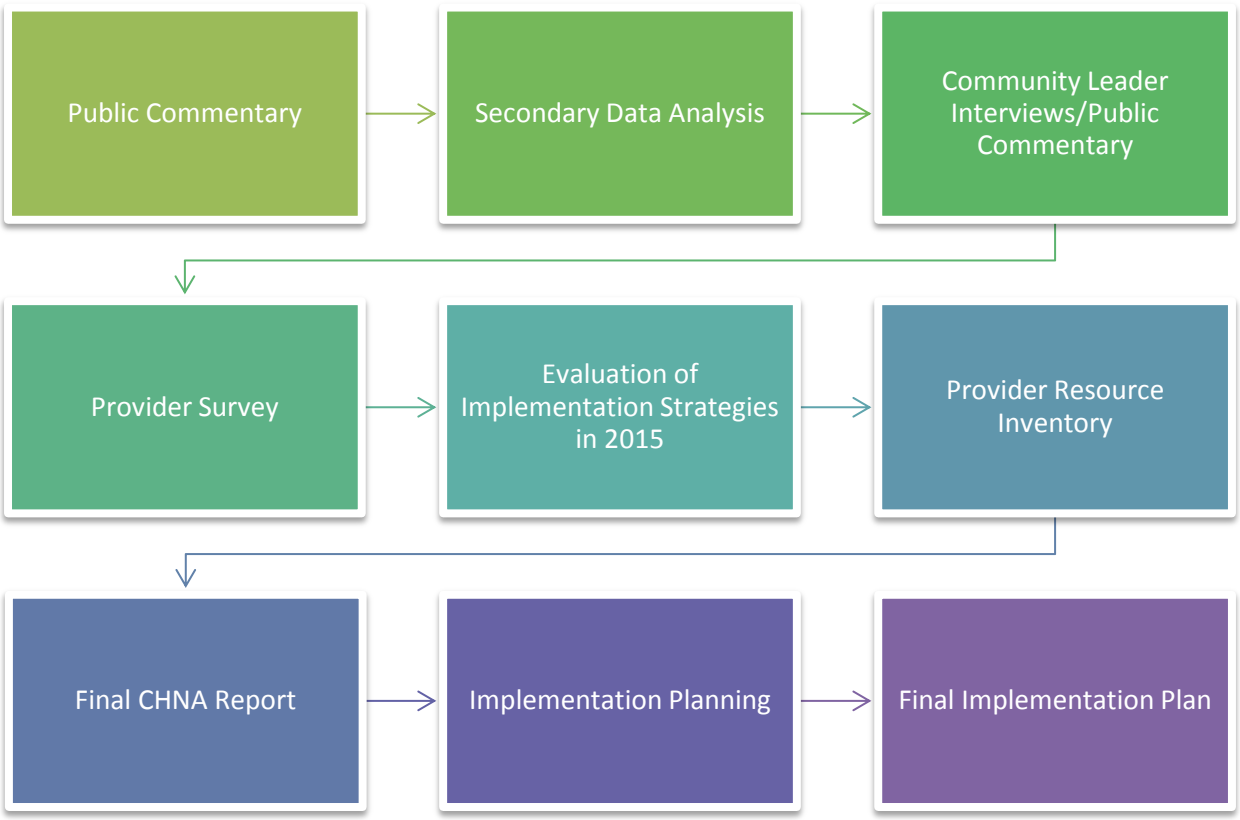
The CHNA process undertaken by AHN, with project management and consultation by Tripp Umbach[1], included input from persons who represent the broad interests of the community served by Westfield Memorial Hospital, including those with special knowledge of public health issues and representatives of vulnerable populations served by the hospital.

The project components used to determine the community health needs included:

- Public commentary on the 2015 CHNA and Implementation Plan
- Evaluation of Implementation Strategies in 2015
- A survey made available to all AHN providers
- Secondary data analysis of health status and socioeconomic environmental factors related to health and well-being of residents
- Community leader interviews
- Provider inventory of programs and services related to key prioritized needs

1 See Appendix D for more information on Tripp Umbach

The data collection findings and prioritization of community health needs are detailed in this final CHNA report. Additional information regarding each component of the project, and the results, are found in the Appendices section of this report. The entire secondary data profile for AHN is available upon request.



Tripp Umbach worked closely with leadership from Westfield Memorial Hospital to complete the CHNA with the goal of gaining a better understanding of the health needs of the region. Westfield Memorial Hospital will use the findings of the assessment to address local health care concerns and to work collaboratively with regional agencies to address broader socioeconomic and education issues in the service area.

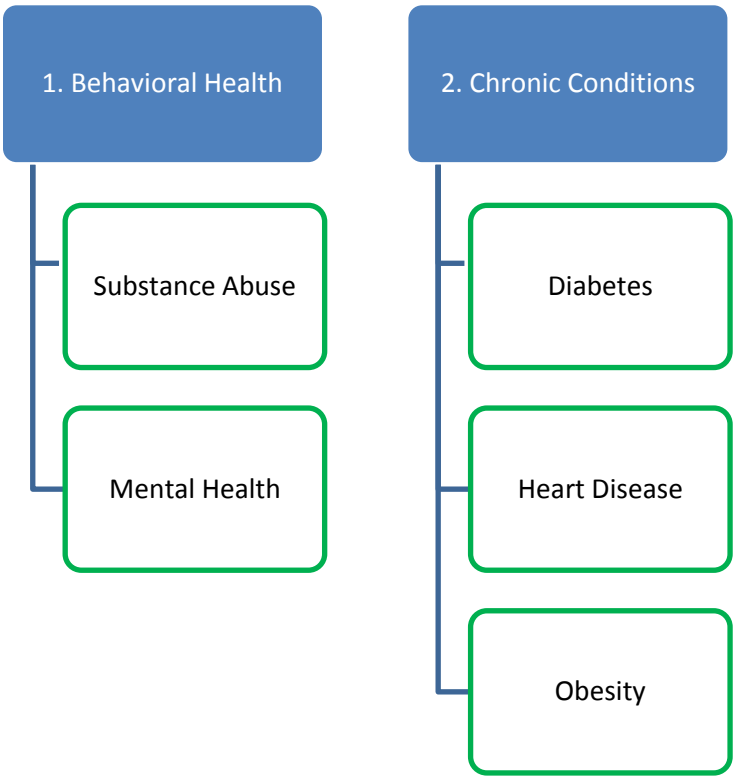
AHN would like to thank all external and internal stakeholders who performed a role in the completion of this CHNA.

Key Prioritized Needs

Tripp Umbach and the internal working group identified four prioritized community needs for Westfield Memorial Hospital. The community health needs are based on qualitative and quantitative data collected during this CHNA as well as input from facility, healthcare, and community leaders. From the beginning of the project, Allegheny Health Network Tripp Umbach placed a high value on maximizing input from each of the eight AHN facilities. Each hospital was provided a platform to determine their own health needs and to build consensus from the leadership teams of each facility. Transparency and self-determination in selecting the needs was a priority throughout the CHNA project.

Figure 1 outlines the five prioritized need areas and key factors and considerations of each need.

Figure 1: Prioritized Community Health Needs for Westfield Memorial Hospital 2018 CHNA



**Note: further information and rationale for the prioritized community health needs can be found in Section 3 of this report. Additional information on data collection can be found in Appendices A and B.*

Section 2. **Community Definition**

Westfield Memorial Hospital's primary service area, where 80% of their inpatient discharges originated, include the following ZIP codes (excluding ZIP codes for P.O. boxes and offices). Secondary data was collected from Chautauqua County, which comprises the entire Westfield Memorial Hospital service area.

Figure 2: Westfield Memorial Hospital Community ZIP Codes

ZIP Code	City	County
14712	Bemus Point	Chautauqua
14728	Dewittville	Chautauqua
14787	Westfield	Chautauqua
14769	Portland	Chautauqua
14784	Stockton	Chautauqua
14716	Brocton	Chautauqua
14775	Ripley	Chautauqua
14747	Jamestown	Chautauqua
14757	Mayville	Chautauqua
14710	Ashville	Chautauqua

Section 3. **Key Findings**

CHNA Need #1: Behavioral Health

Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol, tobacco, and illicit drugs. Substance abuse also does not discriminate – all genders, races, religions and both the rich and poor are susceptible to substance abuse. Repeated use of these substances use can lead to dependence syndrome - a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.

- Key Insight: Substance Abuse was identified as the largest health need by AHN providers.

Drugs (with emphasis on opioids)

Every day, more than 115 people in the United States die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.[2]

- Key Project Insight: Drug use was mentioned as the top health risk/dangerous lifestyle behavior by AHN providers.

In 2016, there were 2,235 opioid-related overdose deaths--- in New York a rate of 15.1 deaths per 100,000 persons—compared to the national rate of 13.3 deaths per 100,000 persons. Since 2010, opioid-related overdose deaths have increased in all categories. 42% of the 281,800 admissions to NYS certified substance abuse treatment programs in 2014 included “any opioid” as the primary, secondary or tertiary drug problem—up 19% from 2010 (100,004). In 2015, New York State prescribers wrote 10.2 million opioid prescriptions or 51.3 prescriptions per 100 persons–a 7.8% decline since 2013 and less than the national rate of 71 prescriptions per 100 persons.3

2 National Institute on Drug Abuse
3 National Institute on Drug Abuse, *Pennsylvania Opioid Summary*

Alcohol and Tobacco Use

According to the New York State Office of Alcoholism and Substance Abuse Services (OASAS) around 12% of New Yorkers (above the age of 11) experience addiction or abuse disorders each year. For the millions who suffer and their families, substance abuse is a growing crisis, especially as it pertains to opioid drugs.

- Key Insight: Nearly 43% of surveyed AHN providers identified alcohol use as a top three health risk/lifestyle behavior.

As in most states, alcohol abuse takes many forms in New York. Abuse can come from all cultural backgrounds and lifestyles, and some may not even realize that they have problems. Harmful cultural attitudes towards social drinking often normalize alcoholism and dangerous behaviors, with 1 out of 15 teen NYC motorists admitting to driving after drinking.[4]

- In 2015, 24% of people who enrolled in OASAS chemical dependence treatment programs did so because of their alcohol problems.
- From 2009 to 2013, around 1.1 million New Yorkers above the age of 11 dealt with alcohol use or dependence. More than 900,000 adults above the age of 20 reported heavy drinking within the previous month of being surveyed.
- Alcohol was a factor in 7,849 vehicle crashes statewide in 2014.

Chautauqua County registers a higher rate of adult smokers than the state of New York. While New York observes only 14% of adults who smoke, Chautauqua County figures at 24%. Similarly, about 20% of Chautauqua County adults partake in excessive drinking, which is higher than the state of New York rate of 17%. Similarly, 33% of Chautauqua County's driving deaths are due to alcohol, which is much higher than the state figure of 22%.[5]

Mental Health Services

Behavioral health disorders, which include substance use and mental health disorders, affect millions of adolescents and adults in the United States and contribute heavily to the burden of disease.[6]

Behavioral health is a key part of a person's overall health. It is just as important as physical health and includes emotional, psychological, and social well-being. Mental disorders involve

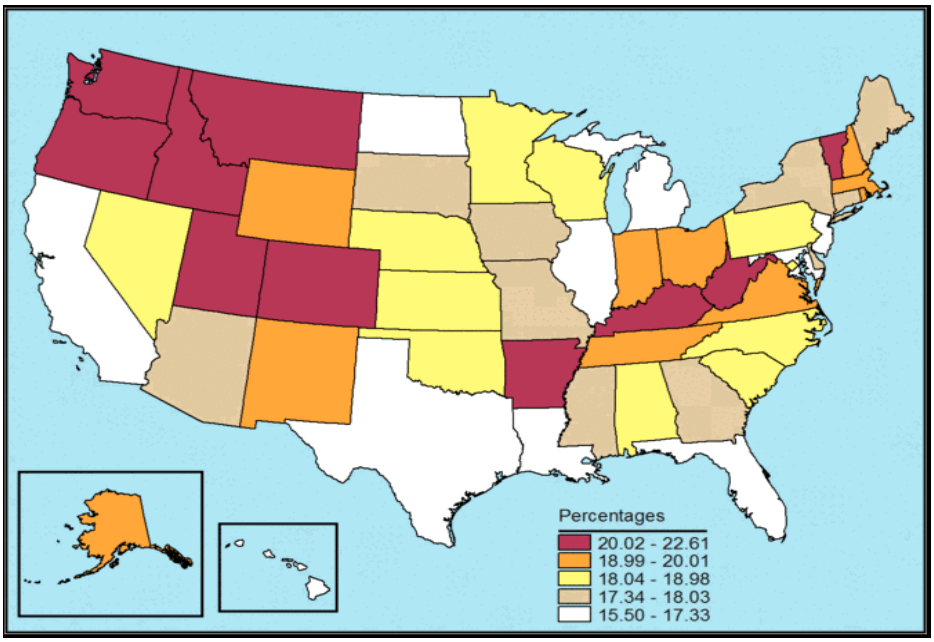
4 Lakeview Health Recovery Center, 2018
5 County Health Rankings, 2018.
6 SAMHSA, 2014

changes in thinking, mood, and/or behavior that may occur often, or less often. Substance use disorders occur when the use of alcohol and/or drugs (like opioids or tobacco) causes health problems or a disability.

- Key Insight: When interviewees during the stakeholder interviews were asked to name the top three health issues in their community, mental health was the number one response, as it was mentioned in 71% of the responses.[7]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), 1:10 adults in the US. are living with a substance use disorder and 1:5 adults are living with a mental disorder. Co-occurring disorders usually means a person has both a mental and substance use disorder. Co-existing disorders usually means a person has both a behavioral and physical health condition. Behavioral health conditions are common. People of all ages, genders, races and ethnicities get these conditions.

Figure 3: Any Mental Illness (AMI) in the Past Year Among Persons Aged 18 or Older, by State



Mental health is an important part of overall health and well-being. Mental health includes our emotional, psychological, and social welfare. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.[8]

The prevalence of mental illness in American households is staggering. According to the National Alliance on Mental Health, one in 25 adults—9.8 million, or 4%—experiences a serious

7 See Appendix A
8 Centers for Disease Control and Prevention, 2018

mental illness in a given year that substantially interferes with or limits one or more major life activities and, one in five youth aged 13–18 (21.4 percent) experiences a severe mental disorder at some point during this period. For children aged 8–15, the estimate is 13%.[9]

It is important to monitor mental illness as it is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer. Mental illness is also associated with lower use of medical care, reduced adherence to treatment therapies for chronic diseases, and higher risks of adverse health outcomes.

The figure above depicts individuals 18 and older who had any type of mental illnesses according to SAMHSA. New York reports a range between 17.34 percent – 18.03% of residents who reported any type of mental illnesses in years 2015-2016.[10]

CHNA Need #2: Chronic Conditions

Obesity

Obesity is a major issue across the United States affecting all demographics. More than one-third (36.5%) of adults in the U.S. are currently obese, and that number has continues to rise.[11] Data from 2015-2016 show that nearly 1 in 5 school age children and young people (6 to 19 years) in the United States has obesity.[12]

New York has the seventh lowest adult obesity rate in the nation (25.7%) – up from 17.1% in 2000 and from 9.3% in 1990.[13]

- Key Insight: 37.3% of surveyed AHN providers identified obesity as one of the top three largest health needs in their service area.

Obesity is one of the largest contributing factors of preventable chronic conditions, including diabetes, hypertension, and stroke. Adults who are overweight are more likely to have high blood pressure and high cholesterol, both of which can lead to major health issues such as heart disease and stroke. As obesity rates are on the rise, so are chronic diseases. The toll and the overall health care costs associated with obesity and chronic diseases are staggering. The

9 National Alliance on Mental Health, 2018

10 Any mental illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

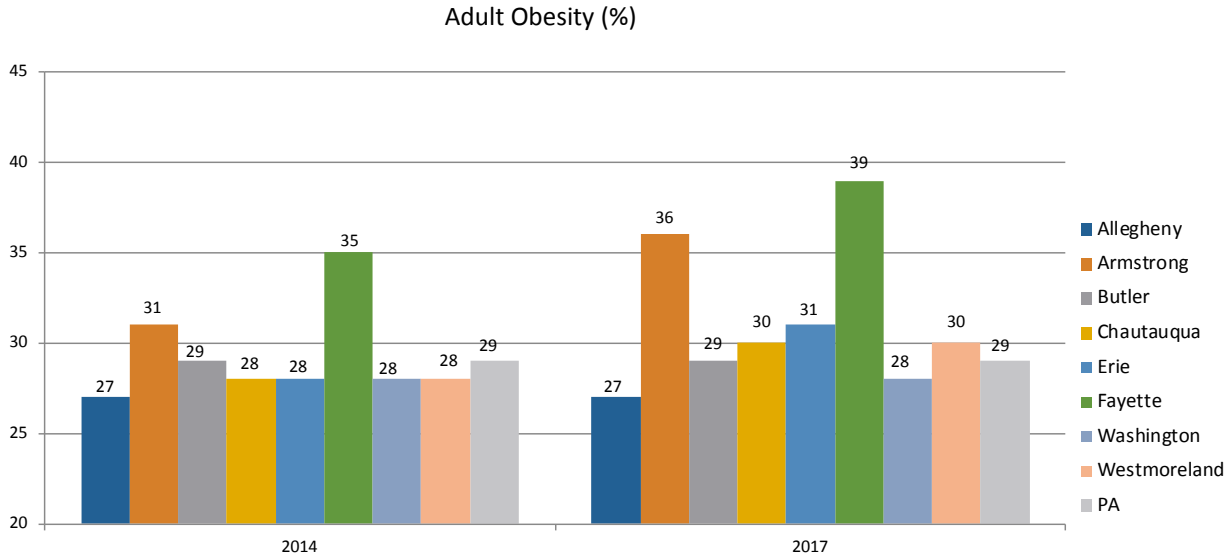
11 “Adult Obesity Facts.” Center for Disease Control and Prevention.

12 Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity among adults and youth: United States, 2015–2016. NCHS Data Brief.

13 The State of Obesity http://stateofobesity.org

CDC estimates that health care costs due to obesity and the chronic diseases that stem from obesity are estimated to be anywhere between $147 billion to $210 billion per year.[14]

Figure 4: Obesity Percentages



Source: 2017 County Health Rankings

Chautauqua County shows an adult obesity rate of 30%, which registers middle of the pack for the Allegheny Health Network study area but is above the New York state rate of 25%.[15]

In addition to a healthy diet, physical activity and fitness also is important to leading a healthy lifestyle and preventing obesity and chronic disease. Physical inactivity is responsible for one in 10 deaths among U.S. adults.[16]

Diabetes

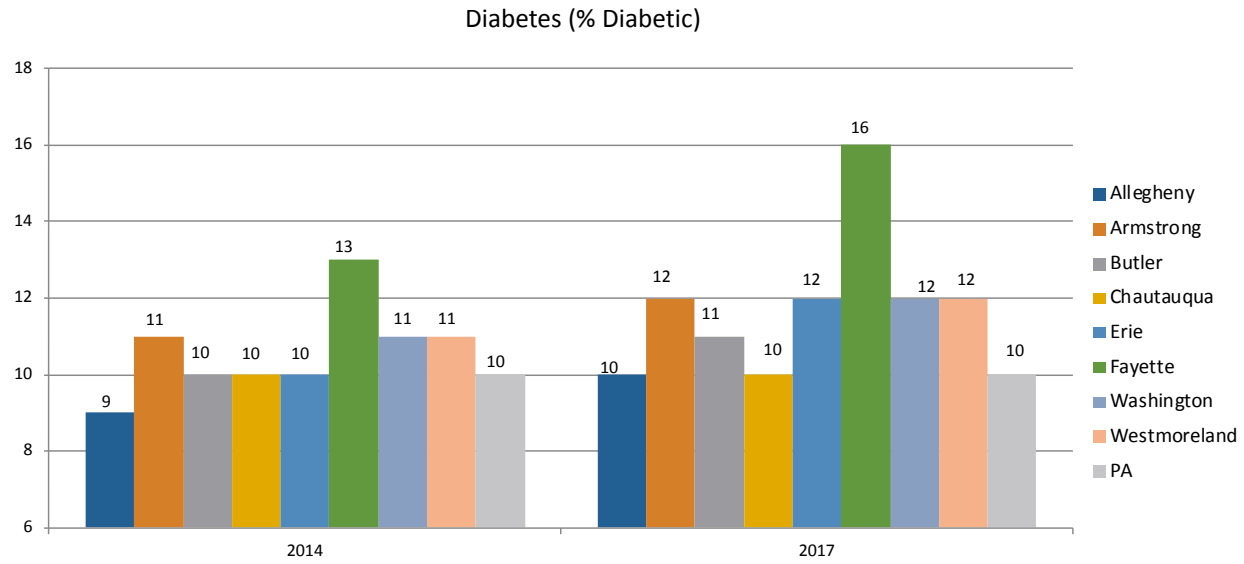
While nutritious food consumption can help prevent diabetes and chronic conditions, socioeconomic and environmental factors serve as barriers to an individual's ability to lead a healthier lifestyle. Income levels also play a role in a person's ability to afford fresh fruits and vegetables. Residents struggling to make a living are not able to make healthy eating a priority. Fresh fruits and vegetables can be expensive; residents with lower incomes turn to cheaper processed foods to feed their families.

- Key Insight: 35.8% of surveyed AHN providers identified diabetes as one of the top three largest health needs in their service area.

14 "The Healthcare Costs of Obesity." The State of Obesity.
15 County Health Rankings, 2017
16 Danaei G, Ding EL, Mozaffarian D, et al. The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors.

Roughly 10% of Chautauqua County adults have diabetes, which is favorable compared to the Allegheny Health Network study area and national average (9.1%).[17]

Figure 5: Percentage of Adults Who Are Diabetic



Source: 2017 County Health Rankings

Diabetes was the seventh leading cause of death in the United States in 2015 based on the 79,535 death certificates in which diabetes was listed as the underlying cause of death. In 2015, diabetes was mentioned as a cause of death in a total of 252,806 certificates.[18]

Heart Disease

Heart disease is a broad term used to describe a range of diseases that affect one's heart and is a general term used to describe several different conditions, all of which are potentially fatal, but are also treatable and/or preventive. The most common type of heart disease is coronary heart disease (CHD), also called coronary artery disease. Other types of heart disease include cardiomyopathy, heart failure, hypertensive heart disease, inflammatory heart disease, pulmonary heart disease, cardiac dysrhythmias and valve heart disease.

5,039, or 4.2% of adults aged 18 and older were told by a doctor that they have coronary heart disease or angina. This indicator is relevant because coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks.[19]

17 Community Commons, 2018
18 American Diabetes Association
19 Community Commons, 2015

- Key Insight: When Allegheny Health Network providers were asked to list the top three health problems in their service areas, heart disease was the fifth most frequent response, with 33% of providers listing that as a top three concern.[20]

The most common type of heart disease is coronary heart disease (CHD). CHD occurs when a substance called plaque builds up that narrows the arteries in the heart. A heart attack occurs when an artery becomes completely blocked, resulting in a lack of blood flow to the heart. Heart disease is the leading cause of death for both men and women in the United States and in New York State.[21]

CVD accounted for nearly 40% of all deaths statewide in 2014. An estimated 7.4% of adults in New York State reported they have had a heart attack, angina/coronary heart disease, or stroke in 2014. One out of five (20.9%) New Yorkers aged 65 and older reported having some type of CVD in 2014.

Westmoreland County has the highest percent of adults with heart disease in the service area at 6.1% and is higher than the state (5.1%) and national rates (4.4%). Armstrong County has the second highest rate (5.7%) rate and is also higher than the state and national rates. About 6,000 people die from stroke in New York State every year.[22]

Certain health conditions, lifestyle, age, and family history can increase the risk for heart disease. About **half of all Americans** (47%) have at least one of the three key risk factors for heart disease: high blood pressure, high cholesterol, and smoking.[23]

An important aspect of lowering risk of cardiovascular disease, is managing certain health behaviors and risk factors, such as diet quality, physical activity, smoking, body mass index (BMI), blood pressure, total cholesterol or blood glucose.

4,640, or 3.2% of adults aged 18 and older in Chautauqua County have ever been told by a doctor that they have coronary heart disease or angina. This compares well with the New York average (4.3%) and national average (4.4%). This indicator is relevant because coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure, high cholesterol, and heart attacks.[24]

20 See Appendix A
21 NY Department of Health
22 NY Department of Health
23 CDC, 2018
24 Community Commons, 2018

Conclusions and Recommendations

With the completion of the 2018 CHNA, Westfield Memorial Hospital will develop goals and strategies for the CHNA implementation phase. In this phase, the hospital will leverage its strengths, resources and outreach to help best identify ways to address community health needs, thus improving overall health and addressing the critical health issues and well-being of residents. The hospital will work with community leaders and organizations to collaboratively address regional health and socioeconomic issues. The comprehensive CHNA provides insight into the most pressing health needs and service gaps in the study area. The implementation planning phase will develop measures, strategies, and goals as to how Westfield Memorial Hospital will address the identified community health needs.

Westfield Memorial Hospital, partnering with public health agencies, community organizations, and regional partners, understands that the CHNA document is not the last step in the assessment phase, but rather the first step in an ongoing evaluation process. The CHNA is a tool that the hospital can use to guide programming and product development to ensure that resources are being used effectively to address health needs as identified by the community.

Recommended Action Steps:

- Communicate the results of the CHNA process to staff, providers, leadership, boards, community stakeholders and the community as a whole.
- Use the inventory of available resources in the community to explore further partnerships and collaborations.
- Identify content experts within the health system to champion existing hospital initiatives and resources and to conduct ongoing evaluation.
- Involve key community stakeholders to participate or be involved in providing expert knowledge on ways to strategically address key community health needs.
- Develop working groups to focus on specific strategies and goals to address the top identified needs in the study area and develop a comprehensive implementation plan.
- Implement/continue with a community engagement strategy to build upon the resources that already exist in the community, including committed community leaders that have been engaged in the CHNA process.

- Consistently evaluate goals and strategies as they are being implemented in the community to see where and when adjustments need to be made in order to achieve maximum community benefit and improved health outcomes.

Communication and continuous planning efforts are vital throughout the next few years. Information regarding the CHNA findings will be important to residents, community groups, leaders and other organizations that seek to better understand the health needs of the communities in the AHN study area and how to best serve these needs.

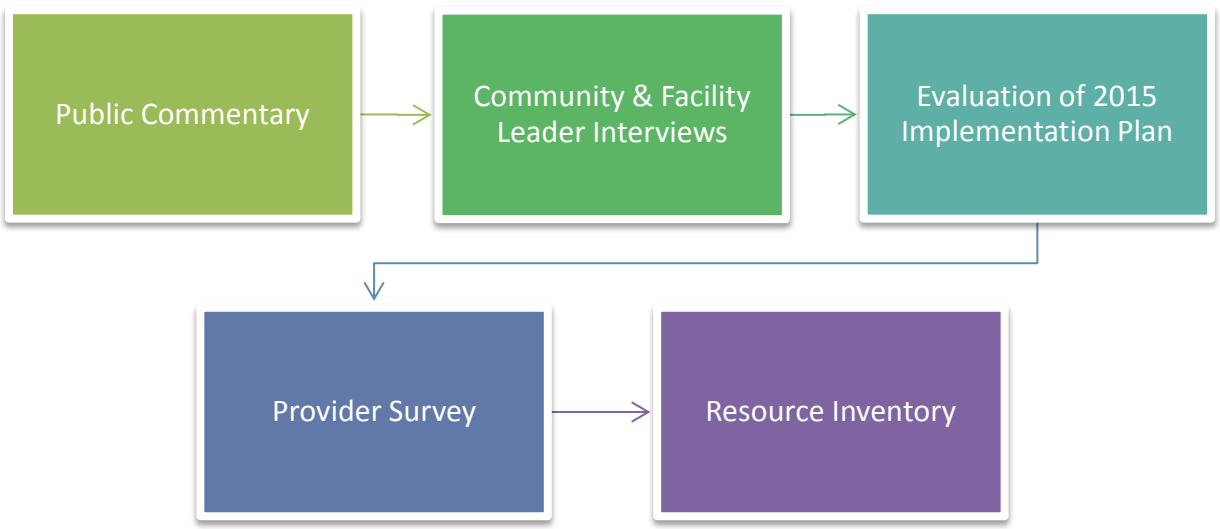
Tripp Umbach, in partnership with AHN, emphasizes that in order to meet the goals and objectives set for in the implementation strategies, Westfield Memorial Hospital must leverage existing partnerships within the region as well as develop new relationships among organizations and agencies in the community. Collaboration effectively utilizes community resources by reducing redundancy of services and increasing capacity for service delivery.

Appendix A: **Primary Data Summary**

Primary Data Collection

A comprehensive community-wide CHNA process was completed for Westfield Memorial Hospital. The CHNA process brought together hospital leadership and key community leaders from health and human service agencies, government, and educational institutions to evaluate the needs of the community. This assessment included primary collection that incorporated public commentary, community leader interviews, a resource inventory, and a provider survey.

A review of all collected primary and secondary data by project leadership and the project Steering Committee input session led to the identification and prioritization of community health needs. Each facility was given three opportunities to identify and select the health care needs that were most prevalent in their service area. Westfield Memorial Hospital will examine and develop strategic actions through an implementation phase that will highlight, discuss and identify ways the hospital will work to address the needs of the communities it serves.



Community/Facility Leader Interviews and Public Commentary

As part of the CHNA process, telephone interviews were completed with community stakeholders in the primary service area to better understand the changing community health environment. During the phone interviews, feedback on the previous CHNA was solicited to evaluate the progress over the prior three years and to improve analysis and reporting for the current CHNA process. Community stakeholder interviews were conducted between the months of June 2018 and September of 2018.

Community stakeholders identified for interviews encompassed a wide variety of professional backgrounds including:

1) public health expertise
2) professionals with access to community health related data
3) representatives of underserved populations

The interviews offered community stakeholders an opportunity to provide feedback on the needs of the community, secondary data resources, and other information relevant to the study.

Tripp Umbach worked closely with the project Steering Committee to identify community leaders from various sectors who are engaged in the community and have a knowledge of the community needs. A Tripp Umbach consultant conducted each interview. Each community stakeholder was asked the same set of questions, as developed by Tripp Umbach and reviewed by project leadership. The interviews provided a platform for stakeholders to identify health issues and concerns affecting residents in the service area, as well as ways to address them.

In addition, Tripp Umbach interviewed the President/CEO. These interviews ensured that the spectrum of interviewees included everyone from members of the community to the individuals who operate the facility on a daily basis. From the onset of the project, AHN made it a priority to be transparent in the identification of the needs for each facility.

The qualitative data collected from community stakeholders are the opinions, perceptions and insights of those who were interviewed as part of the CHNA process.

During the interviews, interviewees were asked to name the top three health concerns in their service area. Below are the top five health needs mentioned most often for all CHNA interviews, totaled from all eight facilities:

1. Mental health (mentioned in 71% of interviews)
2. Substance abuse (mentioned in 64% of interviews)
3. Access to care (mentioned in 61% of interviews)
4. Chronic conditions (mentioned in 58% of interviews)
5. Cost of care (mentioned in 57% of interviews)

Evaluation of 2015 Implementation Planning Strategies

In the 2015 Westfield Memorial Hospital CHNA, behavioral health, cancer, chronic disease, and maternal & child health were identified as top community health needs and implementation planning focus areas. Westfield Memorial Hospital leadership developed goals and strategies to address each identified concern.

In this 2018 CHNA process, Tripp Umbach provided Westfield Memorial Hospital Steering Committee members and leadership with an implementation planning evaluation platform to track the progress of each goal and strategy. Appendix C consists of an updated summary of goals, objectives, and strategies employed by Westfield Memorial Hospital to address the needs from the 2015 CHNA.

Provider Survey

Tripp Umbach employed a health provider survey methodology to gather feedback from providers within Allegheny Health Network. The purpose of the provider health survey was to collect providers' insights on the health status of the patient community they serve including priorities, barriers, and trends. Providers were also asked questions that pertain to the care and services they provider in order to meet these needs. Each hospital within AHN sent emails to their health providers requesting survey participation. A survey link was also posted in an internal newsletter to increase response rates. The survey data collection period ran on Survey Monkey from April through June 2018. In total, a sample size of 163 surveys across all AHN facilities were collected.

The survey included 24 questions in total and the questions below offer a summary of the most important questions:

Q. What do you perceive to be the biggest barrier(s) for people not receiving care? (Check all that apply)

A. Top five results

1. Out of pocket costs/high deductibles, 103 responses (75.18%)
2. No insurance coverage, 83 responses (60.58%)
3. No transportation, 77 responses (56.20%)
4. Not being able to navigate the health care system, 66 responses (48.18%)
5. Lack of mental health facilities, 53 responses (38.69%)

Q. From the following list below, what do you think are the three largest "health problems" in the community you serve?

A. Top ten results

1. Substance Abuse, 59 responses (44.03%)
2. Aging problems (arthritis, hearing/vision loss, etc.), 56 responses (41.79%)
3. Obesity, 50 responses (37.31%)
4. Diabetes, 48 responses (35.82%)
5. Heart disease and stroke, 45 responses (33.58%)
6. Mental health problems, 43 responses (32.09%)
7. Cancers, 32 responses (23.88%)
8. High blood pressure, 25 responses (19.40%)
9. Respiratory/lung disease, 17 responses (12.69%)
10. Fire-arm related injuries, 5 responses (3.73%)

Q. From the following list below, what do you think are the three most pressing "risky behaviors" in the community you serve?

A. Top five results

1. Drug abuse, 75 responses (55.97%)
2. Poor eating habits, 71 responses (52.99%)
3. Substance abuse, 67 responses (50.00%)
4. Lack of exercise, 61 responses (45.52%)
5. Alcohol abuse, 56 responses (41.79%)

Q. What types of improvements would you like to see in the current health system? (Check all that apply)

A. Top five results

1. Affordable health care, 91 responses (67.91%)
2. Access to mental health care, 80 responses (59.70%)
3. Affordable medication, 80 responses (59.70%)
4. Coordination of care, 57 responses (42.54%)
5. Timely access to primary care, 46 responses (43.33%)

Q. In your opinion, what are the reasons why your overall patient population may be noncompliant to treatment/medication plans?

A. Top five results

1. High costs of health care or medications, 104 responses (78.79%)
2. Difficulty "getting around" (transportation challenges or personal mobility challenges), 72 responses (54.55%)
3. Personal reasons (no specific reason/schedule/forgetfulness), 65 responses (49.24%)
4. Lack of insurance coverage, 59 responses (44.70%)
5. Lack of understanding of their treatment plan (excluding language barriers), 55 responses (41.67%)

Provider Resource Inventory

An inventory of programs and services available in the Westfield Memorial Hospital service area/AHN region was developed by Tripp Umbach. The provider inventory highlights available programs and services within Westfield Memorial Hospital's primary service area. The inventory identifies the range of organizations and agencies in the community that are serving the various target populations within each of the priority needs. The inventory provides program descriptions and collects information about the potential for coordinating community activities and creating linkages among agencies.

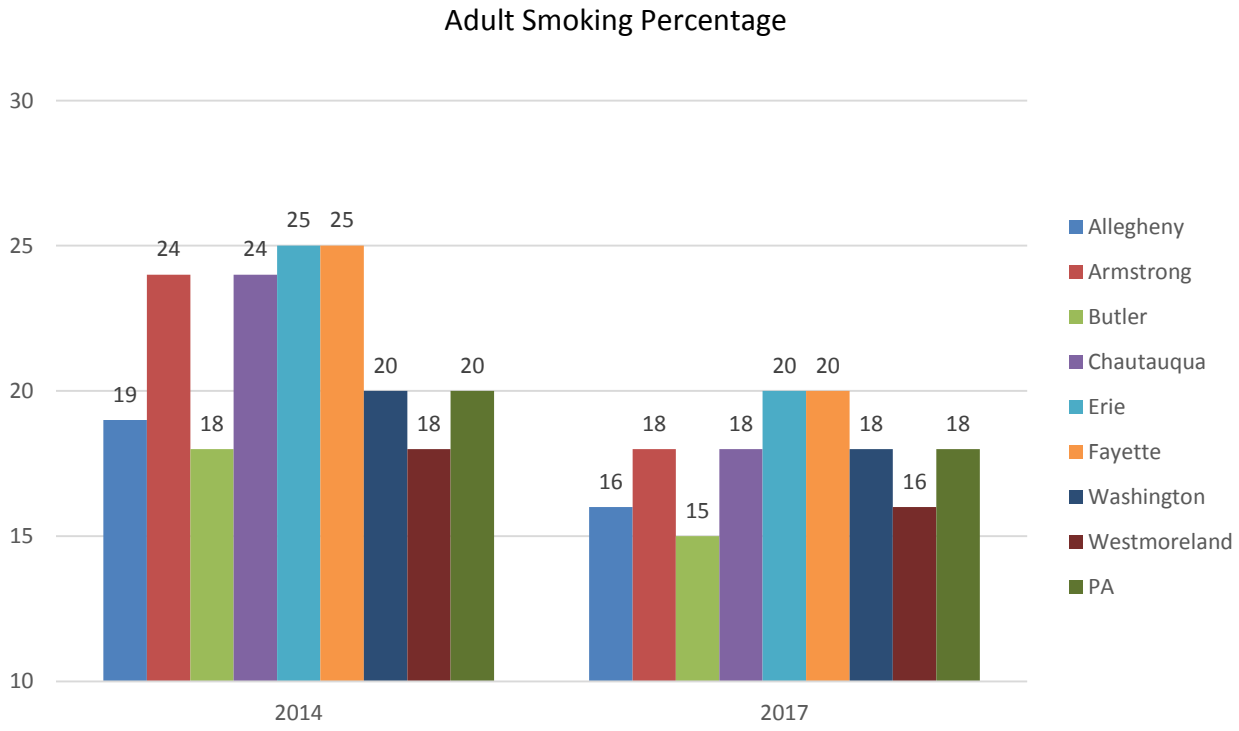
A link to the provider resource inventory will be made available on Allegheny Health Network's website.

Appendix B: **Secondary Data Summary**

Tripp Umbach collected and analyzed secondary data from multiple sources that include the following subjects and health areas: County Health Rankings, Pennsylvania County Health Statistics, Alcohol, Drug Use, and Tobacco Statistics, Mental and Behavioral Health, Homeless Population Data, Rural Health, and School Health Statistics.

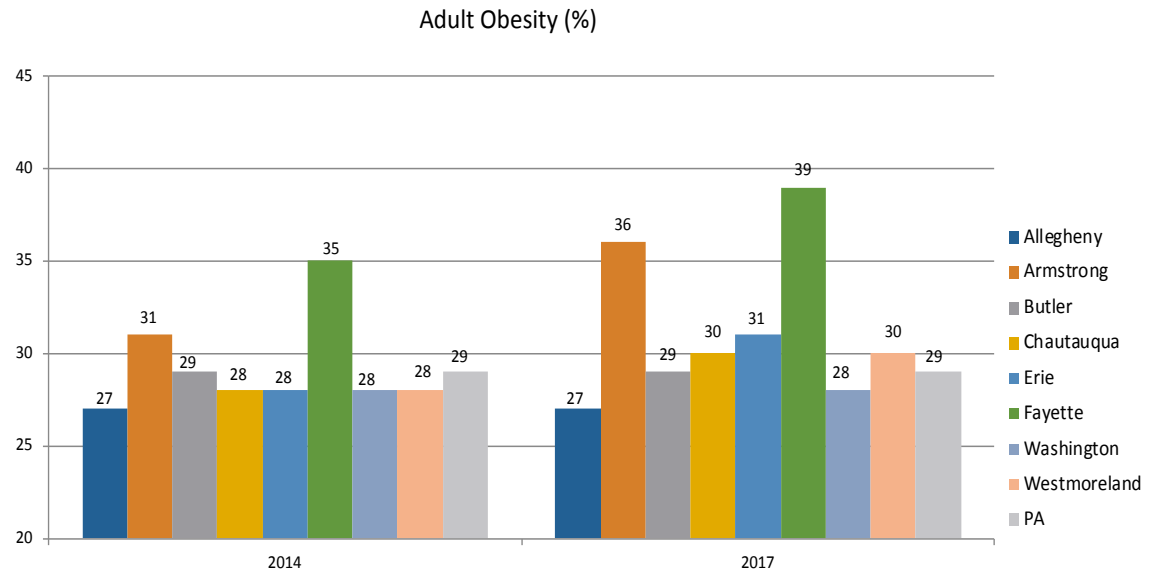
This secondary data summary includes information from multiple health, social and demographics sources. Tripp Umbach used secondary data sources to compile information related to disease prevalence, socioeconomic factors and health behaviors. Where applicable, data was benchmarked against state trends. The secondary data profile includes an overview of health and social conditions in the region, broken down by County or County cluster. Secondary data was used to provide important information, insight, and knowledge into a broad range of health and social issues for the CHNA

This section is intended to provide anecdotal, contextual support for the identified health needs of Allegheny Health Network. The entire secondary data profile for Allegheny Health Network is available upon request.



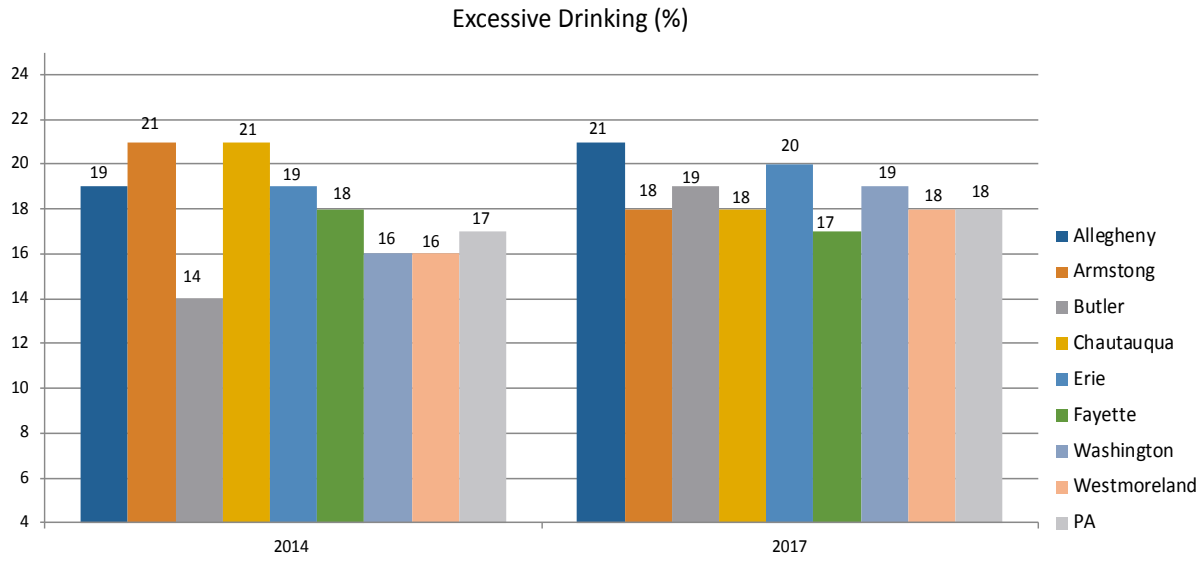
Source: 2017 County Health Rankings

- Key Insight: All counties saw a reduction in adult smoking percentage from 2014 to 2017.

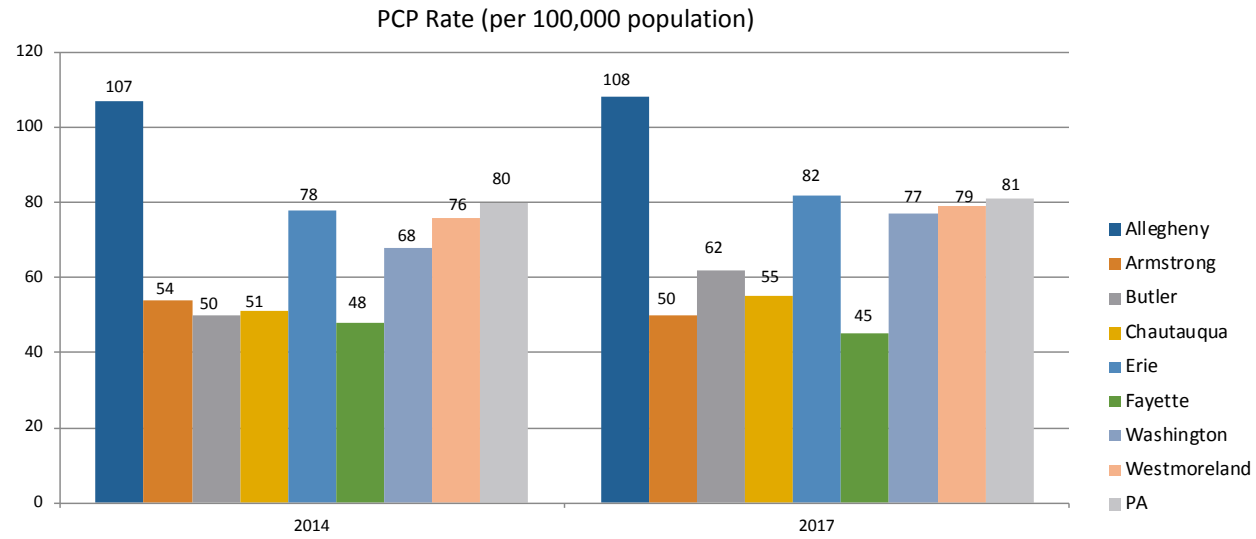


Source: 2017 County Health Rankings

- Key Insight: The rate of adult obesity either increased or remained the same in all counties of the study area.
- Key Insight: Armstrong, Chautauqua, Erie, Fayette, and Westmoreland Counties all register adult obesity rates above the state average.

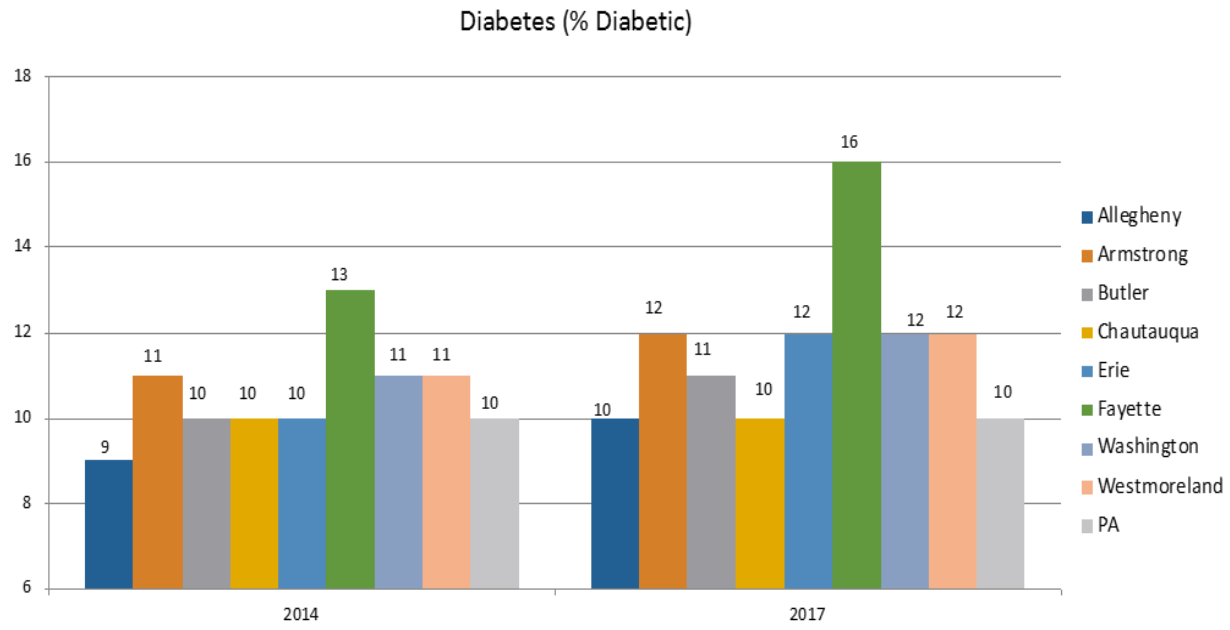


Source: 2017 County Health Rankings



Source: 2017 County Health Rankings

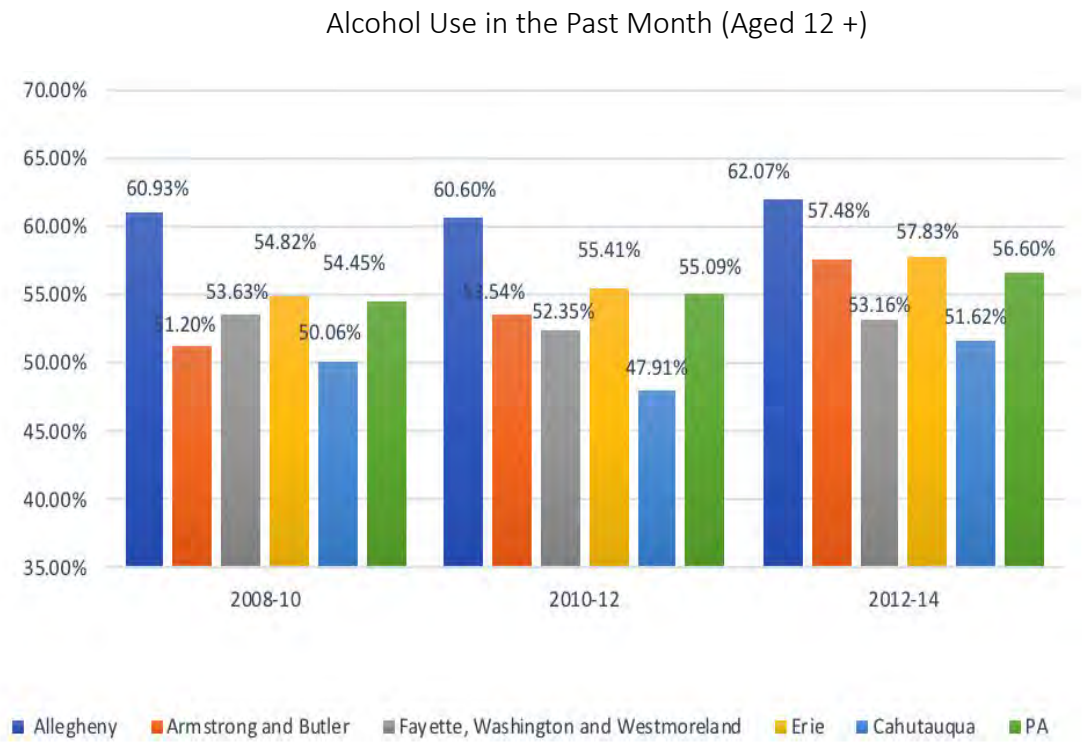
- Key Insight: The rate Of PCP per 100,000 increased in all counties except for Armstrong and Fayette, which declined.
- Key Insight: In 2017, Armstrong, Butler, Chautauqua, Fayette, Washington, and Westmoreland Counties record lower PCP rates compared to the state average.



Source: 2017 County Health Rankings

- Key Insight: The percentage of diabetic adults increased in Allegheny, Armstrong, Butler, Erie, Fayette, Washington, and Westmoreland Counties from 2014-2017.

- Key Insight: All counties in the study area register equal or higher diabetic adults in comparison to the state average.

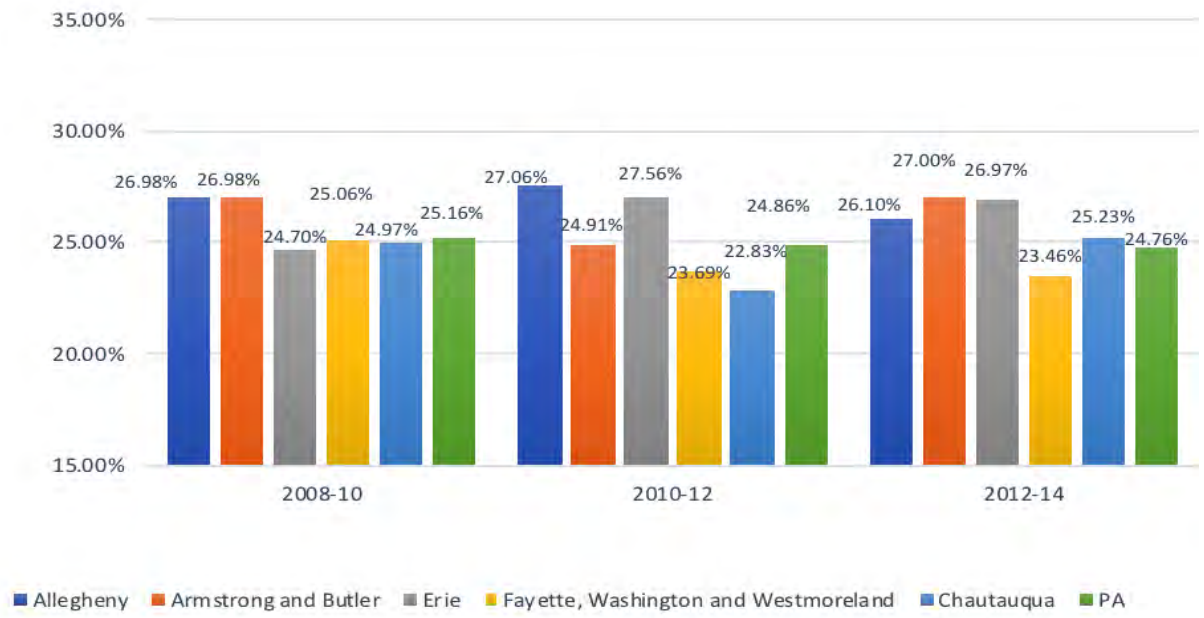


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014

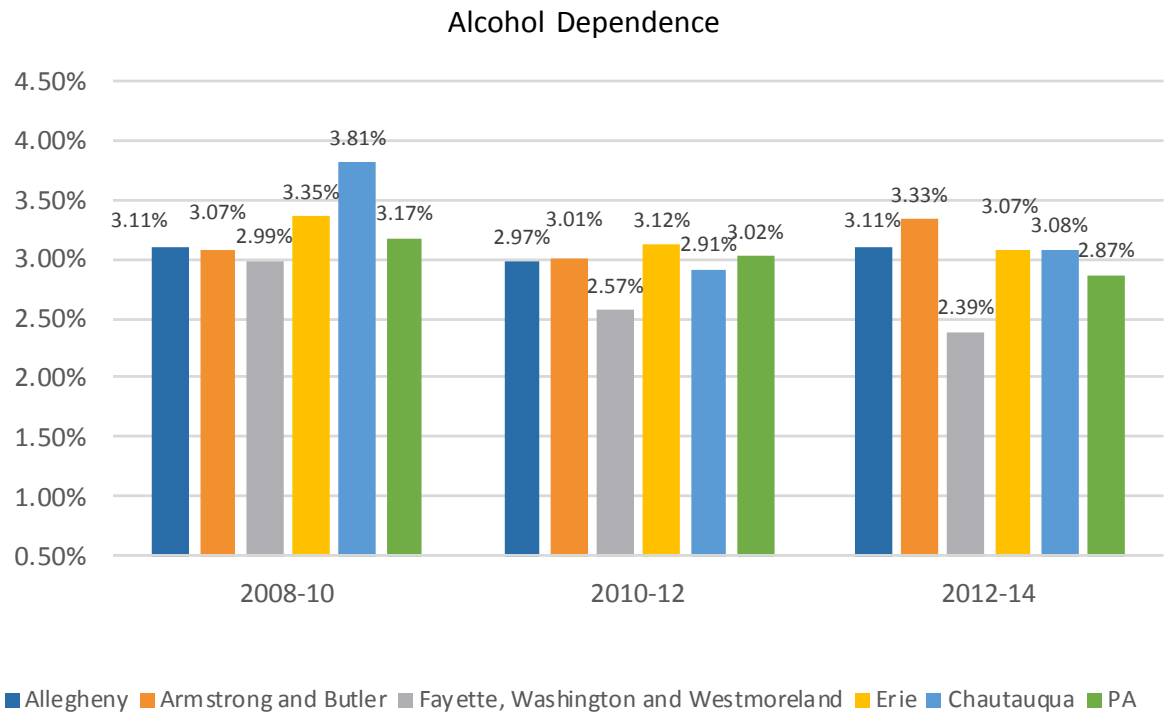
- Key Insight: Armstrong/ Butler[25], Allegheny and Erie counties both report a higher percent of *Alcohol Use* when compared to the state during the most recent 2012-2014 study period.
- Key Insight: Most counties registered relatively equal or slightly higher rates of *alcohol usage* during the last month during the study period.

[25] Armstrong and Butler Counties are grouped together due to their geographic proximity for display purposes.

Binge Alcohol Use



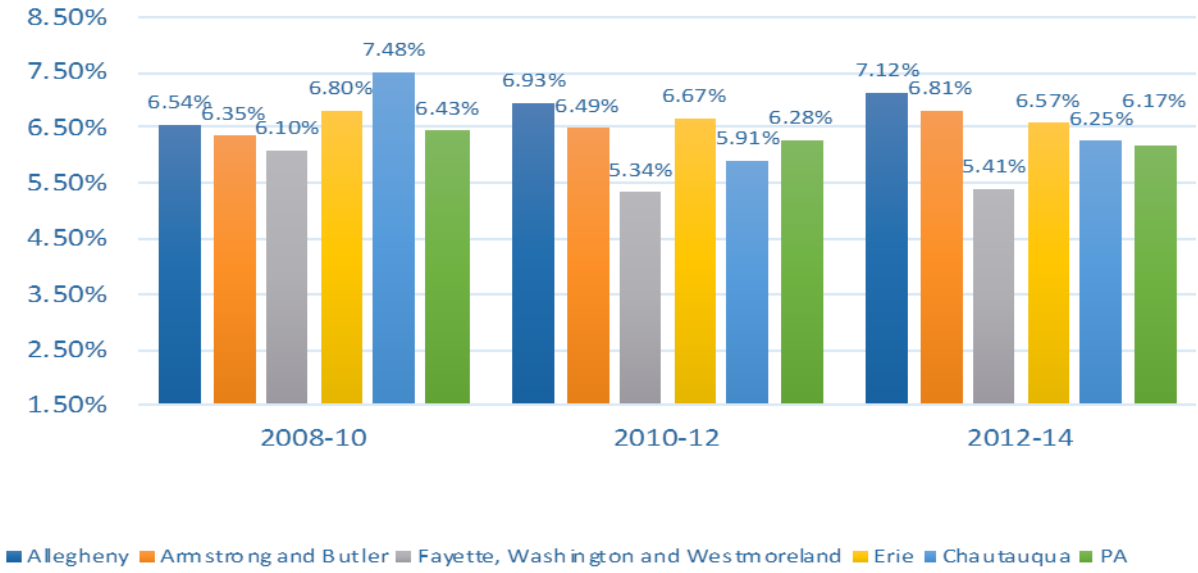
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014

- Key Insight: Allegheny, Armstrong/Butler, Erie, and Chautauqua County all reported a higher rate of *Alcohol Dependence* than the state (3.11%, 3.33%, 3.07%, and 3.08% respectively) during the 2012-2014 study period.

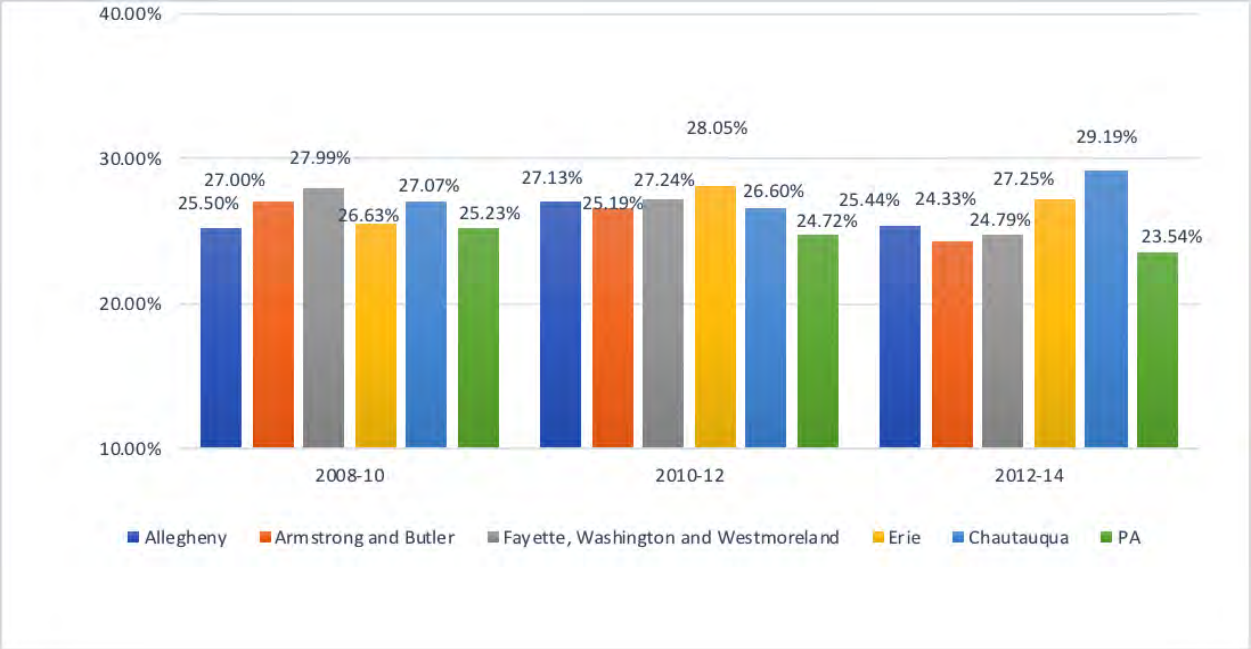
Needing But Not Receiving Treatment for Alcohol Use



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014

- Key Insight: Allegheny, Armstrong/Butler, Erie, and Chautauqua County all reported a higher rate of *Needing But Not Receiving Treatment for Alcohol Use* than the state (7.12%, 6.81%, 6.57%, and 6.25% respectively) during the 2012-2014 study period.

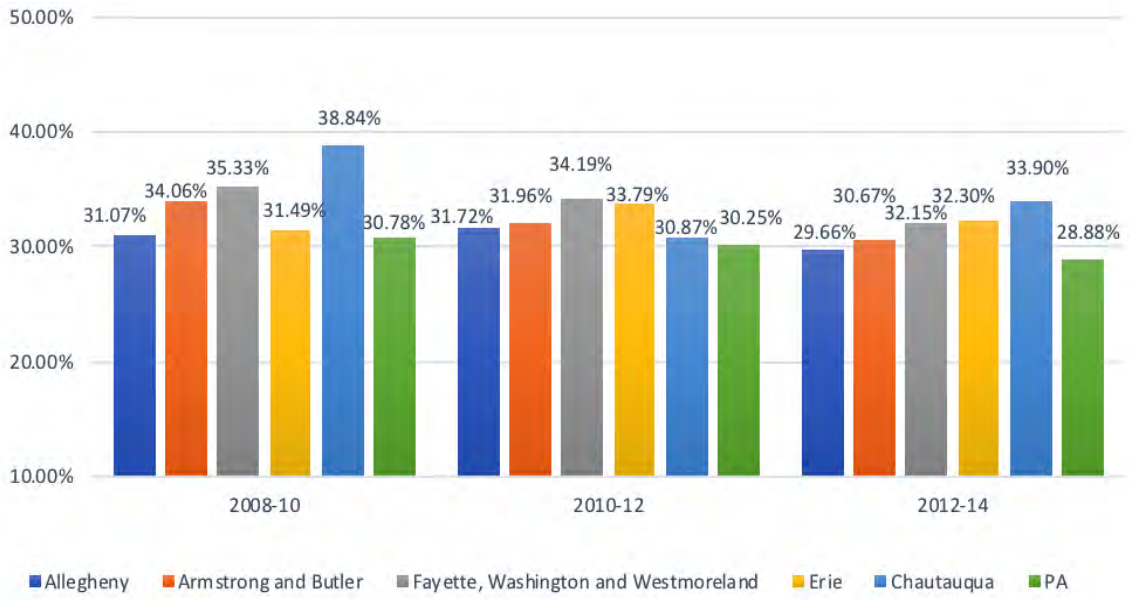
Cigarette Use



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014

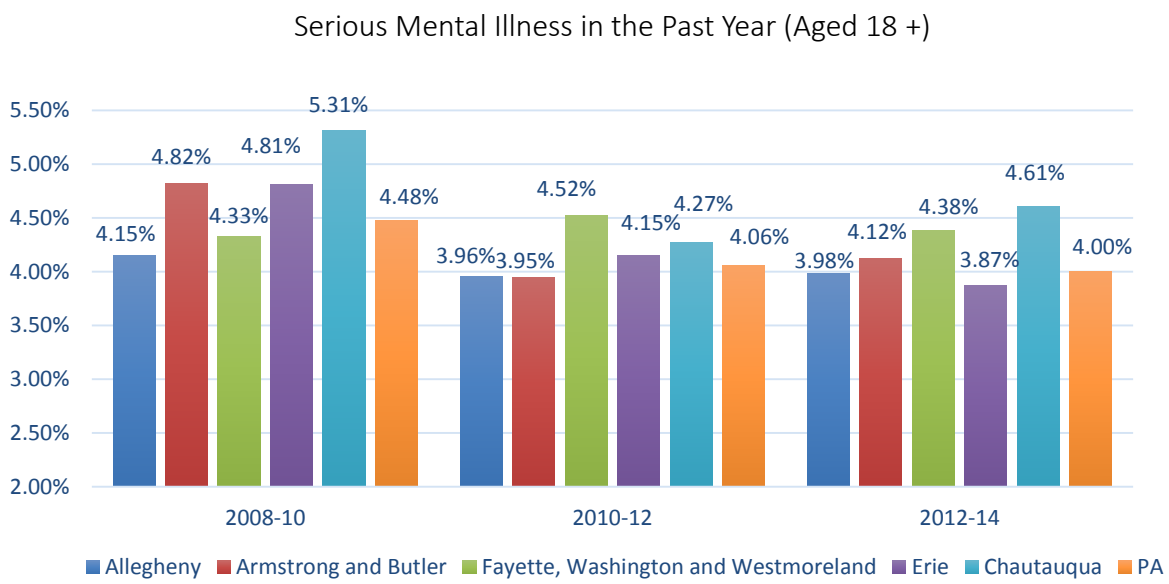
- Key Insight: All County clusters reported a higher rate of *Cigarette Use* than the state during the 2012-2014 study period.

Any Tobacco Use



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014

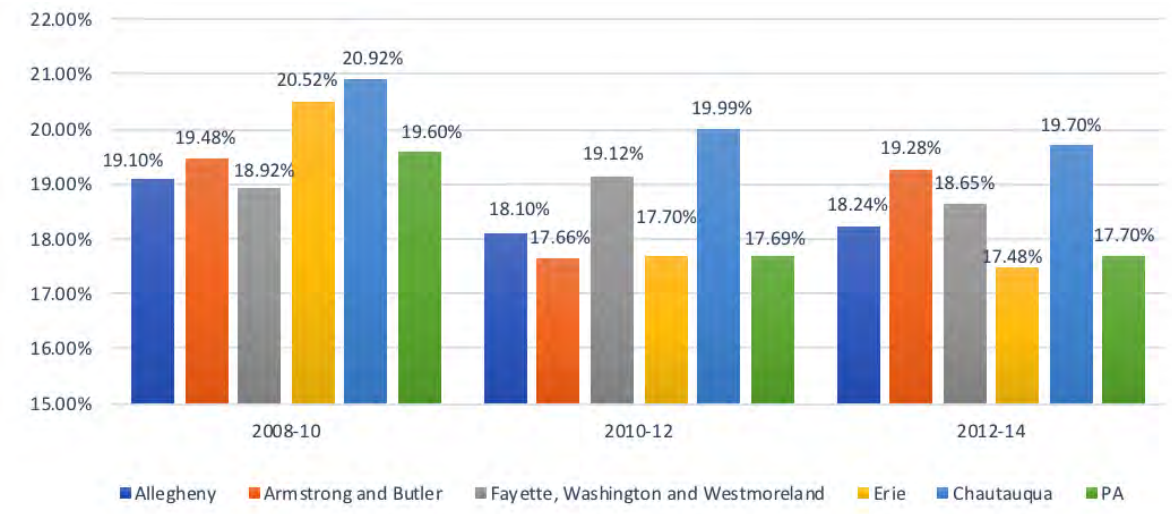
- Key Insight: All County clusters reported a higher rate of *Any Tobacco Use* than the state during the 2012-2014 study period.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2012 and 2014

- Key Insight: Fayette, Washington and Westmoreland County had the largest decline in the rate of *Serious Mental Illness* (4.52% to 4.38%) from 2010-2014.

Any Mental Illness in the Past Year (Aged 18 +)



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2010, 2012-2014

- Key Insight: Chautauqua County reported the highest rate for *Any Mental Illness* at 19.70% while Erie County has the lowest rate and is lower than the state rate

Appendix C: **2015 Implementation Planning Update and Evaluation**

As part of the current CHNA process, Tripp Umbach collaborated with each AHN facility to create an updated evaluation of its progress and strategies used to address the health needs identified in the previous 2015 CHNA. By doing so, each facility will be well positioned to carry over these strategies in 2019 and beyond (if applicable), as well as create strategies for new health needs identified in this CHNA.

1. Health Priority: Behavioral Health

Goal: Monitor compliance by the hospital physicians by participating in New York State I-STOP prescription monitoring program.

Hospital Plan to Meet Objective 1:

All Westfield Emergency Room providers and hospitalists were enrolled in the New York State I-STOP prescription monitoring program. The purpose was to verify patient's frequency of obtaining narcotic drug prescriptions throughout the neighboring communities and NY state. With the implementation of the EPIC computer system, WMH is also able to check the PA registry

- Westfield started reviewing charts in July of 2016. Documentation was not consistent across providers, so in November 2016 a PMP review designee was established, under the direction of the ED Medical Director.
- November – December 2016, 132 narcotic prescriptions were written and reviewed in the NYS registry. 7 patient records or 5% were determined to be suspicious. These statistics were presented to the providers at the January ED provider meeting.
- In 2017, 816 narcotic prescriptions were written. Of those, 33 or 4% were determined to be suspicious.
- For the first 10 months of 2018, 607 narcotic prescriptions were written. Of those, 33 or 5% were determined to be suspicious.

2. Health Priority: Cancer

Goal: Reduce the number of new cancer cases, as well as the illness, disability, and death caused by cancer.

Hospital Plan to Meet Objective 1a: Westfield tracked how many patients who were referred for Direct Colonoscopy and had a Polypectomy performed.

- 2016 July to December - 49 of 130 patients required polypectomy, preventing further problems for 38% of patients tested

- 2017 – 104 of 232 patients required polypectomy, preventing further problems for 45% of patients tested
- 2018 YTD – 115 of 230 patients required polypectomy, preventing further problems for 50% of patients tested

Hospital Plan to Meet Objective 1b: Westfield Radiology Department tracks the number of patients sent a letter to remind them it is time to schedule their Mammogram and what the compliance is to scheduling their Mammogram. Letters are sent out monthly.

- 2016 July to December – 1,274 letters were sent to patients, of those 465 patients scheduled their Mammogram.
- 2016 October – new 3 D Tomosynthesis Mammography Unit installed
- 2017 – 1,928 letters were sent to patients, of those 372 patients scheduled their Mammogram.
- 2018 YTD – 1,567 letters were sent to patients, of those 233 patients scheduled their Mammogram.

Hospital Plan to Meet Objective 1c: Westfield Radiology Department tracks the number of Mammograms done each month and how many are on new patients. New objective added November 2016.

- 2016 Nov- Dec 382 Mammograms done, 26 new patients
- 2017 – 1,863 Mammograms done, 103 new patients
- 2018 YTD – 1,555 Mammograms done, 88 new patients

Hospital Plan to Meet Objective 1d: Westfield will participate in the annual Cancer Awareness Survivor Parade sponsored by Chautauqua County Cancer Services and provide educational material related to early detection.

- 2016 Instead of attending the parade, Radiology handed out promotional items and mailed "Pink for October" letters to physician offices. Letters were also sent to patients who had a Mammogram at WMH in the past. Upgrade to 3-D Mammogram technology was completed in October as well. A lighted pink ribbon and HOPE sign was displayed on the front of the hospital.
- 2016 Gifts were given to patients who had a Mammogram done in October.
- 2017 October Breast Cancer Month - free giveaways of chap stick and pens with breast cancer awareness ribbon on them. No parade held this year.
- 2018 October Breast Cancer Month - free giveaways of calendars and pens with breast cancer information on them. Parade is no longer being held.

Hospital Plan to Meet Objective 2a: Westfield will promote the New York State smoking cessation program with new physical therapy patients. All new patients will be screened and

have their smoking status documented in their chart. They will be offered information on the NYS "Quit Smoking" Hotline.

- 2016 July to Dec. 164 new patients, 95% of them were screened and offered information as needed
- 2017 – 622 new patients, 89% of them were screened and offered information as needed
- 2018 Jan to Feb – 101 new patients, 99% were screened in Jan-Feb. With EPIC implementation these statistics are no longer being kept.

Hospital Plan to Meet Objective 2b: Westfield physical therapy department will promote the "Stepping Out" program for the elderly in the community.

- 2016 Classes held April 26 and July 27
- 2017 Classes held in May
- 2018 No information available

3. Health Priority: Chronic Disease

Hospital Plan to Meet Objective 1a: Westfield will implement a healthy beverage initiative for hospital vending services.

- 2016 New food and drink machines installed, employee asked for input and new healthy items were put in sandwich machine
- 2017 Salads, yogurt and cheese items added
- 2018 Vendor works with staff for ideas, likes and dislikes

Hospital Plan to Meet Objective 1b: Westfield will provide monthly blood pressure screenings at various community locations.

- 2016 Monthly BP screenings were done by auxiliary at YMCA, Community Kitchen and AMBA.
- 2017 Auxiliary members perform blood pressure checks, volumes unknown.
- 2018 Changed to every 2 months, no documentation where screenings were held

Hospital Plan to Meet Objective 1c: Westfield will provide vouchers for the local farmer's market

- 2016 Due to change in hospital administration, it was too late to start program and we missed the time frame. WMH will be working with "Chautauqua Grown" in the spring. This is an initiative of Cornell Cooperative Extension of Chautauqua.
- 2017 Westfield will be working with "Chautauqua Grown" in the spring. This is an initiative of Cornell Cooperative Extension of Chautauqua. No success in getting this

project started. Flyers were distributed within the hospital on how to contact the Cooperative and their locations.

- 2018 Project not started

Hospital Plan to Meet Objective 2a: Westfield will facilitate seamless transition for patients from the hospital to their PCP by scheduling a transfer of care appointment for all patients prior to discharge.

- 2016 – 53 patients discharged from Med/Surg. 39 patients had follow up PCP appointments scheduled, 14 patients had no appointment made due to transfer to another hospital, deceased, home with hospice, returned to nursing home, PCP to call patient or patient to call for appt.
- 2017 - 105 patients discharged from Med/Surg. 39 patients had follow up PCP appointments scheduled, 34 patients had no appointment made due to transfer to another hospital, deceased, home with hospice, returned to nursing home, PCP to call patient or patient to call for appt.
- 2018 YTD – 34 patients discharged from Med/Surg. 2 patients had follow up PCP appointments scheduled, 32 patients had no appointment made due to transfer to another hospital, deceased, home with hospice, returned to nursing home, PCP to call patient or patient to call for appt.
- With EPIC system implementation, tracking of the appointments is more difficult due to the ability to document in various locations of the patient record. Nursing has met and decided to always document the appointment as a nursing NOTE.

Hospital Plan to Meet Objective 2b: Westfield will assist in managing high risk populations by providing nutrition and health education.

2016 - 2018 (see below)

- Provided dietician services at camp, volunteered 100 hours for planning, implementation and education for children and their families.
- Provided Diabetes Prevention classes at Westfield, 22 classes held annually.
- Provided nutritional education on weight management, eating for heart health and diabetes prevention at ECR International in Dunkirk, NY for 100 employees.
- Provide one-on-one outpatient Diabetes education twice weekly.
- Nutrition education sessions held for prevention of diabetes and heart disease.
- Worksite wellness program for 28 Westfield associates concentrating on healthy eating and exercise for Weight Loss. Winner received a Fit-Bit

Miscellaneous Items:

- Sponsored a “Hands Only” CPR and How to Recognize Stroke symptoms class. It was open to associates and community members.
- Participate in Western Region Healthcare Emergency Preparedness IT Downtime Work Group.

Appendix D: **About Tripp Umbach**

Allegheny Health Network contracted with Tripp Umbach, a private health care consulting firm with offices throughout the United States, to complete this community health needs assessment (CHNA). Tripp Umbach has worked with more than 300 communities in all 50 states. In fact, more than one in five Americans lives in a community where our firm has worked.

From community needs assessment protocols to fulfilling the new Patient Protection and Affordable Care Act (PPACA) IRS 990 requirements, Tripp Umbach has turned needs assessments into practical action plans with sound implementation strategies, evaluation processes, and funding recommendations for hundreds of communities. Tripp Umbach has conducted more than 400 community health needs assessments and has worked with over 800 hospitals.

Changes introduced as a result of the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts between providers, public health agencies, and community organizations to improve the overall health of communities.

Tripp Umbach