Allegheny Health Network — AHN Westfield Memorial Hospital

Implementation Strategy Plan

2025 Report

AHN WESTFIELD MEMORIAL

Implementation Strategy Plan 2025

About Allegheny Health Network (AHN)

Allegheny Health Network (AHN) is a leading nonprofit health system based in Pittsburgh, Pennsylvania, dedicated to providing exceptional 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. The facilities have nine surgical centers, six regional cancer centers, and six health and wellness pavilions. Its staff includes over 3,000 physicians, residents, and fellows; 6,000 nurses; and 22,000 employees.[1] 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 encompasses a wide range of health care services, including acute care, outpatient services, rehabilitation, emergency care, and specialty programs. AHN is also recognized for its cutting-edge technology and research initiatives, focusing on advancing medical science and enhancing patient care. AHN is a vital component of the health care landscape focused on delivering high-quality, patient-centered care. Through its extensive services, community engagement, and commitment to health equity, AHN strives to improve the health and well-being of the communities it serves. With a dedication to innovation and excellence, AHN continues to play a crucial role in shaping the future of health care in the region.

Mission

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

Vision

A world where everyone embraces health.

[1] Allegheny Health Network

About Allegheny Health Network Westfield Memorial Hospital

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

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

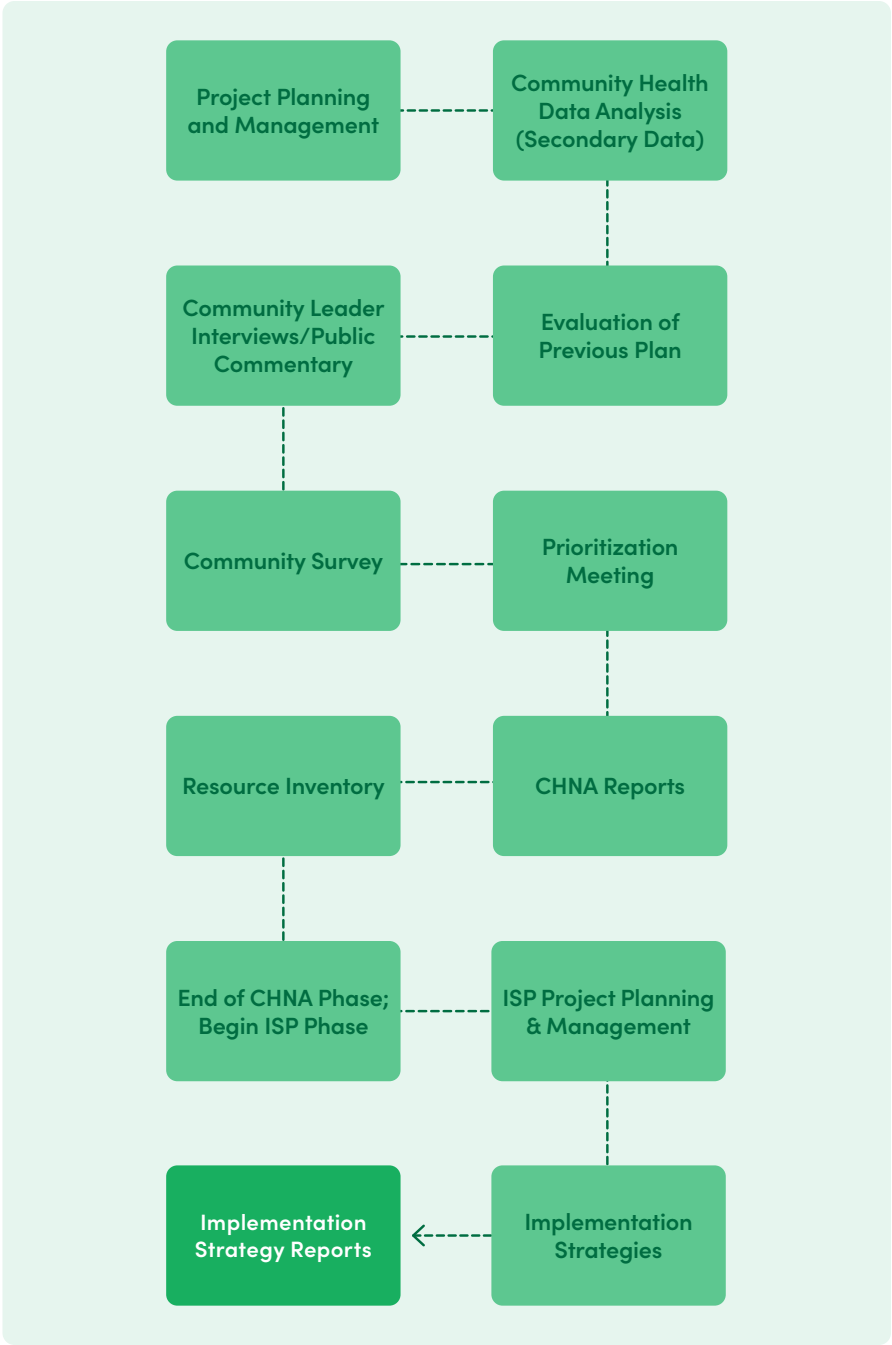
Community Health Needs Assessment and Implementation Strategy Plan Background

In 2024, Allegheny Health Network (AHN) partnered with Tripp Umbach to conduct a comprehensive community health needs assessment (CHNA) for AHN Westfield primarily serving Cattaraugus and Chautauqua counties. The CHNA process included input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of public health issues and representatives of social service agencies. As a continuation of the CHNA, AHN, with the assistance of Tripp Umbach, proceeded to the Implementation Strategy Plan (ISP). The ISP process delineates and describes the hospital's plan for addressing the community health needs identified in the CHNA. The overall CHNA and ISP involves multiple steps, as depicted in the flowchart on the next page.

Overall CHNA and ISP Process Flowchart

Under the Patient Protection and Affordable Care Act (PPACA), all nonprofit hospitals are required to conduct a CHNA every three years. This process ensures hospitals remain responsive to the changing health needs of their communities. The CHNA must identify the hospital's service area, gather input from a wide range of stakeholders, including public health experts and community members, and evaluate the most critical health challenges in the region. After identifying these health needs, hospitals must prioritize them based on their importance and develop an implementation strategy to address them. The strategy should outline potential actions, partnerships, and resources to effectively address the identified needs, ensuring hospitals align their efforts with the health and well-being of their communities.

It is important to note that the ISP is not intended to provide a comprehensive list of how AHN Westfield addresses the community's needs. Instead, it focuses on key actions the hospital commits to taking and monitors its progress of the identified priorities. Although the strategy includes internal and external partners, many clinical departments and AHN institutes will collaborate on these initiatives. Their roles may involve participating in clinical programs and protocols or contributing to educational outreach by sharing expertise, individually or as a team, to address the community's health needs.



Overall Prioritized Needs of Allegheny Health Network Hospitals

2024 Prioritized Needs	Social Determinants of Health (SDOH)					Behavioral Health			Chronic Diseases and Aging					Health Equity
AHN	Transportation	Workforce Development	Cost of Care	Access to Care*	Food Insecurity, Diet, & Nutrition	Substance Use Disorder	Mental Health Services	Postpartum Depression	Diabetes	Heart Disease	Cancer	Aging	Obesity	Social and Workforce Programs**
Allegheny General Hospital	X	X	X		X	X			X	X	X			X
Allegheny Valley Hospital	X				X	X	X		X	X				X
Canonsburg Hospital		X		X										X
Forbes Hospital		X		X	X	X	X				X			X
Grove City Medical Center					X	X	X		X	X	X		X	X
Jefferson Hospital		X			X		X				X			X
Saint Vincent Hospital		X	X		X		X				X			X
West Penn Hospital			X		X			X					X	X
Westfield Memorial Hospital				X	X	X	X	X	X	X	X			X
Wexford Hospital		X			X		X	X		X		X		X
Brentwood Neighborhood Hospital			X	X										X
Harmar Neighborhood Hospital			X	X										X
Hempfield Neighborhood Hospital			X	X										X
McCandless Neighborhood Hospital			X	X										X

* Access to care includes primary care, specialty care, EMS/trauma services, and access to general services.
**Social and Workforce Programs includes, for example, cultural competency and Culturally and Linguistically Appropriate Services (CLAS).

Access to Care

Accessible health care is essential for achieving positive health outcomes and reducing health disparities. When individuals can obtain medical services with ease, they are more likely to receive preventive care, early diagnoses, and timely treatments — ultimately leading to better overall health and well-being. According to a 2022 study by the Kaiser Family Foundation, 27.5 million individuals in the U.S. were uninsured, with low-income individuals, racial and ethnic minorities, and rural residents facing the greatest challenges.[2]

A looming physician shortage further exacerbates access challenges. The Association of American Medical Colleges (AAMC) projects a national shortfall of 86,000 physicians by 2036, driven by an aging population and increasing physician retirements.[3] Similarly, the Robert Graham Center estimates that Pennsylvania will require an additional 1,039 primary care physicians by 2030 — a necessary 11% increase over the current workforce. Addressing these workforce shortages is critical to maintaining access to quality care, particularly in underserved areas.[4]

Ensuring equitable access to health care is fundamental to community well-being and long-term health improvements. Expanding access to care fosters health equity, enhances quality of life, and strengthens community resilience. This is particularly crucial for low-income individuals and rural residents, who often encounter significant barriers to care. Addressing these challenges through targeted strategies and improved health care infrastructure will help build a healthier, more equitable society.

Social Determinants of Health (SDOH): Access to Care				
Goal: Provide OB-GYN outpatient services to the community.				
Impact: Women have more local options to seek medical care.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Women	• Begin offering office hours for OB-GYN services in Westfield.	• Establish consistent office hours. • Market the new service in the Westfield market.	• Number of patients seen in the office.	• Northcoast OB

[2] Kaiser Family Foundation
[3] Association of American Medical Colleges
[4] Association of American Medical Colleges

Food Insecurity, Diet, and Nutrition

Food insecurity — a major social determinant of health — affects millions of individuals and families, particularly in low-income communities where access to nutritious food is often limited. Many areas are classified as food deserts, meaning residents cannot access affordable, healthy food options. Instead, many rely on highly processed, high-calorie foods that lack essential nutrients, increasing the likelihood of diet-related health conditions. Poor nutrition not only exacerbates chronic disease prevalence but also impacts mental health, contributing to stress, anxiety, and depression.[5]

Diet and nutrition are fundamental to overall health, influencing physical well-being to cognitive development. A lack of essential nutrients can weaken the immune system, lower energy levels, and increase vulnerability to illness. Inadequate nutrition during early childhood has severe and lasting consequences, contributing to developmental delays, learning difficulties, and a higher risk of chronic diseases such as obesity, diabetes, and cardiovascular conditions later in life.[6]

The consequences of food insecurity and poor diet extend beyond individual health, affecting educational achievement, workforce productivity, and economic stability. Children who experience hunger or malnutrition often struggle academically due to difficulties concentrating and increased absenteeism caused by illnesses.[7] Adults facing food insecurity may experience diminished work performance and higher health care costs due to preventable diet-related illnesses. Addressing food insecurity through policies that expand access to nutritious food — such as subsidized grocery programs, community gardens, and improved public transportation to grocery stores — can help mitigate these disparities and promote better health outcomes across populations. Ultimately, ensuring access to a healthy diet is not just a matter of personal choice but a critical factor in reducing health inequities and improving overall societal well-being.

Social Determinants of Health (SDOH): Food Insecurity, Diet, and Nutrition				
Goal: Grow and collect food donations that can be used in the local community and support the current food bank that relies 100% on community donations for food.				
Impact: Fulfill the need of feeding individuals and families that need support with obtaining food.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Greater WMH community	• Develop community garden. • Set up a food donation program.	• Using a state grant, finish the development of the community garden. • Work with board members and employees to maintain the garden. • Develop a donation process and safe storage of food. • Partner with local food bank.	• Weight of food grown. • Number of donations to local food bank.	• Westfield Methodist Church

[5] National Library of Medicine
[6] National Library of Medicine
[7] National Library of Medicine

Substance Use Disorder

Substance use disorder (SUD) is a significant public health challenge that profoundly affects behavioral health, contributing to both the development and worsening of mental health conditions. Alcohol and tobacco use, in particular, are major risk factors that can trigger or exacerbate anxiety, depression, and other behavioral health disorders. In Pennsylvania, substance use remains a pressing concern, with alcohol, opioids, methamphetamines, and tobacco posing serious health risks to individuals and communities alike.

SUD affects a substantial portion of the population, leading to an increased burden on the health care system through higher rates of hospitalization, emergency room visits, and chronic disease complications. Excessive alcohol consumption is also linked to impaired cognitive function, increased risk of injury, and a heightened prevalence of co-occurring mental health conditions such as depression and anxiety.[8]

The percentage of drug overdose deaths in New York involving opioids has significantly increased over the past decade. In 2010, opioids were responsible for 69% of overdose deaths, but by 2020 and 2021, this figure had jumped to 85%. This rise is due to the widespread availability of opioids and the increasing potency of illicit substances like fentanyl. In 2021, 30 out of every 100,000 New Yorkers died from a drug overdose, with opioids accounting for 25 of those deaths — an alarming jump from just five opioid-related deaths per 100,000 in 2010. Additionally, New York's opioid overdose death rate exceeded the national average in both 2020 and 2021.[9]

The intersection of substance use and behavioral health underscores the need for comprehensive prevention, treatment, and harm reduction strategies. Expanding access to evidence-based interventions, such as medication-assisted treatment (MAT), mental health counseling, and community-based recovery programs, is essential in addressing SUD and its widespread effects. Addressing the root causes of substance use — including social determinants such as poverty, trauma, and lack of access to care — is crucial in improving behavioral health outcomes and fostering healthier communities.

[8] American Addiction Centers
[9] New York State Comptroller

Behavioral Health: Substance Use Disorder (SUD)				
Goal: Establish protocol to treat eligible overdose patients with Medication Assisted Therapy (MAT).				
Impact: (1) Increased awareness of treatment for overdose complications; and (2) increased services for overdose cases.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Patients served at Westfield Memorial Hospital	• Begin medicating patients that meet criteria with first dose of buprenorphine and transition to Medication Assisted Treatment (MAT) for detox.	• Screen overdose patients in the emergency department for MAT criteria. • Collaborate with Chautauqua County Mobile Crisis Services.	• Number of trainings for hospital staff. • Number of patients receiving MAT.	• Emergency Department • Forbes Pharmacy • Education Department
• Greater WMH community	• Increase community knowledge and access to substance use disorder resources.	• Partner with community-based providers.	• Number of community events.	• Chautauqua County Mental Hygiene

Mental Health Services

Access to mental health services in New York remains a critical public health concern, with many individuals facing significant barriers to receiving necessary care. The state of New York has seen a growing demand for mental health services, a trend that has been exacerbated by the COVID-19 pandemic, economic stressors, and ongoing social challenges.[10] Expanding access to mental health services, ensuring adequate insurance coverage, and addressing barriers such as provider shortages are essential to tackling mental health challenges.

Since unmet mental health needs are self-reported, they reflect factors that influence which groups are more likely to seek treatment. As a result, certain groups may report higher levels of both treatment and unmet need. Unmet needs can stem from barriers such as cost or stigma. In 2023, 14% of adult New Yorkers — approximately 945,000 people — reported an unmet need for mental health treatment over the past year.[11]

Behavioral Health: Mental Health Services				
Goal: Increase referrals from emergency department (ED) to outpatient treatment options.				
Impact: (1) Increased number of patients receiving treatment; and (2) increased awareness of available resources.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Patients served at Westfield Memorial Hospital	• Provide patients presenting to the ED with local options for follow-up care.	• Develop partnerships with area behavioral health providers. • Develop a referral pathway for post-ED follow-up care of addiction and other mental health issues.	• Number of patients referred to mobile crisis services. • Number of local services identified.	• Chautauqua County Mental Hygiene

[10] NYC Health, 2024
[11] NYC Neighborhood Wellness Survey, 2023

Postpartum Depression

Postpartum depression (PPD) is a significant mental health concern that affects many new mothers, impacting their emotional well-being and overall behavioral health. It is characterized by persistent feelings of sadness, anxiety, and exhaustion, which can interfere with a mother's ability to care for herself and her baby. Research suggests that approximately one in 10 women experience PPD, with prevalence rates even higher among individuals with a history of mental health conditions or those facing social and economic hardships.[12]

Early identification and intervention are critical in addressing PPD effectively. Routine depression screenings during prenatal visits and postpartum checkups can help health care providers identify at-risk individuals and ensure timely intervention. Expanding access to mental health resources — including counseling, support groups, and peer support programs — can empower mothers to seek help and manage their symptoms more effectively. Additionally, fostering community support systems that promote maternal mental health, reduce stigma, and provide accessible resources is essential in ensuring that new mothers receive the care and support they need during this critical period.[13]

Behavioral Health: Postpartum Depression (PPD)				
Goal: Increase knowledge and access to postpartum depression resources.				
Impact: Increased awareness of treatment resources for postpartum depression.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Women experiencing postpartum depression	• Increase community knowledge of postpartum depression program.	• Partner with OB group to establish a referral pattern for postpartum depression services.	• Number of patients referred to postpartum depression program. • Number of patients that attend a postpartum depression program. • Number of postpartum depression programs.	• AHN Saint Vincent

[12] BMC Public Health
[13] BMC Public Health

Diabetes

The prevalence of chronic diseases, particularly diabetes, has been steadily rising, mirroring national trends influenced by a combination of factors such as increasing obesity rates, sedentary lifestyles, and an aging population. Type 2 diabetes, which accounts for the majority of diagnoses, is closely tied to lifestyle choices such as poor diet and lack of physical activity. If not effectively managed, this condition can lead to severe and debilitating complications, including heart disease, kidney failure, and vision loss.

Approximately one in three adults (34.5%) in the U.S. have prediabetes, a condition that can progress to type 2 diabetes if not addressed. In New York, this means up to 5.3 million adults may be living with prediabetes. However, awareness of this condition remains alarmingly low. In 2021, only 11.5% of New York adults reported that their health care provider had informed them they had prediabetes. This lack of diagnosis leaves most New Yorkers unaware of their risk, highlighting the urgent need for enhanced screening and public health efforts to prevent the development of diabetes.[14]

Chronic Diseases and Aging: Diabetes				
Goal: To improve quality outcomes associated with diabetes.				
Impact: (1) Increased participation in children's camp; and (2) increase education for campers.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Greater WMH community	• Promote diabetes prevention in the community.	• Host screening and education events. • Identify at-risk patients through biometric screenings. • Present at schools and community groups on healthy living.	• Number of community events. • Number of at-risk patients identified through biometric screenings.	• Diabetes educator
• Young children	• Partner with local children's diabetic camp.	• Provide subject matter support to children at the camp. • Educate campers on diabetes management strategies.	• Staff hours for planning and presenting at the camp. • Number of campers educated.	• Diabetes educator

[14] New York Department of Health

Heart Disease

Heart disease is a prevalent chronic condition in New York, profoundly affecting the health and well-being of its residents. It encompasses a wide spectrum of cardiovascular diseases, including coronary artery disease, heart failure, arrhythmias, and other related disorders that impair the heart's ability to function optimally. As a leading cause of morbidity and mortality, heart disease presents a significant public health challenge, contributing not only to high rates of premature death but also to long-term disability and diminished quality of life for many individuals.[15]

In 2021, about 7.4% of adults in New York reported having experienced a heart attack, angina, coronary heart disease, or stroke. This figure underscores the considerable burden of cardiovascular disease on New Yorkers and highlights the ongoing public health challenge of preventing and managing heart-related conditions.[16] This chronic condition is strongly influenced by modifiable risk factors such as poor diet, physical inactivity, smoking, and excessive alcohol consumption, all of which are prevalent among the population. The rising rates of obesity, hypertension, and diabetes further exacerbate the problem, creating a complex web of interrelated health issues that strain both individuals and the health care system.

Given the scope and impact of heart disease, addressing this chronic condition is critical to improving the overall health of the population. Effective prevention and management strategies, such as promoting healthier lifestyles, improving access to health care, and addressing underlying risk factors, are essential in reducing the incidence of heart disease and mitigating its devastating consequences. Furthermore, expanding public health initiatives aimed at early detection and intervention can help reduce the long-term burden of this chronic disease, ultimately saving lives and improving health outcomes for many.

Chronic Diseases and Aging: Heart Disease				
Goal: Improve quality outcomes associated with heart disease.				
Impact: (1) Increased number of ECHO studies; and (2) Increased utilization of a chronic disease care model.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Cardiac patients	• Begin offering consistent cardiac ECHO services at Westfield Memorial Hospital.	• Use inpatient care pathways established by the network. • Educate PCPs and patients on heart disease management.	• Number of inpatient order sets used to require an ECHO. • Number PCP referrals for outpatient ECHO.	• PCP networks

[15] New York State Department of Health
[16] New York State Department of Health

Cancer

Cancer was identified as a prioritized health need for AHN Westfield based on the community survey results as well as the secondary data analysis. In addition to those data points, AHN Westfield considered their capacity to implement cancer-related programming. Cancer is one of the most common chronic diseases in New York and is second only to heart disease as the leading cause of death. Each year, over 116,000 New Yorkers are diagnosed with cancer. Every year, thousands of New Yorkers receive a cancer diagnosis, with common types including breast, lung, prostate, and colorectal cancer.[17]

Several factors contribute to the rising incidence of cancer, including an aging population, environmental exposures, and lifestyle-related risks such as tobacco use, poor diet, and physical inactivity. Additionally, the increasing prevalence of chronic conditions such as obesity, diabetes, and heart disease can further elevate cancer risk. With cancer rates expected to climb, there is an urgent need for robust public health strategies focused on prevention, early detection, and improved treatment options to combat this chronic disease.

The increasing number of cancer diagnoses and deaths highlights the importance of prioritizing cancer research, access to care, and public awareness campaigns. By addressing the underlying risk factors and promoting healthier lifestyles, New York can work toward reducing the impact of cancer and improving survival outcomes for those affected by this devastating chronic disease.

Chronic Diseases and Aging: Cancer				
Goal: Increase the number of adults who receive age-appropriate screenings.				
Impact: (1) Increased number of lung screenings; and (2) Increased number of early lung cancer detections.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Adults in greater WMH community	• Continue CT lung cancer screening program.	• Continue lung cancer screening protocols. • Educate referring providers of service. • Begin community lung cancer screening.	• Number of studies performed. • Number of patients screened at community events.	• PCP networks

[17] New York State Department of Health

Social and Workforce Programs

Health equity is a crucial aspect of public health that aims to ensure that all individuals, regardless of socioeconomic status 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.

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.

Health Equity – Social and Workforce Programs				
Goal: Identify community leaders to improve preventative care.				
Impact: Improve preventive health maintenance.				
Target Population	**Strategies**	**Action Steps**	**Measures**	**Partners and Resources**
• Greater WMH community	• Identify community leaders.	• Provide opportunity for preventive health screenings.	• Number of population health screenings.	• Chautauqua County Health Department
Goal: Improve cultural and linguistic services within our health care organization.				
Impact: Advance health equity, decrease healthcare disparities, and improve our overall quality of care outcomes.				
• Team members and patients	• Increase utilization of interpretive services.	• Review quarterly reports of language utilization data from the Institute for Strategic Social and Workforce Programs. • Ensure all employees are trained* and prepared to engage language services.	• Number of employees trained. • Increase in utilization of language services (vendor reports provided). • Number of complaints related to language services.	• CyraCom • The Institute for Strategic Social and Workforce Programs

*All AHN employees receive annual mandatory CLAS Standard training in Health Care Environment Training.

Reclassifying Health Equity programs as Social and Workforce Programs better reflects the broader scope of addressing disparities and improving health care access, outcomes, and workforce representation for all populations. It ensures a more direct focus on addressing systemic barriers to care, social determinants of health, and workforce development initiatives. The change aligns with Allegheny Health Network's health care priorities, emphasizing measurable strategies to improve community health outcomes and strengthen the health care workforce. By reframing this category, AHN aims to highlight tangible efforts to improve social well-being and create sustainable workforce solutions that enhance access to quality health care for everyone.

Conclusion

In conclusion, AHN Westfield recognizes that improving access to health care and addressing barriers to health are essential for creating a healthier community. By focusing on overcoming barriers such as access to care, food insecurity, substance use disorders, and mental health challenges, AHN Westfield is committed to ensuring that all individuals have the opportunity to receive the care they need. Through initiatives like expanding access to preventive services, increasing awareness of chronic conditions such as diabetes, heart disease, and cancer, and offering a broad range of care options, AHN Westfield aims to improve health outcomes and reduce health disparities in our community. AHN Westfield is dedicated to creating a health care environment where every individual has the opportunity to live a healthier life and where everyone's well-being is the top priority.

Tripp Umbach
Turning Ideas Into Action