Allegheny Health Network — AHN Saint Vincent Hospital

Community Health Needs Assessment

2024 Report

AHN SAINT VINCENT 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 Saint Vincent 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. In addition, community members are searching for family sustaining employment while the health care system is looking for qualified and dedicated team members.

• Behavioral Health: We believe that everyone deserves access to comprehensive and compassionate care for their mental health needs. However, we recognize many individuals continue to struggle in silence.

• Chronic Disease Management: Chronic diseases such as cancer are a growing concern in our community. These conditions not only impact individual health and well-being, but also place a significant strain on our loved ones, health care system, and local economy.

• Health Equity: We believe that everyone in our community deserves access to quality health care and the opportunity to live a healthy life. We must ensure that all residents have equal access to quality, culturally appropriate health care, regardless of background, primary language, or socioeconomic status.

This is not just a hospital initiative; it's a community-wide effort. We invite you to join us in building a healthier future for our community. Together, we can make a difference.

Sincerely,

Jim Benedict, JD, CPA, MAFIS, FACHE
President, Allegheny Health Network

Christopher Clark, DO, MHA
President, AHN Saint Vincent Hospital

About This Report

Community Health Needs Assessment Overview

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

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

AHN Saint Vincent'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 Saint Vincent 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 demographic, health, and socioeconomic factors at local, state, and national levels. 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 Saint Vincent'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.

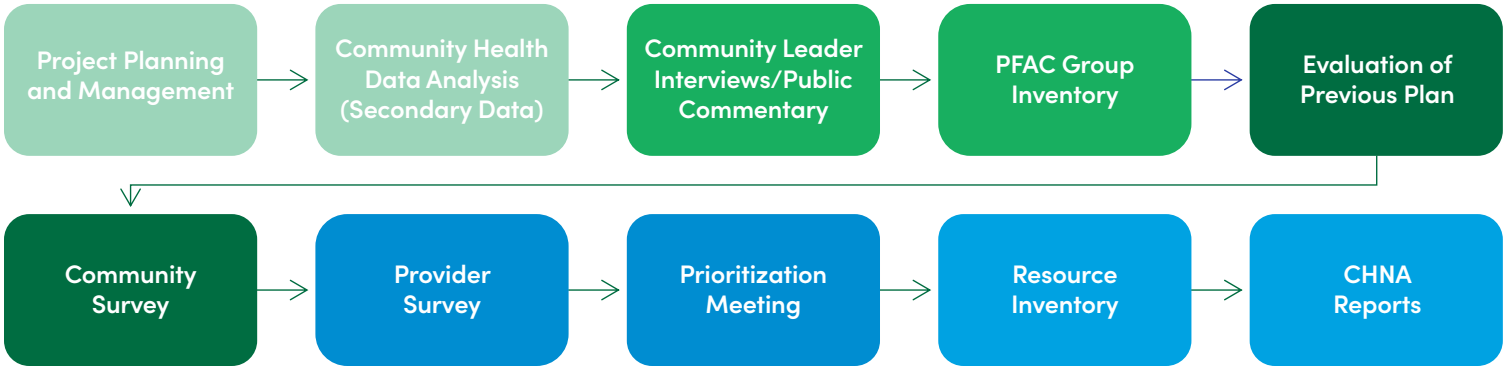
Community Health Needs Assessment Methodology

AHN and AHN Saint Vincent partnered with Tripp Umbach to carry out the 2024 CHNA for AHN Saint Vincent. 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 Saint Vincent. 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 Saint Vincent's assessment.

Community Health Needs Assessment 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 Saint Vincent 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 Saint Vincent gathered data through stakeholder interviews, group interviews, community surveys, and provider surveys to capture the community's perspectives.

County demographics and chronic disease prevalence 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 Saint Vincent

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, has 22,000 employees, and has more than 250 locations that provide 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 more than 3,000 physicians, residents, and fellows; 6,000 nurses; and 22,000 employees. The facilities have nine surgical centers, six regional cancer centers, and six health and wellness pavilions.

AHN encompasses a wide range of health care services, including acute care, outpatient services, rehabilitation, emergency care, and specialty programs. AHN is also recognized for its cutting-edge technology and research initiatives, focusing on advancing medical science and enhancing patient care.

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

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

Vision Statement: A world where everyone embraces health.

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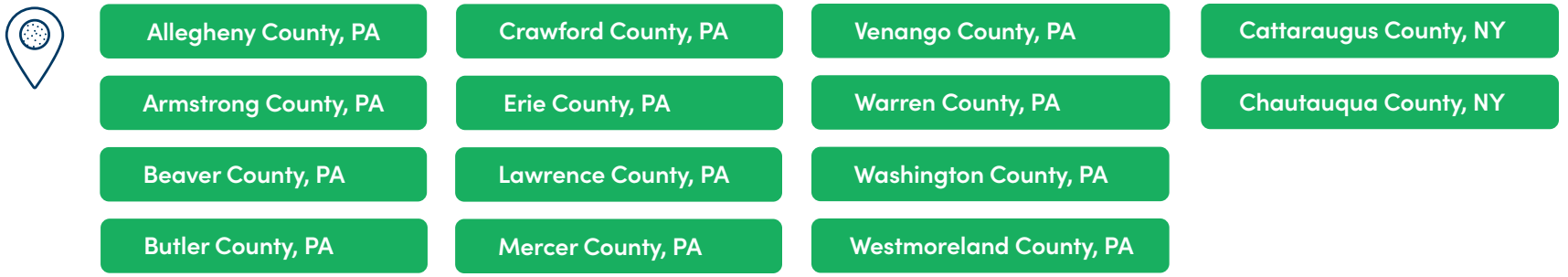
[1] Allegheny Health Network

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



Allegheny Health Network Saint Vincent Hospital

AHN Saint Vincent has served the people in the Lake Erie region since 1875 with a quality of care and service that is second to none. Their expansion and ongoing renovations strengthen the tradition of excellent and transformative health care. Providing various inpatient and outpatient services, along with multiple physician practices and outpatient medical facilities, AHN Saint Vincent has 836 physicians that serve Northwestern Pennsylvania and Southwestern New York regions.

AHN Saint Vincent has 348 full-service hospital beds and over 2,500 employees committed to delivering the highest quality patient care while providing a continuum of services to fit everyone's health care needs. AHN Saint Vincent remains a leader in cardiac, neurological, orthopedic, and women's services and offers patients diverse access to primary care and multiple other specialties.

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 Saint Vincent, 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 Saint Vincent is the primary provider of acute care services in the region. Therefore, hospital service data offers the most accurate representation of the community.

In 2024, 47 ZIP codes were identified as the primary service area for AHN Saint Vincent. The following table highlights the study area focus for AHN Saint Vincent's 2024 CHNA.

Figure 4: 2024 AHN Saint Vincent Hospital's Primary Service Area

Zip Code	Town	County
16327	Guys Mill	Crawford
16329	Irvine	Warren
16335	Meadville	Crawford
16340	Pittsfield	Warren
16350	Sugar Grove	Warren
16351	Tidioute	Warren
16534	Titusville	Crawford
16360	Townville	Crawford
16365	Warren	Warren
16371	Youngsville	Warren
16401	Albion	Erie
16402	Bear Lake	Warren
16403	Cambridge Springs	Crawford
16404	Centerville	Crawford
16405	Columbus	Warren
16407	Corry	Erie
16410	Cranesville	Erie
16411	East Springfield	Erie
16412	Edinboro	Erie
16415	Fairview	Erin
16417	Girard	Erin
16420	Grand Valley	Warren
16421	Harborcreek	Erie
16423	Lake City	Erie
16426	McKean	Erie
16428	North East	Erin
16430	North Springfield	Erin
16433	Saegertown	Crawford
16434	Spartansburg	Crawford
16436	Spring Creek	Warren
16438	Union City	Erie
16440	Venango	Crawford
16441	Waterford	Erie

Zip Code	Town	County
16442	Wattsburg	Erie
16443	West Springfield	Erie
16444	Edinboro	Erie
16501	Erie	Erie
16502	Erie	Erie
16503	Erie	Erie
16504	Erie	Erie
16505	Erie	Erie
16506	Erie	Erie
16507	Erie	Erie
16508	Erie	Erie
16509	Erie	Erie
16510	Erie	Erie
16511	Erie	Erie

AHN Saint Vincent Hospital Awards and Recognitions

For the ninth year in a row, Saint Vincent Hospital was voted Erie's Choice for Best Hospital by the readers of the Erie Times News for 2024.

In 2024, not only was the hospital recognized as the best by winning Erie's Choice, but AHN's Family Practice, and OB-GYN, Ellen Hancox, MD, were also recognized as the best.

AHA Gold Plus designation for Stroke and Heart Failure in 2024.

AHA Silver designation for Coronary Artery Disease NSTEMI in 2024.

Saint Vincent has been recognized by the American Heart Association and American Stroke Association for achieving 85% or higher adherence to all Get with the Guidelines Stroke Performance Achievement indicators for consecutive 12-month intervals in 2022, 2023, and 2024.

In 2023, The following CareChex were received:

- Recognized as top 100 in nation for medical excellence in Coronary Bypass Surgery.
- Recognized as #1 in market for medical excellence in Overall Medical Care.
- Recognized as #1 in market for patient safety in Cardiac Care.

2023 HAP Donate Life Pennsylvania Hospital Challenge Platinum Award Recipient.

In 2022, AHN Saint Vincent was recognized as a Magnet®-designated hospital for excellence in nursing. Only 9% of hospitals have achieved this designation.

AHN Saint Vincent received an A grade from the Leapfrog Group.

Rated Top 10% of hospitals in the Nation for Patient Safety in Overall Surgical Care, Patient Safety in Cancer Center, Patient safety in Cardiac Care, and Patient Safety in Joint Replacement.

Rated No. 1 hospital in Erie for Overall Hospital Care, Overall Surgical Care, Major Cardiac Surgery, Hip Fracture Care, Major Neurosurgery, Orthopedic Care, Pulmonary Care, Pneumonia Care, and Women's Health.

Highmark Blue Distinction recognition for maternity care, cardiac care, hip and knee replacement, and spine surgery.

AHN Saint Vincent was certified as a Primary Stroke Center by the Joint Commission.

AHN Saint Vincent is Accredited by the Commission on Cancer.

Nearly all of AHN Saint Vincent's primary care practices are recognized as Patient-Centered Medical Homes by the National Committee for Quality Assurance.

ACR Diagnostic Imaging Center of Excellence

SRC Center of Excellence in Urology

Becker's Healthcare Top Places to Work in Healthcare

AORN – Center of Excellence in Surgical Safety

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. It is important to note that while 26 organizations are listed, multiple individuals were interviewed representing the same organization. The qualitative data collected from these interviews capture the opinions, perceptions, and insights of the CHNA participants, offering valuable perspectives that enriched the qualitative analysis. Through these discussions, key health needs, themes, and concerns were identified. Each broad theme included several specific issues. Below are the primary themes highlighted by community stakeholders as the most significant health concerns in their area.

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

Figure 5: Community Stakeholder Summary Analysis

Community Stakeholder Summary Analysis: Community Residents

Largest Barriers (Top 5)

1. Affordability
2. Lack of transportation
3. Health literacy
4. No insurance coverage
5. Lack of health care coordination services

Persistent Health Problems (Top 5)

1. Behavioral/Mental Health
2. Heart Disease/Stroke
3. Obesity
4. Diabetes
5. Substance Use Disorder/Addiction

Significant Barriers to Improving Health & Quality of Life (Top 5)

1. Access to substance use/drug/alcohol resources
2. Access to behavioral health resources
3. Access to affordable prescription and OTC medication
4. Affordable, quality childcare
5. Affordable, quality housing/utilities

Persistent High-Risk Behaviors (Top 5)

1. Being overweight/obese
2. Drug abuse
3. Poor eating habits
4. Lack of exercise/physical inactivity
5. Alcohol abuse

Vulnerable Populations (Top 3)

1. Older adults
2. People living with mental illness
3. Low-income

What Should Be Offered to Maintain Optimal Health (Top 5)

1. Preventive health care services
2. Health promotion and education
3. Behavioral health/stress management
4. Community engagement and support
5. Access to healthy foods

Public Commentary

As part of the CHNA, Tripp Umbach gathered feedback on the 2021 CHNA and Implementation Strategy Plan on behalf of AHN Saint Vincent 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 Saint Vincent Hospital stakeholders 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 Saint Vincent Hospital stakeholders reported in their community, descending from the most to the least identified.

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

Figure 6: Community Survey Summary Analysis

Community Stakeholder Summary Analysis: Community Residents

Significant Health Problems (Top 5)

1. Overweight/Obesity/Diabetes
2. Behavioral health
3. Heart disease/stroke/high blood pressure
4. Substance use disorder/addiction
5. Cancer

Risky Behaviors (Top 5)

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

Health Factors Contributing to Healthy Community (Top 3)

1. Access to affordable prescription/OTC medication
2. Access to affordable preventative screenings and vaccinations
3. Access to affordable healthy food options

Social Factors Contributing to Healthy Community (Top 3)

1. Overall feeling of safety/security
2. Affordable, safe, quality housing/utilities
3. Adequate employment

Factors that Improve Quality of Life in the Community (Top 5)

1. Access to affordable prescription and OTC medication
2. Affordable, safe, quality housing/utilities
3. Access to affordable healthy food options
4. Access to mental health resources
5. Affordable, quality child and/or senior care options

Provider Survey

A provider survey was employed to capture health care professionals' unique insights and experiences interacting directly with the community. Providers offer perspectives on emerging health trends, service gaps, barriers to care, and population health challenges. Their input helps identify both unmet needs and existing resources, guiding the development of targeted strategies to improve health outcomes. Additionally, provider surveys enhance the credibility of the CHNA by incorporating expert opinions, ensuring that recommendations align with the realities of health care delivery and the population's specific needs.

The provider survey was conducted from September 4 through September 15, 2024, during which time 232 surveys were collected for analysis. The responses below summarize the key results from the survey.

Figure 7: Provider Survey Summary Analysis

Provider Survey Summary Analysis

Community

Most Important Health Factors (Top 3)

1. Access to affordable prescription and OTC medication
2. Access to mental health resources
3. Access to healthy food options

Most Important Social Factors (Top 3)

1. Affordable, safe, quality housing
2. Adequate employment
3. Overall feeling of safety and security

AHN Hospitals

1. Address the needs of diverse and at-risk population
2. Ensure access to care for everyone, regardless of race, gender, education, and economic status

Economics

Barriers to Care (Top 5)

1. Affordability
2. Availability of services
3. No insurance coverage
4. Lack of transportation
5. Lack of health care coordination services

What is needed to improve quality of life and health

1. Access to affordable prescription and OTC medication
2. Access to mental health resources
3. Access to affordable healthy food options
4. Affordable, safe, quality housing and utilities
5. Affordable, quality child and/or senior care options

Health

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

Population

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 Saint Vincent Hospital have been focused on developing and implementing strategies to address the health needs and concerns in the study area. Additionally, AHN Saint Vincent 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 Saint Vincent Hospital has addressed the following strategies.

Social Determinants of Health

Health Priority: Transportation

Goal: Connect patients with transportation services.

Figure 8: SDOH Access to Care Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
• Set up transportation agreement with Vantage Home Medical (VHMES).	• Sign transportation agreement with VHMES. • Market service for patients who require transportation service. • Identify patients (Med/Non-Med taxi) who benefit from the service. • Increase volume so the vehicle can be stationed at the hospital. • Monitor invoices and request volume data from Vantage.	X	X	X	• Number of patients who utilize service.	• Provided transport services to 2,777 patients.
• Identify and increase transportation services for patients who are receiving care at the Cancer Center.	• Explore Road to Recovery Program (American Cancer Society). • Connect Patients with LIFT Paratransit Services (Erie County). • Ask Legal to review the Traveler's Aid contract (third-party coordination of transport services). • Explore CATA service for patients in Crawford.				• Number of patients who access transportation services. • Number of transportation services identified.	

Health Priority: Workforce Development

Goal: Work with community partners to develop new and innovative workforce initiatives.

Figure 9: SDOH, Workforce Development Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
• Expand the Project Search program with a goal of recruiting 12 students each year.	• Continue to work with Erie City Schools to identify candidates. • Explore expansion into neighboring school districts.	X	X	X	• Number of students in the Project Search Program.	• Completed Project Search with 33 students
• Develop a partnership with Edinboro University for a Medical Assistant Program.	• Work with Edinboro University to develop the program. • Meet with University Staff to define program parameters. • Identify interested students (target population).	X	X	X	• Number of students enrolled in the program.	• Have 20 students enrolled in TAP

Health Priority: Access to Care

Goal: Connect patients to primary care providers (PCPs).

Figure 10: SDOH, Access to Care 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 new PCP visits.	• Identify unattributed patients through the scheduling tool. • Identify unattributed patients through biometric screening. • Partner with the Clinical Access Team. • Implement centralized scheduling. • Utilize Meet Dr. Right events.	X	X		• Number of patients connected to a PCP • Number of participants at community events • Number of new patient visits • Number of online scheduled calls • Number of same-day appointments	• Served 1,209 unattributed patients • Completed 153 new patient appointments • Conducted 102 new patient appointments
• Develop a partnership with Mercy Center for Women to set up a PCP clinic in their facility.	• Tour facility under renovation to identify clinic space. • Meet with Mercy Center leadership to set operational goals and benchmarks. • Identify hospital resources to support the clinic.	X	X	X	• Number of patients who access PCP clinic.	• Clinic space renovated in 2022 • Internal meetings continued through 2023 regarding services at new clinic space. Primary Care Institute to start seeing patients who lack health insurance • AHN Primary care to start providing services in 2024. Working on Timeline & Schedule • Lease agreement being finalized • Primary care and Behavioral Health services to be provided

Health Priority: Food Insecurity, Diet, and Nutrition

Goal: Identify and address food insecurity for AHN hospitals/community.

Figure 11: SDOH, Food Insecurity, Diet, and Nutrition Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
• Educate providers and community-based organizations (CBOs) on food insecurity screening and referral process. Identify food-insecure patients and community members through the SDOH screening tool.	• Patients who screen positive for food insecurity will receive a referral to the Healthy Food Center • Assess the needs of the population served (i.e., food access, transportation, utilities, education, recipes, and other SDOH needs) • Provide healthy foods based on individual needs- chronic disease/ preference/cultural, provide tailored education, connections to community resources, wrap-around services (i.e., SNAP, WIC)	X	X	X	• Number of patients referred to the Healthy Food Center • Number of patients who complete referrals and visits (new vs. follow-up) • Total number of people served • Total number of meals provided	• Conducted 508 patient follow-ups • Served 2,917 total clients • Had 305 referrals • Distributed 24,400 total meals • 85 families received a Thanksgiving dinner box; served 215 people

Behavioral Health

Health Priority: Substance Use Disorder

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

Figure 12: Behavioral Health, Substance Use Disorder Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
• Increase access to community-based education sessions.	• Provide community-based seminars and programs on substance use disorder. • Provide community events that increase awareness of available services to support recovery. • Screen overdose patients coming to the ED for criteria meeting medication-assisted treatment (MAT). • Begin medicating patients who meet the criteria and transition to Gaudenzia for detox. • Education to EMS and the Public of Detox Services.			X	• Number of events. • Number of participants. • Number of patients in MAT. • Number of patients in the warm handoff program.	• Meeting with local Recovery Medicine Team to identify metrics to collect and report in Q3 and Q4 of 2024 • Recovery Medicine Team will collect number of attendees and any marketing initiatives to increase meeting attendance and report in Q3 and Q4 of 2024

Health Priority: Mental Health Services

Goal: Increase knowledge and access to mental health programs and services.

Figure 13: Behavioral Health, Mental Health Services Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
• Increase access to BH programs and services through community-based seminars and programming	• Provide BH programming and education in the community. Develop a list of BH programs and services offered in the community	X	X	X	• Number of outreach events and programming that occurs in the community. Number of people addressed.	• Completed 9,499 new and established patient appointments
• Increase awareness and engagement of BH services through various media, TV, radio, and social media initiatives.	• Develop a list of community BH programs and services to market • Develop marketing strategy for these services. Develop content to be distributed through various media platforms	X	X	X	• Number of new marketing initiatives. • Attendance at community outreach events.	• Participated in Wellness Expo at SVH • Dr. Yang presented at Friends of SVH Meeting • Participated in Panera's Fundraiser for Children's Behavioral Health • Erie County BIPOC Mental Health Seminar • Interviewed on TV regarding Seasonal Affective Disorder and Mental Health Awareness Day • Dr. Yang on WICU (NBC) and WSEE (ABC) to discuss SSRI Medication and the Heat • Events at Grove City College • Events at Brocton School District (NY) • Three (3) media events highlighting services provided

Health Priority: Postpartum Depression

Goal: Increase awareness, education, and screening for perinatal mood disorders

Figure 14: Behavioral Health, Postpartum Depression Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
• Increase education and awareness of perinatal mood disorders.	• Develop Perinatal Intensive Outpatient Program (Started 2/21). • Educate providers on the program and how to make referrals. • Attend community mental health events (Out of Darkness Walk). • Community education for providers and organizations. • Clinical education for Med Students and Staff in Mental Health.	X	X		• Number of referrals to Perinatal IOP. • Number of patients receiving services. • Number of educational events (Community & Clinical).	• Community partners during 2022: - Baby & Me Tobacco Free - Crime Victims Center - Birthroot Doulas - Erie Family Center - Esper Treatment Center - Gaudenzia - Stairways - UPMC Baby Steps - WIC - Erie Diaper Bank - Barber Institute - Sarah Reed - Mindful Mom's Support Group - La Leche League - Emma's Footprint - Adagio - 8 Great Tuesdays
• Increase behavioral health screenings for women utilizing evidence-based screening tools.	• Identify screening tools (EPDS, PASS, MDQ) • Develop a screening process for patients.	X	X		• Number of patients screened	• Screened 1,240 patients and referred 700

Chronic Disease

Health Priority: Diabetes

Goal: Improve management and outcomes for patients diagnosed with diabetes.

Figure 15: Chronic Diseases, Diabetes Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
Connect patients with community-based diabetes prevention programs	• Identify patients in the office (Medical Nutrition TX, RD/Diabetes Educators) who could benefit from diabetes prevention programs. • Refer patients to community partners for diabetes prevention programs (Sight Center of NWPA, YMCA).				• Number of patients identified for referral to diabetes prevention program • Number of referrals made	• Data will be available after publication of this report
Improve self-management skills and outcomes for patients with diabetes.	• Identify patients with diabetes who would benefit from self-management and training programs. • Define metrics to measure the impact of education and training programs.				• Number of patients receiving diabetes self-management and training • Impact on the health of patients who have completed the program (Define Metrics)	• Data will be available after publication of this report

Health Priority: Cancer

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

Figure 16: Chronic Diseases, Cancer Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 – June 30, 2024
• Provide community-based cancer screening events.	• Provide community cancer screening and education events.	X	X	X	• Number of screening events. • Number of participants.	• Screened 422 for cancer • Held four community screening events
• Increase CT lung cancer screening utilization.	• Implement Lung Cancer Screening Navigation. • Expand CT Lung Screening" access/ locations.	X	X	X	• Number of studies performed.	• Screened 2,270 for lung cancer

Health Priority: Obesity

Goal: Improve management and outcomes for patients with obesity risk factors.

Figure 17: Chronic Diseases, Obesity Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
• Increase community-based education programs.	• Work with local school districts on childhood obesity education. • Coordinate programming and BMI screenings for health fairs. • Provide nutrition-focused lectures. • Identify participants through the biometric screening process.				• Number of patients counseled on risk factors.	
• Educate the community on the correlation between weight and health.	• Partner with community organizations to provide education on obesity. • Increase events that encourage health and wellness activities that include physical exercise, nutritional counseling, stress management and prediabetes education.				• Number of community-based education events. • Number of participants.	

Health Equity

Goal: Increase access to care for patients in need of an interpreter and translation services.

Figure 18: Health Equity Strategies from 2021 CHNA and ISP

Strategies	Action Steps	2022	2023	2024	Metrics Per Year	Summary of Outcomes 2022 - June 30, 2024
• Develop a system for patients calling the hospital who require interpreter services.	• Work with telephone operators and interpreters to set up processes when patients call the hospital with interpretation needs.	X	X	X	• Work with telephone operators and interpreters to set up processes when patients call the hospital with interpretation needs.	• Language services and Cyracom translation services provided to over 435 patients; translated over 11 different languages. • Served over 3,410 patients with language services; Provided Cyracom translation on average of 13-23 languages with Spanish being #1 and Arabic #2.
• Provide patients with translated documents.	• Review the current program for translation of hospital menus. • Expand the program to identify and include additional documents for translation.				• Review the current program for translation of hospital menus. • Expand the program to identify and include additional documents for translation.	

Challenges Impacting CHNA Objectives, Path Forward Strategy

The objective and strategy shortfalls from the 2021 CHNA and ISP for AHN Saint Vincent Hospital reflect challenges in multiple key areas, such as transportation, access to care, and specific health conditions like substance abuse disorder, postpartum depression, diabetes, and obesity. Additionally, under the Health Equity objective, AHN Saint Vincent was unable to track the second strategy related to translated documents. This gap in addressing language barriers represents a missed opportunity to improve health equity and access for diverse patient populations, which is essential for reducing disparities in care. These challenges reflect broader difficulties in implementing and monitoring key health initiatives throughout the CHNA cycle.

To ensure success, AHN Saint Vincent is focusing on improving data tracking and reporting processes, particularly in areas like transportation, substance abuse disorder, and health equity, where gaps in data collection may have hindered the progress. Strengthening partnerships with community organizations, setting clear and measurable goals, and establishing consistent data collection protocols will be essential for overcoming these challenges. Additionally, focusing on health equity by prioritizing language access, such as providing translated documents, can significantly improve patient outcomes and reduce disparities. By addressing these opportunities with renewed focus, AHN Saint Vincent will more effectively meet the health needs of its community and further improve overall health outcomes.

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 Saint Vincent 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 Saint Vincent Community at a Glance

Figure 19: Population

	Total Population	Males	Females
Crawford County	83,876	41,371	42,505
Erie County	270,495	134,616	135,879
Warren County	38,492	19,478	19,014
Pennsylvania	12,989,208	6,410,766	6,578,442

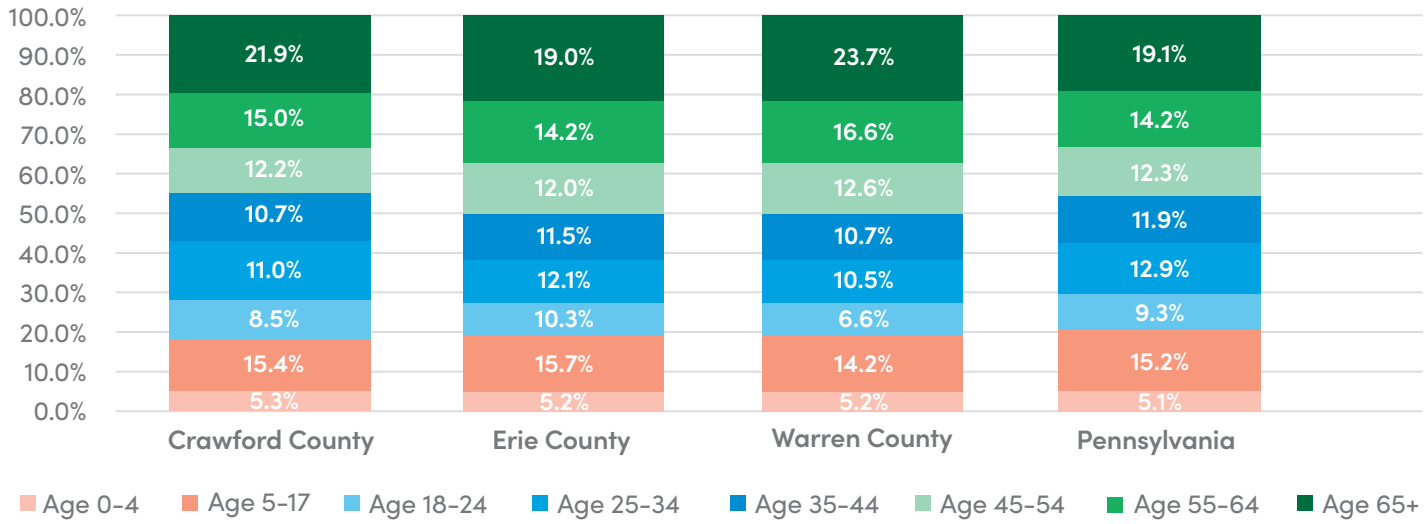
Source: U.S. Census Bureau, American Community Survey 2018-2022

Figure 20: Race

	White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Races
Crawford County	92.7%	1.8%	0.5%	0.2%	0.0%	0.6%	4.2%
Erie County	82.2%	7.6%	2.4%	0.2%	0.0%	1.7%	5.9%
Warren County	94.5%	0.4%	0.4%	0.2%	0.0%	0.3%	4.2%
Pennsylvania	75.0%	11.0%	3.9%	0.2%	0.0%	3.9%	6.0%

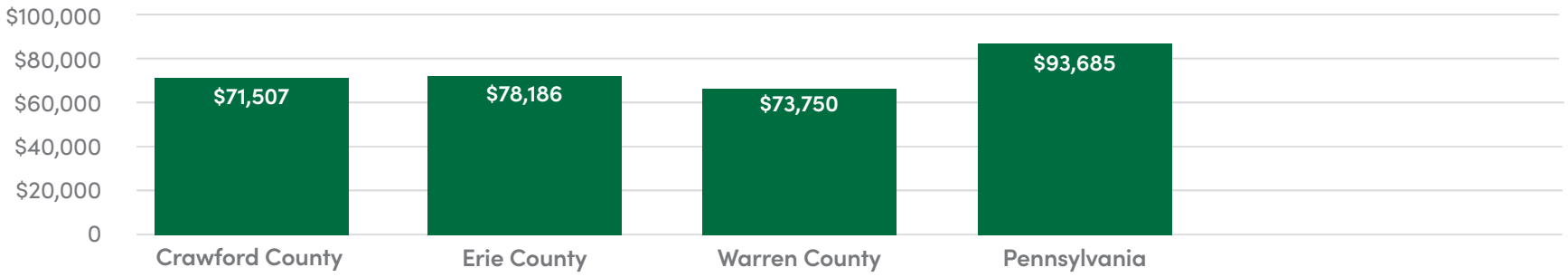
Source: U.S. Census Bureau, American Community Survey, 2020

Figure 21: Age Distribution



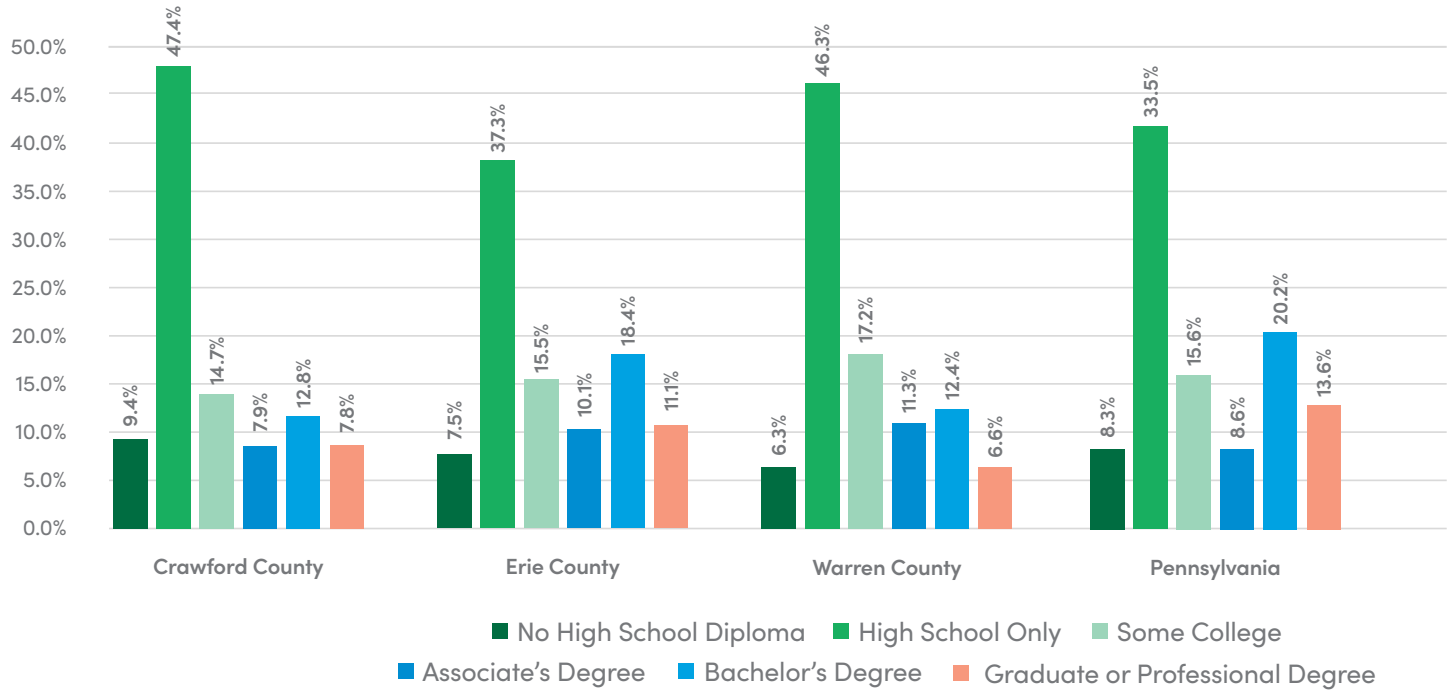
Source: Census Bureau, American Community Survey 2020

Figure 22: Median Household Income



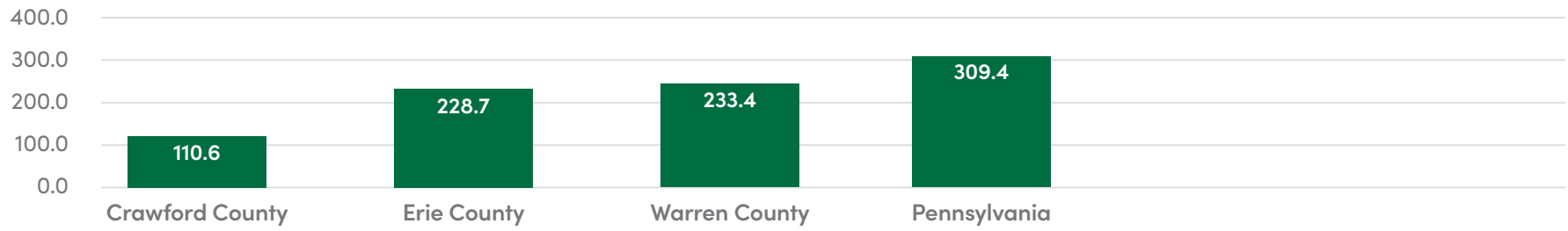
Source: Census Bureau, American Community Survey, 2018-2022

Figure 23: Education Attainment



Source: Census Bureau, American Community Survey, 2020

Figure 24: Violent Crime (per 100,000 population)



Source: Census Bureau, American Community Survey 2020

Figure 25 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 25: Substandard Conditions

Report Area	No Conditions	One Condition	Two or Three Conditions	Four Conditions
Crawford County	77.06%	21.20%	1.72%	0.02%
Erie County	73.09%	25.78%	1.14%	0.00%
Warren County	81.29%	17.69%	0.94%	0.07%
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 26 reveals that all three counties worsened their social and economic factor rankings from 2020 to 2023.

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.[3] 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.[4]

Figure 26: County Health Rankings: (1-67 Counties in PA) (1=Healthiest)

	Year	Health Outcomes	Health Factors	Mortality	Morbidity	Health Behaviors	Clinical Care	Social & Economic Factor	Physical Environment
Crawford County	2023	48	46	45	50	46	29	47	28
	2020	52	48	50	52	61	41	31	27
Erie County	2023	46	48	35	56	52	13	**60**	24
	2020	57	58	43	64	65	21	54	42
Warren County	2023	19	**29**	12	43	**42**	32	**26**	**10**
	2020	26	23	15	45	34	25	24	4

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

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

[4] 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.

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.

In summary, 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 Process

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?

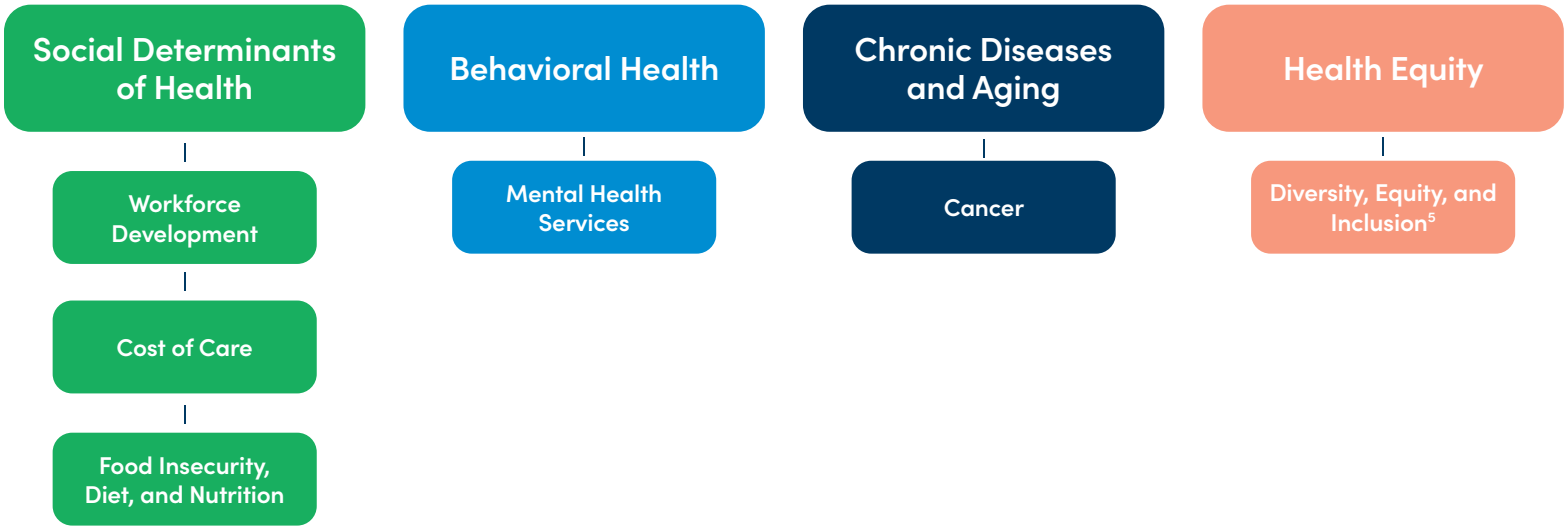
Identification and Prioritization Process

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 as a part of AHN serve a 14-county area and employ more than 22,000 people. The 2024 CHNA for Saint Vincent highlighted the following community needs:

Figure 27: AHN Saint Vincent Hospital 2024 CHNA Needs Assessment



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

A.) Social Determinants of Health

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

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

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

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[6] Healthy People 2030

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.

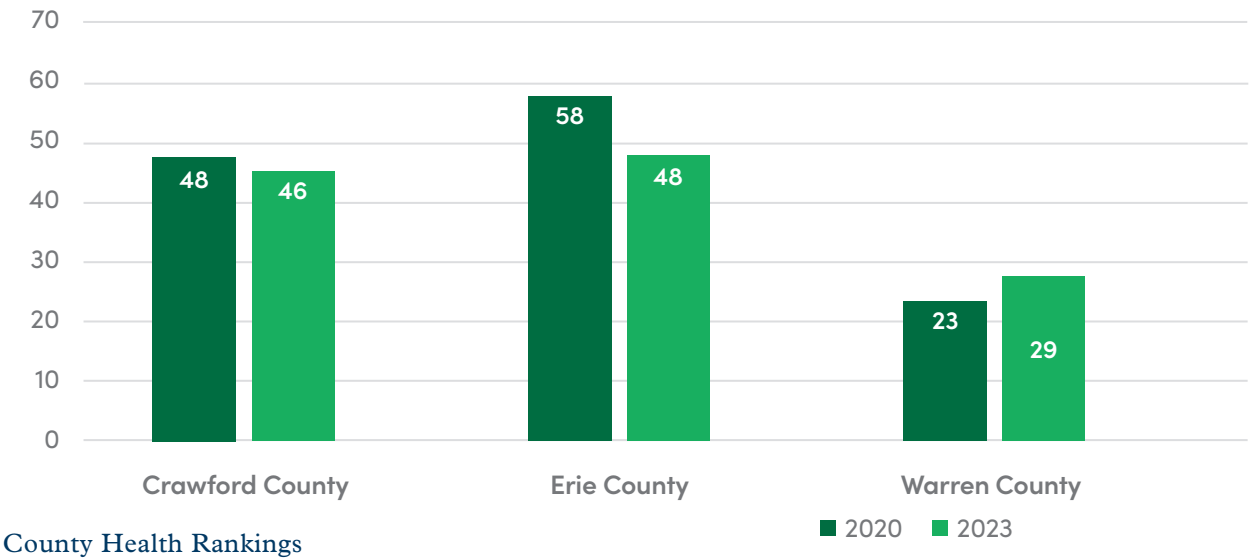
Figure 28: Social Determinants of Health

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 29 below shows that Crawford and Erie County improved their health factor rankings from 2020 to 2023, whereas Warren County worsened their health factor ranking.

Figure 29: : Health Factor Rankings



Source: County Health Rankings

Figure 30 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 30: Engaging the Community

Stakeholder Interviews	PFAC Group Interviews	Community Survey	Provider Survey
• Affordability (i.e., out-of-pocket costs/high deductibles/copays) • Lack of transportation • Health literacy (i.e., inability to comprehend the information provided) • No insurance coverage (uninsured/underinsured) • Lack of health care coordination services (i.e., not being able to navigate the healthcare system) • Access to substance use/ drug/alcohol resources • Access to behavioral health resources • Access to affordable prescription and over-the-counter medication • Affordable, quality childcare	• Health care navigation and health care coordination • Lack of providers • Food insecurity • Transportation • Housing insecurity • Not enough specialists • Cost of services	• Access to affordable prescription and over-the-counter medication • Affordable, safe, quality housing/ utilities • Access to affordable healthy food options • Access to mental health resources	• Affordability • Availability of services • No insurance coverage • Lack of transportation • Lack of health care coordination services

Workforce Development

Workforce Development was identified as a prioritized health need for AHN Saint Vincent Hospital based on the provider survey results and AHN Saint Vincent Hospital's capacity to implement a workforce development program. Workforce development is vital in shaping SDOH by improving access to economic opportunities, enhancing job skills, and promoting overall economic stability. By providing individuals with the education, training, and support necessary to obtain quality jobs, workforce development helps secure stable employment closely tied to better health outcomes. Employment offers financial resources and access to employer-sponsored health benefits, which can significantly reduce barriers to health care. Research shows that individuals with steady, well-paying jobs are more likely to access preventive care and engage in healthy behaviors, reducing the risk of chronic illnesses.

Additionally, workforce development initiatives contribute to SDOH by promoting a skilled labor force, which ensures that health care systems and other industries have the workforce necessary to provide quality services. For example, efforts to train health care workers, especially in underserved areas, can help alleviate provider shortages and improve access to medical care. In rural communities or economically disadvantaged urban areas, workforce training programs focusing on building local health care capacity can lead to more health care professionals working in these regions, helping close the health care access gap and outcomes.

Moreover, workforce development has a broader societal impact by addressing systemic inequities. Vulnerable populations often face barriers to obtaining high-quality education and job opportunities. Workforce development programs that focus on equity, such as those providing vocational training, mentorship, or job placement services, can help break the cycle of poverty and reduce health disparities. When more individuals from these communities have access to stable employment and financial security, they are better positioned to afford housing, transportation, and other key health determinants.

In the long term, investing in workforce development strengthens the economy and reduces societal costs associated with poor health outcomes. When individuals have access to jobs that pay a living wage and offer health benefits, they are less reliant on public assistance programs and emergency health care services, which reduces the strain on public resources. Additionally, by building a workforce that can adapt to changing economic demands, communities become more resilient, and individuals are better prepared to weather economic downturns, further supporting long-term health and well-being.

Figure 31: Percentage of Unemployed Population >16 but Seeking Work

	Year	Unemployment
Crawford County	2022	4.8%
	2021	6.7%
Erie County	2022	5.0%
	2021	7.3%
Warren County	2022	4.7%
	2021	6.7%
Pennsylvania	2022	4.4%
	2021	6.3%

Source: County Health Rankings

Figure 32 below shows the household income ratio at the 80th percentile to income at the 20th percentile. This means when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes. The 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.

Figure 32: Income Inequality

	Inequality Ratio
Crawford County	4.1
Erie County	4.8
Warren County	3.8
Pennsylvania	4.8

Source: County Health Rankings, 2018-2022

Cost of Care

Cost of care was identified as a prioritized health need for AHN Saint Vincent Hospital based on the stakeholder interviews and provider survey results as well as the secondary data analysis. In addition to those data points, AHN Saint Vincent 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.

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. 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 healthcare 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.

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[10] West Health-Gallup Affordability Index

[11] Marketplace.org

Figure 33: Income Inequality

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

Source: America's Health Rankings

Figure 34: Federal Poverty Line (FPL)

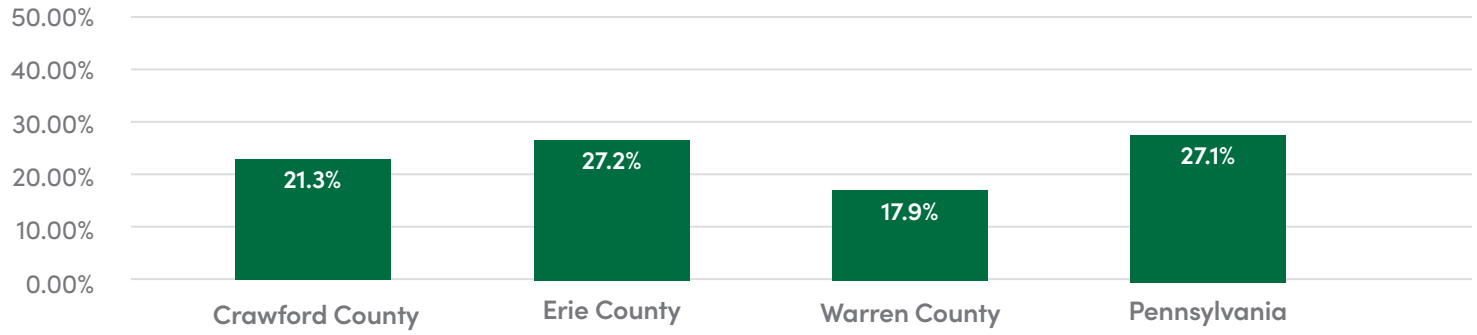
	Children Below 100% FPL	Children Below 200% FPL	Population Below 100% FPL	Population Below 200% FPL
Crawford County	**17.42%**	**48.30%**	**12.7%**	**35.6%**
Erie County	**21.51%**	**44.73%**	**15.4%**	**34.3%**
Warren County	**17.37%**	**41.78%**	11.6%	**31.3%**
Pennsylvania	16.15%	35.03%	11.8%	26.9%

Note: The numbers in bold indicate the percentage is higher than the state percentage. The FPL in 2022 was $13,590 for an individual, $26,500 for a family of four.

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

Figure 35 below reports the percentage of households where housing costs are 30% or more of total household income.

Figure 35: 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 Saint Vincent Hospital based on the community survey and provider survey results as well as the secondary data analysis. In addition to those data points, AHN Saint Vincent 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 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. 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 USDA, more than 47 million people in the U.S., including one in five children, are food insecure. 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.

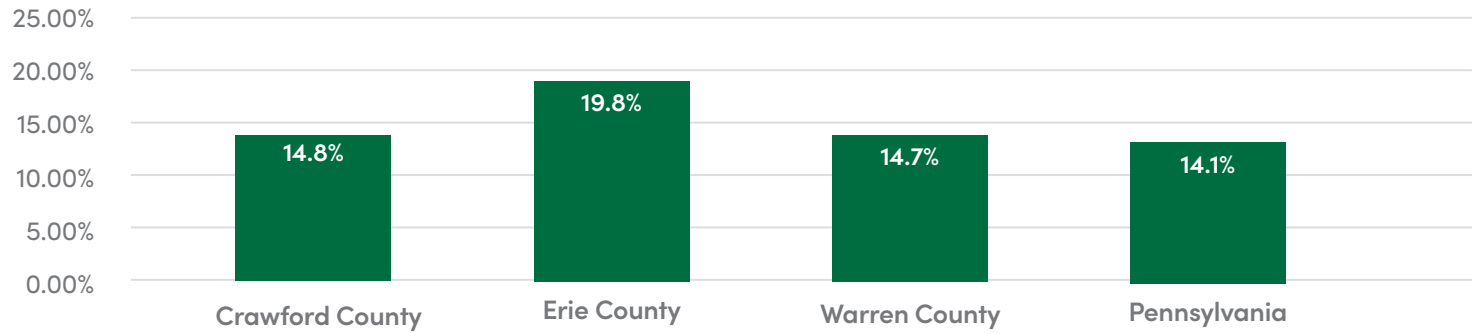
Diet and nutrition are key health factors, influencing everything from physical health to cognitive development. A diet lacking essential nutrients can impair immune function, reduce energy levels, and increase susceptibility to illness. Furthermore, poor nutrition in early childhood has long-term consequences,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

[10] The National Library of Medicine
[11] U.S. Department of Agriculture

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. 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.

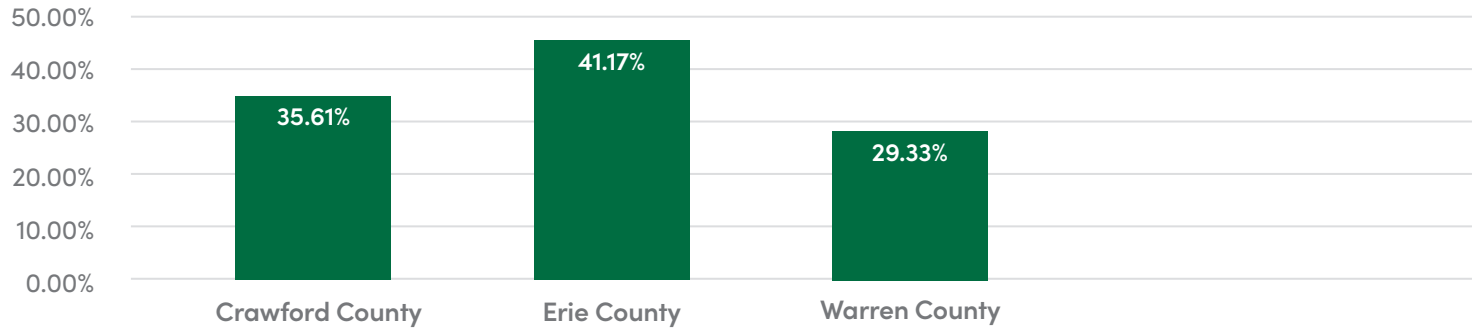
Figure 36: Unmarried Partner Households Receiving SNAP Benefits



Source: U.S. Census Bureau, 2021

[14] Pew Research Center

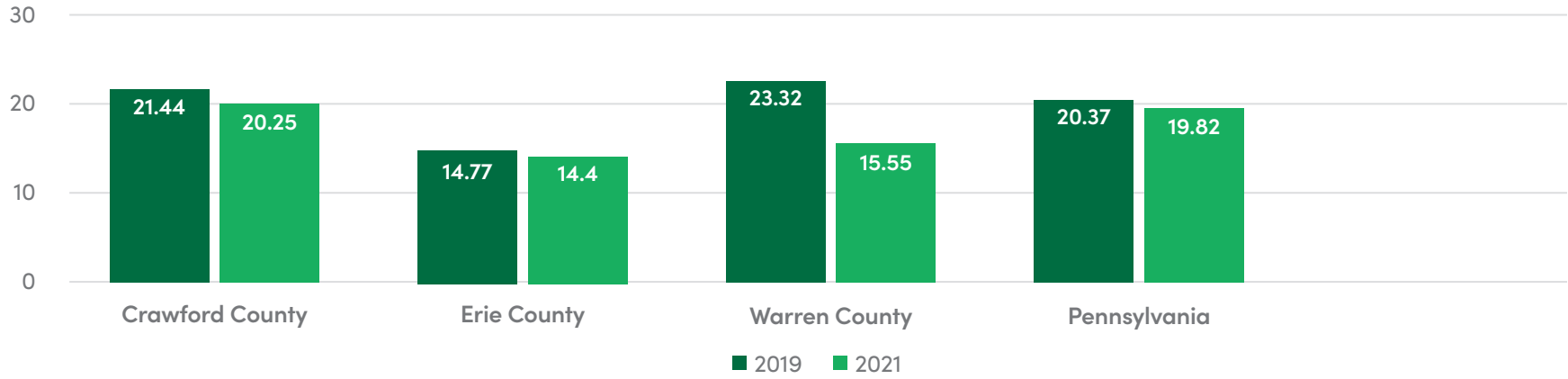
Figure 37: Unmarried Partner Households Receiving SNAP Benefits



Source: The Agency for Healthcare Research and Quality, 2020

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in 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.

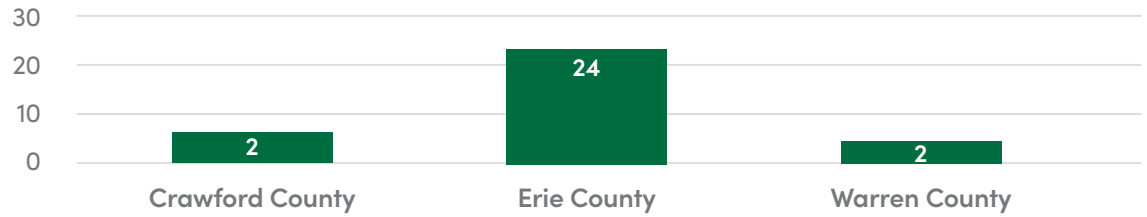
Figure 38: Food Environment – Grocery Stores (per 10,000 population)



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.

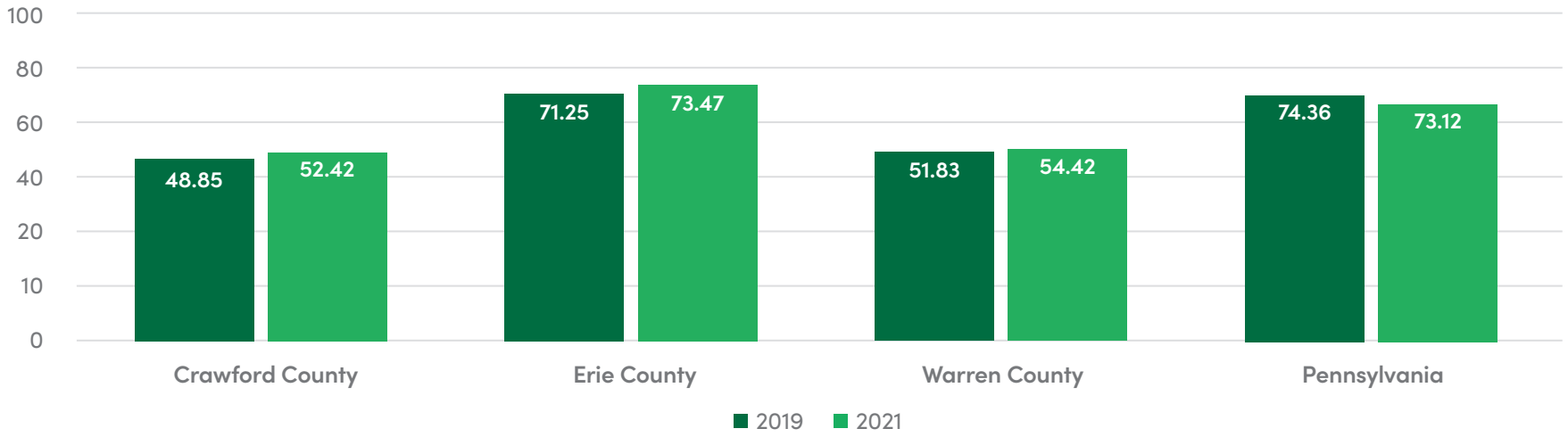
Figure 39: Food Environment – Food Desert Census Tracts



Source: U.S. Census Bureau, 2019

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

Figure 40: 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 Saint Vincent 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 Saint Vincent 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 health care providers, policymakers, community organizations, and residents to develop effective solutions that enhance mental health care across the region.

[7] Kaiser Family Foundation

Figure 41: 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

Mental Health Services

Mental health services was identified as a prioritized health need for AHN Saint Vincent 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 Saint Vincent Hospital considered their capacity to implement mental health programming. The mental health care landscape in Pennsylvania is similarly complex. The demand for mental health services has surged in recent years, worsened by the COVID-19 pandemic, which led to increases in anxiety, depression, and stress-related conditions among the population. Around 19.7% of adults, nearly 2 million people, experience some form of mental illness, placing Pennsylvania 17th in the nation for mental illness prevalence. In Pennsylvania, 51.9% of adults with mental illness do not receive the treatment they need, impacting more than 1 million Pennsylvanians. This issue is even more critical considering the state's suicide rate, which includes 482,000 adults suffering from suicidal thoughts.

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

Expanding access to mental health services, ensuring adequate insurance coverage, and addressing barriers such as provider shortages are essential to tackling these challenges. Additionally, targeted interventions are required for underserved populations, including those facing socioeconomic hardships Figure 42 below shows the average number of mentally unhealthy days reported in the past 30 days (age-adjusted).

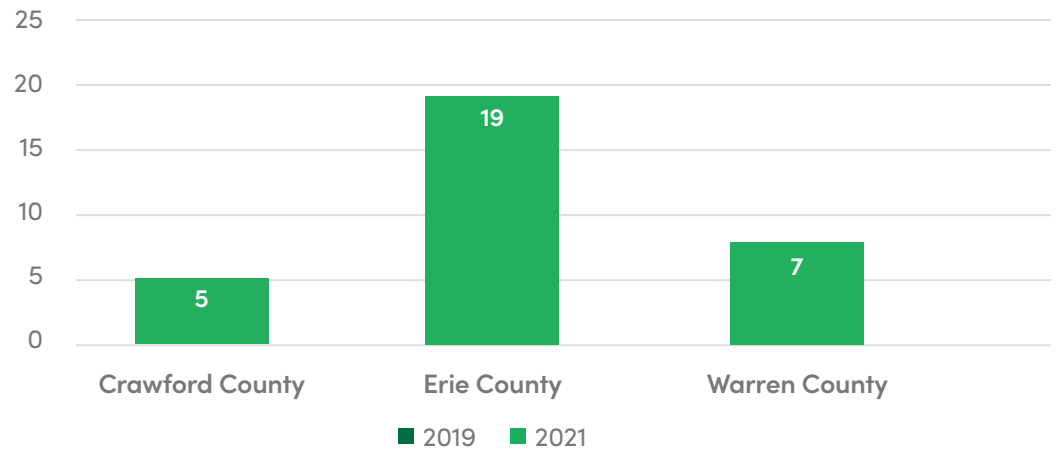
[8] Pennsylvania Department of Health
[9] Pennsylvania Office of the Attorney General

Figure 42: Poor Mental Health Days

	Average Number of Mentally Unhealthy Days in the Past 30 Days
Crawford County	5.4
Erie County	5.1
Warren County	5.1
Pennsylvania	4.7

Source: County Health Rankings, 2021

Figure 43: Facilities That Provide Mental Health Services



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

Figure 44: Ratio of Population to Mental Health Providers

	Mental Health Providers Rate (per 100,000 population)
Crawford County	600:1
Erie County	380:1
Warren County	730:1
Pennsylvania	370:1

Source: County Health Rankings, 2023

C.) Chronic Diseases and Aging

Chronic diseases and aging was identified as a prioritized health need for AHN Saint Vincent 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 Saint Vincent 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. 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. 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. 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. 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.

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[18] Centers for Disease Control and Prevention

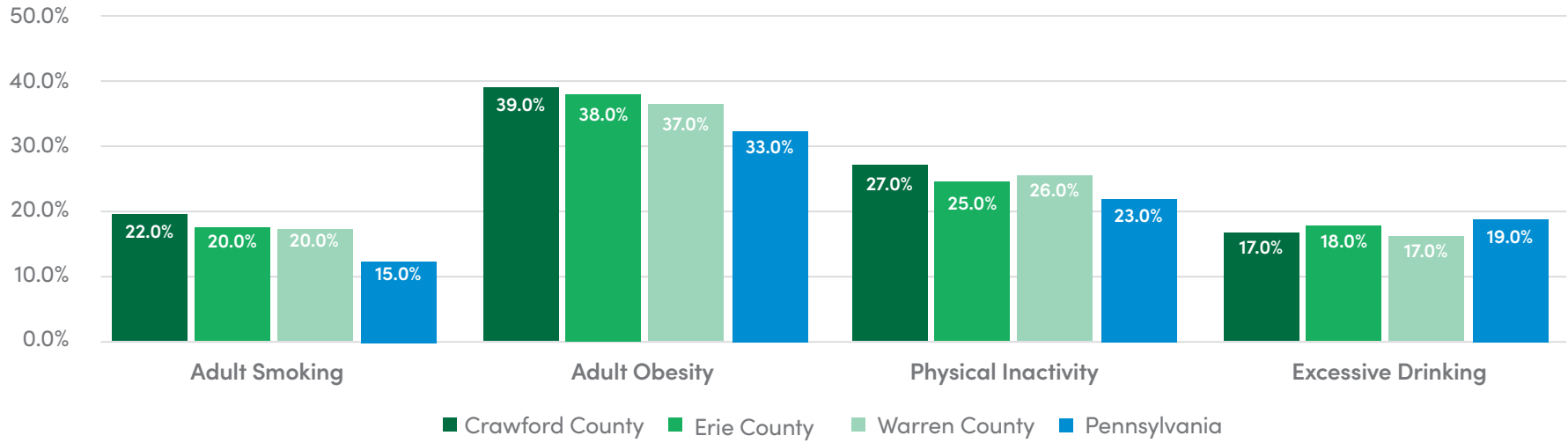
[19] Centers for Disease Control and Prevention

[20] 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.

[21] 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.

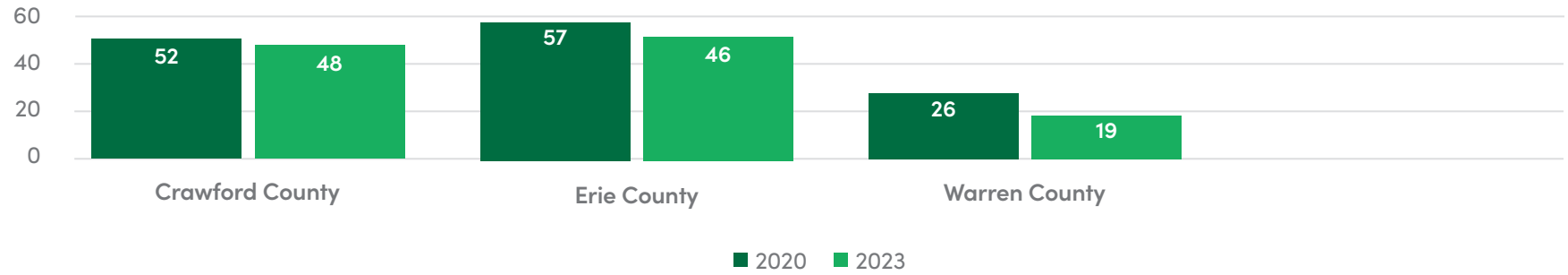
Figure 45: Behaviors Leading to Chronic Conditions



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 46 below shows that all counties in AHN Saint Vincent's service area improved their health outcomes rankings.

Figure 46: 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 47 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 47: Engaging the Community

Stakeholder Interview	PFAC Group Interviews	Community Surveys	Focus Groups/ Interviews
• 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 • Poor eating habits • Lack of physical activity • Unmanaged stress or anxiety • Unsafe driving (DUI, speeding, road rage)	• Behavioral health • Overweight/obesity/diabetes • Substance use disorder/ addiction • Heart disease/stroke/high blood pressure • Cancer

Cancer

Cancer was identified as a prioritized health need for AHN Saint Vincent Hospital based on the community survey results as well as the secondary data analysis. In addition to those data points, AHN Saint Vincent Hospital considered their capacity to implement cancer-related programming. Cancer is a significant chronic disease in Pennsylvania, affecting thousands of residents each year. In a study by the American Cancer Society, the number of cancer diagnoses and deaths is expected to climb in 2024. The study says about 89,410 people in Pennsylvania are projected to be diagnosed with cancer for 2024, and 27,570 people are expected to die. That is slightly up from the organization's 2023 projection of 88,450 diagnoses and 27,460 deaths.

Figure 48: Pennsylvania New Cancer Diagnoses Estimates, 2024

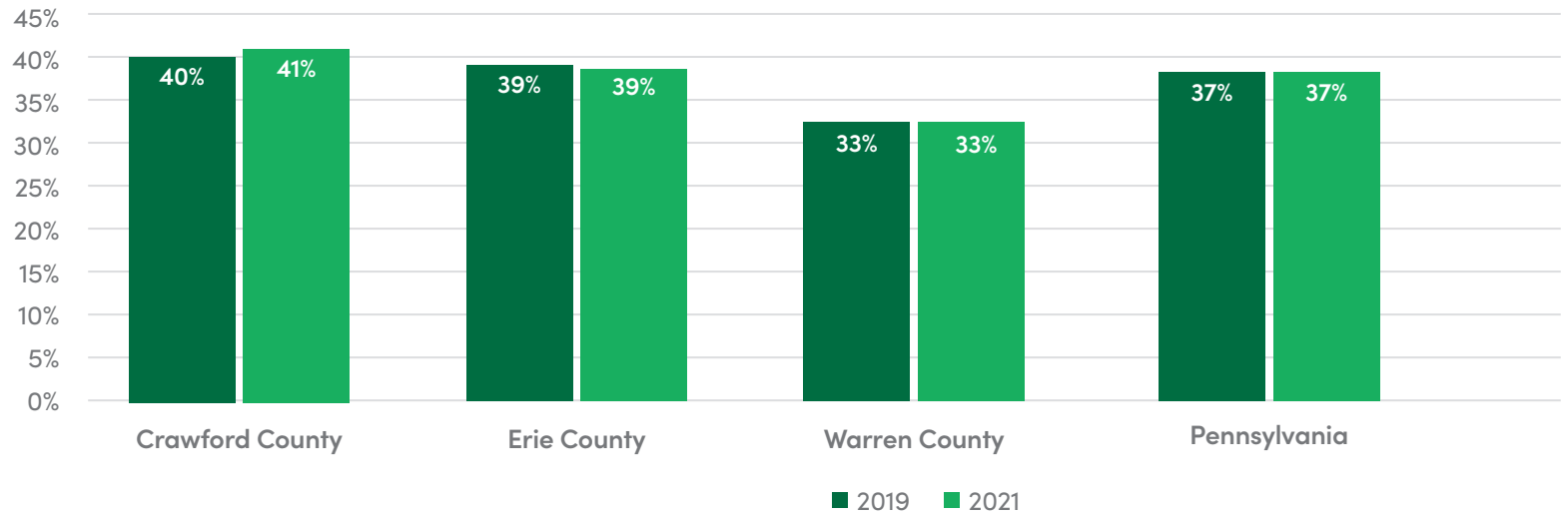
Types of Cancer	2024 Diagnosis Estimate	2024 Death Estimate
Female Breast	13,370	1,820
Colon and Rectum	6,550	2,230
Leukemia	2,710	1,070
Lung and Bronchus	11,200	5,570
Melanoma of the Skin	3,870	N/A
Non-Hodgkin Lymphoma	3,610	930
Prostate	13,010	1,500
Urinary Bladder	4,290	N/A
Uterine Corpus	3,460	N/A

Source: American Cancer Society

[18] American Cancer Society

Figure 49 below reports the percentage of female Medicare beneficiaries aged 35 and older who had a mammogram in most recent reporting year. The American Cancer Society recommends that women aged 45 to 54 should get a mammogram every year, and women aged 55 and older should get a mammogram every other year.

Figure 49: Mammogram Screenings



Source: Centers for Medicare and Medicaid Services

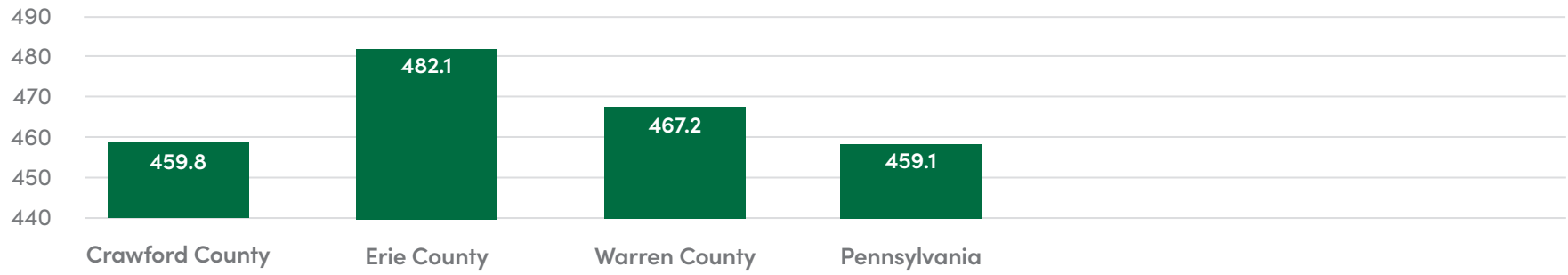
Figure 50: Age-Adjusted Rates of Selected Causes of Death

	Crawford County	Erie County	Warren County	Pennsylvania
All Causes of Death	916.0	870.3	886.7	821.9
Cancer	161.4	161.9	170.1	152.9

Source: Pennsylvania Department of Health, 2018-2022

Several factors contribute to the prevalence of cancer in Pennsylvania, including lifestyle choices, environmental exposures, and genetic predispositions. Risk factors such as tobacco use, poor diet, physical inactivity, and obesity have been linked to an increased risk of developing cancers. Additionally, environmental factors, including exposure to carcinogens in air and water, can heighten cancer risk. Understanding these risk factors is crucial for implementing effective public health initiatives for cancer prevention and education.

Figure 51: Cancer Incidence Rate (Per 100,000 Population)



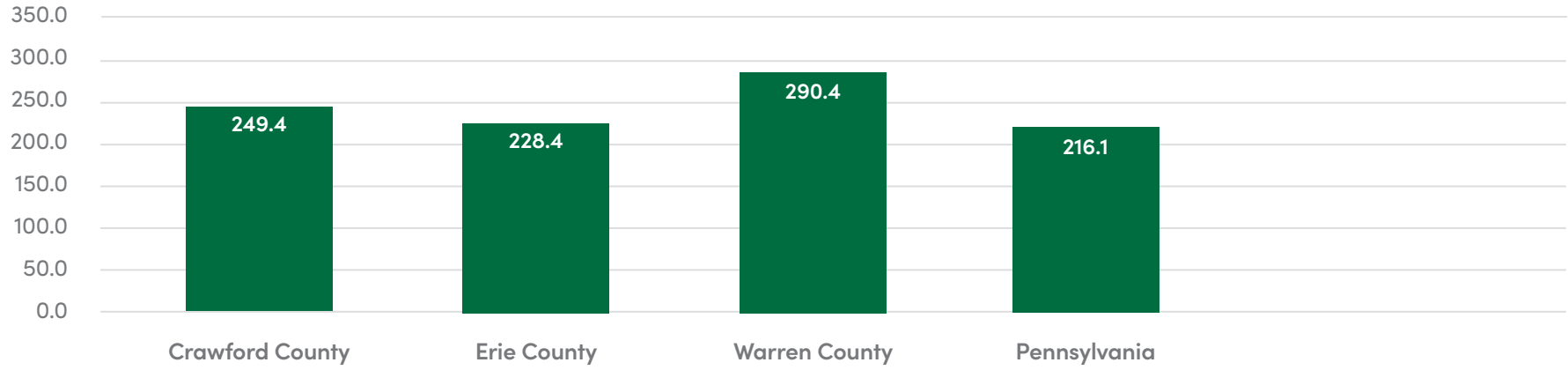
Source: Centers for Disease Control and Prevention, CDC, 2016-2020

Figure 52: Incidence Rates by Type of Cancers

	Crawford County	Erie County	Warren County	Pennsylvania
All Cancers - Male	492.6	498.2	448.6	468.0
All Cancers - Female	390.8	441.4	437.2	424.1
Breast - Female	104.8	128.0	121.3	129.1
Colon and Rectum - Male	46.2	40.8	40.7	41.5
Colon and Rectum - Female	33.7	30.0	35.5	32.7
Lung and Bronchus - Male	68.1	66.5	58.2	63.1
Lung and Bronchus - Female	58.2	61.7	56.6	51.9
Melanoma of the Skin - Male	23.2	21.5	18.5	24.0
Melanoma of the Skin - Female	10.4	15.0	23.7	16.3
Non-Hodgkin Lymphoma - Male	27.3	27.9	25.0	22.4
Non-Hodgkin Lymphoma - Female	16.2	18.4	20.0	15.8
Prostate - Male	98.5	116.3	97.8	104.6
Urinary Bladder - Male	43.1	44.8	39.5	36.5
Urinary Bladder - Female	9.5	9.9	No Data	9.4

Source: Pennsylvania Department of Health, 2017-2021

Figure 53: Cancer Mortality Rate (Per 100,000 Population)



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

D.) Health Equity

Health equity was identified as a prioritized health need for AHN Saint Vincent based upon it being an enterprise-wide priority. In addition, AHN Saint Vincent 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 both 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 healthcare 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 54 delineates the responses from the community leader stakeholder interviews, community surveys, and provider surveys regarding equitable care and maintaining optimal health.

Figure 54: Engaging the Community

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

Diversity, Equity, and Inclusion

Diversity, equity, and inclusion (DEI) was identified as a prioritized health need for AHN Saint Vincent Hospital based upon it being an enterprise-wide priority. In addition, AHN Saint Vincent Hospital considered their capacity to implement DEI programming. DEI in health care is 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 the communities they serve, patients are more likely to feel understood and receive care that is culturally competent. This representation can lead to better communication, increased trust, and better adherence to medical recommendations.

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 not only focuses on representation, but also on 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 that prioritize inclusion are likely to see improvements in 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.

In summary, diversity, equity, and inclusion are vital components of a successful healthcare 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.

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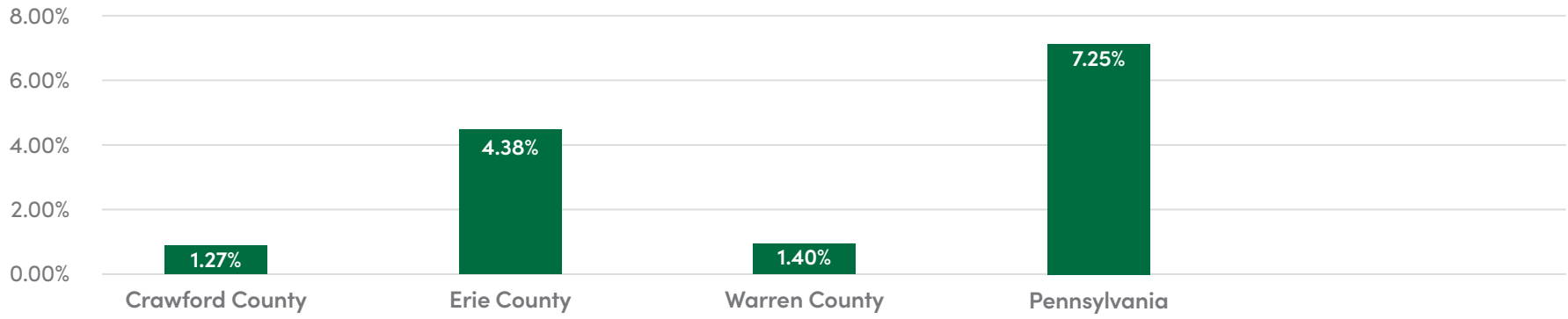
[23] National Library of Medicine

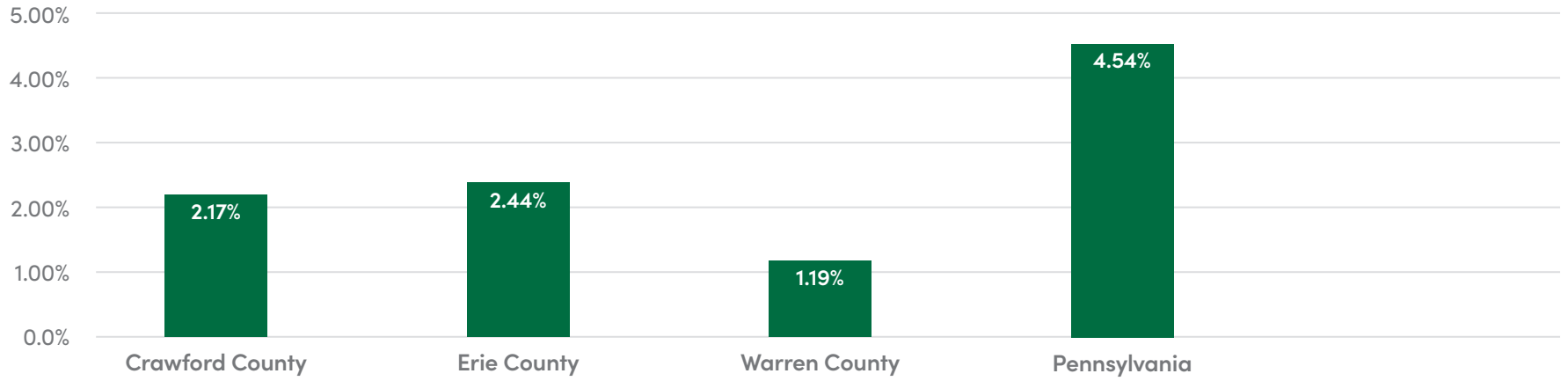
Figure 56 below reports the percentage of the population that is foreign-born. The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national.

Figure 55: Foreign-Birth Population, Percent of Total Population



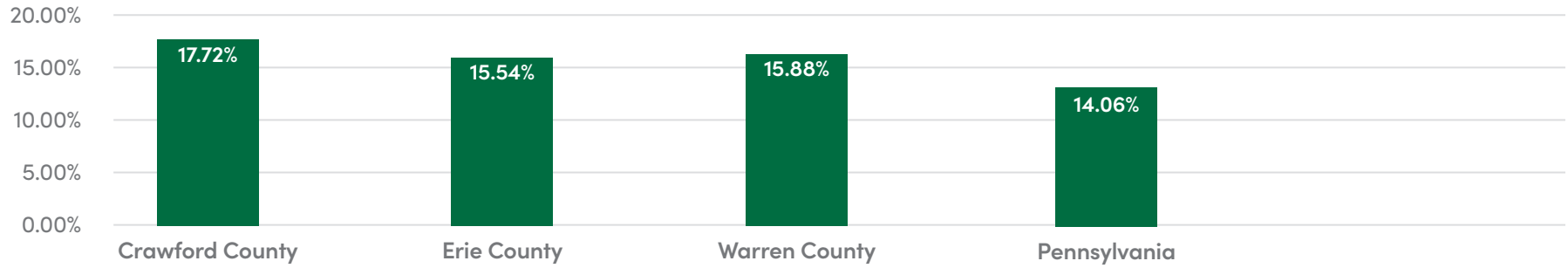
Source: U.S. Census Bureau, 2018-2022

Figure 56: Population with Limited English Proficiency (age 5+)



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

Figure 57: Percentage of Population with a Disability



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

Community Resources Available to Address Identified Needs

In addition to the programs and services offered to the community through AHN Saint Vincent 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.

Identified Significant Health Needs	Local Community Resources Available to Address Needs
Social Determinants of Health – Workforce Development	PA CareerLink, Pennsylvania Department of Labor and Industry, Erie City Mission
Social Determinants of Health – Cost of Care	Dollar For, Medical Assistance for Children and Pregnant Women (PA Dept. of Human Services)
Social Determinants of Health – Food Insecurity, Diet, and Nutrition	Greater Erie Community Action Committee Meals on Wheels, Erie City Mission
Behavioral Health – Mental Health Services	Family Services of NW PA, Erie City Mission, Integrated Behavioral Health Services at Community Health Net
Chronic Diseases and Aging – Cancer	Erie Cancer Wellness Center, Cancer and Careers, Ulman Foundation
Health Equity – Diversity, Equity, and Inclusion	Autism Speaks, Pennsylvania Immigration Resource Center (PIRC)

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.

Saint Vincent 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, Saint Vincent Hospital ensures that the voices of the community are heard and reflected in its health strategies. Partnering with community organizations allows Saint Vincent 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 healthcare and other critical resources.

The path to achieving health equity is long and requires persistent effort, but initiatives such as those undertaken by Saint Vincent 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.

Saint Vincent 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, Saint Vincent 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, Saint Vincent 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 healthcare 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, Saint Vincent 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 that 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, Saint Vincent 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.

Saint Vincent 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, Saint Vincent Hospital and its community partners are working to reduce health disparities and ensure that all individuals can achieve optimal health, regardless of their 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. Secondary data used in the report covers a broader geographic area and is not specifically focused on AHN Saint Vincent's primary service area. Additionally, the primary data gathered through stakeholder interviews, group interviews, community surveys, and provider surveys are limited in its representation of AHN Saint Vincent's service area, as it was collected using convenience sampling.

CHNA Opportunities Requiring Renewed Focus

The unmet objectives and strategies from the 2021 CHNA and ISP for AHN Saint Vincent Hospital reflect challenges in multiple key areas, such as transportation, access to care, and specific health conditions like substance abuse disorder, postpartum depression, diabetes, and obesity. For transportation, while there was success in tracking patient rides throughout the three-year cycle, progress in addressing broader transportation needs, like those for Cancer Center patients, and transportation between Westfield and Saint Vincent Hospital was halted. These areas were discussed but not pursued further, representing a missed opportunity for improving access to care for vulnerable populations.

In the realm of access to care, tracking the number of new primary care provider (PCP) visits was successful during the first two years of the CHNA cycle. However, the process broke down when tracking was discontinued in 2024. Additionally, while efforts were made to develop clinic space at the Mercy Center for Women, the initiative's success remains unclear as it focused more on setup rather than measurable outcomes. Similarly, substance abuse disorder initiatives, such as the warm-handoff program, faced roadblocks due to leadership turnover and the lack of specific goals from the Recovery Medicine Team. Other areas, such as postpartum depression, diabetes, and obesity, experienced inconsistent reporting, lack of metrics, or challenges in implementing effective programs. By addressing these opportunities with renewed focus, ideas and energy, AHN Saint Vincent will more effectively meet the health needs of its community and further improve overall health outcomes.

About Tripp Umbach

Tripp Umbach, a private consulting company, is a nationally renowned firm with extensive experience in conducting CHNAs across diverse regions and populations. In fact, more than one in five Americans lives in a community where our firm has worked. With a deep understanding of health care dynamics, Tripp Umbach employs a comprehensive approach combining quantitative and qualitative data collection methods. This enables them to capture a holistic view of community health needs, including the perspectives of medically underserved and vulnerable populations. Tripp Umbach's methodology ensures that regional stakeholders, from local health care providers to community leaders, are engaged, ensuring that the CHNA reflects a broad spectrum of community insights and priorities.

Over the years, Tripp Umbach has completed numerous CHNAs for hospitals and health care systems, nonprofit organizations, and state entities. Tripp Umbach leverages expertise in identifying pressing health needs and assists organizations in developing targeted strategies to address these issues effectively. Tripp Umbach's CHNAs comply with IRS guidelines for charitable 501(c)(3) tax-exempt hospitals, ensuring that health care providers meet regulatory requirements while improving community health outcomes. Through its rigorous and inclusive process, Tripp Umbach has consistently enabled communities to enhance their health care services, address disparities, and improve overall public health.

Tripp Umbach