Implementation Strategy Plan 2022

AHN SAINT VINCENT

Report

About Allegheny Health Network (AHN)

The hospitals of Allegheny Health Network, as they have for decades, provide exceptional health care to help people live healthy lives and continue to extend their reach, offering a broad spectrum of care and services. The tradition continues by using the latest medical innovations to treat patients. Gaining knowledge through research to constantly improve how to prevent, diagnose, and treat illness, AHN staffs each hospital with experienced, expert, and compassionate physicians, nurses, and other health care professionals dedicated to medicine, people, and healing.

AHN can extend its reach to more people as a health network by offering a broad spectrum of care and services. AHN has 14 hospitals and more than 200 primary- and specialty-care practices. AHN has approximately 2,400 physicians in every clinical specialty, 21,000 providers, and 2,000 volunteers. AHN provides world-class medicine to patients in their communities, across the country, and around the world. AHN's physicians continually explore and develop new treatments that allow us to bring medical discoveries from the laboratory directly to patients. These breakthroughs help save lives and give patients access to the latest treatments for disease and medical conditions. Allegheny Health Network is also committed to educating and training the next generation of doctors by serving as the clinical campus for both Lewis Katz School of Medicine at Temple University and Drexel University College of Medicine.

Allegheny Health Network is an integrated health care system that serves patients from across a four-state region that includes Pennsylvania and portions of New York, Ohio, and West Virginia. AHN has more than 80 medical, surgical, and radiation oncology physician practices; one of the state's most extensive bone marrow transplant and cellular therapy programs; and the nation's largest – and western Pennsylvania's only – radiation oncology network accredited by both the American Society for Radiation Oncology and American College of Radiology. Allegheny Health Network's cancer program has more than 200 clinical trials offered throughout its network of hospitals and clinics.

About AHN Saint Vincent

Founded by the sisters of St. Joseph in 1875, Saint Vincent is Erie's first community hospital. Since then, Saint Vincent has evolved into an integrated healthcare provider. Providing various inpatient and outpatient services, along with multiple physician practices and outpatient medical facilities, Saint Vincent serves the northwestern Pennsylvania and southwestern New York regions.

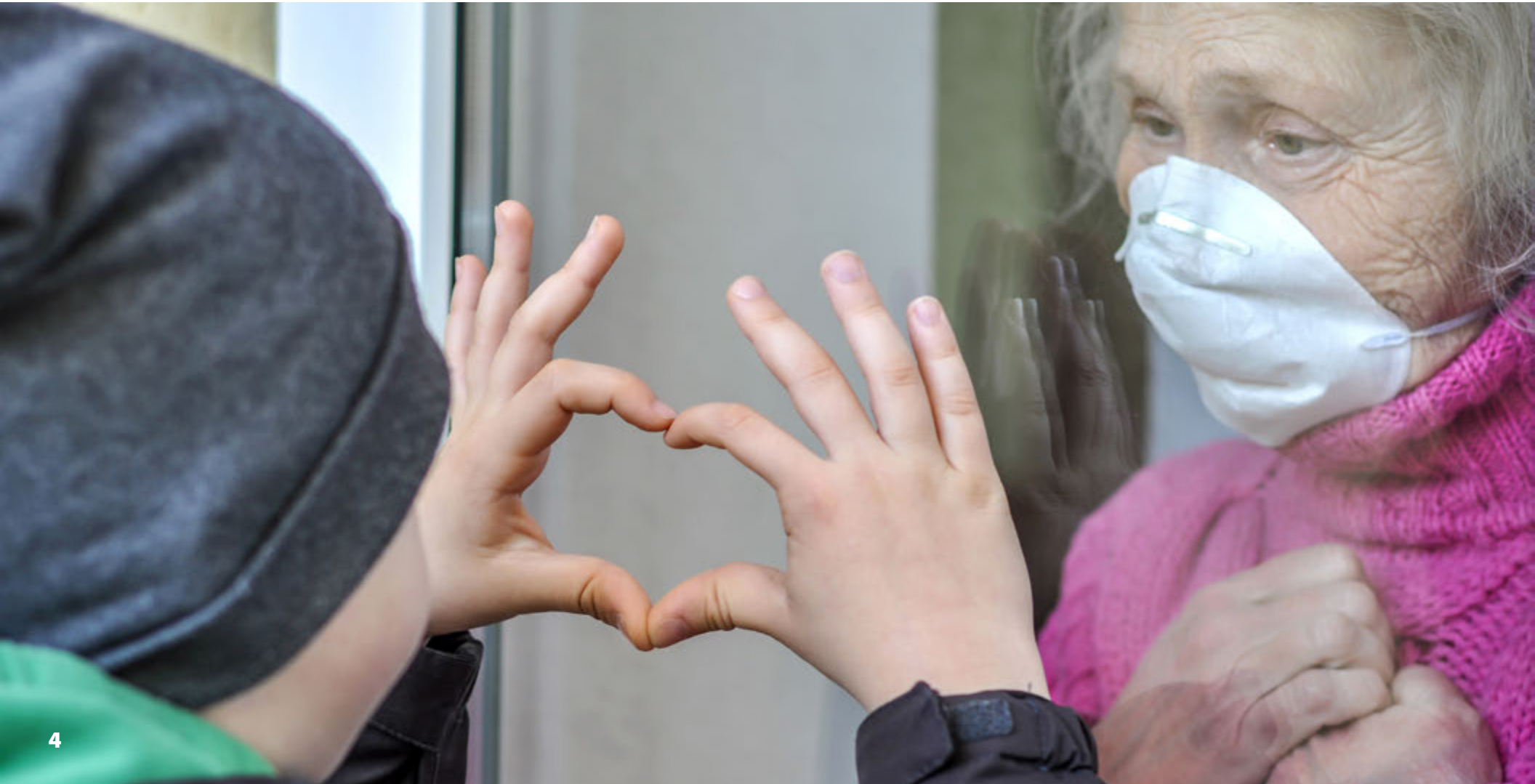
As a member of the Allegheny Health Network, Saint Vincent Hospital is committed to serving Erie and surrounding communities. Providing specialty diagnostic and outpatient services, Saint Vincent is committed to the highest quality patient care, while providing a continuum of services to fit your and your family's healthcare needs. From advanced diagnostics to the latest in cutting edge medical procedures, Saint Vincent Hospital has over 400 physicians dedicated to providing the highest rated community care available.

Mission

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

Vision

A world where everyone embraces health.



Values

People matter

Every person contributes to our success. We strive for an inclusive culture, regarding people as professionals, and respecting individual differences while focusing on the collective whole.

Stewardship

Working to improve the health of the communities we serve and wisely managing the assets that have been entrusted to our care.

Trust

Earning trust by delivering on our commitments and leading by example.

Integrity

Committing to the highest standards encompassing every aspect of our behavior including high moral character, respect, honesty, and personal responsibility.

Customer-focused collaboration

Because no one person has all the answers, we actively seek to collaborate with each other to achieve the right outcomes for our customers.

Courage

Empowering each other to act in a principled manner and to take appropriate risks to do what is right to fulfill our mission.

Innovation

Committing to continuous learning and exploring new, better, and creative ways to achieve our vision.

Excellence

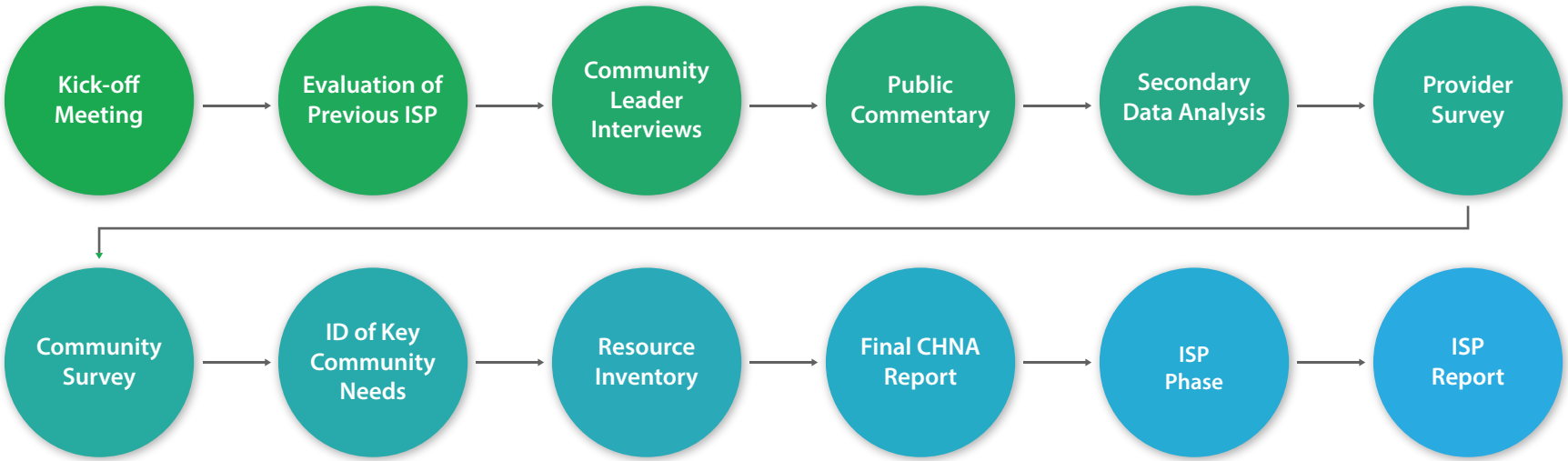
Being accountable for consistently exceeding the expectations of those we serve.

Introduction

Founded by the sisters of St. Joseph in 1875, Saint Vincent is the Erie area's first hospital. Since then, Saint Vincent has evolved into an integrated healthcare provider, spread across the northwestern Pennsylvania region. Saint Vincent continues to remain a leader in cardiac, neurological and women's services and continues to offer patients several options in primary care and specialty physicians.

In 2022, AHN joined together with Tripp Umbach to conduct a comprehensive community health needs assessment (CHNA) for AHN St. Vincent's service area of Crawford, Erie, and Warren counties. The CHNA process included input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of public health issues and representatives of vulnerable populations. The overall CHNA involved multiple steps that are depicted in the below flow chart.

Figure 1: Overall CHNA and Implementation Strategy Plan (ISP) Process Flow Chart



The CHNA and implementation strategy plan meets the requirements of the Patient Protection and Affordable Care Act. The act has changed how individuals are obtaining care and promotes reduced healthcare costs, greater care coordination, and better care and services. Health care organizations and systems are striving to improve the health and social needs of the community they serve through collaboration with local, state and national partners. The implementation strategy plan outlines the needs identified in the CHNA and documents how AHN St. Vincent will be addressing the needs over the next three years. All needs identified in the CHNA will be addressed by AHN St. Vincent.

Allegheny Health Network (AHN)	2021 Prioritized Findings													
	Social Determinants of Health					Behavioral Health			Chronic Disease					Health Equity
	Transportation	Workforce Development	Cost of Care	Access to care*	Food Insecurity, Diet, and Nutrition	Substance Use Disorder	Mental Health Services	Postpartum Depression	Diabetes	Heart Disease	Cancer	COPD	Obesity	Diversity, Equity, and Inclusion**
Allegheny General Hospital	X	X			X	X			X	X	X			X
Allegheny Valley Hospital	X					X	X		X	X				X
Canonsburg Hospital	X			X		X			X	X				X
Forbes Hospital	X					X	X		X	X		X		X
Grove City Medical Center				X			X		X	X			X	X
Jefferson Hospital	X	X	X		X	X					X		X	X
Saint Vincent Hospital	X	X		X	X	X	X	X	X		X		X	X
West Penn Hospital		X			X			X	X		X		X	X
Westfield Memorial Hospital						X	X		X	X	X			X
Wexford Hospital					X	X	X	X		X				X
Brentwood Neighborhood Hospital			X	X										
Harmar Neighborhood Hospital			X	X										
Hempfield Neighborhood Hospital			X	X										
McCandless Neighborhood Hospital			X	X										

* Access to care includes primary care, specialty care, and access to general services.

**Diversity, Equity, & Inclusion includes LGBTQ+ and cultural competency.

A) Social Determinants of Health

The World Health Organization (WHO) defines social determinants of health as the economic and social conditions that influence individual and group differences in health status. These economic and social conditions under which people and groups live may increase or decrease the risk of health conditions or diseases among individuals and populations.

Social and economic factors contribute 40% to our health, health behaviors 30%, genetics 10%, the physical environment 10% and clinical care 10%, according to the Center for Health and Learning (CHL), an outgrowth of an initiative by the Center for Disease Control and Prevention's (CDC) Division of Adolescent and School Health. According to the CDC, poverty limits access to healthy foods and safe neighborhoods, while higher educational attainment is a predictor of better health. Differences in health and health outcomes are striking in communities with poor social determinants of health such as unstable housing, low-income levels, unsafe neighborhoods, or substandard education. Addressing SDOH is paramount to creating a healthier community.

Access to Care

Access to high-quality, comprehensive health care services is essential for maintaining health and preventing and managing disease. Obtaining primary care services and having a primary care physician is a vital part of health care maintenance. Almost one in four Americans do not have a primary care provider (PCP) or health center where they can receive regular medical services. Approximately one in five Americans (children and adults under age 65) does not have medical insurance.[1] Transportation issues, cost, coverage, timeliness of services, and availability of providers are barriers to obtaining health care services.

Across the United States, the projected shortage of 46,900 to 121,900 physicians by 2032 includes both primary care (21,100 to 55,200) and specialty care (24,800 to 65,800). Among specialists, the data project shortages of 1,900 to 12,100 medical specialists; of 14,300 to 23,400 surgical specialists; and of 20,600 to 39,100 other specialists, such as pathologists, neurologists, radiologists, and psychiatrists, by 2032.[2] The Robert Graham Center reports that to maintain current rates of utilization, Pennsylvania will need an additional 1,039 primary care physicians by 2030, a 11% increase compared to the state's current (as of 2010) 9,096 PCP workforce.[3]

SDOH: Access to Care				
Goal: Connect patients to Primary Care Providers (PCP).				
Impact: Increased number of new patient visits in PCP offices.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Patients with unattributed PCP services.	Increase the number of new PCP visits.	• Identify unattributed patients through scheduling tool. • Identify unattributed patients through biometric screening. • Partner with Clinical Access Team. • Implement centralized scheduling. • Utilize Meet Dr. Right events.	• 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	• Clinical Access Team
Mercy Center for Women	Develop partnership with Mercy Center for Women to setup 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 clinic.	• Number of patients who access PCP clinic	• Mercy Center for Women

[1] Healthy People: www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services

[2] Association of American Medical Colleges: www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage

[3] Robert Graham Center: www.graham-center.org/content/dam/rgc/documents/maps-data-tools/state-collections/workforce-projections/Pennsylvania.pdf

Food Insecurity, Diet, and Nutrition

Many communities face a dire need for adequate and healthy foods. Food insecurity is when you do not have the money to purchase the essential and needed healthy foods and you may skip meals because of a lack of finances to secure food. Food insecure families struggle with many aspects associated with poverty, under/unemployment, and inconsistent access to sufficient healthy foods. Difficult decisions whether to pay rent, purchase medication, pay utility bills or buy healthy foods are daily struggles for those living in disparate conditions. Surprisingly, food insecurity affects people of all ages and from many walks of life.

SDOH: Food Insecurity				
Goal: Identify and address food insecurity for AHN Hospitals/Community.				
Impact: (1) Number of patients referred to Healthy Food Center; (2) Number of visits new vs follow up and total served; and (3) total meals provided.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
AHN Patients (inpatient and outpatient) Surrounding community and community-based members	Educate providers and community-based organizations (CBOs) on food insecurity screening and referral process. Identify food insecure patients and community members through SDOH screening tool.	• Patients who screen positive for food insecurity will receive referral to the Healthy Food Center • Assess needs of population served (i.e., food access, transportation, utensils, education, recipes, 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)	• 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	• Highmark Health

Transportation

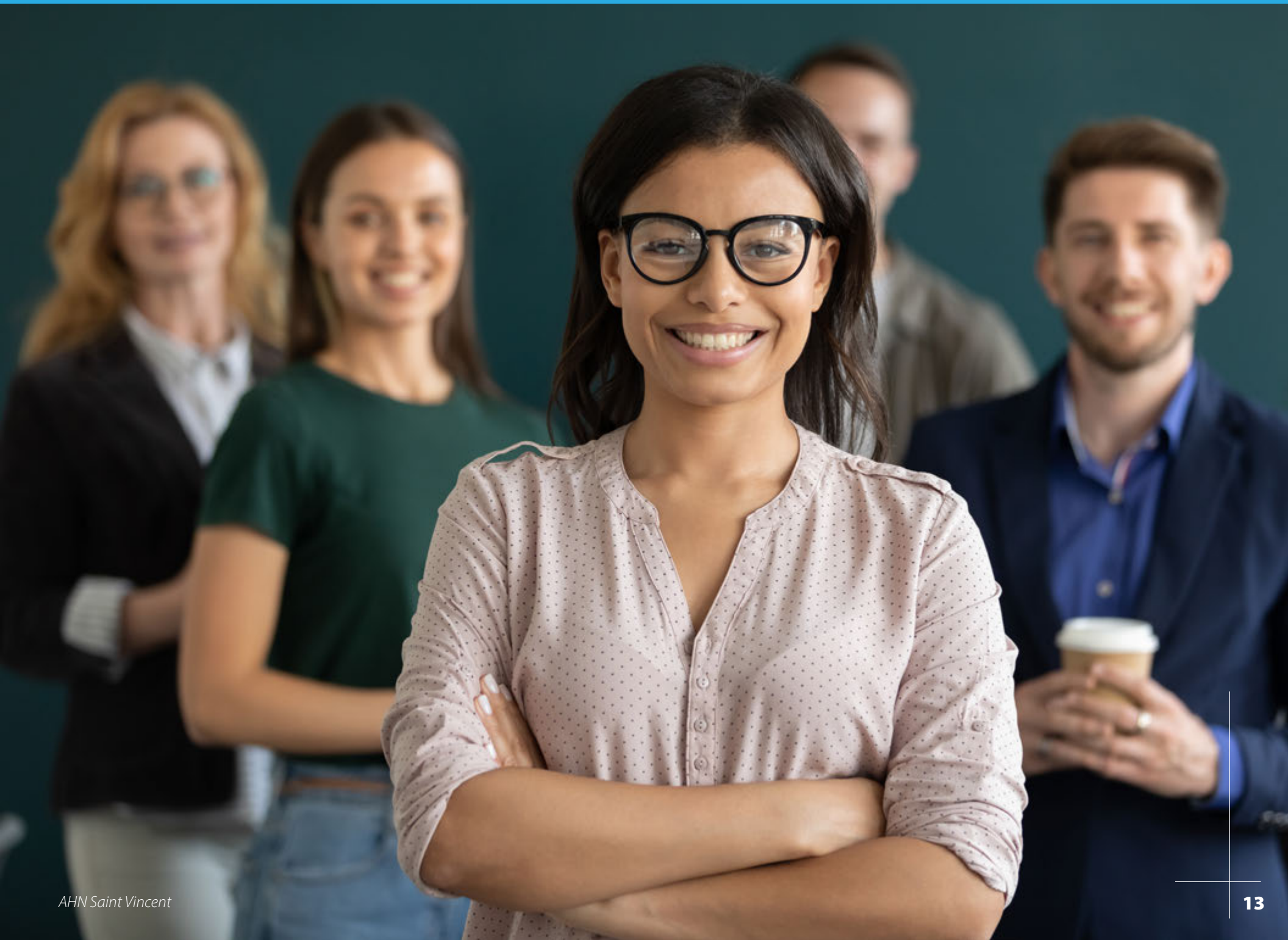
Access to health care services has a significant impact on health, including improved overall physical, social, and mental health status, prevention of disease and disability, and better quality of life. Transportation affects residents in rural and urban communities. Having adequate transportation is often a barrier to accessing services and can significantly affect the quality of people's lives. The lack of vehicle access, cost, long distances, and lengthy times to reach needed services impact travel for residents.

SDOH: Transportation				
Goal: Connect patients with transportation services.				
Impact: Increase options for patients who need assistance with transportation to access the hospital for care.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Patients requiring transportation services	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 service. • Increase volume so vehicle can be stationed at hospital. • Monitor invoices and request volume data from Vantage.	• Number of patients who utilize service.	• Vantage Home Medical Equipment and Service (VHMES)
Patients accessing the AHN Cancer Center who require transportation services	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 Traveler's Aid contract (3rd party coordination of transport services). • Explore CATA service for patients in Crawford.	• Number of patients who access transportation services. • Number of transportation services identified.	• American Cancer Society • Erie County LIFT • Traveler's Aid Program

Workforce Development

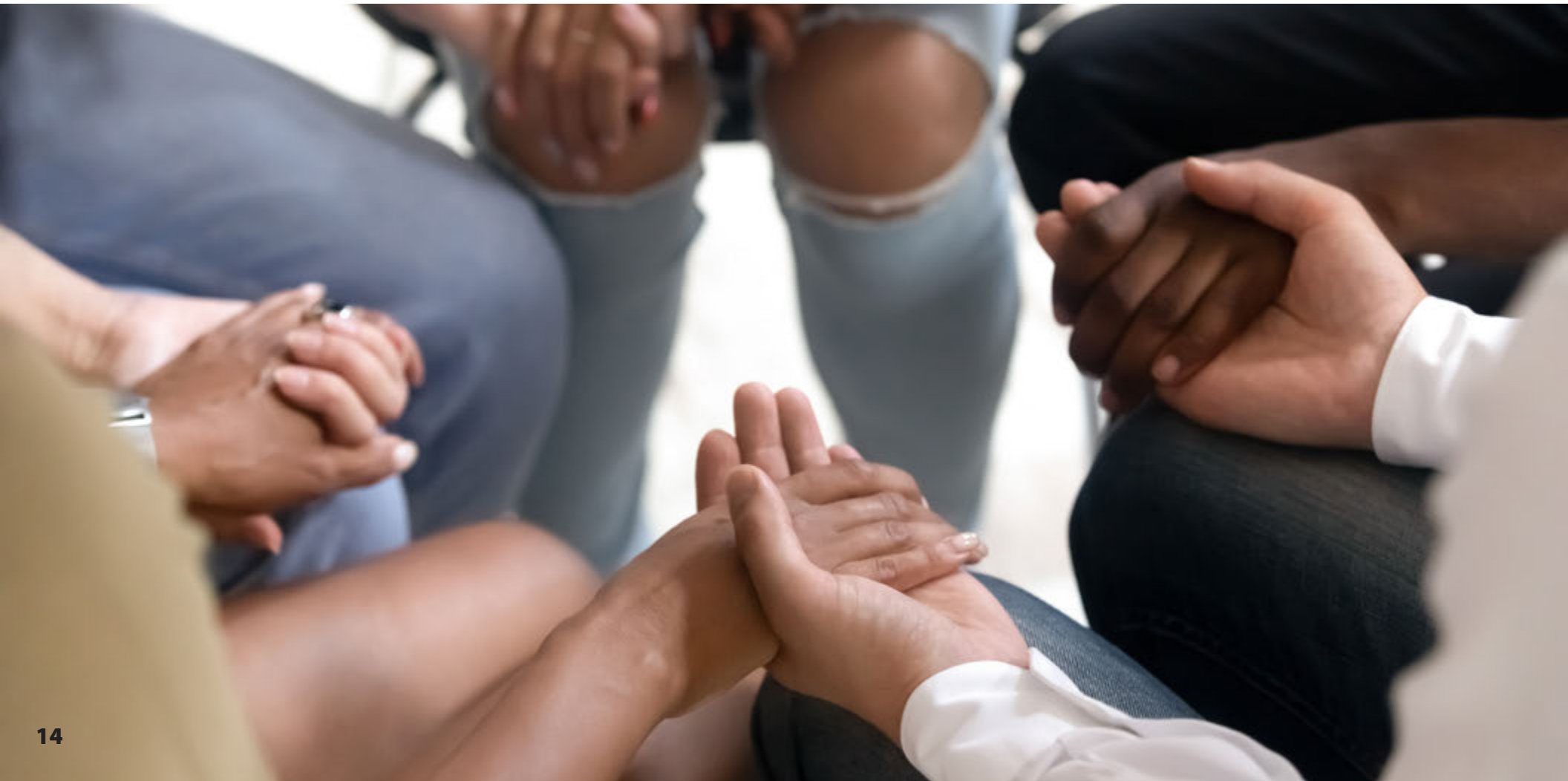
Being employed and having a steady livable income enables one to have choices and options for a healthy lifestyle. Having a comfortable income can provide a safe home environment, food, transportation, health care, and much more.

SDOH: Workforce Development				
Goal: Work with community partners to develop new and innovative workforce initiatives.				
Impact: Strengthen workforce within hospital.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Erie County High School students	Expand 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	• Number of students in Project Search Program.	• Erie City School District
University 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).	• Number of students enrolled in program.	• Edinboro University



B) Behavioral Health

Falling under the umbrella of behavioral health, substance use, and mental health impact the lives of families and individuals throughout the United States. The percentage of residents diagnosed with behavioral health problems has grown exponentially. Along with the growth, the need for mental health services and substance use programs has not diminished. Genetics and socioeconomic factors play vital roles in individuals diagnosed with a mental health problem, and frequently societal factors increase the likelihood of one engaging in unhealthy life choices such as alcohol and drug use. According to the American Hospital Association, behavioral health disorders affect nearly one in five Americans and have community-wide impacts. Hospitals and health systems provide essential behavioral health care services to millions of Americans every day.



Mental Health Services

The prevalence of mental illness in America is vast and continues to grow yearly. According to the National Alliance on Mental Health, one in five U.S. adults experiences a mental illness, one in 20 U.S. adults experience serious mental illness, and 17% of youth (6-17 years old) experience a mental health disorder.

Behavioral Health: Mental Health Services				
Goal: Increase knowledge and access to Mental Health programs and services.				
Impact: (1) Increased access to BH programs; (2) increased awareness of behavioral health (BH) services.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Community members who need access to BH services.	Increase access to BH programs and services through community-based seminars and programming.	• Provide BH programming and education in the community Develop list of BH program and services offered in community	• Number of outreach events and programming that occurs in community. Number of people addressed.	• Community programs
Community members who need access to BH services.	Increase awareness and engagement of BH services through various, media, TV, radio, and social media initiatives.	• Develop list of community BH programs and services to market • Develop marketing strategy for these services Develop content to be distributed through various media platforms	• Number of new marketing initiative. • Attendance at community outreach events.	

Postpartum Depression

Postpartum depression, maternal depression, or the "baby blues" are emotions often experienced by mothers as they prepare for and welcome a new member into their family. After birth, many mothers experience anxiety, depression, guilt, isolation, sadness, hopelessness, emptiness, or overwhelmed emotions. The CDC reports about 1 in 8 women experience symptoms of postpartum depression. Additionally, a recent analysis found the rate of depression diagnosed at delivery was roughly seven times higher in 2015 than in 2000.[4]

Common risk factors associated with maternal depression include race/ethnicity, age, socioeconomic status, history of depression, health problems of the baby, having multiple babies during birth, difficulty breast-feeding, and unwanted or unplanned pregnancy.[5] Depression in mothers can disrupt the bonding experience in infancy. This phase, which is critical and healthy for child development, creates a healthy, nurturing, and empathetic relationship between child and mother. Unfortunately, when the mother is depressed, she is less likely to engage and participate in a healthy and loving parent experience.

Maternal depression is a community and public health problem often having a ripple effect, taking a toll on the well-being and livelihood of mothers and their families. Addressing postpartum requires a community commitment of those who share a common interest and desire to support the health of all mothers and families who seek and require help.

Behavioral Health: Postpartum Depression				
Goal: Increase awareness, education, and screening for perinatal mood disorders.				
Impact: Increased in the amount of screening and services provided to women with perinatal mood disorders.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Women with perinatal mood disorders	Increase education and awareness of perinatal mood disorders.	• Develop Perinatal Intensive Outpatient Program (Started 2/21). • Educate providers on 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.	• Number of referrals to Perinatal IOP. • Number of patients receiving services. • Number of educational events (Community & Clinical).	• Out of the Darkness walk • Med students
Women with perinatal mood disorders	Increase behavioral health screenings for women utilizing evidenced based screening tools.	• Identify screening tools: (EPDS, PASS, MDQ) • Develop screening process for patients.	• Number of patients screened	• Hospital staff

[4] Centers for Diseases Control and Prevention: www.cdc.gov/reproductivehealth/features/maternal-depression/index.html

[5] Mayo Clinic: www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617

Substance Use Disorder

Although progress has been made in lowering rates of substance use in the United States, the use of behavior-altering substances continues to take a major toll on the health of individuals, families, and communities nationwide.

Behavioral Health: Substance Use Disorder				
Goal: Increase knowledge and access to substance use disorder programs and services.				
Impact: (1) increased number of patients that attend education sessions; (2) increased awareness of available resources to support recover; (3) increased number of patients that receive medication assisted therapy; and (4) increased number of patients in the warm hand off program.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Patients with substance use disorders.	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.	• Number of events. • Number of participants.	• Community event workers/ volunteers
Patients who arrive in ED as a result of an overdose.	Increase number of patients eligible for the warm hand off program.	• Screen overdose patients coming to the ED for criteria meeting medication assisted treatment (MAT). • Begin medicating patients that meet criteria and transition to Gaudenzia for detox. • Education to EMS and Public of Detox Services	• Number of patients in MAT. • Number of patients in warm • hand off program.	• Gaudenzia • EMS Services

C) Chronic Diseases

Chronic diseases are a significant cause of disability and death in Pennsylvania and the United States. The seven leading causes of death are heart disease, cancer, stroke, chronic lower respiratory disease (CLRD), unintentional injury, Alzheimer's disease, and diabetes. According to the Pennsylvania Department of Health, chronic disease accounts for about 70.0% of all deaths annually in Pennsylvania. With Pennsylvania's aging population and the advances in health care enabling people to live longer, the cost associated with chronic disease will increase significantly if no changes are made. Clinical preventive services, such as routine disease screening and scheduled immunizations, are key to reducing the effects of chronic disease and reducing death. Preventive services both prevent and detect illnesses and diseases in their earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs.

Chronic Diseases: Cancer				
Goal: increase the number of adults who receive age-appropriate screenings.				
Impact: (increased number of screenings in high-risk communities; (2) increased number of lung cancer studies performed.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Adults	Provide community-based cancer screening events.	• Provide community cancer screening and education events.	• Number of screening events. • Number of participants.	• Community events
	Increase CT lung cancer screening utilization.	• Implement Lung Cancer Screening Navigation. • Expand CT Lung Screening" access/locations.	• Number of studies performed.	• Hospital staff

Chronic Diseases: Diabetes

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

Impact: (1) Increased awareness of risk factors of diabetes; (2) decreased hospital admissions for diabetes related illness.

Target Population	Strategies	Action Steps	Measure	Partners
Patients with risk for diabetes who would benefit from diabetes prevention program	Connect patients with community-based diabetes prevention programs.	• Identify patients in office (Medical Nutrition TX, RD/Diabetes Educators) who could benefit from diabetes prevention programs. • Refer patients with 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	• Sight Center of Northwest Pennsylvania (NWPA) • YMCA
Patients with diabetes who would benefit from self-management and training	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 impact of education and training programs.	• Number of patients receiving diabetes self-management and training • Impact on health of patients who have completed the program (Define Metrics)	• American Diabetes Association

Chronic Diseases: Obesity

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

Impact: (1) Increased number of patients counseled on obesity risk factors; (2) increased number of obesity education events; (3) increased number of Meet Dr. Right events; and (4) increased number of health and wellness events.

Target Population	Strategies	Action Steps	Measure	Partners
Patients with obesity risk factors.	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. • Number of BMI screenings.	• Local school districts
Patients with obesity risk factors.	Educate community on 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.	• Community organizations

D) Health Equity

Diversity, Equity, & Inclusion (DEI)

In recent years, health systems, public and private agencies, and community-based organizations have increasingly focused on the concept of "health equity." Health equity is described as "both the absence of systematic obstacles and the creation of opportunities for all to be healthy." The American Medical Association (AMA) Center for Health Equity imagines health equity as "providing health care that values people equally and treats them equitably and a nation in which all people live in thriving communities where resources work well; systems are equitable and create no harm nor exacerbate existing harms; where everyone has the power, conditions, resources, and opportunities to achieve optimal health."

Significant effort is required to provide equitable and culturally/linguistically appropriate care to a variety of racial and ethnic communities, each with its own cultural traits, health beliefs, and barriers to health care access. Improving health equity extends well beyond the walls of the hospital, reaches deep into the community sectors, and involves both local and state governments where health policies and protocols are developed.

Health Equity: Diversity, Equity, and Inclusion (DEI)				
Goal: Increase access to care for patients in need of interpreter and translation services.				
Impact: Give patients with interpretation and translation needs access to more immediate and higher quality of care.				
Target Population	**Strategies**	**Action Steps**	**Measure**	**Partners**
Patients requiring interpreter services (phone).	Develop system for patients calling the hospital who require interpreter services.	• Work with telephone operators and interpreters to set-up process when patients call the hospital with interpretation needs.	• Number of patients requiring interpreter services • Number of interpreter services provided	• Telephone operators
Patients requiring translation services (documents).	Provide patients with translated documents.	• Review the current program for translation of hospital menus. • Expand program to identify and include additional documents for translation.	• Number of patients benefitting documents being translated • Number of documents translated	• Translators

E) Conclusion

AHN St. Vincent places a strong emphasis on providing exceptional care, ensuring access to equitable health care services, and programs for its surrounding communities. Its efforts to address challenges and complexities of care in serving vulnerable populations such as the homeless, elderly, unemployed/underemployed, ethnic, low-income and diverse populations are recognized at community, state, and national levels.

AHN St. Vincent aspires to improve health, well-being, and health equity for all and understands that "health is more than the absence of disease." Health is based not only on geographic factors- where people were born, live, work and play- but also on economic, cultural, educational, and social factors. By addressing barriers and identifying social and economic factors called social determinants of health that hinder access to equitable health care, AHN St. Vincent aims to heighten overall community health status and to improve quality of life for the diverse communities they serve. The health system may provide a plethora of recognized physicians, best practice services, noteworthy programs and services but if residents lack transportation and insurance, access to care can be difficult. There is a direct correlation between the ease of accessing health care and the overall health of a community.

AHN St. Vincent has addressed many obstacles and accomplished a measurable impact on the community, however, there are still many community health issues that need to be addressed to achieve health equity and anticipated health outcomes. With a focus on the top priorities mentioned above, major and meaningful health concerns for the AHN St. Vincent communities will be addressed.

Tripp Umbach

AHN Saint Vincent Hospital

232 West 25th Street
Erie, PA 16544