# Community Health Needs Assessment June 2019

Ascension
Providence Rochester

Ascension Providence Rochester Hospital (APRH), a member of Ascension, is a non-profit Catholic health system. It is our mission to serve all persons with special attention to those who are poor and vulnerable. We are dedicated to all that we serve creating strong relationships with our community, our physicians, and our associates. APRH is established as an industry leader not only in providing high-quality healthcare but also as an organization that strives to improve the health of our community.

As a health ministry of Ascension, our Mission guides everything that we do and is foundational to our work to transform health care and express our priorities when providing care and services, particularly to those most in need.

In 2019, APRH conducted a Community Health Needs Assessment (CHNA) of the community that we serve. The 2019 assessment was the third CHNA conducted by APRH in our community. The 2015 assessment proved to be a powerful tool in determining community development and community health improvement needs.

We recognize the need for a systematic approach to servicing our community and applaud the federal laws in the Affordable Care Act requiring health care organizations to assess the health needs of the community and adopt implementation strategies to address these needs. The March 2010 passage of the Patient Protection and Affordable Care Act (PPACA) introduced new reporting requirements for private, not-for-profit hospitals to maintain 501(c)(3) tax-exempt status. Effective for tax years beginning after March 2012, each tax-exempt hospital facility must:

- Conduct a Community Health Needs Assessment (CHNA) once every three years on a facility-by facility basis.
- Adopt an implementation strategy, identify action plans, and address unmet community health needs.
- Report the results of each CHNA publicly.

Ascension Providence Rochester Hospital, in collaboration with our community partners and Ascension Michigan Market Community Health leaders, created a survey tool for our CHNA and widely distributed it throughout our primary service areas.

The 2019 CHNA report will provide:

1. A summarized evaluation of the impact of the successes from the 2015 CHNA report.
2. A description of the community served by APRH and a description of how the community was determined.
3. A description of the process and methods used to conduct the CHNA, including how we considered input from persons who represent the broad interests of the community.
4. A summary of the process and criteria used to identify and prioritize the significant community health needs through the CHNA.
5. A description of the potential resources available to address the significant health needs identified through the CHNA.

## SUMMARY OF 2015 CHNA

The 2015 CHNA identified several needs encompassing all regions of our community service areas. The needs were categorized into three general areas of concern:

1. Obesity/Overweight/Nutrition
2. Mental Health
3. Access to Care

Over the past three years, APRH has fully transitioned into the Ascension Health System with a mission focus consistent with the work of the CHNA. The support and focus on our community, our poor and vulnerable and community partnerships/collaborations continues to grow. Ascension Michigan has strategically aligned each ministry to work collaboratively, share resources and best practices, and support each other to allow expanded reach to meet the needs of our communities.

Over the last three years, APRH has implemented action plans designed to fulfill the significant community needs. To address obesity/overweight/nutrition three strategies were implemented with the goal of increasing awareness and participation on healthier lifestyle options.

The first strategy centered around a collaboration with a strong community partner, Rochester Community Schools, providing a program to address healthy lifestyles to each kindergarten classroom in the district. The program, designed to increase awareness on healthy eating and promoting physical activity, reached over 3,000 students and over 150 education hours.

The second strategy focused on increasing the number of new mothers breastfeeding; APRH initiated the Baby Friendly Hospital designation journey. This three-year process promotes best practice for postpartum mothers and newborns with a strong emphasis on increasing exclusive breastfeeding rates. Baby Friendly Hospital designation is on target for completion fall of 2019.

The third strategy launched the initiation of Diabetes Prevention Program (DPP), a CDC-recognized lifestyle change program proven to prevent or delay type 2 diabetes. The APRH program has reached full recognition with the completion of two successful cohorts; a third is at mid-point and the fourth will start at the conclusion of this CHNA cycle. Statistics for the two completed cohorts are very successful with 37 participants losing a total of 447 pounds averaging 200 plus minutes of activity per month. The growth of DPP at APRH aligns with the strategic focus of Ascension Michigan and Ascension National recommendations.

To address mental health, three strategies were implemented with the goal of improving the mental health status of identified populations. The first strategy focused on patients at risk for mental illness in the outpatient therapy setting. A screening tool was developed along with a process for evaluating patients in the outpatient therapy setting; identified at-risk patients were referred for support and provided resources.

The second strategy revolved around increased involvement with community coalitions to promote healthy lifestyles by promoting and reducing substance abuse and promoting safety across all sectors of the community. APRH has collaboratively worked with community coalitions, schools, and not for profit organizations to provide awareness and education campaigns for middle school, high school, families and the broader community.

The third strategy addressed post-partum depression by implementing a post-partum depression screening process to identify mothers at-risk and refer to appropriate mental health services. Post-partum mothers are assessed for risk prior to discharge, those found at-risk are followed up with a phone call approximately 14 days after discharge for further assessment. Post-partum moms identified at-risk are referred to appropriate resources for further medical assessment and support.

To address Access to Care, two strategies were implemented with the goal of increasing access to mammography services to improve early detection of breast cancer. The first strategy APRH initiated was the development of a Breast Care Fund created by the ministry Foundation to collect donations to be used for patients in need of financial assistance to help cover state-of-the-art technology for early detection. With the second strategy, APRH collaborated closely with Oakland County Health Department's Access to Care Work Group to increase resources and educate the community on the available resources across the county. An online resource tool was developed for easy identification of services and locations.

Ascension Providence Rochester Hospital's efforts to address the identified community health needs over this time have been very successful. Much of the success can be attributed to the efforts put into creating valuable community partnerships and collaborations. APRH will continue to strengthen current relationships and seek new partnerships all working together to meet the health needs of our community. We also attribute much of the success to the Ascension community health leaders within the Michigan Market; collaboration, sharing of best practice and resources, and strategic alignment have led to a systematic approach to identifying and addressing the needs of the community.

# EXECUTIVE SUMMARY

The opportunity to strengthen existing relationships and create new relationships within the communities in the areas that we serve is a high priority for APRH. Engaging the community in meaningful and productive assessment and implementation has enhanced the results of our CHNA. The findings will assist leadership in the alignment of organizational strategic goals and in creating successful collaborations addressing the community health needs.

As a health ministry of Ascension, our Mission guides everything that we do and is foundational to our work to transform health care and express our priorities when providing care and services, particularly to those most in need.

## Description of Community Served by the Hospital

Ascension Providence Rochester Hospital is a 290-bed all inclusive medical facility serving communities in Oakland, Macomb, and Lapeer counties; providing service to both urban and rural areas. Job growth and the inflation rate have remained relatively flat, whereas unemployment has shown a slight decrease. The cost of healthcare continues to rise; many employers are reducing benefits or cost shifting to employees as a means to save costs. This results in higher co-pays and deductibles for the patient. This increase in out-of-pocket expenditures is acting as a deterrent in seeking health care services as a result.

Demographically, APRH's primary and secondary service areas' current population is 286,937. The population (286,937) is predicted to increase by 10.2% by 2035. In 2017, the average median household income was $85,055 while an average of 5.8% of households had an income less than $15,000. From 2015 to 2035, the composition of adults age 65+ is projected to increase from 15.7% to 22.7%. In 2017, 6.2% of all persons and 6.6% of children residing in the APRH service area were living at or below poverty.

Ascension Providence Rochester Hospital resides in a highly competitive market in Southeast Michigan. There are three other hospital systems within a six-mile radius that provide competing primary, secondary, and tertiary health care services. APRH's presence with only 290 beds is substantial in that it captures 34% of the market share in its core service area. As of October 2015, APRH joined Ascension, the largest not for profit health system in the nation. APRH's core service area is comprised of three zip codes, and is one of the top three providers in its total service area with 36 zip codes. Key collaborators for APRH include Ascension affiliates in the Southeast Michigan Market including Ascension St. John, Ascension Macomb-Oakland Hospital, Ascension Providence Hospital-Southfield Campus, Ascension Providence Hospital-Novi Campus, and Ascension Genesys Hospital, in addition to long-standing partnerships with Oakland University School of Nursing and the Wayne State School of Medicine.

## Community Survey

The methodology for survey assessment involved the distribution of two assessment tools: a community survey and a key stakeholder survey. The surveys were distributed electronically via email and hard copies during the months of September through November 2018. The survey tools were developed to assess the needs of the community and the individual needs and health status of the responders. The intention of the survey topic selection was to assess a general overview of the community needs. The survey takers were

asked to select the health challenges that they face personally and the challenges that they feel their community faces.

### Community Stakeholders

Community stakeholders of different ages, socioeconomic status, occupations, and cultural backgrounds were invited to participate. APRH established an Advisory Board with members from all sectors of our community. The Advisory Board, including Ad Hoc members, assisted in the distribution of the survey.

### Community Health Needs Assessment Advisory Board Members

- Carolyn Hribar, Planning and Evaluation Supervisor, Oakland County Health Department
- Renee Cortright, Executive Director, Older Persons' Commission
- Mark Hickson, Deputy, Oakland County Sherriff
- Chief Steve Schettenhelm, Chief of Police, Rochester Police Department
- Maria Willett, Special Assistant to the Mayor, City of Rochester Hills
- Tobi Russell, Director, Rochester Area Counseling Services, LLC
- Whitney Litzner, Planning and QA Manager, Macomb County Health Department
- Rheanne Suszek, Executive Director, North Oakland YMCA
- Juliana Harper, Chief Program Officer, Easterseals of Michigan
- Susan Demeniuk, Principal, ACE High School, Rochester Community Schools
- Betsy Raczkowski, Manager, Youth, Rochester Hills Public Library
- Timothy W. Matz, Captain/EMS Coordinator, Rochester Hills Fire Department
- Kevin Ball, Dean of Health Sciences, Oakland University
- Kathy Losinski, Director, Rochester Area Neighborhood House
- Mary Davis, Outreach Manager, Rochester Hills Public Library
- Sarah Mills, MPH, RD, Director of Wellness and Nutrition Education, Gleaners Food Bank of Southeastern Michigan
- Rochelle Bonelli, Gleaners Food Bank of Southeastern Michigan
- Kristi Trevarrow, Executive Director, Downtown Development Authority
- Maggie Bobitz, Vice President, Rochester Regional Chamber of Commerce
- Dr. Michael Duarte, Rochester Academic Family Medicine Clinic & Health Disparities Committee, Wayne State University School of Medicine
- Dr. Phil Riley, Rochester Academic Family Medicine Clinic & Health Disparities Committee, Wayne State University School of Medicine
- Andy Kruse, Director, Community Health, Ascension Michigan
- Deb King, Vice President of Nursing, APRH
- Jacquelyn McKay, Director, Physician Practice Management, Ascension Medical Group
- Anna Pollack, Manager, Social Services, APRH
- Elaine Babbish, Chaplain, APRH
- Tanya Regmont, School Nurse, APRH
- Carissa Rys, Team Lead, Ascension Providence Rochester Foundation
- Laura Mulligan, Coordinator, Community Health & Education, APRH
- Angela DelPup, Administrator, Community Health & Education, APRH

In addition to our Advisory Board distribution, email invitations with survey website link were sent to all our community members in our primary service areas:

- Public/Private Schools
- Public Health
- Business Leaders
- Physicians
- Religious Organizations
- Universities/Colleges
- High School Leadership Groups
- Senior Centers
- Local Government Agencies

Paper surveys were available at all community events during the months of September through November 2018. These events included:

- Community Health Fairs and Expos
- Breast Cancer Walk
- Physician Lectures
- Health Screenings
- Community Events

To specifically identify the needs of the underserved population in our community, surveys were also distributed at area mobile food bank locations.

**Response**

The needs expressed throughout the assessment were common to the secondary data and the participants of the survey encompassing all regions of our community service areas. The needs were categorized into three general areas of concern: Cardiac Health, Healthy Lifestyles, and Mental Wellness. The Hanlon Method for issue prioritization was used by the CHNA Advisory Board to assist in the identification of the three priorities. The Hanlon Method is a long tested Public Health tool. It is a quantitative and qualitative method that provides a fair, reasonable and systematic approach to compare different health problems in a relative framework, as equally and somewhat object manner.

Discussion for improving the areas of concern were generated by the Advisory Board also involving APRH team members, community partners, and physicians. Following discussion, formalized actions plans were created and evaluated for feasibility. Upon approval, the implementation process will be initiated.

The combination of local resources, community collaboration, and the dedication of APRH to the commitment of meeting community needs provides a strong foundation for success. APRH continuously strives to live our mission and will continue to work effortlessly to meet the needs of our entire community.

# PROCESS & METHODOLOGY

## CHNA Guiding Principles and Framework

APRH used the Centers for Disease Controls *Invest in Your Community Model* for understanding of what contributes to a healthy community.


## CHNA Process Overview

APRH follows the seven-step process for completing the CHNA with input from the CHNA Advisory Board.


## Community Survey Report

The methodology for conducting the survey involved the development of two different tools to assess the needs of the community and the individual needs and health status of the responders. The first tool, community survey, asked community members to select the health challenges that they face personally and the challenges that they feel their community faces. The second tool, the stakeholders survey, asked key informants, which included physicians, and community leaders to assess the needs of the community. The

overall intent of both surveys was to assess a general overview of the community needs. The deployment of the survey was from September through November 2018.

Online and paper methodology was used to ensure a wide distribution of the survey allowing all community stakeholders the opportunity to participate. The survey was distributed electronically by email invitations sent to Advisory Board members and all sectors of the community. Paper surveys were available at all community events during the months of September through November 2018. To specifically identify the needs of the underserved population in our community, surveys were also distributed at area mobile food bank locations.

The survey questions were designed to gather information about the specific concerns of the individual, the individual's perception of the needs within the community, general demographic information and where health information is accessed.

### Survey Responses

The total number of surveys collected was 878. The number of community surveys collected was 648; the number of key stakeholder surveys collected was 179; and the number of surveys collected directly from mobile food bank sites was 50.

- *Community Survey:*
  - 80% of the respondents were female, 17% were male.
  - Most of the respondents were 35-54 years of age (62%). Respondents from the 20-35 years of age group made up 8%, 55-64 years of age 16% and 65 years old and up 14%.
  - 82% of respondents were White, 5% were Asian, and 5% Black or African-American.
  - 53% of respondents make $95,000 or more per year; 14% make between $80,000-94,999; 13% make between $50,000-74,999; 11% make between $25,000-49,999 and 8% make less than $25,000 per year.

- *Mobile Food Bank Survey:*
  - 93% of the respondents were female, 7% were male.
  - The majority of the respondents completing the Mobile Food Bank survey were 35-54 years of age (46%). Respondents from the 55-64 years of age group made up 21%; 20-34 years of age 15%; 65 years old and up 15% and 19 years or younger 3%.
  - 43% of respondents were White; 36% Black or African-American; 10% were Hispanic or Latino.
  - 58% of the respondents make less than $25,000 per year; 33% make between $25,000-49,000 a year.
  - The majority of the of the surveys collected from the Mobile Food Banks were from Auburn Hills and southern Rochester Hills.

- *Key Stakeholder Survey:*
  - 34% of respondents serve the senior population; 19% serve families, and 14% serve youth in the community.
  - 19% of the respondents represent the health field; 5% represent the education field; and 2% represent community development.

Ascension Providence Rochester

## Perceptions of the Biggest Health Problems in the Community

| Health Problems in the Community | Surveys | | | | | |
|---|---|---|---|---|---|---|
| | Community | | Food Bank | | Key Stakeholders | |
| | % | Rank | % | Rank | % | Rank |
| Stress and anxiety | 39 | 1 | 26 | 3 | 48 | 1 |
| Weight problems (overweight or eating disorders) | 36 | 2 | 23 | 4 | 27 | 3 |
| Mental health assistance | 34 | 3 | 26 | 3 | 42 | 2 |
| Lack of exercise | 25 | 4 | 8 | 8 | 21 | 6 |
| Alcohol and drug use | 25 | 4 | 18 | 5 | 23 | 5 |
| Help with insurance | 24 | 5 | 38 | 1 | 20 | 7 |
| Healthy eating education | 19 | 6 | 10 | 7 | 14 | 8 |
| Ability to go to the doctor when you need to go | 14 | 7 | 26 | 3 | 14 | 8 |
| Cancer prevention | 13 | 8 | 3 | 10 | 7 | 11 |
| Suicide prevention | 11 | 9 | 10 | 7 | 5 | 13 |
| Pain management/prevention | 8 | 10 | 18 | 5 | 12 | 9 |
| Safe and affordable housing | 8 | 10 | 33 | 2 | 6 | 12 |
| Other | 7 | 11 | 5 | 9 | 8 | 10 |
| Smoking | 6 | 12 | 13 | 6 | 8 | 10 |
| Diabetes education and support | 6 | 12 | 5 | 9 | 25 | 4 |
| Help with high blood pressure | 6 | 12 | 8 | 8 | 12 | 9 |
| None of the above | 3 | 13 | 8 | 8 | 2 | 14 |
| Help with breathing problems (asthma, COPD, etc.) | 2 | 14 | 8 | 8 | 5 | 13 |
| Sexually transmitted diseases and HIV/AIDS | 1 | 15 | 5 | 9 | 1 | 15 |
| Air pollution (dirty air) | 1 | 15 | 3 | 10 | 0 | 16 |
| Better prenatal care | 1 | 15 | 0 | 11 | 1 | 15 |
| Providers in the community are not culturally competent | | | | | 1 | 15 |

Source: Ascension Providence Rochester Community Surveys, 2018

Prepared By: Center for Population Health/SEMHA

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### Determination of Defined Community

The Community Health Needs Assessment Advisory Board determined the defined community would consist of the core zip codes which encompass Rochester, Rochester Hills, Oakland Township and Auburn Hills.

### Secondary Data Sources

In addition to the survey results, secondary data was analyzed from local, state, and federal community health initiatives. Data was collected and analyzed with the assistance of Gary Petroni, Executive Director, Center for Population Health/Southeastern Michigan Health Association consultants using a variety of sources including MDHHS, BRFSS 2016 and 2015; MIDB, 2017; U.S. Census Bureau, ACS Estimates 2012-2016; SEMCOG Regional Development Forecast Population Projections, 2015-2045; Center for Educational Performance and Information, 2018; and MDHHS Community Health Information, 2013-2017.

## Key Demographics

- The primary service areas of APRH encompass Rochester and Rochester Hills. Secondary service areas include cities, villages, and townships of Auburn Hills, Almont, Romeo, Washington, Troy, Utica, Lake Orion, Oakland, Leonard, Oxford, and Dryden.

- The APRH primary and secondary service areas' current population is 286,937. The population (286,937) is predicted to increase by 10.2% by 2035.

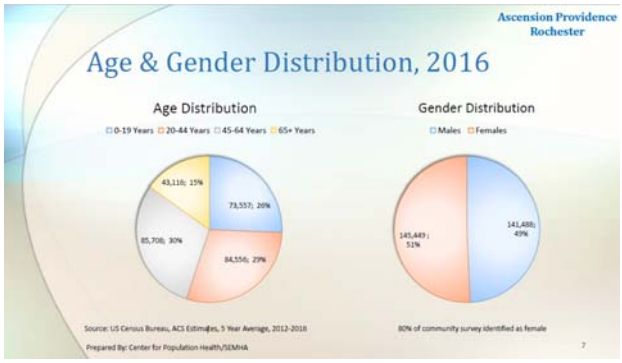
- In 2017, the median household income was $85,055 while an average of 5.8% of households had an income of less than $15,000.

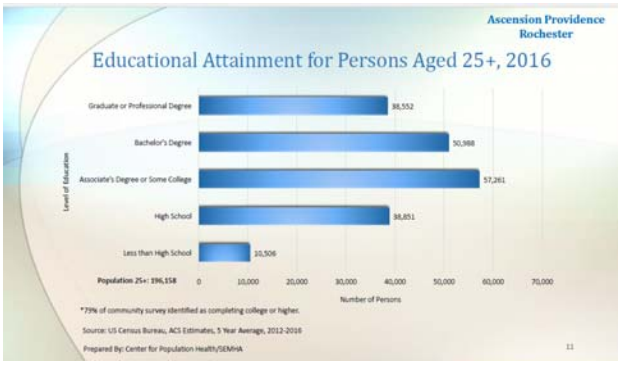
- From 2015 to 2035, the composition of adults age 65+ is projected to increase from 15.7% to 22.7%.

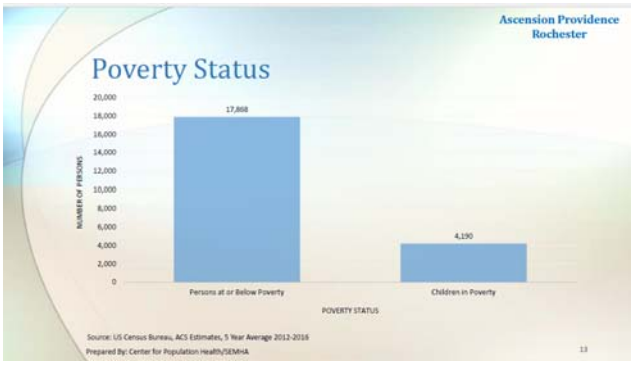
- The racial composition of the APRH service area is predominately white at 85.5%; 7.3% Asian, 4.1% Black; and 3.8% Hispanic or Latino.

- In 2016 community survey identified 79% of adults aged 25+ as completing college or higher.

- In 2017, 6.2% of all persons and 6.6% of children residing in the APRH service area were living at or below poverty.

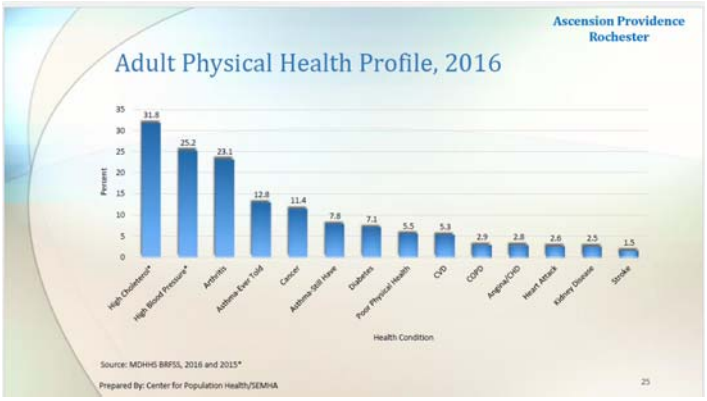
## Survey and Secondary Data Results

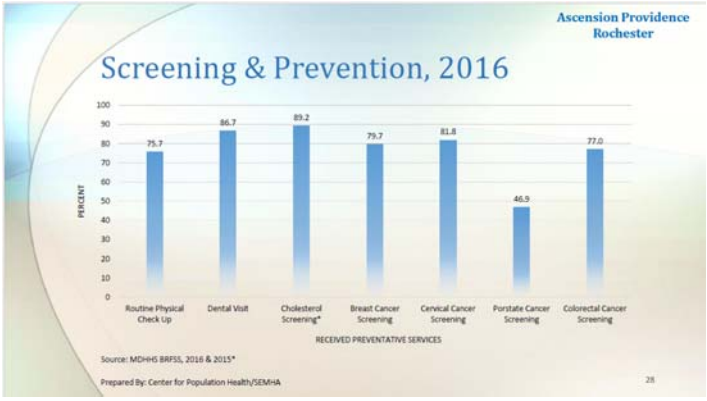
- In 2015 and 2016, adults in the APRH service area were told they had the following chronic disease/risk factors: 31.8% (70,269) told high cholesterol; 25.3% (55,044) told high blood pressure; 23.1% (51,044) told they have arthritis; 5.5% (12,153) reported poor physical health; and 7.1% (15,689) report diabetes.

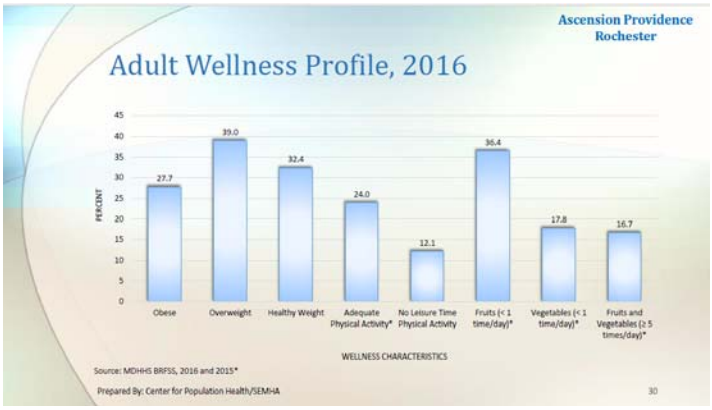
- In 2015 and 2016, access to care and prevention in the APRH service area was favorable: 89.2% (197,107) had a cholesterol screening; 77% (82,629) had a colorectal cancer screening; 75.7% (167,276) had a routine physical checkup; 86.7% (191,583) had a dental visit; and 79.7% (62,423) had a breast cancer screening.

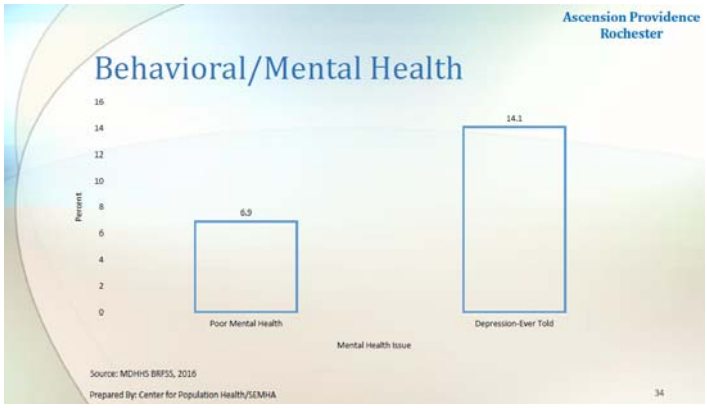
- In 2016, 66.7% of adults reported either being obese or overweight according to body mass index (147,388). Only 32.4% reported being at a healthy weight (71,595). In 2015, only 24% of market area residents reported getting adequate physical activity, 12.1% (26,738) reported no leisure time for physical activity. In 2015, only 16.7% (39,902) of adults reported eating 5 or more servings of fruits and vegetables per day.

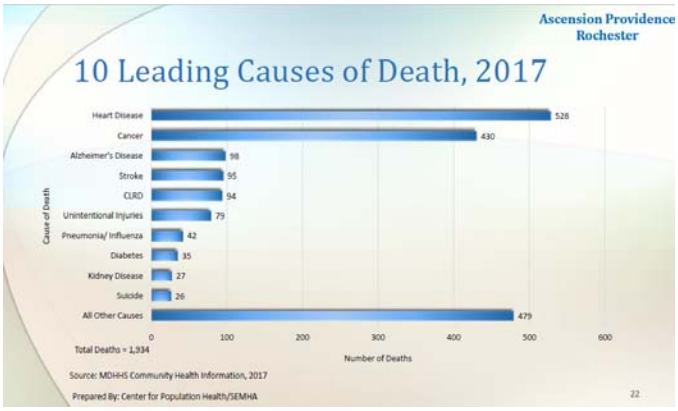
- In 2016, the APRH service area residents reported 6.9% (15,247) poor mental health. 14.1% (31,157) adults reported being told they had a depressive disorder including depression, major depression, dysthymia, or minor depression. In 2017, suicide accounted for 26 deaths in APRH service area and 1.3% of all deaths. The highest frequency of suicide occurred among adults aged 25-54 years old, in 2017.

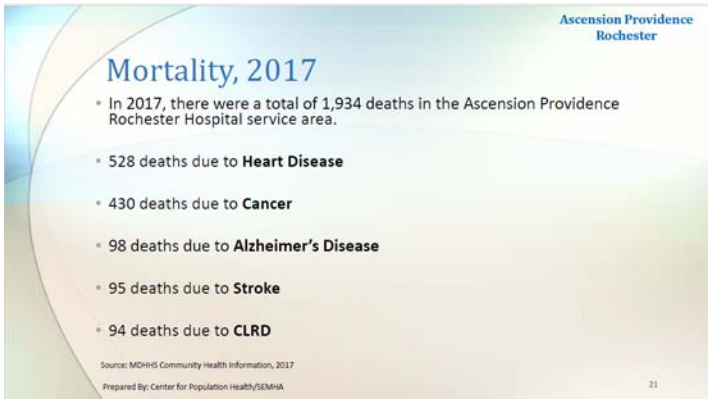





## ASSESSMENT PRIORITIES, HEALTH NEEDS, AND COMMUNITY ASSETS IDENTIFIED

The APRH Advisory Board; comprised of business and community leaders, public health, and representatives from organizations serving the underprivileged in our community, categorized the identified community needs using the Hanlon Approach for issue prioritization into three priority groups: Cardiac Health, Healthy Lifestyles, and Mental Wellness

The Hanlon Method for issue prioritization is a long tested Public Health tool. It is a quantitative and qualitative method that provides a fair, reasonable, and easy way to compare different health problems in a relative framework, as equally and somewhat object manner. The needs expressed throughout the assessment were common to the secondary data and the participants of the survey encompassing all regions of our community service areas.

### ***Cardiac Health***:

Respondents identified cardiac health as the top area of concern. This priority is consistent with local and state data gathered by Michigan Department of Health and Human Services (MDHHS) and data national from U. S. Department of Health and Human Services reporting heart disease as the leading cause of death at the local, state and national level.

***Resources:*** APRH has a strong cardiovascular service line with the added support of the Ascension Michigan network of providers and services qualified to address all cardiac health concerns. APRH provides many levels of cardiovascular care, including cardiac and vascular surgery, cardiac rehabilitation, diagnosis and screening technology. Education and awareness is also provided through Speakers Bureau on community requested topics, physician lectures, community events such as health fairs, worksite wellness fairs and Farmer's Market.

***Priority opportunity areas identified are to the increase awareness of current cardiac health screenings, increase collaborations with community partners to promote cardiac health for all ages, and increase education. Action plans will address these areas.***

***Healthy Lifestyles:*** Improve nutrition, increase physical activity and reduce diabetes.

Respondents identified several needs related to obesity including concerns to improve nutrition and diabetes. This priority is consistent with Oakland County's Energizing Connections for Healthier Oakland (ECHO) assessment and initiatives, Michigan's Health and Wellness Four Healthy Behaviors initiative and Healthy People 2020 initiatives. Identification of obesity, poor nutrition, and lack of physical activity as a priority community health need aligns APRH with local, state and national initiatives. In addition, other health needs of concern (cancer, high blood pressure, stroke, and heart disease) would reduce risk factors with initiatives that address healthy lifestyles.

***Resources:*** The APRH's Diabetes Education & Nutrition Counseling Center offers assessment, planning and counseling with individual instruction, group classes, and Diabetes Prevention Program (DPP). The Community Health & Education Department at APRH offers health and wellness education at school district health fairs, churches, local community events, and worksites upon request. Education is also provided through Speakers Bureau on community requested topics, physician lectures, and a variety of programs and classes promoting healthy lifestyles.

The nature of our community provides easy walk-ability and access to parks, shopping, nature trails, and bike paths to allow opportunity for physical activity. APRH is committed to improving the health and wellness of our communities and fully supports local government initiatives and wellness coalitions in their efforts to impact the overall health of our community.

***Priority opportunity areas identified for healthy lifestyles. Action plans will address these areas.***

***Mental Wellness***: Stress, anxiety, mental health services, substance abuse rehabilitation services, teen crisis services.

Respondents identified access to stress, anxiety, mental health services, suicide, and substance abuse treatment (alcohol, drugs, and tobacco), as areas of concern. This priority is consistent with Oakland County's Energizing Connections for Healthier Oakland (ECHO) assessment and initiatives, Michigan Department of Community Health Strategic Priorities and Healthy People 2020 initiatives. APRH is working to strengthen these factors through education classes and youth-led community improvement initiatives.

***Resources:*** The Community Health & Education Department at APRH offers health and wellness education at school district health fairs, churches, local community events, and worksites upon request. Education is also provided through Speakers Bureau on community requested topics, physician lectures, and a variety of

programs and classes promoting healthy lifestyles. APRH provides a confidential assessment, Psychiatric Evaluation Resource Center (PERC); a 24-hour phone line for psychiatric intake and referral and resources. APRH offers a variety of support groups such as Alcoholic Anonymous, and Bipolar Support Group. APRH also provides community referrals, resources, and support through the Wellness Center at the Older Person Commission (OPC).

***Priority opportunity areas identified are the increase awareness of current mental health programs, increase collaborations with community partners to promote the improvement of mental wellness for all ages, and increase education. Action plans will address these areas.***

## COMMUNITY NEEDS NOT ADDRESSED

Identified needs that will not be addressed were determined by availability of services in the community. Chronic diseases with substantial support in the community such as cancer, lung disease and arthritis are supported by strong APRH programs with a variety of available resources in addition to the support of the American Cancer Society, American Lung Association and the Arthritis Foundation.

## NEXT STEPS

The APRH team and community team members will collaborate on appropriate areas of identified need and guide the development of implementation strategies and individual action plans for each area of opportunity. Measureable outcome indicators will also be established. The team will appropriately communicate the CHNA results and the Implementation Plan Strategy to the community using a variety of methods.