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St. Vincent Hospital Community Health Needs Assessment - 2018

Conducted by: [Tripp Umbach](#)

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Section 1. Executive Summary

Introduction

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

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



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.

As an AHN member hospital, St. Vincent is committed to continuously improving access to the highest quality care and building upon the tradition of medical excellence. This commitment to the patient experience is demonstrated by the enhancements to the surgical and emergency suites which highlight Saint Vincent's expertise in leading-edge technology. Construction also continues on the 36,474 square-foot Cancer Center that will transform oncology care and improve access to leading-edge treatments, technologies, and clinical trials for the region.

Saint Vincent has been recognized for its quality of care as staff maintains a patient centered approach to providing care. With a focus on customer service and convenience, Saint Vincent Hospital is rated No. 1 in Erie for Medical Excellence in:

- Overall Hospital Care, Medical Care and Surgical Care
- Cancer Care
- Cardiac Care
- Major Cardiac Surgery
- Heart Attack Treatment
- Heart Failure Treatment
- Stroke Care
- Gastrointestinal Hemorrhage Care
- Women's Health

In 2018, AHN joined together with Tripp Umbach to conduct a comprehensive community health needs assessment for the St. Vincent Hospital service area of Crawford, Erie, and Warren counties. The following report documents each project step as well as the key findings from the project.

Objectives and Methodology

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



Coordination and management of strategies based upon the outcomes of a CHNA and implementation strategies improves health outcomes of the communities this hospital serves.

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

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

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

The CHNA process undertaken by AHN, with project management and consultation by Tripp Umbach¹, included input from persons who represent the broad interests of the community served by St. Vincent Hospital, including those with special knowledge of public health issues and representatives of vulnerable populations served by the hospital.

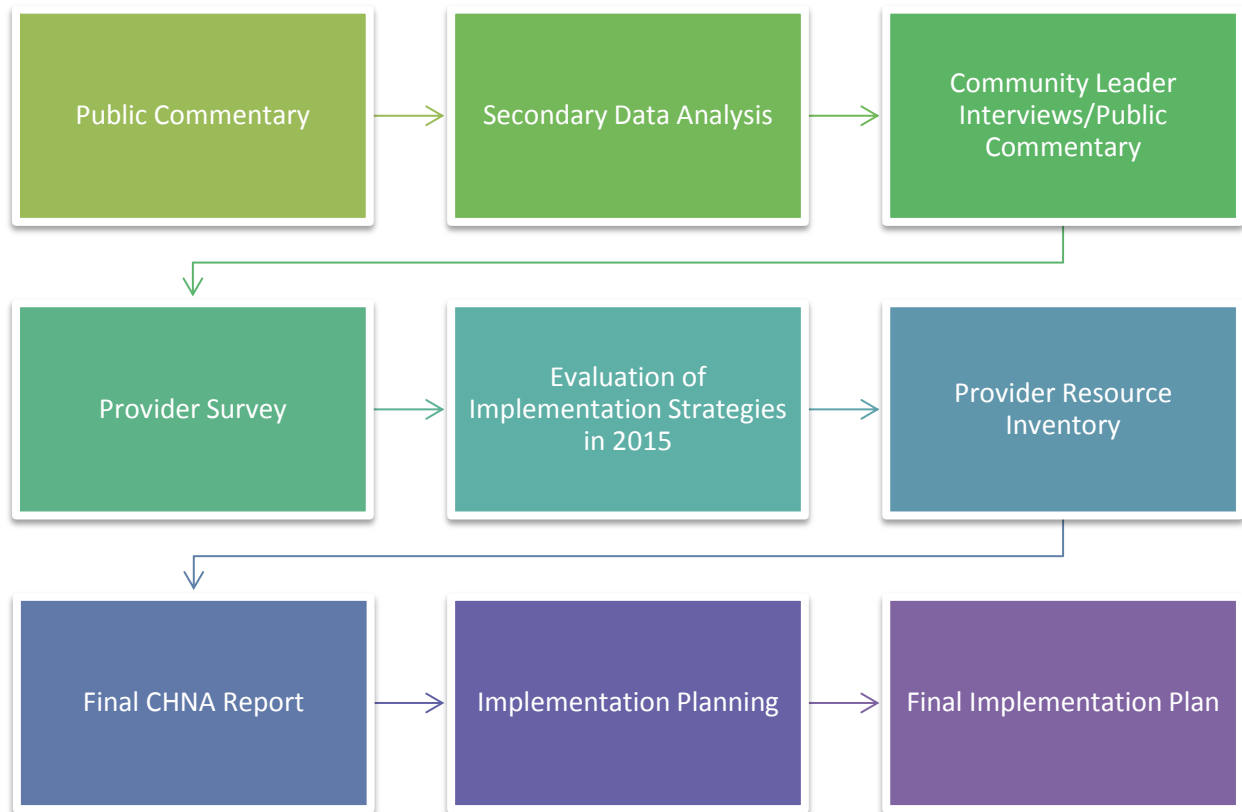
The project components used to determine the community health needs included:

- Public commentary on the 2015 CHNA and Implementation Plan
- Evaluation of Implementation Strategies in 2015
- A survey made available to all AHN providers

¹ See Appendix D for more information on Tripp Umbach

- Secondary data analysis of health status and socioeconomic environmental factors related to health and well-being of residents
- Community leader interviews
- Provider inventory of programs and services related to key prioritized needs

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



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

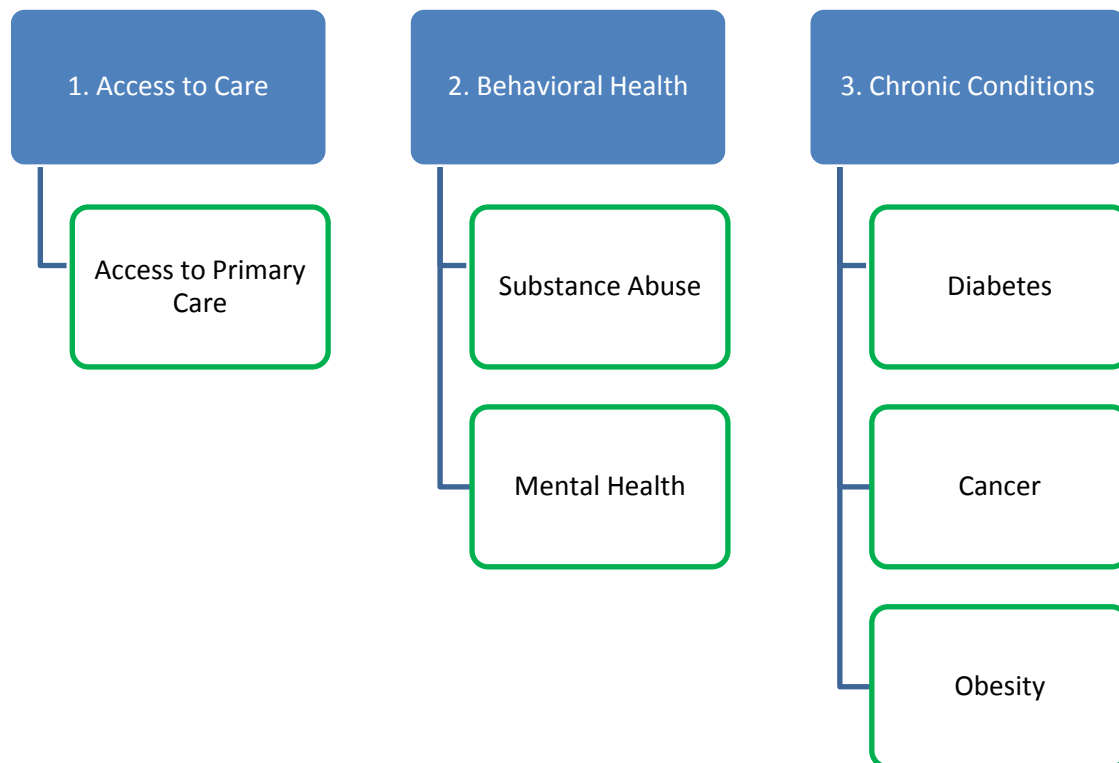
AHN would like to thank all external and internal stakeholders who performed a role in the completion of this CHNA.

Key Prioritized Needs

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

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

Figure 1: Prioritized Community Health Needs for St. Vincent Hospital 2018 CHNA



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

Section 2. Community Definition

St. Vincent’s primary service area, where 80% of their inpatient discharges originated, include the following ZIP codes (excluding ZIP codes for P.O. boxes and offices). For the sake of capturing data most efficiently, secondary data was collected for Erie County, which comprises the largest portion of the St. Vincent Hospital service area in terms of population.

Figure 2: St. Vincent Hospital Community ZIP Codes

ZIP Code	City	County
16327	Guys Mills	Crawford
16329	Irvine	Warren
16335	Meadville	Crawford
16340	Pittsfield	Warren
16350	Sugar Grove	Warren
16351	Tidioute	Warren
16354	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	Erie
16417	Girard	Erie
16420	Grand Valley	Warren
16421	Harborcreek	Erie
16423	Lake City	Erie
16426	McKean	Erie
16428	North East	Erie
16430	North Springfield	Erie
16433	Saegertown	Crawford
16434	Spartansburg	Crawford
16436	Spring Creek	Warren
16438	Union City	Erie
16440	Venango	Crawford
16441	Waterford	Erie

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

Section 3. Key Findings

The health status of a community depends on many factors, including quality of health care, social and economic determinants, individual behaviors, heredity, education and the physical environment. Communities across the U.S. face numerous challenges and issues that negatively affect the overall health status of residents and hinder growth and development. In the St. Vincent Hospital study area, six community health issues and needs were identified:

1. Access to Care: Primary Care
2. Behavioral Health: Mental Health Services
3. Behavioral Health: Substance Abuse
4. Chronic Conditions: Diabetes
5. Chronic Conditions: Cancer
6. Chronic Conditions: Obesity

Within each of the community health need areas, multiple factors must be considered. Health behaviors, education, and socioeconomic/environmental conditions greatly affect an individual's health status and ability to overcome health issues in the region. It is important for health providers and community-based organizations to understand the regional health issues and be aware of the most needed services and improvements.

CHNA Need #1: Access to Care, Primary Care

Access to primary health care is perhaps the most important segment of the care continuum. The ability for an individual to access health care is key to having a healthy life. Typically, access to care refers to the opportunity (and ease) in which people can obtain health care, but it can also refer to having or utilizing health care coverage. Disparities in health service access can significantly affect an individual's and a community's quality of life in a negative way. A lack of available health resources, the high cost of services, and being uninsured can serve as some of the top barriers to accessing health care services.



- **Key Insight:** When surveyed, 9.4% of providers in the Allegheny Health Network reported that lack of primary care physician is one of the greatest barriers to accessing services.

Across the U.S., a predicted shortage of as many as 90,000 physicians by 2025 will serve as an access issue.² Demand for primary care services is projected to grow, mostly due to population aging and growth. Aging and population growth are projected to account for 81% of the change in demand between 2010 and 2020. The remainder of the projected change in demand is associated with the estimated expansion of health insurance coverage under full implementation of the Affordable Care Act, including an assumption that all states expand Medicaid.

- **Key Insight:** 60.5% of surveyed providers in the Allegheny Health Network reported that lack of insurance is one of the greatest barriers to accessing services.

Based on current utilization patterns, demand for primary care physicians is projected to grow more rapidly than physician supply.

- The number of primary care physicians is projected to increase from 205,000 FTEs in 2010 to 220,800 FTEs in 2020, an 8% increase.
- The total demand for primary care physicians is projected to grow by 28,700, from 212,500 FTEs in 2010 to 241,200 FTEs in 2020, a 14% increase.

Without changes to how primary care is delivered, the growth in primary care physician supply will not be adequate to meet demand in 2020, with a projected shortage of 20,400 physicians. While this deficit is not as large as has been found in prior studies, the projected shortage of primary care physicians is still significant.³

Approximately 1 in 5 Americans (children and adults under age 65) do not have medical insurance.⁴ People without medical insurance are more likely to lack a usual source of medical care, such as a PCP, and are more likely to skip routine medical care due to costs, increasing their risk for serious and disabling health conditions. When they do access health services, they are often burdened with large medical bills and out-of-pocket expenses. Specifically, Erie County shows the lowest rate of insurance within the study area (11% of the population).⁵



² Bernstein, Lenny. "U.S. faces 90,000 doctor shortage by 2025, medical association warns." The Washington Post.

³ HRSA Health Workforce

⁴ Healthy People 2020

⁵ 2018 County Health Rankings

Access to health services affects a person’s health and well-being. Regular and reliable access to health services can:

- Prevent disease and disability
- Detect and treat illnesses or other health conditions
- Increase quality of life
- Reduce the likelihood of premature (early) death
- Increase life expectancy

Primary care providers (PCPs) play an important role in protecting the health and safety of the communities they serve. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

While PA scores fairly well at access and affordability (15th best in the country), access to Primary Care Physicians is a priority in the Saint Vincent Hospital service area. Crawford, Erie and Warren counties fall below the state average for the number of PCPs per 100,000 with Warren County having the fewest PCPs per 100,000.⁶

Figure 3: PCP Rates

Report Area	Primary Care Physicians, 2014	Primary Care Physicians, Rate per 100,000 Pop.
Crawford County, PA	58	66.53
Erie County, PA	241	86.55
Warren County, PA	23	56.51
Pennsylvania	12,643	98.9
United States	279,871	87.8

Community Commons, 2014

⁶ Community Commons 2014

Further, portions of Erie and Crawford Counties are designated in health professional shortage area (HPSA), while all of Warren County is designated as health professional shortage area .⁷ This indicator is relevant because access to regular primary care is important to preventing major health issues and emergency department visits. Access to clinical preventive services in must address logistic factors such as adequate transportation to help patients access the care they need. Addressing this social determinant is a major key in reducing health disparities and improving the health of all Americans

CHNA Need #2: Behavioral Health

Mental Health Services

Mental health is a growing issue across the U.S. Approximately one in five adults in the U.S. – or 43.8 million residents – experiences mental illness in a given year. 21.5% of youth age 13 through 18 experiences a severe mental disorder at some point during their lives.⁸ In many instances, mental illness and substance abuse go hand-in-hand; among the 20.2 million adults in the U.S. with a substance abuse issue, approximately 10.2 million have a co-occurring mental health issue.⁹

Consequences of untreated and ineffective mental health issues include:

- Mood disorders, including major depression, dysthymic disorder and bipolar disorder, are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44.¹⁰
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions.¹¹
- Adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.¹²
- More than 90% of children who die by suicide have a mental health condition.¹³
- Each day an estimated 18-22 veterans die by suicide.¹⁴

7 HRSA. <https://data.hrsa.gov/tools/shortage-area/hpsa-find>

8 “Mental Health by the Numbers” National Alliance on Mental Illness. 2016.

9 “Mental Health by the Numbers” National Alliance on Mental Illness. 2016.

10 Agency for Healthcare Research and Quality, The Department of Health & Human Services. (2009). HCUP Facts and Figures: Statistics on Hospital-based Care in the United States, 2009.

11 Colton, C.W. & Manderscheid, R.W. (2006). Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. Preventing Chronic Disease: Public Health Research, Practice and Policy.

12 National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness.

13 U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health.

Approximately 20% of youth (13-18) experience severe mental disorders in a given year (13% for ages 8-15) and about 10.2 million adults in the U.S. have co-occurring mental health and addiction disorders. 60% of adults and nearly 50% of youth (8-15) with a mental illness received no mental health treatment in the previous year.¹⁵



With high rates of mental illness and substance abuse across the nation and in the state of Pennsylvania, it is increasingly important for residents to be able to seek and obtain quality care and treatments in order to manage their conditions. However, many struggling with mental and behavioral health issues are unable to access treatment. 56.5% of adults with mental illness received no past year treatment, and for those

seeking treatment, 20.1% continue to report unmet treatment needs.¹⁶ The rate of behavioral health providers, cost of care, and uninsured levels play a role in a person's ability to receive behavioral health care.

- **Key Insight:** 32.0% of surveyed providers in the Allegheny Health Network reported that mental health services is one of the top three health needs in their service area.

Erie County (570:1) lags behind the state average (560:1) in mental health providers per population.¹⁷ Pennsylvania reports a range between 18.0%– 18.9% of residents who reported any type of mental illnesses in years 2015-2016. For 2016, the rate of Individuals with Any Mental Illness has increased in Pennsylvania compared to the rest of the nation (18.76% compared to 18.07%).¹⁸

- **Key Insight:** Access to mental health services was the second most frequent answer (59.7%) among surveyed AHN providers when asked what types of improvements they would like to see in the current health care system.

Accessing behavioral health care is pertinent as behavioral health issues can have detrimental effects on the health of individuals and communities. For example, those living with serious mental illness face an increased risk of developing a chronic medical condition. An adult with a serious mental illness dies on average 25 years sooner than someone without a serious mental illness; the deaths typically stem from a treatable chronic condition.¹⁹

14 U.S. Department of Veteran Affairs Mental Health Services Suicide Prevention Program. (2012). Suicide Data Report, 2012

15 National Alliance on Mental Illness, Mental Illness Facts and Numbers, 2016

16 Mental Health American. 2018.

17 County Health Rankings, 2018

18 SAMSA

19 "Mental Health by the Numbers" National Alliance on Mental Illness. 2016.

In addition, untreated mental health conditions prevent individuals from leading everyday lives. Mental illness may prevent individuals from obtaining an education and having a stable job, both of which are important to an individual's well-being, as well as the overall health of a community. Improved access to behavioral health care services for all residents will help those dealing with mental illness and substance abuse to receive the treatment they need.

Substance Abuse

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

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

Policies which influence the levels and patterns of substance use and related harm can significantly reduce the public health problems attributable to substance use, and interventions at the health care system level can work towards the restoration of health in affected individuals.²⁰

Drugs (with emphasis on opioids)

Every day, more than 115 people in the United States die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is \$78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.²¹

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

In 2016, there were 2,235 opioid-related overdose deaths--- in Pennsylvania a rate of 18.5 deaths per 100,000 persons—compared to the national rate of 13.3 deaths per 100,000 persons. Since 2010, opioid-related overdose deaths have increased in all categories. Heroin overdose deaths have increased from 131 to 926; synthetic opioid overdose deaths have

20 World Health Organization

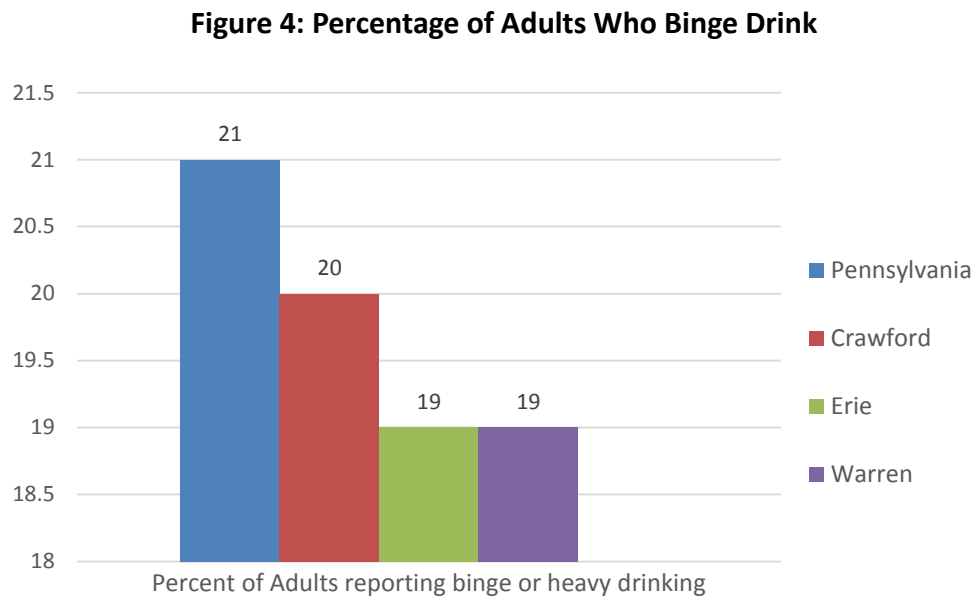
21 National Institute on Drug Abuse

increased from 98 to 1,309; and prescription opioid overdose deaths have increased from 411 to 729 deaths.²²

In the study area, the opioid epidemic was a health issue that was discussed very frequently – many interviewees were concerned about the perceived growing levels of opioid abuse in the St. Vincent service area.

Alcohol and Tobacco Use

Nearly 43% of surveyed AHN providers identified alcohol use as a top three health risk/lifestyle behavior. Crawford County reported a higher rate of binge alcohol use (20%) than both Erie (19%) and Warren counties (19%); however, all were below the PA average (21%).²³



Additionally, 30% of Warren County residents smoke cigarettes, while 26.2% of Erie County residents smoke cigarettes, which is higher than the state average (20.8%) and national average (18.1%).²⁴

22 National Institute on Drug Abuse, *Pennsylvania Opioid Summary*

23 SAMSHA, 2018

24 Community Commons, 2014

Figure 5: Smoking Among Adults

Report Area	Total Population Age 18+	Total Adults Regularly Smoking Cigarettes	Percent Population Smoking Cigarettes (Age-Adjusted)
Crawford County, PA	68,993	13,592	20.6%
Erie County, PA	215,722	54,362	26.2%
Warren County, PA	32,996	8,876	30%
Pennsylvania	9,857,384	1,961,619	20.8%
United States	232,556,016	41,491,223	18.1%

CHNA Need #3: Chronic Conditions

Diabetes

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

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

Over 10% of Erie County adults have diabetes, which is higher than the state average (9.1%).²⁵

25 Community Commons, 2014

Figure 6: Diabetes Rates Among Adults

Report Area	Total Population Age 20+	Population with Diagnosed Diabetes	Population with Diagnosed Diabetes, Age-Adjusted Rate
Crawford County, PA	65,624	7,678	9.7%
Erie County, PA	209,578	24,311	10.3%
Warren County, PA	32,088	4,011	9.9%
Pennsylvania	9,702,557	1,028,685	9.17%
United States	236,919,508	23,685,417	9.19%

Diabetes was the seventh leading cause of death in the United States in 2015 based on the 79,535 death certificates in which diabetes was listed as the underlying cause of death. In 2015, diabetes was mentioned as a cause of death in a total of 252,806 certificates.²⁶

Cancer

Unfortunately, cancer is a local, national, and worldwide chronic disease that has affected millions of people. Consider the scope of cancer on a national level:²⁷

- In 2018, an estimated 1,735,350 new cases of cancer will be diagnosed in the United States and 609,640 people will die from the disease.
- The most common cancers (listed in descending order according to estimated new cases in 2018) are breast cancer, lung and bronchus cancer, prostate cancer, colon and rectum cancer, melanoma of the skin, bladder cancer, non-Hodgkin lymphoma, kidney and renal pelvis cancer, endometrial cancer, leukemia, pancreatic cancer, thyroid cancer, and liver cancer.
- The number of new cases of cancer (cancer incidence) is 439.2 per 100,000 men and women per year (based on 2011–2015 cases).
- Cancer mortality is higher among men than women (196.8 per 100,000 men and 139.6 per 100,000 women).

²⁶ American Diabetes Association

²⁷ Cancer.gov

- When comparing groups based on race/ethnicity and sex, cancer mortality is highest in African American men (239.9 per 100,000) and lowest in Asian/Pacific Islander women (88.3 per 100,000).
- Approximately 38.4% of men and women will be diagnosed with cancer at some point during their lifetimes (based on 2013–2015 data).

In Pennsylvania, there are projected to be 80,960 estimated new cases in 2018 and 28,620 estimated deaths in 2018 alone.²⁸ The most common cancer diagnoses in Pennsylvania are breast (female), lung, prostate, and colon.²⁹

Obesity

Obesity is a major issue across the United States affecting all demographics. More than one-third (36.5%) of adults in the U.S. are currently obese, and that number has continued to rise.³⁰ Data from 2015-2016 show that nearly 1 in 5 school age children and young people (6 to 19 years) in the United States has obesity.³¹ Obesity is particularly prevalent across the Southern and Appalachian portions of the U.S. Pennsylvania experiences fairly high rates of obesity, as the state had the 25th highest obesity rate in the nation in 2017.³²

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

Obesity is one of the largest contributing factors of preventable chronic conditions, including diabetes, hypertension, and stroke. Adults who are overweight are more likely to have high blood pressure and high cholesterol, both of which can lead to major health issues such as heart disease and stroke. As obesity rates are on the rise, so are chronic diseases. The toll and the overall health care costs associated with obesity and chronic diseases are staggering. The CDC estimates that health care costs due to obesity and the chronic diseases that stem from obesity are estimated to be anywhere between \$147 billion to \$210 billion per year.³³



28 American Cancer Society

29 American Cancer Society

30 "Adult Obesity Facts." Center for Disease Control and Prevention.

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

32 The State of Obesity <http://stateofobesity.org>

33 "The Healthcare Costs of Obesity." The State of Obesity.

Pennsylvania has the 25th highest adult obesity rate in the nation, according to *The State of Obesity: Better Policies for a Healthier America*. Pennsylvania's adult obesity rate is currently 30.3%, up from 20.3% in 2000 and from 13.7% in 1990.³⁴ Erie County reports that 10.3% of its adult population lives with diagnosed diabetes, which is higher than the state average (9.1%) and national average (9.1%).³⁵

Roughly, 34% of Crawford County is considered obese, with Warren County measuring at 33.3% and 31% of Erie County is considered obese. All counties' rate of obesity is higher than the state average (29.0%) and national average (27.5%).³⁶ In addition to a healthy diet, physical activity and fitness also is important to leading a healthy lifestyle and preventing obesity and chronic disease. Physical inactivity is responsible for one in 10 deaths among U.S. adults.³⁷

Figure 7: Obesity Among Adults

Report Area	Total Population Age 20+	Adults with BMI > 30.0 (Obese)	Percent Adults with BMI > 30.0 (Obese)
Crawford County, PA	65,809	22,704	34.3%
Erie County, PA	208,696	65,113	30.9%
Warren County, PA	31,952	10,736	33.3%
Pennsylvania	9,696,134	2,844,376	29%
United States	234,188,203	64,884,915	27.5%

34 The State of Obesity, Pennsylvania, <https://stateofobesity.org/states/pa>

35 Community Commons, 2014

36 Community Commons, 2014

37 Danaei G, Ding EL, Mozaffarian D, et al. The Preventable Causes of Death in the United States: Comparative Risk Assessment of Dietary, Lifestyle, and Metabolic Risk Factors.

Conclusions and Recommendations

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



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

Recommended Action Steps:

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

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

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



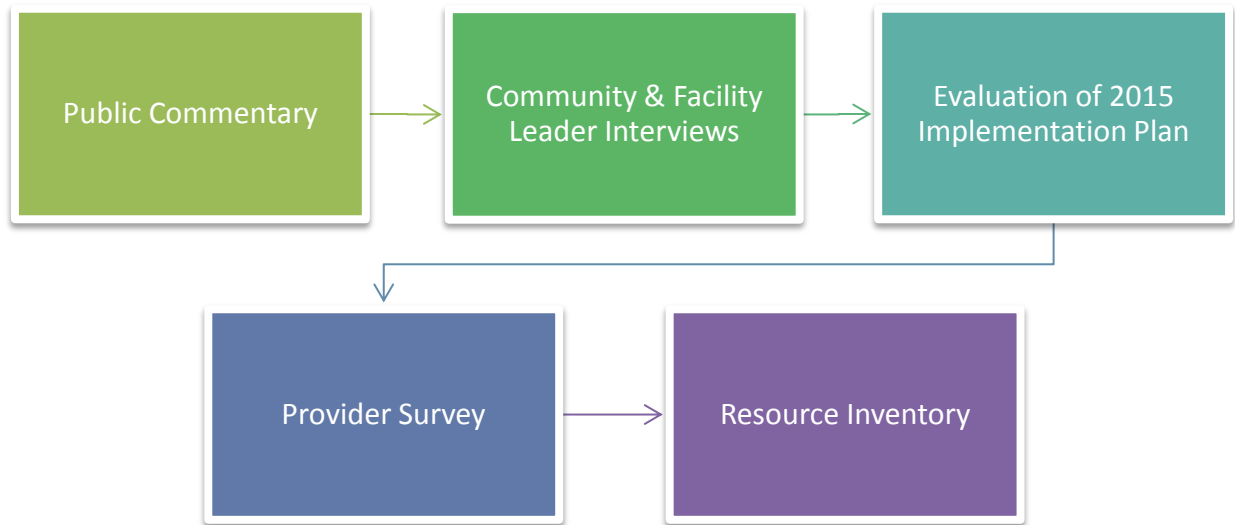
Tripp Umbach, in partnership with AHN, emphasizes that in order to meet the goals and objectives set for in the implementation strategies, St. Vincent Hospital must leverage existing partnerships within the region as well as develop new relationships among organizations and agencies in the community.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

Appendix A: Primary Data Summary

Primary Data Collection

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

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



Community/Facility Leader Interviews and Public Commentary

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

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

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

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

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

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

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

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

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

Evaluation of 2015 Implementation Planning Strategies

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

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

Provider Survey

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

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

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

A. Top five results

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

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

A. Top ten results

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

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

A. Top five results

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

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

A. Top five results

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

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

A. Top five results

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

Provider Resource Inventory

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

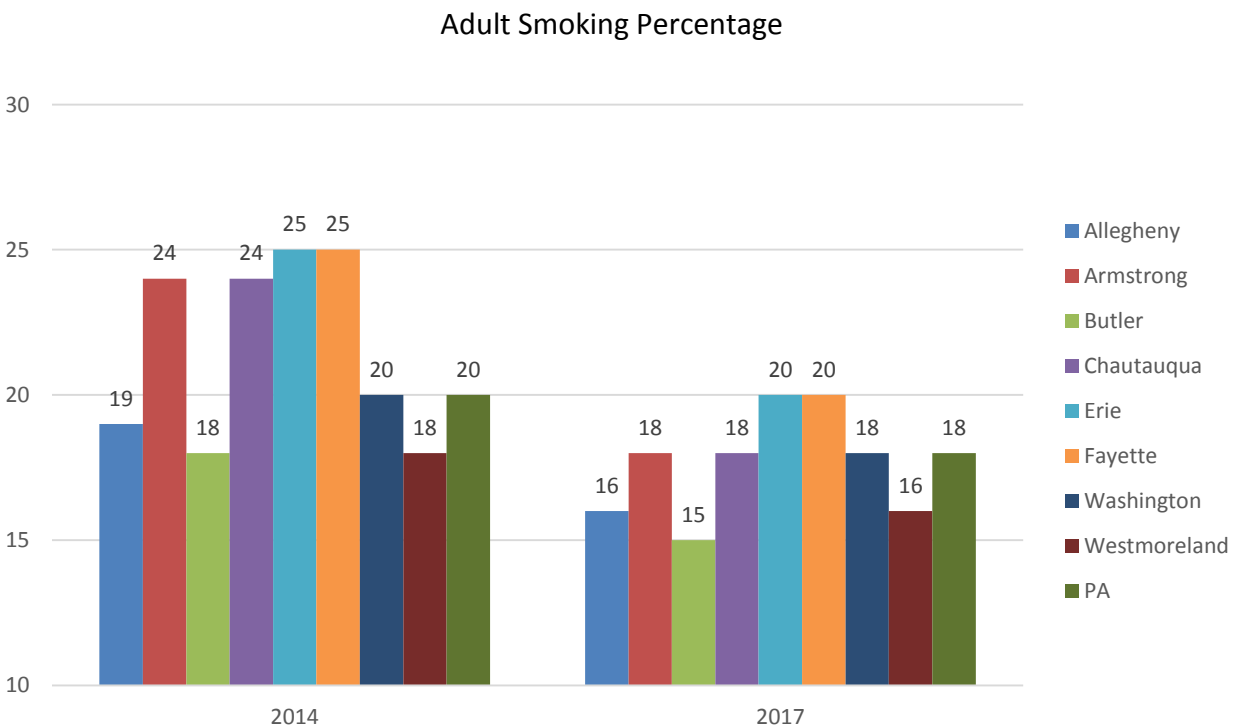
A link to the provider resource inventory will be made available on Allegheny Health Network’s website.

Appendix B: Secondary Data Summary

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

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

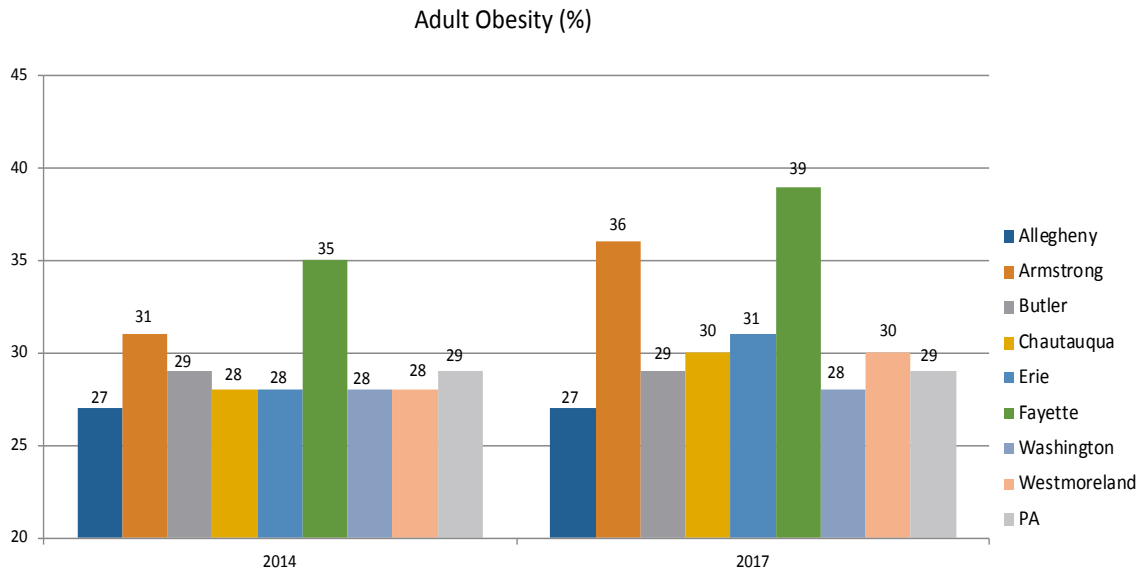
This section is intended to provide anecdotal, contextual support for the identified health needs of Allegheny Health Network. The entire secondary data profile for Allegheny Health Network is available upon request.



Source: 2017 County Health Rankings

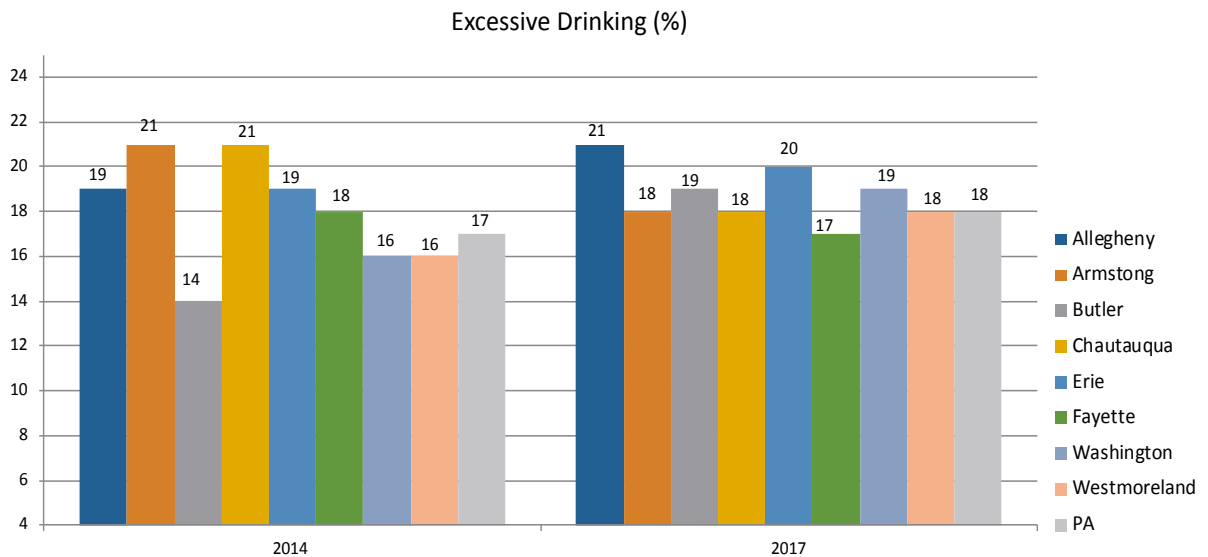
- **Key Insight:** All counties saw a reduction in adult smoking percentage from 2014 to 2017.

- **Key Insight:** In 2017, Erie and Fayette Counties record an adult smoking percentage above the state average.



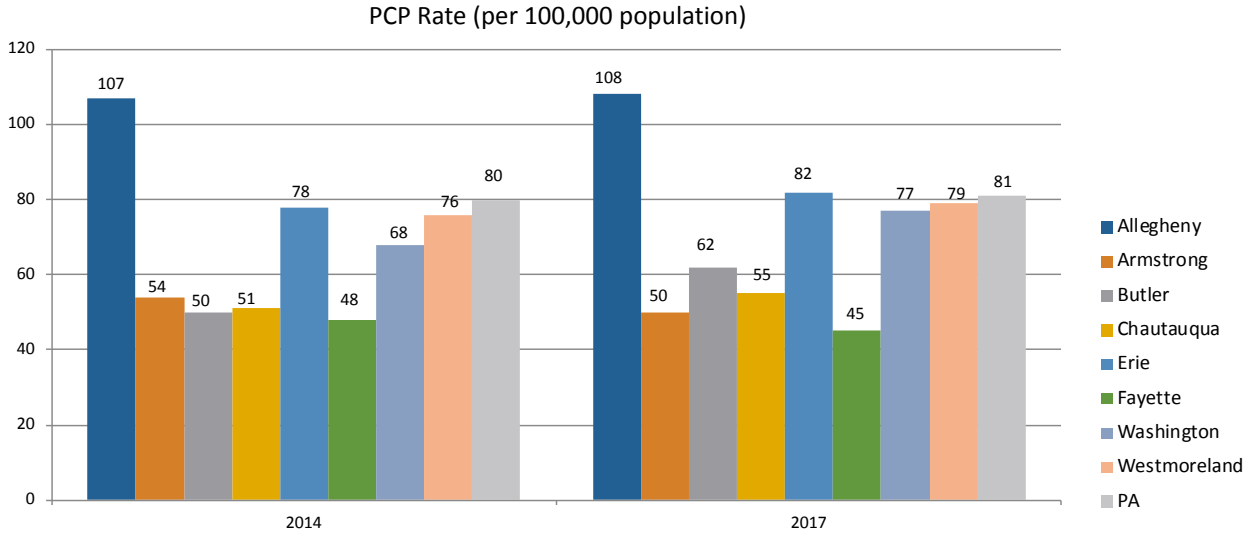
Source: 2017 County Health Rankings

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



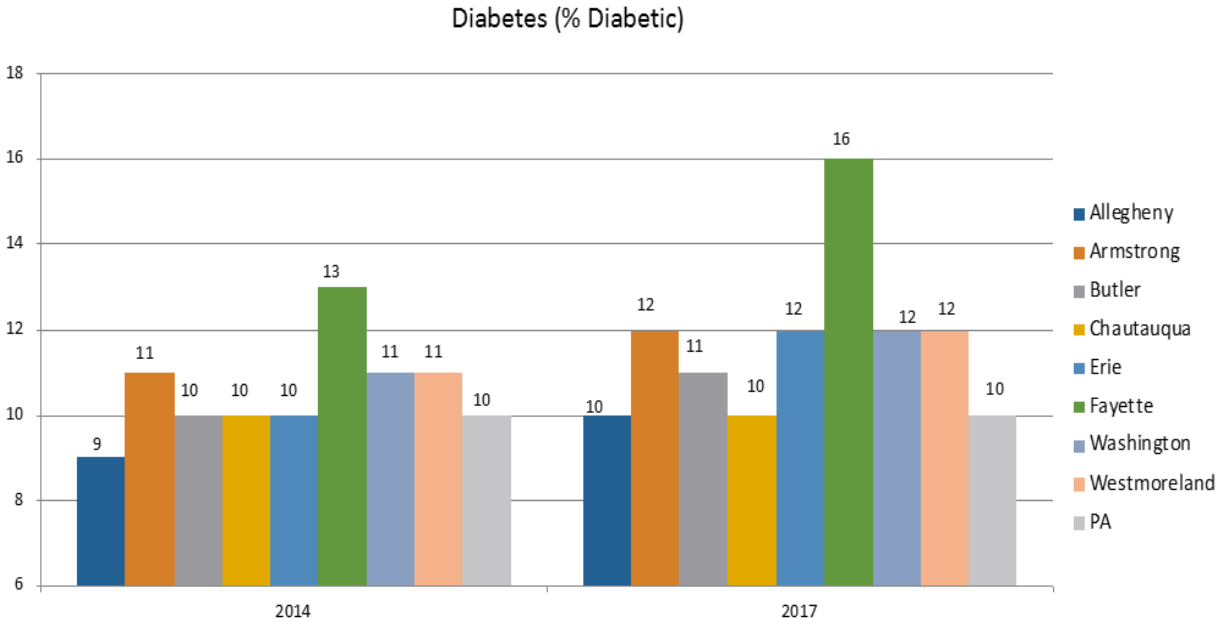
Source: 2017 County Health Rankings

- **Key Insight:** Butler County saw the largest decrease in excessive drinking from 2014 to 2017.
- **Key Insight:** In 2017, Allegheny, Butler, Erie, and Washington Counties all registered excessive drinking rates higher than the state average.



Source: 2017 County Health Rankings

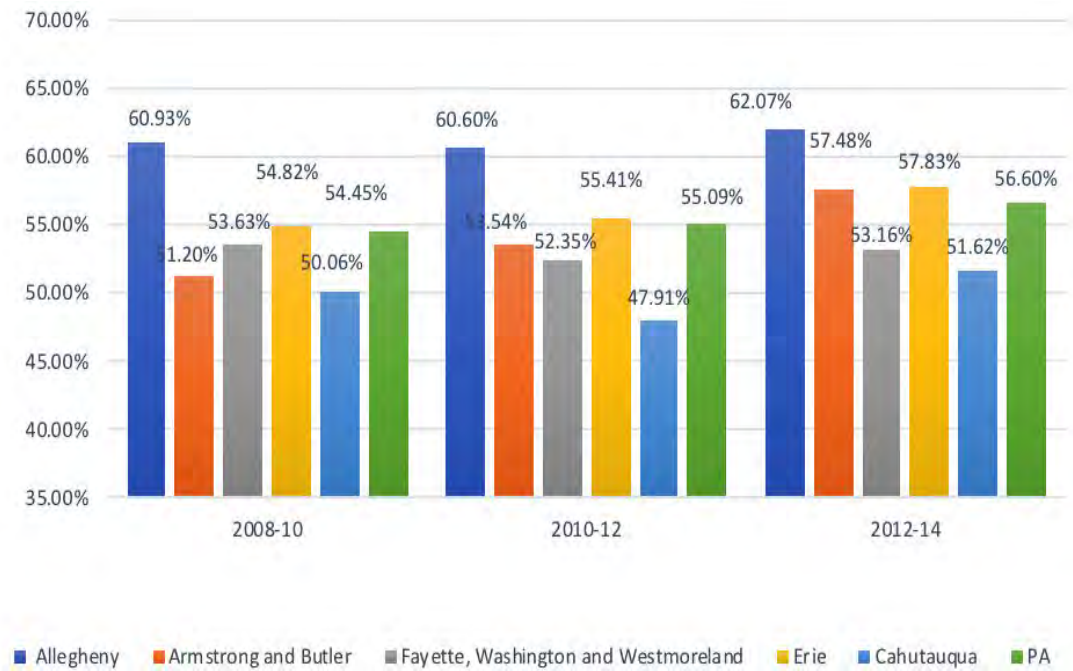
- **Key Insight:** The rate Of PCP per 100,000 increased in all counties except for Armstrong and Fayette, which declined.
- **Key Insight:** In 2017, Armstrong, Butler, Chautauqua, Fayette, Washington, and Westmoreland Counties record lower PCP rates compared to the state average.



Source: 2017 County Health Rankings

- **Key Insight:** The percentage of diabetic adults increased in Allegheny, Armstrong, Butler, Erie, Fayette, Washington, and Westmoreland Counties from 2014-2017.
- **Key Insight:** All counties in the study area register equal or higher diabetic adults in comparison to the state average.

Alcohol Use in the Past Month (Aged 12 +)

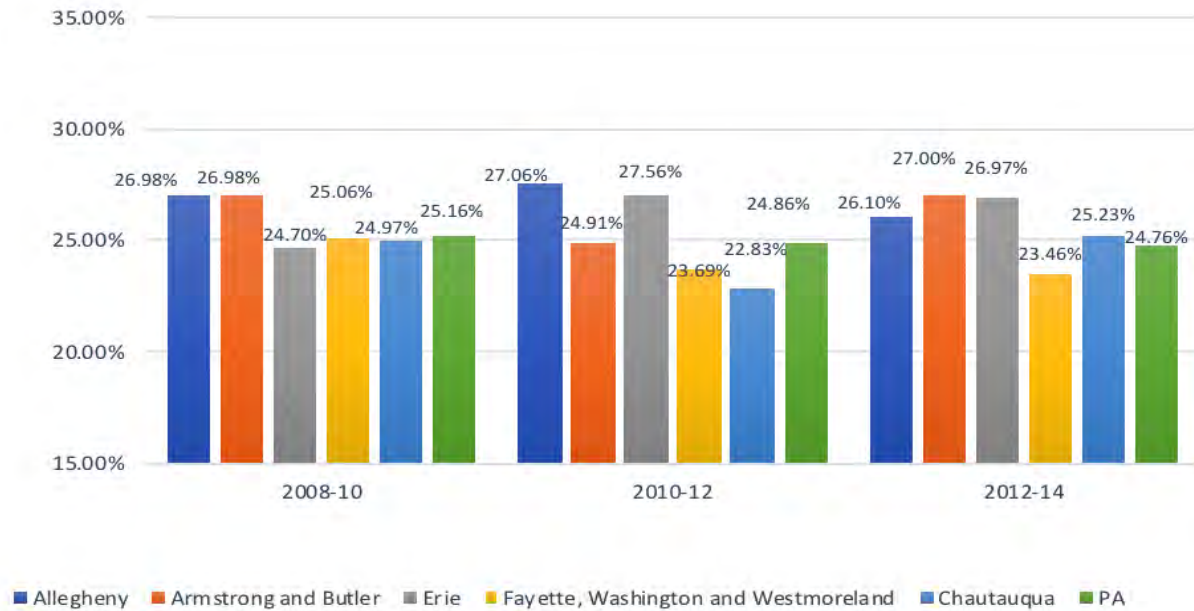


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014

- **Key Insight:** Armstrong/ Butler³⁸, Allegheny and Erie counties both report a higher percent of Alcohol Use when compared to the state during the most recent 2012-2014 study period.
- **Key Insight:** Most counties registered relatively equal or slightly higher rates of alcohol usage during the last month during the study period.

³⁸ Armstrong and Butler Counties are grouped together due to their geographic proximity for display purposes.

Binge Alcohol Use

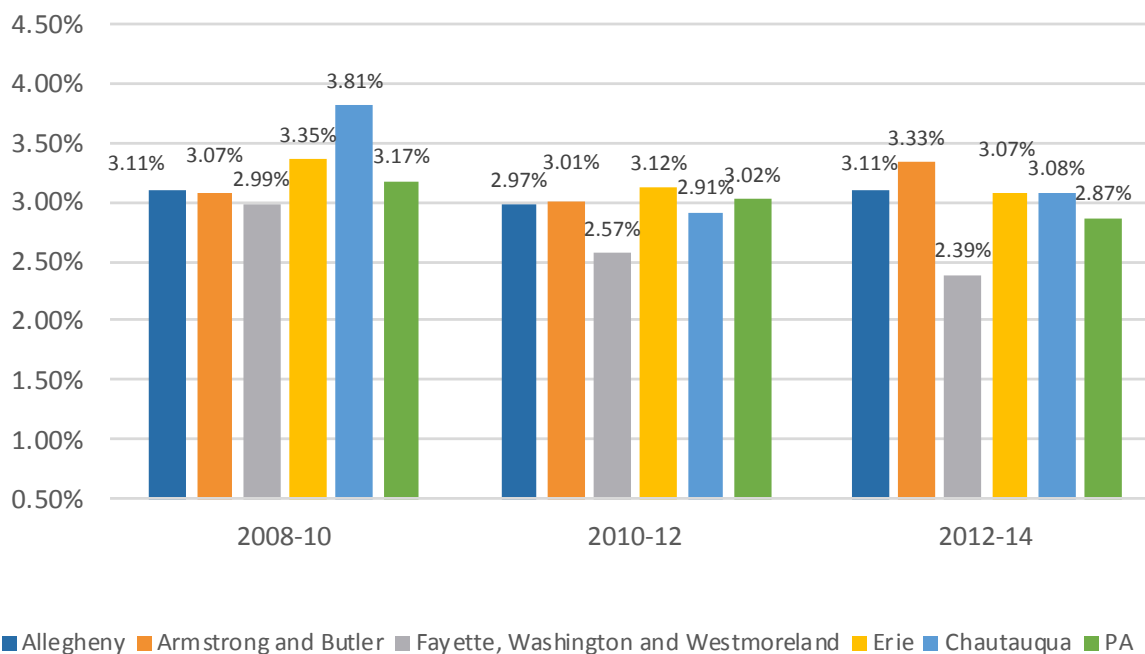


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2014

- **Key Insight:** Allegheny, Armstrong/Butler and Erie County all reported a higher rate of Binge Alcohol Use than the state (26.10%, 27.00% and 26.97% respectively) during the 2012-2014 study period.
- **Key Insight:** Fayette, Washington, & Westmoreland County³⁹ saw the largest decrease in Binge Alcohol Use throughout the study period.

³⁹ Fayette, Washington, and Westmoreland Counties were grouped together due to their geographic proximity for display purposes.

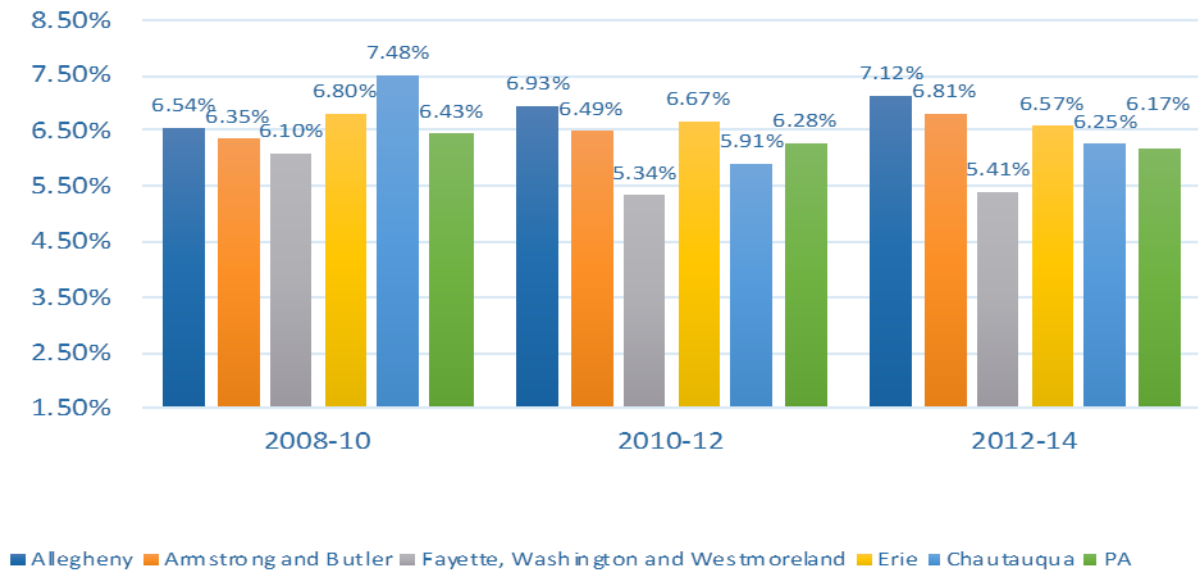
Alcohol Dependence



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

- **Key Insight:** Allegheny, Armstrong/Butler, Erie, and Chautauqua County all reported a higher rate of Alcohol Dependence than the state (3.11%, 3.33%, 3.07%, and 3.08% respectively) during the 2012-2014 study period.
- **Key Insight:** Fayette, Washington, & Westmoreland, as well as Erie County, saw the largest decrease in Alcohol Dependence throughout the study period.

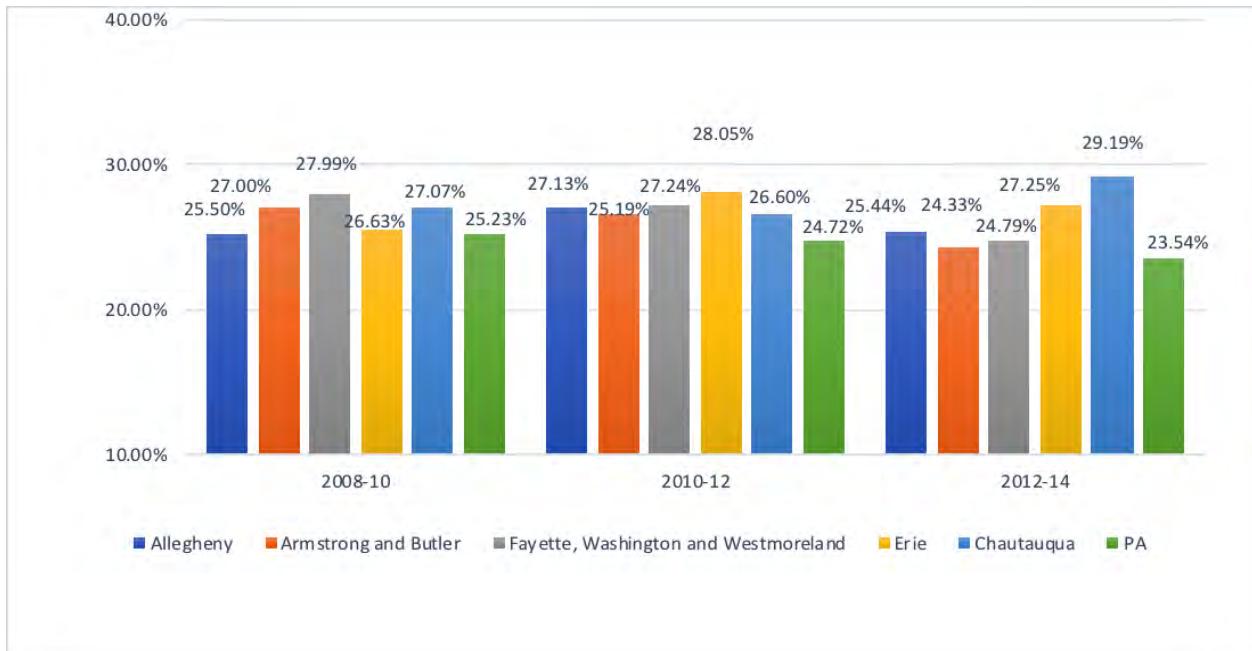
Needing But Not Receiving Treatment for Alcohol Use



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

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

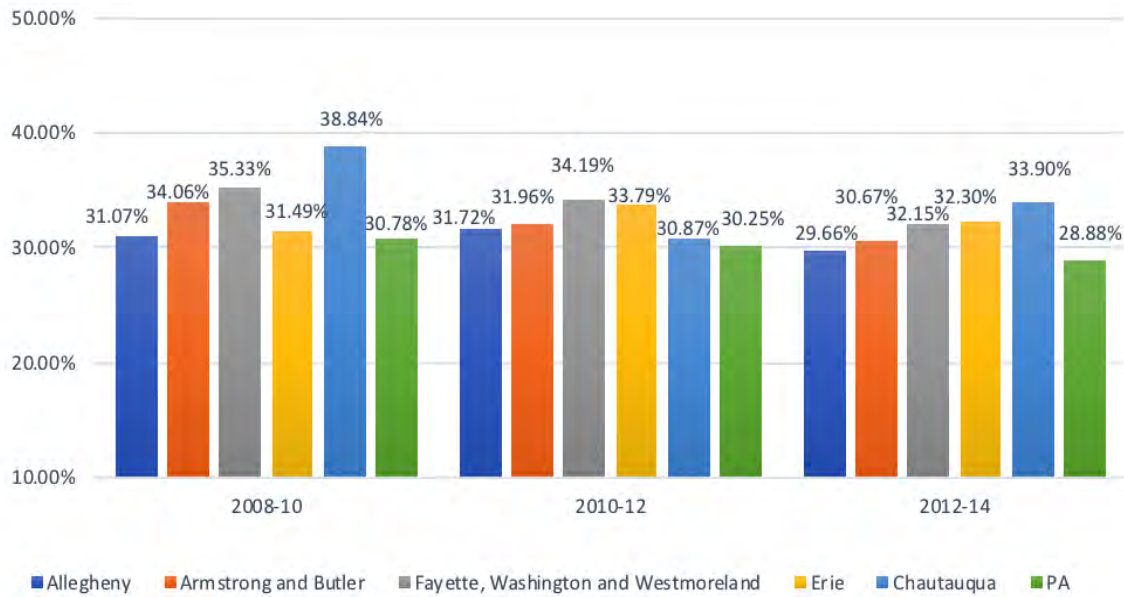
Cigarette Use



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

- **Key Insight:** All County clusters reported a higher rate of Cigarette Use than the state during the 2012-2014 study period.
- **Key Insight:** Fayette, Washington, and Westmoreland County registered the largest decrease in Cigarette Use during the entire study period.

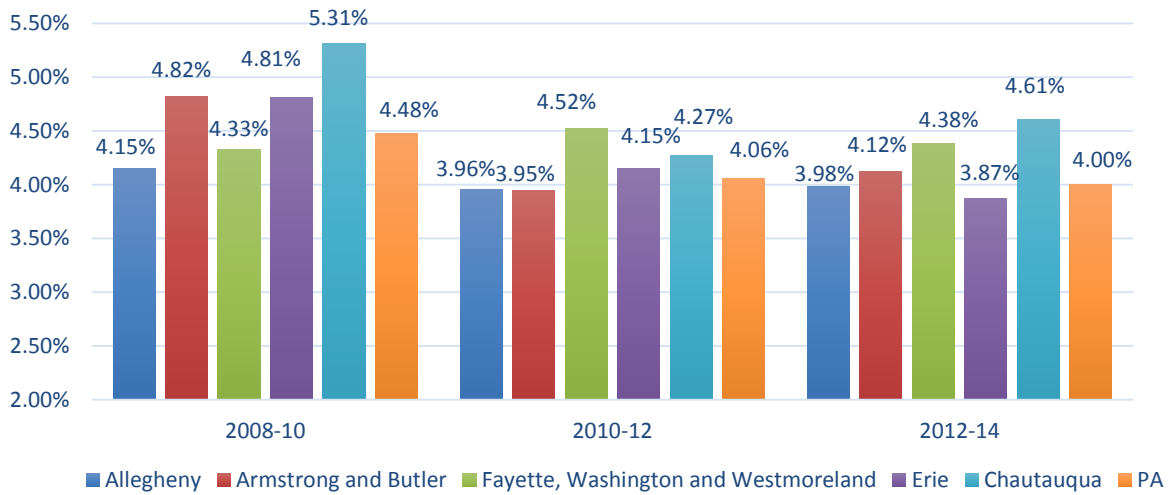
Any Tobacco Use



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

- **Key Insight:** All County clusters reported a higher rate of Any Tobacco Use than the state during the 2012-2014 study period.
- **Key Insight:** Fayette, Washington, and Westmoreland County registered the largest decrease in Any Tobacco Use during the entire study period.

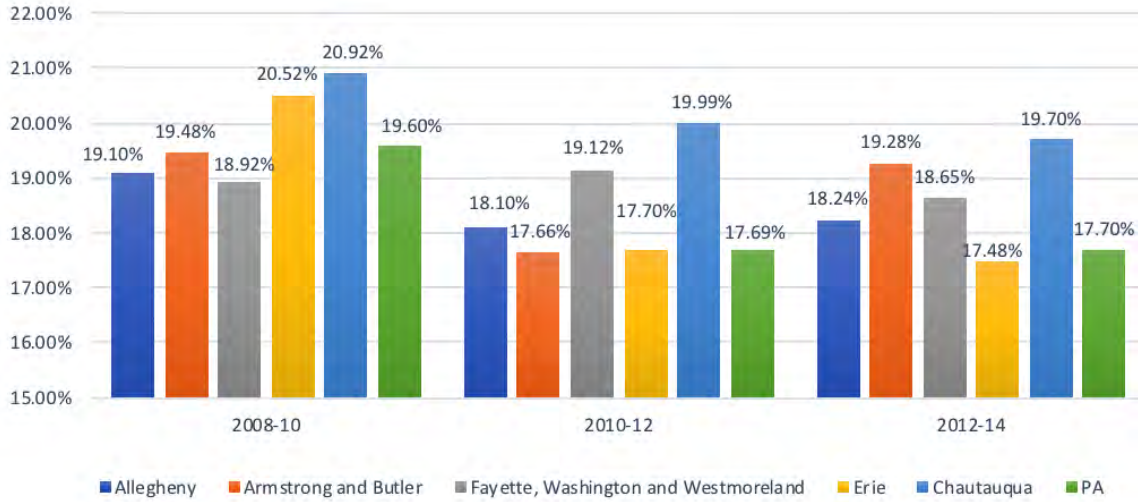
Serious Mental Illness in the Past Year (Aged 18 +)



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

- **Key Insight:** Fayette, Washington and Westmoreland County had the largest decline in the rate of Serious Illness (4.52% to 4.38%) from 2010-2014.
- **Key Insight:** Allegheny and Erie County have lower rates of Serious Illness than the state rate of 4.0% during the 2012-2014 study period.

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



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

- **Key Insight:** Chautauqua County reported the highest rate for Any Mental Illness at 19.70% while Erie County has the lowest rate and is lower than the state rate
- **Key Insight:** Allegheny Armstrong and Butler counties report a sharp rise in the rates of residents with any mental illness from 2010-2012 to 2012-2014.

Appendix C: 2015 Implementation Planning Update and Evaluation

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

1. Health Priority: Behavioral Health

Goal: Reduce mortality and morbidity related to mental health and substance use disorders.

Plan to Meet Objective 1:

Increased utilization of outpatient behavioral health services particularly for the most vulnerable populations.

- Saint Vincent has partnered with the Barber National Institute to provide outpatient mental health services.
- This program which launched late in the 2nd quarter of 2016 has resulted in more than 900 outpatient behavioral health appointments and getting patients in to see a psych provider within 7-10 days.

Plan to Meet Objective 2:

Increase knowledge and skills of first responders and community members around behavioral health.

- Training was to be provided by Millcreek Paramedic Service. This initiative was delayed because of a change to leadership and then never pursued any further.

Plan to Meet Objective 3:

Increase the number of healthcare providers integrating behavioral health and physical health.

- Instituted a behavioral health services liaison with a focus on adult and geriatric patient populations. The liaison performs more than 200 patient assessments each year and coordinates patient access to inpatient behavioral health services.

2. Health Priority: Cancer

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

Plan to Meet Objective 1:

Increase the percentage of adults who receive timely age-appropriate cancer screenings based on the most recent guidelines.

- Over the last 2 years 248 patients have been given an order for a CT Lung Screening of which more than 60% have been identified to have an incidental or non-incidental finding.

Plan to Meet Objective 2:

Reduce the incidence rate for the top four most commonly diagnosed cancers: prostate (male), lung and bronchus, colon and rectum, and breast (female) and the overall cancer mortality rate by promoting healthy lifestyle behaviors related to tobacco use and diet and exercise.

- Provided education and information at community events related to self care and cancer prevention lifestyles
- Implemented an oncology nurse navigation program to include; breast, GI/Colon Cancers, and Survivorship as well as Inpatient/Transition of care
- 8 radiologists completed LungRads assessments, both onsite and remote readers.
- Utilized new 3D mammography and MRI imaging for breast studies. 7,610 3D mammography studies in 2017 and 137 breast MRI's with biopsies in 2017

Plan to Meet Objective 3:

Increase access to health screenings and education to high-risk populations.

- 191 CT screenings of current and past heavy smokers were performed in 2017
- In collaboration with the Susan G. Kommen Foundation, 107 vouchers were provided for free mammograms to uninsured women

3. Health Priority: Chronic Disease

Goal 1: Decrease preventable chronic disease by ensuring access to resources, knowledge, and opportunities for residents to adopt healthy behaviors.

Plan to Meet Objective 1:

Increase primary care providers' recommendations for preventative screenings per risk and age guidelines.

- Utilized the patient specific pre-visit planning worksheet to address screening gaps at each visit
- Use patient registries and targeted outreach for primary care offices to provide reminders and education about preventive screenings. In 2017 40 patients were referred for screenings.

- 2018 Utilize tools that are in our electronic health record to identify patients for outreach
- 2018 lists are given to practices for outreach on screening exams past due

Plan to Meet Objective 2:

Provide health screenings and education to high risk populations.

- Provided education on obesity and health risks related to obesity to 284 patients
- Forty-eight Bariatric Informational seminars provided to patients interested in starting the bariatric program
- 3,167 Body Mass Index (BMI) assessments performed on patients in the bariatric program
- In 2017, there were 132 vascular screenings performed in the community and 62 screens performed in first quarter of 2018.
- Saint Vincent has conducted screenings and education for more than 800 individuals at local senior living centers and community centers.

Plan to Meet Objective 3:

Partner with community organizations to promote healthy lifestyles.

- Saint Vincent has partnered with local employers to provide over 3,000 biometric screenings for their employees and appropriate necessary referrals for any positive findings.
- Saint Vincent has provided 370 physicals to school children. Education and counseling were provided to any children with positive findings and the school nurse sent information and recommendations to parents of any children with positive findings.
- Saint Vincent’s mobile medical unit has provided 383 homeless individuals with screenings and treatment for minor acute symptoms as well as providing counseling and referrals when appropriate

% of Patients Screened with Elevated Values

	Elevated Triglycerides	Elevated Cholesterol	Elevated Glucose	Elevated BMI
	> 150	>200	>99	>24.9
2016	29%	33%	29%	72%
2017	29%	35%	29%	73%
2018	24%	37%	28%	72%

Goal 2: Improve management and outcomes for patients diagnosed with a chronic disease.

Plan to Meet Objective 1:

Reduce hospital 30 day readmission rates for chronic disease.

- Instituted Care Manager rounds on all Medicare patients to ensure a follow up appointment is scheduled within 7 days of discharge. A care manager contacts patient at home within 48 hours of discharge to ensure patient has all they need. If non Medicare patient, the office nurse will do outreach to the patient and ensure they have an appointment scheduled within 7-14 days
- Achieved a consistent readmission rate of 9% or less
- 2018 achieved an average readmission rate of 4% of the patients we are care managing
- Established Chronic Care Management services to our rising risk patients; with certain disease states; such as: COPD and CHF
- 2018 CHF Pathway was developed for patients with this chronic illness
- Enhanced community care managers are looking at the top 5% of our sickest Medicare patients

Plan to Meet Objective 2:

Manage high risk populations through care coordination and partnership with social service partners.

- Saint Vincent has partnered with local employers to provide over 3,000 biometric screenings for their employees and appropriate necessary referrals for any positive findings.
- Saint Vincent's mobile medical unit has provided 383 homeless individuals with screenings and treatment for minor acute symptoms as well as providing counseling and referrals when appropriate.

Plan to Meet Objective 3:

Partner with community organizations to promote healthy lifestyles.

- Saint Vincent's mobile unit has provided screenings and education to 522 persons through local community centers and senior living residences.
- Saint Vincent's mobile medical unit has partnered with the local churches who offer shelter to provide 383 homeless individuals with screenings and treatment for minor acute symptoms as well as providing counseling and referrals when appropriate
- Saint Vincent provided community screening and education at 8 Great Tuesdays throughout the summer focusing on chronic disease management and prevention.

- Saint Vincent partnered with a Gannon University and The Erie County Department of Health to host a weekly event for the Bayfront community focusing of wellness and life style modification.
- Saint Vincent provided vascular screening and education by a peripheral vascular surgeon at the Asian Pacific Festival.

4. Health Priority: Maternal and Child Health

Goal: Reduce morbidity and mortality by improving the health and quality of life of women, infants, children, caretakers and their families, especially in vulnerable communities.

Plan to Meet Objective 1:

Reduce the proportion of preterm and low birth weight births and reduce the disparity between White, African American, and Hispanic populations.

- Implemented new pre-natal educational offerings that are included in the classes provided through the OB providers
- Established a Maternal Fetal Medicine clinic in conjunction with Allegheny Health Network for specialty pre-natal care to expectant mothers with high risk pregnancies

Plan to Meet Objective 2:

Reduce the disparity between White, African American, and Hispanic mothers who receive prenatal care

within the first trimester.

- Implemented new pre-natal educational offerings that are included in the classes provided through the OB providers
- Established a Maternal Fetal Medicine clinic in conjunction with Allegheny Health Network for specialty pre-natal care to expectant mothers with high risk pregnancies

Plan to Meet Objective 3:

Reduce the number of Neonatal Abstinence Syndrome babies

- Started the “Growing Hope” program that provides counseling and services to Women with opioid addiction who are pregnant
- Established collaboration with the Gaudenzia “House of Healing” for patient access, patient and staff education, community outreach.
- Offers classes in signs of addiction for their babies, withdrawal impact, smoking impact, appropriate pain relief during labor and post-partum, shaken baby syndrome, and newborn milestones.

Plan to Meet Objective 4:

Reduce the disparity between White, African American, and Hispanic births resulting in infant mortality

- Implemented patient teaching and education during ante partum outpatient admissions
- Using discharge instructions to provide new mother with information on SIDS, car seat safety, childproofing home, domestic violence, and postpartum depression.

Plan to Meet Objective 5:

Partner with community organizations to improve prenatal indicators (including not smoking during pregnancy, not drinking during pregnancy, prenatal care in first trimester, etc.).

- Implemented smoking and alcohol risks during pregnancy in the prenatal classes and Growing Hope program

Appendix D: About Tripp Umbach

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

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

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

