

Community Health Needs Assessment

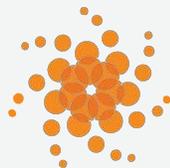
2016 FINAL SUMMARY REPO



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HERITAGE VALLEY
HEALTH SYSTEM

SUBMITTED BY



HOLLERAN

COMMUNITY ENGAGEMENT RESEARCH & CONSULTING

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TABLE OF CONTENTS

Executive Summary	1
Community Health Needs Assessment Background	2
Community Health Needs Assessment Overview	5
I. Demographic Characteristics of Online Survey Participants	5
II. Key Health Issues	7
III. Emergency Department Visits, Readmissions, and Ambulatory Sensitive Admissions	10
IV. Health Risk Behaviors	12
V. Access to Primary Health Care	14
VI. Resources/Changes Needed to Improve Access and Health Outcome	17
VII. Suggestions and Recommendations	18
Key Findings	19
Identification of Community Health Issues	20
Community Health Implementation Strategy	21
Appendix A. Community Meeting Participants	22
Appendix B. Small Group Discussion Notes	23
Appendix C. 2013 Implementation Strategy Outcomes	27

EXECUTIVE SUMMARY

Beginning in August 2015, Heritage Valley Health System undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in Beaver County and select municipalities in the western section of Allegheny County. The purpose of the assessment was to reinforce Heritage Valley Health System's commitment to the health of residents and align its health prevention efforts with the community's greatest needs. The assessment examined a variety of health indicators including chronic health conditions, access to health care and social determinants of health. Heritage Valley Health System contracted with Holleran Consulting, a research firm based in Lancaster, Pennsylvania, to execute this project.

The completion of the CHNA enabled Heritage Valley Health System to take an in-depth look at its community. The findings from the assessment were utilized by Heritage Valley Health System to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. Heritage Valley Health System is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Online Community Survey
- Focus Group Discussions
- Implementation Plan

Previous CHNA

Heritage Valley Health System conducted a comprehensive CHNA in 2013 to evaluate the health needs of individuals living in the hospital service area. The purpose of the assessment was to gather information about local health needs and health behaviors. The assessment helped Heritage Valley Health System to identify five health issues and develop a community health implementation plan to improve the health of the surrounding community.

Prioritized Community Health Issues for the Next Three Years

Based on feedback from community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, Heritage Valley Health System plans to continue its community health improvement focus on the following health priorities that were originally identified in the 2013 CHNA:

- Access to Primary Care
- Healthy Living
- Diabetes
- Smoking
- Cardiovascular/Respiratory Health

Major outcomes from the 2013 priority areas included:

- Opened the Edgeworth Medical Neighborhood in 2013 and the West Allegheny Medical Neighborhood in 2015. These became the fifth and sixth Medical Neighborhoods.
- Recruited 8 primary care physicians and 23 mid-level providers. Retention for physicians was 100% and was 83% for mid-level providers.
- Increased women identified with gestational diabetes from a baseline of 48 in FY2013 to 74 in FY2015.
- Developed and implemented the Diabetes Support Group at two locations.
- Increased participation in the pediatric asthma program from 108 in FY2013 to 123 in FY2015.

A full list of outcomes can be found in Appendix C.

COMMUNITY HEALTH NEEDS ASSESSMENT BACKGROUND

Hospital Overview

Driven by its mission, “to improve the health and well-being of all people in the communities we serve,” Heritage Valley Health System has delivered exceptional and compassionate patient care for residents of Allegheny, Beaver, Butler and Lawrence counties in Pennsylvania; eastern Ohio; and the panhandle of West Virginia. Heritage Valley Health System offers a wide array of medical, surgical and diagnostic services at its two hospitals, Heritage Valley Sewickley and Heritage Valley Beaver.

In partnership with more than 480 physicians and 3,700 employees, Heritage Valley offers a wide array of medical, surgical, and diagnostic services, as well as comprehensive community health programs for patients with chronic conditions in 60 physician offices and 18 community satellite facilities.

Community Overview

Heritage Valley defined their current service area based on an analysis of the geographic area where individuals utilizing Heritage Valley health services reside. The service area is summarized below:

- | | |
|------------------------|-------------------------|
| ➤ Ambridge Borough | ➤ Imperial Township |
| ➤ Baden Borough | ➤ Industry Borough |
| ➤ Beaver Borough | ➤ Koppel Borough |
| ➤ City of Aliquippa | ➤ Leetsdale Borough |
| ➤ City of Beaver Falls | ➤ Midland Borough |
| ➤ Clinton Township | ➤ Monaca Borough |
| ➤ Conaway Borough | ➤ Neville Township |
| ➤ Coraopolis Borough | ➤ New Brighton Borough |
| ➤ Crescent Township | ➤ New Galilee Township |
| ➤ Darlington Township | ➤ Oakdale Borough |
| ➤ Enon Valley Borough | ➤ Rochester Borough |
| ➤ Freedom Borough | ➤ Sewickley Borough |
| ➤ Georgetown Borough | ➤ Shippingport Borough |
| ➤ Hookstown Borough | ➤ South Heights Borough |

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

- An Online Community Survey was conducted with individuals residing in Beaver County and selected municipalities located within Allegheny County. The survey was designed to assess their health status, health risk behaviors, preventive health practices and needs, health care access primarily related to chronic diseases, and community assets and opportunities. The survey took approximately 10 to 15 minutes to complete and a total of 2,907 residents completed the survey throughout the service area.
- Focus Group Discussions: Two focus groups were conducted on March 21st and 22nd, 2016. The first focus group was conducted at Heritage Valley Chippewa in Chippewa, PA, with 14 representatives from the community, while the second one took place at Heritage Valley Edgeworth in Sewickley, PA, with 12 representatives from the community. The purpose of the focus groups was to gather qualitative feedback from community residents regarding health care access issues among low income population groups in both counties.

Online Community Survey Study Background

As noted earlier, the current CHNA utilized an online community survey methodology as one of its research components and was based on a convenience sample of 2,907 respondents. In contrast, the 2013 community survey was conducted via phone interviews and was based on a statistically valid sampling of 403 individuals. While the 2015 and 2013 surveys are similar for the most part and results from the 2013 survey have been aggregated and comparisons were provided where applicable, the findings from the two surveys should be compared and interpreted with caution due to the difference in the methodologies and some survey questions.

Research Partner

Heritage Valley Health System contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 23 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected, analyzed and interpreted data from the online community survey
- Collected, analyzed and interpreted data from the two focus groups
- Conducted implementation and prioritization sessions in collaboration with Heritage Valley Health System; and
- Prepared all reports

Community Representation

Community engagement and feedback were an integral part of the CHNA process. Heritage Valley Health System sought community input through focus group discussions with community residents, an online community member survey available to all residents, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared

knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

As with all research efforts, there are some limitations related to this study's research methods that should be acknowledged. Data based on self-reports should be interpreted with particular caution. In some instances, both community member survey participants and focus group discussants may over-or underreport behaviors and illnesses based on fear of social stigma depending on the health outcome of interest or misunderstanding the question being asked. In addition, respondents may be prone to recall bias where they may attempt to answer accurately, but remember incorrectly.

In addition, timeline and other restrictions may have impacted the ability to survey all community stakeholders. Heritage Valley Health System sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, Heritage Valley Health System prioritized community health issues in collaboration with its research partner, Holleran Consulting, and developed an implementation plan to address prioritized community needs.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

The following sections present the results of the analysis of the online community survey and focus group discussions.

I. Demographic Characteristics of Online Survey Participants

Of the total 2,907 respondents, 71.9% are female and 28.1% are male. The vast majority of respondents identify themselves as White (96.4%) and Blacks/African-Americans represent 2.0%. Approximately 1% of all respondents identify as Latino/Hispanic. Approximately 29% of all respondents are between the ages of 55 and 64 years. An additional 28.1% of all respondents are between the ages of 65 and 80 years old. Nearly, two-thirds of the respondents are married (65.2%) and approximately 12% and 10% of respondents were single and divorced respectively.

Table 1. Demographic Information

Demographics	
Gender	
Male	28.1%
Female	71.9%
Age	
18 – 24	1.6%
25 – 34	7.7%
35 – 44	12.3%
45 – 54	17.5%
55 – 64	29.2%
65 – 80	28.1%
81+	3.5%
Marital Status	
Married	65.2%
Divorced	10.2%
Widowed	7.6%
Separated	2.1%
Never married	11.8%
Member of an unmarried couple	3.2%
Race/Ethnicity	
White	96.4%
Black/African American	2.0%
American Indian/Alaska Native	0.3%
Asian/Pacific Islander	0.3%
Hispanic/Latino - <i>can be of any race, for example, White Hispanic</i>	1.2%
Other	0.9%

Education is an important social determinant of health. Anecdotal evidences indicate that individuals who are less educated tend to have poorer health outcomes. Nearly 40.0% of respondents have an undergraduate degree or higher and a quarter of respondents attained some college, technical school or nursing school. In regard to employment status, the majority of respondents (46.8%) are currently employed and working full-time while 30.8% are retired. Another indirect measure of health outcome is household income, as it provides a foundation for determining poverty status. One-third of the respondents have an annual household income of \$75,000 or more. Nearly 16% of respondents were found to be in the lowest income brackets, earning an annual income of less than \$25,000.

Table 2. Demographic Information (Cont'd)

Demographics	
Level of Education	
Grades 1-8 (elementary school)	0.1%
Grades 9-11 (Some high school, but no diploma)	0.6%
Grade 12 (High school diploma or GED)	20.3%
College 1 year to 3 years (Some college or technical school)	25.0%
Associate's degree	13.3%
College 4 years or more (College graduate)	22.4%
Graduate or professional-level degree	16.8%
Other	1.5%
Employment Status	
Employed, working full-time	46.8%
Employed, working part-time	9.6%
Not employed, looking for work	1.9%
Not employed, NOT looking for work	0.9%
Retired	30.8%
Disabled, not able to work	5.2%
Student	0.7%
Homemaker	4.1%
Annual household income from all sources	
Less than \$10,000	3.1%
\$10,000-\$14,999	3.7%
\$15,000-\$19,999	3.1%
\$20,000-\$24,999	5.7%
\$25,000-\$34,999	11.4%
\$35,000-\$49,999	15.5%
\$50,000-\$74,999	23.9%
\$75,000 and more	33.6%

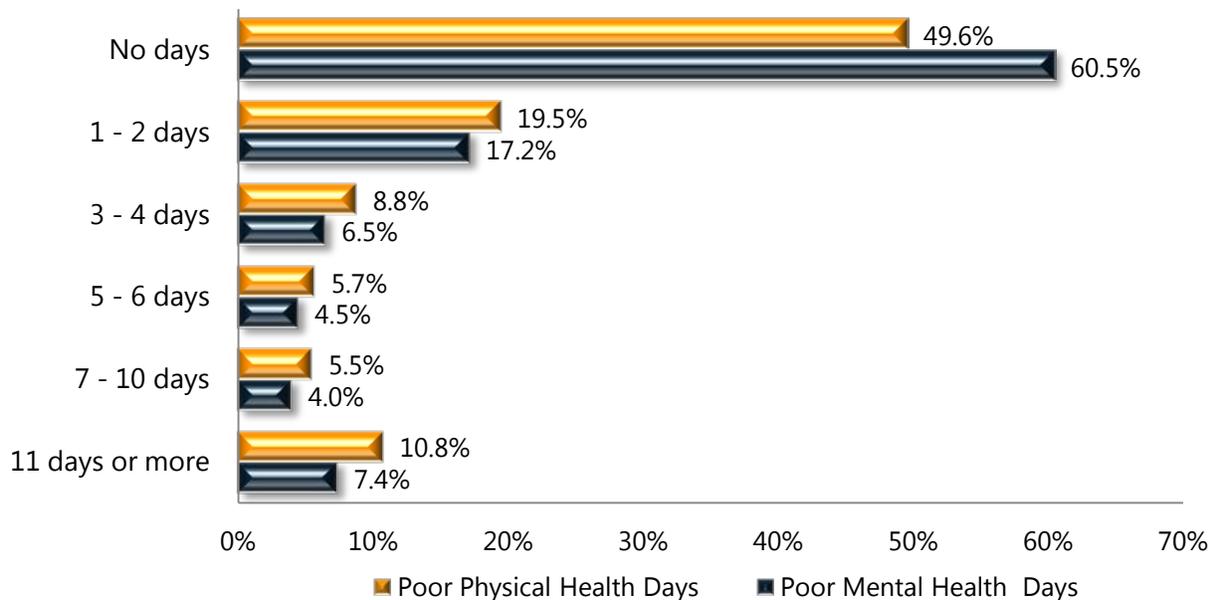
II. Key Health Issues

Overall Physical Health Status

Survey participants were asked to rate their overall health, including both physical and mental health. In general, self-reported measures of health are favorable among service area residents. Just under half of respondents (48.3%) reported having very good or excellent overall health, while 16% of respondents reported having fair or poor health. The findings, when compared to 2013, represent a decrease in the percentage of respondents with excellent, fair, or poor health and an increase in good or very good health.

Physical & Mental Health Status

Approximately half of the respondents reported not suffering from physical illness or injury during the past 30 days. However, nearly 20% reported having one to two days of poor physical health and 8.8% reported having three to four days of poor physical health. Respondents were also asked to rate their feelings of stress and depression they may have had in the past 30 days. Nearly, 40% of respondents in the service area felt stressed or depressed during the past month. This finding represents a marked decrease in the percentage of respondents reporting “No days” of poor mental health from 2013 (77.6% in 2013 vs. 60.5% in 2015). The following figure depicts the 2015 survey participants’ self-reported poor physical and mental health days.



Inability to work or do daily activities due to poor physical or mental health was also measured in the survey. A strong majority of respondents (76.4%) reported they did not have poor physical or mental health conditions in the past month that prevented them from carrying out their daily routines. In contrast, about 7% of respondents reported being unable to work or do daily activities for 11 days or more in the past month because of poor physical or mental health.

Diagnosis of Chronic Health Conditions

In 2013, secondary data analysis revealed the major causes of death in both Beaver and Allegheny counties to be heart disease and cancer, at 26.4% and 27% for heart disease, and 23.4% and 25.1% for cancer respectively. Online community survey participants were asked to disclose the chronic conditions they have been diagnosed with. High blood pressure topped the list with nearly one-half of respondents (48%) reporting being diagnosed with this condition. Of those respondents who are currently hypertensive, 88.4% are taking medication for it. High cholesterol was a close second, with 46% of respondents being diagnosed with this condition. This statistic represents an increase by 7.6% since 2013. Nearly two-thirds of respondents reported taking medication to treat the condition. It is well-documented that chronic illnesses such as high blood pressure and high cholesterol significantly increase one's risk for heart disease and other complications, if not properly managed.

Diabetes is a serious disease that can be managed through appropriate use of medications, physical activity, and diet. Approximately 17% of all survey respondents reported having been diagnosed with diabetes. The results, as they compare to 2013, show a slight increase. Of those individuals who reported being diagnosed with diabetes in the current study, 82.4% are taking a diabetes medication.

The National Institute of Health recommends people with diabetes see their doctor every 3 to 6 months or 2 to 4 times a year. The largest percentage of survey respondents (36.8%) reported seeing their health care provider 3 to 4 times in the past 12 months. Approximately 80% reported seeing their health care provider at least twice in the past 12 months. The number of diabetics who did not see a health professional at all in the past 12 months (4.9%) closely mirrors that of the 2013 statistic (5.2%).

An A1C lab test measures the average level of blood sugar over a three-month period of time. The largest percentage of respondents (41.4%) reported that they received the A1C test two times in the past year. In comparison to 2013, more diabetics received the test one to three times in 2015 and fewer diabetics reported receiving the test no times. Diabetes education helps individuals with diabetes learn how to manage their disease and practice healthy behaviors, such as eating healthy, being physically active, and monitoring blood sugar levels. Of those respondents who reported being diagnosed with diabetes, 56.8% have taken a diabetes training class on how to self-manage their disease.

Respondents were also asked to report on conditions like heart disease, stroke, asthma, and chronic obstructive pulmonary disorder (COPD). Asthma and COPD are the most diagnosed conditions in the service area. Approximately 17% of respondents have been diagnosed with asthma. The percentages represent an increase by approximately 8% since 2013. In addition, respondents mentioned "Other" types of diseases that were not included in the survey. Three of the most frequently mentioned diseases include atrial fibrillation and other types of heart disease (41 mentions), arthritis (32 mentions) and thyroid disease (31 mentions).

Key Health Issues in the Community

Survey participants were asked to identify the top five most pressing health issues in their community. Respondents could choose from a list of 24 health issues as well as suggest their own that were not on the list. Cancer was the primary area of shared concern among service area respondents. Over two-thirds of respondents (67.3%) selected this issue as one of the top five most pressing health issues

facing their county. Overweight/Obesity was also a concern shared by 65.3% of respondents. The third most pressing health issue, as viewed by the respondents, was drug/alcohol abuse with a 45.4% rating. Heart disease and diabetes were ranked 4th and 5th with a rating of 43.9% and 39.3% respectively. The following table shows the breakdown of the percent of respondents who selected the top 10 health issues from a list of 24 health issues.

Table 3. Ranking of the Top Five Most Pressing Health Issues by Community Residents

Rank	Key Health Issues	Count	Percent of Respondents Who Selected The Issue*
1	Cancer	1830	67.3%
2	Overweight/Obesity	1777	65.3%
3	Drug Abuse/Alcohol Abuse	1235	45.4%
4	Heart Disease	1194	43.9%
5	Diabetes	1068	39.3%
6	Alzheimer's Disease/Aging Issues	967	35.6%
7	High Blood Pressure	894	32.9%
8	Mental Health/Suicide	788	29.0%
9	Tobacco Use/Smoking	712	26.2%
10	Access to Care/Uninsured	701	25.8%

* Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

With these statistics in mind, focus group participants were asked to identify any barriers they had experienced in managing their chronic diseases, if they had one. The following bullet points highlight some of the key findings.

- **More Ongoing Education for the Patient**

Since chronic conditions are issues individuals deal with long-term, many participants felt that more ongoing education should be provided by the hospital. They felt this was currently sorely lacking. One participant recalled "heart attack clubs" and "stroke clubs" that served as support groups for individuals with those conditions. The participant elaborated, "Those were valuable because there were nurses and doctors there that you could tell something to. Plus they kept you abreast of the latest and greatest research that was going on."

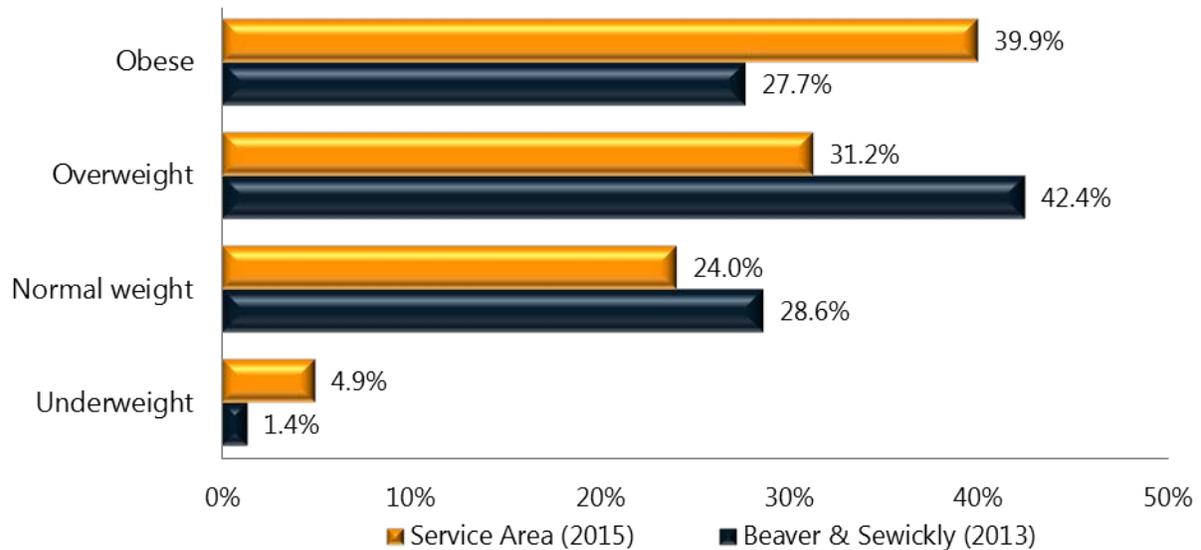
- **Coordination of Care**

Often with chronic conditions, individuals find themselves seeing several specialists to treat their disease and their symptoms. The majority of participants agreed that there was a serious lack of communication and coordination of care between specialists, as well as with the patient's primary care provider. There was a general consensus among participants that care needs to be coordinated by the physicians in order to have less responsibility on the patient.

Body Mass Index

Body Mass Index (BMI) is significantly influenced by diet and physical activity and is often correlated with chronic health conditions. It is calculated based on the height and weight of an individual. The

ability to maintain a healthy body mass index through diet and physical activity is influenced by both behavioral and environmental indicators. Approximately 70% of all respondents are overweight or obese. The percentage is comparable to the 2013 figure. However, a notably higher percentage of respondents in the current study are obese versus overweight.



III. Emergency Department Visits, Readmissions, and Ambulatory Sensitive Admissions

Looking at the Emergency Department visits data provided by Heritage Valley Health System for the Fiscal Year 2014-2015, injury and poisoning was the number one cause of ED visit, followed by symptoms, signs, ill-defined conditions; musculoskeletal and connective tissue; respiratory system; and digestive system. In regard to the top five principal diagnoses, patients who visited the ED were most commonly diagnosed with Abdominal Pain (unspecified site), Urinary Tract Infection, Head Injury, Headache, and Acute Upper Respiratory Infection. The following table summarized the information outlined here.

Table 4. ED Visits and Principal Diagnosis

	"Product Line"	Count
1	Injury & Poisoning	20,728
2	Symptoms Signs Ill-defined Conditions	20,372
3	Musculoskeletal and Connective Tissue	7,622
4	Respiratory System	7,261*
5	Digestive System	4,656
6	Genitourinary System	4,243
7	Nervous System and Sense Organs	3,599
8	Skin and Subcutaneous Tissue	3,399

9	Mental Disorders	2,413
10	Circulatory System	1,817*
	Principal Diagnosis	Count
1	Abdominal Pain Unspecified Site	1,963
2	Urinary Tract Infection	1,395
3	Head Injury	1,387
4	Headache	1,310
5	Acute Upper Respiratory Infection	1,291*
6	Chest Pain	1,270*
7	Other abdominal pain	1,154
8	Lumbago	1,128
9	Bronchitis	1,116*
10	Pain in limb	1,007

* denotes 2013 CHNA area of priority

In regard to re-admissions within 30 days, most patients were re-admitted into the hospital for the following top 5 health conditions: Septicemia or Severe Sepsis, Heart Failure or Shock, Renal Failure with major complications, Esophagitis, Gastroenteritis, miscellaneous digestive disorders without major complications, and simple Pneumonia or Pleurisy with major complications.

Table 5. Re-admissions within 30 Days

	Re-admissions and Causes	Count
1	Septicemia or severe sepsis	127
2	Heart failure or shock	106*
3	Renal failure with major complications	52
4	Esophagitis, Gastroenteritis, Misc. digestive disorders without major complications	51
5	Simple pneumonia or pleurisy with major complications	49*
6	Major joint replacement without major complications	47
7	Heart Failure or shock with complications	42*
8	chronic obstructive pulmonary disease with major complications	41*

* denotes 2013 CHNA area of priority

When looking at the discharge data for the primary diagnosis for an “ambulatory sensitive condition” for the fiscal year 2014-2015, all of the top 5 diagnoses are related to Cardio, Respiratory Disease or Diabetes.

Table 6. Ambulatory Sensitive Conditions

	Ambulatory Sensitive Conditions	Count
1	Bacterial Pneumonia	566
2	COPD	385
3	Hypertension	377
4	Congestive Heart Failure	366
5	Diabetes	302

IV. Health Risk Behaviors

This section illustrates the health risk behaviors that contribute to poor health as identified by the online community survey and focus group discussions.

Dietary Behaviors

It is widely supported that physical activity coupled with healthy eating can prevent health concerns such as obesity, diabetes, heart disease and many others. Online community survey participants were asked about their consumption of fruits and vegetables. Fruit could be fresh, frozen, or canned, but fruit juice was excluded. Approximately 44% of all respondents consume fruits one to four times per day and nearly 28% of respondents reported eating dark green vegetables one to four times a day. However, a substantial proportion of respondents are only consuming fruits and dark green vegetables two to four times per week (approximately 24% for fruits consumption and 34% for dark green vegetables consumption). In regard to soda and/or sugar-sweetened drink consumptions, over 40% of survey participants reported that they never drink such beverages. Of those who did consume these drinks, the majority reported drinking such beverages less than once per week (soda: 31.6% and sugar-sweetened drinks: 26.9%).

Strong evidence indicates that high salt intake increases blood pressure, which can lead to heart disease and other chronic conditions. In regard to sodium/salt intake, one-half of survey participants reported that they were not watching or reducing their salt or sodium intake currently.

Environmental influences such as access to foods for home consumption may be an important mediating factor in the relationship between neighborhood environment, diet quality, and chronic conditions such as obesity. Survey participants were asked about their access to food in their households in the past month. The survey also measured the quality of access. Approximately, 78% of respondents reported having enough of the kinds of food they wanted to eat. However, 18% of respondents reported that while they had enough food, they did not always have the kinds of food they wanted to eat.

To delve deeper into the dietary behaviors of community residents and examine what motivates people to engage in healthy eating habits, focus group participants were asked about their regular eating habits and the motivating factors that help them eat healthier foods. The participants discussed quite a few barriers to eating healthy foods such as cost, time to prepare foods, and familial obligations.

Motivating factors to eat healthier foods, according to participants, included:

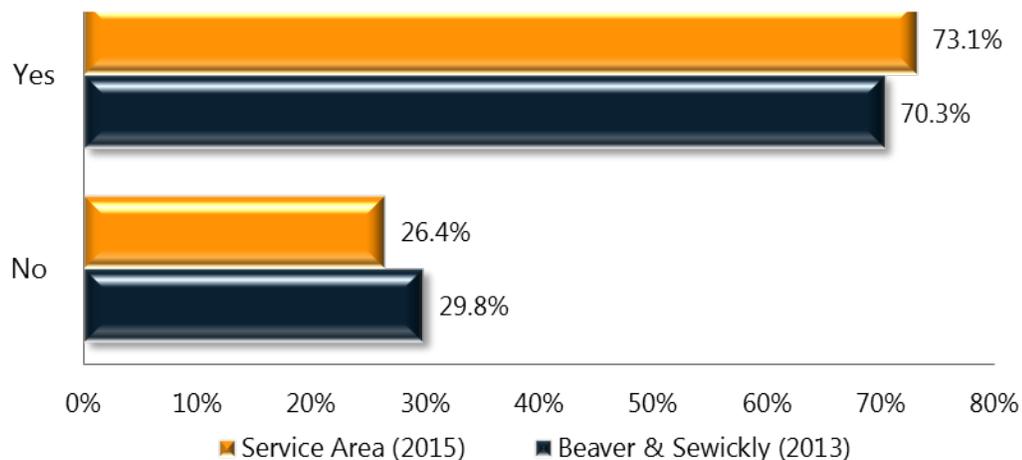
- Free weight watchers program
- Free diabetes classes
- Support/wellness groups
- Belonging to a farm co-op

Physical Activity

Physical activity can prevent health concerns such as obesity and overweight, heart disease, and many others. It is recommended that individuals regularly engage in at least 30 minutes of moderate physical activity, preferably daily, and at least 20 minutes of vigorous physical activity several days a week.

Approximately 73% of respondents reported that they have participated in leisure time physical activity during the past month. This percentage represents a 3% increase since 2013.

Among respondents who participated in physical activity, the majority (66.1%) reported participating in moderate physical exercise 1 to 4 times per week, and another 20.2% engaged in moderate activities 5 to 10 times per week. On the other hand, of those respondents who were physically active, 38.3% engaged in vigorous physical activities and the majority of respondents (56.8%) engaged in vigorous exercise for 30 minutes to 1 hour and 59 minutes. These findings may indicate that the majority of service area residents engage in physical activity on a regular basis.

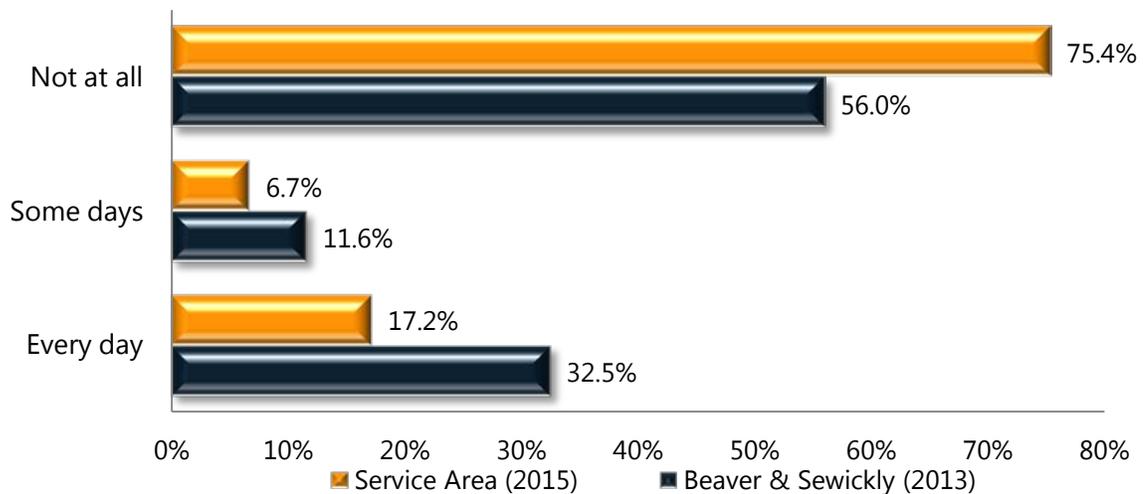


In order to augment this finding, focus group participants were asked if they currently engage in regular physical exercise and what would motivate them to remain or become physically active on a regular basis. Many of the participants felt that it is an individual's personal responsibility to take control of their health. They were mixed in their responses to their regular exercise habits. One participant mentioned working too much as a barrier to participating in regular exercise. However, the participants also offered some motivating factors to help individuals get active. These included:

- Not getting old and being stuck at home
- Being involved
- Living a long life
- Financial rewards
- Having more energy

Tobacco Use

Risky behaviors related to tobacco use were measured as part of the survey. Approximately 43% of respondents reported smoking at least 100 cigarettes in their lifetime. This result is comparable to the 2013 finding. Among this group, approximately three-quarters of respondents reported they currently do not smoke at all. In contrast, 17.2% reported they smoke every day. Both of these figures represent a positive finding when compared to the 2013 survey, where nearly a third of survey participants reported smoking every day and only 56% reported they did not smoke currently.



V. Access to Primary Health Care

This section illustrates the health coverage status of residents and highlights the barriers related to access to health care that contribute to poor health.

Health Insurance Coverage

Health insurance coverage can have a significant influence on health outcomes. Survey participants were asked to indicate whether or not they have health care coverage, including insurance, prepaid plans, or government plans, such as Medicare and Medicaid. About 60% of the respondents indicated they were insured through their employer or someone else's employer. In contrast, 3.2% of respondents are currently uninsured.

Respondents who reported as having an insurance coverage were then asked to indicate their annual insurance deductible. Approximately, 31% of respondents had annual deductible of \$500 or less and 23.3% of respondents paid \$501 - \$2,000 per year towards their insurance deductible.

Health Care Provider

Approximately 93% of respondents in the service area have one or more person who they think of as their personal doctor. In other words, 7% are without a medical home. The percentage of respondents in the service area with at least one personal doctor has increased by 3% since 2013.

However, focus group participants discussed difficulty both with finding primary care providers accepting new patients, as well as getting a timely appointment with their primary care provider. One participant shared, “My brother-in-law hadn’t been to a primary care provider in a while...he couldn’t get in to see the primary care provider - they weren’t taking new patients. He had to go find another one, and they weren’t taking new patients. So for the people who need a new doctor, there [are] no opportunities to get one.” Others expressed difficulty obtaining appointments with their current primary care providers. If they weren’t able to get appointments, some discussed going to MedExpress or the ER for services, while others said they would go online to self-diagnose.

Quality of Care

In regard to their experiences accessing health care, focus group participants discussed a variety of positive and negative experiences. Many of the participants commonly agreed that obtaining timely appointments for non-urgent matters is relatively easy and seamless. Still many others expressed enthusiasm for the ability to make appointments online via email as opposed to waiting to speak to someone on the phone. In addition, participants mentioned that upon arriving for services, the wait time has become much shorter over the years, particularly in walk-in clinics and when seeking lab services.

However, a general concern for the elderly’s health care needs was commonly voiced. Participants expressed concerns over treatment of the elderly in nursing homes. One participant stated, “If you go on any website and look at the homes for the elderly, I don’t know if you’ll find anything positive about it.” Therefore, based on participant feedback, there appears to be a perception of limited affordable quality care options available for the elderly within the community.

When asked what they felt were the strengths of primary health services in their county, focus group participants identified the following strong points:

- **Proximity to Academic Institutions:** The breadth of academic institutions in the Pittsburgh area, access to clinical trials for people that are really sick, transplant surgeries, the University of Pittsburgh were all identified as being huge assets to the community.
- **National Reputation and Specialty Providers:** Many expressed positive experiences with the hospitals and raved about the care, especially in regard to the children’s hospital. Another participant stated how easy it is to access care and obtain an appointment relatively quickly in almost any specialty area. This is not always the case in different parts of the country.
- **Convenient Care Clinics and Walk-In Sick Care:** Most of the participants agreed that having the option of the Convenient Care Clinics at Heritage Valley is nice. However, many agreed there were long wait times at these clinics, and they preferred to go to some of the other urgent care centers in the area, such as MedExpress and at Walgreens. Another common complaint among the group in regards to the Convenient Care Clinic was the fact that there is not a physician on-site.

- **Technology:** Participants seemed pleased with the new technology that is being implemented at Heritage Valley, particularly related to ease of requesting appointments via email, accessing records electronically such as lab/test results, and requesting prescriptions online.

Barriers to Accessing Health Services

Understanding the perceived barriers to accessing health services can be very eye-opening as it often gets to the less obvious reasons people avoid or delay seeking health care. By far, the most commonly encountered barrier among survey participants was the inability to pay insurance co-pays and deductibles (78.8%) followed by lack of health insurance coverage (59.7%), difficulty to understand/navigate health care system (26.9%), lack of transportation (25.3%), and being unable to find a doctor or get an appointment (24.7%). Responses are summarized in the table below.

Table 7. Barriers to Accessing Health Care

Rank	Key Health Issues	Percent of Respondents Who Selected The Barrier*
1	Cost/Paying Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	78.8%
2	Lack of Health Insurance Coverage	59.7%
3	Difficult to Understand/Navigate Health Care System	26.9%
4	Lack of Transportation	25.3%
5	Can't Find Doctor/Can't Get Appointment	24.7%
6	Basic Needs Not Met (Food/Shelter)	22.6%
7	Lack of Trust	14.9%
8	Not enough time	14.3%
9	Lack of Child Care	8.0%
10	Language/Cultural Issues	2.4%

* Respondents could select more than one option, therefore the percentages may sum to more than 100.0%.

When asked if there were reasons that keep them from receiving medical care, most focus group participants mentioned costs related to insurance, deductibles, services and medications as a very important reason for why services may not be obtained. One participant discussed concerns related to insurance companies and their approval process for patient testing. The participant felt more conversations should be held between insurance companies and healthcare providers about appropriate testing. The participant mentioned that this will help to ensure that all patients are able to obtain necessary tests that will be paid for by insurance.

Difficulty to navigate the health care system appeared to be a common theme in the focus group discussions. A few participants discussed situations where they needed to schedule two separate appointments to address two different issues, which they found to be quite an inconvenience. The participants agreed that these situations could be chalked up to insurance and billing requirements, which appeared to be very frustrating and confusing to the groups. Other participants expressed concern about all people within the hospital not being within their network, which translated into patients receiving different bills from everyone that works on them.

Surprisingly, many of the participants indicated fear and frustration as a big reason for why they would not receive medical care. Most participants expressed frustration and anxiety over being put through unnecessary testing and diagnoses at the hospital, which is an indicator of distrust. One participant explained, "I've been afraid to go to the ER for fear, not for treatment, for fear of if I'm admitted, and I'm going to go through the gamut of those hospitalists."

VI. Resources/Changes Needed to Improve Access and Health Outcome

Community survey participants were asked what resources or services were missing in the community. Approximately, 47% indicated that free/low cost dental care services are missing in the community. Free/low cost medical care and eye care were the second and third most needed resources and services that were identified by respondents. In addition, respondents indicated through an open-ended question that affordable health care and affordable senior housing were missing.

Focus group participants were asked to identify some changes in health care that needed to be made in order to improve the health of residents in the community. Key findings from the discussions are highlighted below.

- **Increased Staff and Improved Quality of Staff**

In general, the group agreed that there are enough specialty physicians in the area. However, some participants did point out a few specialty areas they felt were lacking including mental health services, dermatology, and rheumatology.

- **Improved Utilization of Technology**

Most of the participants see the improved technology along with electronic health records as a benefit. However, many were concerned with the quality of the technology as they have personally encountered issues with the system. Others felt that the technology was not being utilized to its full potential by staff and offered that a little extra technology training for staff may help the situation.

- **More Patient Advocacy**

Many participants expressed dissatisfaction with the decreased presence of primary care providers in the hospital. Participants further explained that hospitalists, physicians whose primary focus is the general medical care of hospitalized patients, are primarily providing care within the hospital and many shared a concern that their primary care physicians are not kept in the loop.

Communication with Health Care Provider

Focus group participants were asked if they find it easy or difficult to communicate with their health care provider and give reasons pertaining to their response in that regard. The participants commonly agreed that they felt their providers do not actively listen to their concerns. One participant shared, "Sometimes I think I tell my doctor things and he just totally ignores it...I wish he would listen more." Participants mentioned that providers seem to pre-diagnose prior to hearing the patients' concerns, particularly when dealing with patients with chronic conditions. However, many also felt that this was not the case across the board as it really varies by provider.

Lack of communication between providers within a practice, as well as with those in the hospital, was an area of concern. Some participants felt that there was a serious lack of communication between their primary care doctor and others that work in their office.

Lastly, one participant in particular was concerned with the health literacy level at which important information was being conveyed to them by the doctor. The participant also noted that information provided on the electronic health record is not easily understood.

Awareness of Available Resources

The majority of participants expressed that information is widely available. However, most feel it is an individual's personal responsibility to find the information and there was doubt as to whether people in the community were actually doing this. On the positive side, the participants did agree that most community members are aware of the walk-in clinics available throughout the community.

In terms of the elderly population, there was a general consensus that they are not aware of the resources available in the community. Participants felt that the elderly population generally becomes aware of services by word of mouth or through referrals from a doctor. Participants felt that only having information available online is a barrier for the older adult population. To help improve elderly awareness and access to resources, one participant suggested providing an advocate system to assist with the navigation through community resources.

Two additional issues discussed were how the participants felt the community lacked awareness and understanding of provider networks and health financing. In terms of provider networks, the participants mentioned they are not always notified by their providers when they no longer accept certain insurance plans. One participant felt that the community as a whole finds the healthcare system confusing, particularly related to health financing. As the participant stated, "I'm always bewildered by the bills. I get it, and it says so much. You look at it, and they say they are paying a third...The whole finance system for healthcare is a confusing mess and nobody really knows what's happening."

VII. Suggestions and Recommendations

Survey participants were asked to comment on what is being done well in the community. The most common responses referenced improved access to health care where most procedures are done in the same location, available preventative health services including flu shots and free screenings, education and outreach, and parks and recreation. Heritage Valley Health System was mentioned by several individuals as taking important steps toward creating healthier communities. Many respondents also praised the various awareness campaigns and health fairs that focused on seniors.

To round out the feedback from community members and focus group participants, respondents were asked to provide suggestions/recommendations that they felt would be helpful in addressing the health needs of the community. The majority of survey participants recommended providing support and services for seniors who find it difficult to navigate the healthcare system. A comment offered by one

survey participant summarizes the sentiment shared by many community survey participants in regard to providing better age-friendly health care services for seniors living in the community.

“Have many older folks here. They need guidance navigating thru the healthcare system. They think EOBs are bills and don't understand co-pays and what/what not to pay for, etc. Too many people who can't get prompt appointments to see doctors are being told by physician offices to go to the ED. This increases out of pocket co-pay expenses and clogs up the ED with unnecessary patient visits. A better system for physician access would be appropriate here.”

The need to provide free/low cost medical care to those who need it was also frequently mentioned. Respondents also pointed out the need for more health education and outreach programs in the area, specially related to chronic disease management, nutrition, and overall healthier lifestyles.

KEY FINDINGS

While each individual research component provides a unique perspective on the health status of residents living in the service area, a number of overlapping health issues are evident. The following list outlines the key themes that stood out across the research components.

- **Access to Care:** Overall insurance coverage appears to be favorable as evidenced through the community survey and focus group discussions. However, the inability to pay insurance co-pays, deductibles, and prescription medications was found to be a significant barrier for service area residents. Difficulty to navigate the health care system was also mentioned as one of the top three barriers in the community survey and was a common theme in the focus group discussions. Services that were seen as missing or insufficient in the service area were free/low cost dental, medical, and eye care. Focus group participants also identified difficulty finding primary care providers that are accepting new patients, as well as getting a timely appointment with their primary care provider. According to focus group discussants, increasing the number and quality of staff, improving utilization of technology, and more patient advocacy could curb some of these barriers.
- **Most Pressing Health Issues:** High blood pressure, high cholesterol, and diabetes were some of the most diagnosed health conditions among community survey participants. On the other hand, respondents identified cancer, overweight/obesity, drug/alcohol abuse, heart disease, and diabetes as being the most pressing health issues in their community. In addition, the majority of survey participants were found to be overweight or obese, and compared to 2013, a notably higher share of survey participants are obese.
- **Older Adult Health Issues:** The health needs of older adults population in the community was highly emphasized in both research components. These needs include affordable quality care options, preventive health services, prescription assistance, and transportation, among others. It was also identified that the elderly population was not aware of community resources that are available to them.

- **Healthy Behavior Motivators:** Focus group participants identified cost, time needed to prepare foods, and familial obligations as barriers to eating healthy foods and mentioned efforts such as free diabetes classes, support/wellness groups, and free weight watchers program as potential motivators to adopting healthier lifestyles.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization Session

Individuals representing Heritage Valley, regional health care organizations, the state health nurse, community agencies, and area social service organizations identified top five priority areas during the 2013 CHNA prioritization session. After reviewing the 2015 CHNA key findings, Heritage Valley has decided to continue their focus on the prioritized health needs and bring measurable impact in these areas of need over the next three-year cycle. The priority areas include:

- Access to Primary Care
- Healthy Living
- Diabetes
- Smoking
- Cardiovascular/Respiratory Health

Community Meeting

On June 10, 2016, the Heritage Valley Health System hosted a community meeting with 18 members of the community as well as key health system staff to review the results of the 2016 Community Health Needs Assessment (CHNA). The goal of the meeting was to take a deeper look at the prioritized health needs identified during the 2013 CHNA process and to set the stage for community health improvement initiatives and the development of the hospital's Implementation Strategy around how to further impact these areas of need. A full list of attendees can be found in Appendix A.

The community meeting was facilitated by Holleran Consulting. The meeting began with an abbreviated research overview. The overview presented findings from the online community survey and the focus groups as well as provided comparisons to data from the 2013 CHNA. Following the research overview, participants engaged in a lively large group discussion focused around their initial thoughts and reactions to the research. Collectively, the group felt that substance abuse was a much larger issue in the community than what appeared in the research. Therefore, it was decided that this would be one of the topics discussed during the small group breakouts.

Small group discussions then took place in which participants were broken up into four separate groups around the following health issues:

- Access to Care
- Healthy Living
- Chronic Disease Management
- Smoking, Drugs, and Alcohol

Each group was asked to identify resources that currently exist in the service area, resources that are missing, and recommendations on how to better address the priority area. Information gleaned from the small group discussion will be used by the Heritage Valley Health System to create their Implementation Strategy for the next three-year cycle. Notes from the small group discussions can be found in Appendix B.

COMMUNITY HEALTH IMPLEMENTATION STRATEGY

Strategies to Address Community Health Needs

Heritage Valley Health System developed an Implementation Strategy to illustrate the hospital's specific programs and resources that support ongoing efforts to address the identified community health priorities. This work is supported by community-wide efforts and leadership from the Executive Team and Board of Directors. The goal statements for each of the five priority areas are listed below. See the separate documents – CHNA Implementation Strategy for Heritage Valley Beaver and CHNA Implementation Strategy for Heritage Valley Sewickley for information on objectives for 2016 to 2019 and a list of community resources.

Prioritized Health Issue #1: Access to Primary Care

Goal: Increase access to affordable, quality health care for service area residents.

Prioritized Health Issue #2: Healthy Living

Goal: To increase the percentage of service area residents that are at a healthy weight through eating a healthy diet and regular physical activity.

Prioritized Health Issue #3: Diabetes

Goal: Reduce risk factors for diabetes and pre-diabetes and improve management of chronic disease through healthy lifestyle choices.

Prioritized Health Issue #4: Smoking

Goal: Educate the community on the health issues related to smoking to increase the percentage of residents who quit or attempt to quit smoking

Prioritized Health Issue #5: Cardiovascular/Respiratory Health

Goal: Reduce risk factors for cardiovascular and respiratory health issues through healthy lifestyle choices.

Appendix A. Community Meeting Participants

Michael Baker	Heritage Valley Health System
Arlene Bell	Heritage Valley Health System
Mary Ann Bolland	Homemaker - Home Health Aide Service
Kathy Brodala	Pennsylvania Department of Health
Dan Brooks	Heritage Valley Health System
Dina Ciabattoni	Continuum of Care Coordinator Beaver County
Kevin Flannery	Sewickley Borough
Doug Florey	Laughlin Children's Center
Lesley Hallas	Beaver County Children and Youth Services
Mary Lou Harju	Lutheran Senior Life
Trish Hooper	Sewickley Valley YMCA
Valerie Howard	Robert Morris University
Ginny Keller	Center for Hope
Michelle Kreutzer	Pittsburgh Airport Area Chamber of Commerce
Jack Manning	Beaver County Chamber of Commerce
Karen McCreary	Concordia Visiting Nurses
Lisa McCoy	Beaver County Behavioral Health
Norm Mityr	Heritage Valley Health System
Susan Nirschel	Lutheran Senior Life
Dayna Revay	Beaver County Children and Youth Services
Linda Snyder	Adagio Health
John Thomas	Church In The Round

Appendix B. Small Group Discussion Notes

Priority Area: Access to Care

Existing Resources and Services

- **Current Services**
 - Numerous no-cost or low cost healthcare services in county
 - Primary health network
 - Adagio Health & HVHS Family Planning Beaver for Women’s healthcare
 - WIC for child nutrition
 - Problems in accessing may be zero knowledge of the services within the community
- **Barriers**
 - for healthcare providers, individual provider credentialing is lengthy, complicated and is a barrier
 - Recruitment of qualified and credentialed providers
 - Could recruit through practicums and internships but staff has difficulty doing extra work
 - Poor transportation system

Missing Resources and Services

- Primary Health Care Services that are free/low cost
- Hiring more CRNPs to provide care but keep cost down; investigate loan repayment (J-1) for recruitment of providers
- Community Resource Guides – Awareness
- Transportation
- Mental Health Services

Recommendations

- Desire to pull together key community stakeholders (e.g., today’s group) on a monthly basis – more of an upper/mid-level group to discuss operations & collaborative opportunities (persons perhaps one step down from the Executive Director level).
- Collaboration between Health Care (Physical and Mental Health) and Social Service, Behavioral Health to create one streamlined intake form – use one intake form that can collect multiple levels of information and can be coordinated with county agencies to ensure a client’s needs are not overlooked.

Priority Area: Healthy Living

Existing Resources and Services

- Senior Centers
- Farmer's Markets
- Discounted Food Markets
- Life Smart
- Food Banks/Distribution
- Community Food Events – Summer Feeding For Kids
- 5210 Program
- HVHS Hospital and Convenient Care Offices
- YMCA (2) and Planet Fitness

Missing Resources and Services

- Ease of transportation
- Reliable Health Education (School Age and up)
- Physician Office Hours

Recommendations

- Collaboration with local municipalities on healthy living criteria and programs
- Ex. Walk My City Programs and smoking – public areas

Priority Area: Smoking, Drugs, and Alcohol

Existing Resources and Services

- Hospital Emergency Rooms
- Gateway Rehab Center Twp.

Missing Resources and Services

- Detox Beds
- Mental Health Access
- Counseling/Referrals

Recommendations

1. Court has options when crime due to addiction or mental health – separate track
2. Education, Quality – all levels/public officials/doctor's/community leaders
3. Education for youth/children
4. Skill Development – not college – trade school
5. Addiction is at all ages, demographics
6. Look at addiction as a disease – mental illness and addiction treatment

Priority Area: Chronic Disease Management

Existing Resources and Services

- HVHS – Diabetes program
- Y – LiveStrong for cancer survivors
- Arthritis – enhance fitness, twinges aqua exercise
- Parkinson’s classes
- HVHS – Community Health Programs

Missing Resources and Services

- Senior Center access
- Community care network – assign nurse, case worker for high need, high risk patients at Discharge – like Meadville Health System
- Palliative care gaps in Chronic Disease management – lack of home care for people under 60
- Difficult to find staff for programs and services, get reimbursements
- Affordable housing stock for those who face physical limitations
- Medical innovation allows people to live longer, but are they living better? Quantity vs. Quality?

Recommendations

- Better and more reimbursement system
- Innovation for home care
- Education on self-care, patient care navigation to connect people to education/services
- Better understanding of home life, challenges to living better
- Physician house calls – Mobile Clinic
- Often people have more than one chronic disease

Appendix C. 2013 Implementation Strategy Evaluation and Outcomes

As the 2013 Implementation Plans for Heritage Valley Beaver and Heritage Valley Sewickley were substantively identical (except for hospital-specific identification) this evaluation applies to both plans. This evaluation asks and answers the question, “Were the planned activities accomplished or was there substantial progress toward implementation of the planned activities?” It does not attempt to ask and answer the broader question, “What impact did these activities have on the health and well-being of area residents?”

Access to Primary Care

Continue to deploy/enhance Medical Neighborhoods

- Opened Edgeworth Medical Neighborhood in August, 2013 and West Allegheny Medical Neighborhood in April, 2015; Heritage Valley’s fifth and sixth Medical Neighborhoods

Study various Primary Care service delivery models

- Heritage Valley Medical Group (HVMG) conducted planning, examining the issues of access to care and medical neighborhoods and identified the Patient Centered Medical Home as the preferred service delivery model

Align ConvenientCare sites with primary care practices

- ConvenientCare sites are either co-located with primary care practice sites (four of the six locations) or are a mile or two away; medical oversight for ConvenientCare practitioners is provided by primary care physicians; primary care practices refer after hour patients to ConvenientCare; ConvenientCare patients are linked to their primary care physician through the electronic medical record; patients without a primary care physician are referred to a practice accepting new patients

Participate in insurer based initiatives to enhance primary care services and revise payment models

- HVMG participated in shared savings agreements with UPMC Health Plan and Aetna/Health America and had an agreement with Highmark for enhanced payments if specific criteria were met
- Planning through Premier for potential Clinical Integration program

Utilize EMR to enhance collaborative relationships between primary care and specialists

- 90 HVMG physicians have successfully attested for Meaningful Use 2 – year 1

Recruit and position appropriate numbers of primary care physicians and mid-level providers to meet the community need

- Since July, 2013 eight primary care physicians and twenty mid-level providers (certified registered nurse practitioners and physician assistants) have been added to Heritage Valley Medical Group; four of the mid-level providers have left the group

Healthy Living

Collaborate with local organizations and groups to encourage exercise and healthy eating

- Community health services staff participated in 72 community events with a variety of local organizations between July 2014 and June 2015

Establish and grow a culture of health among employees and volunteers

- Number of wellness programs established – no new programs have been established; maintain bio-metric screenings (yes); offer healthy options in vending machines – this varies by site; serve healthy foods at meetings – foods at meetings have been significantly reduced due to budget constraints; healthier food options in hospital cafeterias – healthy food options are available and nutritional information has been added so it is easier for employees and guests to make healthy choices; employees that enroll and complete the Group Lifestyle Balance Program are eligible to receive Wellness Credits

Continue childhood obesity program (Club 5210)

- Maintained program with Quaker Valley School District and Sewickley Valley YMCA; added programs with Rochester Area, Beaver Area, and New Brighton School Districts and Beaver County YMCA; 73 3rd to 5th graders enrolled in FY2015

Increase participation in LifeSmart program

- Number of participants in LifeSmart program (baseline = 263); 240 participated in LifeSmart; enrollment down due to instructor retirement which temporarily reduced program capacity

Increase the number of community health promotion events

- Target = 65; achieved in FY2013; exceeded 70 in both FY2014 and FY2015

Diabetes

Create a diabetes registry

- The Patient Centered Care (PCC) module was added to the physician office electronic health record Allscripts software in September 2014; this module identifies and helps to manage at-risk populations by providing dashboard displays of completed or incomplete measures for the physician or office staff as well as providing disease specific pursuit lists; this is a tool for case management and promotes ensuring annual eye exams and foot exams for diabetic patients
- The health system will seek to acquire population health management software to create a diabetes registry

Link diabetes patients to a primary care physician

- Patients at the Emergency Departments and ConvenientCare with high blood glucose levels are referred to a primary care physician; community residents that participated in Heritage Valley Health System free glucose screenings are linked to their primary care physicians

Utilize the registry to coordinate a collaborative care model for diabetes with primary care physicians

- This step is on hold pending acquisition of population health management software and the recruitment of additional endocrinologists

Offer a set of integrated educational and behavioral modification opportunities for diabetes patients

- Develop a Diabetes Support group – accomplished in 2014; maintained in 2015 at two locations; six sessions were held in FY2015
- Maintain the LifeSmart pre-diabetes program – yes
- Maintain Healthy Living with Diabetes classes and individual education – yes

Increase locations for Healthy Living with Diabetes classes

- Baseline was 2 locations as of June 30, 2013; no locations were added as health insurance co-pays for these classes continue to be a barrier for people using this program which suppresses demand for these classes, making additional locations not necessary at this time

Increase women identified with gestational diabetes

- Baseline was 48 women in FY 2013; 61 women were seen in FY 2014; 74 were seen in FY2015

Establish a Diabetes Support Group

- Establish the group and hold at least 8 meetings; accomplished in 2014; 6 sessions were held in FY2015

Provide same day nutrition and nurse educator appointments

- Scheduling of same day appointments – this was not implemented, due to health insurance reimbursements for some payors, which do not pay for the second service for same day services

Increase community awareness, education and screenings

- Number of community events related to diabetes compared to FY2013, baseline = 17; there was participation in 20 events in FY 2015

Increase participants in Diabetes Education Program and LifeSmart

- Number of participants compared to FY2013; baseline = 646 for diabetes program and 263 for LifeSmart; 777 enrolled in the diabetes program in FY2015; 240 participated in LifeSmart; enrollment down due to instructor retirement which temporarily reduced program capacity

Maintain ADA recognition

- Continued ADA certification – accomplished as of July, 2014 and good through 2018

Smoking

Focus smoking prevention initiatives on pregnant women

- Continued smoking prevention and cessation work with women in High Risk Pregnancy Program – accomplished

Utilize community-based smoking prevention programs

- Number of referrals to PA Quit Line (not monitored)
- Number of referrals to Heritage Valley smoking cessation program (13 referrals from January through May, 2016)

Cardiovascular/Respiratory Health

Increase participants in pediatric asthma program

- Number of participants compared to FY2013; baseline = 108; 123 participants in FY2015

Link patients at risk with healthy living objectives

- Appropriate patients referred to LifeSmart program

Reduce readmission rate within 30 days for these conditions using an aggressive collaborative/integrated care paradigm

- Readmission rate within 30 days – has stayed near FY2013 rate of 11.6% in FY2014 and FY2015; lowered to 10.8% for first three quarters of FY2016

Gain JCAHO certification for both hospitals as stroke centers and maintain certification

- Both hospitals were certified in 2013
- Both hospitals were re-certified in 2015

Initiate a community education campaign for stroke risk factors and warning signs

- Community education campaign conducted in 2013 and repeated since then; the campaign is on the warning signs of stroke; conducted at health fairs