
















Ohio Valley Hospital Community Health Needs Assessment

2016 Executive Summary





Ohio Valley HOSPITAL

This page intentionally left blank.

ACKNOWLEDGEMENTS

The Ohio Valley Hospital (OVH) Community Health Needs Assessment (CHNA) was developed with the support of Strategy Solutions, Inc. (SSI), the consulting group engaged by OVH to assist with the assessment. Representatives from OVH and SSI worked collaboratively to guide and conduct the assessment. A steering committee made up of senior representatives of OVH, as well as representatives from local health departments, leading health and social service organizations and county government provided additional input. The combined expertise, input and knowledge of the members of the steering committee was vital to the project. This group deserves special recognition for their tireless oversight and support of the CHNA process.

During this CHNA project, ten individuals were interviewed by SSI including representatives from faith-based organizations, health and social service agencies, public health officers, media, community development, public safety, school district personnel, and public and elected officials.

Finally, information was gathered by the project team through a series of focus groups. These information-gathering efforts allowed the project team and steering Committee to gain a better understanding of the health status, health care needs, service gaps and barriers to care of those living in Allegheny County, which represents the service area of OVH. The administration of OVH would like to thank all of those who were involved in this project, particularly those who participated in interviews, focus groups and information gathering.

PROJECT COORDINATION

Megan (Eaton) Hinds	Ohio Valley Hospital
Debra Thompson	Strategy Solutions, Inc.
Kathy Roach	Strategy Solutions, Inc.
Jacqui Catrabone	Strategy Solutions, Inc.
Robin McAleer	Strategy Solutions, Inc.

STEERING COMMITTEE MEMBERS

Joanne Marie Andiorio, Ph.D.	Sto Rox Community Health Center – Retired
David Bytnar	Sto Rox Health Center
Sr. Sarah Crotty	Focus on Renewal
Lisa Dalena	Ohio Valley Hospital – Geropsych Unit
Jim Lightner	Ohio Valley Hospital – Emergency Services
Angelo Lupariello, MD	Advanced Kidney Care
Sue Pfeifer	Ohio Valley Hospital – Occupational Medicine
Craig Rippole	Trinity Commercial Development, LLC
Peg Spisak	Ohio Valley Hospital – Patient Safety
Sarah Stewart	Ohio Valley Hospital – Community Services/Seniors
Susan Zikos	Ohio Valley Hospital – Dietician/Diabetes Educator

TABLE OF CONTENTS

TABLE OF TABLES

TABLE OF FIGURES

This page intentionally left blank.

MESSAGE TO THE COMMUNITY

Ohio Valley Hospital (OVH) is proud to present its 2016 Community Health Needs Assessment (CHNA) Report. This report summarizes a comprehensive review and analysis of health status indicators, public health, socioeconomic, demographic and other qualitative and quantitative data from the primary service area of OVH. This report also includes secondary and disease incidence and prevalence data from Allegheny County, as the OVH service area includes certain zip codes within this county (see **Table 1** and **Figure 1,** page 8 for a listing of zip codes and the service area map). The data was reviewed and analyzed to determine the priority needs and issues facing the region.

The primary purpose of this assessment was to identify the health needs and issues of the community defined as the primary service area of OVH. In addition, the CHNA provides useful information for public health and health care providers, policy makers, social service agencies, community groups and organizations, religious institutions, businesses, and consumers who are interested in improving the health status of the community and region. The results enable the hospital, as well as other community providers, to more strategically identify community health priorities, develop interventions and commit resources to improve the health status of the region.

The full report is also offered as a resource to individuals and groups interested in using the information to inform better health care and community agency decision making.

Improving the health of the community and region is a top priority of OVH. Beyond the education, patient care and program interventions provided by OVH, we hope the information presented is not only a useful community resource, but also encourages additional activities and collaborative efforts that improve the health status of the community.

EXECUTIVE SUMMARY

The 2016 Ohio Valley Hospital (OVH) Community Health Needs Assessment (CHNA) was conducted to identify significant health issues and needs, as well as to provide critical information to OVH and others in a position to make a positive impact on the health of the region's residents. The results enable the hospital and other community partners to more strategically establish priorities, develop interventions and direct resources to improve the health of people living in the OVH service area.

To assist with the CHNA process, OVH retained Strategy Solutions, Inc. (SSI), Erie, PA, a planning and research firm whose mission is to create healthy communities to conduct the collaborative study. The assessment followed best practices as outlined by the Association of Community Health Improvement. The assessment was also designed to ensure compliance with current Internal Revenue Service (IRS) guidelines for charitable 501(c)(3) tax-exempt hospitals that was published in December 2014. This CHNA and its supplemental resource data located in the appendices document include a detailed examination of the following areas:

- Evaluation of the 2013 OVH CHNA
- Demographics & Socio-Economic Indicators
- Access to Quality Health Care
- Chronic Disease
- Healthy Environment
- Healthy Mothers, Babies and Children
- Infectious Disease
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Injury

Secondary public health data on disease incidence and mortality, as well as behavioral risk factors, were gathered from numerous sources including the Pennsylvania Department of Health, Healthy Communities Institute, the Centers for Disease Control, Healthy People 2020, and County Health Rankings, as well as a number of other reports and publications. Data were collected for OVH, although some selected national data is included where local/regional data was not available. Demographic data were collected from the Nielsen/Claritas demographic database. Primary qualitative data collected specifically for this assessment included a total of ten in-depth interviews with individuals from different constituencies and interest groups representing the needs of the OVH service area, along with seven focus groups reaching a total of 80 participants. In addition to gathering input from stakeholder interviews, input and guidance also came from OVH and community representatives who served on the OVH Steering Committee.

After all primary (stakeholder interviews and focus groups) and secondary data were reviewed and analyzed by the Steering Committee during a meeting on March 9, 2016, the data suggested a total of 46 distinct issues, needs and possible priority areas for potential intervention by OVH. Members of the OVH Steering Committee met on April 11, 2016 to review the final priorities (see **Table 22** on page 63). Using the methodology of looking at the four prioritization criteria of (i) accountable role of the hospital, (ii) magnitude of the problem, (iii) impact on other health outcomes and (iv) capacity (systems and resources) to implement evidence-based solutions, along with the rank order of the final priorities selected by the OVH Steering Committee, the following nine priorities are considered the most significant. Refer to **Table 21** on page 62 for a more in-depth description of the four prioritization criteria.

1. Chronic Disease: Diabetes
2. Chronic Disease: Cardiovascular Disease (Heart Disease, Cholesterol, etc.)
3. Chronic Disease: Overweight/Obesity
4. Access to Quality Health Services: Knowledge of all Services in the Area
5. Access to Quality Health Services: Primary Care Services
6. Access to Quality Health Services: Transportation for Self/ Healthcare Workers
7. Mental Health/Substance Abuse: Mental Health

8. Physical Activity/Nutrition: Eating Habits/Access to Healthy Foods
9. Tobacco Use: Smoking

The implementation strategies selected by OVH and its community partners will address the most significant needs through a variety of implementation strategies which is published in a separate document.

This page intentionally left blank.

METHODOLOGY

To guide this assessment, the hospital's leadership team formed a Steering Committee that consisted of hospital and community agencies who represented the broad interests of the local region. These included representatives who understood the needs and issues related to various underrepresented groups including medically underserved populations, low-income persons, minority groups, and those with chronic disease and mental health needs, individuals with expertise in public health, and internal program managers. The OVH Steering Committee met three times between November 2015 and April 2016 to provide guidance on the various components of the CHNA.

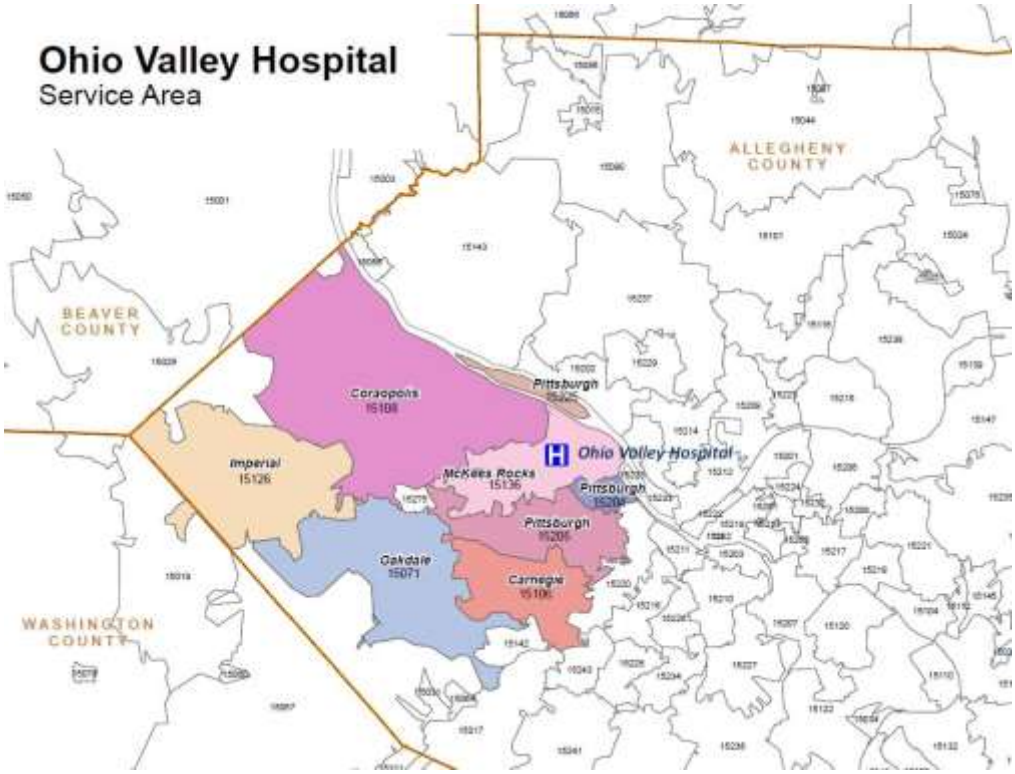
Service Area Definition

Consistent with IRS guidelines at the time of data collection, the project partners defined the community by geographic location based on the service area of OVH. **Table 1** outlines the zip codes and municipalities that are included in the OVH primary service area. The geography of the OVH region is illustrated in **Figure 1**. Zip Code 15275 is in the middle of the service area, but has no population and, therefore, is not included in the demographic analysis of the OVH region. The hospital does, however, target this business district with awareness materials.

Table 1. Service Area Zip Codes

Zip Code	City
15071	Oakdale
15106	Carnegie
15108	Coraopolis
15126	Imperial
15136	McKees Rocks
15204	Corliss
15205	Crafton
15225	Neville Island

Figure 1: OVH Overall Service Area



Asset Inventory

The hospital staff identified existing health care facilities and resources within their primary service area and the region overall available to respond to the significant health needs of the community. Resource directories currently utilized by the hospital's case management and social service

departments were compiled. The information included in the asset inventory and map includes a listing of community and hospital services:

Community Resources:

Assisted Living
Clinic
Dentist
Diabetes Education
Dialysis
Drug Abuse & Alcohol Treatment
Family Planning
Food Bank
Nutritional Education
Physicians-Surgeons
Psychiatry and Mental Health
Rehab and Physical Therapy
Support Groups
Women's Health
Vein Care

Hospital Resources:

Acute Rehabilitation Unit
Addiction Medicine
Cardiology
Cardiovascular Medicine
Career Center
Cataract & Eye Surgery Center
Colon & Rectal Surgery
Emergency Department
Endocrinology
Family Medicine
Gastroenterology
General & Vascular Surgery
General Surgery
Gynecology
Infectious Disease
Internal Medicine
Laboratory Services
Nephrology
Neurology
Nutrition Services
Occupational Medicine
Oncology & Hematology
Ophthalmology
Oral & Maxillofacial Surgery
Orthopedics
Otolaryngology
Pain Treatment Center
Plastic & Reconstructive Surgery
Podiatry
Psychiatry
Pulmonary
Radiology & Medical Imaging
Rehabilitation Services
Respiratory Care Services
Rheumatology
Schools of Nursing
Sleep Evaluation Center
Surgical Services
Thoracic & Cardiovascular Surgery
Urology
Wound Care Center

Qualitative and Quantitative Data Collection

In an effort to examine the health related needs of the residents of the service area and to meet current IRS guidelines and requirements, the methodology employed both qualitative and quantitative data collection and analysis methods. The staff, Steering Committee members and consulting team made significant efforts to ensure that the entire primary service territory, all socio-demographic groups and all potential needs, issues and underrepresented populations were considered in the assessment to the extent possible given the resource constraints of the project. This was accomplished by identifying focus groups and key stakeholders that represented various subgroups in the community. In addition, the process included public health participation and input, through extensive use of the PA Health Department and Centers for Disease Control data and public health department participation on the Steering Committee.

The secondary quantitative data collection process included demographic and socio-economic data obtained from Nielsen/Claritas (www.claritas.com); disease incidence and prevalence data obtained from the Pennsylvania Departments of Health and Vital Statistics; Behavioral Risk Factor Surveillance Survey (BRFSS) data collected by the Centers for Disease Control and Prevention; American Community Survey and the Healthy People 2020 goals from HealthyPeople.gov. In addition, various health and health related data from the following sources were also utilized for the assessment: the US Department of Agriculture, the Pennsylvania Department of Education, and the County Health Rankings (www.countyhealthrankings.org). Selected data was also included from the Allegheny County 2013 PA Youth Survey and the National Survey Results on Drug Abuse – 1975-2013. Selected Emergency Department and inpatient utilization data from the hospital was also included. Economic data was obtained through the U.S. Census Bureau, Small Area Income and Poverty Estimates and the North Central PREP Partner's 2014 Internal Assessment and Evaluation of Regional Economy Report. Data presented are the most recent published by the source at the time of the data collection.

The primary data collection process included qualitative data from ten stakeholder interviews conducted during October and November 2015 by staff members of SSI. Refer to Appendix E (pages 161-164) of the Supplemental Data Resource for a copy of the interview guide. **Table** 2 lists

the stakeholders interviewed. Stakeholders interviewed included individuals with expertise in the following disciplines and/or organizational affiliations:

- Faith-Based Organization
- Police Department
- Health Center
- Media
- Physician
- School District
- Community Development
- Government Officials

Table 2. OVH Stakeholder Interviews

Date Conducted	Name	Organization	Title
10/20/15	Chris Crytzer	Focus on Renewal	Associate Director of External Relations
10/20/15	Chief Anthony Bruni	Kennedy Township Police Department	Chief of Police
10/22/15	Fr. Regis Ryan	Sto Rox Neighborhood Family Health Center	Executive Director
10/26/15	Doug Hughey	Allegheny West Magazine	Publisher/Editor
10/28/15	Dr. Gary Sauer	Doctors Sauer and Liebensperger Family Practice	
10/28/15	Terry DeCarbo	Sto Rox Schools	Superintendent
10/28/15	Taris Vrcek	McKees Rocks CDC	Executive Director
10/28/15	Anita Kulik	Kennedy Township	Commissioner
11/5/15	Dr. Gene Battistella	West Hills Medical Providers	

Date Conducted	Name	Organization	Title
11/6/15	Rep. Nick Kotik	45th Legislative District	State Representative

Focus groups were conducted with seven different groups in October 2015 representing the following groups as seen in **Table 3**. Refer to Appendices F and G (pages 165-173) of the Supplemental Data Resource for copies of the focus group questions used.

Table 3. OVH Focus Groups Conducted

Date Conducted	Group	Total # Participants
10/14/15	YMCA	9
10/14/15	Food Bank	14
10/21/15	Diabetic Support Group	6
10/21/15	Food Bank	6
10/23/15	Flu Clinic	9
10/28/15	Seniority	28
10/28/15	Willows	8
	TOTAL PARTICIPANTS	**80**

Interviews and focus groups captured personal perspectives from community members, providers, and leaders with insight and expertise into the health of

a specific population group or issue, a specific community or the county overall.

Needs/Issues Prioritization Process

On November 9, 2015, the OVH Steering Committee met to review the secondary data collected through the needs assessment process. On March 9, 2016, the OVH Steering Committee met to discuss needs and issues present in their local service territory. The team from SSI, including Debra Thompson, President of Strategy Solutions, Inc., and Kathy Roach, Project Manager/Research Analyst, presented the data to the OVH Steering Committee and discussed the needs of the local area, what the hospital and other providers are currently offering the community, and discussed other potential needs that were not reflected in the data collected. A total of 46 possible needs and issues were identified, based on disparities in the data (differences in sub-populations, comparison to state, national or Healthy People 2020 goals, negative trends, or growing incidence). Four criteria, including accountable role, magnitude of the problem, impact on other health outcomes, and capacity (systems and resources to implement evidence based solutions), were identified that the group would use to evaluate identified needs and issues.

During the two weeks after the meeting, Steering Committee members from the hospital completed the prioritization exercise using the Survey Monkey Internet survey tool to rate each the needs and issues on a one to ten scale by each of the selected criteria.

Nine Steering Committee members (75%) participated in the prioritization exercise.

The consulting team analyzed the data from the prioritization exercise and rank ordered the results by overall composite score (reflecting the scores of all criteria) for the OVH region, as well as for the hospital's Steering Committee.

On April 11, 2016, OVH's Steering Committee met again to discuss the prioritization results and determine which needs and issues would be addressed in the implementation strategy.

Review and Approval

The OVH CHNA report was approved by the OVH Board of Directors on May 31, 2016.

Evaluation of the 2013 OVH CHNA Implementation Strategies

OVH conducted an evaluation of the implementation strategies undertaken since the completion of the 2013 CHNA. Although the status for most county level indicators did not move substantially, it is clear that OVH is working to improve the health of the community.

In reviewing the status of the priority area, OVH reported the following:

Priority Area: Chronic Disease, Senior Population
Goal: Address diabetes, obesity and other chronic diseases prevalent in the community, by implementing prevention and diabetes management strategies within the senior population.

In evaluating this priority area, OVH reported that the following objectives of this priority area had been met:

Host Annual Diabetes Day: OVH hosted its annual Diabetes Day each March (2013, 2014 and 2015), with each year seeing an increase in the attendance for this event. In 2014, the hospital instituted an outreach program to target those participants who attended the event the previous year. OVH also started a survey in 2014 to track who attends the event on a yearly basis.

The hospital continued to offer free health screenings during the event, including bone density scans, foot screenings, blood glucose, blood pressure, height, weight, BMI, body fat analysis, visual acuity, and Glaucoma screenings. OVH also offered A1C testing with the results of this test sent to

either the person's primary care physician (PCP) or, if no PCP, a recommendation on a PCP to see for their A1C results.

OVH's Seniority members were encouraged to attend Diabetes Day by making it their monthly meeting, especially since most of the vendors present for this event were geared to the senior population.

Increase the awareness regarding the importance of Diabetes education and screening in the community: OVH marketed their Annual Diabetes Day through the hospital's website, flyers posted around the OVH and handed out around the community, including at Focus on Renewal and local churches, and through the monthly Seniority newsletter. The hospital also marketed the event through social media, including Facebook and Diabetes Day blog. OVH also reached out to 500 people via email and mail informing them of Diabetes Day, Living Well with Diabetes classes and free support groups.

OVH also has hospital employees and OVH nursing students attend community health fairs to administer flu shots, bone density testing and other screenings, as well as offering information regarding Diabetes. The hospital's senior living center also hosts a series of lectures with OVH physicians in order to educate the community on a wide range of health issues. For the hospital's annual 5K run, Diabetes and nutrition educational brochures where inserted into each runner's packets.

OVH partnered with the Western Area YMCA's after school program/health initiative through the funding of their healthy snack, as well as offering discussion on healthy habits and healthy life choices.

Facilitate Seniority meetings that include screenings, testing and education: Each month, OVH sponsors a lecture series for Seniority members on a variety of topics including, Diabetes, health and nutrition and chronic disease management. The hospital has also instituted healthy food demonstrations at these meetings to promote healthy snacking and eating. OVH's Rehab Services Department also attended various monthly meetings to showcase exercises that can be done in a chair or very easily for seniors with limited mobility. At certain times of the during the Seniority monthly meetings, free glucose testing and body fat analysis was also provided to the members.

Conduct Living Well with Diabetes classes: OVH has created a physician referral program called Living Well with Diabetes. This is a ten-hour program which consists of an individual, private consultation, followed by eight, one-hour group class time, designed to provide information and skills to assist with the management of their Diabetes. Topics discussed during this program include: nutrition, exercise, stress, medication, blood glucose monitoring, prevention/detection/and treatment of high and low blood sugar, and long-term complications of high/low blood sugar. The hospital has reported that there are 12-50 people who attend the Diabetes Support Group at any one time, with two people attending the monthly Diabetes classes. OVH is currently working with the YMCA to be the host site for a pre-Diabetes class that will be held in the fall of 2015 and continue as a pilot for one year.

Free Diabetes Support Group meetings: As stated above, OVH offers a Diabetes Support Group that is attended by anywhere from 12 to 50 people at any one time, offering education, problem solving and full support on living with Diabetes.

This page intentionally left blank

For purposes of this assessment, the OVH service area geography is defined as the primary service area of Oakdale, Carnegie, Coraopolis, Imperial, McKees Rocks, Corliss, Crafton and Neville Island in Allegheny County, PA.

The above listed primary service area was used to pull Demographic data from Nielsen/Claritas and the U.S. Census Bureau – American Family Survey in order to report on the areas of: population, sex, race, age, marital status, educational status, household income, employment and poverty status, and travel time to work. Below are the Demographic conclusions from this data. For a more in-depth review of the Demographic data, please see pages 1-14 of OVH's CHNA Supplemental Data Resource, Appendix A.

Demographic Conclusions

- The Ohio Valley Hospital service area population has been steadily increasing and is projected to continue to increase from 131,102 in 2015 to 133,823 in 2020.
- There are slightly more females (51.3%) than males (48.7%).
- Over three-fourths of the residents in the service area are White (84.9%).
- Over one third (40.6%) of the population is between the ages of 25 and 54, while almost one-third of the population (28.9%) is between the ages of 55 and 84.
- Just under half (44.8%) of the population is married.
- One in four (42.2%) have received an Associate Degree or higher educational attainment. A little under one in ten (6.5%) residents has not graduated high school.

- Just over one in ten households (11.4%) have an annual income of $15,000 or less. Almost half (46.1%) have annual incomes less than $50,000.
- Over half of the population (62.3%) is currently employed. Very few (5.5%) residents are currently unemployed.
- Almost three-fourths of those employed (65.6%) travel less than 30 minutes to work.

Asset Inventory

A list of community assets and resources that are available in the community to support residents was compiled and is mapped in **Figure 2** and listed in OVH's CHNA Supplemental Data Resource, Appendix B, pages 15-30. The assets identified are broken down into the following sections:

Community Resources:

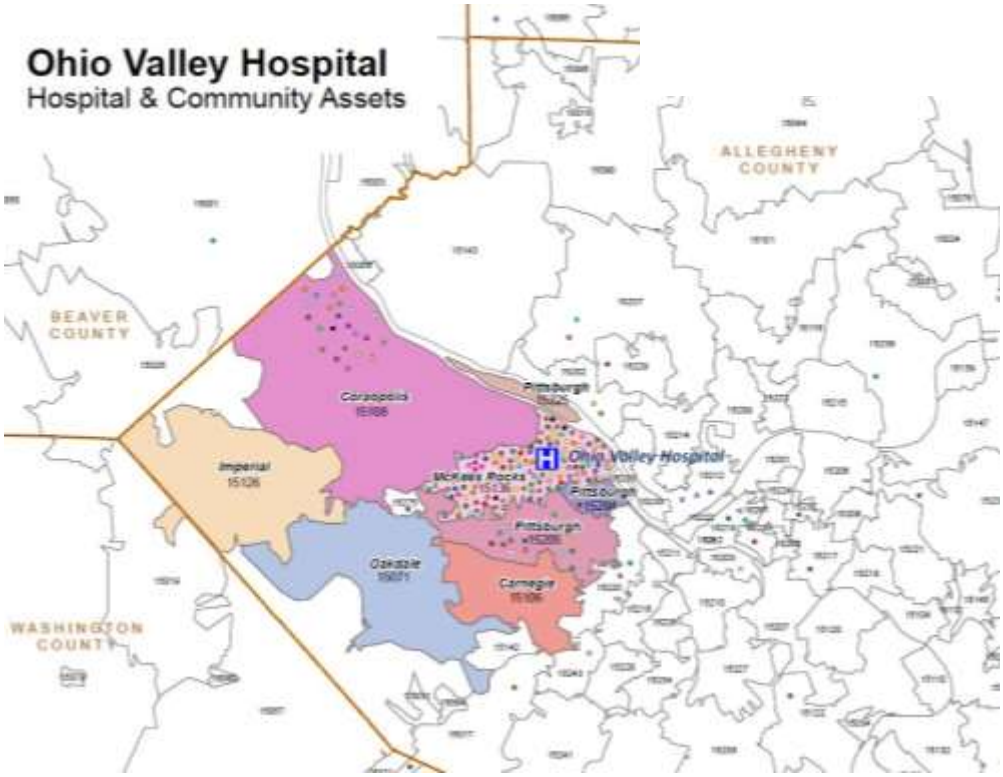
Assisted Living
Clinic
Dentist
Diabetes Education
Dialysis
Drug Abuse & Alcohol Treatment
Family Planning
Food Bank
Nutritional Education
Physicians-Surgeons
Psychiatry and Mental Health
Rehab and Physical Therapy
Support Groups
Women's Health
Vein Care

Hospital Resources:

Acute Rehabilitation Unit
Addiction Medicine
Cardiology
Cardiovascular Medicine
Career Center
Cataract & Eye Surgery Center
Colon & Rectal Surgery
Emergency Department
Endocrinology
Family Medicine
Gastroenterology
General & Vascular Surgery
General Surgery
Gynecology
Infectious Disease
Internal Medicine
Laboratory Services
Nephrology
Neurology
Nutrition Services
Occupational Medicine
Oncology & Hematology

Ophthalmology
Oral & Maxillofacial Surgery
Orthopedics
Otolaryngology
Pain Treatment Center
Plastic & Reconstructive Surgery
Podiatry
Psychiatry
Pulmonary
Radiology & Medical Imaging
Rehabilitation Services
Respiratory Care Services
Rheumatology
Schools of Nursing
Sleep Evaluation Center
Surgical Services
Thoracic & Cardiovascular Surgery
Urology
Wound Care Center

Figure 2: OVH Asset Resources Map



Community Assets

- Assisted Living
- Clinic
- Dentist
- Diabetes Education
- Dialysis
- Drug Abuse & Alcohol Treatment
- Family Planning
- Food Bank
- Nutrition Education
- Physicians-Surgeons
- Psychiatry and Mental Health
- Rehab and Physical Therapy
- Support Groups
- Vein Care
- Women's Health

Hospital Assets

- Acute Rehabilitation Unit
- Addiction Medicine
- Cardiology
- Cardiovascular Medicine
- Career Center
- Cataract Eye Surgery Center
- Colon & Rectal Surgery
- Emergency Department
- Endocrinology
- Family Medicine
- Gastroenterology
- General & Vascular Surgery
- General Surgery
- Gynecology
- Infectious Disease
- Internal Medicine
- Labratory Services
- Nephrology
- Neurology
- Nutrition Services
- Occupational Medicine
- Ohio Valley Primary Care
- Oncology

Hospital Assets cont.

- Oncology & Hematology
- Ophthalmology
- Oral & Maxillofacial Surgery
- Orthopedics
- Otolaryngology
- Pain Treatment Center
- Plastic & Reconstructive Surgery
- Podiatry
- Psychiatry
- Pulmonary
- Radiology & Medical Imaging
- Rehabilitation Services
- Respiratory Care Services
- Rheumatology
- School of Nursing
- Sleep Evaluation Center
- Surgical Services
- Thoracic & Cardiovascular Surgery
- Urology
- Would Care Center

Key Findings – BRFSS & Public Health Data

This assessment reviewed a number of indicators at the county level from the statewide Behavioral Risk Factor Survey (BRFSS), as well as disease incidence and mortality indicators. For this analysis, the service area data was compared to state and national data where possible.

As outlined in the following tables, when looking at the BRFSS questions related to OVH's primary service area data, the regional rates that were worse than Pennsylvania include the percentage of people with no personal health care provider and adults who reported binge drinking (5 drinks for men; 4 for women).

The Chronic Disease public health data within OVH's primary service area that have regional rates worse than Pennsylvania include: breast cancer incidences, bronchus and lung cancer incidences, bronchus and lung cancer mortality, prostate cancer incidences, prostate cancer mortality, heart disease mortality, coronary heart disease mortality, cardiovascular mortality, and cerebrovascular (stroke) mortality. Mammogram screenings is lower than the state.

Regarding Healthy Environment, OVH's primary service area has increasing rates of students with asthma.

For the Healthy Mothers, Babies and Children indicators, OVH's primary service area has increasing rates of teen live birth outcomes and students in grades K-6 who are overweight. The service area also saw a decrease in rates for breastfeeding.

For the selected indicators within Infectious Disease, and Mental Health and Substance Abuse, OVH's primary service area has increasing rates of influenza and pneumonia mortality, chlamydia, females with chlamydia, males with chlamydia, gonorrhea, females with gonorrhea, males with gonorrhea, drug-induced mortality, mental and behavioral disorders mortality.

The 2013 Pennsylvania Youth Survey for children in grades 8, 10 and 12 for the OVH primary service area shows that there are increasing rates in lifetime alcohol, marijuana and pain reliever use; and percent of students who drove after using marijuana in grades 10 and 12 is also increasing.

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Red indicates that the regional data is worse than the comparison and green indicates better than the comparison. Yellow indicates that one county is higher and another is lower.

Overall Key Findings

Table 4 below highlights the key findings of the Behavioral Risk Factor Survey for OVH.

Table 4. OVH Behavioral Risk Factor Comparative Table

	ALLEGHENY	ALLEGHENY	ALLEGHENY	Trend	PA	PA	PA	US	US	HP 2020	PA	US	HP 2020
Behavior Risk	**2008-2010**	**2011-2013**	**2012-2014**	**+/-**	**2008-10**	**2011-13**	**2012-14**	**2010**	**2013**	**Goal**	**Comp**	**Comp**	**Comp**
ACCESS													
Reported Health Poor or Fair	14.0%	15.0%	15.0%	+	15.0%	17.0%	17.0%	14.7%	16.7%		-	-	
Physical Health Not Good for 1+ Days in the Past Month	36.0%	39.0%	38.0%	+	37.0%	38.0%	37.0%				-/+		
Poor Physical or Mental Health Preventing Usual Activities in the Past Month	21.0%	23.0%	22.0%	+	21.0%	22.0%	22.0%				-/+		
No Health Insurance	12.0%	12.0%	12.0%	=	13.0%	16.0%	15.0%	17.8%	16.8%	0%	-	-	+
No Personal Health Care Provider	13.0%	16.0%	17.0%	+	11.0%	13.0%	14.0%		22.9%	16.1%	-/+	-	+/-
Routine Check-up Within the Past 2 Years	83.0%	84.0%	85.0%	+	83.0%	83.0%	83.0%		81.3%		+/=	+	
Needed to See a Doctor But Could Not Due to Cost, Past Year	10.0%	11.0%	11.0%	+	11.0%	13.0%	12.0%		15.3%	4.2%	-	-	+
CHRONIC DISEASE													
Ever Told They Have Heart Disease- Age 35 and older	6.0%	6.0%	6.0%	=	7.0%	7.0%	7.0%	4.1%	4.1%		-	+	
Ever Told They Had a Heart Attack- Age 35 and Older	6.0%	5.0%	6.0%	-/=	6.0%	6.0%	7.0%	4.2%	4.3%		-	+	
Ever Told They Had a Stroke- Age 35 and older	3.0%	4.0%	5.0%	+	12.0%	4.0%	4.0%		2.8%		+/-/=	+	
Ever Told They Had a MI, Heart Disease, or Stroke- Age GE 35	11.0%	12.0%	13.0%	+	12.0%	12.0%	13.0%				-/=		
Ever Told They Had Kidney Disease, Not Including Kidney Stones, Bladder Infection or Incontinence	ND	2.0%	2.0%	=	ND	2.0%	2.0%		2.5%		=	-	
Overweight (BMI 25-30)	63.0%	62.0%	63.0%	-/=	64.0%	65.0%	65.0%	68.8%	69.0%		-	-	
Obese (30-99.99)	28.0%	26.0%	26.0%	-	28.0%	29.0%	30.0%	27.5%	29.4%	30.5%	-	-	-
Adults Who Were Ever Told They Have Diabetes	9.0%	9.0%	10.0%	=/+	9.0%	10.0%	10.0%		9.7%		-/=	-/=	
HEALTHY ENVIRONMENT													
Adults Who Have Ever Been Told They Have Asthma	15.0%	13.0%	13.0%	-	14.0%	14.0%	14.0%	13.8%	14.1%		+/-	+/-	
Adults Who Currently Have Asthma	9.0%	9.0%	9.0%	=	10.0%	10.0%	10.0%	9.1%	9.0%		-	=	
INFECTIOUS DISEASE													
Adults Who Had a Pneumonia Vaccine, Age 65 and older	77.0%	79.0%	78.0%	+	70.0%	71.0%	70.0%	68.8%	69.5%	90.0%	+	+	-
Ever Tested for HIV, Ages 18-64	32.0%	37.0%	38.0%	+	34.0%	38.0%	38.0%		35.2%	73.6%	-/=	+/-	-
MENTAL HEALTH AND SUBSTANCE ABUSE													
Mental Health Not Good 1+ Days	34.0%	36.0%	36.0%	+	34.0%	36.0%	36.0%				-/=		
Adults Who Reported Binge Drinking (5 drinks for men, 4 for women)	19.0%	20.0%	20.0%	+	17.0%	18.0%	17.0%	17.1%	16.8%	24.4%	+	+	-
At Risk for Heavy Drinking (2 drinks for men, 1 for women daily)	6.0%	8.0%	7.0%	+	5.0%	6.0%	6.0%		6.2%		+/=	+/-	
Reported Chronic Drinking (2 or more drinks daily for the past 30 days)	6.0%	7.0%	6.0%	+/=	6.0%	6.0%	6.0%	5.0%			+/-		
PHYSICAL ACTIVITY AND NUTRITION													
No Leisure Time/Physical Activity in the Past Month	19.0%	21.0%	20.0%	+	25.0%	21.0%	21.0%	23.9%		32.6%	-/=		-
No Leisure Time/Physical Activity in the Past Month: Education Level College	14.0%	14.0%	13.0%	=/-	15.0%	14.0%	13.0%				+/=		
TOBACCO USE													
Adults Who Reported Never Being a Smoker	54.0%	52.0%	53.0%	-	54.0%	53.0%	54.0%	56.6%	55.0%		-/=	-	
Adults Who Reported Being a Former Smoker	28.0%	25.0%	26.0%	-	26.0%	26.0%	25.0%	25.1%	25.3%		+/=	+/-	
Adults Who Reported Being a Former Smoker (Female)	24.0%	23.0%	23.0%	-	23.0%	22.0%	22.0%				+		
Adults Who Reported Being A Former Smoker (Male)	32.0%	28.0%	28.0%	-	29.0%	29.0%	29.0%				+/-		
Currently using Chewing Tobacco, Snuff, or Snus, Somewhat or Everyday (Adults)	ND	3.0%	3.0%	=	ND	4.0%	4.0%		4.2%		-	-	
Adults Who Have Quit Smoking at Least 1 Day in the Past Year (daily)	48.0%	53.0%	56.0%	+	50.0%	54.0%	54.0%			80.0%	+/-		-
Adults Who Reported Being a Current Smoker	18.0%	22.0%	21.0%	+	20.0%	22.0%	21.0%	17.3%	18.8%	12.0%	+/-/=	+/-	+
Adults Who Reported Being An Everyday Smoker	13.0%	17.0%	16.0%	+	15.0%	16.0%	15.0%	12.4%	13.4%		+/-	+/-	

Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Red indicates that the regional data is worse than the comparison and green indicates better than the comparison. Yellow indicates that one county is higher and another is lower.

Table 5 highlights various public health indicators included in the assessment for OVH.

Table 5. OVH Public Health Indicators – Table 1 of 2

	ALLEGHENY COUNTY					Trend	PA (2008)	PA (the last year)	US (2010)	US (2012)	HP 2020	PA	US
Public Health Data	**2008**	**2009**	**2010**	**2011**	**2012**	**+/-**	**Rate**	**Rate**	**Rate**	**Rate**	**Goal**	**Comp**	**Comp**
CHRONIC DISEASE													
Breast Cancer Rate per 100,000	79.0	76.1	73.2	73.3	78.1	+/-	71.2	69.4	121.9	122.0	41.0	+	-
Breast Cancer Mortality Rate per 100,000	14.4	16.1	12.0	13.8	12.2	+/-	13.9	12.5	22.2	21.5	20.7	-	-
Bronchus and Lung Cancer Rate per 100,000	79.7	76.8	73.6	75.5	67.6	-	69.9	63.9		73.0		+	+/-
Bronchus and Lung Cancer Mortality Rate per 100,000	54.5	53.4	52.2	52.4	52.3	-	51.6	46.5		57.9	45.5	+	-
Colorectal Cancer Rate per 100,000	47.2	49.5	41.3	42.6	40.0	+/-	49.5	42.5		46.1	38.6	+/-	+/-
Colorectal Cancer Mortality Rate per 100,000	19.1	17.0	15.9	15.8	14.9	-	18.1	15.8	16.9	18.1	14.5	+/-	+/-
Ovarian Cancer Rate per 100,000	13.7	12.2	13.9	10.6	11.8	+/-	13.5	11.9		11.3		+/-	+/-
Ovarian Cancer Mortality Rate per 100,000	8.5	8.3	9.2	7.7	8.9	+/-	8.7	7.9		7.5		+/-	+/-
Prostate Cancer Rate per 100,000	145.0	134.7	124.9	119.9	112.1	-	148.7	101.7		128.3		+	+/-
Prostate Cancer Mortality Rate per 100,000	22.2	20.3	19.9	18.6	22.1	-	24.2	19.1		20.8	21.8	+/-	+/-
Heart Disease Mortality Rate per 100,000	210.7	191.5	185.4	193.5	180.1	-	207.3	175.2		176.8		+	+
Heart Attack Mortality Rate per 100,000	18.3	17.3	16.5	17.7	17.7	-	20.4	17.9		89.2		+/-	-
Coronary Heart Disease Mortality Rate per 100,000	156.4	140.4	135.4	139.2	129.3	-	138.5	115.3		108.91	103.4	+	+
Cardiovascular Mortality Rate per 100,000	268.2	243.1	236.4	246.2	225.6	-	264.5	225.5		233.73		+	+/-
Chronic Lower Respiratory Disease (COPD) Rate per 100,000	43.1	39.2	37.0	41.5	36.2	-	42.8	38.4	40.8		102.6	+/-	
Cerebrovascular Mortality Rate per 100,000	43.4	38.6	39.2	38.2	34.3	-	41.8	36.8	39.1	39.9	34.8	+/-	+/-
Diabetes Mortality Rate per 100,000	19.9	16.2	17.4	16.8	20.6	+/-	21.3	22.0	20.8	73.28	66.6	+/-	-
Type I Diabetes, Students		0.32%	0.32%	0.34%	0.36%	+/=	19.6	0.32%				+/=	
Type II Diabetes, Students		0.08%	0.08%	0.08%	0.07%	-/=	0.30%	0.06%				+	
Alzheimer Mortality Rate per 100,000	20.7	17.9	18.3	20.0	18.5	-	22.8	18.7		26.8		+/-	-
HEALTHY ENVIRONMENT													
Student Health Asthma		4.3%	11.4%	11.8%	12.4%	+	6.8%	12.05%				+/-	
HEALTHY MOTHERS, BABIES AND CHILDREN													
Prenatal Care First Trimester	85.6%	87.1%	88.8%	89.2%	89.1%	+	70.5%	72.4%		70.8%	77.9%	+	+
Non-Smoking Mother During Pregnancy	83.0%	83.8%	84.8%	85.1%	86.8%	+	84.1%	85.2%		89.3%	98.6%	+/-	-
Non-Smoking Mother 3 Months Prior to Pregnancy	80.1%	80.9%	81.9%	82.5%	84.5%	+	77.6%	80.1%		76.8%		+/=	+
Low Birth-Weight Babies Born	8.9%	8.1%	8.0%	7.7%	7.6%	-	8.3%	8.1%		8.0%	7.8%	+/-	+/-
Mothers Reporting WIC Assistance	31.3%	32.1%	31.5%	30.8%	28.4%	+/-	39.0%	39.3%				-	
Mothers Reporting Medicaid Assistance	33.6%	32.0%	22.9%	25.8%	30.0%	-	31.2%	33.6%				+/=	
Breastfeeding	64.0%	68.5%	68.4%	70.1%	72.0%	+	66.5%	73.1%		77.0%	81.9%	-	-
Teen Pregnancy Rate per 100,000, Ages 15-19	41.7	38.0	38.2	33.4	30.6	-	44.3	33.7	34.2	30.0	36.2	+/-	+
Teen Live Birth Outcomes, Ages 15-19	57.1%	59.1%	58.1%	57.8%	59.7%	+	67.6%	69.5%		73.4%		-	-
Infant Mortality	8.3%	7.4%	7.6%	6.1%	5.9%	-	7.3%	7.0%	6.2%	6.1%	6.0%	+/-	+/-
Overweight BMI, Grades K-6		15.6%	17.4%	17.3%		+		15.9%				+/-	
Obese BMI, Grades K-6		15.2%	15.9%	15.3%		+		16.7%			15.7%	-	
Overweight BMI, Grades 7-12		17.1%	17.5%	17.1%		+/=		16.4%		30.3%		+	-
Obese BMI, Grades 7-12		15.3%	15.0%	15.9%		+/-		17.7%		13.7%	16.1%	-	+

Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Red indicates that the regional data is worse than the comparison and green indicates better than the comparison. Yellow indicates that one county is higher and another is lower.

Table 6 highlights various public health indicators included in the assessment for OVH.

Table 6. OVH Public Health Indicators – Table 2 of 2

	ALLEGHENY COUNTY					Trend	PA (2008)	PA (the last year)	US (2010)	US (2012)	HP 2020	PA	US	HP Goal
Public Health Data	**2008**	**2009**	**2010**	**2011**	**2012**	**+/-**	**Rate**	**Rate**	**Rate**	**Rate**	**Goal**	**Comp**	**Comp**	**Comp**
INFECTIOUS DISEASE														
Lyme Disease Rate per 100,000	1.3	2.4	1.5		0.8	+/-	32.1	39.4		8.6		-	-	
Influenza and Pneumonia Mortality Rate per 100,000	17.8	16.9	17.3	19.6	15.1	+/-	16.7	13.3	16.2	15.1		+	+/=	
Chlamydia Rate per 100,000	428.2	403.4	412.1	489.0	524.2	+/-	339.3	430.9				+		
Chlamydia Rate per 100,000 (Female)	593.7	557.9	556.4	647.8	693.9	+/-	476.9	575.0				+/-		
Chlamydia Rate per 100,000 (Male)	246.0	232.1	254.6	316.4	340.6	+/-	193.7	279.1				+/-		
Gonorrhea Rate per 100,000	177.6	126.0	134.7	157.4	194.6	+/-	88.9	120.6		106.7		+	+	
Gonorrhea Rate per 100,000 (Female)	199.3	149.4	154.9	179.0	219.5	+/-	97.1	128.0				+		
Gonorrhea Rate per 100,000 (Male)	153.7	99.9	112.7	133.7	167.7	+/-	80.3	112.8				+/-		
MENTAL HEALTH AND SUBSTANCE ABUSE														
Drug-Induced Mortality Rate per 100,000	18.6	17.8	18.6	20.5	22.7	+/-	15.3	19.2		10.2	11.3	+/-	+	+
Mental & Behavioral Disorders Mortality Rate per 100,000	36.3	35.4	41.5	42.0	46.5	+/-	34.0	43.0		63.3		+/-	-	
INJURY														
Auto Accident Mortality Rate per 100,000	6.5	6.2	6.7	5.5	5.7	+/-	11.9	10.0	11.9	10.7	12.4	-	-	-
Suicide Mortality per 100,000	10.1	10.6	9.8	10.8	11.7	+/-	11.9	12.1	12.1	4.5	10.2	-	+	+/-
Fall Mortality Rate per 100,000	10.0	8.5	12.2	11.8	11.5	+/-	8.0	8.4	8.1	9.6	7.2	+	+/-	+
Firearm Mortality Rate (Accidental, Suicide, Homicide)	13.1	12.2	11.2	11.7	12.6	-	10.6	11.0	10.1	10.1	9.3	+	+	+

Source: Pennsylvania Department of Health, Centers for Disease Control, www.healthypeople.gov

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Red indicates that the regional data is worse than the comparison and green indicates better than the comparison. Yellow indicates that one county is higher and another is lower.

Table 7 highlights various county health indicators included in the assessment for OVH.

Table 7. OVH County Health Rankings

	ALLEGHENY COUNTY			Trend	PA - 2013	PA (the last year)	US - 2010	HP 2020	PA	US	HP Goal
Other Indicators	2013	2014	2015	+/-	Rate	Rate	Rate	Goal	Comp	Comp	Comp
ACCESS											
Mammogram Screenings	58.0%	49.4%	50.9%	-	66.8%	63.4%	67.1%	81.1%	-	-	-
HEALTHY ENVIRONMENT											
Unemployment Rates	7.0%	6.9%	6.5%	-	7.9%	7.4%	8.9%		-	-	
High School Graduation Rates	86.0%	86.0%	89.0%	+	83.0%	85.0%		82.4%	+		+
Children Living in Poverty	19.0%	19.0%	19.0%	=	19.0%	19.0%			=		
Children Living in Single Parent Homes	34.0%	33.0%	33.0%	-	32.0%	33.0%			+/=		
PHYSICAL ACTIVITY AND NUTRITION											
Limited Access to Healthy Foods	6.0%	6.0%	6.0%	=	4.0%	4.0%			+		
Food Insecurity		14.0%	14.0%	=		14.0%			=		
Children Eligible for Free Lunch	32.0%	32.0%	33.0%	+	33.0%	34.0%			-		
TOBACCO USE											
Adults who Smoke		19.0%	19.0%	=	21.0%	20.0%	20.0%	12.0%	-	-	+

Source: County Health Rankings, Centers for Disease Control, www.healthypeople.gov

Table 8 highlights various youth survey indicators included in the assessment for OVH.

The color coding illustrates comparisons to the Healthy People 2020 goal or the national rate (if there is no HP 2020 goal). Red indicates that the regional data is worse than the comparison and green indicates better than the comparison. Yellow indicates that one county is higher and another is lower.

Table 8. OVH 2013 Pennsylvania Youth Survey

MENTAL HEALTH AND SUBSTANCE ABUSE	ALLEGHENY COUNTY			Trend	PA	US	PA	US
	2009	2011	2013	+/-	Rate	Rate	Comp	Comp
Alcohol Child/Adolescent Lifetime Use					2013	2013		
Grade 6	17.2%		14.1%	-	13.3%		+/-	
Grade 8	33.1%		35.8%	+	35.1%	27.8%	+/-	+
Grade 10	48.3%		65.3%	+	61.5%	52.1%	+/-	+/-
Grade 12	58.0%		79.3%	+	74.2%	68.2%	+/-	+/-
Overall	36.8%		48.2%	+	56.9%		-	
Marijuana Child/Adolescent Lifetime Use								
Grade 6	1.1%		1.9%	+	0.8%		+	
Grade 8	8.0%		10.5%	+	6.4%	16.5%	+	-
Grade 10	13.4%		31.7%	+	25.8%	35.8%	+\-	-
Grade 12	33.3%		50.3%	+	40.3%	45.5%	+/-	+/-
Overall	11.4%		22.8%	+	18.9%		+/-	
% of Children/Adolescents Who Drove After Drinking								
Grade 6	0.4%		0.5%	+	0.2%		+	
Grade 8	0.4%		1.1%	+	0.4%		+/=	
Grade 10	0.8%		2.0%	+	1.8%		+/-	
Grade 12	9.7%		10.7%	+	8.7%		+	
Overall	1.9%		3.3%	+	2.9%		+/-	
% of Children/Adolescents Who Drove After Using Marijuana								
Grade 6	0.4%		0.2%	-	0.1%		+	
Grade 8	0.6%		0.8%	+	0.4%		+	
Grade 10	1.2%		3.1%	+	2.4%		+/-	
Grade 12	9.8%		13.5%	+	12.4%		+/-	
Overall	2.1%		4.1%	+	4.1%		-/=	
% Pain Reliever Child/Adolescent Lifetime Use								
Grade 6	1.9%		2.6%	+	2.1%		+/-	
Grade 8	2.5%		4.6%	+	4.1%		+/-	
Grade 10	4.7%		10.4%	+	8.3%		+/-	
Grade 12	8.0%		16.5%	+	12.1%		+/-	
Overall	3.6%		8.3%	+	6.8%		+/-	

Source: 2013 Pennsylvania Youth Survey, National Survey Results on Drug Abuse – 1975-2013

Other Secondary Data: Hospital Utilization Rates

As seen in **Table 9**, from 2013 through 2015, hospital inpatient discharges for ambulatory care sensitive conditions for Ohio Valley Hospital (OVH) increased for: bacterial pneumonia, severe ENT infections, angina, and COPD.

For the same time period, hospital ER and inpatient discharges for mental health for OVH, as seen in **Table 10**, increased for: Dementia, alcohol-related incidences, drug-related incidences, other chronic organic psychotic, Schizophrenia, manic disorder, depression, bi-polar, paranoia psychosis, anxiety, and conduct/social disturbances.

Table 11 shows that from 2013 to 2015, hospital DRG conditions for OVH increased for: hypertension, breast cancer, cancer, alcohol/drug abuse, and COPD.

In reviewing the data for OVH regarding the hospital's service lines by DRG conditions, **Table 12** shows increases in Cardiology, General/Colon/Rectal Surgery, Endocrinology, GI, General Medicine, Hematology/Oncology, Nephrology, Neurology, Oral Surgery, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonary, and Spine Surgery for the period 2013 to 2015.

Table 9. Ambulatory Care Sensitive Conditions-ER Only

Ambulatory Care Sensitive Conditions - ER Only			
Preventable Conditions	**2013**	**2014**	**2015**
Congenital Syphilis	0	0	0
Failure to Thrive	0	0	0
Dental Conditions	0	0	0
Vaccine Preventable Cond	11	11	3
Hemophilus Meningitis ages 1-5	0	0	1
Iron Deficinecy Anemias	0	0	0
Nutritional Deficiencies	0	0	0
Acute Conditions			
Bacterial Pneumonia	105	80	106
Cervical Cancer	0	0	0
Cellulitis	0	0	0
Convulsions	0	0	0
Dehydration	1	0	0
Gastroenteritis	240	224	186

Ambulatory Care Sensitive Conditions - ER Only			
Hypoglycemia	4	1	4
Kidney/Urinary Infection	274	303	264
Pelvic Inflammatory Dis	0	0	0
Severe ENT Infections	207	237	247
Skin Grafts with Cellulitis	0	0	0
Chronic Conditions			
Angina	2	11	5
Asthma	0	0	0
COPD	426	333	429
CHF	0	1	0
Diabetes with ketoacidosis	0	0	0
Diabetes with other conditions	0	0	0
Diabetes without other conditions	0	0	0
Chronic Conditions			
Grand Mal and other Epileptic	0	0	0
Hypertension	104	88	75
Tuberculosis- Non Pulmonary	0	0	0
Pulmonary Tuberculosis	0	0	0

Table 10. Hospital ER and Outpatient Discharges for Mental Health

Mental Health ICD-9 File						
Code	**2013 ER**	**2013 OUT-OPT**	**2014 ER**	**2014 OUT-OPT**	**2015 ER**	**2015 OUT-OPT**
Drug Related	83	62	91	113	130	75
Anxiety	96	88	95	94	109	58
Alcohol Related	51	4	63	8	58	7
Depressions	20	67	13	50	29	42
Other Chronic Organic Psychotic	11	19	13	29	12	19
Manic Disorder	6	57	5	60	11	57
Bi Polar	7	68	5	69	11	70
Paranoia Psychosis	4	15	7	19	11	15
Schizophrenia	2	19	2	19	7	71
Conduct/Social Disturbances	0	0	2	1	3	4
Transient Organic Psychotic	3	3	3	0	2	3
Dementia	0	4	0	6	1	5
Psychogenic Disorders	1	1	1	0	1	1

Mental Health ICD-9 File						
Code	2013 ER	2013 OUT-OPT	2014 ER	2014 OUT-OPT	2015 ER	2015 OUT-OPT
Stress Related	4	11	10	3	1	6
Adjustment Related	1	2	3	0	1	2
Phobias	0	0	0	0	0	0
Personality Disorders	0	1	0	0	0	0
Sexual Deviations	0	3	0	2	0	3
Sleep Disorders	0	4	0	10	0	6
Eating Disorders	0	0	0	0	0	0
Emotional- Youth	0	2	0	0	0	0
Mental Retardation	0	4	0	8	0	2

Table 11. Hospital DRG Conditions

DRG File			
DRG File	2013	2014	2015
Hypertension	3	15	12
CHF	112	130	93
Breast Cancer	1	1	2
Cancer	3	3	7
Pneumonia	149	134	145
Complications Baby	0	0	0
Bronchitis/Asthma	27	29	26
Alcohol/Drug Abuse	13	19	22
COPD	127	136	139
Fracture	15	18	5

Table 12. Service Line by DRG

Service Line by DRG			
	2013	2014	2015
Cardio-Thoracic Surgery	34	20	25
Cardiology	422	530	533
General/Colon/Rectal Surgery	261	215	274
Dermatology	126	95	117
Endocrinology	107	100	118
GI	332	372	344
General Medicine	45	59	85
Hematology/Oncology	114	116	118

Service Line by DRG			
	2013	**2014**	**2015**
Infectious disease	49	28	36
Normal Newborn and Neonates	0	0	0
Nephrology	114	124	122
Neurology	98	120	132
Neurosurgery	33	19	30
OB/GYN	25	20	9
Ophthalmology	6	10	3
Oral Surgery	1	2	2
Orthopedic Surgery	276	301	321
Otolaryngology	25	34	33
Plastic Surgery	27	29	15
Psychiatry	241	287	356
Pulmonary	495	489	497
Musculoskeletal	22	19	20
Spine Surgery	8	7	10
Urology	69	69	60
Vascular Surgery	135	120	115

The following tables (**Tables 13-20**) depict conditions by zip code for the years 2012-2015 based on ICD-9 outpatient hospital utilization data. The top three conditions that residents from the service area zip codes were seen include:

- Diabetes
- Heart Related Condition(s)
- Bronchitis

Overall, the number of residents being seen in the hospital for each condition appears to be declining, although some zip codes have seen fluctuation in these numbers over the years.

When looking at Oakdale, zip code 15071, the following observations can be made:

- The number of residents seen in the hospital due to diabetes has fluctuated over the four years, but when comparing 2012 to 2015, the number has decreased in half.

- Heart related conditions increased in 2013, but have been decreasing ever since.
- Residents being seen for bronchitis had been steadily increasing since 2012, but in the most recent year reduced my more than half.
- The mental health related numbers have fluctuated over the years but decreased in the recent year as well as when compared to 2012.
- Drug related visits had been increasing, although in the most recent year no visits were reported.
- Hypertension numbers have remained fairly consistent.

Table 13. DRG Breakdown by Oakdale Zip Code 15071

Oakdale Zip Code: 15071					
	Year				
	2012	2013	2014	2015	Total
Diabetes	191	100	130	86	277
Heart Related	28	37	29	14	108
Bronchitis	11	12	20	8	51
Pneumonia	12	10	12	9	43
Mental Health Related	7	5	7	2	21
Drug Related	1	3	4	0	8
Hypertension	1	1	1	0	3
Total	251	168	203	119	511

When looking at Carnegie, zip code 15106, the following observations can be made:

- The number of residents seen for diabetes has fluctuated over the past few years, but has been increasing since 2014 and when compared to 2012 has almost doubled.
- Heart related conditions have been steadily decreasing over the past four years and have reduced by half when comparing 2012 to 2015.
- Residents being seen for bronchitis decreased between 2012 and 2013, but has been increasing ever since; although is still lower when compared to 2015.
- The mental health related numbers have been increasing since 2012; although has been steady over the past two years.
- Drug related visits have remained fairly consistent over the last four years.

- Hypertension numbers have remained fairly consistent over the last four years.

Table 14. DRG Breakdown by Carnegie Zip Code 15106

Carnegie Zip Code: 15106					
	Year				
	2012	**2013**	**2014**	**2015**	**Total**
Diabetes	94	201	98	163	229
Heart Related	47	38	22	21	128
Bronchitis	16	4	10	11	41
Pneumonia	15	7	9	3	34
Mental Health Related	1	2	4	4	11
Drug Related	0	1	2	1	4
Hypertension	0	0	1	0	1
Total	173	253	146	203	448

When looking at Coraopolis, zip code 15108, the following observations can be made:

- The number of residents seen for diabetes has fluctuated over the past few years, but has been increasing since 2014.
- Heart related conditions have fluctuated over the past four years, but decreased between 2014 and 2015 and is lower when comparing 2012 to 2015.
- Residents being seen for bronchitis increased between 2012 and 2013, but has been decreasing ever since.
- The number of visits for pneumonia has been decreasing over the past four years.
- The mental health related numbers increased between 2012 and 2013, but then decreased and has remained consistent.
- Alcohol related visits drastically increased between 2012 and 2013, and have been decreasing ever since.
- Drug related visits have fluctuated over the past four years, but has been increasing the past two years.
- Hypertension numbers have been decreasing over the past several years and has been steady the last two.

Table 15. DRG Breakdown by Coraopolis Zip Code 15108

Coraopolis Zip Code: 15108					
	Year				
	2012	**2013**	**2014**	**2015**	**Total**
Diabetes	753	519	497	556	1197
Heart Related	118	106	115	79	418
Bronchitis	32	44	38	33	147
Pneumonia	46	35	34	25	140
Mental Health Related	25	30	22	22	99
Alcohol Related	2	15	2	1	20
Drug Related	4	6	4	5	19
Hypertension	5	1	0	0	6
Total	985	756	712	721	2046

When looking at Imperial, zip code 15126, the following observations can be made:

- The number of residents seen for diabetes has fluctuated over the past few years.
- Heart related conditions have also fluctuated over the past four years, but have decreased in the most recent year.
- Residents being seen for bronchitis has been steadily decreasing over the past four years.
- The number of pneumonia related visits has fluctuated over the four years, but has deceased in the most recent year and when compared to 2012.
- The mental health related numbers increased between 2012 and 2013, but then decreased and has remained consistent.
- Drug related visits have fluctuated over the past four years, but has decreased in the most recent year.

Table 16. DRG Breakdown by Imperial Zip Code 15126

Imperial Zip Code: 15126					
	Year				
	2012	2013	2014	2015	Total
Diabetes	142	119	135	104	249
Heart Related	19	21	23	20	83
Bronchitis	12	8	6	4	30
Pneumonia	8	3	5	2	18
Mental Health Related	4	7	4	2	17
Drug Related	2	2	3	1	8
Total	187	160	176	133	405

When looking at McKees Rocks, zip code 15136, the following observations can be made:

- The number of residents seen for diabetes had been decreasing over the initial three years, but increased in the most recent year.
- Heart related conditions have steadily been decreasing over the last four years.
- Residents being seen for bronchitis increased between 2012 and 2013, but has been decreasing ever since.
- The number of visits for pneumonia has fluctuated over the last four years, with a decrease in the most recent year.
- The mental health related numbers increased between 2012 and 2013, where they remained steady before decreasing in the most recent year.
- Alcohol related visits decreased between 2012 and 2013 and then have been increasing ever since.
- Drug related visits decreased between 2012 and 2013 and then have been increasing ever since.
- Hypertension numbers decreased between the first two years but have been increasing since.
- Visits related to dental conditions have been consistent.

Table 17. DRG Breakdown by McKees Rocks Zip Code 15136

McKees Rocks Zip Code: 15136					
	Year				
	2012	**2013**	**2014**	**2015**	**Total**
Diabetes	1212	1091	1024	1058	3000
Heart Related	311	301	259	167	1038
Bronchitis	186	198	172	140	696
Pneumonia	78	66	77	71	292
Mental Health Related	54	69	69	45	237
Alcohol Related	25	12	35	48	120
Drug Related	34	19	27	16	96
Hypertension	4	0	2	3	9
Dental	0	0	0	1	1
Total	1904	1756	1665	1549	5489

When looking at Corliss, zip code 15024, the following observations can be made:

- The number of residents seen for diabetes decreased between the first two years and then has been increasing.
- Residents being seen for bronchitis has fluctuated over the last four years but has decreased in the most recent year.
- Heart related conditions have also fluctuated over the last few years, with an increase in the most recent.
- The number of visits for pneumonia has fluctuated over the last four years, with a slight decrease in the most recent year.
- The mental health related numbers increased between 2012 and 2013, but have been decreasing the last two.
- Drug related visits have fluctuated over the last few years, with a decrease in the most recent.
- Alcohol related visits decreased between the first two years and have remained consistent.
- Hypertension related visits decreased between the first two years and have remained consistent.

Table 18. DRG Breakdown by Corliss Zip Code 15204

Corliss Zip Code: 15204					
	Year				
	2012	**2013**	**2014**	**2015**	**Total**
Diabetes	254	219	228	237	688
Bronchitis	50	40	48	43	181
Heart Related	35	51	36	42	164
Pneumonia	26	13	17	16	72
Mental Health Related	6	9	4	3	22
Drug Related	4	1	3	0	8
Alcohol Related	2	0	0	0	2
Hypertension	1	0	0	0	1
Total	378	333	336	341	1138

When looking at Crafton, zip code 15205, the following observations can be made:

- The number of residents seen for diabetes has fluctuated over the last four years with an increase in the most recent year.
- Heart related conditions have fluctuated over the last four years with a decrease in the most recent year.
- Residents being seen for bronchitis has steadily been decreasing.
- The number of visits for pneumonia has fluctuated over the last four years, with an increase in the most recent year.
- The mental health related numbers increased between 2012 and 2013 but have been decreasing since.
- Drug related visits decreased between 2012 and 2013 and then have been increasing ever since.
- Alcohol related visits increased between 2012 and 2013 and then increased to remain consistent the last two years.
- Hypertension numbers have been fairly steady.

Table 19. DRG Breakdown by Crafton Zip Code 15205

Crafton Zip Code: 15205					
	Year				
	2012	2013	2014	2015	Total
Diabetes	346	356	337	352	959
Heart Related	78	55	83	57	273
Bronchitis	69	49	42	32	192
Pneumonia	38	34	23	31	126
Mental Health Related	18	26	22	14	80
Drug Related	9	3	6	6	24
Alcohol Related	1	2	8	7	18
Hypertension	0	0	1	1	2
Total	559	525	522	500	1674

When looking at Neville Island, zip code 15225, the following observations can be made:

- The number of residents seen for diabetes has fluctuated over the last four years with a decrease in the most recent year.
- Heart related conditions have fluctuated over the last four years with a decrease in the most recent year.
- Residents being seen for bronchitis has steadily been decreasing.
- Drug related visits have fluctuated with a slight increase in the recent year.
- The mental health related numbers have fluctuated; although there was an increase in the most recent year.
- The number of visits for pneumonia increased in 2013 to decrease the following year.

Table 20. DRG Breakdown by Neville Island Zip Code 15225

Neville Island Zip Code: 15225					
	Year				
	2012	2013	2014	2015	Total
Diabetes	16	25	21	17	52
Heart Related	6	2	6	5	19
Bronchitis	4	2	1	1	8
Drug Related	1	0	1	2	4
Mental Health Related	1	1	0	2	4
Pneumonia	0	3	0	0	3
Total	28	33	29	27	90

Primary Research Results

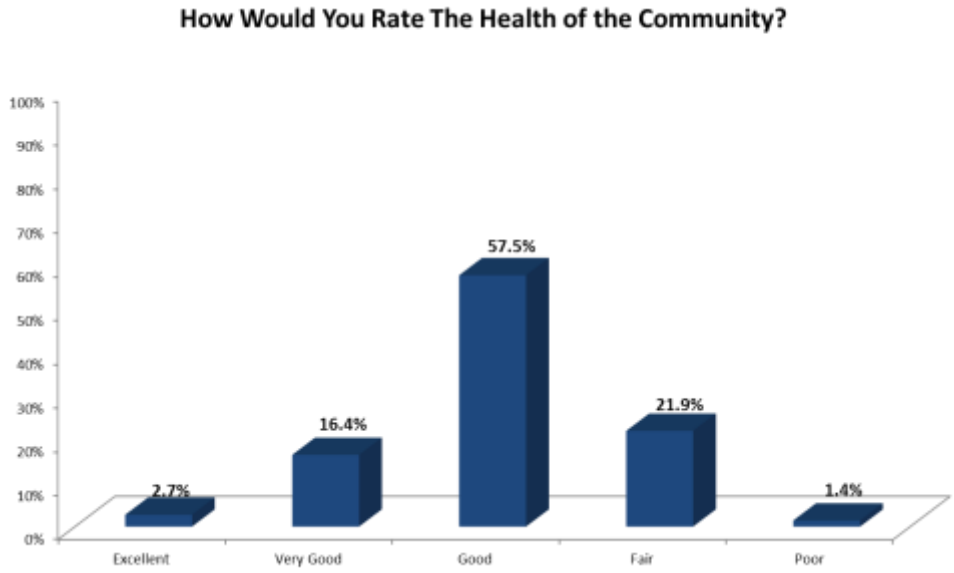
A total of ten stakeholder interviews were conducted throughout the region. Stakeholders were identified as experts in a particular field related to their background, experience or professional position and/or someone who understood the needs of a particular underrepresented group or constituency. A total of seven focus groups were conducted in the overall region.

While the interviews, and focus groups were conducted across the region with various community constituencies, they were conducted using a convenience sample and thus are not necessarily representative of the entire population. The results reported herein are qualitative in nature and reflect the perceptions and experiences of interview and focus group participants.

Overall Community Health Status

As seen in **Figure 3**, just under a quarter (23.3%) of the participants rated the health of the community as "Fair" or "Poor", while over half (57.5%) rated the health of the community as "Good."

Figure 3. Focus Groups – Community Health Status



Source: 2015 OVH Focus Groups, Strategy Solutions, Inc.

Suggestions to improve community health by stakeholders interviewed included:

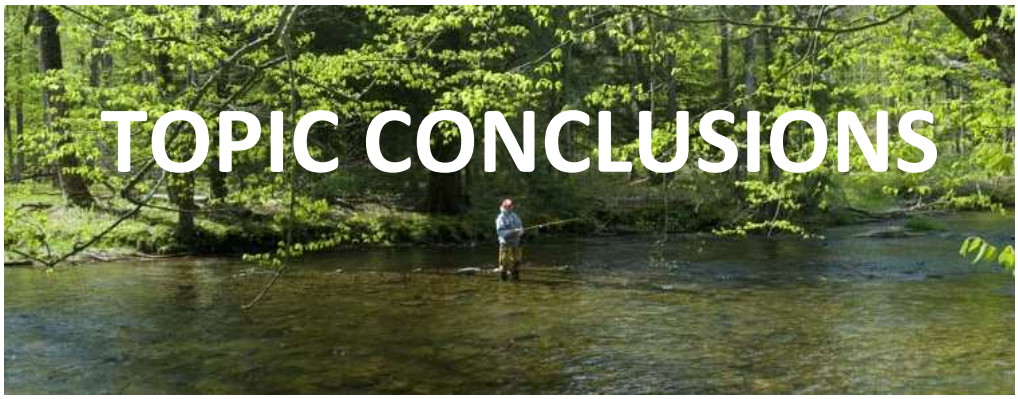
- More activities geared to younger people and families
- Programs for younger people on healthy living
- Need to bring local and county governments together to address these needs
- Have a community pool that is accessible, but there is no longer a lifeguard (Boys Club needs resource to staff the position)
- Better infrastructure to connect kids to health professionals (costly for parents to get them there)
- More activities geared to younger people and families
- Programs for younger people on healthy living
- Need to bring local and county governments together to address these needs
- Have a community pool that is accessible, but there is no longer a lifeguard (Boys Club needs resource to staff the position)
- Better infrastructure to connect kids to health professionals (costly for parents to get them there)
- More activities geared to younger people and families
- Programs for younger people on healthy living

- Need to bring local and county governments together to address these needs
- Have a community pool that is accessible, but there is no longer a lifeguard (Boys Club needs resource to staff the position)
- Better infrastructure to connect kids to health professionals (costly for parents to get them there)

Initiatives Currently Underway

- UPMC sponsors races
- Highmark sponsors things in the community
- Family Practice has dieticians available
- Educational program for seniors (over age 55)
- Health Fairs
- Diabetes Programs
- Live Well Allegheny
- Yoga classes in the park (will be offered next year)
- Focus on economic empowerment and bringing in companies that provide career sustaining employment
- Working with Penn State Extension to offer cooking classes in the community (this fall)
- Working with Focus on Renewal to develop commercial kitchen
- Pastor Hogan is in the community speaking with people and has been successful in getting some heroin users off the street and connected to church
- Focus on Renewal does intake and makes referrals for substance abuse
- There are a few halfway houses in the community
- Working with County and Friends of River – to connect trail to Allegheny Passage
- Health Center is partnering with four mental health providers to address mental health problem
- OVH should join the neighborhood partnership
- Schools have Healthy Family Night where they talk about nutrition and food choices (and are fed healthy food)
- Sto Rox Health Center offers a clinic (primary care, women's health, podiatrist, OB/GYN, optometrist) with connections to OVH
- Community Development Corporation is working on community development improvements

- CSX is renovating train area to make it intermodal transition between trucks and trains
- Focus on Renewal has food bank, computer classes, etc…
- OVH added transportation services
- Community Development Corporation has fresh foods on Friday afternoon
- Focus on Renewal is trying to put together programs for wellness for girls and healthy eating
- Focus on Renewal offers positive parenting program which is now at the Art Center so children can play and do activities
- OVH Gero-Psych program
- OVH publishes health information, conducts initiatives in the area – very visible in the community
- YMCA offers after school program, health and wellness programs
- OVH has a top notch nursing program (which offers scholarships to those that qualify)
- OVH does screening seminars and healthy information
- OVH has Seniority group with lectures
- OVH offers bio screenings for $30
- Mobile health to provide screenings
- Hospital writes off a lot of those that are uninsured
- Sto Rox clinic does a great job and offers a lot of services



Access to Quality Health Care

Access to comprehensive, quality health care is important for the achievement of health equity and for increasing the quality of life for everyone in the community. For a more in-depth review of the Access to Quality Health Care data, please see pages 33-48 of OVH's CHNA Supplemental Data Resource, Appendix C.

Stakeholders were asked to identified the needs of the community regarding access to quality health care. Responses included:

- Lot of patients can't afford medication so they don't take it
- Costs of medications and insurance
- Public transportation isn't great
- There is not much in the community for individuals with physical disabilities
- Hard for people to access health institutes
- Not sure children are getting to wellness visits to ensure milestones are being met
- Access to affordable health care is an issue in McKees Rocks
- Health Center used to provide free services but now there is a copay – so people are not using the services as much
- People who need to go to the hospital don't because of the copays
- People are refusing medical care because of outstanding medical bills
- Emergency services
- Primary Care – we have a physician shortage, more emphasis on preventative care and outpatient care
- Access to Care – people do not see doctors for preventative care

- Affordability of Care – lot of people with high deductible so the first lump sum comes out of their pocket

Focus Group participants were asked to identify the needs of the community regarding access to health care. Responses included:

- Transportation is a problem
- There is no free dental clinic - dental care is a problem
- Need for a resource guide in doctors' offices
- Community lacks services for seniors (senior center, meals on wheels)
- No podiatrist in the community
- People lack health insurance
- Welfare denials
- New insurance wants tests repeated which is costly
- Due to cost people do not get medical care when they need it

There are a number of observations and conclusions that can be derived from the data related to Access to Quality Health Care. They include:

- The percentage of adults without health insurance in Allegheny County (12.0%) is lower than the PA and US rates but is higher than the HP goal of 0%.
- The percentage of adults with no personal health care provider is significantly higher (17.0%) than the PA rate (14.0%).
- The percentage of adults not seeing the doctor due to costs (11.0%) is higher than the HP goal of 4.2% but lower than the PA and US rates.
- According to the PRC National Child & Adolescent Health Survey, one in four children (24.5%) in the Northeast Region experienced a barrier or delay in accessing the care they needed, which is lower than the United States (29.4%).
- According to the PRC National Child & Adolescent Health Survey, the majority (91.7%) of children in the Northeast Region had a routine physician visit in the past year, which is higher when compared to the United States (85.3%).
- The study also found that 83.6% of children in the Northeast region had an annual routine dental check-up, which is slightly lower than the United States (84.9%).
- The Northeast region (19.5%) had the lowest number of children accessing health care through an urgent care center when compared to the other regions and the United States (28.6%).

- Almost one-third of the focus group respondents (27.9%) rated their personal health as fair or poor.
- The majority of focus group (57.5%) respondents rated the health status of the community as good.
- Focus group participants noted cost of specialists, the need for specialists to communicate with each other, appointment scheduling, cost of copays, not knowing what is covered under insurance plan, and larger print on medicine bottles as access problems.
- Focus group participants noted that needed services include transportation, free dental clinic, need for resource guide in doctors' offices, services for seniors (senior center, meals on wheels), podiatrist, health insurance, welfare coverage, non-repetition of tests, and more affordable health services as access needs.
- Stakeholders identified better medication management, affordable health care/medication/ insurance, transportation, more offerings for people with physical disabilities, access to health institutes,, the need for the health clinic to be free (no copays), emergency services, physician shortage, lack of preventative care for children and adults and large deductibles as access needs.

Chronic Disease

Conditions that are long-lasting, relapse, remission and continued persistence are categorized as Chronic Disease. For a more in-depth review of the Chronic Disease data, please see pages 49-70 of OVH's CHNA Supplemental Data Resource, Appendix C.

Focus Group participants identified arthritis as a top community need. They also noted that joint issues, diabetes, heart problems, obesity, and breast cancer were also needs of the community.

Stakeholders interviewed identified the following chronic disease needs in the community:

- Diabetes
- Obesity
- Heart Disease
- Hypertension
- Aging population and the needed services to manage their care

- A lot of cancer in the area (lung cancer do to coal/mining, bladder cancer)
- Emphysema

There are a number of observations and conclusions that can be derived from the data related to Chronic Disease. They include:

- Breast cancer incidence rates are significantly higher for all years but 2011 when compared to the PA rate and lower than the US rate.
- The Allegheny County trend for breast cancer deaths has been decreasing for the years 2009-2012 and is lower than the PA and US rates and HP goal.
- Bronchus and lung cancer rates were significantly higher than PA for the years 2008-2011 and higher than PA for 2012.
- Bronchus and lung cancer mortality rates were significantly higher for the years 2010-2012 than PA and higher than the HP goal but lower than the 2012 US rate.
- Colorectal cancer incidence rate for 2012 (40.0) is lower than the PA rate (42.5) and the US rate (46.1) but higher than the HP goal (38.6).
- Colorectal cancer mortality rate for 2012 (14.9) is lower than the PA rate (15.8) and US rate (18.1) and slightly higher than the HP goal (14.5).
- Prostate cancer incidence rate for 2012 (112.1) is significantly higher than the PA rate (101.7) but lower than the US rate (128.3).
- Prostate cancer mortality rate for 2012 (22.1) is slightly higher than the PA rate (19.1), US rate (20.8) and HP goal (21.2).
- Mammogram screening rates have been decreasing over the past three years (58.0%, 49.4% and 50.9%) and are lower that the PA rate (63.4%), the US rate (67.1%) and the HP goal (81.1%).
- The trend for heart disease mortality rate is showing a decline over the five-year period, but the 2012 rate (180.1) is still higher than the PA rate (175.2) and US rate (176.8).
- Heart attack mortality rate for 2008 (18.3) was significantly lower than the PA rate (20.4) and is slightly lower (17.7) than the 2012 PA rate (17.9).
- For all five years ending 2012, the coronary heart disease mortality rate has been significantly higher than the PA rate, as well as being higher than the US rate and HP goal.
- The cardiovascular mortality rate for 2011 (246.2) was significantly higher than the PA rate.

- The 2012 chronic lower respiratory disease (COPD) rate (36.2) is lower than the PA rate (38.4) and HP goal (102.6).
- The trend for the cerebrovascular mortality rate has been decreasing over the last five years and for 2012 (34.3) is lower than the PA rate (36.8), the US rate (39.9) and HP goal (34.8).
- The percentage of adults age 35 and older who were ever told they had a stroke (4.0%) for the period 2011-2013 is higher than the US (2.8%) and equal to PA.
- Diabetes mortality rates for the years 2009-2011 were significantly lower than the PA rates. For 2012, the rate is lower (20.6) than the PA rate (22.0), the US rate (73.28) and the HP goal (66.6).
- According to the PRC National Child & Adolescent Health Survey, twice as many children in the Northeast region (1.4%) have diabetes compared to the United States (0.7%).
- Stakeholders interviewed listed diabetes, obesity, heart disease, hypertension, aging population, cancer and emphysema as chronic disease needs of the community.
- Focus group participants identified the following as chronic disease needs: diabetes, high blood pressure, heart problems, COPD, obesity, cancer, arthritis, kidney problems and sleep apnea.
- 2016 Focus Group participants report the following to be serious problems (where 5=Very Serious Problem, 4=Serious Problem, 3=Somewhat of a Problem, 2=Small Problem, and 1=Not a Problem):
    - Arthritis (4.0)

Healthy Environment

Environmental quality is a general term which refers to varied characteristics that relate to the natural environment such as air and water quality, pollution and noise, weather as well as the potential effects such characteristics have on physical and mental health. In addition, environmental quality also refers to the socio-economic characteristics of a given community or area, including economic status, education, crime and geographic information. For a more in-depth review of the Healthy Environmental data, please see pages 71-82 of OVH's CHNA Supplemental Data Resource, Appendix C.

Focus Group participants identified several environmental problems as contributing to community health needs. High unemployment (which causes low self-esteem), a lot of homeless people, high number of burglaries in the

area, the need shelters, playgrounds are not safe, lot of safety issues/violence in the area, poverty and crime were identified as health problems of the community.

Stakeholders interviewed were asked to comment on the needs of the community surrounding environmental problems. Their responses included:

- Air quality is not the cleanest
- Generational poverty is an issue – bad habits and practices get handed down
- This is a low socioeconomic environment which puts people in the position to have to make choices to survive which do not always include health
- Poverty – constant problem with Section 8 and public housing
- People are afraid if they find a job they will lose their benefits

There are a number of observations and conclusions that can be derived from the data related to Healthy Environment. They include:

- High school graduation rates in Allegheny County are higher than the state and nation as well as the HP goal.
- The unemployment rates in Allegheny County are lower than PA and are showing a decreasing trend.
- The percentage of students with asthma is trending upward for the years 2009-2012.
- According to the PRC National Child & Adolescent Health Survey, one in ten children (10.6%) in the Northeast Region have Asthma, which is slightly lower when compared to the United States (11.6%).
- Slightly more than one in four (27.0%) children in the United States had an Asthma related visit to the Emergency Room or Urgent Care Facility.
- Stakeholders identified air quality, generational poverty, low socioeconomic environment, Section 8 and public housing, and losing welfare benefits if hired as environment-related needs
- Focus group participants indicated that high unemployment, homelessness, burglaries, need for shelters, unsafe playgrounds, safety issues/violence, poverty, and crime are the most important environment-related needs.

Healthy Mothers, Babies and Children

The well-being of children determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system. The healthy mothers, babies and children topic area addresses a wide range of conditions, health behaviors, and health systems indicators that affect the health, wellness, and quality of life for the entire community. For a more in-depth review of the Healthy Mothers, Babies and Children data, please see pages 83-102 of OVH's CHNA Supplemental Data Resource, Appendix C.

Focus Group participants identified lack of parenting skills, high number of single parents, the need for women's health, and child abuse as the top Healthy Mothers, Babies and Children problems facing the community.

Stakeholders interviewed identified lack of parenting (either not being present or do not have the skills), OVH no longer has maternity ward
Need pediatrics and family care – there are a lot of young families in the community.

There are a number of observations and conclusions that can be derived from the data related to Healthy Mothers, Babies and Children. They include:

- The percentage of mothers accessing prenatal care during the first trimester is significantly higher than PA for the five years 2008-2012 and for 2012 is above the US and HP goal.
- The percentage of non-smoking mothers during pregnancy is significantly higher than PA for years 2010 and 2012 but is lower than the US and HP goal for 2012.
- The percentage of non-smoking mothers three months prior to pregnancy is significantly higher than PA for the five years 2008-2012.
- Babies born with a low birth rate percentage for 2012 (7.6%) is significantly lower than PA (8.1%) and is slightly lower than the US (8.0%) and HP goal (7.8%).
- The percentage of mothers reporting WIC assistance is significantly lower than PA for the five years 2008-2012.
- The percentage of mothers reporting Medicaid assistance is significantly lower than PA for the four years 2009-2012 and is trending upward for the years 2011 and 2012.

- The percentage of mothers who breastfeed is significantly lower than PA for the five years 2008-2012 but for 2012 (72.0%) is lower than the US (77.0%) and HP goal (81.9%).
- The teen pregnancy rate for Allegheny County was significantly lower than PA for the years 2008-2009 and 2011-2012, and for 2012 (30.6) is below the HP goal (36.2).
- Teen live birth outcomes percentages for the five years 2008-2012 are significantly lower than PA.
- Infant mortality percentages for Allegheny County are trending downward for the last five years.
- The percentage of students in grades K-6 that were overweight in 2011 (17.3%) is higher than PA (15.9%).
- The percentage of students in grades 7-12 that were overweight in 2011 (17.1%) is higher than the 2012 PA percentage (16.4%) but lower than the US (30.3%).
- The percentage of students in grades 7-12 that were obese in 2011 (15.9%) is lower than PA (17.7%) and the HP goal (16.1%) but higher than the US (13.7%).
- Stakeholders interviewed identified lack of parenting skills, OVH no longer offering a maternity ward, and pediatrics and family care as needs in the community.
- Focus group participants identified lack of parenting skills, number of single parents, and the lack of women's health as needs in the community.

Infectious Disease

Pathogenic microorganisms, such as bacteria, viruses, parasites or fungi, cause infectious diseases; these diseases can be spread, directly or indirectly, from one person to another. These diseases can be grouped in three categories: diseases which cause high levels of mortality; diseases which place on populations heavy burdens of disability; and diseases which owing to the rapid and unexpected nature of their spread can have serious global repercussions (World Health Organization). For a more in-depth review of the Infectious Disease data, please see pages 103-114 of OVH's CHNA Supplemental Data Resource, Appendix C.

Focus group participants mentioned that pneumonia was a small problem in the community.

There are a number of observations and conclusions that can be derived from the data related to Infectious Disease, although the topic was not discussed in Stakeholder Interviews. They include:

- The percentage of adults age 65 and older who had a pneumonia vaccine was significantly higher than PA for the years 2008-2010, 2011-2013 and 2012-2014 but was lower than the HP goal.
- The influenza and pneumonia mortality rate was significantly higher than the PA rate for the years 2009-2012.
- Lyme disease incidence rates are significantly lower than the PA rates for the recording years of 2008-2010 and 2012.
- The percentage of adults age 18-64 who have ever been tested for HIV for 2012-2014 (38.0%) is equal to the PA percentage but lower than the HP goal (73.6%).
- The chlamydia rates for all adults, females and males for the past five years (2008-2012) have been significantly higher than the PA rate.
- The gonorrhea rates for all adults, females and males for the past five years (2008-2012) have been significantly higher than the PA rate.
- Stakeholder interviews did not comment on infectious diseases.
- Focus group participants mentioned that pneumonia was a small problem.

Mental Health and Substance Abuse

Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the World Health Organization's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease." Mental health is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

According to the World Health Organization, substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance 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.

Western and Central Pennsylvania has experienced an epidemic of heroin and opiate abuse in the past 8-10 years. Pennsylvania now has the 7th highest drug overdose mortality rate in the United States, with over 3,000 deaths being heroin-related overdoses. Drug overdose deaths in Pennsylvania have now exceeded the number of deaths from automobile accidents. For a more in-depth review of the Mental Health and Substance Abuse data, please see pages 115-124 of OVH's CHNA Supplemental Data Resource, Appendix C.

Stakeholders interviewed mentioned the following mental health and substance abuse needs:

- Mental health is a huge problem
- High school students using drugs – need better education to stay away from drugs
- Drug and alcohol addiction
- Prescription drug abuse is a problem (there are a lot of people selling their prescriptions)
- Crime and Violence revolves around drug activity
- Drugs are a big problem seen in every community
- Health Center no longer has anyone offer counseling services
- Focus on Renewal does not have any crisis funds to help

There are a number of observations and conclusions that can be derived from the data related to Mental Health and Substance Abuse. They include:

- Mental and behavioral disorders mortality rate for 2012 (46.5) is significantly higher than the PA (43.0) but lower than the US rate (63.3).
- The percentage of adults who reported binge drinking (5 drinks for men; 4 for women) was significantly higher for the years 2011-2013 and 2012-2014 than the state, but is below the HP goal of 24.4%.
- The percentage of adults who were at risk for heavy drinking (2 drinks for men; 1 for women daily) was significantly higher (8.0%) than PA (6.0%) for 2011-2013.
- The 2012 drug-induced mortality rate (22.7) was significantly higher than the PA rate (19.2), and higher than the US (10.2) and HP goal (11.3).

- Youth alcohol and prescription narcotic drug use increases with age throughout high school and has increased over the past four years in Allegheny County.
- Marijuana use has increased over the past four years in Allegheny County.
- Youth driving after drinking or using marijuana has increased slightly over the past few years.
- Stakeholders interviewed identified mental health, high school students using drugs, drug and alcohol addiction, prescription drug abuse, crime and violence as it revolves around drug activity, Health Center no longer offering counseling services and Focus on Renewal not having any crisis funds to help as mental health and substance abuse needs.
- Focus group participants identified drugs and alcohol, depression, mental health medication and mental stress as mental health and substance abuse needs.
- Focus group participants mentioned that Alzheimer disease was somewhat of a problem in the area.

Physical Activity and Nutrition

Regular physical activity reduces the risk for many diseases, helps control weight, and strengthens muscles, bones and joints. Proper nutrition and maintaining a healthy weight are critical to good health. Physical activity and nutrition topics explored include: levels of physical activity, availability of fast or fresh food, and utilization of free and reduced-price lunches for school aged children. For a more in-depth review of the Physical Activity and Nutrition data, please see pages 125-134 of OVH's CHNA Supplemental Data Resource, Appendix C.

Focus Group participants mentioned the following as top community health needs regarding physical activity and nutrition: hospital offer diet and nutrition classes, people do not watch what they eat or exercise, people live sedentary lifestyles, and people are too busy to cook – poor diet.
Stakeholders interviewed identified the following physical activity and nutrition needs in the community: lifestyle – poor diet and inactivity, nutrition education, recreation/opportunities for physical education, nutrition is a major issue – try to encourage people to visit farm truck foods that come weekly, awareness of available community recreation (3rd street park has reopened and has outdoor fitness equipment), students are not all

receiving good nutrition, more fresh produce, education – not sure clients realize a bottle of water is healthier than a bottle of soda, people struggle to find time to exercise and prepare a healthy meal (quicker to get fast food), and nutrition coaching.

There are a number of observations and conclusions that can be derived from the data related to Infectious Disease. They include:

- According to the PRC National Child & Adolescent Health Survey, just under half (43.2%) of children in the United States are physically active seven days a week. The majority (97.4%) are active at least one day per week.
- The study found that less than half (41.0%) of children in the Northeast Region were physically active for an hour or longer in the past week, which is slightly lower than the United States (43.2%).
- According to the PRC National Child & Adolescent Health Survey, just under half (43.2%) of children in the United States are physically active seven days a week. The majority (97.4%) are active at least one day per week.
- According to the PRC National Child & Adolescent Health Survey, over half (59.9%) of children in the United States are spending more than an hour per day playing video games or watching TV.
- Slightly fewer (49.3%) are spending over an hour on a computer, cell phone or other hand held device.
- Over half (65.2%) of the children in the Northeast Region are spending over three hours in on “screen time”, which is higher than the United States (63.8%).
- According to the PRC National Child & Adolescent Health Survey, one in three (33.9%) children is receiving five or more servings of fruits and vegetables per day, which is lower compared to the United States (41.8%).
- Over half (69.9%) of children in the United States are eating fast food at least one time per week.
- Stakeholders interviewed identified poor diet and inactivity, bad nutrition, nutrition education, recreation/opportunities for physical education, available community recreation, school nutrition, food bank nutrition, time to exercise and prepare a healthy meal and nutrition coaching as physical activity and nutrition needs.

- Focus group participants identified diet and nutrition classes, awareness of nutrition/exercise, sedentary lifestyle and too busy to cook as physical activity and nutrition needs.

Tobacco Use

Tobacco Use is an important public health indicator as it relates to a number of chronic disease issues and conditions. For a more in-depth review of the Tobacco Use data, please see pages 135-142 of OVH's CHNA Supplemental Data Resource, Appendix C.

Focus Group participants rated smoking as somewhat of a problem and commented that a lot of people smoke and smoking causes health problems.

Stakeholders interviewed identified the following Tobacco Use needs:

- Rates of emphysema due to tobacco use
- Smoking is a big problem
- Second hand smoke
- See health care professionals smoking
- People need to want to stop

There are a number of observations and conclusions that can be derived from the data related to Tobacco Use. These include:

- The percentage of male adults who reported being a former smoker is showing a downward trend from 2008-2014.
- The percentage of adults who reported being a current smoker for 2012-2014 (21.0%) is equal to the PA percentage but higher than the US (18.8%) and HP goal (12.0%).
- The 2012-2014 percentage of adults who quit smoking at least one day in the past year (56.0%) is lower than the HP goal (80.0%).
- The percentage of adults who reported being an everyday smoker is trending upward from 2008-2014 and the 2012-2014 percentage (16.0%) is higher than the US percentage of 13.4%.
- Stakeholders interviewed identified emphysema, smoking, second hand smoke, the need for people to want to stop smoking and seeing health care professionals smoking as tobacco use needs.
- Focus group participants identified the large number of smokers and smoking causes health problems as tobacco use needs.

- Focus group participants mentioned that smoking was somewhat of a problem in the area.

Unintentional and Intentional Injury

The topic of injury relates to any intentional or unintentional injuries that can be suffered by individuals. Injury topics explored include: auto accident mortality, suicide, fall mortality, firearm mortality, burns, head injuries and domestic violence. For a more in-depth review of the Demographic data, please see pages 143-150 of OVH's CHNA Supplemental Data Resource, Appendix C.

Focus Group participants noted that gun violence was an identified community health needs.

Stakeholders interviewed commented that domestic abuse might be a problem.

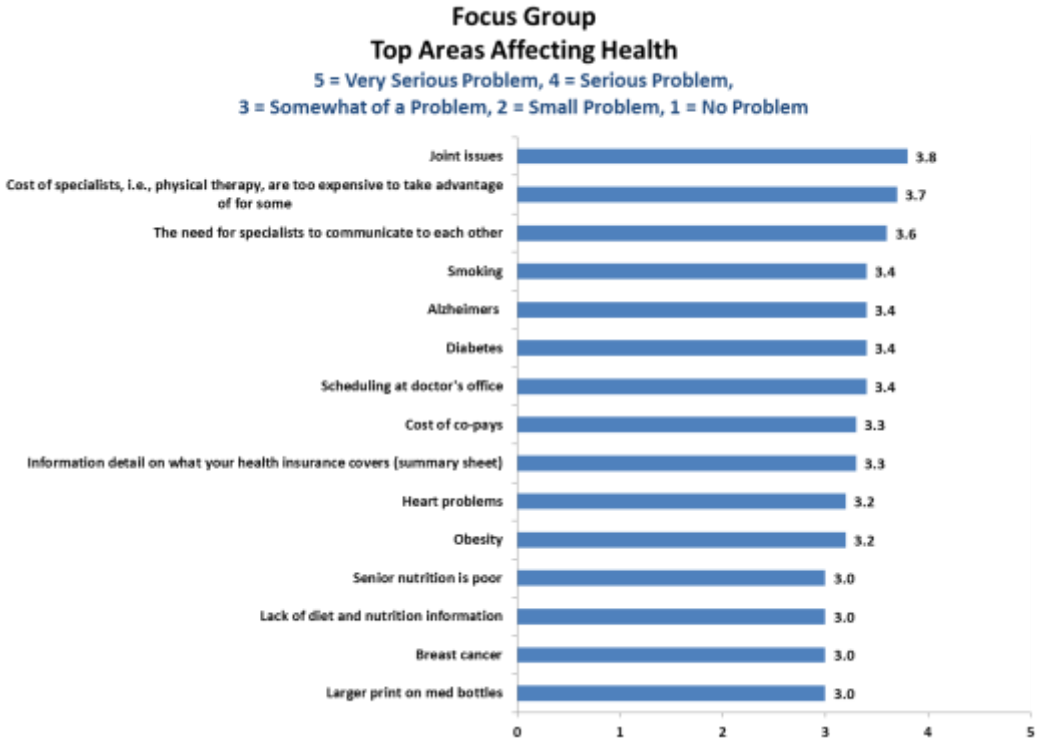
There are a number of observations and conclusions that can be derived from the data related to Unintentional and Intentional Injury, although the topic was not discussed in stakeholder interviews. These include:

- The auto accident mortality rate for the five years 2008-2012 was significantly lower than the PA rate and lower than the US rate and HP goal.
- The suicide mortality rate for 2012 (11.7) is slightly lower than the PA rate (12.1) and slightly higher than the HP goal (10.2).
- According to the PRC National Child & Adolescent Health Survey, 7.1% of children in the Northeast region had an injury serious enough to require medical attention in the past year, which is lower when compared to the United State (10.6%).
- The fall mortality rate is significantly higher than the PA rate for the years 2008 and 2010-2012 and above the HP goal of 7.2.
- The firearm mortality rate for 2012 (12.6) is higher than the PA rate (11.0), the US rate (10.1) and the HP goal (9.3).
- Stakeholders interviewed mentioned domestic abuse as a possible need.
- Focus group participants indicated gun violence as a need.

Top Priorities

Focus Group participants ranked the most serious health needs for the community, as seen in **Figure 4**.

Figure 4. Focus Group Most Serious Community Health Needs



Source: OVH Focus Groups, 2016

The listing below illustrates the overall top priorities by topic area, based on input from Stakeholder Interviews and Focus Groups. There were a total of 51 identified needs.

Access

1. Access to health insurance
2. Access to a primary care services
3. Affordability of health care/insurance costs/copays/deductibles
4. Access to transportation for self/healthcare workers
5. Knowledge of all services in the area
6. Access to short-term home health assistance
7. Access to at-home risk assessment
8. Health/insurance literacy
9. Access to shorter pre-approval wait time
10. Communication between doctors/specialists/ insurance companies
11. Better scheduling at doctor's offices
12. Access to patient advocate
13. Elder Care Nutrition Services
14. Communication between home health workers/patient/family
15. Medication management
16. Health care safety training regarding medication management

Chronic Disease

17. Breast Cancer
18. Lung Cancer
19. Ovarian Cancer
20. Prostate Cancer
21. Colorectal Cancer
22. Cardiovascular Disease (Heart Disease, Cholesterol, etc.)
23. Cerebrovascular Disease (stroke)
24. Diabetes
25. COPD/Chronic Bronchitis
26. Alzheimer Disease
27. Overweight/Obesity
28. Arthritis
29. Melanoma/Skin Cancer

Healthy Environment

30. Asthma

Healthy Mothers, Babies and Children

31. Childhood Obesity
32. Tobacco Use During Pregnancy
33. Breastfeeding
34. Teen Pregnancy
35. Teen Live Birth Outcomes

Infectious Diseases

36. Pneumonia
37. Chlamydia
38. Gonorrhea
39. HIV testing

Mental Health and Substance Abuse

40. Alcohol Abuse
41. Drug Abuse/Mortality
42. Mental Health
43. Prescription Drug Misuse/Abuse
44. Youth Risk Behaviors

Physical Health and Nutrition

45. Eating Habits/Access to Healthy Foods

Social Environment

46. Poverty/Lack of Jobs/unemployment

Tobacco Use

47. Smoking

Injury

48. Auto accidents
49. Suicide
50. Falls
51. Firearm

Prioritization and Significant Health Needs

As a result of the primary and secondary data analysis, the consulting team identified 46 distinct community needs and issues that demonstrated disparity, negative trend or gap between the local/ regional data and the state, national or healthy people goal and/or that qualitative information suggested that it was a growing need in the community. At their meeting on March 9, 2016, the OVH Steering Committee agreed with the list of potential needs, participated in prioritizing the needs based on the selected criteria and met again on April 11, 2016 to discuss the prioritization results. **Table 21** identified the selected criteria.

Table 21. Prioritization Criteria

		Scoring		
Item	**Definition**	**Low (1)**	**Medium**	**High (10)**
Accountable Role	The extent to which the issue is an important priority to address in this action planning effort for either the health system or the community	This is an important priority for the community to address	This is important but is not for this action planning effort	This is an important priority for the health system(s)
Magnitude of the problem	The degree to which the problem leads to death, disability or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers of people affected; no risk for epidemic	Moderate numbers/ % of people affected and/or moderate risk	High numbers/ % of people affected and/or risk for epidemic
Impact on other health outcomes	The extent to which the issue impacts health outcomes and/or is a driver of other conditions	Little impact on health outcomes or other conditions	Some impact on health outcomes or other conditions	Great impact on health outcomes and other conditions
Capacity (systems and resources) to implement evidence based solutions	This would include the capacity to and ease of implementing evidence based solutions	There is little or no capacity (systems and resources) to implement evidence based solutions	Some capacity (system and resources) exist to implement evidence based solutions	There is solid capacity (system and resources) to implement evidence based solutions in this area

Table 22 illustrates the needs of the service area ranked by the steering committee. The top 15 needs that were identified by the OVH CHNA Steering Committee include diabetes, cardiovascular disease (heart disease, cholesterol, etc.), COPD/chronic bronchitis, cerebrovascular disease (stroke), overweight/obesity, lung cancer, knowledge of all services in the area, primary care services, access to patient advocate, transportation for self/ healthcare workers, Alzheimer disease, prescription drug misuse/abuse, mental health, alcohol abuse, drug abuse/mortality, arthritis, pneumonia, medication management, asthma, and health care safety training regarding medication management.

Table 22. OVH CHNA Prioritization Survey Sorted by Total of Accountability, Magnitude, Impact and Capacity

			Hospital 8.0 or above			
	Accountability	Magnitude	Impact	Capacity	Total	Rank
Chronic Disease: Diabetes	9.71	8.63	9.38	9.00	36.72	1
Chronic Disease: Cardiovascular Disease (Heart Disease, Cholesterol, etc.)	9.38	7.63	8.38	8.50	33.89	2
Chronic Disease: COPD/Chronic Bronchitis	8.63	7.50	8.86	8.75	33.74	3
Chronic Disease: Cerebrovascular Disease (Stroke)	8.75	6.75	9.13	8.50	33.13	4
Chronic Disease: Overweight/Obesity	9.13	7.13	7.88	7.00	31.14	5
Chronic Disease: Lung Cancer	8.50	7.13	8.00	7.38	31.01	6
Access to Quality Health Services: Knowledge of all Services in the Area	8.00	7.25	7.63	7.88	30.76	7
Access to Quality Health Services: Primary Care Services	8.38	6.13	8.13	6.88	29.52	8
Access to Quality Health Services: Access to Patient Advocate	8.88	5.50	7.38	7.38	29.14	9
Access to Quality Health Services: Transportation for Self/Healthcare Workers	6.25	7.88	7.88	7.00	29.01	10
Chronic Disease: Alzheimer Disease	8.25	6.13	8.00	6.63	29.01	11
Mental Health/Substance Abuse: Prescription Drug Misuse/Abuse	6.00	7.88	8.50	6.50	28.88	12
Mental Health/Substance Abuse: Mental Health	5.63	7.25	8.38	7.25	28.51	13
Mental Health/Substance Abuse: Alcohol Abuse	6.25	7.25	8.75	6.13	28.38	14
Mental Health/Substance Abuse: Drug Abuse/Mortality	5.88	7.75	8.50	5.75	27.88	15
Chronic Disease: Arthritis	8.50	5.50	6.75	6.63	27.38	16
Infectious Disease: Pneumonia	7.75	6.00	6.86	6.50	27.11	17
Access to Quality Health Services: Medication Management	5.57	7.38	7.38	5.88	26.21	18
Healthy Environment: Asthma	6.13	6.50	7.75	5.75	26.13	19
Access to Quality Health Services: Health Care Safety Training Regarding Medication Management	5.25	7.25	6.88	6.63	26.01	20
Chronic Disease: Colorectal Cancer	7.25	5.50	6.38	6.63	25.76	21
Physical Activity/Nutrition: Eating Habits/Access to Healthy Foods	5.13	6.38	7.75	5.63	24.89	22
Chronic Disease: Prostate Cancer	7.00	5.38	5.75	6.63	24.76	23
Access to Quality Health Services: Access to Short-Term Home Health Assistance	5.71	6.38	7.00	5.50	24.59	24
Access to Quality Health Services: Affordability of Health Care/Insurance Costs/Co-Pays/Deductibles	5.63	6.75	8.25	3.88	24.51	25
Access to Quality Health Services: Communication Between Doctors/Specialists/Insurance Companies	6.75	6.50	6.50	4.63	24.38	26
Access to Quality Health Services: Health/Insurance Literacy	5.00	6.75	6.25	6.25	24.25	27
Tobacco Use: Smoking	3.25	7.38	7.25	5.38	23.26	28
Access to Quality Health Services: Elder Care Nutrition Services	5.88	5.13	5.63	6.13	22.77	29
Chronic Disease: Melanoma/Skin Cancer	6.75	4.88	5.75	5.00	22.38	30
Access to Quality Health Services: Access to At-Home Risk Assessment	6.00	5.00	6.00	5.25	22.25	31
Injury: Falls	3.88	6.50	6.00	5.13	21.51	32
Injury: Suicide	3.25	6.00	6.50	5.75	21.50	33
Access to Quality Health Services: Health Insurance	4.38	7.25	7.38	2.38	21.39	34
Infectious Disease: HIV Testing	4.63	5.00	7.00	4.75	21.38	35
Access to Quality Health Services: Shorter Pre-Approval Wait Time	4.50	4.63	5.25	5.00	19.38	36
Access to Quality Health Services: Better Scheduling at Doctor's Offices	5.63	4.25	5.13	4.00	19.01	37
Access to Quality Health Services: Communication Between Home Health Workers/Patient/Family	3.75	5.38	5.75	4.13	19.01	38
Healthy Mothers, Babies & Children: Childhood Obesity	2.63	5.88	6.88	3.25	18.64	39
Social Environment: Poverty/Lack of Jobs/Unemployment	2.00	6.38	7.50	2.75	18.63	40
Healthy Mothers, Babies & Children: Tobacco Use During Pregnancy	2.00	5.29	6.25	3.13	16.67	41
Healthy Mothers, Babies & Children: Teen Pregnancy	2.00	5.13	6.63	2.88	16.64	42
Healthy Mothers, Babies & Children: Teen Live Birth Outcomes	2.13	4.63	6.00	3.25	16.01	43
Healthy Mothers, Babies & Children: Breastfeeding	2.00	4.63	4.75	3.13	14.51	44
Injury: Auto Accidents	2.75	4.38	4.88	2.25	14.26	45
Injury: Firearm	2.13	4.75	5.00	2.00	13.88	46

Members of the OVH CHNA Steering Committee met on April 11, 2016 to review the final priorities selected by the prioritization process. Using the methodology of looking at the four prioritization criteria of (i) accountable role of the hospital, (ii) magnitude of the problem, (iii) impact on other health outcomes and (iv) capacity (systems and resources) to implement

evidence-based solutions, along with the rank order of the final priorities selected by the OVH Steering Committee, the following priorities are considered the most significant to OVH:

- Chronic Disease: Diabetes
- Chronic Disease: Cardiovascular Disease (Heart Disease, Cholesterol, etc.)
- Access to Quality Health Services: Transportation for Self/Healthcare Workers
- Access to Quality Health Services: Knowledge of Services in the Area
- Mental Health/Substance Abuse: Mental Health
- Tobacco Use: Smoking
- Physical Activity/Nutrition: Eating Habits/Access to Healthy Foods

The above significant needs will be addressed in OVH's Implementation Strategy which will be published under separate cover and accessible to the public.

Please refer to Appendix D – Prioritization Criteria Listings on pages 151-160 in the Supplemental Data Resource to see how the needs were prioritized by the different criteria of:

- Accountability (hospital role)
- Magnitude and Impact
- Magnitude, Impact and Capacity
- Top ten needs comparison by total ranking, accountability and magnitude and impact

Review and Approval

The 2016 Community Health Needs Assessment was presented and approved by the OVH Board of Directors on May 31, 2016. The Ohio Valley Hospital 2016 Community Health Needs Assessment is posted on the OVH website (ohiovalleyhospital.org). Printed copies are available by contacting: meaton@ohiovalleyhospital.org.