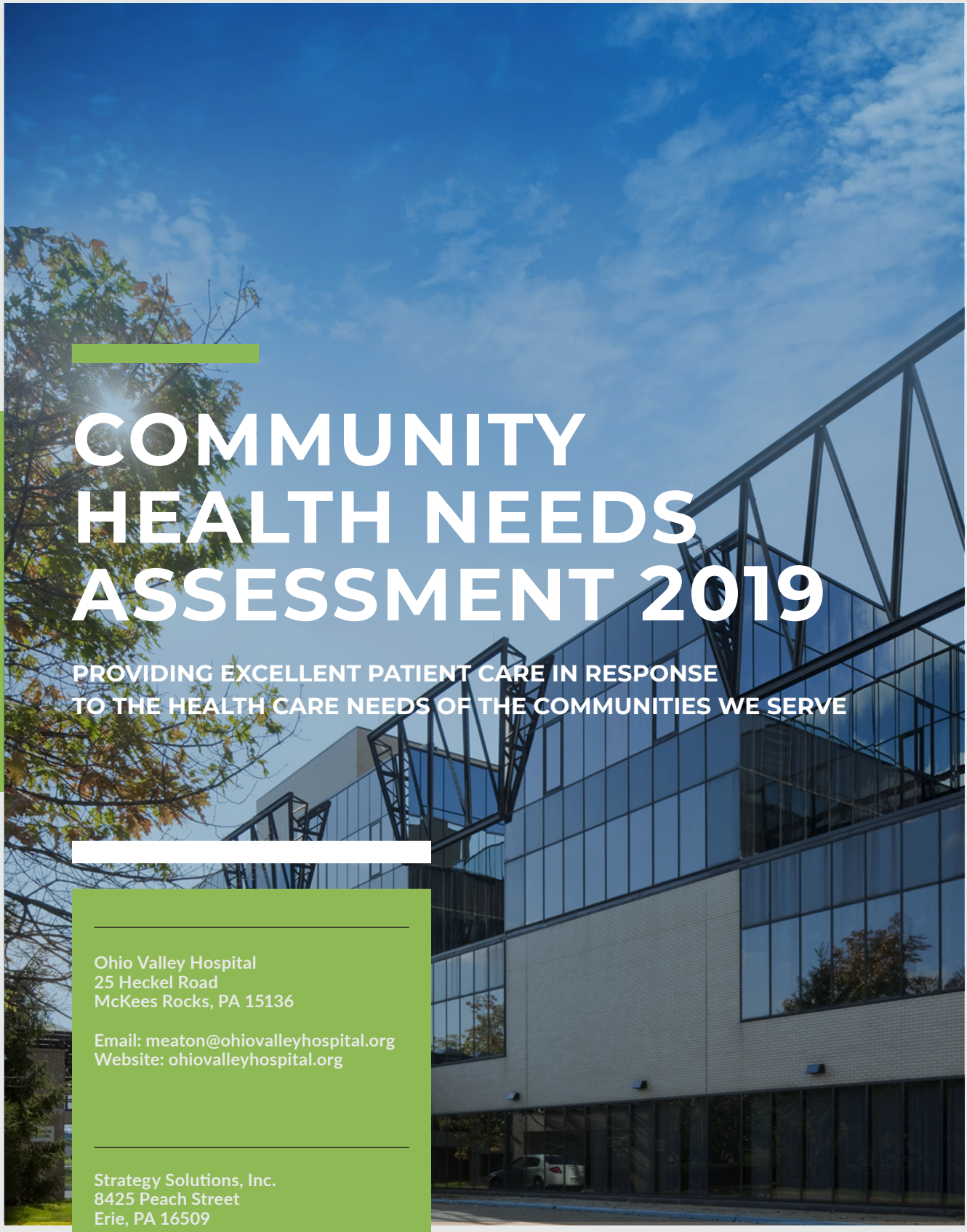


COMMUNITY HEALTH NEEDS ASSESSMENT 2019

PROVIDING EXCELLENT PATIENT CARE IN RESPONSE TO THE HEALTH CARE NEEDS OF THE COMMUNITIES WE SERVE

Ohio Valley Hospital
25 Heckel Road
McKees Rocks, PA 15136

Email: meaton@ohiovalleyhospital.org
Website: ohiovalleyhospital.org

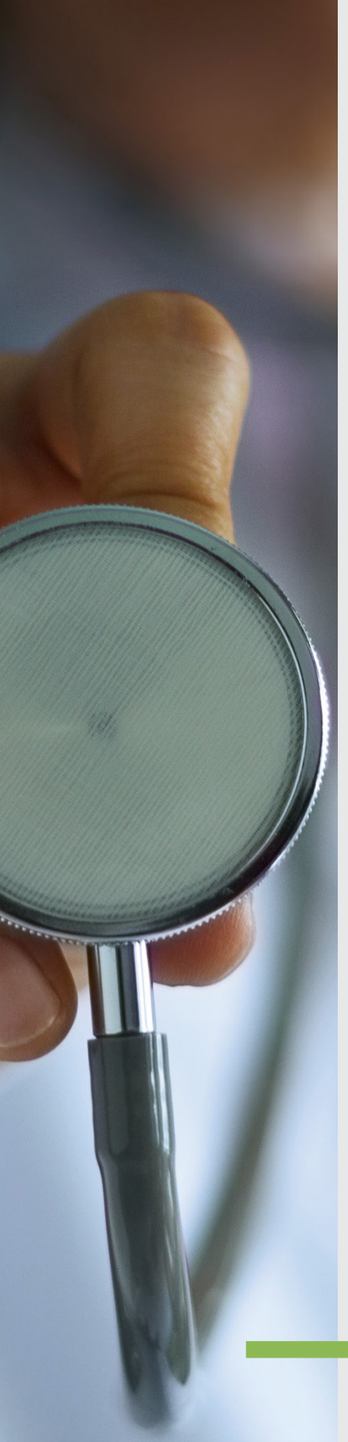
Strategy Solutions, Inc.
8425 Peach Street
Erie, PA 16509

Email 1: info@getstrategy.com
Email 2: Debbie@getstrategy.com

Website: www.getstrategy.com

Ohio Valley HOSPITAL

part of Heritage Valley Health System



COMMUNITY HEALTH NEEDS ASSESSMENT 2019

Quality, Integrity, Accountability, Innovation, Transparency

The mission of Ohio Valley Hospital (OVH) is to deliver quality, personalized health care services to our patients and families in a caring manner, and to provide educational programs for future health care professionals. The values of OVH are Quality, Integrity, Accountability, Innovation and Transparency.

At OVH, we are proud of our legacy, offering more than 120 years of services and healthcare to our community. We are dedicated to continuing this tradition of service and responsiveness to the greater Pittsburgh area.

2019

Ohio Valley HOSPITAL
part of Heritage Valley Health System

CONTENT OF CHNA

WELCOME TO OUR COMMUNITY HEALTH NEEDS ASSESSMENT

PROVIDING OUR COMMUNITY WITH A PERSONALIZED APPROACH TO HIGH QUALITY HEALTH CARE

THANK YOU FOR BEING A PART OF OUR COMMUNITY.

Ohio Valley Hospital (OVH), now a subsidiary of Heritage Valley Health System, is proud to present its 2019 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/disease incidence and prevalence data from Allegheny County, the primary service area of the hospital. The data was reviewed and analyzed to determine the top priority needs and issues facing the region overall.

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.

Improving the health of the community is the foundation of the mission of OVH, and an important focus for everyone in the service region, individually and collectively. In addition to the education, patient care, and program interventions provided through the hospital, we hope that the information in this CHNA will encourage additional activities and collaborative efforts to improve the health status of the community that OVH serves.

OUR MESSAGE TO THE COMMUNITY MEMBERS OF THE OHIO VALLEY HOSPITAL SERVICE AREA:

Ohio Valley Hospital (OVH) is committed to meeting the health needs of our region and growing with our communities to provide access to high quality care, close to home. To achieve this goal, we must understand the community's evolving unmet health needs. To that end, OVH completed the 2019 Community Health Needs Assessment (CHNA), which identifies the region's health priorities. Along with our Implementation Strategy, it highlights the path OVH will embark on over the next three years.

The mission of OVH is to provide programs and services that improve the quality of life for people in our community. This mission guides our planning and decision-making and as a result, OVH is pleased to present its 2019 Community Health Needs Assessment (CHNA).

The results of this CHNA will help us to more strategically identify community health priorities, develop interventions and commit resources to improve the health status of the region. This 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.

Hospitals are required to conduct a CHNA every three years to retain their nonprofit status. OVH was founded in the 1890s. Over the course of the last 120-plus years, we have worked consistently to provide programs and services that improve the quality of life for people in our community. This mission guides our planning and decision-making. That is why in 2018, Ohio Valley Hospital joined together with Heritage Valley Health System. Ohio Valley Hospital chose to become a subsidiary of Heritage Valley Health System in an effort to enable the former to enhance its medical staff, expand clinical services, and fund future capital projects. Going forward over the next three years, we will also look at areas where we can strengthen our CHNA for the 2022 plan.

For our 2019 CHNA, our hospital and community partners will work together to develop strategies to address each of the following regional health priorities:

- Chronic Disease
    - Diabetes
    - Cardiovascular Disease
    - Respiratory Disease
- Mental Health
    - Substance Use Disorder
- Access to Quality Health Care
- Overweight/Obesity

The most important aspect of the CHNA process is community partnership and engagement. Resident feedback pertaining to the health status of the community is integral to planning and executing interventions, programs, and activities. Each of our community partners bring significant and unique expertise. We look forward to our continued work together to ensure that vulnerable individuals receive the care and services they need. We are much stronger together than we would be individually, and the community benefits from our collaboration.

Sincerely,

Michael Miller
President and CEO
Ohio Valley Hospital, Part of Heritage Valley Health System

OHIO VALLEY HOSPITAL

Throughout our more than 120 year history, OVH's mission has been to deliver quality, personalized health care services to our patients and families in a caring manner, and to provide educational programs for future health care professionals.

OVH is a 124-bed, not-for-profit hospital, with more than 250 physicians in 26 medical specialties and a full range of advanced diagnostic tools and treatments. First established in the 1890s as a place to treat railroad workers, OVH now features a wide range of medical and surgical services. Today, it is OVH's mission to provide programs and services that improve the quality of life for community members across its service area. The staff strives to provide caring, cost-effective and friendly health care, and views safety and quality as top priorities.

In the spring of 2019, after receiving final regulatory approval, OVH and Heritage Valley Health System officially joined together. The two not-for-profit healthcare institutions share the common mission of bringing high-quality, cost effective healthcare to their now-combined communities. By unifying the organizations, the enlarged health system can expand their footprint to further meet the healthcare needs of the region.

OVH is now a subsidiary of Heritage Valley Health System. The alignment will enable OVH to enhance its medical staff, expand clinical services and fund future capital projects. OVH, like many independent community hospitals, has been challenged over past years by increasing operating costs and decreasing reimbursement. This affiliation with Heritage Valley Health System will allow OVH to continue. "Our priority has always been, and will continue to be, to provide and increase quality healthcare for our community members," said Mark Brennan, Chair of the Board of OVH. "Affiliating with Heritage Valley Health System will allow us to do just that."

THANK YOU

We offer special thanks to the representatives of the CHNA Steering Committee and to the 64 citizens and stakeholder participants of interviews and community surveys who generously gave their time and input to provide insight and guidance to the process. Steering Committee members are listed in Table 1 below.

2019 Community Health Needs Assessment

Table 1
Steering Committee Members

Name	Company	Position
Rebecca Brady	Sto-Rox Neighborhood Health Council	Chief Operating Officer and Associate Executive Director
Lisa Dalena	Ohio Valley Hospital	Community Relations Coordinator
Megan Hinds	Ohio Valley Hospital	Director of Marketing and Communications
Lydia Morin	Focus on Renewal	Former Director of Development and Communications
Dr. Kaye-Ann Newton	Ohio Valley Hospital	Endocrinologist
Sue Pfeifer	Ohio Valley Hospital	Practice Manager – BusinessFit Occupational Medicine Program
Ellie Pfeuffer	Focus on Renewal	Director of Development
Craig Rippole	Trinity Commercial Development, LLC	Vice Chairman of the Board for Ohio Valley Hospital
Kristen Spezialetti	Ohio Valley Hospital	Coordinator, Community Services
Peg Spisak	Ohio Valley Hospital	Director of Medical Staff and Regulatory Affairs
Susan Zikos	Ohio Valley Hospital	Diabetes Educator

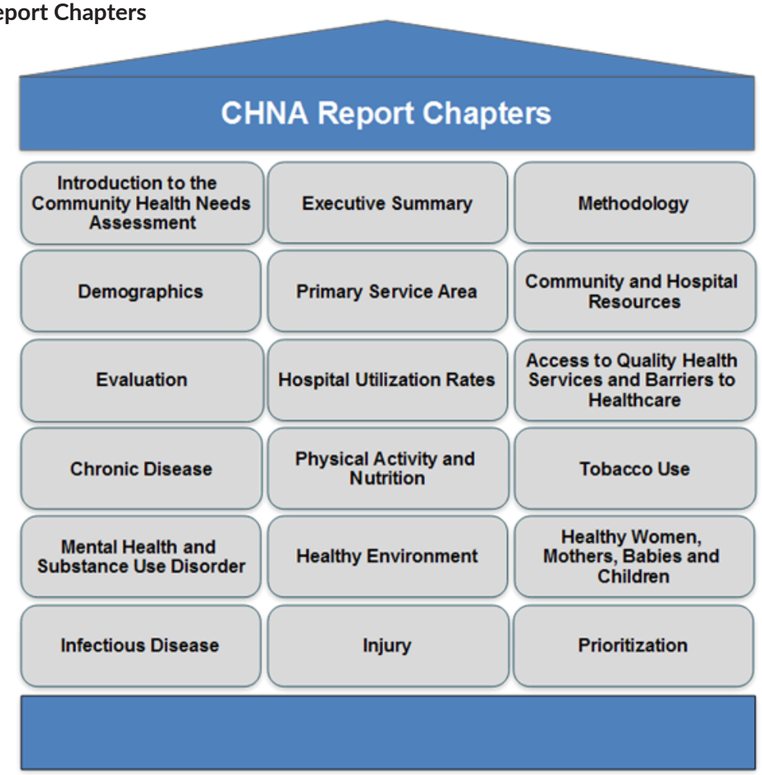
EXECUTIVE SUMMARY

A Community Health Needs Assessment (CHNA) helps to gauge the health status of a community and guide development and implementation of strategies to create a healthier community. The CHNA process also promotes collaboration among local agencies and provides data to evaluate outcomes and impact of efforts to improve the population's health. The CHNA process supports the commitment of a diverse group of community agencies and organizations working together to achieve a healthy community.

Facilitated by Strategy Solutions, Inc., a planning and research firm with its mission to create healthy communities, this CHNA follows best practices as outlined by the Association for Community Health Improvement, a division of the American Hospital Association, and ensures compliance with Internal Revenue Service (IRS) guidelines (IRS Notice 2011-52) for charitable 501(c)(3) tax-exempt hospitals that was published in December 2014. The process has taken into account input from those who represent the broad interests of the communities served by Ohio Valley Hospital (OVH), including those with knowledge of public health, the medically underserved, and populations with chronic disease.

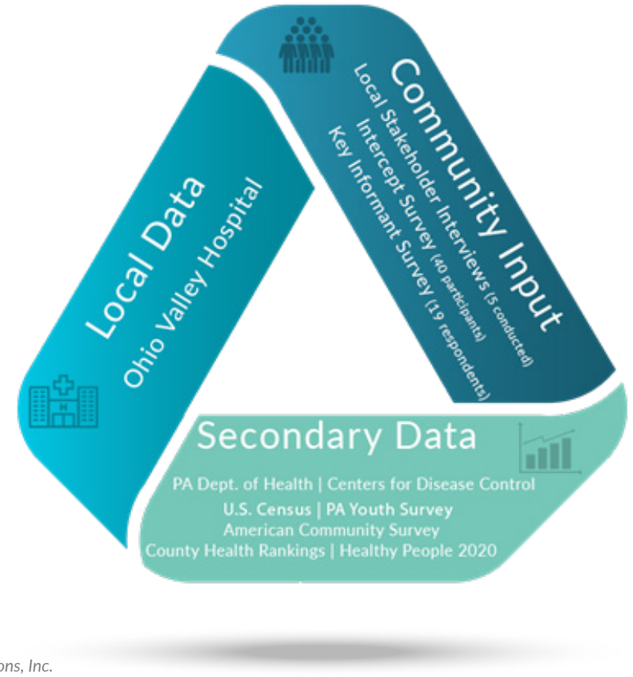
The 2019 OVH CHNA was conducted to identify primary health issues, current health status, and health needs to provide critical information to those in a position to make a positive impact on the health of the region's residents. The results enable community members to more strategically establish priorities, develop interventions, and direct resources to improve the health of people living in the community. This CHNA includes a detailed examination of the following areas as seen in Figure 1 below.

Figure 1
CHNA Report Chapters



To support this assessment, data from numerous qualitative and quantitative sources were used to validate the findings, using a method called triangulation outlined in Figure 2.

Figure 2
Data Triangulation



Source: 2019 Strategy Solutions, Inc.

Secondary data on disease incidence and mortality, as well as behavioral risk factors were gathered from the Pennsylvania Department of Health and the Centers for Disease Control, as well as Healthy People 2020, County Health Rankings, US Census, American Community Survey, and the 2017 PA Youth Survey. Aggregate utilization data was included from OVH patient records (no private patient information was ever transmitted to Strategy Solutions, Inc.). The indicators reported on for OVH's 2019 CHNA can be found in Appendix A of this report.

Demographic data was collected from Claritas-Pop-Facts Premier, 2019, Environics Analytics. Primary data collected specifically for this study were based on the primary service area of the hospital. OVH collected a total of 19 key informant surveys and 40 intercept surveys, as well as conducted five stakeholder interviews.

On March 25, 2019, the OVH Steering Committee met to review the secondary data collected through the needs assessment process and discussed needs and issues present in the hospital's service territory. The team from SSI, including Kathy Roach, Community Health Improvement Project Manager, and Robin McAleer, Project Coordinator and 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, including other stakeholders to receive input from. After additional key informant surveys, intercept surveys and stakeholder interviews were conducted through the month of April, a total of 42 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.

For the two weeks ending May 10th, Steering Committee members from the hospital and community completed the prioritization exercise using the Survey Monkey Internet survey tool to rate each of the needs and issues on a one to ten scale by each of the selected criteria. Six Steering Committee members 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. See Table 11 – Prioritization Results on page 49 for a detailed listing of the prioritization of identified needs. As a result of the Steering Committee's prioritization exercise, the following areas will be a focus of OVH for intervention and action planning over the next three years:

- Chronic Disease
    - o Diabetes
    - o Cardiovascular Disease
    - o Respiratory Disease
- Mental Health
    - o Substance Abuse Disorder
- Access to Quality Health Care
- Overweight/Obesity

Review and Approval

The OVH Board of Directors approved the hospital's CHNA on June 18, 2019. The Heritage Valley Health System Board of Directors approved the OVH 2019 CHNA on June 27, 2019.

METHODOLOGY

METHODOLOGY

To guide this assessment, OVH's leadership team formed a Steering Committee that consisted of hospital and community leaders who represented the broad interests of their 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, those with chronic disease needs, individuals with expertise in public health, and internal program managers. The OVH Steering Committee met on September 26, 2018 and March 25, 2019 to provide guidance on the various components of the CHNA.

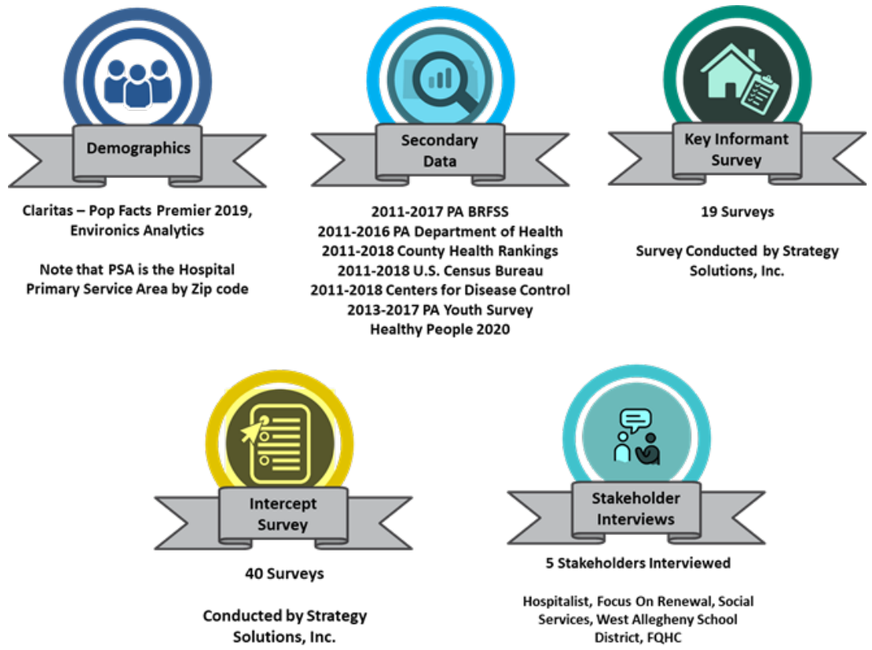
Consistent with IRS guidelines at the time of data collection, OVH defined its primary service area as the following eight zip codes in Allegheny County, shown in Table 2:

Table 2
OVH's Primary Service Area by Zip Code

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

Figure 3 is a summary of the methodology used to create the 2019 OVH CHNA report.

Figure 3
OVH 2019 CHNA Methodology Summary



Source: 2019 Strategy Solutions, Inc.

In an effort to examine the health related needs of the residents of the county-wide 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 area, 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 key stakeholders that represented various subgroups in the community. In addition, the process included public health input, through extensive use of PA Health Department and Centers for Disease Control data.

The secondary quantitative data collection process included demographic and socio-economic data obtained from Claritas-Pop-Facts Premier, 2019, Environics Analytics; 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 Pennsylvania Department of Education, and the County Health Rankings (www.countyhealthrankings.org). Selected data was also included from the Allegheny County 2017 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. Data presented are the most recent published by the source at the time of the data collection.

Key Informant Survey Collection Tool

The purpose of conducting a Key Informant Survey is obtain vital information about the community from an "expert" in a particular area or discipline. It is used to gather information for a needs assessment and utilize the findings for effective prevention planning. The Survey tool can be used to assess if the needs in your community have changed over time and to identify the top needs and priorities from a diverse point of view.

The audience for the Key Informant Survey collection tool included professionals within various disciplines related to the Social Determinants of Health and underrepresented populations. It also targeted individuals who didn't make the Stakeholder Interview list from whom the Steering Committee wanted to receive feedback. The Key Informant Survey was developed and distributed as an on-line survey through SurveyMonkey, as well as in paper format. The survey was launched on March 25, 2019 and closed on May 6, 2019. A total of 19 individuals completed the Key Informant Survey.

Intercept Survey Collection Tool

An Intercept Survey is a research method used to gather on-site feedback from an identified population in a location where they are a "captive audience." The audience for the Intercept Survey collection tool included individuals who were members of underserved populations. Intercept Surveys were conducted as in-person interviews by consultants at community events, OVH's Pulmonary Rehabilitation Department, and a Focus on Renewal luncheon. A total of 40 intercept surveys were conducted, as shown in Table 3.

Table 3
Intercept Surveys Conducted

Date Completed	Group	Number of Participants
March 31, 2019	Toast of the Rox Greater McKees Rocks Area Rotary French Toast Breakfast	30
April 12, 2019	OVH Pulmonary Rehabilitation Department	4
April 12, 2019	Focus on Renewal Community Luncheon	6
	Total Participants	40

Stakeholder Interviews

The purpose of conducting Stakeholder Interviews is to gather information to explore complex issues, allow follow up questions to clarify for understanding, and to provide immediate results. It also enables the research team to pilot test ideas and reach underrepresented populations. The audience for the Stakeholder Interview collection tool included those community members who represent the underserved population through programs and services offered. A total of 5 Stakeholder Interviews were conducted by the consulting team via telephone between January 18, 2019 and April 2, 2019. Interview questions included the following topics: top community health needs, environmental factors driving the needs, efforts currently underway to address needs and advice for the Steering Committee. Table 4 is a listing of the stakeholders interviewed. See Appendix D for the stakeholder interview guide used for this assessment.

Table 4
Stakeholder Interviews Conducted

Name	Organization	Representing	Date of Interview
Cindy Haines	Focus On Renewal	Underserved Populations	January 18, 2019
Adrienne Roberts	McKees Rocks Community Development Corporation	Underserved Populations and Businesses	January 18, 2019
Dr. Christopher Shattuck	West Allegheny School District	Parents and Youth	January 21, 2019
Dr. Sayed Ali	Ohio Valley Hospital	Community	March 17, 2019
Dr. Sara Silvestri	Sto-Rox Family Health Center	Underserved Populations	April 2, 2019

Previous OVH CHNA Report

No written comments were received from the community by OVH regarding the previous 2016 CHNA report.

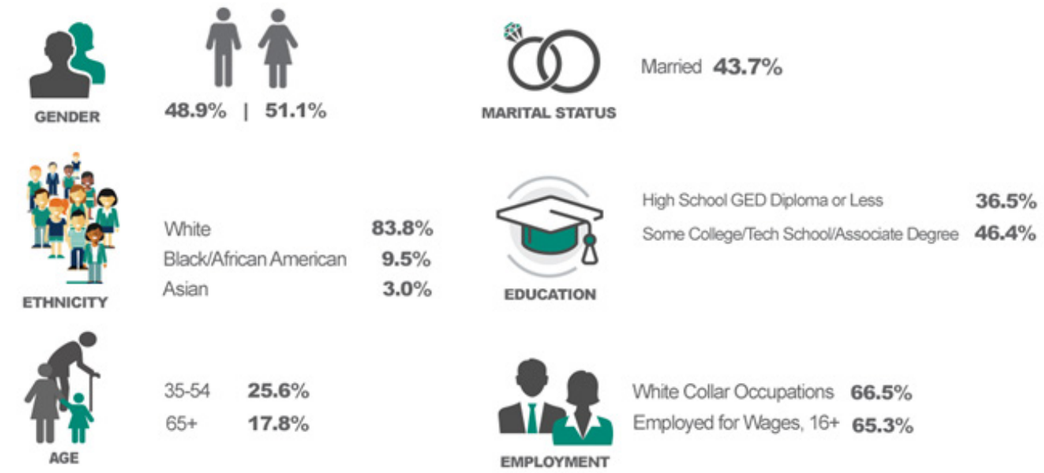
DEMOGRAPHICS

DEMOGRAPHICS

For purposes of this assessment, the OVH service area geography is defined as eight zip codes within Allegheny County, Pennsylvania. These eight zip codes were used to pull demographic data from Claritas-Pop-Facts Premier, 2018, Environics Analytics and the U.S. Census Bureau – American Community 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.

The population in the hospital's service area was projected to increase from 131,111 in 2019 to 132,115 in 2024, an increase of 0.8%. There were slightly more females (51.1%) than males (48.9%). The population was predominantly Caucasian (83.8%). The median age was 41.5 and was projected to increase slightly to 42.6 by 2024. Just over one-third (35.2%) of residents had never been married, while 43.7% were married, 3.7% were separated, 10.6% were divorced and 6.8% were widowed. Those who did not complete high school were 6.4%, while 30.1% were a high school graduate, 25.4% had a bachelor's degree and 11.9% had an advanced degree. The average household income was $86,668, with 8.5% of families living in poverty. Most (94.9%) of the labor force was employed. Summary of the demographics are shown in Figure 4 below.

Figure 4
OVH's Service Area Demographics Summary

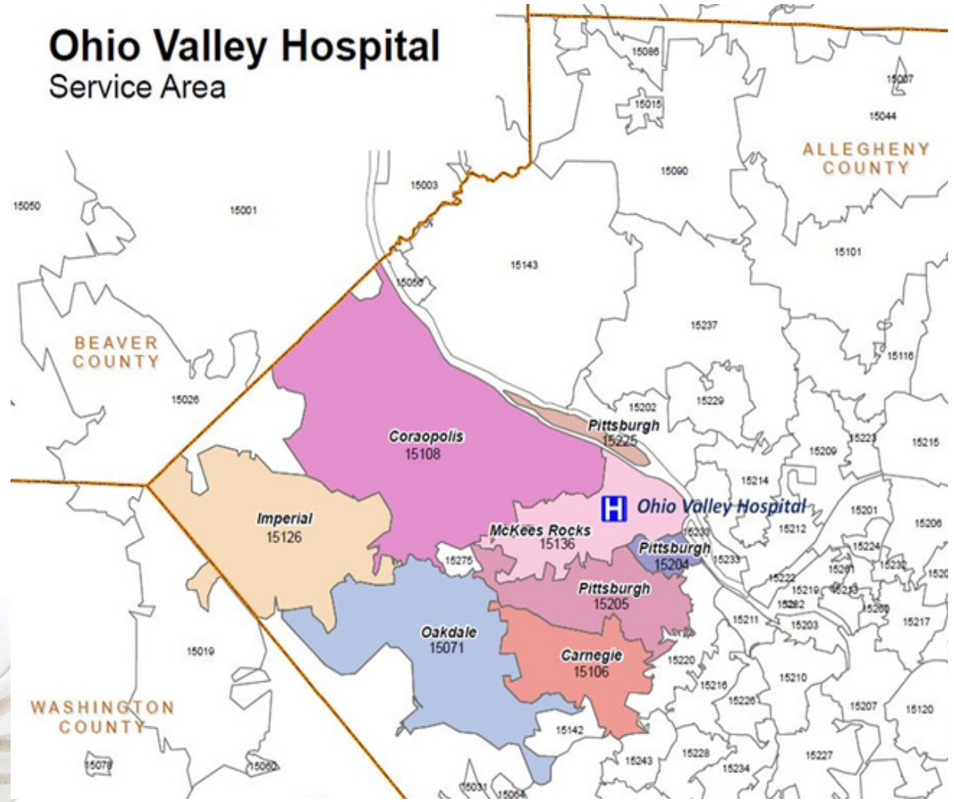


Source: Claritas-Pop-Facts Premier, 2019, Environics Analytics

PRIMARY SERVICE AREA

As previously mentioned, OVH's primary service area covers eight zip codes within Allegheny County. The primary service area map depicting the zip codes serviced by the hospital is shown in Figure 5 below.

Figure 5
OVH Primary Service Area



COMMUNITY AND HOSPITAL RESOURCES

COMMUNITY AND HOSPITAL RESOURCES

Resources that are available in OVH's service area to respond to the significant health needs of the community can be found in the United Way's PA 2-1-1 Southwest. The PA 2-1-1 Southwest is part of the national 2-1-1 Call Centers initiative that seeks to provide an easy-to-remember telephone number and web resource for finding health and human services– for everyday needs and in crisis situations. Residents can search the United Way's vast database of services and providers to find the help they need. The Southwest Region includes Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Mercer, Somerset, Washington and Westmoreland Counties. Figure 6 below shows the number of resources available in the hospital's service area per United Way 2-1-1 categories. For a complete listing of available services, please visit http://pa211sw.org/. The community resources are listed in Appendix E of this report. The hospital's resources are reported in Table 5 and are also listed in Appendix E.

Figure 6
PA 2-1-1 Southwest Service Category Breakdown for OVH Service Area

Source: United Way's PA 2-1-1 Southwest

Table 5
Hospital Resources

Acute Rehabilitation Unit	Radiology and Medical Imaging - Continued
Cardiology	Dual Energy X-Ray Absorptiometry
Cardiology Services	MRI
Cardiac Rehabilitation Program	Ultrasonography
Cardiac Catherization Lab	Interventional Radiology
Cataract & Eye Surgery Center	Rehabilitation Services
Colon & Rectal Surgery	Physical Therapy
Community Health	Pilates
Vaccines:	Occupational Therapy
Chickenpox (Varicella)	Speech Therapy
Flu Shot (Seasonal Influenza)	Our Balance and Fall Prevention Center
Hepatitis A, B, and A/B	Inpatient Rehabilitation
Measles, Mumps and Rubella	Outpatient Rehabilitation
Meningitis	Respiratory Care Services
Rabies	Sleep Evaluation Center
Pneumonia	Surgical Services
Tdap	Inpatient Surgeries
Shingles	Colorectal
Travel Immunizations	Ear, Nose and Throat
Testing	Gynecology
TB Skin	Laparoscopic
Prescribed Therapeutic Injections	Orthopedic
Exposure to Blood/Body Fluid Follow-Up	Orthopedic/Podiatry
Emergency Department	Spine
Laboratory Services	Peripheral Vascular
Health Check Preventive Blood Screening	Urology
Inpatient/Outpatient Blood Testing	Outpatient Surgeries
Clinical Pathology	Colorectal
Anatomic Pathology	Ear, Nose and Throat
Nutrition Services	General
Internal Nutrition	Gynecology
Outpatient Dietitian	Laparoscopic
Diabetes Education	Ophthalmology
Orthopedics	Orthopedic (Including Hand, Elbow, Foot)
Spine Care	Spine
Sports Medicine and General Ailments	Sports Medicine
Additional Foot & Ankle Conditions	Plastic
Hand & Upper Extremity	Maxillofacial
Steroid Injections	Peripheral Vascular
Pulmonary Health Center	Podiatry
Radiology and Medical Imaging	Urology
Computed Tomography (CT)	Robotic-Assisted Surgeries
Digital Mammography	Willow Brook Geropsychiatric Unit
Diagnostic Radiology (X-Ray)	

Source: Ohio Valley Hospital

EVALUATION

EVALUATION OF THE 2016 OVH CHNA IMPLEMENTATION STRATEGIES

OVH conducted an evaluation of the implementation strategies undertaken since the completion of the 2016 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. It is important to note that strategies identified for Year 3 were put on hold due to the recent affiliation with Heritage Valley Health System and will be revisited during the 2019 Implementation Plan. Figures 8 and 9 below highlight the major accomplishments that the hospital made in each of the two goals that were outlined in their implementation strategy action plan.

Figure 8
3-Year Evaluation of 2016 CHNA Summary – Goal 1

Goal 1: Improve Health Status Through Chronic Disease and Care Management Across the Continuum, Especially as it relates to Diabetes, Cardiovascular Disease and Mental Health

1 DIABETES
- Held Annual Diabetes Day
- Offered Living Well with Diabetes classes
- Partnered with YMCA to offer Pre-Diabetes classes
- Offered Wound Care program
- Continued Diabetes Support Group
- Collaborated with Focus on Renewal to offer nutrition education (Steel Chef)

2 CHRONIC DISEASE
- Offered nutrition programs to public and various support groups
- Continued to offer Cardiac Rehab
- Continued to offer Pulmonary Rehab
- Participated in community health fairs and events - education and screenings

3 MENTAL HEALTH
- Continued to offer Geropsych and Outpatient Psych Services (adults over 25)
- Conducted speaking engagements throughout the community
- Collaborated with community partners to address Mental Health needs
- Promoted Suicide prevention education and incorporated into staff orientation

4 DEPRESSION SCREENING
- Instituted the PHQ-2 Depression Screening tool in all OVH PCP offices

5 HEALTH/ WELLNESS
- Hosted Annual Community 5K race with 260 runners in 2019; increase from 2018
- Continued to offer nutrition and healthy eating classes to the community
- Partnered with YMCA for nutrition and exercise programs
- Continued to fund the YMCA's after school nutrition program

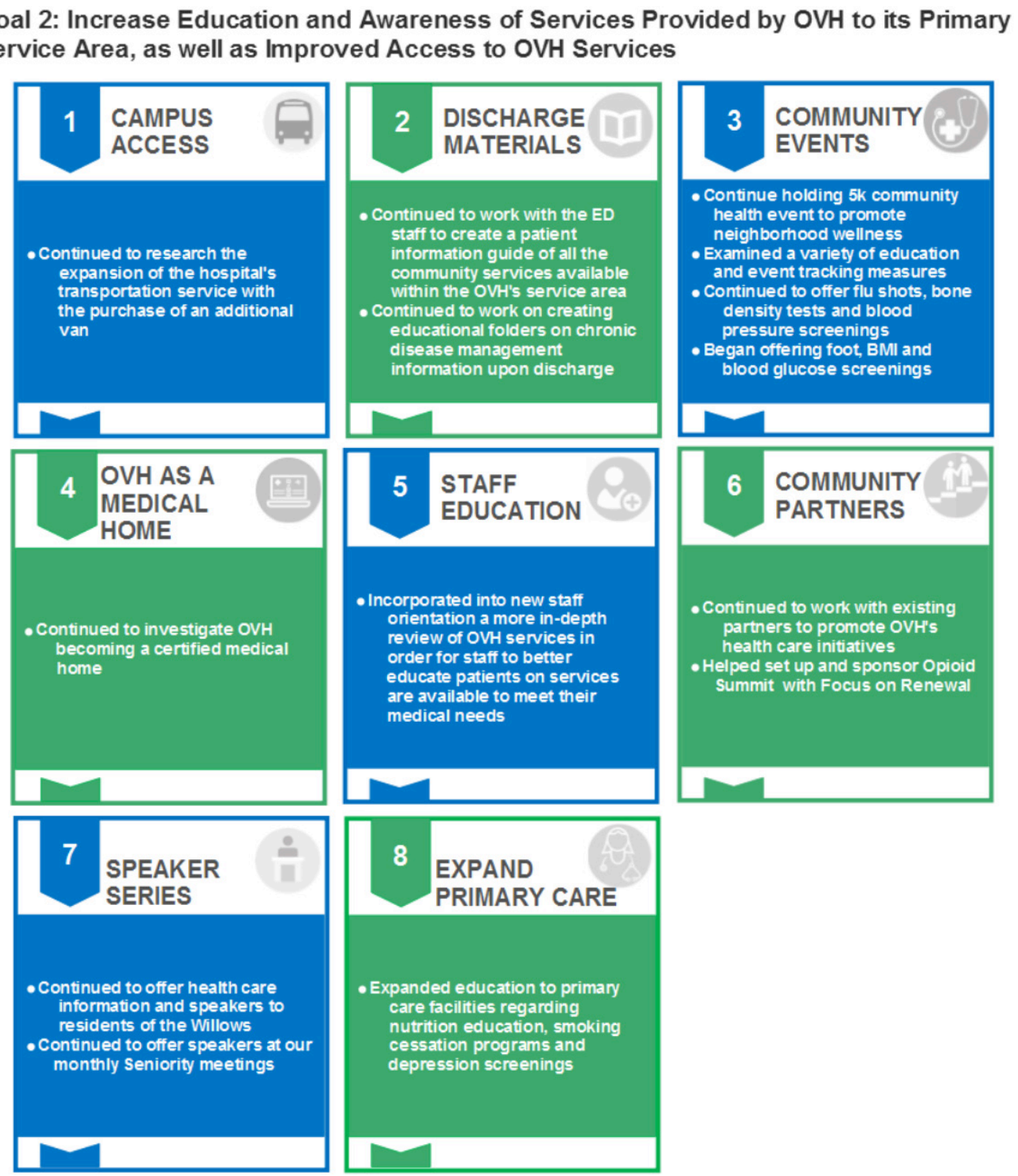
6 SMOKING CESSATION
- Successfully made OVH campus a Smoke-Free Campus

7 LOWER READMISSIONS
- Offered education on chronic disease management with a focus on Diabetes
- Hired a Transitional Care Coordinator to assist with education and management of chronic diseases

8 EDUCATION
- Continued to offer monthly Seniority monthly education classes on various chronic disease topics
- Continued to offer disease management education during Cardiac and Pulmonary Rehab

9 POPULATION HEALTH
- Created protocol for discharge follow up
- Hired a New Patient Advocate whose main focus is to interact with patients on a daily basis
- Increase knowledge of services available in the community through primary care mailing
- Created protocols for SEPSIS, VTE, Falls

Figure 9
3-Year Evaluation of 2016 CHNA Summary – Goal 2



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

Priority Area: Chronic Disease, Senior Population
Goal: Improve Health Status Through Chronic Disease and Care Management Across the Continuum, Especially as it Relates to Diabetes, Cardiovascular Disease and Mental Health

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

Objective A: Continue Offering Diabetes Programs to the Community

Host Annual Diabetes Day: OVH hosted its annual Diabetes Day each March (2017, 2018 and 2019), with a total of over 320 participants attending this event over the two-year reporting period. The hospital also expanded its vendors that participated in Diabetes Day, from four in 2017 to 20 in 2018, including the Blood Bank that offered iron and anemia screenings. Besides the A1c, bone density and blood pressure screenings, the hospital also offered in 2018 cholesterol, bone density, BMI and food health screenings. OVH's School of Nursing students participated in Diabetes Day, providing Diabetes education to attendees. In 2019, students also prepared presentations and worked in the community room. Other activities that occurred during this annual event included speakers, a panel discussion, cooking demonstrations and food lectures.

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. Table 6 shows the breakdown by year of attendees for Diabetes Day.

Table 6
OVH Diabetes Day Three-Year Summary

	2017	2018	2019
Number of Attendees	161	168	168
Number of Surveys Completed	n/a	64	61
Number of Vendors	14	16	20
Glucometer Reading	75	81	81
Blood Pressure	77	71	83
BMI	n/a	45	83
A1c	77	82	85
Cholesterol	n/a	82	85
Wound Food Check	37	46	35
Bone Density	58	62	57
Total Number of Tests	324	469	509

Source: 2017, 2018 and 2019 OVH

Conduct Living Well with Diabetes classes: OVH continued to offer 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. For Year 1, there were 11 participants, with 7 completing the program (63.6% completion rate). There have been no referrals to the program from the ED; however, in the 4th quarter, there were 18 inpatient CDE referrals and 4 outpatient DSME referrals. During Year 1, a referral program was being created for an automatic referral program for the inpatient side. Until this referral program is automated, referrals will be tracked manually. During Year 2, there were 15 participants (over a 30% increase over Year 1) with 100% of participants completing the program. In the spring of Year 2, ER referrals to the Living Well with Diabetes began. Also in Year 2, OVH's Dr. Newton began creating orders for the hospital's Outpatient Dietitian/Diabetes Educator to visit and speak with those patients diagnosed with Diabetes in the ER and promote the Living Well with Diabetes program.

Diabetes Support Group: 83 participants for Year 1 and 69 participants for Year 2. There have been 7 speakers over the two-year period and the topics covered included: vacation travel, foot care, "Ask the Pharmacist," things that can raise blood sugar, counting carbs, breaking the sugar habit, and mindful eating. 6 participants attended a grocery store tour in Year 1.

Pre-Diabetes Classes in partnership with the Western Area YMCA: 21 participants in Year 1. During the 4th quarter of Year 1, a tracking mechanism was put into place to record weight loss. For the five participants in quarter four, the average weight loss was 6.8%. For Year 2, this partnership changed due to a flood that permanently damaged and closed the Western Area YMCA. The hospital offered space on campus for the Pre-Diabetes Classes to occur and eight participants took advantage of this program. In Year 2, OVH began writing recipes for the monthly YMCA newsletter.

Continue to promote wound care health for those persons with Diabetes: For Year 1, a total of 1,419 patients were seen for wound care (894 at Kennedy Center and 525 at Mt. Nebo locations). Out of those 1,419 patients, 458 of them were Diabetic (32.3% of patients seen). There were no referrals to the Nutrition Program during Year 1. For the first six months of Year 2, a total of 350 patients were seen for wound care (194 at Kennedy Center and 156 at Mt. Nebo locations). Out of those 350 patients, 187 were Diabetic (53.5% of patients seen). Wound Care education was provided to 55 home health nurses during Year 2, as well as continuing education for all floor nurses on the protocol for wound care to patients. This continuing education occurred once per week on the awareness of pressure ulcers in order to reduce these ulcers among Diabetic patients.

Promote Diabetes Management through communication with Marketing Department of upcoming events; add events to monthly OVH Calendar: Diabetes Support Group has doubled in size over the past year (from 12 to 24). During Year 1, Diabetes Program activities have been added not only to the OVH Website but also to the hospital's Facebook page. The event details are also added onto OVH's Intranet for employee notification and involvement. For Year 2, the Diabetes Support Group has maintained its size and the Diabetes Day events were added to the hospital's website event calendar.

Collaborate with Focus On Renewal on nutrition education: Over the course of Year 1, 41 families participated in this program with a combined 66 hours of educational classes on food safety, food prep on a budget, and family interaction. OVH also sponsored dinner nights at the Family Table and hosted a Family Table Funfest. For Year 2, the Family Table program had 35 participants receiving healthy cooking demonstrations and food discovery experiences. This program was discontinued for Year 3. A new program targeting youth called the Steel Chef began. In partnership with Focus On Renewal, the Steel Chef is a cooking competition where OVH's Nutrition Services Department paired up with a group of high school students to compete in a cooking competition. OVH's Head Chef and team were crowned competition winners in Year 2.

Collaborate with the ER on redoing the Diabetes information that is handed out in the ER at discharge: During Year 1, the Diabetes information flyer handed out in the ER was recreated. Other Diabetes collateral material was also updated during 2016-2017. The ED is still working with Marketing on a packet of information to handout at discharge.

Incorporate Diabetes Education and OVH offerings into the School of Nursing curriculum: September – December 2016, the School of Nursing students created Diabetes posters for use at OVH's Diabetes Day in March. The Diabetes Educator also spoke to the nursing students during their clinical care rotations to educate the students on OVH's Diabetes program and protocols established at the hospital. School of Nursing students became more involved with the actual day of Diabetes Day in Years 2 and 3.

Objective B: Promote chronic disease management services to increase utilization

Continue to offer Nutrition Programs to the public and through various support groups: Attended Sto-Rox nutrition committee meetings. Also offered 39 insulin-injection trainings throughout Years 1 and 2. Continue to offer Diabetes Programs – it was determined through the course of Year 1 that this action step is a duplicative effort to Objective A. Therefore, beginning in Year 2, this action step was eliminated.

Continue to offer Cardiac Rehab Program:

- For Year 1, offered five Cardiac Rehab classes a day and, due to its popularity, continued the afternoon program. For Year 2, these classes were only offered four times a day as it was determined that during the winter months, the attendance slowed. Once the weather improved, the classes were again offered five times a day.
- For the first 6 months of Year 1, there were 38 participants, 26 of program participants had met their goals. There was a net weight of 59.3 lbs. lost and there was a 44% quit rate among smokers entering Cardiac Rehab. For Year 2, there were 31 new participants to the Cardiac Rehab Program. Weight loss and participation quit rate tracking beginning in Year 2 was handled by a third-party – UPMC – so data is no longer available.
- For the last 6 months of Year 1, there were 51 participants in Phase 2, and 73 participants in Phase 3, with an average attendance rate between the two phases of 89%.
- Education classes included food demonstrations and nutrition lectures.
- Surveys were conducted at the beginning and end of the program to track depression.

Continue to promote and offer Pulmonary Rehab Program:

- The number of visits to Pulmonary Rehab was 2,090 (817 visits for regular Pulmonary Rehab – billed to insurance, and 1,273 visits for the maintenance program – patient pays out-of-pocket monthly fee of $44.00). For Year 2, the number of referrals to the program was 35. The number of visits to PHC was 1,247 (539 visits for regular Pulmonary Rehab – billed to insurance – and 708 for the maintenance program – patient pays out-of-pocket monthly fee of $44.00).
- The number of no-shows: For Year 1, out of 1,528 scheduled visits, 523 were no-shows (34.2% no-show rate). For Year 2, out of 824 scheduled visits, 232 were no-shows (28.0% no-show rate, down from Year 1).
- For Year 1, the number of patients who completed 100% of the program was 25. For Year 2, the number of participants who completed 100% of the program was 19.
- In Year 1, 18 patients were discharged from the program due to various reasons (noncompliance, CTB, insurance issues or just stopped coming). In Year 2, only two patients were discharged from the program.
- For Year 1, the number of subsidized patients through BreathePA was 1 patient (4 patients did not want to complete the BreathePA paperwork) and 1 patient received funding through the hospital's charity care program. For Year 2, five patients were offered participation in the BreathePA program but the patients were uncomfortable filling out the paperwork so no subsidies for this program occurred in Year 2.

Continue participation at health fairs and other public events promoting OVH services:
OVH participated in 10 health fairs and public events for Year 1, with approximately 600 people attending the various events that were tracked (three events were not tracked for attendees). For Year 2, OVH participated in 18 community health fairs and public events for Year 2, with over 2,000 people attending the various events. The Marketing Department has been continuing to offer support to various departments for coordinating these health fairs and public events by ensuring that the events are equipped with marketing materials, tablecloths, and promotional items for giveaways. The Marketing Department also attends community health fairs and events when necessary to promote OVH services.

Objective C: Promote an increase in Mental Health services

Continue to promote and offer Geropsych (for those over 55) and Outpatient Psych (for those over 25) services to increase utilization: During Year 1, researching a protocol to establish a follow-up visit one week after discharge back to facility to ensure care is present and increase communication between hospital/primary care physician and the facility. Currently, still researching the protocol – but promoting services and advertising on-line and through health fairs, including creating a virtual Dementia Tour. Also looking at starting to have the patient sign consent for their PCP to receive a discharge summary so that the PCP is in the "loop" regarding their treatment, along with improving communication between the patient, their PCP and OVH. The end result is to reduce readmission rates as care will continue with PCP. During Year 2, the marketing has shifted from targeting those over 40 for outpatient psych to those over 25. Also, Laurel Care, a drug and alcohol counseling center opening in 2018 and patients are being referred to and from this center and the PCP offices.

Continue to conduct speaking engagements or psychiatrist-lead lectures; health fairs and sponsored programs, i.e. annual NAMI Walk; participate in mental health week with flyers created: conducted 13 outreach events during Year 1 with 168 participants on the 7 events tracked. Forms and education protocols have been instituted during Year 1 to ensure better tracking of participants moving forward. For Year 2, nine outreach events took place with 151 participants. Participants were not tracked for the table OVH had outside of the hospital's cafeteria during Mental Health Awareness Week in September 2018.

Collaborate with community providers regarding mental health needs: During Year 1, OVH participated in the JRA Mental Health Providers Partnership by hosting a collaborative meeting. This meeting focused on mental health issues within the senior population of the community. Also participated in Allegheny County's Point-in-Time Homeless Count in January of 2017. In Year 2, OVH participated in an Opioid Summit with community members representing not only the hospital, but also law enforcement, government, mental health and substance use providers. Also in Year 2, the hospital, along with Willowbrook, hosted monthly StoRox Mental Health Providers Partnership meetings with over 30 people in attendance on a monthly basis. OVH conducted Mental Health First Aid training in Year 2 with 26 people being trained. Representation at this training consisted of children and families, Focus On Renewal, North Hills Community Outreach, Chartiers Mental Health and Brightside Academy.

Research reinstating Geropsych screenings for depression and anxiety at seniority events for outpatient people: During Year 2, research was conducted on how best to reinstate Geropsych screenings for depression and anxiety. It was determined that this screening will be tied into population health and the screenings will first be first conducted at Willowbrook and then to community members. This project was due to begin in Year 3; with our recent affiliation we have decided to table this for further research and review in 2019.

Objective D: Institute PHQ-2 in One OVH Primary Care Facility

Institute PHQ-2 in one OVH Primary: Finalized in Year 2, depression screening (PHQ-2 and PHQ-9) is being conducted in all of OVH's PCP offices as it is a quality measure for MIPS. Both screening tools have been built into a patient's EMR.

Objective E: Continue to offer health and wellness activities

Offer annual Community 5K: The 36th annual OVH and Kennedy Township Community 5K took place on May 13, 2017. In 2017, there were 260 participants, which was an increase of 39%, or an additional 70 runners/walkers, from 2016 (187). For 2018, 230 runners/walkers participated in the 5K, which was a decrease of 13.0%, or 30 participants, from 2017. For 2019 and the 38th annual 5K, 260 runners/walkers participated in the 5K, which was an increase of 30 runners and inline with 2017 participation.

Continue offering nutrition and healthy eating classes: as mentioned in Objective A above, OVH participated in the Steel Chef program that Focus on Renewal hosted. The Steel Chef is a program whereby high school students receive cooking lessons and culminates in a cooking competition. This program affords students the opportunity to visit a professional kitchen and learn how to: read recipes, what healthy and nutritional foods are, and how to prepare and cook meals. The night of the competition, teams were given mystery ingredients and had to prepare meals for a sold out crowd. For Year 2, 12 high school students participated and OVH's team was crowned Top Steel Chef.

Investigate partnerships with FOR and the Western Area YMCA regarding nutrition and exercise programs: OVH and YMCA have partnered to offer nutrition and exercises programs at The Willows where the community is always invited and welcome. As previously mentioned, OVH no longer sponsors the Family Table as of Year 3; however the Steel Chef program has taken its place. For Year 2, OVH also offered a yoga class at Focus on Renewal.

Continue funding of Western Area YMCA after school nutrition program – a new Director for the YMCA occurred during Year 1 and tracking of measurements did not happen, although the after school program did continue that OVH sponsors. For Year 1 and Year 2, OVH sponsored the after school nutrition program at the YMCA with 175 students participating in Year 1 and 165 students participating in Year 2. OVH continued to sponsor the program in Year 3, which is not completed so number of participating students is not currently available.

Objective F: Institute Smoking Cessation Program

Make OVH a smoke-free campus: OVH successfully transitioned the campus to a smoke-free campus on October 1, 2017. We also had an employee smoke-free date of April 1st and offered employee smoking cessation programs to assist with this culture change.

Objective G: Continue to work on keeping the readmission rates for chronic disease low from year to year

Offer education on chronic disease management – this objective was not started in Year 1 due to staff change. It was determined that for Year 2, the hospital would hire a Transitional Care Coordinator to assist with any chronic disease management education. Tracking for DRG 30-day readmission rates began at the beginning of Year 2. For same DRG 30-day readmissions, OVH saw a decline from 5.4% to 2.3% in Year 2. The hospital also saw a decline in all DRG 30-day readmissions from 10.0% to 9.7%.

Objective H: Continue to offer the chronic disease education classes

Pulmonary Rehab education classes continue to be a success at OVH with 1,376 participants. Cardiac Rehab education classes continued to be offered five times a day out of convenience for its patients and had a total of 188 participate in this very extensive process. The Seniority group monthly meetings continued to be held at OVH with over 300 seniors participating in these educational classes. Topics that were presented to this group included: health literacy, Medicare knowledge, osteoporosis, fall prevention, stroke awareness, heart health, allergies, hearing loss, eye health, depression, healthy eating, hospice and palliative care.

Objective I: Continue to offer population health care at Home Partnership: Dissolved during Year 1 so this objective was removed for Years 2 and 3.

Decrease complaints – this action step is ongoing. Protocols are in place on how to handle complaints and grievances received by a patient using the "4444 Call4Care" service (30 minute response time is the goal). Complaints and grievances are also received via voicemail, email, and on-line submission; when received after normal business hours they may take longer than the 30 minute contact window. The complaints and grievances are hard to track, as also receive calls through these methods that are not complaints or grievances. Continual updates to these protocols are ongoing. In Year 2 a new process from Studor was put into place for making discharge follow-up phone calls. Patients with a discharge status of home are contacted as a follow-up to their stay in their house. For the first six months, over 1,400 discharge calls were made. Also in Year 2, a new Patient Advocate was hired with their main focus being on rounding patients daily.

Create materials for employee orientation on OVH services and how to communicate with patients: during the Year 1 evaluation process, it became clear that this action step was duplicative to Goal 2, Objective E - Add an education piece to employee orientation focusing on services offered by the hospital to better equip employees to understand and refer to OVH services. Therefore for Year 2, this action step will be removed.

Increase knowledge of OVH services through postcard mailing to residents outside OVH area: a marketing campaign began in Year 1 and even included working with Imaging to remind women of their annual mammography through a postcard reminder system.

Conduct Teddy Bear Clinic at clinics in area: this offering was not worked on during Year 1 due to staffing and resource issues. We will continue to monitor staff and resources and implement the program should we have the required resources to do so.

Outreach of OVH services at health fairs, seniors centers and living facilities: during the Year 1 evaluation process, it became clear that this action step was duplicative to Goal 1, Objective B – Promote chronic disease management services to increase utilization. Therefore, this objective was removed for Year 2.

Create protocols on quality metrics on: sepsis, VTE, falls, restraints: Through this evaluation process, it was discovered that protocols have been in place for VTEs, falls and restraints and that re-education of these protocols (nursing and physician driven) took place in Year 1. For Year 2, a Meditech protocol was put into place to identify Sepsis early. Because of this protocol, OVH is seeing a better compliance regarding Sepsis, although the protocol was re-evaluated during Year 2 to create a better EMR system. Year 2 also saw a continuing of staff education around fall prevention, proper use of restraints as well as the use of alternative restraints for patients. A Fall Prevention Task Force at the hospital was created in Year 2 and OVH saw a decrease in falls, especially falls with trauma, due to the task force and additional staff education and training.

Create employee training on: reducing falls, back injuries, proper restraints, VTE, Sepsis: The Star Center came to OVH in July 2016 to conduct trainings. They educated both nurses and nursing associates on Sepsis, falls and restraints. During the first half of 2017, OVH's Clinical Educator conducted competency skills labs on Sepsis, falls and restraints for nurses and nursing associates. VTE and Patient Transfer Safety is covered in clinical orientation and each new hire receives this education. VTE is also covered in the annual Clinical Standards Workshop, along with annual education on Safe Patient Transfers. For Year 2, OVH saw a 32.6% reduction in falls, a 59.4% reduction in VTEs and a 22.0% reduction in Sepsis cases.

Objective J: Continue OVH's health care at Home Partnership: Dissolved during Year 1 so this objective was removed for Years 2 and 3.

Goal 2 : Access – Increase Education and Awareness of Services Provided by OVH to its Primary Service Area, as well as Improved Access to OVH Services

Objective A: Increase awareness of access to OVH medical campus through OVH's transportation vans: while not yet accomplished we believe that our recent affiliation with Heritage Valley Health System will allow us to extend our coverage area and aid in helping our expanding community in 2019.

Objective B: Research what outside materials for health are given/offered to patients upon discharge from the ED

Create education folders with OVH information and information of shared resources: due to staff change in responsibilities, this objective did not begin in Year 1. Research on best practices for educational folders began in Year 2. This project was due to continue in Year 3; with our recent affiliation we have decided to table this for further research and review in 2019.

Increase access to patient information guide of all services available in the primary service area: during the evaluation process, it was determined that the patient information guide that the hospital has been using for years and is constantly updating is available for access by inpatients. It is also available in all brochure racks throughout the hospital, and available by mail if a community member requests it. Due to the staff changes in the ER, this objective delayed. This project was due to begin in Year 3; with our recent affiliation we have decided to table this for further research and review in 2019.

Objective C: Continue to participate in community health fairs by and creating testing cards for participants to keep track of their readings from test to test

Work with IT to create a tracking program in OVH's computer system: This project was due to begin in Year 3; with our recent affiliation we have decided to table this for further research and review in 2019.

Offer flu shots, bone density tests and blood pressure screenings: Besides offering these tests during Diabetes Day (as reported in Goal 1, Objective A), bone density screenings were conducted on 60 people in Year 1. The hospital utilized the students from OVH's School of Nursing to assist with education at health fairs. Topics covered included arthritis, stroke prevention, diabetes management, high blood pressure, controlling cholesterol, healthy eating, dealing with stress, dealing with depression, pain management, and physical activity.

Objective D: Investigate becoming a certified medical home: This project was due to begin in Year 3; with our recent affiliation we have decided to table this for further research and review in 2019.

Objective E: Add an education piece to employee orientation focusing on services offered by the hospital to better equip employees to understand and refer to OVH services: In Year 1, the hospital successfully added a more extensive tour of the hospital and detailed explanation of services offered by OVH to all new employees during orientation so that staff can be better equipped to assist patients and talk about all of the available services. This education is now a permanent fixture in the new employee orientation.

Objective F: Continue working with the Rotary through the Willows and OVH to promote health care initiatives

For Years 1 and 2, OVH continued to attend Rotary meetings and share information about OVH and the Willows, as well as volunteer at community events hosted by the Rotary clubs in the area.

Objective G: Continue to offer health care information and speakers to residents of Willows

The progress report included:

- Due to a staff change in Year 1, this objective did not begin until Year 2.OVH staff provide education and screenings to residents of the Willows on a variety of topics related to older adults, including healthy eating, falls prevention, and depression.

Objective H: Expand primary care to promote nutrition, smoking cessation, and psychological screenings

The progress report included:

- Due to staff change, expanding primary care to promote nutrition, smoking cessation and psychological screenings began in Year 2 with BMI screenings being conducted at every patient visit. For those patients presenting with a high BMI, the provider now provides patient education on how to lower their BMI through nutrition changes. The PCP offices also began offering smoking screenings for all patients who use or had used any type of tobacco product. For current smoker patients, they are also given recommendations on how to quit smoking by the provider.

HOSPITAL UTILIZATION RATES

HOSPITAL UTILIZATION RATES

As seen in Table 6, from 2017 through 2019, hospital ER discharges for ambulatory care sensitive conditions at OVH increased for: Gastroenteritis, Diabetes with Ketoacidosis, and Diabetes with Other Conditions.

For the same time period, hospital Emergency Department and/or Inpatient Discharges for Mental Health, as seen in Table 7, increased for: Transient Organic Psychotic, Schizophrenia, Paranoia Psychosis, Personality Disorders, Sexual Deviations, Psychogenic Disorders, Stress Related, Adjustment Related, and Conduct/Social Disturbances.

Table 8 shows that from 2017 to 2019, conditions that resulted in a hospitalization by DRG (Diagnostic Related Group) for OVH increased slightly for: Hypertension and Breast Cancer.

For the same time period, conditions that resulted in a hospitalization by Service Line by DRG for OVH increased for: Infectious and Parasitic and Mental Dissociative Disorders.

Table 6
Emergency Department Discharges for Ambulatory Care Sensitive Conditions

Ambulatory Care Sensitive Conditions- ER Only			
Preventable Conditions	**2017**	**2018**	**2019**
Failure to Thrive	0	0	0
Dental Conditions	0	0	0
Vaccine Preventable Conditions	8	5	5
Iron Deficiency Anemias	2	5	0
Nutritional Deficiencies	0	0	0
Acute Conditions			
Bacterial Pneumonia	4	5	3
Cervical Cancer	0	0	0
Cellulitis	80	71	41
Convulsions	23	23	21
Gastroenteritis	168	188	173
Hypoglycemia	0	0	0
Kidney/Urinary Infection	350	336	235
Pelvic Inflammatory Disease	7	8	2
Severe ENT Infections	754	626	451
Chronic Conditions			
Angina	6	5	6
Asthma	341	286	225
COPD	273	213	168
Congestive Heart Failure	11	12	8
Diabetes with ketoacidosis	33	47	34
Diabetes with other conditions	35	51	40
Diabetes without other conditions	49	60	41
Grand Mal and other Epileptic	40	23	33
Hypertension	88	99	66
Tuberculosis- Non Pulmonary	1	0	0

Source: Ohio Valley Hospital, 2019

Table 7
Hospital Emergency Department and/or Inpatient Discharges for Mental Health

Emergency Department and/or Inpatient Discharges for Mental Health						
Code	2017 ED	2017 IN	2018 ED	2018 IN	2019 ED	2019 IN
Dementia	23	23	27	17	19	20
Alcohol Related	43	6	37	9	13	2
Drug Related	75	66	51	26	37	29
Transient Organic Psychotic	0	2	0	0	1	2
Other Chronic Organic Psychotic	0	5	0	8	0	1
Schizophrenia	5	36	21	45	11	69
Manic Disorder	0	0	0	0	0	0
Depressions	33	52	35	46	32	36
Bipolar	6	66	5	48	3	35
Paranoia Psychosis	12	10	12	11	13	4
Anxiety	197	69	163	68	137	51
Phobias	0	2	0	0	0	0
Personality Disorders	1	0	0	1	0	1
Sexual Deviations	0	4	0	4	0	5
Psychogenic Disorders	1	3	3	1	2	0
Sleep Disorders	0	4	0	1	0	1
Eating Disorders	0	3	0	0	0	0
Stress Related	4	4	3	2	6	4
Adjustment Related	0	4	0	4	2	0
Conduct/Social Disturbances	0	7	2	8	2	11
Emotional Disorder- Youth	1	0	0	0	0	0
Mental Retardation	1	4	0	4	0	2

Source: Ohio Valley Hospital, 2019

Table 8
Hospital DRG Conditions

DRG File			
DRG File	2017	2018	2019
Hypertension	4	14	6
Congestive Heart Failure	133	135	117
Breast Cancer	0	2	1
Cancer	27	15	19
Pneumonia	129	190	102
Complications Baby	0	0	0
Bronchitis/Asthma	36	19	13
Alcohol/Drug Abuse	36	44	27
COPD	165	97	53
Fracture	34	46	26

Source: Ohio Valley Hospital, 2019

Table 9
Hospital Service Lines by DRG Conditions

DRG File			
DRG File	2017	2018	2019
Nervous System	234	245	100
Eye	5	4	2
ENT	24	29	10
Respiratory	461	449	250
Circulatory	547	524	340
Digestive	342	316	211
Hepatobiliary and Pancreas	117	111	76
Musculoskeletal	497	519	354
Skin and Subcutaneous Tissue	141	125	73
Endocrine and Nutritional	196	155	71
Kidney and Urinary Tract	251	221	101
Male Reproductive	7	12	4
OB/GYN	8	9	3
Pregnancy/Childbirth	1	0	0
Newborn/Neonates	0	0	0
Blood and Blood Forming Organs	59	43	27
Myeloproliferative DDs	5	5	3
Infectious and Parasitic	70	139	108
Mental Dissociative Disorders	266	339	291
Alcohol/Drug Use	36	44	25
Injuries, Poison, and Toxic Effect of Drugs	39	37	22
Burns	1	0	0
Factors Influencing Health Status	76	61	49
Multiple Significant Trauma	0	1	0
Human Immunodeficiency Virus Infection	5	0	0

Source: Ohio Valley Hospital, 2019

ACCESS TO QUALITY HEALTH SERVICES

ACCESS TO QUALITY HEALTH

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.

WHERE THERE ARE OPPORTUNITIES

Mammography Screenings

The percentage of females receiving a mammography screening in Allegheny County has decreased from 2011 (56.7%) to 2018 (53.9%) which is below the state (64.8%) and Healthy People 2020 Goal (81.1%).

WHERE WE ARE MAKING A DIFFERENCE

Fair or Poor Health

The percentage of residents in Allegheny County who report their health as fair or poor has remained consistent in the county and in 2015-2017 (15.0%) was significantly lower when compared to the state (17.0%) and was also lower than the nation (16.7%).

> "The hospital does a good job providing transportation and access to healthy foods, as well as dietitians/diet coaches when medical needs require a change in diet and lifestyle for healthy living."
> ~Key Informant Survey Respondent

Health Insurance

The percentage of adults ages 18-64 who do not have health insurance has been decreasing in Allegheny County since 2011-2013 (12.0%) to 2015-2017 (7.0%) which is lower than the state (9.0%) and nation (11.9%) although still above the Healthy People 2020 Goal (0.0%).

No Personal Care Provider

While the percentage of Allegheny County residents who do not have a personal health care provider has remained fairly steady over the past several years in 2015-2017 (15.0%) was comparable to the state (14.0%) and Healthy People 2020 Goal (16.1%) but below the nation (21.8%).

Routine Check-Up

The percentage of adults in Allegheny County who have had a routine check-up within the past two years has increased from 2011-2013 (84.0%) to 2015-2017 (87.0%) which is comparable to the state (85.0%) and above the nation (83.6%).

Needed to See a Doctor but Could Not Due to Cost

While the percentage of adults who needed to see a doctor but could not due to cost has remained fairly consistent in Allegheny County in 2015-2017 (9.0%) was comparable to the state (11.0%), below the nation (12.1%) and falls short of the Healthy People 2020 Goal (4.2%).

WHAT THE COMMUNITY IS SAYING

Figure 7 below shows that over 50% of Key Informant Survey respondents rated the health of their community as Fair or Poor (53.0%). Figure 8 shows that less than one third of Intercept Survey Respondents (30.0%) rated the health of their community as Fair or Poor.

Figure 7
What Key Informants Are Saying: Health of the Community

Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.

Figure 8
What Intercept Survey Respondents Are Saying: Health of the Community

Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.

Most (72.7%) of the Key Informant Survey respondents agree that residents have access to a primary care provider when needed. Many also agree residents have access to diabetic services (60.0%) and specialists (63.6%) when needed. Less than half of the respondents (45.5%) agree that residents have access to a dentist when needed.

Key Informant Survey respondents the following as the top underserved populations in the community:

- Low Income/Poor (75.0%)
- Uninsured/Underinsured (75.0%)
- Homeless (75.0%)
- Disabled (62.5%)

One stakeholder indicated that there is nothing available in the community for people who suffer from allergies or asthma. A few stakeholders commented that there is limited support for the aging population including a lack of transportation and home services as well as aging services in general.

BARRIERS TO HEALTHCARE

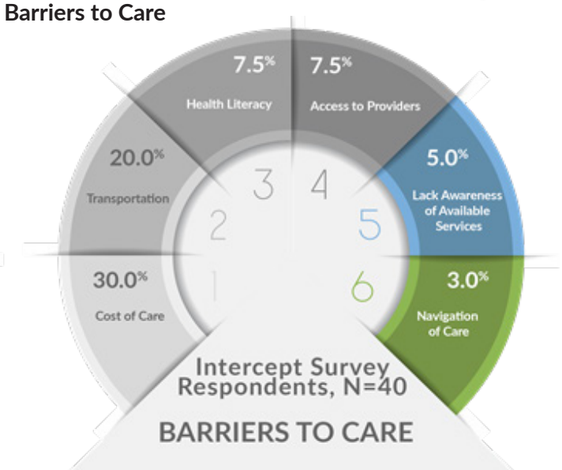
According to Healthy People 2020, barriers or social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. Understanding the relationship between how population groups experience "place" and the impact of "place" on health is fundamental to the barriers of health—including both social and physical determinants.

Figure 9 shows that 100% of Key Informant Survey respondents said that Access to Insurance was the top barrier to care. Survey respondents ranked Affordability of Health Care (87.5%) and the Inability to Pay out of Pocket Expenses (87.5%) as the next top barriers to care, with Language/Cultural (80.0%) as the fourth top barrier to care. Figure 10 illustrates how Intercept Survey Respondents ranked Barriers to Care. Less than a third of Intercept Survey Respondents said Cost of Care (30.0%) was the top barrier to care and Transportation (20.0%) as the second top barrier to care.

Figure 9
What Key Informants Are Saying – Barriers to Care

Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.

Figure 10
What Intercept Survey Respondents Are Saying – Barriers to Care



Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.

Very few Key Informant Survey respondents agree that there is a sufficient number of providers accepting Medicaid/Medical Assistance in the area (30.0%), that transportation is available to medical appointments (36.4%), or that there is a sufficient number of bi-lingual providers (9.1%).

Intercept survey respondents were personally experiencing difficulty getting health care related to the cost of co-pays, lack of accommodating hours, transportation and challenges with insurance.

One of the stakeholders indicated that 31.0% of the population has issues with transportation to the point it is affecting their daily living.

CHRONIC DISEASE

CHRONIC DISEASE

Conditions that are long-lasting, relapse, in remission and have continued persistence are categorized as chronic diseases.

WHERE THERE ARE OPPORTUNITIES

"Through outreach into the community, the hospital provides education and access to dietary, health and wellness programs and resources."

~Key Informant Survey

Diabetes

The Diabetes mortality rate per 100,000 has been steadily increasing in Allegheny County since 2014 (16.8) and in 2016 (20.1) is comparable to the state (20.2) and nation (21.0).

Obesity

The percentage of adults who are obese has been increasing in Allegheny County from 2011-2013 (26.0%) to 2015-2017 (29.0%) which is comparable to the state (31.0%), nation (30.1%) and Healthy People 2020 Goal (30.5%).

Breast Cancer

The Breast Cancer incidence rate per 100,000 has increased in Allegheny County since 2011 (132.2) and in 2015 (145.9) was significantly higher when compared to the state (131.2). The most recent incidence rate for the state is 2014 (123.9) at which time the rate in Allegheny County (139.9) was higher.

The Breast Cancer mortality rate per 100,000 in Allegheny County has fluctuated over the past several years and in 2016 (24.1) was higher when compared to the state (21.4) and Healthy People 2020 Goal (20.7%). Data for the nation is available for 2014 (20.5) at which time the county (19.2) was comparable.

Bronchus and Lung Cancer

Although the Bronchus and Lung Cancer incidence rate per 100,000 has decreased in Allegheny County since 2011 (75.5) in 2015 (67.8) the rate was significantly higher when compared to the state (63.2). Data is available for the nation in 2014 (50.8) at which time the county rate (71.9) was higher.

Colorectal Cancer

The Colorectal Cancer mortality rate per 100,000 in Allegheny County has remained fairly steady and in 2016 (14.8) was comparable to the state (14.7) and Healthy People 2020 Goal (14.5). There is continued opportunity as the rate compared to the state in 2014 (11.9) was higher in the county (16.1).

Liver and Intrahepatic Bile Duct Cancer

In 2015, the Liver and Intrahepatic Bile Duct Cancer incidence rate per 100,000 in Allegheny County (11.1) was significantly higher when compared to the state (11.1) and had been increased from 7.9 the prior year.

Prostate Cancer

The Prostate Cancer mortality rate per 100,000 in Allegheny County has fluctuated in recent years but did increase from 15.6 in 2015 to 20.7 in 2016, which is comparable to the state (19.2) and Healthy People 2020 Goal (21.8). Compared to the nation in 2014 (19.1) the rate was comparable (19.5).

Heart Health

Although the Heart Disease morality rate per 100,000 has been decreasing in Allegheny County in 2016 (183.0) the rate is still significantly higher when compared to the state (175.8). In 2015 (188.7) the rate was higher when compared to the nation (218.0).

The Heart Failure mortality rate per 100,000 has increased in Allegheny County from 2011 (17.7) to 2016 (22.8) and is comparable to the state (23.9). The rate in 2015 (23.1) was just below the nation (25.4).

While the Coronary Heart Disease mortality rate per 100,000 has been decreasing since 2011 (139.2) in 2016 (120.7) is still significantly higher when compared to the state (107.6) and above the Healthy People 2020 Goal (103.4). The rate in 2015 (125.1) was comparable to the nation (126.2).

Lyme Disease

The Lyme Disease incidence rate per 100,000 has fluctuated and although the rate increased from 22.6 in 2015 to 32.9 in 2016, is still significantly lower when compared to the state (89.5).

WHERE WE ARE MAKING A DIFFERENCE

Bronchus and Lung Cancer

The Bronchus and Lung Cancer mortality rate per 100,000 has decreased in Allegheny County since 2011 (52.4) to 2016 (39.8) and was comparable to the state (40.9). The rate in 2016 was below the Healthy People 2020 Goal (45.5). Data for the nation is available for 2014 (34.7) at which time the county (45.8) was higher.

Colorectal Cancer

In Allegheny County the Colorectal Cancer incidence rate per 100,000 has decreased from 42.6 in 2011 to 37.6 in 2015, which was significantly lower when compared to the state (41.9) as well as below the Healthy People 2020 Goal (39.9). When looking at 2014 where data is available for the nation (33.7) the rate for the county (40.1) was higher.

Ovarian Cancer

While the Ovarian Cancer incidence rate per 100,000 has remained comparable in Allegheny County over the past several years in 2015 (9.3) was just below the state (11.6).

Prostate Cancer

The Prostate Cancer incidence rate per 100,000 has been decreasing in Allegheny County since 2011 (119.9) and in 2015 (91.1) was significantly lower when compared to the state (104.4). The rate was also lower in 2014 (90.9) when compared to the nation (95.5).

Thyroid Cancer

The Thyroid Cancer incidence rate per 100,000 had been significantly higher when compared to the state from 2011-2014, but between 2014 (23.8) and 2015 (19.8) the rate decreased and was comparable to the state (19.3).

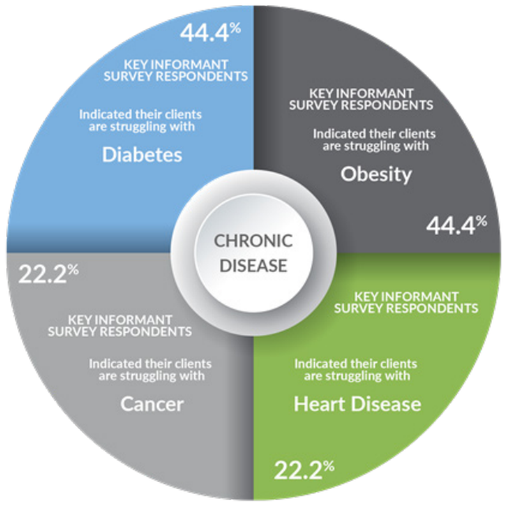
Cerebrovascular Disease

The Cerebrovascular Disease mortality rate per 100,000 in Allegheny County has decreased from 2011 (38.2) to 2016 (36.0) and is comparable to the state (36.8) and just above the Healthy People 2020 Goal (34.8). The rate in 2015 (34.2) was significantly lower than the state and below the nation (47.8).

WHAT THE COMMUNITY IS SAYING

When responding to questions regarding what their clients are struggling with in relation to chronic disease, Figure 11 shows that Key Informant Survey respondents mentioned that Diabetes (44.4%) and Obesity (44.4%) were top diseases their clients are struggling with, along with Cancer (22.2%) and Heart Disease (22.2%).

Figure 11
What Key Informants are Saying – Chronic Disease



Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.

Two of the Key Informant Survey respondents talked about barriers for individuals living with a chronic condition. They identified the following:

- Burden of a diagnosis
- Cost of medication and medical needs
- Social support

They identified the following as challenges those living with diabetes experience:

- Burden of cost of medication – especially insulin

Two of the stakeholders identified Diabetes as a top community health need. They talked about limited access to healthy food options and the lack of support for activities that promote healthy lifestyle habits.

PHYSICAL ACTIVITY AND NUTRITION

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.

WHERE THERE ARE OPPORTUNITIES

Free or Reduced Lunch

The percentage of children receiving free or reduced lunch has been increasing in Allegheny County since 2013 (31.6%) to 2018 (42.1%), although remains below the state (48.2%).

> "We can all make more of an effort to be healthy and to live a healthy lifestyle."
>
> ~Intercept Survey Participant

WHERE WE ARE MAKING A DIFFERENCE

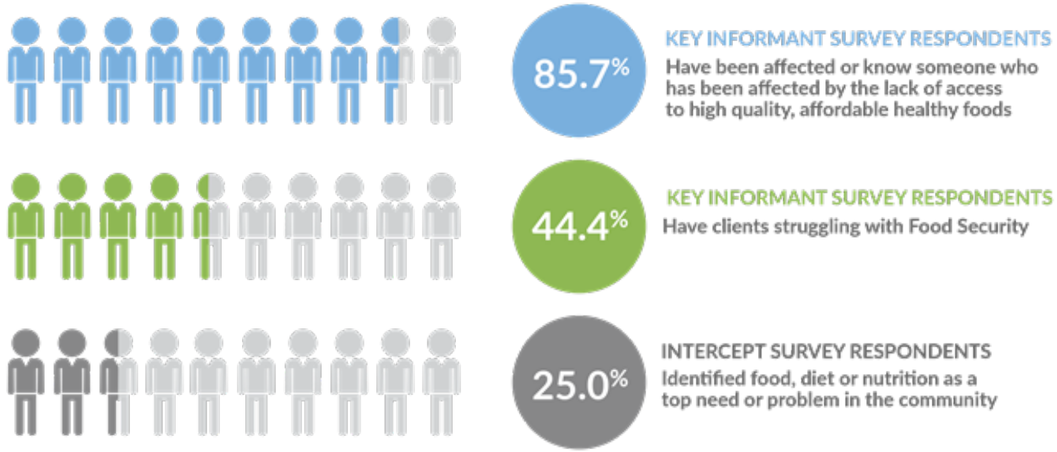
Leisure Time Activity

The percentage of adults with no leisure time/physical activity in the past month has decreased slightly in Allegheny County since 2013-2015 (24.0%) to 2015-2017 (22.0%) and is currently lower than the state (25.0%) and Healthy People 2020 Goal (32.6%) than the state (25.0%) and Healthy People 2020 Goal (32.6%).

WHAT THE COMMUNITY IS SAYING

Figure 12 shows that 85.7% of Key Informant Survey respondents mentioned they or someone they know have been affected by the lack of access to high quality, affordable health foods and that 44.4% of Key Informant clients struggle with food security. One-fourth of Intercept Survey respondents identified food, diet or nutrition as a top need or problem in the community.

Figure 12
What Key Informants and Intercept Survey Respondents are Saying – Physical Activity and Nutrition



Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.

Two stakeholders identified food security as a top community problem. As an agency that provides services, one noted that they feed 252 families a month and offer seniors boxed lunched. This stakeholder noted that they serve 350 people lunch a year who would not otherwise have lunch. Another commented that 41.0% of the population reports food insecurity. They noted that there are high rates of poverty. This stakeholder also commented that people might be aware of food pantries but might not have transportation to get there. Lastly, they commented that people are not always open about admitting they have a problem with food which makes it difficult to offer assistance.

TOBACCO USE

TOBACCO USE

Tobacco Use is an important public health indicator as it relates to a number of chronic disease issues and conditions.

WHERE THERE ARE OPPORTUNITIES

Adults

The percentage of adults who report having quit smoking at least one day in the past year has been decreasing from 53.0% in 2011-2013 to 46.0% in 2015-2017, which is lower than the state (51.0%) and Healthy People 2020 Goal (80.0%).

Youth

The percentage of students who report vaping or using c-cigarettes has increased for students in grades 10 and 12, with county rates higher than both the state and nation for both. Those vaping nicotine and marijuana has increased.

WHERE WE ARE MAKING A DIFFERENCE

Adults

The percentage of adults who report never being a smoker in Allegheny County has been increasing since 2011-2013 (52.0%) to 2015-2017 (56.0%) and is currently comparable to the state (55.0%) and nation (57.2%).

The percentage of adults who report being a current smoker has been decreasing since 2011-2013 (22.0%) and in 2015-2017 (19.0%) is comparable to the state (18.0%) and nation (17.0%) but above the Healthy People 2020 Goal (12.0%).

The percentage of adults who report being an everyday smoker has also been decreasing in the county from 17% in 2011-2013 to 13.0% in 2015-2017, which is comparable to the state (13.0%) and nation (12.3%).

Youth

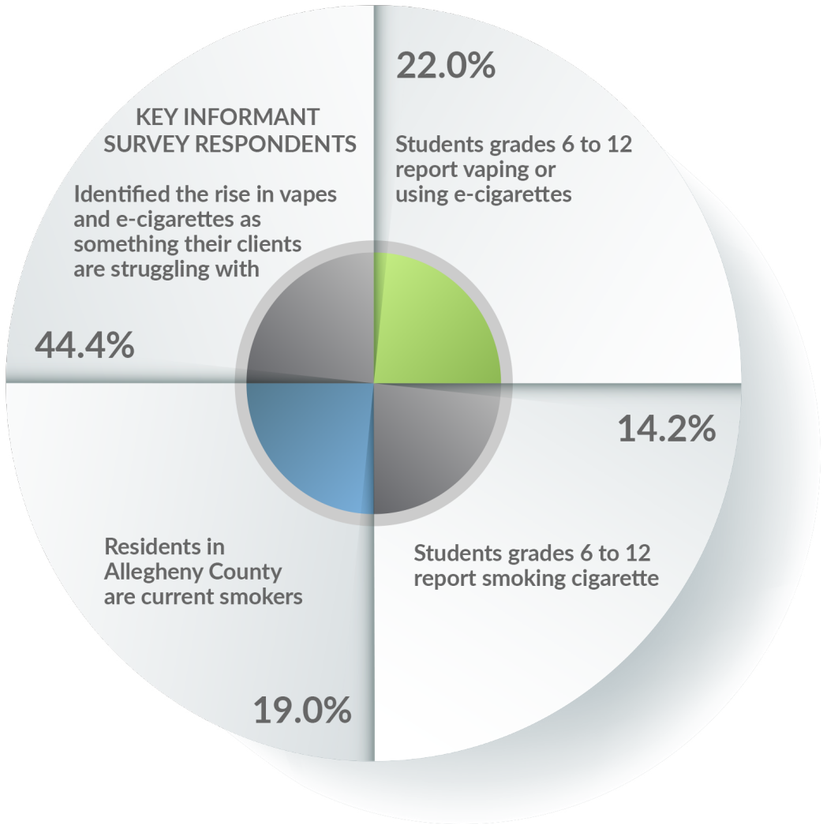
The percentage of students in grades 10 and 12 who report lifetime cigarette use has been decreasing and for those in grade 10 (15.1%) is comparable to the state (16.2%) and nation (15.9%), while those in grade 12 (23.0%) are lower than the state (29.0%) and nation (26.6%). The 30-day cigarette use has also decreased for students in grades 10 and 12 with the 12th grade percentage (8.3%) lower than the state (12.2%).

The percentage of students in grades 10 (6.7%) and 12 (12.6%) who report lifetime use of smokeless tobacco has also been declining and both are lower than the state (8.9% and 15.9% respectively). The 30-day smokeless tobacco use has also decreased for grades 10 and 12 with the 12th grade percentage (3.5%) lower than the state (7.5%).

WHAT THE COMMUNITY IS SAYING

Figure 13 illustrates what Key Informant Survey respondents are commenting on regarding tobacco. Four in ten respondents (44.4%) identified the rise in vapes and e-cigarettes as something their clients are struggling with. Less than a quarter of PA Youth Survey respondents mentioned that students in grades 6-12 report vaping or using e-cigarettes (22.0%) or smoking cigarettes (14.2%). Roughly two out of ten PA Department of Health BRFSS respondents mentioned they are current smokers (19.0%).

Figure 13
What the Community is Saying – Tobacco



Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc., 2015-2017 PA Youth Survey, 2016 PA Department of Health, BRFSS

Two stakeholders identified smoking as a top community problem. One commented that during a 1½ hour meeting there is a need for a smoke break, and no one has signed up for the smoking cessation program. Another noted that 29.0% report tobacco use daily added that they refer a lot of people to the PA quit line. Another identified vaping and juuls and a community problem commenting on the impact of nicotine addiction on the next generation of children. This stakeholder also noted that when working in schools, 80.0% of students have tried some form of e-cigarette and 50.0% use regularly.

MENTAL HEALTH & SUBSTANCE USE DISORDER

MENTAL HEALTH AND SUBSTANCE USE DISORDER

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.

WHERE THERE ARE OPPORTUNITIES

Mental Health

The percentage of adults who report their mental health was not good one or more days in the past month has increased in Allegheny County from 2011-2013 (36.0%) to 2015-2017 (39.0%) and is comparable to the state (38.0%).

The Suicide mortality rate per 100,000 has increased from 10.8 in 2011 to 14.0 in 2016, which is comparable to the state (14.6) but above the Healthy People 2020 Goal (10.2).

> "I see this issue daily with the families I serve. There are issues that I see that I can't help with. I would love to have our own mental health component where we have someone on staff that would help with these issues."
> ~Community Stakeholder

Adult Substance Use

The percentage of adults in Allegheny County who binge drink (5 drinks for males, 4 drinks for females) has been significantly higher when compared to the state for years 2011-2017 and has been increasing. In 2015-2017 (23.0%) the percentage who report binge drinking was significantly higher than the state (18.0%) as well as higher when compared to the nation (16.9%) and comparable to the Healthy People 2020 Goal (24.2%). Those adults age 18-44 were also significantly more likely to report binge drinking (33.0%) when compared to the state (27.0%).

The Drug-Induced mortality rate per 100,000 in Allegheny County has increased from 20.5 in 2011 to 51.7 in 2016, which is significantly higher when compared to the state (38.5) and is above the Healthy People 2020 Goal (11.3).

The percentage of adults who report excessive drinking has fluctuated and has increased in recent years (20.7% in 2017 to 24.3% in 2018). The percentage in 2018 is higher when compared to the state (20.5%).

Youth Substance Use

The percentage of students in 6th grade who report lifetime use of alcohol has increased from 14.1% in 2013 to 19.9% in 2017, which is higher when compared to the state (16.8%).

The percentage of students in 8th grade who report lifetime use of marijuana has increased since 2013 (10.5%) and in 2017 (14.1%) is higher when compared to the state (8.4%). Student usage for grades 10 and 12 are also higher when compared to the state.

WHERE WE ARE MAKING A DIFFERENCE

Mental Health

The Mental and Behavioral Disorders Mortality rate per 100,000 in Allegheny County has remained steady over the years and in 2016 (41.3) was comparable to the state (42.7). In 2015 (43.3) the rate was lower when compared to the nation (48.0).

Adult Substance Use

The percentage of adults age 18-44 in Allegheny County at risk for heavy drinking (2 drinks for men and 1 drink for women daily) has been decreasing from 12.0% in 2011-2013 to 9.0% in 2015-2017 which is comparable to the state (7.0%).

Those age 18-44 in the county who reported chronic drinking (2 or more drinks daily for the past 30 days) has also decreased from 9.0% in 2011-2013 to 6.0% in 2015-2017, which is comparable to the state (6.0%).

The percentage of Alcohol Impaired Driving Deaths in the county has been decreasing since 2016 (31.1%) to 2018 (27.1%), which is lower when compared to the state (30.1%).

Youth Substance Abuse

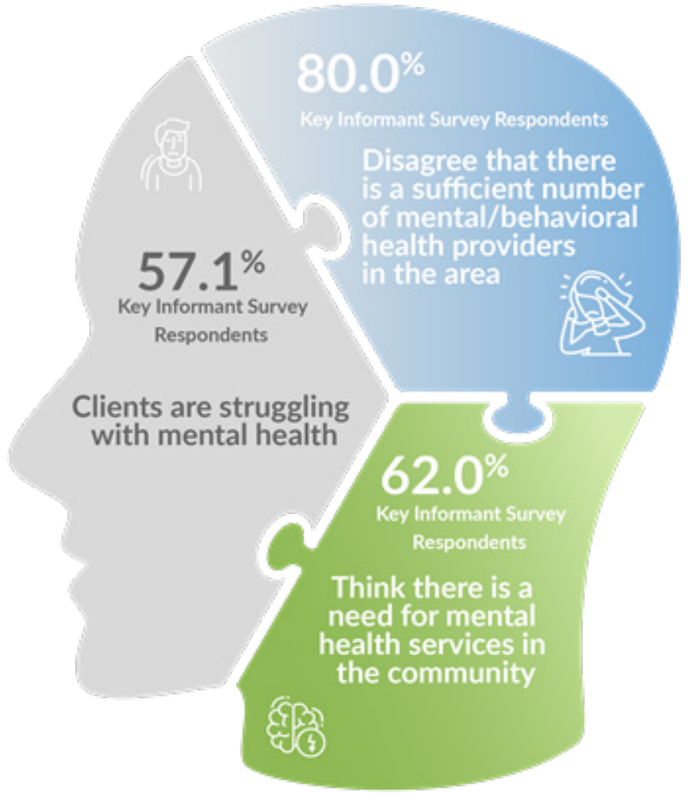
The percentage of students in grades 10 and 12 who report lifetime alcohol use has been decreasing since 2013 (65.3%, 79.3%) to 2017 (56.4%, 71.0%), although in 2017 the percentages are higher than the nation. The percentage of students in 12th grade who drove after drinking decreased in half from 10.7% in 2013 to 5.1% in 2017.

Students who use prescription narcotics in Allegheny County in grades 10 and 12 has decreased from 2013 (10.4%, 16.5%) to 2017 (5.6%, 7.4%).

WHAT THE COMMUNITY IS SAYING

Figure 14 illustrates that eight out of ten Key Informant Survey respondents (80.0%) disagree that there is a sufficient number of mental and behavioral health providers in the area. Almost two-thirds of respondents (62.0%) think there is a need for mental health services in the community, and 57.1% of Key Informant Survey respondents mention they have clients who are struggling with mental health.

Figure 14
What Key Informant Survey Respondents are Saying – Mental Health



Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.,

Key Informant Survey respondents identified the following as barriers or things that individuals with mental illness struggle with:

- Proper care
- Financial aid
- Lack of resources or priority of our culture
- Not enough providers
- Resources that manage both mental and physical health needs
- Difficulty managing and understanding available resources
- Ability to obtain an appointment in a timely fashion as many providers have wait lists
- Lack of professional level of care

Three of the stakeholders identified mental health as a top problem in the community. One shared an example of someone who knows they need services but when they are in the midst of a crisis they don't even want to get services because they had a negative experience in the past. Another noted that these individuals often have a poor support system and socioeconomic issues. The other stakeholder noted that mental health issues are pervasive in the community running the full continuum of mild depression to harsh maniac depression, bipolar or schizophrenia.

Key Informant Survey respondents identified the following as barriers or things individuals with substance use/abuse issues struggle with:

- Faith
- Feeling judged by the system/Stigma of seeking help
- Lack of professional level care
- Not enough resources available for treatment
- Safe environment to remain clean and sober
- Limited access to resources to aid in recovery
- Addressing mental and/or physical health needs that are underlying due to substance use

Four of the stakeholders identified substance use as a problem in the community. One talked about statistics in the area and what you hear in the media regarding overdoses. Another noted that these individuals often have a poor support system and socioeconomic issues. One stakeholder talked about an opioid use summit and the common knowledge that EMS makes several house calls for an overdose reaction. The final stakeholder added that according to local law enforcement there is a downward trend with regards to overdoses. It was noted that the type of heroin in the area is not as harsh or polluted and the impact NARCAN is having on saving individuals in distress.

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.

WHERE THERE ARE OPPORTUNITIES

When looking at the secondary data, no opportunities were identified for Healthy Environment.

WHERE WE ARE MAKING A DIFFERENCE

High School Graduation

High school graduation rates have been increasing in Allegheny County since 2014 (86.3%) to 2018 (88.9%) which is higher than the state (85.4%). When comparing the county to the nation in 2016 the graduation rate in the county (89.6%) was higher than the nation (84.0%).

Children Living in Poverty

The percentage of children living in poverty has remained steady in Allegheny County and in 2018 (15.2%) was lower when compared to the state (18.4%). When compared to the nation (41.0%) in 2016 the percentage of children living in poverty in the county (18.5%) was lower.

Disconnected Youth

The percentage of disconnected youth in the county has remained steady and in 2018 (10.3%) was lower when compared to the state (12.8%).

Asthma

The percentage of adults ever told they have asthma in Allegheny County has fluctuated and in 2015-2017 (12.0%) is lower than the state (15.0%) and comparable to the nation (14.0%).

WHAT THE COMMUNITY IS SAYING

Key Informant Survey respondents identified the following as barriers or things those living in poverty struggle with:

- Nutrition
- Education
- Limited options for healthy whole foods as Access does not cover fresh fruits and vegetables
- Limited access to address needs through available resources
- Funding to pay for healthcare
- Transportation
- General lack of access to healthcare and healthy lifestyle options

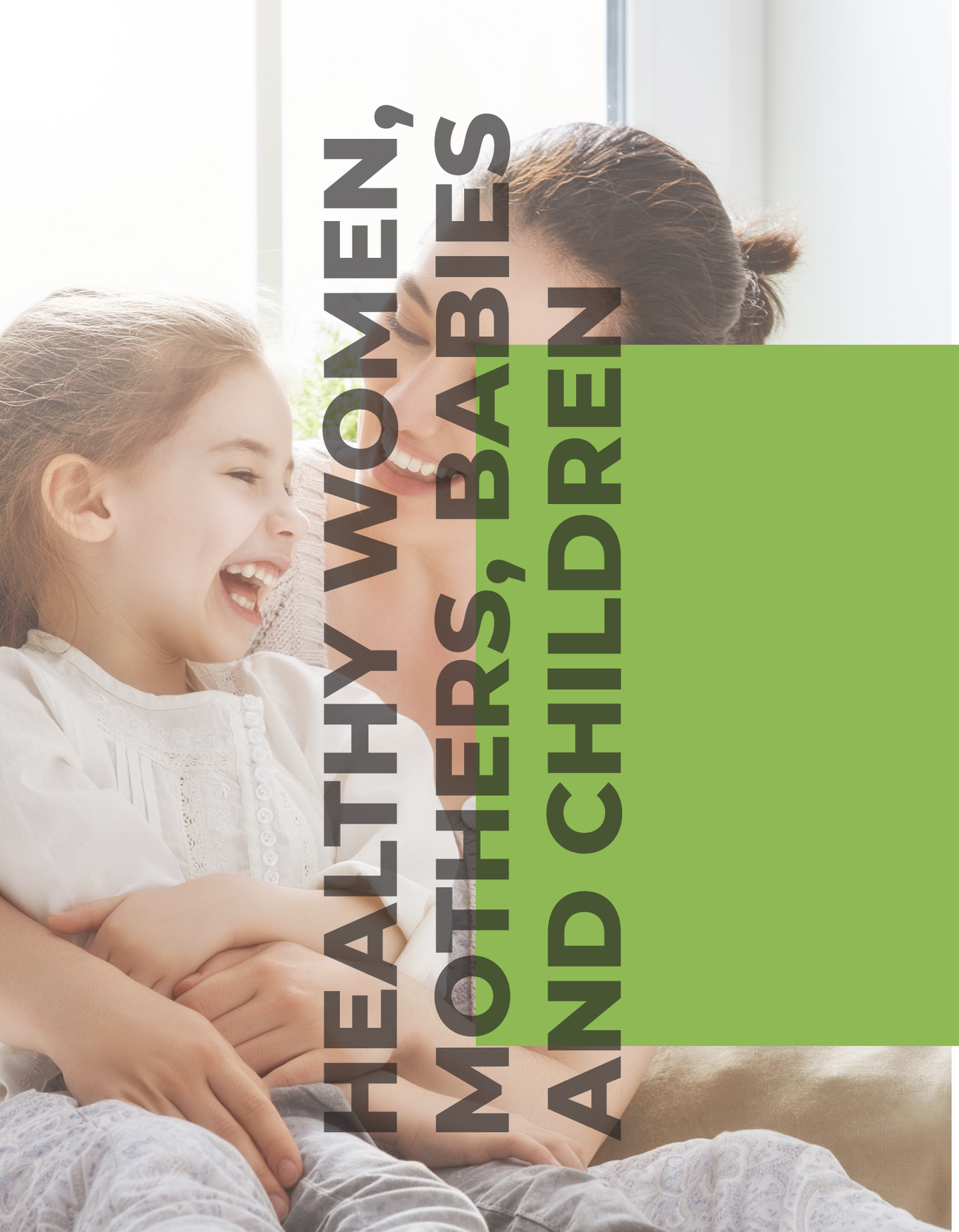
They identified the following facing those who are homeless:

- Nutrition
- Education
- Cost
- Transportation
- Feeling judged
- Lack of insurance
- Access to food and shelter
- Substance use and abuse
- Difficulty navigating services due to lack of resources
- Criminal history limiting ability to obtain employment and housing

Intercept survey respondents talked about the following needs:

- Senior housing
- Education
- Decent living conditions
- Better paying jobs/not enough jobs
- Violence/Shootings

One stakeholder talked about generational poverty and the need for trauma informed care. Those struggling with poverty have the stress of not knowing if they are going to be evicted or where their next meal is coming from. Another talked about the bed bug problem that occurs twice a year and the related health concerns. Another talked about social isolation noting a lot of people do not have any support system.



HEALTHY WOMEN, MOTHERS, BABIES AND CHILDREN

HEALTHY WOMEN, MOTHERS, BABIES & 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.

WHERE THERE ARE OPPORTUNITIES

Assistance

The percentage of mothers receiving Medicaid Assistance has increased from 2011 (25.8%) to 2016 (28.5%, although remains significantly lower when compared to the state (32.9%).

Breastfeeding

Although the percentage of mothers breastfeeding has increased from 70.1% in 2011 to 79.9% in 2016 it was significantly lower when compared to the state (81.1% in 2016) during that time.

Teen Pregnancy

Live birth outcomes for teens age 15-17 decreased from 2011 (56.9%) to 2016 (52.7%) and was significantly lower compared to the state (67.4% in 2016) during that timeframe. Although increasing live birth outcomes for those age 18-19 were also significantly lower when compared to the state for 2011 through 2016.

WHERE WE ARE MAKING A DIFFERENCE

Prenatal Care

The percentage of women receiving prenatal care during the first trimester has remained steady in Allegheny County and has been significantly higher when compared to the state from 2011 to 2016. In 2016 (87.6%) the percentage was significantly higher when compared to the state (73.8%) and exceeds the Healthy People 2020 Goal (77.9%).

Smoking

The percentage of mothers who report not smoking during pregnancy has increased from 2011 (85.1%) to 2016 (90.0%). The percentage in Allegheny County has been significantly higher when compared to the state for years 2012 through 2016 (88.5%) but falls below the Healthy People 2020 Goal (98.6%).

The percentage of nonsmoking mothers three months prior to pregnancy in Allegheny County has been increasing since 2011 (82.5%) to 2016 (87.5%) and has been significantly higher each year when compared to the state (84.3% in 2016).

Assistance

The percentage of mothers reporting WIC assistance in Allegheny County has decreased form 30.8% in 2011 to 25.0% in 2016 and has been significantly lower when compared to the state (35.0% in 2016) for that time period.

Teen Pregnancy

The teen pregnancy rate per 1,000 for those ages 15-17 has decreased from 19.1 in 2011 to 9.1 in 2016 which was significantly lower when compared to the state (10.6) and is below the Healthy People 2020 Goal (36.2). The teen pregnancy rate for those age 18-19 has decreased since 2011 (51.4) and 2016 (34.4) and was significantly lower when compared to the state for that timeframe. In 2016 the rate was also lower when compared to the nation (38.1) and the Healthy People 2020 Goal (104.6).

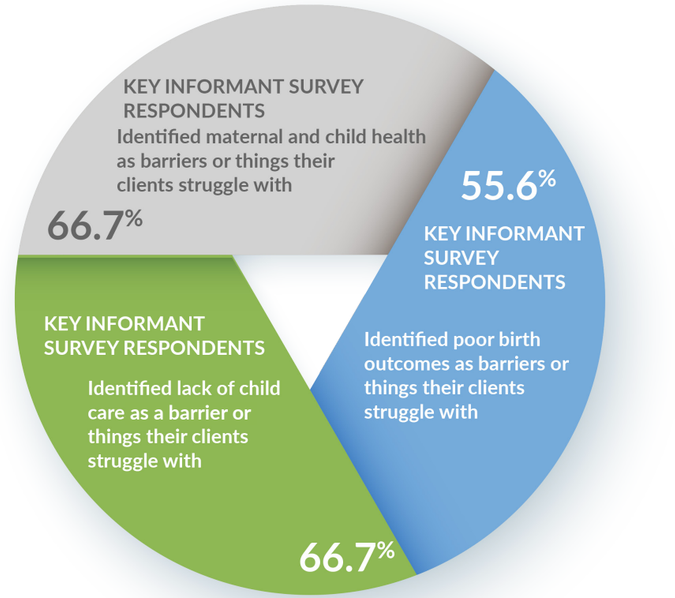
Childhood Obesity

The percentage of students in grades K-6 considered overweight has decreased from 17.4% in 2011 to 14.4% in 2016, which was comparable to the state (15.2%). Those students grades K-6 considered obese was lower in Allegheny County (13.7% when compared to the state (16.7%), as were students in grades 7-12 (16.3% county vs. 19.1% state).

WHAT THE COMMUNITY IS SAYING

As shown in Figure 15, two-thirds of Key Informant Survey respondents identified maternal and child health as barriers or things their clients struggle with (66.7%) and identified lack of childcare (66.7%) as a barrier or things their clients struggle with. Over half of respondents (55.6%) identified poor birth outcomes as barriers or things their clients struggle with.

Figure 15
What Key Informant Survey Respondents are Saying – Healthy Women, Mothers, Babies and Children



Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc.

Key Informant Survey respondents identified the following as barriers or things children struggle with:

- Parental leadership
- Poor parenting examples
- Lack of parks
- Access to education on health and wellness and programs encouraging it
- Access to healthcare

They identified the following for pregnant women:

- Lack of ability to receive proper care and information

Over one third (37.5%) of Key Informant Survey respondents identified children as an underserved population.

One stakeholder talked about the number of children with allergies noting that parents often do not know what symptoms to look for. Another stakeholder talked about childhood obesity noting that students are not active outside of school, spending free time on video games. They noted that the foods students are consuming do not have much nutritional value. There has been an increase in the number of children who are overweight.

This topic area was not addressed by Intercept Survey respondents.

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).

WHERE THERE ARE OPPORTUNITIES

The Chlamydia rate per 100,000 in Allegheny County has been increasing since 2011 (489.0) to 2016 (491.3) during which time the rate has been significantly higher when compared to the state (445.4 in 2016). The rate in 2016 was just below the nation (497.3).

The Gonorrhea rate per 100,000 in the county has increased from 157.4 in 2011 to 164.7 in 2016. The rate has been significantly higher when compared to the state (114.3 in 2016) and in 2016 higher when compared to the nation (145.8).

WHERE WE ARE MAKING A DIFFERENCE

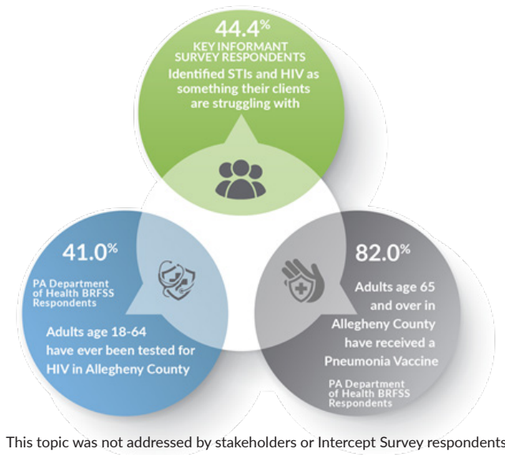
In Allegheny County the Influenza and Pneumonia rate per 100,000 decreased from 2011 (19.6) to 2016 (13.6) and is comparable to the state (13.7) and nation (13.5). The percentage of adults age 65 and older has been increasing since 2011-2013 (79.0%) to 2015-2017 (82.0%) during which time it was significantly higher when compared to the state. The percentage in the county in 2016 was higher than the state (74.0%) and nation (73.4) but below the Healthy People 2020 Goal (90.0%).

The percentage of adults age 18-64 ever tested for HIV has increased in the county from 37.0% in 2011-2013 to 41.0% in 2015-2017 and is comparable to the state (41.0%).

WHAT THE COMMUNITY IS SAYING

As shown in Figure 16, four out of ten Key Informant Survey respondents identified STIs and HIV as something their clients are struggling with. As reported on the 2015-2017 PA Department of Health BRFSS, 82.0% of adults age 65 and over in Allegheny County have received a pneumonia vaccine and 41.0% of adults age 18-64 have ever been tested for HIV.

Figure 16 What the Community is Saying – Infectious Disease



This topic was not addressed by stakeholders or Intercept Survey respondents.

Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc., 2015-2017 PA Department of Health, BRFSS

INJURY

The topic of injury relates to any intentional or unintentional injuries that can be suffered by individuals.

WHERE THERE ARE OPPORTUNITIES

In Allegheny County the Fall Mortality rate per 100,000 has been significantly higher when compared to the state for years 2011 through 2016 (11.2 county, 8.8 state) and is above the Healthy People 2020 Goal (7.2). The rate (12.2) was higher when compared to the nation (10.4) in 2015.

The Firearm Mortality rate per 100,000 has fluctuated in the county and in 2016 (13.0) is comparable to the state (11.9) but above the Healthy People 2020 Goal (9.3). Compared to the nation (11.3) in 2015 the county rate was higher (14.0).

WHERE WE ARE MAKING A DIFFERENCE

The Auto Accident Mortality rate per 100,000 in Allegheny County has remained steady and was significantly lower when compared to the state for years 2011 through 2016 (6.2 county, 9.4 state). When compared to the nation (11.7) in 2015 the county rate was lower (5.9). The county also exceeds the Healthy People 2020 Goal (12.4). and Healthy People 2020 Goal (32.6%).

WHAT THE COMMUNITY IS SAYING

Figure 17 shows that less than one-fourth of the Key Informant Survey respondents (22.2%) indicated that their clients struggle with injury prevention or falls. As reported by the PA Department of Health in 2016, the fall mortality rate in Allegheny County was 11.2, significantly higher than the state rate of 8.8. The Suicide Mortality rate was 14.0, comparable to the state (14.6).

Figure 17 What the Community is Saying – Injury

This topic was not addressed by stakeholders or Intercept Survey respondents.

Source: 2019 OVH Key Informant Survey, Strategy Solutions, Inc., 2015-2017 PA Department of Health, BRFSS

PRIORITIZATION

On March 25, 2019, the OVH Steering Committee met to review the secondary data collected through the needs assessment process and discussed needs and issues present in the hospital's service territory. The team from SSI, including Kathy Roach, Community Health Improvement Project Manager, 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, including other stakeholders to receive input from. After additional key informant surveys, intercept surveys and stakeholder interviews were conducted through the month of April, a total of 42 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. Table 10 identified the selection criteria.

Table 10
Prioritization Criteria

		Scoring		
Item	Definition	Low (1)	Medium (5)	High (10)
Accountable Organization	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 an 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

Accountable Organization: The purpose of the first criterion is to get your input regarding whether the "hospital/health system" is the accountable entity to address the selected issue or if the accountable entity should be "another community partner or other entity." If you think that the hospital/health system should take a leadership role on this issue, you want to choose (10) or one of the buttons on the right side of the scale. If you think that a community partner or other entity should take a leadership role on this issue, choose (1) or one of the buttons on the left side of the scale. If you think that this is not an issue that should be addressed through this initiative, please choose (5) or one of the buttons toward the middle of the scale.

Magnitude of the Problem: The purpose of this second criterion is to get your input regarding the "magnitude of the problem." If this is something that affects a large number of people or puts the community at risk for an epidemic, please vote this high (10) or one of the buttons toward the right side of the page. If this is something that affects a low number of people, please vote this low (1).

Impact on Other Health Outcomes: The purpose of this third criterion is to get your input regarding the "impact" on health outcomes or other conditions. If this is something that has a large impact on health outcomes or other conditions, please vote this high (10) or one of the buttons toward the right side of the page. If this is something that has little impact on health outcomes or other conditions, please vote this low (1).

Capacity: (systems and resources) to Implement Evidence Based Solutions: The purpose of this fourth criterion is to get your input regarding the "capacity" of the health system/community to address this issue and implement evidence based solutions. Evidence based solutions are programs that are "proven" to achieve a positive outcome when implemented. If there is solid capacity in place to address this issue, please vote this high (10) or one of the buttons toward the right side of the page. If this is something that has little current capacity to address the issue or implement solutions, please vote this low (1).

For the two weeks ending May 10th, Steering Committee members from the hospital and community completed the prioritization exercise using the Survey Monkey Internet survey tool to rate each of the needs and issues on a one to ten scale by each of the selected criteria. Six Steering Committee members 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.

Starting from a similar strong commitment to the community and having adjacent service areas, the newly affiliated organizations will each work on community health priorities with partner organizations in a complementary and synergistic way, by building on the strengths and resources of each community. The areas of focus over the next three years include Access to Quality Health Services, Chronic Disease, and Mental Health.

Table 11
Prioritization Results

	Accountability (A)	Magnitude (M)	Impact (I)	Capacity (C)	Total A+M+I+C	Ranking
Chronic Disease: Diabetes	8.0	7.7	7.7	7.7	31.0	1

	Accountability (A)	Magnitude (M)	Impact (I)	Capacity (C)	Total A+M+I+C	Ranking
Chronic Disease: Cardiovascular Disease (Heart Disease, Cholesterol, etc.)/Stroke	7.8	7.0	7.7	7.3	29.8	2
Chronic Disease: COPD/Chronic Bronchitis	7.5	7.3	7.7	7.0	29.5	3
Mental Health: Mental Health Issues/Treatment (i.e., depression, bi-polar, etc.)	8.3	5.7	7.0	7.7	28.6	4
Chronic Disease: Obesity/Overweight	7.3	7.7	7.3	5.7	27.9	5
Chronic Disease: Health Screenings (including mammogram screenings)	8.3	5.7	6.3	7.3	27.6	6
Access to Quality Health Services: Specialty Medical Care	7.3	7.0	7.3	5.7	27.3	7
Mental Health: Face-to-Face Mental Health Services	6.8	6.3	6.3	7.7	27.1	8
Access to Quality Health Services: Mammogram Screenings	8.3	4.7	6.0	7.7	26.6	9
Access to Quality Health Services: Transportation to/from Medical Services/Cost	5.8	6.7	7.0	7.0	26.4	10
Mental Health: Lack of Mental Health Providers (long wait times to get appointment)	6.5	6.3	6.3	6.3	25.5	11
Access to Quality Health Services: Affordability of Health Care Premiums/Copays/Deductibles/Cost/Meds	3.8	8.3	8.0	5.3	25.4	12
Physical Activity/Nutrition: Food Insecurity/Access/Affordability/Nutritional Food Options	5.5	6.3	7.3	5.7	24.8	13
Access to Quality Health Services: Communication/Education on Available Services in the Area/Navigating System	5.5	5.0	6.3	6.7	23.5	14
Substance Use Disorder: Lack of Treatment Services	4.5	7.0	7.3	4.7	23.5	15
Mental Health: Support System when Returning to Community	6.0	5.7	6.0	5.7	23.3	16
Substance Use Disorder: Drug Addiction/Overdose/Opioid Epidemic	4.5	7.3	6.7	4.7	23.2	17
Chronic Disease: Cancer	5.8	4.7	7.7	4.7	22.8	18
Mental Health: Stigma	5.8	6.0	5.3	5.7	22.8	19
Access to Quality Health Services: Access to Providers and Services (evening/weekend hours)	7.0	4.3	6.3	5.0	22.7	20

	Accountability (A)	Magnitude (M)	Impact (I)	Capacity (C)	Total A+M+I+C	Ranking
Substance Use Disorder: Support Services When Return to Community	4.5	7.0	6.7	4.3	22.5	21
Physical Activity/Nutrition: Physical Activity Options	5.0	5.7	6.3	5.3	22.3	22
Access to Quality Health Services: Bring Programs to the Community Where People Live	5.5	4.7	5.3	6.7	22.2	23
Access to Quality Health Services: Inappropriate Use of the ER	6.8	4.7	5.7	5.0	22.1	24
Substance Use Disorder: Stigma	4.8	6.3	6.3	4.7	22.1	25
Access to Quality Health Services: Access to Health Education Programs/Education on Illnesses	6.0	4.7	5.3	5.7	21.7	26
Substance Use Disorder: Alcohol Abuse/Deaths	4.5	6.0	6.0	5.0	21.5	27
Substance Use Disorder: Don't Know What Services are Available and How to Access Services	4.5	6.3	6.0	4.7	21.5	28
Healthy Environment: Asthma	5.0	5.0	6.0	5.3	21.3	29
Access to Quality Health Services: Elder Care Services	4.5	4.7	5.7	5.0	19.8	30
Tobacco Use: Vaping/E-Cigarettes	4.3	5.3	6.3	3.7	19.6	31
Tobacco Use: Smoking	4.3	4.7	6.7	3.7	19.3	32
Injury: Older Adult Safety/Mobility	4.3	4.7	6.0	4.0	18.9	33
Injury: Falls	4.3	4.3	6.3	4.0	18.9	34
Healthy Environment: Allergies	4.3	4.7	5.7	4.0	18.6	35
Access to Quality Health Services: Language Barriers/Cultural Competency/Health Literacy	4.5	3.7	5.7	4.7	18.5	36
Access to Quality Health Services: Dental Hygiene/Dental Problems	2.8	6.0	6.0	3.3	18.1	37
Access to Quality Health Services: Poverty (trauma experiences/lack of job opportunities)	3.0	5.0	6.7	3.0	17.7	38
Healthy Environment: Social Isolation	4.3	5.0	5.3	3.0	17.6	39
Healthy Environment: Human Trafficking	3.5	5.0	5.0	3.3	16.8	40
Access to Quality Health Services: Housing/Homelessness (security/affordability/senior housing)	3.0	4.3	5.0	3.0	15.3	41
Infectious Disease: Sexually Transmitted Diseases	3.3	3.3	4.7	3.0	14.3	42

Source: 2019 OVH Prioritization Results, Strategy Solutions, Inc.

Much of the above significant needs will be addressed in OVH's Implementation Strategy, which will be published under a separate cover and accessible to the public. The four (4) areas with a few sub areas that OVH will be focusing on over the next three years through the Implementation Strategy Action Plan are:

- Chronic Disease
    - Diabetes
    - Cardiovascular Disease
    - Respiratory Disease
- Mental Health
    - Substance Abuse Disorder
- Access to Quality Health Care
- Overweight/Obesity

REVIEW AND APPROVAL

The 2019 CHNA was presented and approved by the OVH Board of Directors on June 18, 2019 and the Heritage Valley Health System Board of Directors on June 27, 2019. The OVH 2019 CHNA is posted on the OVH website (www.ohiovalleyhospital.org). Printed copies are available by contacting: Megan Hinds, Director of Marketing and Communications by calling 412-777-6365 or emailing meaton@ohiovalleyhospital.org.

APPENDIX A EXECUTIVE SUMMARY INDICATORS

Ohio Valley HOSPITAL part of Heritage Valley Health System Community Health Needs Assessment 2019 83

TABLE 12: PENNSYLVANIA DEPARTMENT OF HEALTH BEHAVIORAL RISK FACTORS SURVEILLANCE SYSTEM (1 OF 2)

	ALLEGHENY COUNTY					Trend	PA	US	HP 2020	PA	US	HP 2020
PA BEHAVIORAL RISK FACTORS SURVEILLANCE SYSTE	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	+/-/=	Comp	Comp	Comp	2015-2017	2016	Goal
ACCESS												
Reported Health Poor or Fair	15.0%	15.0%	16.0%	16.0%	**15.0%**	=	-	-		17.0%	16.7%	
Physical Health Not Good for 1+ Days in the Past Month	39.0%	38.0%	39.0%	38.0%	38.0%	-	-			39.0%		
Poor Physical or Mental Health Preventing Usual Activities in the Past Month	23.0%	22.0%	23.0%	23.0%	23.0%	=	-			24.0%		
No Health Insurance (ages 18-64)	**12.0%**	12.0%	10.0%	9.0%	7.0%	-	-	-	+	9.0%	11.9%	0%
No Personal Health Care Provider	16.0%	**17.0%**	16.0%	16.0%	15.0%	-	+	-	-	14.0%	21.8%	16.1%
Routine Check-up Within the Past 2 Years	84.0%	85.0%	86.0%	87.0%	87.0%	+	+	+		85.0%	83.6%	
Needed to See a Doctor But Could Not Due to Cost, Past Year	11.0%	11.0%	10.0%	10.0%	9.0%	-	-	-	+	11.0%	12.1%	4.2%
CHRONIC DISEASE												
Ever Told They Have Heart Disease- Age 35 and older	6.0%	6.0%	7.0%	7.0%	6.0%	=	-	+		7.0%	4.1%	
Ever Told They Had a Heart Attack- Age 35 and Older	5.0%	6.0%	7.0%	7.0%	6.0%	+	-	+		7.0%	4.4%	
Ever Told They Had a Stroke- Age 35 and older	4.0%	5.0%	5.0%	5.0%	4.0%	=	-	+		5.0%	3.0%	
Ever Told They Had a Heart Attack, Heart Disease, or a Stroke-Age 35 and Older	12.0%	13.0%	13.0%	14.0%	12.0%	=	-			13.0%		
Ever Told They Had Kidney Disease, Not Including Kidney Stones, Bladder Infection or Incontinence	2.0%	2.0%	2.0%	2.0%	2.0%	=	-	-		3.0%	2.8%	
Overweight (BMI 25+)	62.0%	63.0%	65.0%	65.0%	64.0%	+	-	-		66.0%	65.4%	
Obese (BMI 30+)	**26.0%**	**26.0%**	29.0%	30.0%	29.0%	+	-	-	-	31.0%	30.1%	30.5%
Adults Who Were Ever Told They Have Diabetes	9.0%	10.0%	10.0%	10.0%	9.0%	=	-	-		11.0%	10.5%	
HEALTHY ENVIRONMENT												
Adults Who Have Ever Been Told They Have Asthma	13.0%	13.0%	14.0%	14.0%	12.0%	-	-	-		15.0%	14.0%	
Adults Who Currently Have Asthma	9.0%	9.0%	9.0%	9.0%	9.0%	=	-	-		10.0%	9.1%	
Source: Pennsylvania Department of Health Behavior Risk Factor Surveillance System												

ND = Not Displayed. Age-adjusted rates will not be shown for counts < 20 due to unreliability of such calculations based on small numbers. For similar reasons all other rates, ratios, or percentages will not be shown for counts < 10. If the population is less than 300 then the frequency count and rate will be suppressed.

Note: A rate, ratio or percentage that appears in **red** for a county denotes a significantly higher value compared to Pennsylvania. A **blue** rate, ratio or percentage denotes a significantly lower value.

Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions."

US BRFSS data comes from the BRFSS Surveillance System CDC website in the prevalence and rends data tool (search was done for location all states, DC and Territories:

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TABLE 13: PENNSYLVANIA DEPARTMENT OF HEALTH BEHAVIORAL RISK FACTORS SURVEILLANCE SYSTEM (2 OF 2)

	ALLEGHENY COUNTY					Trend	PA	US	HP 2020	PA	US	HP 2020
PA BEHAVIORAL RISK FACTORS SURVEILLANCE SURVEY	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	+/-/=	Comp	Comp	Comp	2015-2017	2016	Goal
INFECTIOUS DISEASE												
Adults Who Had a Pneumonia Vaccine, Age 65 and older	**79.0%**	**78.0%**	**77.0%**	**79.0%**	**82.0%**	+	+	+	-	74.0%	73.4%	90.0%
Ever Tested for HIV, Ages 18-64	37.0%	38.0%	39.0%	39.0%	41.0%	+	=			41.0%		
MENTAL HEALTH AND SUBSTANCE ABUSE												
Mental Health Not Good 1+ Days in the Past Month	36.0%	36.0%	37.0%	39.0%	39.0%	+	+			38.0%		
Adults Who Reported Being Binge Drinkers (5 drinks for men, 4 for women)	**20.0%**	**20.0%**	**21.0%**	**22.0%**	**23.0%**	+	+	+	-	18.0%	16.9%	24.2%
At Risk for Heavy Drinking (2 drinks for men, 1 for women daily)	**8.0%**	7.0%	7.0%	7.0%	7.0%	-	+	+		6.0%	6.5%	
Reported Chronic Drinking (2 or more drinks daily for the past 30 days)	7.0%	6.0%	6.0%	6.0%	6.0%	-	=			6.0%		
Adults age 18-44 who Reported Being Binge Drinkers (5 drinks for men, 4 for women)	**32.0%**	**32.0%**	**32.0%**	**32.0%**	**33.0%**	+	+			27.0%		
At Risk for Heavy Drinking, ages 18-44 (2 drinks for men, 1 for women daily)	**12.0%**	10.0%	9.0%	9.0%	9.0%	-	+			7.0%		
Reported Chronic Drinking, ages 18-44 (2 or more drinks daily for the past 30 days)	9.0%	8.0%	7.0%	6.0%	6.0%	-	=			6.0%		
PHYSICAL ACTIVITY AND NUTRITION												
No Leisure Time/Physical Activity in the Past Month			24.0%	23.0%	22.0%	-	-		-	25.0%		32.6%
No Leisure Time/Physical Activity in the Past Month: Education Level College			11.0%	10.0%	11.0%	=	-			13.0%		
TOBACCO USE												
Adults Who Reported Never Being a Smoker	52.0%	53.0%	55.0%	56.0%	56.0%	+	+	-		55.0%	57.2%	
Adults Who Reported Being a Former Smoker	25.0%	26.0%	26.0%	25.0%	25.0%	=	-	+		26.0%	24.9%	
Adults Who Reported Being a Former Smoker (Female)	23.0%	23.0%	23.0%	23.0%	23.0%	=	=			23.0%		
Adults Who Reported Being A Former Smoker (Male)	28.0%	28.0%	29.0%	28.0%	28.0%	=	-			30.0%		
Currently using Chewing Tobacco, Snuff, or Snus, Somewhat or Everyday	3.0%	3.0%	3.0%	3.0%	3.0%	=	-	-	+	4.0%	3.9%	0.2%
Adults Who Have Quit Smoking at Least 1 Day in the Past Year (daily)	53.0%	56.0%	56.0%	54.0%	46.0%	-	-			51.0%		80.0%
Adults Who Reported Being a Current Smoker	22.0%	21.0%	20.0%	19.0%	19.0%	-	+	+		18.0%	17.0%	12.0%
Adults Who Reported Being An Everyday Smoker	17.0%	16.0%	15.0%	13.0%	13.0%	-	=	+		13.0%	12.3%	
Source: Pennsylvania Department of Health Behavior Risk Factor Surveillance System												

ND = Not Displayed. Age-adjusted rates will not be shown for counts < 20 due to unreliability of such calculations based on small numbers. For similar reasons all other rates, ratios, or percentages will not be shown for counts < 10. If the population is less than 300 then the frequency count and rate will be suppressed.

Note: A rate, ratio or percentage that appears in **red** for a county denotes a significantly higher value compared to Pennsylvania. A **blue** rate, ratio or percentage denotes a significantly lower value.

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TABLE 14: PENNSYLVANIA DEPARTMENT OF HEALTH PUBLIC HEALTH DATA (1 OF 2)

	ALLEGHENY COUNTY						Trend	PA	US	HP Goal	PA (the last year)	US	HP 2020
PUBLIC HEALTH DATA	2011	2012	2013	2014	2015	2016	+/-/=	Comp	Comp	Comp	Rate	Rate	Goal
CHRONIC DISEASE													
Breast Cancer Rate per 100,000	132.2	141.3	132.5	139.9	145.9		+	+	+		131.2	123.9	
Late Stage Breast Cancer Rate per 100,000	45.8	45.7	45.0	44.1	45.6		-	+		+	44.5		42.2
Breast Cancer Mortality Rate per 100,000	23.7	21.1	24.3	19.2	21.7	24.1	+	+	-	+	21.4	20.5	20.7
Bronchus and Lung Cancer Rate per 100,000	75.5	67.6	67.4	71.9	67.8		-	+	+		63.2	50.8	
Bronchus and Lung Cancer Mortality Rate per 100,000	52.4	52.3	46.6	45.8	44.8	39.8	-	-	+	-	40.9	34.7	45.5
Colorectal Cancer Rate per 100,000	42.6	40.0	42.5	40.1	37.6		-	-	+	-	41.9	33.7	39.9
Colorectal Cancer Mortality Rate per 100,000	15.8	14.9	13.4	16.1	15.3	14.8	-	+	+	+	14.7	11.9	14.5
Leukemia Rate per 100,000	15.7	14.9	15.6	16.0	15.2		-	+			14.4		
Leukemia Mortality Rate per 100,000	8.0	7.2	6.5	6.9	6.1	6.9	-	+			6.4		
Liver and Intrahepatic Bile Duct Cancer Rate per 100,000	8.3	7.1	8.5	7.9	11.1		+	+			8.8		
Liver and Intrahepatic Bile Duct Cancer Mortality Rate per 100,000	6.2	6.5	5.3	7.3	7.3	7.2	+	+			6.5		
Oral Cavity and Pharynx Cancer Rate per 100,000	12.8	11.8	10.8	11.9	11.4		-	-			11.6		
Oral Cavity and Pharynx Cancer Mortality Rate per 100,000	1.7	1.7	1.6	2.2	2.3	1.9	+	-			2.3		
Ovarian Cancer Rate per 100,000	10.6	11.8	11.9	12.3	9.3		-	-	+		11.6	11.0	
Ovarian Cancer Mortality Rate per 100,000	7.7	8.9	7.8	7.5	6.3	7.4	-	+	+		6.8	7.0	
Prostate Cancer Rate per 100,000	119.9	112.1	99.6	90.9	91.1		-	-	-		104.4	95.5	
Prostate Cancer Mortality Rate per 100,000	18.6	22.1	19.7	19.5	15.6	20.7	+	+	+	-	19.2	19.1	21.8
Thyroid Cancer Rate per 100,000	26.8	24.3	26.5	23.8	19.8		-	+			19.3		
Thyroid Cancer Mortality Rate per 100,000	ND	ND	0.8	ND	ND	ND					0.5		
Heart Disease Mortality Rate per 100,000	193.5	180.1	185.9	186.0	188.7	183.0	-	+	-		175.8	218.0	
Heart Failure Mortality Rate per 100,000	17.7	17.7	20.4	20.0	23.1	22.8	+	-	-		23.9	25.4	
Coronary Heart Disease Mortality Rate per 100,000	139.2	129.3	128.7	128.3	125.1	120.7	-	+	-	+	107.6	126.2	103.4
Cardiovascular Mortality Rate per 100,000	246.2	225.6	234.4	232.7	236.4	233.0	-	+	-		225.8	285.6	
Cerebrovascular Mortality Rate per 100,000	38.2	34.3	37.1	34.7	34.2	36.0	-	-	-	+	36.8	47.8	34.8
Diabetes Mortality Rate per 100,000	16.8	20.6	20.1	16.8	19.9	20.1	+	-	-		20.2	21.0	
Type I Diabetes, Students (School Year End)	0.34%	0.36%	0.36%	0.35%	0.36%	0.35%	+	+			0.33%		
Type II Diabetes, Students (School Year End)	0.08%	0.07%	*	0.06%	0.05%	0.06%	-	=			0.06%		
Lyme Disease Rate per 100,000	ND	0.8	2.6	66.8	22.6	32.9	+	-			89.5		
Alzheimer's Disease Mortality Rate per 100,000	20.0	18.5	16.6	21.0	24.2	23.1	+	+	-		21.6	25.4	
HEALTHY ENVIRONMENT													
Student Health Asthma (School Year End)	11.8%	12.4%	12.0%	11.4%	12.3%	11.5%	-	-			12.1%		
Number of Days Ozone Levels Over National Ambient Air Quality Standard	20.0	32.0	7.0	5.0	9.0	7.0	-						

Source: Pennsylvania Department of Health

* The Diabetes data provided by the EDDIE database did not have anything for Student's with Type II diabetes listed for the school year 12-13

2016-year for those rates | 2015-year for those rates | 2014-year for these rates

website source for US cancer data:https://gis.cdc.gov/grasp/USCS/DataViz.html

website source for US heart disease, stroke (change to filter by all indicators and select bar graph to get US rates too):
https://nccd.cdc.gov/DHDSP_DTM/rdPage.aspx?rdReport=DHDSP_DTM.ExploreByTopic&filter=area&islPriority=P3&islTopic=T4&islFilterby=1&go=GO

US Alzheimer's Disease rate for year 2014: https://www.cdc.gov/media/releases/2017/p0525-alzheimer-deaths.html

https://www.kff.org/other/state-indicator/diabetes-death-rate-per-100000/?currentTimeframe=0&sortModel=%7B"colId":"Location","sort":"asc"%7D

TABLE 15: PENNSYLVANIA DEPARTMENT OF HEALTH PUBLIC HEALTH DATA (2 OF 2)

	ALLEGHENY COUNTY						Trend	PA	US	HP Goal	PA (the last year)	US	HP 2020
PUBLIC HEALTH DATA	2011	2012	2013	2014	2015	2016	+/-/=	Comp	Comp	Comp	Rate	Rate	Goal
HEALTHY MOTHERS, BABIES AND CHILDREN													
Prenatal Care First Trimester	89.2%	89.1%	88.9%	88.7%	86.3%	87.6%	-	+		+	73.8%		77.9%
No Prenatal Care	1.0%	0.5%	0.4%	0.5%	0.4%	0.4%	-	-			1.6%		
Non-Smoking Mother During Pregnancy	85.1%	86.8%	87.3%	88.0%	89.4%	90.0%	+	+		-	88.5%		98.6%
Non-Smoking Mother 3 Months Prior to Pregnancy	82.5%	84.5%	85.1%	85.6%	87.2%	87.5%	+	+			84.3%		
Low Birth-Weight Babies Born	7.7%	7.6%	7.5%	7.7%	7.5%	8.5%	+	+		+	8.2%		7.8%
Mothers Reporting WIC Assistance	30.8%	28.4%	27.7%	26.7%	25.6%	25.0%	-	-			35.0%		
Mothers Reporting Medicaid Assistance	25.8%	30.0%	29.0%	28.4%	27.7%	28.5%	+	-			32.9%		
Breastfeeding	70.1%	72.0%	74.4%	77.2%	78.1%	79.9%	+	-		-	81.1%		81.9%
Teen Pregnancy Rate per 1,000 Ages 15-17	19.1	17.4	13.1	12.5	12.5	9.1	-	-		-	10.6		36.2
Teen Pregnancy Rate per 1,000 Ages 18-19	51.4	47.1	41.9	37.0	31.6	34.4	-	-		-	38.1		104.6
Teen Live Birth Outcomes, Ages 15-17	56.9%	55.2%	59.5%	57.8%	55.5%	52.7%	-	-			67.4%		
Teen Live Birth Outcomes, Ages 18-19	58.3%	61.8%	62.3%	60.7%	61.2%	61.9%	+	-			71.8%		
Infant Mortality	6.1	5.9	6.6	5.6	6.2	5.9	-	-	=	-	6.1	5.9	6.0
Overweight BMI, Grades K-6 (School Year End)	17.4%	16.8%	16.6%	15.1%	14.6%	14.4%	-	-			15.2%		
Obese BMI, Grades K-6 (School Year End)	15.4%	14.9%	15.3%	14.4%	14.1%	13.7%	-	-		-	16.7%		15.7%
Overweight BMI, Grades 7-12 (School Year End)	17.1%	18.9%	19.8%	15.5%	15.8%	15.7%	-	-			16.5%		
Obese BMI, Grades 7-12 (School Year End)	15.9%	16.1%	17.0%	15.9%	15.4%	16.3%	+	-		+	19.1%		16.1%
INFECTIOUS DISEASE													
Influenza and Pneumonia Mortality Rate per 100,000	19.6	15.1	17.8	16.0	17.2	13.6	-	-	+		13.7	13.5	
Chlamydia Rate per 100,000	489.0	524.2	494.9	463.8	475.8	491.3	+	+	-		445.4	497.3	
Gonorrhea Rate per 100,000	157.4	194.6	176.2	169.3	158.2	164.7	+	+	+		114.3	145.8	
MENTAL HEALTH AND SUBSTANCE ABUSE													
Drug-Induced Mortality Rate per 100,000	20.5	22.7	21.9	25.8	33.9	51.7	+	+		+	38.5		11.3
Mental & Behavioral Disorders Mortality Rate per 100,000	42.0	46.5	45.7	43.1	43.3	41.3	-	-	-		42.7	48.0	
Alcohol Liver Disease Mortality Rate per 100,000	3.3	3.1	4.2	5.0	3.9	4.3	+	+			3.4		
INJURY													
Auto Accident Mortality Rate per 100,000	5.5	5.7	6.4	6.3	5.9	6.2	+	-	-	-	9.4	11.7	12.4
Suicide Mortality per 100,000	10.8	11.7	12.9	11.4	12.9	14.0	+	-	-	+	14.6	13.7	10.2
Fall Mortality Rate per 100,000	11.8	11.5	13.1	11.2	12.2	11.2	-	+	+	+	8.8	10.4	7.2
Firearm Mortality Rate (Accidental, Suicide, Homicide)	11.7	12.6	13.1	12.4	14.0	13.0	+	+	+	+	11.9	11.3	9.3

Source: Pennsylvania Department of Health

* The Diabetes data provided by the EDDIE database did not have anything for Student's with Type II diabetes listed for the school year 12-13

2016-year for those rates	2015-year for those rates	2014-year for these rates
US Influenza/Pneumonia mortality: https://www.cdc.gov/nchs/pressroom/sosmap/flu_pneumonia_mortality/flu_pneumonia.htm		US suicide mortality rates: https://www.cdc.gov/nchs/fastats/suicide.htm
US Chlamydia rates: https://www.cdc.gov/std/stats16/chlamydia.htm		US fall mortality rates: https://www.cdc.gov/nchs/fastats/accidental-injury.htm
US Gonorrhea rates: https://www.cdc.gov/std/stats16/gonorrhea.htm		US Firearm mortality: https://www.cdc.gov/nchs/fastats/injury.htm
US mental and behavioral disorders mortality rate: https://www.healthsystemtracker.org/chart/u-s-relatively-high-mortality-rate-mental-behavioral-disorders/		US Infant mortality: https://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm
US auto accident mortality rates: https://www.cdc.gov/nchs/fastats/accidental-injury.htm		

TABLE 16: COUNTY HEALTH RANKINGS FOR ALLEGHENY COUNTY

COUNTY HEALTH RANKINGS	ALLEGHENY COUNTY								Trend	PA	US	HP Goal	PA (the last year)	2016 US	HP 2020
Other Indicators	2011	2012	2013	2014	2015	2016	2017	2018	+/-/=	Comp	Comp	Comp	Rate	Rate	Goal
Access															
Mammography Screenings	56.7%	58.2%	58.0%	49.4%	50.9%	53.0%	53.9%	53.9%	-	-		-	64.8%		81.1%
HEALTHY ENVIRONMENT															
Unemployment Rates	6.9%	7.7%	7.0%	6.9%	6.5%	5.3%	4.8%	5.2%	-	-			5.4%		
High School Graduation Rates				86.3%	89.1%	89.6%	88.9%	88.9%	+	+	+		85.4%	84.0%	
Children Living in Poverty	16.7%	15.6%	19.1%	18.5%	18.5%	18.5%	16.5%	15.2%	-	-	-		18.4%	41.0%	
Children Living in Single Parent Homes	32.8%	32.8%	33.7%	33.2%	33.3%	32.9%	33.2%	32.2%	-	-	-		33.8%	35.0%	
Disconnected Youth							10.3%	10.3%	=	-			12.8%	11.7%	
Frequent Physical Distress						10.3%	10.2%	10.5%	+	-			11.9%		
PHYSICAL ACTIVITY AND NUTRITION															
Food Insecurity				13.6%	14.0%	14.4%	14.2%	14.0%	+	+	+	+	13.1%	12.5%	6.0%
Limited Acccess to Healthy Foods			6.4%	6.4%	6.4%	6.4%	6.4%	5.7%	-	+			4.6%		
Free or Reduced Lunch			31.6%	31.6%	32.5%	34.2%	41.9%	42.1%	+	-			48.2%		
Mental Health and Substance Abuse															
Frequent Mental Distress						11.4%	10.8%	11.5%	+	-			13.0%		
Mental Health Providers					433:1	411:1	390:1	363:1	-	-			559:1		
Insufficient Sleep						36.4%	36.4%	36.4%	=	-			37.9%		
Excessive Drinking	20.4%	19.5%	18.9%	19.0%	19.0%	21.1%	20.7%	24.3%	+	+			20.5%		
Alcohol Impaired Driving Deaths				27.2%	26.5%	31.1%	30.1%	27.1%	-	-	+		30.1%	28.0%	
Source: www.countyhealthrankings.org															

US graduation rate year ending 2016 taken from: https://www.edweek.org/ew/section/multimedia/data-us-graduation-rates-by-state-and.html

US child poverty rate: https://www.mailman.columbia.edu/public-health-now/news/america%E2%80%99s-child-poverty-rate-remains-stubbornly-high-despite-important-progress

US children living in single parent homes: https://datacenter.kidscount.org/data/tables/107-children-in-single-parent-families-by#detailed/1/any/false/870/10,11,9,12,1,185,13/432,431

US disconnected youth: http://www.measureofamerica.org/disconnected-youth/

US low birthweight babies: https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm

US teen birth rate 15-19: https://www.cdc.gov/teenpregnancy/about/index.htm

US food insecurity: http://www.feedingamerica.org/hunger-in-america/the-united-states/

US Alcohol Impaired Driving: https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812450

TABLE 17: PENNSYLVANIA YOUTH SURVEY (1 OF 3)

PAYS DATA	ALLEGHENY COUNTY			Trend	PA	US (MTF)	PA	US (MTF)
SUBSTANCE USE AND RELATED RISKY BEHAVIOR	2013	2015	2017	+/-/=	Comp	Comp	2017	2017
Alcohol Child/Adolescent Lifetime Use								
Grade 6	14.1%	21.1%	19.9%	+	+		16.8%	n/a
Grade 8	35.8%	29.4%	34.7%	-	+	+	33.0%	23.1%
Grade 10	65.3%	59.4%	56.4%	-	+	+	53.0%	42.2%
Grade 12	79.3%	77.6%	71.0%	-	+	+	69.2%	61.5%
Overall	48.2%	54.2%	49.0%	+	+		43.3%	n/a
Marijuana Child/Adolescent Lifetime Use								
Grade 6	1.9%	3.5%	2.6%	+	+		0.9%	n/a
Grade 8	10.5%	12.9%	14.1%	+	+	+	8.4%	13.5%
Grade 10	31.7%	30.8%	26.7%	-	+	-	22.4%	30.7%
Grade 12	50.3%	50.5%	47.1%	-	+	+	38.1%	45.0%
Overall	22.8%	30.1%	25.4%	+	+		17.7%	n/a
% of Children/Adolescents Who Drove After Drinking								
Grade 6	0.5%	0.0%	0.5%	=	+		0.4%	n/a
Grade 8	1.1%	0.9%	0.2%	-	-		1.1%	n/a
Grade 10	2.0%	1.4%	1.4%	-	+		1.3%	n/a
Grade 12	10.7%	8.0%	5.1%	-	-		5.5%	n/a
Overall	3.3%	3.2%	2.2%	-	=		2.2%	n/a
% of Children/Adolescents Who Drove After Using Marijuana								
Grade 6	0.2%	1.0%	0.8%	+	+		0.3%	n/a
Grade 8	0.8%	1.2%	0.7%	-	-		0.8%	n/a
Grade 10	3.1%	2.5%	2.2%	-	+		1.7%	n/a
Grade 12	13.5%	12.7%	13.1%	-	+		10.3%	n/a
Overall	4.1%	5.2%	5.0%	+	+		3.5%	n/a
Pain Reliever (Prescription Narcotics) Child/Adolescent Lifetime Use								
Grade 6	2.6%	2.9%	1.8%	-	=		1.8%	n/a
Grade 8	4.6%	2.7%	4.1%	-	+		3.9%	n/a
Grade 10	10.4%	8.8%	5.6%	-	-		5.9%	n/a
Grade 12	16.5%	12.0%	7.4%	-	-	+	8.8%	6.8%
Overall	8.3%	7.7%	5.1%	-	=		5.1%	n/a
Source: Pennsylvania Youth Suvey								

TABLE 17: PENNSYLVANIA YOUTH SURVEY (2 OF 3)

PAYS DATA	ALLEGHENY COUNTY			Trend	PA	US (MTF)	PA	US (MTF)
VAPING/E-CIGARETTE USE	2013	2015	2017	+/-/=	Comp	Comp	2017	2017
Vaping/e-cigarette (30-day use)								
Grade 6	n/a	3.3%	2.7%	-	+		2.3%	n/a
Grade 8	n/a	12.4%	11.1%	-	+	+	10.9%	6.6%
Grade 10	n/a	25.1%	30.4%	+	+	+	21.9%	13.1%
Grade 12	n/a	27.9%	33.7%	+	+	+	29.3%	16.6%
Overall	n/a	20.9%	22.0%	+	+		16.3%	n/a
Vaping Substances Used By Students Who Use Vaping Product in the Past Year-Just Flavoring								
Grade 6	n/a	39.3%	33.9%	-	+		29.8%	n/a
Grade 8	n/a	71.2%	64.5%	-	-		74.8%	n/a
Grade 10	n/a	80.0%	66.1%	-	-		73.9%	n/a
Grade 12	n/a	71.7%	56.9%	-	-		67.2%	n/a
Overall	n/a	73.8%	60.5%	-	-		67.3%	n/a
Vaping Substances Used By Students Who Use Vaping Product in the Past Year-Nicotine								
Grade 6	n/a	3.6%	0.0%	-	-		3.5%	n/a
Grade 8	n/a	5.8%	14.9%	+	+		14.6%	n/a
Grade 10	n/a	20.4%	42.3%	+	+		32.2%	n/a
Grade 12	n/a	26.0%	48.6%	+	+		43.1%	n/a
Overall	n/a	19.6%	39.0%	+	+		29.4%	n/a
Vaping Substances Used By Students Who Use Vaping Product in the Past Year-Marijuana or Hash Oil								
Grade 6	n/a	3.6%	1.8%	-	-		1.9%	n/a
Grade 8	n/a	4.8%	9.2%	+	+		7.2%	n/a
Grade 10	n/a	10.9%	15.2%	+	+		12.9%	n/a
Grade 12	n/a	19.0%	28.2%	+	+		18.5%	n/a
Overall	n/a	12.7%	19.0%	+	+		12.6%	n/a
Vaping Substances Used By Students Who Use Vaping Product in the Past Year-Other Substance								
Grade 6	n/a	0.0%	0.0%	=	-		1.6%	n/a
Grade 8	n/a	1.0%	2.1%	+	+		1.7%	n/a
Grade 10	n/a	2.1%	2.3%	+	+		1.3%	n/a
Grade 12	n/a	3.1%	1.2%	-	+		0.9%	n/a
Overall	n/a	2.2%	1.7%	-	+		1.3%	n/a
Vaping Substances Used By Students Who Use Vaping Product in the Past Year-I don't Know								
Grade 6	n/a	57.1%	64.3%	+	-		68.0%	n/a
Grade 8	n/a	24.0%	29.8%	+	+		19.0%	n/a
Grade 10	n/a	8.8%	11.5%	+	+		8.7%	n/a
Grade 12	n/a	11.6%	3.7%	-	-		6.3%	n/a
Overall	n/a	14.2%	13.5%	-	-		16.0%	n/a
Source: Pennsylvania Youth Suvey								

Ohio Valley HOSPITAL part of Heritage Valley Health System Community Health Needs Assessment 2019 97

TABLE 18: PENNSYLVANIA YOUTH SURVEY (3 OF 3)

PAYS DATA	ALLEGHENY COUNTY			Trend	PA	US (MTF)	PA	US (MTF)
SUBSTANCE USE	2013	2015	2017	+/-/=	Comp	Comp	2017	2017
Cigarettes (Lifetime Use)								
Grade 6	4.1%	8.8%	4.0%	-	+		2.7%	n/a
Grade 8	10.3%	11.5%	10.5%	+	+	+	9.4%	9.4%
Grade 10	25.7%	20.8%	15.1%	-	-	-	16.2%	15.9%
Grade 12	34.9%	36.5%	23.0%	-	-	-	29.0%	26.6%
Overall	18.2%	22.2%	14.2%	-	-		14.5%	n/a
Smokeless Tobacco (Lifetime Use)								
Grade 6	0.8%	1.7%	0.7%	-	-		1.1%	n/a
Grade 8	3.8%	1.8%	4.6%	+	+	-	4.4%	6.2%
Grade 10	12.7%	10.2%	6.7%	-	-	-	8.9%	9.1%
Grade 12	21.4%	21.3%	12.6%	-	-	+	15.9%	11.0%
Overall	9.2%	10.7%	6.8%	-	-		7.6%	n/a
Cigarettes (30-day Use)								
Grade 6	1.7%	1.7%	0.3%	-	-		0.6%	n/a
Grade 8	3.9%	2.5%	3.3%	-	+	+	2.5%	1.9%
Grade 10	12.1%	6.7%	5.0%	-	-	=	6.0%	5.0%
Grade 12	18.9%	16.3%	8.3%	-	-	-	13.2%	9.7%
Overall	8.7%	8.1%	4.7%	-	-		5.6%	n/a
Smokeless Tobacco (30-day Use)								
Grade 6	0.5%	1.1%	0.3%	-	=		0.3%	n/a
Grade 8	1.8%	0.4%	2.2%	+	+	+	1.8%	1.7%
Grade 10	6.5%	4.4%	2.7%	-	-	-	4.2%	3.8%
Grade 12	10.5%	11.8%	3.5%	-	-	-	7.5%	4.9%
Overall	4.6%	5.3%	2.4%	-	-		3.5%	n/a
Source: Pennsylvania Youth Suvey								

APPENDIX B
KEY INFORMANT 2019 SURVEY

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

Thank you to our valued community partners for taking the time to respond to the Ohio Valley Hospital Key Informant Survey. Your input is vital to helping us identify the needs within the communities we serve as part of our Community Health Needs Assessment. The survey should take you no more than 10 minutes to complete. We ask that you please take a few minutes to complete this survey by March 15, 2019.

Thank you in advance for your participation!

* 1. Please select your **primary** community affiliation:

- ○ Nonprofit/Social Service
- ○ For Profit/Business
- ○ Government

* 2. Please provide additional information on the type of community affiliation (Please Check All That Apply):

Healthcare/Public Health	Faith-Based Organization	Professional Services (i.e. banking and financial services, insurance, law, accounting, real estate, etc.)
Education/Youth Services	Cultural Organization	
☐ Transportation	☐ Community Organization	☐ Criminal Justice
☐ Housing	☐ Retail	Agriculture
☐ Mental/Behavioral Health	☐ Manufacturing	☐ Utilities
☐ Other (Please Specify)	☐	☐
☐	☐	☐
☐		

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

3. What groups does your company/agency service? (Please mark all that apply)

- [ ] General Public
- [ ] Other Businesses/Employers
- [ ] Homeless
- [ ] Low Income
- [ ] Other (Please Specify)
- [ ] Elderly
- [ ] Veterans
- [ ] Children
- [ ] Women

4. What demographic(s) are most supported by your services? (Please mark all that apply)

- [ ] Black/African American
- [ ] White/Caucasian
- [ ] Hispanic/Latino
- [ ] Other (please specify)
- [ ] Native American/American Indian
- [ ] Asian/Pacific Islander
- [ ] All of the above

5. Overall, how would you rate the health status of the community?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

6. Why did you rate the health status of the community the way you did?

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

Prevention Institute defines four basic elements of community health: 1) Equitable opportunity including racial justice, jobs and education; 2) Place including parks and open space, transportation, housing, air, water and safety; 3) People including social networks and willingness to act for the common good, and; 4) Health Care Services including preventive services, treatment services, access, cultural competency, and emergency response.

Different groups face their own unique set of barriers and challenges regarding health. Please take a minute and think about the various population groups listed below and the unique challenges they face in maintaining a healthy lifestyle. Taking into consideration the definition above, please list the barriers/challenges these populations face. For example you may list: lack of available services, no health insurance, cost of medications, limited access to fresh fruits and vegetables, etc. There are no right or wrong answers, we are just trying to get a sense for challenges different population groups are experiencing.

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

7. Considering this overall look at what it takes to have a healthy community, what do you view as the major issues and barriers impacting the health of the following populations in our community? You may answer N/A or leave blank.

Children	
Adults	
Workforce	
Seniors (Age 65+)	
Individuals Without Health Insurance	
Individuals with Mental Health Issues	
Individuals with Substance Use/Abuse Issues	
Individuals with Transportation Issues	
Individuals with English as their Second Language	
Individuals who have Experienced Trauma	
Individuals Living in Poverty	
Individuals Experiencing Homelessness	
Individuals Living with a Chronic Condition	
Individuals Living with HIV/AIDS	
Pregnant Women	
Undocumented Individuals	
Individuals living with Diabetes	
Other	

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

employees struggle with? What services do you or your organization provide to address these issues? Check all that apply.

	Barriers/Clients Struggle With	Provide Services to Address
Affordability of healthcare	○	○
Access to primary care	○	○
Access to secondary care	○	○
Access to dental care	○	○
Access to mental health care	○	○
Access to health insurance	○	○
Food Security (accessibility to nutritious food)	○	○
Mental Health/ Illness	○	○
Diabetes	○	○
Heart Disease	○	○
Obesity	○	○
Substance Abuse including Opioid Addiction	○	○
Asthma	○	○
Cancer	○	○
STI's& HIV	○	○
Injury prevention/falls	○	○
Older adult safety/mobility	○	○
Living with a disability	○	○
Rise in vapes and e-cigarettes	○	○
Maternal and child health	○	○

	Barriers/Clients Struggle With	Provide Services to Address
Poor birth outcomes	○	○
Inappropriate ER use	○	○
Poverty/low wages	○	○
Housing security (affordable housing)	○	○
Homelessness	○	○
Stressed infrastructure due to increased population	○	○
Transportation	○	○
Human Trafficking	○	○
Access to Diabetes Education	○	○
Inability to pay out of pocket expenses (co-pays, prescriptions, etc.)	○	○
Inability to navigate healthcare system	○	○
Language/cultural barriers	○	○
Time Limitations (long wait times, limited office hours, time of work)	○	○
Lack of childcare	○	○

Other (please specify)

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

9. Please rate your level of agreement with the following statements:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Residents in the area are able to access a primary care provider when needed (Family Doctor, Pediatrician, General Practitioner)	○	○	○	○	○
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	○	○	○	○	○
Residents are able to access a dentist when needed	○	○	○	○	○
There is a sufficient number of providers accepting Medicaid/Medical Assistance in the area	○	○	○	○	○
There is a sufficient number of bi-lingual providers in the area	○	○	○	○	○
There is a sufficient number of mental/behavioral health providers in the area	○	○	○	○	○
Transportation for medical appointments is available to area residents when needed	○	○	○	○	○
Residents in the area have access to Diabetic Services when needed	○	○	○	○	○

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

10. Are there specific populations in this community that you think are not being adequately served by local health services?

- ○ Yes
- ○ No

11. Which populations do you think are underserved? Please check all that apply.

- ☐ Low Income/Poor
- ☐ Uninsured/Underinsured
- ☐ Hispanic/Latino
- ☐ Homeless
- ☐ Immigrant/Refugee
- ☐ Seniors/Aging/Elderly
- ☐ Other (please specify)
- ☐ Black/African American
- ☐ Disabled
- ☐ Young Adults
- ☐ Children/Youth
- ☐ None

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

12. In general, where do you think most uninsured and underinsured individuals living in the area go when they are in need of medical care?

- ◯ Hospital Emergency Department
- ◯ Walk-In/Urgent Care Center
- ◯ Doctor's Office
- ◯ Don't Know
- ◯ Health Clinic/FQHC
- ◯ Other (please specify)

13. Please share any additional information/comments regarding uninsured/underinsured individuals and/or underserved populations.

14. What other vulnerable populations exist in your community?

15. What are the major issues/barriers impacting these populations?

16. In general, what barriers do you think people in the community experience accessing health care?

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

17. Please identify key resources or services you feel are needed to improve access to health care for residents in the community. Please check all that apply.

- ☐ Free/Lost Cost Dental Care
- ☐ Transportation
- ☐ Mental Health Services
- ☐ Substance Abuse Services
- ☐ Free/Low Cost Medical Care
- ☐ Primary Care Providers
- ☐ Health Education/Information/Outreach
- ☐ Health Screenings
- ☐ Bi-lingual Services
- ☐ Medical Specialists
- ☐ Prescription Assistance
- ☐ None
- ☐ Other (please specify)

18. Overall, how well do you think existing programs and services are doing to promote good health in the community?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

19. What more could be done to promote good health in the community?

20. Have any of these affected you, your employees, co-workers, or the population you serve? (Please mark all that apply)

- ☐ Lack of affordable and adequate housing
- ☐ Lack of safe roads and sidewalks
- ☐ Homelessness
- ☐ Lack of early childhood development/childcare
- ☐ Employment opportunities/lack of jobs
- ☐ Lack of transportation
- ☐ Poverty
- ☐ Lack of access to high quality, affordable healthy foods
- ☐ Lack of recreation opportunities
- ☐ Lack of access to fresh, available drinking water
- ☐ Other (please specify)

Ohio Valley Hospital Community Health Needs Assessment Key Informant Survey

21. To what extent do you feel existing programs and services are meeting the needs within our community?

- ◯ Adequately meeting the needs of the community
- ◯ Somewhat meeting the needs of the community
- ◯ Not meeting the needs of the community

22. What resources need to be developed or strengthened to adequately meet the needs in the community?

23. Please feel free to share any other comments you have:

Thank you for taking the time to provide your valuable input into our Community Health Needs Assessment. We would like to include as much community level data as possible in our report. If you are currently offering a program/service in the community and have any outcomes or impact data we would appreciate it if you could please send to Kathy Roach at kathy@getstrategy.com.

APPENDIX C
2018 INTERCEPT SURVEY

APPENDIX C – INTERCEPT SURVEY

1. **How would you rate the health of your community (where you and your family/friends/ neighbors live)? Would you say it is (circle one):**

   Excellent Very Good Good Fair Poor

   a. **Why do you say that?**

2. **How would you rate your personal health? Would you say it is (circle one):**

   Excellent Very Good Good Fair Poor

3. **What would you say are the top 3 health needs/problems of the community (where you and your family/friends/neighbors live)? Why do you say that?**

Top 3 Health Needs/Problems	Why did you say this?
1.	
2.	
3.	

4. **Based on the 3 needs/problems you just listed, what, if anything, is the hospital and/or community doing to correct these needs or offer services?**

5. **What additional programs/services are needed in the community that you feel are missing? What would you like to see in your community to help you?**

6. **What things are stopping you or your family from getting health care (example: cost, transportation, etc.)?**

APPENDIX D
2018 STAKEHOLDER INTERVIEW GUIDE

Ohio Valley HOSPITAL

OHIO VALLEY HOSPITAL

STAKEHOLDER INTERVIEW GUIDE

Interview with:

Interviewed by/date:

Thank you for taking the time to talk with us to support the Ohio Valley Hospital Community Health Needs Assessment Process.

1. First of all, could you tell me a little bit about yourself and your background/ experience with community health related issues.

2. What, in your opinion, are the top 3 community health needs for Allegheny County?	**3. What, in your opinion are the issues and the environmental factors that are driving these community health needs?**
1.	
2.	
3.	
Others mentioned:	

4. Check to see if the area they were selected to represent is one of the top priorities identified above. If not mentioned, say….

Our records indicate that you were selected to participate in these individual interviews because you have specific background/experience/ knowledge regarding _____. What do you feel are the key issues related to this topic area?

What, in your opinion are the issues and the environmental factors that are driving the needs in this topic area?

5. What activities/initiatives are currently underway in the community to address the needs within this topic area?

6. What more, in your opinion, still needs to be done in order to address this community health topic area.

7. What advice do you have for the project steering committee who is implementing this community health assessment process?

APPENDIX E COMMUNITY AND HOSPITAL RESOURCES LISTING

APPENDIX E: COMMUNITY AND HOSPITAL RESOURCES LISTING

HOSPITAL RESOURCE LISTING

Ohio Valley Hospital Hospital Services	Address	City	State	Zip	Phone Number
Ambulance Services					
NorthWest EMS	366 Helen Street	McKees Rocks	PA	15136	In case of an emergency, always dial 9-1-1 Main: 412-331-2600
BusinessCare (formerly BusinessFit Occupational Medicine)					
Heritage Valley BusinessCare – Robinson	2201 Park Manor Blvd Suite 500	Pittsburgh	PA	15205	724-777-6369
Heritage Valley BusinessCare – Center	79 Wagner Road Suite 100	Monaca	PA	15061	724-773-6464
Cardiology Services					
Cardiac Services	25 Heckel Road 2nd Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6161
Cardiac Rehabilitation Program	25 Heckel Road 4th Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6849
Cardiac Catheterization Laboratory	25 Heckel Road 4th Floor of Main Hospital	Kennedy Township	PA	15136	Non-Invasive Diagnostic Procedures: 412-777-6136 Minimally-Invasive Diagnostic Procedures: 412-777-6595
Cataract and Eye Surgery Center					
Ohio Valley Cataract and Eye Surgery Center	25 Heckel Road	Kennedy Township	PA	15136	412-777-6161
Community Health					
Community Health (testing and immunizations)	25 Heckel Road 3rd Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6514
Emergency Department					
Ohio Valley Hospital Emergency Department	25 Heckel Road 1st Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6161

Ohio Valley Hospital Hospital Services	Address	City	State	Zip	Phone Number
Laboratory Services					
Main Laboratory	25 Heckel Road 2nd Floor of Main Hospital	Nutrition Services Department	PA	15136	412-777-6177
Phlebotomy Site	25 Heckel Road 2nd Floor of the Medical Office Building	Kennedy Township	PA	15136	412-777-6288
Nutrition Services					
Nutrition Services Department	25 Heckel Road 1st Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6161
Outpatient Dietitian	25 Heckel Road 1st Floor of the Medical Office Building Suite 102	Kennedy Township	PA	15136	412-777-6205
Diabetes Educator	25 Heckel Road 1st Floor of the Medical Office Building Suite 102	Kennedy Township	PA	15136	412-777-6205
Orthopedics					
Orthopedic Unit	25 Heckel Road 5th Floor	Kennedy Township	PA	15136	412-777-6722
Blue Distinction Center Plus Knee and Hip Replacement Program	25 Heckel Road 5th Floor	Kennedy Township	PA	15136	412-777-6177
Orthopedic Class	25 Heckel Road 5th Floor	Kennedy Township	PA	15136	412-777-6772
Pulmonary Health Center					
Ohio Valley Hospital Pulmonary Health Center	25 Heckel Road 1st Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6470
Radiology and Medical Imaging Department					
Radiology and Medical Imagine Services Department	25 Heckel Road 2nd Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6257

Ohio Valley Hospital Hospital Services	Address	City	State	Zip	Phone Number
Rehabilitation Services					
Acute Rehabilitation Unit	25 Heckel Road 3rd Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6770
Balance and Fall Prevention Center	25 Heckel Road 2nd Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6231
Rehabilitation Services Department	25 Heckel Road 2nd Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6231
Speech Therapy	25 Heckel Road 2nd Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6231
Respiratory Care Services					
Respiratory Care Services	25 Heckel Road 4th Floor of Main Hospital in Cardiology department	Kennedy Township	PA	15136	412-777-6157
Sleep Evaluation Center					
Sleep Evaluation Center	25 Heckel Road 2nd Floor of Main Hospital in Cardiology Services wing	Kennedy Township	PA	15136	412-777-6921
Surgical Services					
Surgical Services	25 Heckel Road 4th Floor of Main Hospital	Kennedy Township	PA	15136	412-777-6161
Transportation Service					
Ohio Valley Hospital Courtesy Van	25 Heckel Road	Kennedy Township	PA	15136	412-777-6924
Willow Brook Geropsychiatric Unit					
Willow Brook Geropsychiatric Unit	25 Heckel Road 3rd Floor of Main Hospital	Kennedy Township	PA	15136	412-777–6420

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COMMUNITY RESOURCE LISTING

Agency	Address	City	State	Zip	Phone Number	Web Address
Basic Needs						
St. Vincent de Paul Society, Pittsburgh-Coraopolis Thrift Store	415 Chess Street & Route 51 North	Coraopolis	PA	15108	412-264-2378	http://www.svdppitt.org/
Holy Family Institute Duquesne Light Utility Assistance Program McKees Rocks	19 May Street	McKees Rocks	PA	15136	412-331-8665	http://www.hfi-pgh.org/what-we-do/utility-assistance/
Tudi Mechanical Systems - Heat for the Needy (Furnaces)	343 Munson Avenue	McKees Rocks	PA	15136	412-771-8678	http://www.heatfortheneedy.com/
Bridge to Independence, Inc. Family Focus	583-587 Corey Avenue	Braddock	PA	15204	412-271-5787	http://www.bti.pghfree.net/
Bridge to Independence PennFree Bridge Housing	16 Holland Avenue	Braddock	PA	15204	412-271-5787	http://www.bti.pghfree.net/
Produce to People Sheraden	2940 Sheraden Boulevard	Pittsburgh	PA	15204	412-460-3663 x 727	https://www.pittsburghfoodbank.org/producetopeople/
American Cancer Society	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
American Cancer Society Road to Recovery (Transportation)	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
Consumer Services						
Better Business Bureau of Western PA	520 East Main Street	Carnegie	PA	15106	877-267-5222	https://www.bbb.org/local-bbb/bbb-of-western-pennsylvania
Better Business Bureau of Western PA-BBB Military Line	520 East Main Street	Carnegie	PA	15106	412-456-2700	https://www.bbb.org/local-bbb/bbb-of-western-pennsylvania
Just Harvest Tax Assistance at Robert Morris University	6001 University Boulevard	Moon Township	PA	15108	Main Phone 2-1-1	http://www.pghfreetaxes.org/

Agency	Address	City	State	Zip	Phone Number	Web Address
Allegheny County DHS Focus on Renewal Tax Assistance McKees Rocks	500 Chartiers Avenue	McKees Rocks	PA	15136	2-1-1	http://alleghenycounty.us/human-services/index.aspx
Focus on Renewal Pittsburgh Financial Empowerment Center	500 Chartiers Avenue	McKees Rocks	PA	15136	800-298-0237	http://www.advantageccs.org/
Criminal Justice and Legal Services						
Focus on Renewal Sto-Rox Neighborhood Corp Community Legal Clinic	500 Chartiers Avenue	McKees Rocks	PA	15136	412-331-1685 x 230	http://www.forstorox.org/
Holy Family Institute Stop Now and Plan (SNAP) Program	19 May Street	McKees Rocks	PA	15136	412-331-2684	http://www.hfi-pgh.org/
Veteran's Health Administration Pittsburgh Vet Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Education						
Carylnton School District Hi 5 Kindergarten Readiness	435 Kings Highway	Carnegie	PA	15106	412-429-8400	http://www.carlynton.k12.pa.us/
West Allegheny School District Hi 5 Kindergarten Readiness	600 Donaldson Road	Oakdale	PA	15071	724-695-3422	http://www.westasd.org/kindergarten5093.aspx
AIU Head Start Coraopolis	863 Fifth Avenue	Coraopolis	PA	15108	412-394-5861	http://www.aiu3.net/
Cornell School District Hi 5 Kindergarten Readiness	1099 Maple Street	Coraopolis	PA	15108	412-264-5010	http://www.cornell.k12.pa.us/
Moon Area School District Hi 5 Kindergarten Readiness	8353 University Boulevard	Moon Township	PA	15108	412-264-9440	http://www.moonarea.net/
AIU Head Start McKees Rocks	225 Olivia Street	McKees Rocks	PA	15136	412-394-5861	http://www.aiu3.net/
Focus on Renewal Learning Center	420 Chartiers Avenue	McKees Rocks	PA	15136	412-331-1685	http://www.forstorox.org/

Agency	Address	City	State	Zip	Phone Number	Web Address
Focus on Renewal Positive Parenting Preschool	420 Chartiers Avenue	McKees Rocks	PA	15136	412-331-1685	http://www.forstorox.org/
Montour School District Hi 5 Kindergarten Readiness	225 Clever Road	McKees Rocks	PA	15136	412-490-6500 x 6221	http://www.montourschools.com/
Sto-Rox School District Hi 5 Kindergarten Readiness	600 Russellwood Avenue	McKees Rocks	PA	15136	412-771-3213	http://www.srsd.k12.pa.us/
Environment and Public Health/Safety						
Allegheny County Health Department	542 Fourth Avenue	Pittsburgh	PA	15219	412-687-2243	https://www.alleghenycounty.us/healthdepartment/index.aspx
Food Banks						
Inter-Church Food Bank	618 Russelwood Avenue	McKees Rocks	PA	15136	412-771-4088	https://www.pittsburghfoodbank.org/agency/inter-church-food-bank/
West Allegheny Food Pantry	520 Route 30	Imperial	PA	15126	724-695-1305	https://www.pittsburghfoodbank.org/agency/west-allegheny-ministerial-association/
Focus on Renewal	15/16 Bell Avenue Hays Manor Building	McKees Rocks	PA	15136	412-276-1011	http://www.forstorox.org/foodpantry
Health Care						
Horizons Hospice-Hospice Care-Carnegie	221 West Main Street	Carnegie	PA	15106	888-966-0808	
Choices Pregnancy Services-Coraopolis	626 Fifth Avenue	Coraopolis	PA	15108	412-264-0200	http://www.pregnancychoice.org/
Choices Pregnancy Services-Mobile Clinic	626 Fifth Avenue	Coraopolis	PA	15108	412-264-0200	http://www.pregnancychoice.org/
Heritage Valley Health System-Community Health Services Nutrition Services	935 Thorn Run Road	Moon Township	PA	15108	866-328-8389	http://www.heritagevalley.org/
Heritage Valley Health System-Moon Township	935 Thorn Run Road	Moon Township	PA	15108	866-328-8389	http://www.heritagevalley.org/
Planned Parenthood of W. PA Moon Branch Office	935 Beaver Grade Road	Moon Township	PA	15108	412-264-7205	http://www.plannedparenthood.org/health-center/centerDetails.asp?f=2827&a=91470&v=details

Agency	Address	City	State	Zip	Phone Number	Web Address
Ohio Valley General Hospital	25 Heckel Road	McKees Rocks	PA	15136	412-777-6161	http://www.ohiovalleyhospital.org/
Sto-Rox Family Health Center Affordable Care Act - Application Assistance	710 Thompson Avenue	McKees Rocks	PA	15136	412-771-6460	http://www.storoxfqhc.org/
Sto-Rox Neighborhood Family Health Center	710 Thompson Avenue	McKees Rocks	PA	15136	412-771-6462	http://www.storoxfqhc.org/
Sto-Rox Neighborhood Family Health Center Dental Services	710 Thompson Avenue	McKees Rocks	PA	15136	412-771-6462	http://www.storoxfqhc.org/sto-rox/
American Cancer Society	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
American Cancer Society I Can Cope Program	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
American Cancer Society Look Good, Feel Better Program	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
East Liberty Family Health Center Affordable Care Act-Churchland Street Application Assistance	7171 Churchland Street	Pittsburgh	PA	15205	412-361-8284	http://www.elfhcc.com/
Veteran's Health Administration Pittsburgh Vet Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Income Support and Employment						
Allegheny County Health Department-Carnegie WIC Office	2121 Noblestown Road	Carnegie	PA	15106	412-922-5312	http://www.achd.net/wic
Allegheny County Health Department McKees Rocks WIC Office	710 Thompson Avenue	McKees Rocks	PA	15136	412-331-5410	http://www.achd.net/wic/index.html

Agency	Address	City	State	Zip	Phone Number	Web Address
Veteran's Health Administration Pittsburgh Vet Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Individual and Family Life						
Church of the Atonement, Episcopalian	618 Washington Avenue	Carnegie	PA	15106	412-279-1944	http://www.achd.net/wic
Miracle House Ministries	708 Idlewood Avenue	Carnegie	PA	15106	412-276-5073	http://vfeo15.org/contact.html
Special Olympics Pennsylvania-Allegheny County	404 First Street	Heidelberg	PA	15106	412-279-5450	http://specialolympicspa.org/
Special Olympics Pennsylvania-Allegheny County-Volunteer Opportunities	404 First Street	Heidelberg	PA	15106	412-279-5454	http://specialolympicspa.org/
Resurrection Lutheran Church-Disaster Volunteer Site	7600 Steubenville Pike	Oakdale	PA	15071	412-788-4513	
Coraopolis Youth Creations-Give a Gift	1022 5th Avenue	Coraopolis	PA	15108	412-310-7053	http://www.youthcreations.net/
Valley Care Adult Day Services-Moon Township	650 Cherrington Parkway	Moon Township	PA	15108	412-264-0104	http://valleycareassociation.org/
AIU Sto-Rox Family Center	618 Russellwood Avenue	McKees Rocks	PA	15136	412-771-6817	www.aiu3.net
Boys & Girls Clubs of Western PA Sto-Ken-Rox Branch	Willow & Deweyville Street	McKees Rocks	PA	15136	412-771-0428	http://www.bgcwpa.org/
Family Support Center Hays Manor	Bell Avenue Building 13, Basement	McKees Rocks	PA	15136	412-331-5620	
Family Support Center McKees Rocks	701 Chartiers Avenue	McKees Rocks	PA	15136	412-771-6460	http://www.forstorox.org/

Agency	Address	City	State	Zip	Phone Number	Web Address
Family Support Center Meyers Ridge Community	901 Gray Street	McKees Rocks	PA	15136	412-771-6009	
Focus on Renewal Positive Parenting Preschool	420 Chartiers Avenue	McKees Rocks	PA	15136	412-331-1685	http://www.forstorox.org/
Ken Mawr United Presbyterian Church	1760 Pine Hollow Road	McKees Rocks	PA	15136	412-331-2863	http://www.kenmawrchurch.org/childrens-ministries/vacation-bible-school.html
American Cancer Society Prostate Cancer-Man to Man	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
American Cancer Society Reach to Recovery	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
Crafton United Presbyterian Church After School	80 Bradford Avenue	Pittsburgh	PA	15205	412-921-2293	http://www.craftonup.com/
Heritage Valley Health System - Staunton Clinic Independent Support Services	300 Bilmar Drive	Pittsburgh	PA	15205	412-928-8687	http://www.heritagevalley.org/
March of Dimes Western PA Market	5168 Campbells Run Road	Pittsburgh	PA	15205	412-505-2200	http://www.marchofdimes.com/
Special Olympics Pennsylvania - Greene County Volunteer Opportunities	200 Cedar Ridge Drive	Pittsburgh	PA	15205	724-998-8109	http://specialolympicspa.org/
Steps to Independence Summer Camp	300 Cedar Ridge Drive	Pittsburgh	PA	15205	412-254-4784	http://www.stepstoindependence.org/
Veteran's Health Administration Pittsburgh Vet Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Mental Health and Substance Use Disorder Services						
Clean and Sober Humans Association C.A.S.H. Club	821 Broadway Avenue	McKees Rocks	PA	15136	412-875-0020	412-875-0020

Agency	Address	City	State	Zip	Phone Number	Web Address
Holy Family Institute Stop Now and Plan (SNAP) Program	19 May Street	McKees Rocks	PA	15136	412-331-2684	http://www.hfi-pgh.org/
Mercy Behavioral Health McKees Rocks	710 Thompson Avenue	McKees Rocks	PA	15136	412-323-4500	www.pmhs.org
Veteran's Health Administration Combat Call Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	877-927-8387	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Veteran's Health Administration Pittsburgh Vet Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Veteran's Health Administration Pittsburgh Vet Center Veteran Counseling Program	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Organizational/Community/International Services						
Better Business Bureau of Western PA-BBB Military Line	520 East Main Street	Carnegie	PA	15106	412-456-2700	https://www.bbb.org/local-bbb/bbb-of-western-pennsylvania
LifeSpan, Inc. Chartiers Senior Resource Center	300 Lincoln Avenue	Carnegie	PA	15106	412-276-5056	http://www.lifespanpa.org/
Kennedy Township Police Dept. Residents Emergency Program	340 Forest Grove Road	Coraopolis	PA	15108	412-331-2408	http://www.kennedytwp.com/public-safety/
Pennsylvania House of Representatives-State Representative Nick Kotik	1350 Fifth Avenue	Coraopolis	PA	15108	412-264-4260	http://www.pahouse.com/Kotik
Society of St. Vincent Donation Pic/Up-Coraopolis Store	415 Chess Street	Coraopolis	PA	15108	412-264-2378	http://www.svdppitt.org/
St. Vincent de Paul Society, Pittsburgh-Coraopolis Thrift Store	415 Chess Street & Route 51 North	Coraopolis	PA	15108	412-264-2378	http://www.svdppitt.org/

Agency	Address	City	State	Zip	Phone Number	Web Address
LifeSpan, Inc. Imperial Community Resource Center	540 Penn Lincoln Drive	Imperial	PA	15126	724-218-1669	http://www.lifespanpa.org/
Carnegie Library of Pittsburgh Sheraden Branch	720 Sherwood Avenue	Pittsburgh	PA	15204	412-331-1135	http://www.carnegielibrary.org/locations/sheraden
Sheraden Senior Center	720 Sherwood Avenue	Pittsburgh	PA	15204	412-777-5012	
Veteran's Health Administration Pittsburgh Vet Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Target Populations						
Better Business Bureau of Western PA-BBB Military Line	520 East Main Street	Carnegie	PA	15106	412-456-2700	https://www.bbb.org/local-bbb/bbb-of-western-pennsylvania
Huntington's Disease Society of America-Western PA Chapter	1140 Thorn Run Road	Coraopolis	PA	15108	412-833-8180	http://www.hdsa.org/wpa
Merakey Innovative Care and Education Solutions-Intellectual and Developmental Disabilities-Coraopolis	1996 Ewings Mill Road	Coraopolis	PA	15108	412-299-7777	http://www.merakey.org/
Bridge to Independence PennFree Bridge Housing	16 Holland Avenue	Braddock	PA	15204	412-271-5787	http://www.bti.pghfree.net/
American Cancer Society	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
American Cancer Society I Can Cope Program	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
American Cancer Society Prostate Cancer-Man to Man	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/

Ohio Valley HOSPITAL part of Heritage Valley Health System Community Health Needs Assessment 2019 141

Agency	Address	City	State	Zip	Phone Number	Web Address
American Cancer Society Reach to Recovery	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
American Cancer Society Road to Recovery (Transportation)	320 Bilmar Drive	Pittsburgh	PA	15205	888-227-5445 x 1	http://www.cancer.org/
March of Dimes Western PA Market	5168 Campbells Run Road	Pittsburgh	PA	15205	412-505-2200	http://www.marchofdimes.com/
Steps to Independence Summer Camp	300 Cedar Ridge Drive	Pittsburgh	PA	15205	412-254-4784	http://www.stepstoindependence.org/
Veteran's Health Administration Combat Call Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	877-927-8387	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Veteran's Health Administration Pittsburgh Vet Center	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All
Veteran's Health Administration Pittsburgh Vet Center Veteran Counseling Program	2500 Baldwick Road Suite 15	Pittsburgh	PA	15205	412-920-1765	http://www2.va.gov/directory/guide/facility.asp?ID=592&dnum=All