HALIFAX REGIONAL HOSPITAL
SOUTH BOSTON, VIRGINIA

2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

ADOPTED BY BOARD RESOLUTION
(June 24, 2013)[1]

QHR | Consulting Services

[1] Response to Schedule H (Form 990) Part V B 2 and section 501(r)1

QHR | Consulting Services

Dear Community Resident:

Halifax Regional Hospital (HRH) welcomes you to review this document as we strive to meet the health and medical needs in our community. All not-for-profit hospitals are required to develop this report in compliance with the Affordable Care Act.

The "2013 Community Health Needs Assessment" identifies local health and medical needs and provides a plan to indicate how HRH will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, HRH, are meeting our obligations to efficiently deliver medical services.

HRH will conduct this effort at least once every three years. As you review this plan, please see if, in your opinion, we have identified the primary needs and if our intended response should make appropriate needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, along with other organizations and agencies, can collaborate to bring the best each has to offer to address the more pressing, identified needs.

The report is a response to a federal requirement of not-for-profit hospital"s to identify the community benefit it provides in responding to documented community need. Footnotes are provided to answer specific tax form questions; for most purposes, they may be ignored. Of greater importance, however, is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

Please think about how to help us improve the health and medical services our area needs. I invite your response to this report. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier.

Thank You

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EXECUTIVE SUMMARY

Executive Summary

Halifax Regional Hospital ("HRH" or the "Hospital") is organized as a not-for-profit hospital. A Community Health Needs Assessment (CHNA) is part of the required hospital documentation of "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures HRH identifies and responds to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital[2]. Tax reporting citations in this report are superseded by the most recent 990 H filings made by the hospital.

In addition to completing a CHNA, and funding necessary improvements, a not-for-profit hospital must document the following:

Financial assistance policy and policies relating to emergency medical care;

Billing and collections; and

Charges for medical care.

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS), and the U.S. Department of the Treasury[3].

Project Objectives

HRH partnered with Quorum Health Resources (QHR) for the following[4]:

Complete a CHNA report, compliant with Treasury – IRS;

Provide the Hospital with information required to complete the IRS – 990h schedule; and

Produce the information necessary for the Hospital to issue an assessment of community health needs and document its intended response.

Brief Overview of Community Health Needs Assessment

Typically, non-profit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c) 3 of the Internal Revenue Code; however, the term 'Charitable Organization' is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to the less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

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[2] Part 3 Treasury/IRS – 2011 – 52 Notice … Community Health Needs Assessment Requirements… and https://www.federalregister.gov/articles/2013/04/05/2013-07959/community-health-needs-assessments-for-charitable-hospitals

[3] As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at http://federalregister.gov/a/2012-15537

[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

Emergency room open to all, regardless of ability to pay;

Surplus funds used to improve patient care, expand facilities, train, etc.;

Controlled by independent civic leaders; and

All available and qualified physicians are privileged.

Specifically, the IRS requires:

Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a CHNA at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment;

The assessment may be based on current information collected by a public health agency or non-profit organization and may be conducted together with one or more other organizations, including related organizations;

The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues;

The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources);

Each hospital facility is required to make the assessment widely available and ideally downloadable from the hospital web site;

Failure to complete a CHNA in any applicable three-year period results in a penalty to the organization of $50,000. For example, if a facility does not complete a CHNA in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a CHNA in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four); and

An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

This report was developed under the guidance of IRS/Treasury 2011-52 as modified by the Draft Federal Regulations published in the April 5, 2013 Federal Register.

[5] Section 6652

APPROACH

Approach

To complete a CHNA, the hospital must:

Describe the processes and methods used to conduct the assessment;

- Sources of data and dates retrieved;
- Analytical methods applied;
- Information gaps impacting ability to assess the needs; and
- Identification of with whom the Hospital collaborated.

The proposed regulations provide that a hospital facility"s CHNA report will be considered to describe how the hospital facility took into account input if the CHNA report:

(1) Summarizes, in general terms, the input provided and how and over what time period such input was provided;

(2) Provides the names of organizations providing input and summarizes the nature and extent of the organization"s input; and

(3) Describes the medically underserved, low income, or minority populations being represented by organizations or individuals providing input.

Describe the process and criteria used in prioritizing health needs;

Describe existing resources available to meet the community health needs; and

Identify the programs and resources the hospital facility plans to commit to meeting each identified need and the anticipated impact of those programs and resources on the health need.

QHR takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data, and resolve any data inconsistency or discrepancies from the combined opinions formed from local experts. We rely on secondary source data - and most secondary sources use the county as the smallest unit of analysis. We asked our local expert area residents, to note if they perceived the problems, or needs, identified by secondary sources to exist in their portion of the county.[6]

Most data used in the analysis is available from public internet sources. Critical data needed to address specific regulations or developed by the individuals cooperating with us in this study is displayed in the report or the appendix. Data sources include:[7]

[6] Response to Schedule H (Form 990) Part V B 1 i
[7] Response to Schedule H (Form 990) Part V B 1 d

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Halifax County compared to all Virginia counties	February 15, 2013	2002 to 2010
www.communityhealth.hhs.gov	Assessment of health needs of Halifax County compared to its national set of "peer counties"	February 15, 2013	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital"s primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends and socio-economic characteristics;	February 15, 2013	2012
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	February 15, 2013	2012
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	February 15, 2013	2012
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	February 15, 2013	1989 through 2009
www.dataplace.org	To determine availability of specific health resources	February 15, 2013	2005
www.cdc.gov	To examine area trends for heart disease and stroke	February 15, 2013	2007 to 2009
www.CHNA.org	To identify potential needs among a variety of resource and health need metrics	February 15, 2013	2003 to 2010
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	February 15, 2013	2013

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	February 15, 2013	2010 published 11/29/12

In addition, we deployed a CHNA "Round 1" survey to our Local Expert Advisors to gain local input as to local health needs and the needs of priority populations. Local Expert Advisors were local individuals selected to conform to the input required by the Federal guidelines and regulations.[8]

We received community input from 27 Local Expert Advisors. Survey responses started Tuesday March 5, 2013 at 7:59 a.m. and ended with the last response on Monday, March 18, 2013 at 8:23 a.m.;

Information analysis augmented by local opinions showed how Halifax County relates to its peers in terms of primary and chronic needs and other issues of uninsured persons, low-income persons, and minority groups; respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition, and if so, who needs to do what[9].

When the analysis was complete, we put the information and summary conclusions before our local group of experts[10] who were asked to agree or disagree with the summary conclusions. They were free to augment potential conclusions with additional comments of need; and new needs did emerge from this exchange.[11] Consultation with 24 local experts occurred again via an internet-based survey (explained below) during the period beginning Monday, April 8, 2013 12:32 p.m. and ending Monday April 22, 2013 11:25 a.m.

With the prior steps identifying potential community needs, the local experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts. Experts answer questionnaires in a series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provide an anonymous summary of the experts" forecasts from the previous round, as well as reasons provided for their judgments. The process encourages experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority community needs.

In the HRH process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and challenge conclusions developed from

[8] Response to Schedule H (Form 990) Part V B 1 h; complies with 501(r)(3)(B)(i)
[9] Response to Schedule H (Form 990) Part V B 1 f
[10] Part response to Schedule H (Form 990) Part V B 3
[11] Response to Schedule H (Form 990) Part V B 1 e

the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support and other needs receiving identical point allocations.

We dichotomized the rank order into two groups: high priority needs and low priority needs. The determination of the break point - high as opposed to low - was a qualitative interpretation by QHR and the HRH executive team where a reasonable break point in rank occurred, indicated by the weight amount of points each potential need received and the number of local experts allocating any points to the need. When presented to the HRH executive team, the dichotomized need rank order identified which needs the Hospital considered high responsibility to respond vs. low responsibility to respond. The result provided a matrix of needs and guided the Hospital in developing its implementation response[12].

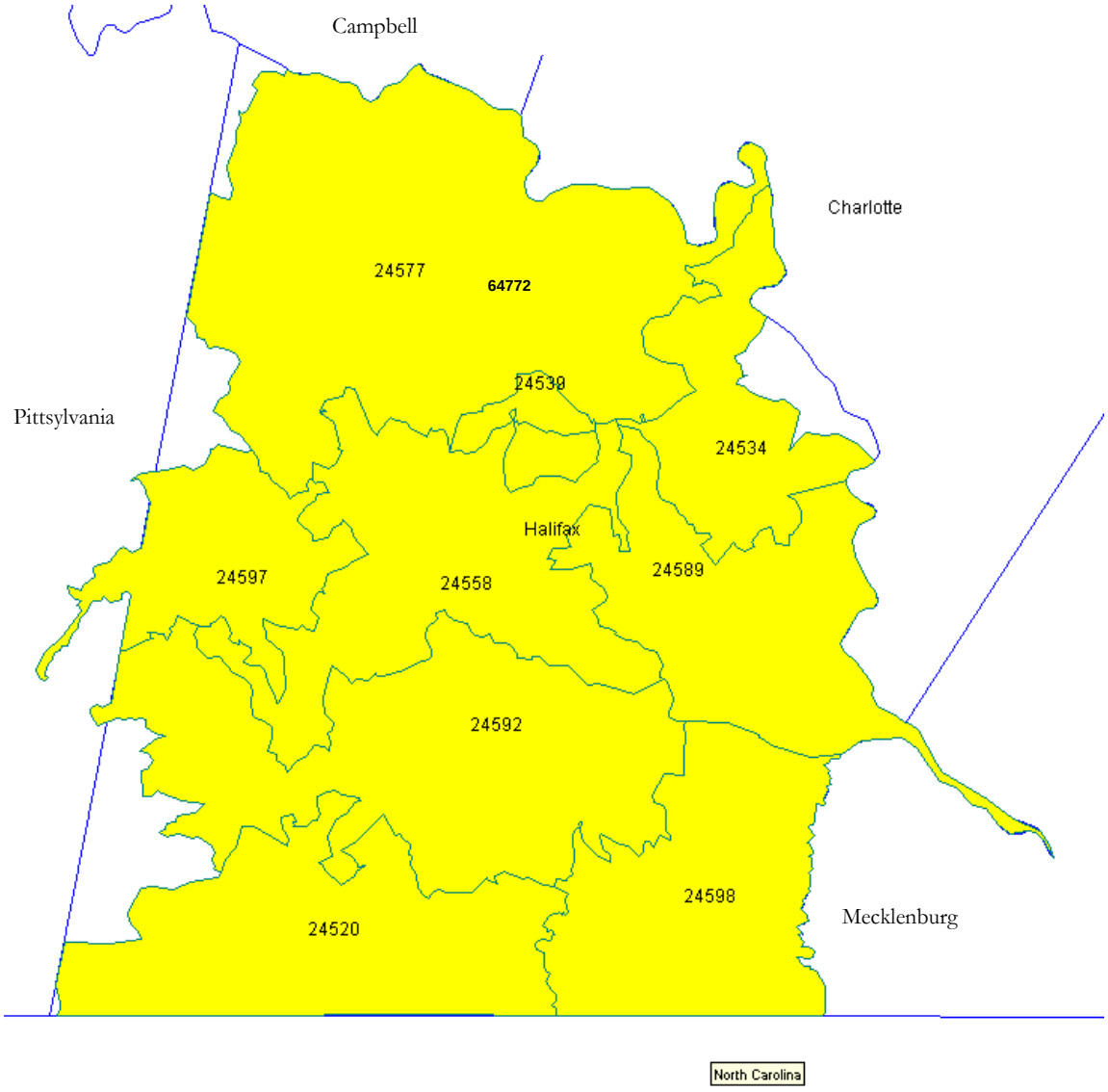
The proposed regulations provide that in order to "assess" the health needs of the community it serves, a hospital facility must identify significant health needs of the community, prioritize those health needs, and identify potential measures and resources (such as programs, organizations, and facilities in the community) available to address the health needs[13]. The proposed regulations clarify a CHNA need only identify significant health needs and need only prioritize, and otherwise assess, those significant health needs identified. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves[14]. By definition, the high priority needs are deemed "Significant" needs as defined by the regulations.

[12] Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g
[13] Draft regulations page 30
[14] Draft regulations page 32

FINDINGS

Findings

Definition of Area Served by the Hospital Facility[15]



HRH, in conjunction with QHR, defines its service area as Halifax County in Virginia, which includes the following ZIP codes:

24520 – Alton	24534 – Clover	24539 – Crystal Hill
24558 – Halifax	24577 – Nathalie	24589 – Scottsburg
24592 – South Boston	24597 – Vernon Hill	24598 – Virgilina

In 2011, the Hospital received 67.5% of its patients from this area.[16]

[15] Responds to IRS Form 990 (h) Part V B 1 a
[16] Truven MEDPAR patient origin data for the hospital; Responds to IRS Form 990 (h) Part V B 1 a

Demographic of the Community[17]

The 2012 population for Halifax County is estimated to be 35,387[18] and expected to decline slightly at a rate of (0.1%). This is in contrast to the 3.9% national rate of growth and the Virginia growth rate of 5.2%. Halifax County in 2017 anticipates a population of 35,337.

According to the population estimates utilized by Truven, provided by The Nielsen Company, the 2012 median age for the county is 44.2 years, which is older than the Virginia median age (37.3 years) and the national median age (36.8 years). The 2012 Median Household Income for the area is $33,724 which is lower than the Virginia median income of $58,6 and the national median income of $49,559. Median Household Wealth and Medial Home values follow the same pattern, being below Virginia and National values. Halifax"s unemployment rate as of March 2013 was 8.7%[19], which is worse than the 5.3% Virginia statewide and the national civilian unemployment rate of 7.6%.

The portion of the population in the county over 65 is 19.6%, well above the Virginia average of 12.2%. The portion of the population of women of childbearing age is 16.4%, considerably below the Virginia 20.3% value and national average of 20.1%. 60.3% of the population is White non-Hispanic. "All others" constitute 1.7% of the population. The Hispanic population comprises 1.7% of the total. Black non-Hispanic constitutes the largest minority, 36.2% of the population.

Demographics Expert 2.7
2012 Demographic Snapshot
Area: Halifax CO
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2000 Total Population	36,518	281,421,906
2012 Total Population	35,387	313,095,504
2017 Total Population	35,337	325,256,835
% Change 2012 - 2017	-0.1%	3.9%
Average Household Income	$44,261	$67,315

	2012	2017	% Change
Total Male Population	16,768	16,767	0.0%
Total Female Population	18,619	18,570	-0.3%
Females, Child Bearing Age (15-44)	5,803	5,636	-2.9%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2012	% of Total	2017	% of Total	USA 2012 % of Total
0-14	6,403	18.1%	6,203	17.6%	20.2%
15-17	1,478	4.2%	1,396	4.0%	4.3%
18-24	2,565	7.2%	3,011	8.5%	9.7%
25-34	3,449	9.7%	3,552	10.1%	13.5%
35-54	9,427	26.6%	8,134	23.0%	28.1%
55-64	5,136	14.5%	5,433	15.4%	11.4%
65+	6,929	19.6%	7,608	21.5%	12.9%
Total	35,387	100.0%	35,337	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2012 Household Income	HH Count	% of Total	USA % of Total
<$15K	3,342	22.5%	13.0%
$15-25K	2,253	15.2%	10.8%
$25-50K	4,610	31.1%	26.7%
$50-75K	2,480	16.7%	19.5%
$75-100K	1,160	7.8%	11.9%
Over $100K	1,001	6.7%	18.2%
Total	14,846	100.0%	100.0%

EDUCATION LEVEL

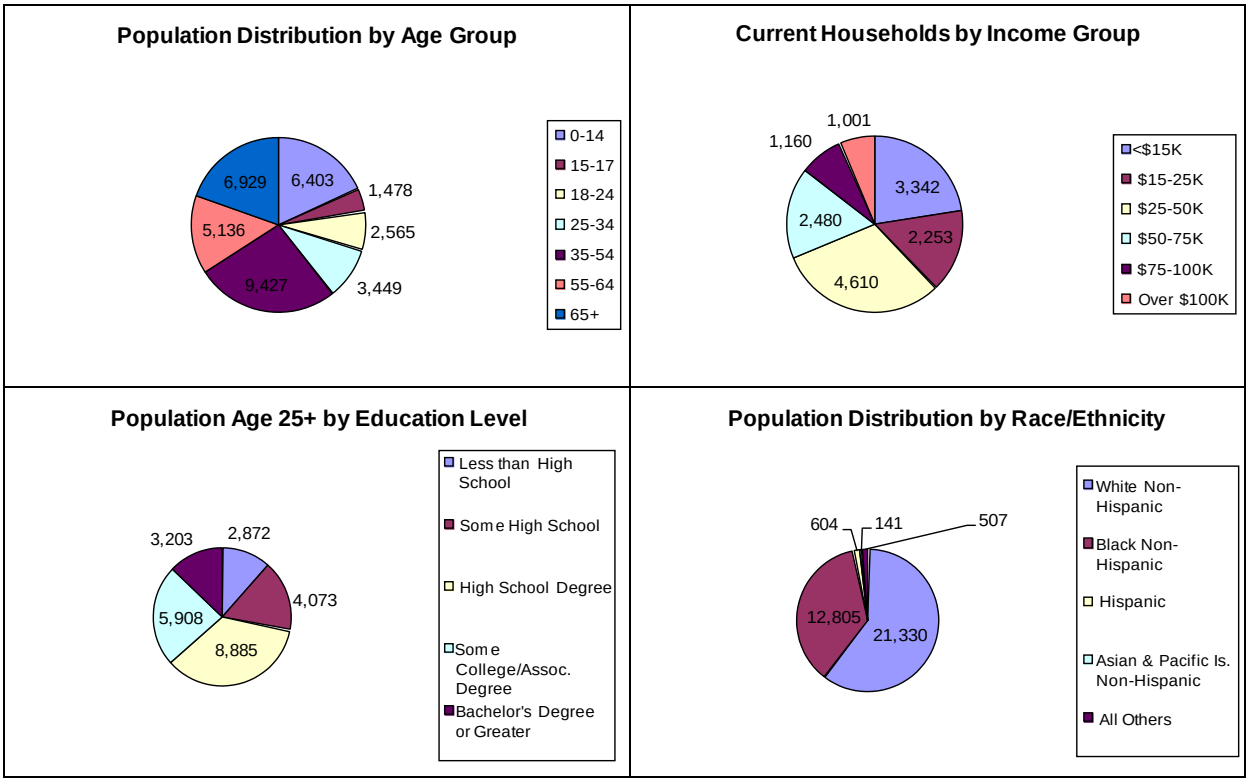
	Education Level Distribution		
2012 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	2,872	11.5%	6.3%
Some High School	4,073	16.3%	8.6%
High School Degree	8,885	35.6%	28.7%
Some College/Assoc. Degree	5,908	23.7%	28.5%
Bachelor's Degree or Greater	3,203	12.8%	27.8%
Total	24,941	100.0%	100.0%

RACE/ETHNICITY

	Race/Ethnicity Distribution		
Race/Ethnicity	2012 Pop	% of Total	USA % of Total
White Non-Hispanic	21,330	60.3%	62.8%
Black Non-Hispanic	12,805	36.2%	12.3%
Hispanic	604	1.7%	17.0%
Asian & Pacific Is. Non-Hispanic	141	0.4%	5.0%
All Others	507	1.4%	2.9%
Total	35,387	100.0%	100.0%

[17] Responds to IRS Form 990 (h) Part V B 1 b
[18] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[19] http://research.stlouisfed.org/fred2/series/VAHALI3URN

2012 Demographic Snapshot Charts



2012 Benchmarks
Area: Halifax CO
Level of Geography: ZIP Code

Area	2012-2017 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2012-2017	Females 15-44 % of Total Population	Females 15-44 % Change 2012-2017	Median Household Income	Median Household Wealth	Median Home Value
USA	3.9%	36.8	12.9%	15.5%	20.1%	-0.9%	$49,559	$54,682	$167,021
Virginia	5.2%	37.3	12.2%	20.7%	20.3%	-0.8%	$58,633	$70,596	$232,019
Selected Area	-0.1%	44.2	19.6%	9.8%	16.4%	-2.9%	$33,724	$55,171	$97,341

Demographics Expert 2.7
DEMO0003.SQP

The population also was examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important adverse potential findings. Items with blue text are viewed as statistically important potential beneficial findings. Items with black text are viewed as either not statistically different from the national normal situation or not being a favorable nor an unfavorable consideration in our use of the information.

Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle		
BMI: Morbid/Obese	109.2%	27.9%
Vigorous Exercise	92.6%	46.8%
Chronic Diabetes	138.8%	14.4%
Healthy Eating Habits	96.2%	28.5%
Very Unhealthy Eating Habits	104.8%	2.9%
Behavior		
I Will Travel to Obtain Medical Care	98.5%	29.3%
I Follow Treatment Recommendations	81.9%	33.0%
I am Responsible for My Health	95.0%	62.3%
Pulmonary		
Chronic COPD	163.3%	6.3%
Tobacco Use: Cigarettes	111.7%	29.0%
Chronic Allergies	99.5%	23.8%
Cancer		
Mammography in Past Yr	107.2%	48.6%
Cancer Screen: Colorectal 2 yr	103.3%	25.5%
Cancer Screen: Pap/Cerv Test 2 yr	86.0%	51.8%
Routine Screen: Prostate 2 yr	97.6%	31.1%
Orthopedic		
Chronic Lower Back Pain	123.6%	27.8%
Chronic Osteoporosis	140.5%	13.6%

Health Service Topic	Demand as % of National	% of Population Affected
Heart		
Routine Screen: Cardiac Stress 2yr	103.9%	16.2%
Chronic High Cholesterol	116.9%	26.1%
Routine Cholesterol Screening	92.6%	47.0%
Chronic High Blood Pressure	138.2%	36.4%
Chronic Heart Disease	162.0%	13.5%
Routine Services		
FP/GP: 1+ Visit	104.8%	92.5%
Used Midlevel in last 6 Months	104.3%	43.4%
OB/Gyn 1+ Visit	80.5%	37.1%
Ambulatory Surgery last 12 Months	102.7%	19.8%
Internet Usage		
Use Internet to Talk to MD	67.6%	9.8%
Facebook Opinions	93.3%	9.6%
Looked for Provider Rating	76.1%	11.0%
Misc		
Charitable Contrib: Hosp/Hosp Sys	93.3%	22.3%
Charitable Contrib: Other Health Org	90.7%	35.4%
HSA/FSA: Employer Offers	96.5%	49.8%
Emergency Service		
Emergency Room Use	106.1%	36.0%
Urgent Care Use	88.0%	20.8%

Leading Causes of Death

Cause of Death			Rank among all counties in VA	Rate of Death per 100,000 age adjusted		
VA Rank	Halifax Co. Rank	Condition	(#1 rank = worst in state)	VA	Halifax Co.	Observation
1	1	Heart Disease	72 of 134	171.7	212.5	As expected
2,10,13,15,20,27, 28,29,30,32,33, 35,36,43	2	Cancer	61 of 134	176.5	203.6	Higher than expected
19,22,23	3	Accidents	19 of 134	33.3	64.8	Higher than expected
3	4	Stroke	49 of 134	42.3	58.7	Higher than expected
4	5	Lung	46 of 134	39.4	46.7	As expected
9	6	Blood Poisoning	8 of 134	17.4	29.9	Higher than expected
8	7	Diabetes	59 of 134	19.6	25.8	As expected
7	8	Kidney	27 of 134	19.7	24.0	Higher than expected
11	9	Flu - Pneumonia	42 of 134	16.2	23.7	Higher than expected
14	10	Suicide	53 of 133	11.9	14.1	Higher than expected
6	11	Alzheimer's	125 of 134	23.3	11.3	Lower than expected
12	12	Hypertension	57 of 132	7.1	7.9	As expected
31	13	Homicide	30 of 123	4.9	7.7	Higher than expected
21	14	Liver	96 of 133	7.7	6.6	Lower than expected
24	15	Parkinson's	95 of 132	6.6	4.5	As expected

Primary and Chronic Disease Needs and Health Issues of Uninsured Persons, Low-Income Persons, and Minority Groups

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups, and other vulnerable population segments. Specific studies identifying needs of such groups, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity, and socioeconomic status. The directive includes a charge to examine disparities in "priority populations," which are groups with unique health care needs or issues that require special attention.[20]

Nationally, this report observes the following trends:

Measures for which Blacks were worse than Whites and are getting better:

- Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
- HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
- Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

Measures for which Blacks were worse than Whites and staying the same:

- Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over ; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
- Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
- Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;
- Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;

[20] http://www.ahrq.gov/qual/nhdr10/Chap10.htm 2010

- Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
- Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
- Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months who got care as soon as wanted; emergency department visits where patients left without being seen; and
- Access – People with a usual primary care provider; people with a specific source of ongoing care.

Measures for which Asians were worse than Whites and getting better:

- Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.

Measures for which Asians were worse than Whites and staying the same:

- Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
- Access – People with a usual primary care provider.

Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and staying the same:

- Heart Disease – Hospital patients with heart failure who received recommended hospital care;
- HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
- Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
- Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;
- Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; and

- Access – People under age 65 with health insurance.

Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and getting worse:

- Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
- Patient safety – Adult surgery patients who received appropriate timing of antibiotics.

Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting better:

- Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
- Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
- Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.

Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:

- Cancer – Women age 40 and over who received a mammogram in the last 2 years; adults age 50 and over who ever received colorectal cancer screening;
- Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
- Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
- HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
- Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
- Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
- Lifestyle modification – Adults with obesity who ever received advice from a health provider to exercise more;

- Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
- Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
- Timeliness – Adults who needed care right away for an illness, injury, or condition in the last 12 months who got care as soon as wanted;
- Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
- Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons

Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting worse:

- Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

We asked a specific question to our Local Expert Advisors about unique needs of priority populations. We reviewed their response to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received to identify unique population needs to which we should respond. Specific opinions from the Local Expert Advisors are summarized as follows[21]:

People need community health care services

Income (uninsured) is a concern

Obesity, dental treatment, chronic diabetes and mental health resources are specific issues needing attention

Statistical information about special populations follows:

[21] All comments and the analytical framework behind developing this summary appear in Appendix A.

Vulnerable Populations: Halifax County, VA

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	9,054
Are unemployed	1,102
Are severely work disabled	1,489
Have major depression	2,154
Are recent drug users (within past month)	2,378

nda No data available.

[1] *The most current estimates of prevalence, obtained from various sources (see the Data Sources, Definitions, and Notes for details), were applied to 2008 mid-year county population figures.*

Access to Care: Halifax County, VA

In addition to use of services, access to care may be characterized by medical care coverage and service availability

Uninsured individuals (age under 65)[1]	4,267
Medicare beneficiaries[2]	
Elderly (Age 65+)	6,301
Disabled	1,936
Medicaid beneficiaries[2]	7,449
Primary care physicians per 100,000 pop[2]	56.5
Dentists per 100,000 pop[2]	31.1
Community/Migrant Health Centers[3]	No
Health Professional Shortage Area[3]	Yes

nda No data available.

[1] *The Census Bureau. Small Area Health Insurance Estimates Program, 2006.*
[2] *HRSA. Area Resource File, 2008.*
[3] *HRSA. Geospatial Data Warehouse, 2009.*

Findings

Upon completion of the CHNA, QHR identified several issues within the HRH community:

Conclusions from Public Input to Community Health Needs Assessment

Our group of 27 Local Expert Advisors participated in an on-line survey to offer opinions about their perceptions of community health needs and potential needs of unique populations.

Responses were first obtained to the question: "What do you believe to be the most important health or medical issue confronting the residents of your County?" In summary, we receive the following commentary regarding the more important health or medical issues:

> Lack of health care resources with an emphasis on primary care and dental issues
>
> Obesity and children issues
>
> Also noted (to a lesser degree of concern) were concerns about area mental treatment resources, emergency service, cancer and need for educational resources

Responses were then obtained to the question: "Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what?" In summary, we received the following commentary regarding the more important health or medical issues impacting priority populations:

> People need community health care services
>
> Income (uninsured) is a concern
>
> Obesity, dental treatment, chronic diabetes and mental health resources are specific issues needing attention

Summary of Observations from Halifax County Compared to All Other Virginia Counties and Independent City, in Terms of Community Health Needs

In general, Halifax County residents are among the least healthy compared to the healthiest in Virginia.

In a health status classification termed "Health Outcomes", Halifax ranks number 112 among the 133 Virginia ranked counties and independent cities (best being #1). Typifying the problem, Premature Death (deaths prior to age 75) is about 20% higher than average for Virginia, and Virginia is slightly better than the national average. This rate has been declining (a desirable trend) during the last 20 years but noticeable improvement has occurred primarily in the last two years. Low Birth

Weight Births is a driver for the high county score. It is significantly higher than the Virginia average and almost doubles the national goal. Self Reported health status measures show Halifax residents having values barely within the margin of error for being considered at the state averages although all are vastly above national goals.

In another health status classification "Health Factors", Halifax County ranks marginally better, ranking number 110 among the 133 Virginia counties and independent cities. Social and Economic Factors are the indicators influencing a lower position among the rankings. Excepting violent crime, all metrics are significantly worse than the Virginia average. Violent crime, while more than double the national goal is almost half the VA average. Children in poverty and Children in single-parent households occur at rates about double the Virginia average. Educational metrics are below the state average and unemployment is 40% above the state average. Clinical Care metrics likewise are detrimental to the rankings. Mammography screening rates are below the state average and significantly below the national goal. Physician to population ratio and dentist to population ratio dramatically (adversely) exceed averages and desired levels. The only positive positioned indicator is diabetic screening rate which has achieved the national goal value of testing 90% of the population.

Healthy Behaviors while appearing high are mostly insignificantly different from the Virginia average. All values, however, greatly exceed the desired national goal levels. Adult obesity, for example, not only exceeds the state average it is trending to greater excess. Physical inactivity was improving toward the state average until 2006 but also is now trending to greater excess. Motor vehicle crash deaths are about triple the state average and national goal. Sexually transmitted disease exceeds the state average rate and is about four times the national goal. Teen births likewise significantly exceed the VA average and are more than double the national goal.

Physical Environment factors rank Halifax County in the bottom 25% of all Virginia counties and independent cities. The driving factor for the low score is the high percentage (11% compared to VA 4%) of low-income individuals who do not live close to grocery stores having healthy foods. Likewise, the percentage of fast food restaurants is double the national goal. Pollution metrics for air and water quality are beneficial considerations. Health Factor Conditions where improvement remains to achieving national goals include every metric analyzed except the following:

Diabetic Screening

High School Graduation (no national goal established but value is below VA average)

Drinking Water Safety

Summary of Observations from Halifax County Peer Comparisons

The federal government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic and demographic characteristics. Health and wellness

observations when Halifax County is compared to its national set of Peer Counties and compared to national rates make the following observations:

UNFAVORABLE observations occurring at rates worse than national AND worse than among Peers (Please note this list of adverse indicators is considerably longer than typically observed):

Low Birth Weight (less than 2,500g)

Very Low Birth Weight (less than 1,500g)

Premature Births

Births to Unmarried Women

No Care in First Trimester

Infant Mortality

Black non Hispanic Infant Mortality

Neonatal Infant Mortality

Post Neonatal Infant Mortality

Breast Cancer (female)

Colon Cancer

Homicide

Motor Vehicle Injuries

Stroke

SOMEWHAT A CONCERN observations because occurrence is worse than national average BUT better than the Peer group average, OR, better than national average BUT worse than Peer group average:

Births to Women Under 18

Births to Women Age 40 to 54

Lung Cancer

Suicide

BETTER performance than Peers and National rates:

Coronary Heart Disease

White non Hispanic Infant Mortality

Unintentional Injury

Conclusions from the Demographic Analysis Comparing Halifax County to National Averages

Halifax County in 2012 comprises 35,387 residents. Since 2000 it has experienced population decline and anticipates basically no sizable change through the next five years to achieve 35,337 residents. The population is 60.3% non-Hispanic White. Asian & Pacific Island non-Hispanics constitute 0.4% of the population. Hispanics comprise 1.7% of the population. Black non-Hispanics are the largest minority population at 36.2%. 19.6% of the population is age 65 or older. This is a considerably larger population segment than the elderly comprise elsewhere in Virginia or in comparison to the national average. 16.4% of the women are in the childbirth population segment. This segment is considerably smaller than as elsewhere in Virginia or in comparison to the national average. The median income in the County is below the VA and national averages. Household wealth is at the national average but below the Virginia average. Median Home Value is considerably below the VA and national averages.

The following areas were identified from a comparison of the county to national averages:

Metrics impacting more than 25% of the population and statistically significantly different from the national average include the following. All are considered adverse findings unless otherwise noted:

Obtained a Pap/Cervix test in last 2 years 14% below average impacting 52% of the population

Obtained a Mammogram in last 2 year 7% above average impacting 49% of the population; a beneficial finding

Obtain routine cholesterol screening is 7% below average impacting 47% of the population

Engage in Vigorous Exercise is 7% below average impacting 47% of the population

Obtained an OB/GYN visit last year is 20% below average impacting 37% of the population

Chronic high blood pressure 38% above average impacting 36% of the population

Used an Emergency Room in last year 6% above average impacting 36% of the population

I follow treatment recommendations is 18% below average impacting 33% of the population

Tobacco Use 12% above average impacting 29% of the population

Morbid obese 9% above average impacting 28% of the population

Chronic low back pain 24% above average impacting 28% of the population

Chronic high Cholesterol 17% above average impacting 26% of population

Situations and Conditions statistically significantly different from the national average but impacting less than 25% of the population include the following. All are considered adverse findings unless otherwise noted:

Chronic diabetes 39% above average impacting 14% of the population

Chronic osteoporosis 40% above average impacting 14% of population

Chronic heart disease 62% above average impacting 14% of the population

Chronic COPD 63% above average impacting 6% of the population

Key Conclusions from Consideration of the Other Statistical Data Examinations

Additional observations of Halifax County found:

Palliative Care (programs focused to relieve disease symptoms pain and stress arising from serious illness) do not exist in the County. Hospice Care (programs providing comfort care during terminal disease) exist.

Among the leading causes of death, Halifax County has a significantly lower death rate in 2 of the 15 leading causes of death and a significantly higher death rate in 8 of the 15 leading causes of death. Ranking the causes of death in Halifax County finds the leading causes to be the following (in descending order of occurrence):

1. Heart Disease 212.5 (rate per 100,000) – County ranks #72 of 134 in VA (#1 rank = worse in state), above VA average
2. Cancer 203.6 – significantly higher than expected, rank #61 of 134, above VA average
3. Accidents 64.8 – significantly higher, rank #19 of 134, above VA average, among men and women age 15-24 leading cause of death in VA
4. Stroke 58.7 – significantly higher, rank #49 of 134, above VA average
5. Lung Disease 46.7 – rank #46 of 134, above VA average
6. Blood Poisoning 29.9 – significantly higher, rank #8 of 134, above VA average
7. Diabetes 25.8 – rank #59 of 134, above VA average
8. Kidney Disease 24 – significantly higher, rank #27 of 134, above VA average
9. Flu/Pneumonia 23.7 – significantly higher, rank #42 of 134, above VA average
10. Suicide 14.1 – rank #53 of 134, above VA average, 8th VA cause of death among men, 20th cause of death among women, #3 cause of death among 15-24 age females and males in VA

Heart Disease Mortality during 2007 through 2009 (427.6 per 100,000) is above the national average (359.1) but it is significantly higher for the Black population (529.2 compared to the national rate of 483.8). Halifax is placed in the second highest national quintile of counties (60% to 80% of all counties in the nation).

The incident of Stroke deaths (122.5 compared to the national average of 78/100,000) is in the highest national classification. However, the death rate among the Black population in Halifax County is significantly higher (148.2 compared to the national average for Blacks at 116.4/100,000)

Male life expectancy in 2009 was 10.3 years behind the top 10 best international country rates (second worse international classification). This improved from 1989 when it was among the worst performers (lowest classification of life expectancy in the world). Life expectancy for Women is 7.3 years behind the 10 best international country rates (also in the second worse international classification). Females did not achieve the same degree of improvement as Males did in Halifax County.

Halifax is designated as a Primary care and Dental and Mental Health, Health Professional Shortage Area. It also qualifies as a Medically Underserved Area, making it eligible for some federal physician recruitment assistance.

Importantly higher percentages of Halifax residents have the following attributes. 20.3% of Halifax County residents (27.6% of children) live in poverty. 19.58% of residents are recipients in the Supplemental Nutritional Assistance Program, 61% of children participate in free / reduced price meal program. There are fewer than average grocery stores per population and a higher than average number of liquor stores. (heavy alcohol consumption is below VA and national average.) 41.9% of the population live in a "food desert". Air quality is not a problem.

22.45% of residents do not have a consistent source of primary care (no doctor). 33.4% of the population has not visited a dentist in the last year.

EXISTING HEALTH CARE FACILITIES, RESOURCES AND IMPLEMENTATION PLAN

Significant Health Needs

We used the priority ranking of area health needs by the Local Expert Advisors to organize the search for locally available resources as well as the response to the needs by HRH.[22] The following list:

Identifies the rank order of each identified Significant Need;

Presents the factors considered in developing the ranking;

Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term;

Identifies HRH current efforts responding to the need;

Establishes the Implementation Plan programs and resources HRH will devote to attempt to achieve improvements;

Documents the Leading Indicators HRH will use to measure progress;

Presents the Lagging Indicators HRH believes the Leading Indicators will influence in a positive fashion, and;

Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, Halifax Regional Hospital, Inc. is the major hospital in the service area. Halifax Regional Hospital is a 192 bed, acute care medical facility located in South Boston, VA. The next closest facilities are outside the service area and include:

Danville Regional Medical Center, a 250 bed acute care facility located in Danville, VA (33 miles, 47 minutes from South Boston, VA)

Community Memorial Hospital, a 274 bed acute care facility located in South Hill, VA (51.3 miles, 1 hour and 5 minutes from South Boston, VA)

Centra Southside Community Hospital, an 86 bed acute care facility located in Farmville, VA (59 miles, 1 hour and 29 minutes from South Boston, VA)

Person Memorial Hospital, a 102 bed acute care facility located in Roxboro, NC (24.6 miles, 32 minutes from South Boston, VA)

All data items analyzed to determine significant needs are "Lagging Indicators", measures presenting results after a period of time, characterizing historical performance. Lagging Indicators tell you nothing about how the outcomes were achieved. In contrast the HRH Implementation Plan utilizes "Leading Indicators". Leading Indicators anticipate change in the Lagging Indicator. Leading

[22] Response to IRS Form 990 h Part V B 1 c

Indicators focus on short-term performance, and if accurately selected, anticipate the broader achievement of desired change in the Lagging Indicator. In the QHR application Leading Indicators also must be within the ability of the hospital to influence and measure.

Significant Needs

1. CANCER – 2nd cause of death, rate higher than expected, 61st VA rank County (1st is worst) above VA average rate of death; Advisors cite "cancer" as a secondary problem concern; Mammography screening below VA average and national goal, recent Mammogram beneficial 7% above average impacts 49% of population; rates worse than national and peer average for Breast Cancer (female) and Colon Cancer; rates exceed peer or national average for Lung Cancer; obtained recent Pap/Cervix 14% below average impacts 52% of population

Opportunity Statement: Cancer detection and screening services need greater participation

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

Every Woman"s Life grant

HRH Endoscopy

HRH Radiology

HRH Health Expo – community education opportunity

HRH Health Nite Out – community education opportunity

HRH Life & Health quarterly newsletter

Annual Prostate Screening Event

LabChoice, including Direct Access Testing

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:[23]

Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how HRH resources can benefit their initiatives. HRH will initiate efforts by contacting each organization to establish a forum for effort collaboration.

Allocating resources to acquire educational material to distribute to patients receiving a cancer diagnosis or interested in the disease

Providing a schedule of educational seminars to patients and interested residents

Re-apply for Komen Foundation funding to support breast cancer screenings

[23] This section in each need for which the hospital plans an implementation strategy responds to Schedule H (form 990) Part V Section B 6. a. and 6. b.

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

An increase in the use of screening and cancer detection services leading to earlier intervention and increased survival

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Volume of colonoscopy and mammography exams should increase from 2012 volumes.

- 2012 colonoscopy exams = 1389
- 2012 mammography exams = 4261
- 2013 Prostate screenings (2012 not available) =

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Cancer death rate per 100,000

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Halifax County Cancer Association	P.O. Box 1891 Halifax, VA 24558	434-476-2714
American Cancer Society – local/regional branch	130 LeGrande Ave. Charlotte Courthouse, VA 23923	434-542-4334
H.O.P.E. – local cancer support group	P.O. Box 1891 Halifax, VA 24558	434-575-2969
Bosom Buddies – support group for women with breast cancer	215 Lakeside Drive Buffalo Junction, VA 24529	434-374-5207
Connected by Cancer & Beyond – one day annual cancer conference	Massey Cancer Center, VCU Susan Mathena Institute for Advanced Learning & Research 150 Slayton Avenue Danville, VA 24540	434-766-6649
Fuller Roberts Clinic	2212 Wilborn Avenue South Boston, VA 24592	434-572-8921

2. Obesity / Overweight –

Advisors cite problem "Obesity"; Adult obesity exceeds VA average trending worse; Morbid obese 9% above average impacts 28% of the population; Vigorous Exercise 7% below average impacts 47% of population; Physical inactivity trending to VA average, now trending worse; fast food restaurants double national goal; few grocery stores per population, higher number liquor stores; 41.9% live in "food desert"

Opportunity Statement: Increase awareness of maintaining a healthy weight and lifestyle.

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

Eating for a Healthy Weight & Heart class

Health Nite Out educational programming

Annual HRHS Healthy Living EXPO

HRH Life & Health Quarterly Newsletter

HRH inpatient and outpatient nutrition counseling

HRH employee wellness program (HRH is area"s largest employer)

Mindful Eating program implemented in HRH facilities by food services

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

HRH will pursue grant funding to establish a local coalition to develop an integrated approach to obesity by coordinating efforts and formulating a multi-component obesity prevention intervention initiative.[24]

HRH will lead by example by fostering employee involvement in a worksite prevention intervention.[25]

Label foods to show serving size and nutritional content: availability and awareness of nutritional information content may decrease calorie consumption.

Make water available and promote consumption of water in place of sweetened beverages.

Institute workplace incentives for physical activity.

Implement breastfeeding programs to increase breastfeeding initiation, exclusive breastfeeding, and duration of breastfeeding.

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

HRH anticipates a greater percentage of residents will no longer be obese

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Number of active members in coalition

Number of participants in health events and BMI screenings:

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Reduction in the percent of Halifax residents having an obesity value equal to or greater than 30 from 33%, or 1.15 standard deviations above the VA mean

[24] http://www.countyhealthrankings.org/policies/multi-component-obesity-prevention-interventions
[25] http://www.countyhealthrankings.org/app/#/new-mexico/2013/measure/factors/11/policies

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
YMCA of South Boston and Halifax County	650 Hamilton Blvd., South Boston, VA 24592	434-572-8909
Weight Watchers	1005 Washington Avenue South Boston, VA 24592	434-575-7195
Curves	3340 Halifax Road, South Boston, VA 24592	434-572-8626
South Boston Parks & Rec	1620 Jeffress Blvd. South Boston, VA 24592	434-575-4230
Halifax County Parks & Rec	1030 Mary Bethune Road Halifax, VA 24558	434-476-3332
Halifax County Public Schools	1030 Mary Bethune Road Halifax, VA 24558	434-476-2171

3. CORONARY HEART DISEASE – 1st cause of death Heart Disease 72nd VA rank County (1st is worst), death rate is above VA average, death rate better than peer and national average; Chronic heart disease 62% above average impacts 14% of population; Heart Disease Mortality 2007 to 2009 above national average

Opportunity Statement: The incident of Coronary Heart Disease caused deaths needs to decrease

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

Annual HRHS Healthy Living Expo

HRHS Business Outreach Program – visits to local businesses to provide educational programming and blood pressure screenings

HRH CardioPulmonary Rehabilitation Program

Health Nite Out education programming

Local health fair participation

HRH Life & Health quarterly newsletter

HRH inpatient and outpatient nutrition counseling

Low-cost self-referral direct access testing at HRH laboratory

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

Increase public awareness of direct access testing services

Evaluate feasibility of adding a vascular lab to HRH Center for Cardiovascular Services

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

Coronary Heart Disease deaths should decrease

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Number of Stress Tests performed at HRH

- 2012 value = 767

Number of cardiac rehabilitation patients involved in Phase 2 rehabilitation program

- 2012 value = 126

Number of Lipid panels conducted (tracking to begin with 2013)

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Number of heart disease deaths in Halifax County.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
YMCA of South Boston and Halifax County	650 Hamilton Blvd. South Boston, VA 24592	434-572-8909
Halifax Heart Center	2232 Wilborn Avenue South Boston, VA 24592	434-572-8977
Weight Watchers	1005 Washington Avenue South Boston, VA 24592	434-575-7195

4. MATERNAL AND INFANT MEASURES – Low Birth Weight Births higher than VA average, doubles national goal; Teen births exceeds VA average, double national goal; Rates worse than national and peer avg. include Low Birth Weight; Very Low Birth Weight; Premature Births; Births to Unmarried Women; No Care in First Trimester; Infant Mortality; Black non-Hispanic Infant Mortality; Neonatal Infant Mortality; Post Neonatal Infant Mortality; rates exceed peer or national average include Births to Women Under 18, Births to Women Age 40 to 54; rate better than peer and national average for White non-Hispanic Infant Mortality

Opportunity Statement: Increase the percent of pregnant women seeking care during the first trimester

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Prepared Childbirth Program

HRH Physicians and medical practices as listed on www.HRHS.org website

Baby Basics Class

HRH Life & Health quarterly newsletter

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES: HRH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:

Lack of expertise: this is a complex issue that is a longstanding and intractable challenge in our area.

A lack of identified effective interventions to address this need: The state of Virginia is still debating the merits of various approaches to improving the conditions of young families and women in their childbearing years.

This need is being addressed by other organizations.

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

The assumption is that guidance will come from the state departments of health, social services and children"s services to assist localities in developing interventions to address this need in the future. HRH participates in a variety of local committees and boards that address this issue, and will continue to monitor the subject to determine how best to assist.

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

None as HRH will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources.

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

N/A

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Southside Community Service Board – child case management	424 Hamilton Blvd. South Boston, VA 24592	434-572-6916
Health Dept. Maternal/Child Care Coordination and WIC	1030 Mary Bethune Road Halifax, VA 24558	434-476-4863
DSS – enrollment in various maternal/child programs	1030 Mary Bethune Road Halifax, VA 24558	434-476-6594
Smart Beginnings Early Childhood Initiative	Edwina Gill 109 Campus Drive Alberta, VA 23821	434-949-6612

5. PRIORITY POPULATIONS – Advisors cite problem "children issues"; Children in poverty"; Advisor priority population concern "People need community health care services, income (uninsured), "obesity, dental treatment, chronic diabetes and mental health resources"; and Children in single-parent households double VA average; Educational metrics below VA average: low-income do not live close to grocery; Heart Disease Mortality Black population significantly higher; Black death rate significantly higher compared to Black national average; 20.3% of residents (27.6% of children) live in poverty; 19.58% receive "food stamps"; 61% of children get free / reduced meals

Opportunity Statement: Child health and Prevention resources need to increase

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

Halifax Regional Dental Clinic

HRH Patient financial assistance program

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES: HRH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:

The need is addressed by other organizations

The need is addressed in already existing HRH programming although not as a consolidated whole

There exists a lack of identified effective interventions to address the need.

This need grouping incorporates a broad spectrum of social and economic challenges which create an overall environment that causes population members to struggle to maintain a functional lifestyle on many fronts. HRH believes that efforts to address these challenges must incorporate economic, educational, and social efforts as well as healthcare interventions. HRH will monitor the local attempts to address these issues to determine how we can best assist.

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

The assumption is that the conditions giving rise to this set of related needs can only be with long term community planning, and that even those plans will depend upon larger economic and social forces outside of our control.

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

None as HRH will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources.

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

N/A

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Halifax County Health Dept.	1030 Mary Bethune Street Halifax, VA 24558	434-476-4863
Halifax County Public Schools	1030 Mary Bethune Street Halifax, VA 24558	434-476-2171
Halifax County DSS	1030 Mary Bethune Street Halifax, VA 24558	434-476-6594
Tri-County Community Action	1176 Huell Matthews Highway South Boston, VA 24592	434-575-7916
Southside Community Services Board	424 Hamilton Blvd. South Boston, VA 24592	434-572-6916
VA Employment Commission	2506 Houghton Avenue South Boston, VA 24592	434-572-8064
Southern Virginia Higher Education Center	820 Bruce Street South Boston, VA 24592	434-572-5440

6. MENTAL HEALTH / SUICIDE / Substance Abuse – Suicide 10th cause of death, 53rd rank VA County (1st is worst), above VA average, 3rd cause of death in the 15-24 age group; Advisors cite "mental treatment resource" secondary problem concern; Self-Reported health status at VA average; death rate vastly above national goals; Suicide rates exceed peer or national average; Mental Health shortage area

Opportunity Statement: Increased access to behavioral health services is needed.

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

HRH Depression Screening Program

HRH Center for Behavioral Health Outreach Program

HRH Life & Health quarterly newsletter

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how HRH services can benefit their initiatives.

Emergency service staff will be trained in suicide tendency identification and awareness of intervention strategies

HRH will evaluate the feasibility of providing telehealth mental health service opportunities

HRH will evaluate to improve efforts for recruitment of psychiatrist

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

The development of a behavioral health service program using a combination of resources and technologies as appropriate and feasible

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Fewer TDOs (temporary detainment orders)

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Improvement in ranking on the County Health Rankings list

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Community Services Board	424 Hamilton Blvd South Boston, VA 24592	434-572-6916
Mental Health Assn. of Halifax County	554 North Main Street South Boston, VA 24592	434-572-3992
Hope for Tomorrow Counseling	435 Main Street South Boston, VA 24592	434-575-0147
Emily Noblin Counseling Services	57 Mountain Road Halifax, VA 24558	434-476-6038
Halifax Counseling Center	100 Mountain Road Halifax, VA 24558	434-476-8888
Family Preservation Services	1320 Seymour Drive South Boston, VA 24592	434-572-8598
Debra Savage, LCSW	3401 Old Halifax Road South Boston, VA 24592	434-575-3017
Halifax County DSS	1030 Mary Bethune Street Halifax, VA 24592	434-476-6594

7. DENTISTS – Advisors cite problem "Lack of health care resources emphasizing dental issues"; DDS to population ratio dramatically (adversely) exceed average and desired level; Dental care shortage area; 33.4% of population had no DDS visit in last year

Opportunity Statement: Increase the Dentist to population ratio

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH: Halifax Regional Dental Clinic

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

HRH will review the success of its dentist recruitment process to ensure the most desirable practice environment resulting in an increase of Dentists.

HRH will hire a second dentist for the dental clinic

HRH will hire a third dental assistant to increase patient flow through the clinic

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

Increase in Dental services in Halifax County

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Increase in the number of dentists in Halifax County accepting patients

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Dentist to population ratio, Halifax County is 3,079 residents per Dentist or 0.34 standard deviations above the Virginia mean ratio.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Keith Pyle, DDS	420 Hamilton South Boston, VA	434.572.6577
Richard Bradley, Jr., DDS	187 S Main South Boston, VA	434.476.7885
Michael Peer, DDS	1997 Hamilton South Boston, VA	434.575.5677
Michele Ah, DDS	420 Hamilton South Boston, VA	434.575.8488
Norman Williams, DDS	1515 Noblin South Boston, VA	434.572.4585

8. Diabetes – 7th cause of death Diabetes 59th ranking among VA Counties (1st is worst); death rate above VA average; diabetic screening rates achieved national goal; Chronic diabetes 39% above average (more serious), impacts 14% of population

Opportunity Statement: Public awareness of healthy A1c blood sugar levels needs to be increased.

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH educational program about reducing diabetes as a complication for heart attack and stroke

Diabetes Group Class – meets approx.12 times during each CY

HRH Physicians and medical practices as listed on www.HRHS.org website

HRH Life & Health quarterly newsletter

Health Nite Out education programming

Annual HRHS Healthy Living EXPO

Local health fair participation (Blood glucose screening provided)

Low-cost self-referral direct access testing through HRH laboratory

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how HRH services can benefit their initiatives. HRH will initiate efforts by contacting each organization to establish a forum for effort collaboration.

HRH will pursue grant funding to establish a local coalition to develop an integrated approach to the related health challenges of coronary heart disease, obesity and diabetes with the goal of coordinating efforts and formulating a multi-component prevention and intervention initiative.[26]

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN:

More people will be tested for diabetes, and will be diagnosed earlier in the disease process, resulting in better control of blood sugar levels and better compliance with recommended protocols.

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Increase in the number of A1c screenings conducted by the HRH laboratory

Increase in the number of blood glucose tests conducted at local community health events

Volume of patients engaging in nutritional counseling should increase from 2012 volumes.

- 2012 diabetes management service participants = 534

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Percent of diabetic Medicare enrollees receiving HbA1c screening in Halifax County in 2010 was 773 diabetics, 90% have screening values which is -0.8 standard deviations below the VA mean.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Halifax Endocrinology and Osteoporosis Center	2232 Wilborn Avenue South Boston, VA 24592	434-575-5844
Lake Country Area Agency on Aging	Main Office, South Hill, VA	434-447-7661

9. STROKE – 4th cause of death, rate higher than expected, 49th VA rank County (1st is worst); death rate above VA average; death rates worse than national and peer average; Stroke deaths in highest national classification

[26] http://www.countyhealthrankings.org/policies/multi-component-obesity-prevention-interventions

Opportunity Statement: The incident of death from Strokes needs to decline

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

HRH Emergency service

HRH Stroke/Aphasia Support Group

HRH Physical, Occupational and Speech Therapy program for neurological impairments

Stroke Support Group

Health Nite Out education programming

Annual HRHS Healthy Living EXPO

HRH Emergency Department Teleneurology program

HRH Life & Health quarterly newsletter

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

HRH will enhance efforts to make residents aware of stroke symptoms and benefits from rehabilitation

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

Patients having stroke related degenerative conditions would have enhanced restorative and coping skills

Increased public awareness of stroke indications resulting in increased presentation of patients earlier in the condition onset where intervention is most effective

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Number of stroke patients participating in rehabilitation programs

- 2012 participants = 136

Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival

- 2012 value not available

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Improvement in the stroke death rate ranking of counties in Virginia so as to not exceed the state average (Halifax value rank 49 of 134 with rate of 58.7 deaths per 100,000 [significantly high] compared to VA average death rate of 42.31)

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
South Boston Fire Dept.	403 Broad Street South Boston, VA 24592	434-575-4291
Halifax Fire Dept.	375 North Main St. P O Box 513 Halifax, VA 24558	434-476-6001
Clover Fire Dept.	1020 N. Gayle St., P O Box 199 Clover, VA 24534	434-454-7340
Virgilina Fire Dept.	8052 Florence Ave., P O Box 266 Virgilina, VA 24598	434-585-4444
Scottsburg Fire Dept.	3050 Scottsburg Rd., P O Box 96 Scottsburg, VA 24589	434-454-6700
Turbeville Fire Dept.	1002 Melon Road South Boston, VA 24592	434-753-6726
Cluster Springs Fire Dept.	1009 Black Walnut Church Rd. P O Box 110 Cluster Springs, VA 24535	434-575-7094
Liberty Fire Dept.	4070 Liberty Road 2245 Lower Liberty Road Nathalie, VA 24577	434-349-3395
North Halifax Fire Dept.	4201 Leda-Grove Road Nathalie, VA 24577	434-349-3500
Oak Level Fire Dept.	2019 Oak Level Rd., P O Box 64 Vernon Hill, VA 24597	434-476-2550
Midway Fire Dept.	11009 Bill Tuck Hwy 5090 Ramble Road Virgilina, VA 24598	434-572-6194
Triangle Fire Dept.	3060 Morton"s Ferry Road 4205 Hunting Creek Road Nathalie, VA 24577	434-454-6845
Halifax County Rescue Squad	700 Hamilton Blvd., PO Box 183 South Boston, VA 24592	434-572-3960

10. BLOOD PRESSURE (HIGH) – 38% above average impacts 36% of population

Opportunity Statement: Hypertension as a cause of death needs to decline

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

HRH cardiovascular services

Annual HRHS Healthy Living Expo

HRHS Business Outreach Program – visits to local businesses to provide educational programming and blood pressure screenings

HRH CardioPulmonary Rehabilitation Program

Health Nite Out education programming

Local health fair participation

HRH inpatient and outpatient nutrition counseling

HRH Life & Health quarterly newsletter

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES: HRH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:

This need is addressed by other HRH plans and programs described in this document under the need statements of obesity, coronary heart disease and diabetes

This need is addressed by other organizations

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

The assumption is that plans and programs devoted to addressing other needs delineated by this document will also address the issues that result in hypertension.

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

None as HRH will not actively engage in implementation efforts but will monitor and support the efforts taken by others, including the organizations shown below as resources.

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Halifax ranks #57 for Hypertension as a cause of death in Virginia, above the state average. This ranking and relationship to the state average is what will be monitored for progress.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Halifax Heart Center	2232 Wilborn Avenue South Boston, VA 24592	434-572-8977
YMCA of South Boston and Halifax County	650 Hamilton Blvd. South Boston, VA 24592	434-572-8909
Weight Watchers	1005 Washington Avenue South Boston, VA 24592	434-575-7195
Curves	3340 Halifax Road South Boston, VA 24592	434-572-8626

11. PHYSICIANS – Advisors cite problem "Lack of health care resources emphasizing primary care; DR to population ratio adversely exceeds average and desired level; OB/GYN visit last year 20% below average impacts 37% of population; Primary care shortage area and medically underserved; 22.45% of residents no source of primary care

Opportunity Statement: Increase the Primary Care providers to population ratio

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH physician and midlevel recruitment

Virginia College of Medicine student physician placement at HRH

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

HRH will review the success of its physician recruitment process and enter discussions with the medical staff about how to construct the most desirable practice environment.

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

Increase in the primary care medical resources in Halifax County

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Number of primary care practitioners in Halifax County accepting patients.

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Primary care physician to population ratio, Halifax County is 2,347 residents per primary care physician or 0.09 standard deviations above the Virginia mean ratio.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Local Centers of Higher Education:		
SVHEC affiliated programs	820 Bruce Street South Boston, VA 24592	434-572-5440
SVCC	109 Campus Drive Alberta, VA 23821	434-949-1000

12. ACCIDENTS – 3rd cause of death, leading cause age 15-24; rate higher than expected, 19th rank Co in VA (1st is worst) above VA average; Motor vehicle crash deaths triple VA average.; Motor Vehicle Injury rates worse than national and peer average.; Unintentional Injury Rate better than peer and national average

Opportunity Statement: Reduce the number of deaths caused from automobile accidents.

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Emergency service

HRHS Emergency department

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES: HRH DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED FOR THE FOLLOWING REASONS:

Although there have been many programs through the schools to address issues surrounding the relationship between alcohol and traffic accidents, and in spite of the fact that AA meets regularly in our area to help with matters of substance abuse there are no identified means to prevent impaired driving that have been shown to be effective.

The issues involved with traffic accidents are addressed by other organizations, including those listed below as resources.

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

The assumption is that this is an intractable problem requiring the efforts of many community actors, including public organizations, churches, individual parents, and the schools. It is beyond our capacity to undertake a project of this scope, however HRH will monitor the efforts of others, collaborate where possible, and assist where it will benefit the community.

LEADING INDICATOR HRH WILL USE TO MEASURE COMMUNITY PROGRESS:

Number of automobile trauma victims presenting in HRH emergency service

- 2012 automobile trauma patients = 524

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Motor Vehicle crash deaths per 100,000 population in Halifax there were 78 or 1.59 standard deviations above the VA mean.

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
South Boston Fire Dept.	403 Broad Street South Boston, VA 24592	434-575-4291
Halifax Fire Dept.	375 North Main St. P O Box 513 Halifax, VA 24558	434-476-6001
Clover Fire Dept.	1020 N. Gayle St., P O Box 199 Clover, VA 24534	434-454-7340
Virgilina Fire Dept.	8052 Florence Ave., P O Box 266 Virgilina, VA 24598	434-585-4444

Scottsburg Fire Dept.	3050 Scottsburg Rd., P O Box 96 Scottsburg, VA 24589	434-454-6700
Turbeville Fire Dept.	1002 Melon Road South Boston, VA 24592	434-753-6726
Cluster Springs Fire Dept.	1009 Black Walnut Church Rd. P O Box 110 Cluster Springs, VA 24535	434-575-7094
Liberty Fire Dept.	4070 Liberty Road 2245 Lower Liberty Road Nathalie, VA 24577	434-349-3395
North Halifax Fire Dept.	4201 Leda-Grove Road Nathalie, VA 24577	434-349-3500
Oak Level Fire Dept.	2019 Oak Level Rd., P O Box 64 Vernon Hill, VA 24597	434-476-2550
Midway Fire Dept.	11009 Bill Tuck Hwy 5090 Ramble Road Virgilina, VA 24598	434-572-6194
Triangle Fire Dept.	3060 Morton"s Ferry Road 4205 Hunting Creek Road Nathalie, VA 24577	434-454-6845
Halifax County Rescue Squad	700 Hamilton Blvd., PO Box 183 South Boston, VA 24592	434-572-3960
Halifax County Public Schools	1030 Mary Bethune Street Halifax, VA 24558	434-476-2171

13. COPD / (LUNG DISEASE) / PULMONARY – 5th cause of death; Lung Disease ranks Halifax 46th among VA County (1st is worst); above VA average; Chronic COPD 63% above average impacts 6% of population

Opportunity Statement: The incidence of COPD-related deaths needs to decrease.

HRH RESOURCES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

HRH Physicians and medical practices as listed on www.HRHS.org website

HRH CardioPulmonary Rehabilitation Program

Halifax Regional Home Health

HRH Better Breathers Support Group

HRH Health Nite Out – community education opportunity

HRH Life & Health quarterly newsletter

HRH IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

HRH will initiate efforts by contacting each organization to establish a forum for effort collaboration.

HRH Stop smoking program

HRH smoke free campus and facilities

ANTICIPATED RESULTS FROM HRH IMPLEMENTATION PLAN

Enhanced awareness will result in patients presenting earlier in the disease process.

LEADING INDICATOR HRH WILL USE TO MEASURE PROGRESS:

Number of patients diagnoses with 78605 (shortness of Breath), 51889 (Other Lung Disease NEC)

- Halifax 2012 diagnosis 78605 = 160
- Halifax 2012 diagnosis 51889 = 151

LAGGING INDICATOR HRH WILL USE TO IDENTIFY IMPROVEMENT

Reduction in Lung Disease as cause of death from Halifax 2012 value of 47 deaths per 100,000

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
Pulmonary Associates of Southside VA	2210 Wilborn Avenue South Boston, VA 24592	434-575-5864
Community Services Board smoking cessation programs	424 Hamilton Avenue South Boston, VA 24592	434-572-6916

Other Needs Identified During the CHNA Process

14. Predisposing Factors – All Social and Economic Factors excepting violent crime, are significantly worse than VA average. Violent crime, double national goal but is half the VA average unemployment 40% above VA average; Healthy Behaviors are at VA average

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

15. Smoking / Tobacco Use – Tobacco Use 12% above average impacts 29% of population

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

16. Life Expectancy / Premature Death – Premature Death (prior to 75) 20% higher than average for VA; Male life expectancy is in second worst classification, improved from lowest classification in „89; Women also in second worst classification did not improve as Males did

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

17. Cholesterol (High) – routine screening 7% below average impacts 47% of population; Chronic high Cholesterol 17% above average impacting 26% of population

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

18. Kidney Disease – 8th cause of death, rate higher than expected, 27th rank VA County (1st being worst), above VA average death rate

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

19. Sexually Transmitted Disease – exceeds VA average four times national goal

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

20. Alcohol/Substance Abuse – heavy alcohol consumption below VA and national average

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

21. Physical Environment – factors rank County in bottom 25% of all VA counties and independent cities; air and water quality beneficial factors; Drinking Water Safety at national goal; Air quality no problem

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

22. Compliance Behavior – Advisors cite "need for educational resources" secondary problem concern; follow treatment recommendations 18% below average impacts 33% of population

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

23. Chronic Osteoporosis – 40% above average impacts 14% of population

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

24. Blood Poisoning – 6th cause of death, rate higher than expected, 8th rank VA County (1=worst in VA) of 134 Counties, above VA average death rate

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

25. Emergency Service – Advisors cite "emergency service" secondary problem concern; Used ER in last year 6% above average impacts 36% of population

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

26. Homicide – rates worse than national and peer average

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

27. Palliative Care & Hospice – Palliative Care (focused on disease symptom relief) do not exist, Hospice Care do exist

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

28. Flu/Pneumonia – 9th cause of death, rate higher than expected, 42nd rank VA County (1st being worst), death rate above VA average

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

29. Low Back Pain (Chronic) – 24% above average impacts 28% of population

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

30. Housing Conditions for the elderly and disabled – Community Need identified by Local Expert Advisors

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

31. Skilled Care Program – Community Need identified by Local Expert Advisors

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

32. Insurance is a major concern (accuracy, coverage, accounting, promptness) – Community Need identified by Local Expert Advisors

Other Local Resources identified during the CHNA process which are believed available to respond to this need include the following:		
None Identified during the process		

Overall Community Need Statement and Priority Ranking Score:

Significant Needs Where Hospital Has Implementation Responsibility[27]

1. Cancer
2. Obesity/Overweight
3. Coronary Heart Disease
6. Mental Health / Suicide
7. Dental
8. Diabetes
9. Stroke
11. Physicians
13. COPD / (Lung Disease) / Pulmonary

Significant Needs Where Hospital Did Not Develop Implementation Plan

4. Maternal and Infant Measures
5. Priority Populations
10. Blood Pressure (High)
12. Accidents

Other Needs Where Hospital Developed Implementation Plan

None

Other Identified Needs Where Hospital Did Not Develop Implementation Plan

14. Predisposing Factors
15. Smoking / Tobacco Use
16. Life Expectancy / Premature Death
17. Cholesterol (High)
18. Kidney Disease
19. Sexually Transmitted Disease
20. Alcohol/Substance Abuse
21. Physical Environment

[27] The hospital in this summary listing indicates it has addressed each need identified in the CHNA and elects to develop an Implementation Strategy for selected Significant Needs. Reference Schedule H (Form 990) Part V Section B 7.

22. Compliance Behavior
23. Chronic Osteoporosis
24. Blood Poisoning
25. Emergency Service
26. Homicide
27. Palliative Care & Hospice
28. Flu/Pneumonia
29. Low Back Pain (Chronic)
30. Housing Conditions for the elderly and disabled
31. Skilled Care Program
32. Insurance is a major concern (accuracy, coverage, accounting, promptness)

APPENDICES

Appendix A – Local Expert Advisor Opinion About Significant Needs

A total of 27 Local Expert Advisors participated in the first round of an on-line survey offering opinions regarding their perceptions of community health needs. The following is an analysis of their responses:

The first question was open-ended: "What do you believe to be the most important health or medical issue confronting the residents of your County??" Answers were placed in a "Word Cloud" format for analysis and generated the following image:

In summary, we receive the following commentary regarding the more important health or medical issues:

> Lack of health care resources with an emphasis on primary care and dental issues
>
> Obesity and children issues
>
> Also noted (to a lesser degree of concern) were concerns about area mental treatment resources, emergency service, cancer and need for educational resources

Word Clouds are analytical tools which give greater visual prominence to words appearing more frequently in the source text. This information visualization establishes a portrait of the aggregate responses, presenting the more frequently used terms with greater text size and distinction in the visual depiction. Common article word (i.e., "a," "the," etc.), non-contextual verbs (i.e., "is," "are," etc.) and similar words used when writing sentences are suppressed by this application.

Specific verbatim comments received were as follows:

Many low to moderate income residents are uninsured and fail to seek medical attention until its serious. -There is an acute need for adult dental care for low income individuals. -Obesity

Accessibility to, and choice of, health care providers.

Affordable health care

Childhood, adolescent and adult obesity resulting from lack of knowledge concerning proper nutrition.

Continuity of health care for children and adults.

General Health and Wellness Full, Local treatment for all Diagnosed Conditions (i.e. Cancer Treatment)

Halifax County has limited mental health resources for children. That would include mentoring, counseling services, psychological services, and psychiatric services. Although tele-med is available, many parents are not comfortable with this service and prefer a face-to-face contact. Referrals are made for counseling services, but waiting lists are the norm instead of the exception.

I believe lack of coordinated access to healthcare is the primary issue for our area. This includes lack of access because of financial reasons or lack of insurance, as well as lack of knowledge about healthcare services available and how to best utilize resources. I believe that follow up after medical interventions/office or ER visits is poor because no single source, such as a case manager, is looking over the individuals' totality of healthcare needs and coordinating comprehensive care.

I believe that lack of education and poverty create health and/or medical issues in our area. Our community does not seem to be focused on physical education and physical activity. The community has a YMCA but the facility is out dated and lacks up to date equipment and programs. This combination leads to a variety of health conditions including obesity, heart disease and diabetes.

I believe that the most important health issue facing the residents of Halifax County is obesity and the diseases that stem from being obese.

I believe the most important health issue in Halifax County is obesity.

I believe the most important health or medical issue/s confronting the residents of my county are mental health, drug and alcohol addiction, and financial resources to seek care. These issues are impacted greatly in the ages 14-35 and retirees aged 62 and above by lack of funds in terms of the economic climate, which makes affordability a challenge, especially in the low-income, minority community.

In a county with a population that's falls well below the state average in education attainment, employment and income levels, a very high percentage of citizens rely totally on government health care assistance. Whether it is a lack of insurance, finances or education, or a combination of all, too many citizens do not practice preventive or healthy lifestyles. I think this may also result in sending patients home before they are ready and increasing numbers of 'return' admissions. An older population and stagnant population growth will place additional challenges to providing for aging citizens and health care needs. Within a 2 hour drive of Halifax County are some of the leading health care facilities in the country. But we have to arrive alive. An excellent emergency room is critical in terms of prompt medical attention that ensures accurate diagnosis and treatment.

In my opinion, people are not taking the necessary steps to prevent health problems such as cancer, diabetes, heart disease, etc. Also, the cost of healthcare is a major concern.

In my opinion, the most important health or medical issue in Halifax County is the high rate of cancer. I am not sure of any studies comparing Halifax to the National average of cancer patients, but I feel there is an alarming amount of cases for our community.

It may seem very broad but the lack of insurance/medical coverage for adults in this area is critical. When a client calls our agency many times they have had procedures done that they are unable to afford which sends his/her family into crisis mode. The lack of health insurance has killed more people than we can determine. Those who are not insured or underinsured typically go without being seen or tend to go without medications thus adding to the high percentage of mortality.

Lack of affordable health care which forces the uninsured to use Emergency Rooms for routine care.

Lack of education to knowing when a condition requires emergency care versus standard primary physician care.

Lack of personal resources to be able to meet medical needs.

Lack of preventative care and lack of primary care options are the biggest health issues confronting Halifax County. With regard to the lack of preventative care, there are programs provided by Halifax Regional that work to improve preventative care. However, from my observations as a prosecutor and attorney, the lower socio-economic segment of the community (which is not a small segment) tends to wait to obtain care to the point where any illness has spread/grown into a serious condition rather than working to address any health issue in advance. This is true, from my observations, not only regarding short term issues, e.g., sniffles/colds/sinus infections not being addressed adequately and then turning into bronchitis/pneumonia, but also with long term health issues, e.g., diet, exercise, etc. which tend to not be addressed resulting in diagnosis of diabetes, hypertension, heart/lung disease, etc. From my experience, most of these issues are ignored by many until the

individual cannot ignore the issue any longer, usually after 20-30 years of poor diet, exercise, and health maintenance which would, if addressed sooner, result in fewer long term maladies and healthier individuals. Along with the above, most of the individuals I have observed tend to use the emergency room as a primary care office, often, as stated above, because they wait until a small health issue blossoms into a major health issue. Nonetheless, in many instances, these individuals will appear for minor issues such as a stuffy nose, chest congestion, etc. that would be better suited to be addressed by a primary care facility. To that end, Halifax Regional has recently opened a primary care facility which is very helpful to the community. More such facilities need to be opened as my own experience is that the waiting room is always close to capacity and the average wait is well over an hour and sometimes two hours. I highlight that not as a criticism to Halifax Regional but to highlight the need for additional services. One final issue which is important would be the lack of sufficient dental facilities to provide for the needs of the community. Again Halifax Regional has opened a dental facility primarily to address underprivileged and/or needy children"s dental needs but my guess is the clinic's capacity will be far overwhelmed by demand.

Lack of services to children between the ages of 3- 5 years old to include mental health and dental services.

Nutrition and life style choices are challenging many county residents and leading to underperforming preschoolers, obesity, and cardiovascular issues.

Obesity

Specialists and counseling availability for children and adults

The most important health issue confronting the residents of our county is lack of preventive care for children and adults. There is a need to work more directly with the adult population in various settings to help the adults and our children understand the role of heredity and lifestyle in their future well belling or lack thereof early enough to develop healthy lifestyle choices.

There are two. Dental Care and Primary Health Care

There are two. Dental Care and Primary Health Care
With no public transportation reaching further than town limits, individuals who are not on Medicaid/Medicare must pay exorbitant prices to private individuals for a ride to keep their doctor appointments. Mental health patients as well as others who do not have jobs or are not old enough to qualify for other aid, routinely stop seeing the doctor and taking necessary medications because they cannot afford the ride to medical treatment appointments. With the gun control/mental health issues facing today's political discussions, this problem exists in Halifax and the surround area and manifests itself as a health or medical issue.

Our second question to the Local Experts was "Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons,

minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what."

The responses generated the following image:

In summary, we received the following commentary regarding the more important health or medical issues impacting priority populations:

> People need community health care services
>
> Income (uninsured) is a concern
>
> Obesity, dental treatment, chronic diabetes and mental health resources are specific issues needing attention

Specific verbatim comments received were as follows:

> 1) Education- Our health care professionals can do a better job at educating our community about the benefits of preventive care. 2)There needs to be some type of on-going communication with area churches/schools to assist with distributing information to the masses and market to a broader audience with inclusive diversity. 3) Make getting fit fun for the family. People of any background mainly minorities don't have a routine exercise regimen in place because life gets in the way and the bills have to be paid. Might there be some way that our health care system could provide/challenge families to put forth the extra

effort to get healthy. 4)Outreach- For people in general the hospital is not a fun place to visit or have to go...however, if certain outreach models were in place to address the chronic diseases starting at say middle school age on up we would have a healthier and more educated community in terms of wellness.

Access to information and resources may be a need that should be addressed. How does the medical community create a "traveling" resource center? How does it connect with the schools to provide on-site assessments and offer access to parents and guardians? Who else can help with offering education and motivating experiences to establish healthy eating and exercise as an appropriate lifestyle? There are lots of stakeholders and many service providers . . . it"s time to pull them together and create the plan with specific action steps.

Again, Cancer comes to the forefront in my opinion. Also we are faced with the lack of experts in certain fields of medicine, i.e.: ENT, Dermatology, Allergist. The Hospital has made great strides for low income households by opening the new Dental Clinic in the Houghton Industrial Park, no child should be denied dental services, way to go HRHS

All of my concerns in question #2 refer to uninsured, low-income and minority groups. I believe the hospital already offers some free or low cost services for these groups, however it may need to be expanded to a greater degree. Educating these groups of existing services is also important. Involving local churches and using media that targets the minority audience maybe helpful in getting the word out.

As in the previous answer, low income populations within or not within minority groups who live outside of area covered by any type of public transportation are having to pay large prices to private individuals to transport them to doctor appointments.

As previously discussed, the lower socio-economic sector of the community could well be served by better preventative services. I will note that these services are offered by several different groups/agencies but aren't always fully utilized. Also, the lack of primary care facilities and lack of dental facilities need to be addressed with regard to capacity to meet the community's needs.

COPD and obesity appear to be chronic problems for low income and uninsured. There needs to be a comprehensive educational effort to explain how to prevent these problems before they occur. That begins with education, including early childhood education. This could be a joint community effort led by the hospital but including SVHEC, public schools, health department, Chamber, etc.

Greater support for young families, such as centralized, professional child care tied into the healthcare system.

Halifax needs better wellness and fitness facilities. The YMCA is in great need of repair and upgrade.

Help or assistance is needed regarding cancer patients, drug and alcohol users, and dental concerns. Skill care program concerns include insurance coverage, feelings of discrimination in terms of admissions, time in unit, discharge, information to patients' families, accounting discrepancies, etc. It is good to see the current dental health offerings which should improve that particular health issue, especially affecting the low-income segment of the population in our community. Strong and growing community involvement includes health fairs, programs at the hospital, and staff (full-range) speaking and presenting to specific social and church groups, which is helpful in bridging the level of medical and health-related education. This has been, and is, a real plus for our needs in the community. Trauma-based, immediate care programs and transport modes are areas that could be improved upon. Currently, critical care and trauma patients are typically transferred to out-of-town health facilities that offer specific treatment for condition/s. Local treatment could prove lifesaving in regard to time involved. It would be of benefit to the health field to stay atop environmental issues that affect ground water and air pollution, location, and emissions. These concerns have an even greater impact on persons with existing conditions that may be aggravated, and may also generate new problems for the general population (HazMat, uranium mining, wood burning facilities). I have been pleased with what I see in terms of the hospital being pro-active, not only with the hospital improving options and offering community-based care and services in critical care situations but also improving physical facilities.

Helping people understand the dying process for the terminally ill. HRH Hospice has a wonderful booklet on the dying process that was helpful to my family and me when both of our parents were ill. Maybe workshops or support groups involving people who have been through such situations to discuss and share with the general public would help more people consider quality of life versus extended life support efforts and major medical procedures on behalf of their loved ones. I think a new hospice outreach program would be effective with some volunteer family members of deceased individuals leading the conversations.

I believe that mental health issues and services to meet the needs of especially low-income and uninsured persons exist in our area. I also believe that mental health services for children are drastically lacking. The responsibility to increase services lie in both the public and private sector by providing qualified mental health professionals to meet the needs.

I think that all of the specific groups mentioned above would benefit from a hospital or community health or medical clinic. You do have the hospital E.R. and the Primary Care Facility, however, a clinic would meet the needs of that target group, for the continuity of care.

In my opinion, low income persons are able to get Medicaid or Medicare relatively easy which pays most (or all) of health care costs once they reach a small deductible. But, other people that may have lost a job or have high deductibles on their work insurance have issues getting certain parts of health care covered.

It is more difficult now, particularly for some of the middle class and low income people to pay copays. Most, if not all, medical offices require the copay to be paid when seen and it is certainly understandable economically, but that is the very reason some people don't come to the doctor. They don't have $25 or $40 to see the doctor and money to pay for gas to get there and money to pay for the prescriptions after the visit. People who are hurting financially have three priorities: shelter, food and gas. Health care is last on the list and dental care is even lower. Dental care and primary health care for preventative services and chronic disease management is needed (Hypertension, diabetes).

Many young people in Halifax County are involved in drug use and/or use tobacco products. When adults use these products and then conceive children, learning and behavioral difficulties are common.

Obesity and tobacco abuse are two lifestyle related health issues that heavily impact our population, and these issues are more prevalent among low income and lower educated groups. I believe it is partially responsibility of the healthcare community to address these issues, but also the responsibility of social and human services groups to address these issues through social campaigns, support services, and educational interventions for all age groups.

Obesity is a major issue in our area. This contributes to a variety of health related issues. I feel that people should receive assistance if they are making efforts to improve their health. No system can survive if it continues to help those who will not help themselves. Nutrition education could be helpful for high risk families. The hospital and other government agencies can provide the education but ultimately the individuals need to be held accountable. If the hospital and the YMCA could partner then individuals could be assisted as they improved their health and wellness. think the hospital and other government

Obesity, diabetes and hypertension are all related to the overall problem in our community of poor nutrition resulting from generational poverty. To overcome these issues, the local workforce must become trained for 21st century employment. Secondly, proper nutrition must be stressed in school cafeterias with the message carried home to the parents. These issues are generational and will not be easily overcome, but the process must begin or the community becomes more unhealthy and unattractive for those who might want to relocate here.

Preventive health care.

The most at-risk sub-population of our citizens are those with serious mental illness and who also have both acute and chronic health care needs. segragated FFS reimbursement systems produce barriers for effective treatment of behavioral and physical health care. Recent studies show a range of 62%-186% increase in the cost of care of people with comorbidity of mental health across arthritis, asthma, cancer, diabetes, CHF, migraine, and COPD conditions. The needed innovation for this group is integrated and coordinated MH-

medical care that addresses * Persistent medical and BH illness/symptoms * Impairment and disability * High medical care service use and cost to deliver improved health and lower cost of care returns.

The primary health issue that is the root of many other health issues in this community is obesity. Obesity is especially prevalent among low income people and minorities and it is can become very costly to treat these people if they are uninsured. Obesity leads to diabetes, high blood pressure, heart disease, high cholesterol levels, cancer and many other medical conditions. Diabetes, one of the obesity related diseases, effects 18.7 percent of all African-Americans over the age of 20 in the United States. More needs to be done in the community to educate people about exercise and eating healthy foods and the health risks associated with obesity.

There are substance abusers in our community who often find themselves in the court system - criminal and domestic. Commonly abused substances include alcohol, cocaine and prescription drugs. Community based treatment is needed.

Yes, medical care as a general rule needs a complete overhaul. Healthcare should be affordable to any person. This is extremely true to uninsured, low income and other special populous groups. However, this must be a manageable system.

Yes, the low income, the elderly, the uninsured persons, and those in remote areas lack access to quality health care. There are many residents that are covered by Medicaid, but some who are just above the income guidelines fall through the cracks. They have to choose between heat, food and medicines. Programs such as Pharmacy Connection help, but there are many elderly with no computer access, adequate transportation etc to get the help they need. Maybe a few Urgent Care facilities would help?
Yes, there is a need for primary health care needs in the community for the treatment of and continuity of care for chronic illnesses such as high blood pressure and diabetes. Low income individuals who are without insurance or have insurance but cannot afford the co-pay arehaving to choose between medicine and gas/food. Even middle class individuals are feeling the effects of having increased copays for MD visits, medications and for some, it is too much and opt for no care at all. Those who opt for no care at all will wait until they are in a health crisis to be seen by the doctor increasing the risk for stroke and diabetic complications and increased ER visits and hospitalizations, which has copays as well for various services. Others utilize walk in clinics to get their "most important" medicine filled as a "tide me over action" until they can afford their other medicines or will go without until extra money comes in, taking the medicine on a conservative self prescribed schedule instead of the medically prescribed schedule just to make the medicine last as long as it can (high BP meds for instance). Increasing the number of primary care physicians in the area would be one area of consideration but with a physician shortage coming in the near future, perhaps increasing NP's and PA's might be a consideration to handle chronic diseases with referral

mechanisms in place for complications beyond the NP & PA's expertise. I know this concept is being utilized across the county already but I see a need for additional primary health care providers who can accept sliding scale patients (payment based on income). In regard to utilizing walk in clinics as the only source of medical care or "tide me over health care", one loses the benefit of a medical home or more simple, you lose continuity of care particularly when you hop around to the different walk in clinics. Perhaps that is the individuals choice but we as health care professionals have a responsibility to educate our patients on the importance of a medical home as well as the importance of taking medicines as prescribed, providing referrals to Med Assist and Social Services, etc. to assist our patients in getting the help they need to obtain the medicines they need to be in optimal health.

Appendix B – Process to Identify and Prioritize Community Need

Response from Local Expert Advisors[28]

Need Candidate	Total Allocated Points	Cumulative Percent of Response	Number of Local Experts Voting for Need	Point Break from Higher need	Need Determination
1. CANCER	232	10.5%	20		Significant Needs
2. OBESITY/OVERWEIGHT	157	17.7%	17	75	
3. CORONARY HEART DISEASE	148	24.4%	17	9	
4. MATERNAL AND INFANT MEASURES	135	30.5%	17	13	
5. PRIORITY POPULATIONS	134	36.6%	17	1	
6. MENTAL HEALTH / SUICIDE	130	42.5%	18	4	
7. DENTAL	115	47.8%	16	15	
8. DIABETES	110	52.8%	17	5	
9. STROKE	106	57.6%	15	4	
10. BLOOD PRESSURE (High)	102	62.2%	16	4	
11. PHYSICIANS	98	66.7%	14	4	
12. ACCIDENTS	85	70.5%	15	13	
13. COPD / (LUNG DISEASE) / PULMONARY	83	74.3%	12	2	
14. PREDISPOSING FACTORS	47	76.5%	11	36	Other Identified Needs
15. SMOKING / TOBACCO USE	46	78.5%	13	1	
16. LIFE EXPECTANCY / PREMATURE DEATH	45	80.6%	11	1	
17. CHOLESTEROL (HIGH)	44	82.6%	13	1	
18. KIDNEY	44	84.6%	12	0	
19. SEXUALLY TRANSMITTED DISEASE	44	86.6%	11	0	
20. ALCOHOL/SUBSTANCE ABUSE	42	88.5%	13	2	
21.PHYSICAL ENVIRONMENT	39	90.3%	10	3	
22. COMPLIANCE BEHAVIOR	26	91.5%	10	13	
23. CHRONIC OSTEOPOROSIS	26	92.6%	9	0	
24. BLOOD POISONING	26	93.8%	8	0	
25. EMERGENCY SERVICE	23	94.9%	9	3	
26. HOMICIDE	23	95.9%	8	0	
27. PALLIATIVE CARE & HOSPICE	22	96.9%	10	1	
28. FLU/PNEUMONIA	22	97.9%	9	0	
29. LOW BACK PAIN (Chronic)	21	98.9%	8	1	
30. Housing Conditions for the elderly and disabled	5	99.1%	1	16	
31. Skilled Care Program	5	99.3%	1	0	
32. Insurance is a major concern (accuracy, coverage, accounting, promptness)	5	99.5%	1	0	
Total	2200		22		

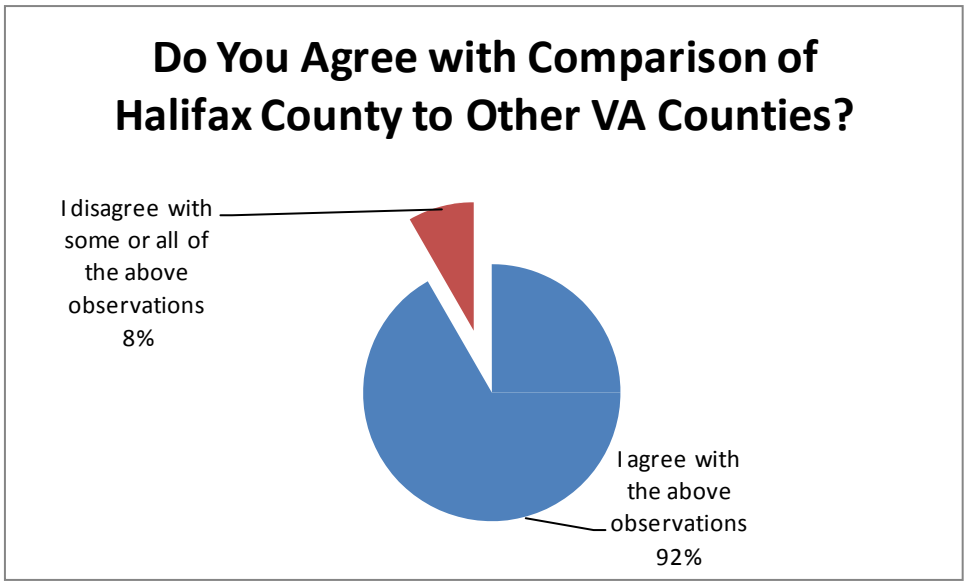
[28] Responds to IRS Schedule H (990) Part V B 1. g. and V B 1. h.

Individuals Participating as Local Expert Advisors

Organization	Position	Area of Expertise
Southern VA Higher Education Ctr	Associate Director of CNE	nursing education
Southern VA Higher Education Center	Executive Director	adult education
Halifax County Rescue Squad	Paramedic/EMS Captain	Emergency Medicine/Critical Care
Southside Community Services	Executive Director	Public Behavioral Health
Presto Products Company	HR Manager	Employee Relations and benefit administration
Halifax County Public Schools	Superintendent School	education
Halifax County Public Schools	Psychologist Division	School psychological services in a public school setting
Halifax County Public Schools	Attendance Officer Sheriff	Long term area resident having worked in industry and public sector
Halifax County Sheriff's Office	Zone Disaster Specialist	Law Enforcement
American Red Cross	President/CEO	Needs of individuals who typically need the aid of charitable organizations
Lake Country Area Agency on Aging	CEO	Area Agency on Aging
United Way of Halifax Co.	Chief of Police	Community Engagement / Partnership
Town of South Boston Police Dept.	Secretary	Public Safety
Rob Land Development	Director	Community representative
Halifax County DSS	Circuit Court Judge	social services
10th Judicial Circuit	Deputy Supt of Schools (ret)	Law
Halifax Co Public Schools	Director	public education
Halifax County Tourism	RN, BSN, MBA Public Health Nurse	Marketing/promotions
Halifax County Health Department	Community Viability Specialist	Public Health
Virginia Cooperative Extension	Executive Director	community development/engagement
Halifax County Industrial Development Authority	Commonwealth's Attorney	Industrial/Economic Developement
Halifax County Commonwealth's Attorney	Director of Workforce Services	Long Term Resident
Southern Virginia Higher Education Center	Head Start Director/ Deputy Director	Workforce development, higher education
Tri-County Community Action Agency, Inc.	Director of Patient Services	Child Care
Halifax County Cancer Association	President	cancer patient in Halifax County
Jeffress Funeral Home	Retired School Nurse Coordinator	funeral director serving mostly afro-american population in Halifax County, VA.
Halifax County Public Schools	NA	School Nursing, prek thru 12. Also public health needs of children , in the community.
Volunteer Organizations	President/CEO	Long term resident and volunteer
Tri-County Community Action Agency	Past President	Support Programs for Low Income
South Boston Lions Club		long term area resident

Advice Received from Local Experts

Q. Do you agree with the observations formed about the comparison of Halifax County to all other Virginia counties?



high levels of cancer rate in county as well as absence of a targeted health awareness program that reaches citizens outside of townships

I am aware of the accuracy of the above statistics, especially those relating to low birth rates, teenage pregnancies, single parent families, not receiving basic health needs such as

immunizations because of my involvement with a program that tracked data, so know the data to be accurate.

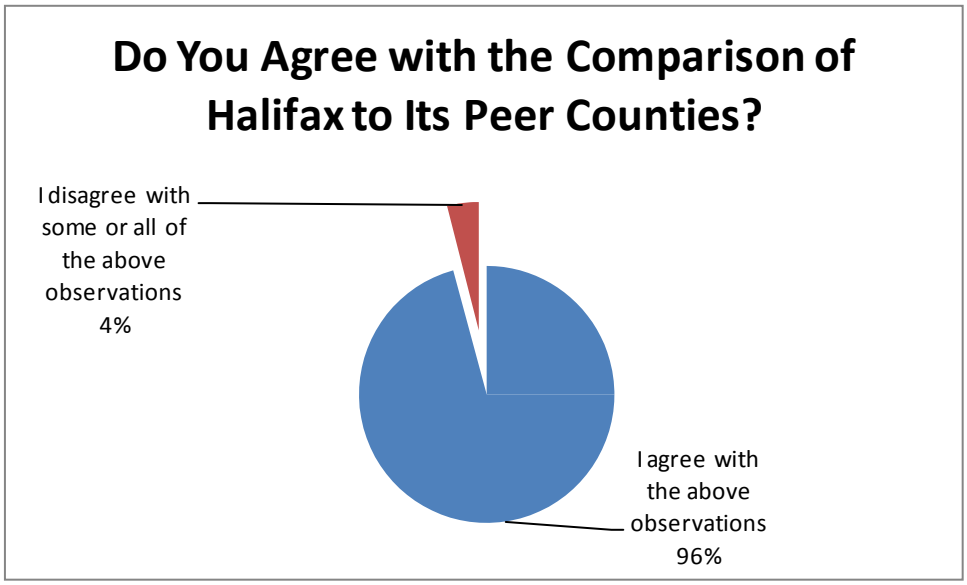
In my experience, the general health of the citizens I dealt with was not good as evidenced by the factors cited.

No public transportation from rural parts of the county for low income or individuals without a mode of transportation to travel for necessities as well as medical needs.

not so much that I disagree with the facts, but I disagree with some of the measures used; for instance, the distance to grocery stores is more a reflection of the fact that we are rural rather than being a reflection of a physical environment issue - and, of course, it's not realistic to change this

These metrics are sobering.

Q. Do you agree with the observations formed about the comparison of Halifax County to its Peer counties?

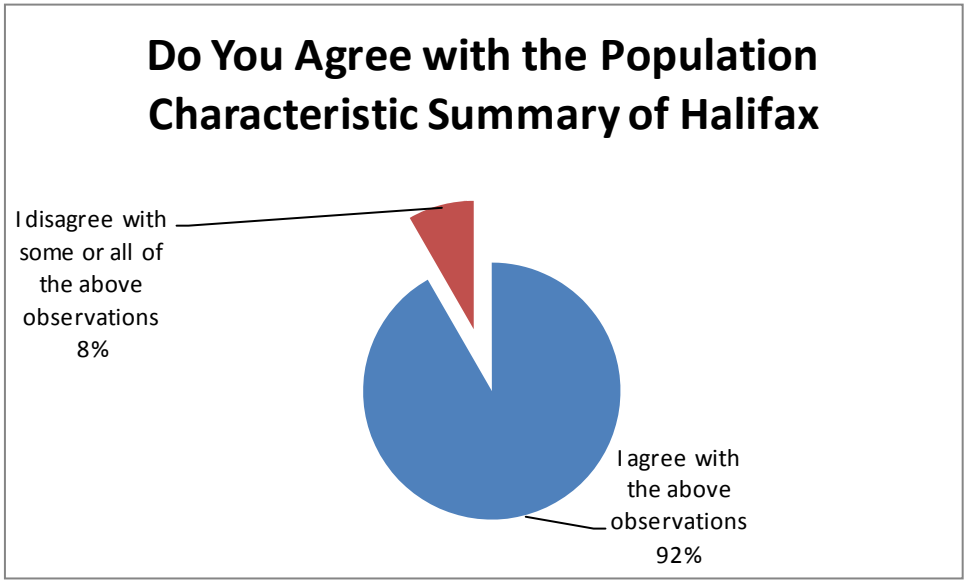


I am not sure I agree with the coronary health ranking

I am surprised that in the category of "somewhat a concern" does not include Kidney problems and diabetes

My participation in an organization that tracked much of the above data corroborates the accuracy.

Q. Do you agree with the observations formed about the population characteristics of Halifax County?



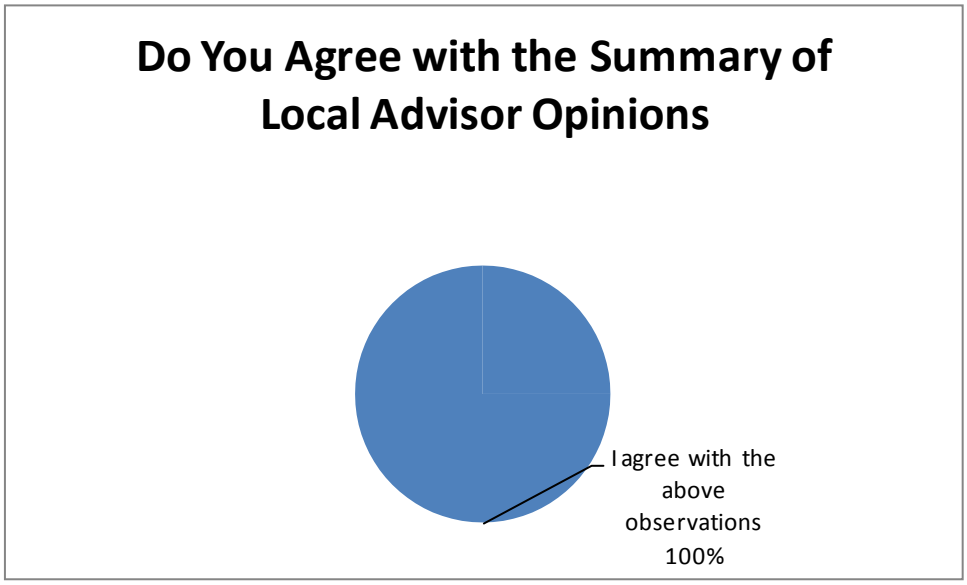
A large percentage of the women in this county do not fall into the "7% above average impacting 49% of the population" as listed above due to personal financial situation and lack of adequate health coverage. This would also be a factor regarding the OB/GYN noted above, as the testing is often requested at same time. The financial factor is often the same regarding No. 7 above, where people with no insurance or poor financial status depend on the emergency room for general health care situations. The rest of the findings seem correct.

based on people I know in Halifax County, I would guesstimate the numbers/statistics above reflect their health situations.

I believe the data is accurate and reflects the health needs in our area.

the last page said we compare better for coronary artery dz, but this page says chronic heart disease is 62% above average - doesn't seem to match

Q. Do you agree with the observations formed about the opinions from local residents?



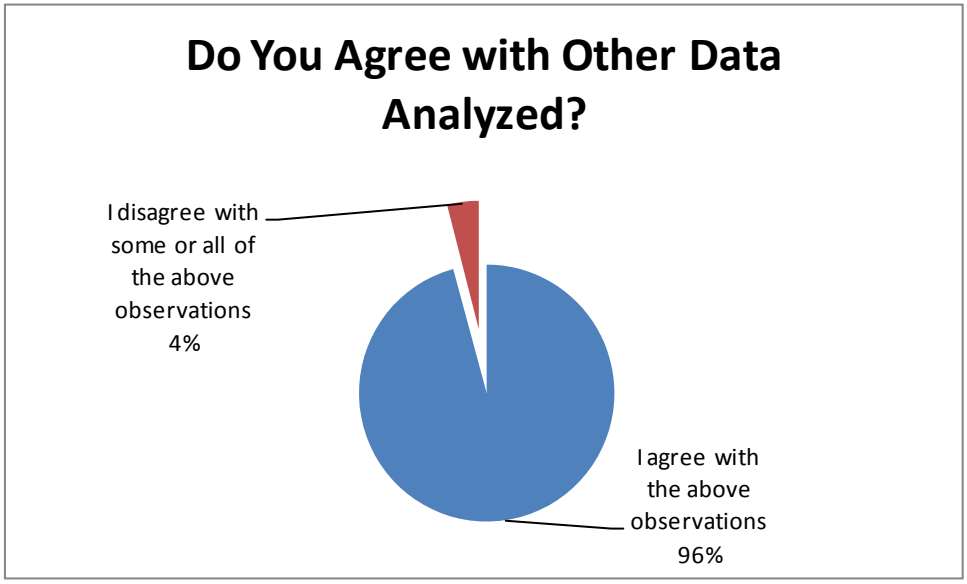
I also think that health care navigators are needed to help citizens with care and managing resources from home.

Part of the issue is the education and motivation of each person. Consider establishing a core group who would collaborate and coordinate a countywide educational campaign and design motivational strategies to encourage individuals to "excel" in a healthy lifestyle.

The observations are compatible with my responses the first survey.

The observations reflect the health needs in our community.

Q. Do you agree with the observations formed about the additional data analyzed about Halifax County?



I agree with the data. We tend not to pay attention to the health needs. I think the data needs to be presented to all area stakeholders in such a way that forces a community wide plan.

I think the # of residents who do not have a consistent source of primary care is greater than 22.45% as well as the number of people who have not visited a dentist including small pre-school and school aged children.

Appendix C – Illustrative Schedule H (Form 990) Part V B Potential Response

Illustrative IRS Schedule H Part V Section B (form 990)[29]

Community Health Need Assessment Answers

1. **During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9**

   Illustrative Answer – **Yes**

   If "Yes," indicate what the Needs Assessment describes (check all that apply):

   a. **A definition of the community served by the hospital facility**
   b. **Demographics of the community**
   c. **Existing health care facilities and resources within the community that are available to respond to the health needs of the community**
   d. **How the data was obtained**
   e. **The health needs of the community**
   f. **Primary and chronic disease needs and health issues of uninsured persons, low-income persons and minority groups**
   g. **The process for identifying and prioritizing community health needs and services to meet the community health needs**
   h. **The process for consulting with persons representing the community's interests**
   i. **Information gaps that limit the hospital facility's ability to assess the community's health needs**
   j. **Other (describe in Part VI)**

   Illustrative Answer – check a. through i. Answers available in this report are found as follows:

   1. a. – See Footnotes #15 (page 10) & #16 (page 10)

   1. b. – See Footnotes #17 (page 11)

   1. c. – See Footnote #22 (page 27)

   1. d. – See Footnotes #7 (page 5)

   1. e. – See Footnotes #11 (page 7)

   1. f. – See Footnotes #9 (page 7)

[29] Questions are drawn from 2012 f990sh.pdf Forms and may change when the hospital is to make its 990 h filing

1. g. – See Footnote #12 (page 8) & #28 (page 62)

1. h. – See Footnote #8 (page 7) & #28 (page 62)

1. i. – See Footnote #6 (page 5)

1. j. – No response needed

2. **Indicate the tax year the hospital facility last conducted a CHNA: 20 _ _**

   Illustrative Answer – 2013
   See Footnote #1 (Title page)

3. **In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted**

   Illustrative Answer – Yes
   See Footnotes #10 (page 7)

4. **Was the hospital facility's Need Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.**

   Illustrative Answer – No

5. **Did the hospital facility make its CHNA widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)**

   a. **Hospital facility's website**
   b. **Available upon request from the hospital facility**
   c. **Other (describe in Part VI)**

   Illustrative Answer – check a. and b.
   The hospital will need to obtain Board approval of this report, document the date of approval, and then take action to make the report available as a download from its web site. It may also be prudent to place a notice in a paper of general circulation within the service area noting the report is available free upon request.

6. **If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):**

   a. **Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA**
   b. **Execution of an implementation strategy**
   c. **Participation in the development of a community-wide plan**
   d. **Participation in the execution of a community-wide plan**

e. Inclusion of a community benefit section in operational plans
f. Adoption of a budget for provision of services that address the needs identified in the CHNA
g. Prioritization of health needs in its community
h. Prioritization of services that the hospital facility will undertake to meet health needs in its community
i. Other (describe in Part VI)

Illustrative Answer – check a, b, g and h.

6. a. – See footnote #23 (page 28)

6. b. – See footnote #23 (page 28)

6. g. – See footnote #12 (page 8)

6. h. – See footnote #12 (page 8)

7. Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs?

Illustrative Answer – Yes
Part VI suggested documentation – See Footnote #27 (page 49)

8. a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
b. If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?
c. If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

Illustrative Answers – 8. a, 8 b, 8 c – No