Sentara Obici Hospital

Community Health Needs Assessment 2019

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Sentara Obici Hospital

Community Health Needs Assessment (CHNA)

2019

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Introduction

Sentara Obici Hospital (SOH) has conducted a community health needs assessment of the area that we serve. The assessment provides us with a picture of the health status of the residents in our communities and provides us with information about health and health-related problems that impact health status.

Our assessment includes a review of population characteristics such as age, educational level, and racial and ethnic composition because social factors are important determinants of health. The assessment also looks at risk factors like obesity and smoking and at health indicators such as infant mortality and preventable hospitalizations. Community input is important so the assessment also includes survey results from key stakeholders including public health, social services, service providers, and those who represent underserved populations. The report also includes findings from focus groups with community members on health issues and barriers to achieving good health.

The needs assessment identifies numerous health issues that our communities face. Considering factors such as size and scope of the health problem, the severity and intensity of the problem, the feasibility and effectiveness of possible interventions, health disparities associated with the need, the importance the community places on addressing the need, and consistency with our mission "to improve health every day", we have identified a number of priority health problems in our area to address in our implementation strategy:

- **Chronic Disease (including Diabetes, Heart Disease, Cancer)**
- **Mental health & Substance Abuse**
- **Nutrition (to include Obesity and Hunger)**

Our previous Community Health Needs Assessment also identified a number of health issues. An implementation strategy was developed to address these problems. The hospital has tracked progress on the implementation activities in order to evaluate the impact of these actions. The implementation progress report is available at the end of this report.

SOH works with a number of community partners to address health needs. Information on available resources is available from sources like 2-1-1 Virginia and Sentara.com. Together, we will work to improve the health of the communities we serve.

Your input is important to us so that we can incorporate your feedback into our assessments. You may use our online feedback form available on the Sentara.com website. Thanks!

Demographic Information

Population

Highlight Population: The combined population of the Sentara Obici Hospital (SOH) service area numbers over 161,500 people. The service area of SOH is comprised of 7 localities: the Cities of Suffolk and Franklin as well as the Counties of the Isle of Wight, Southampton, Gates County, NC, Sussex and Surry. Suffolk is the most populous locality in the service region, followed by Isle of Wight. The other localities, Sussex, Southampton County, The City of Franklin, Surry County and Gates County, NC, are rural with small populations scattered throughout the area.

Sentara Obici Hospital Service Area

Source: Truven/Market Expert

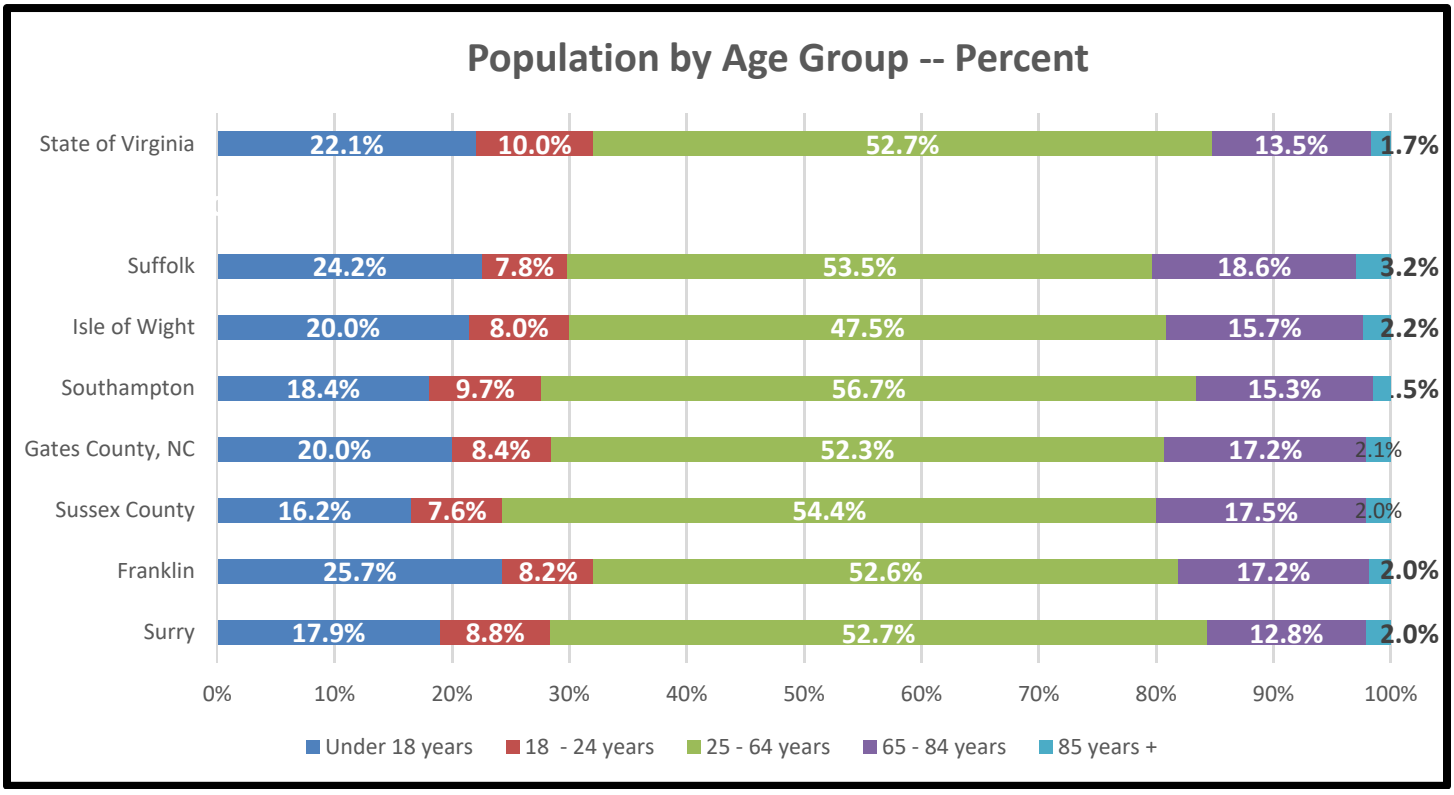
Population Change 2010 - 2018		
Locality	**Total Population**	**Change Percent**
State of Virginia	8,492,022	6.1%
Suffolk	91,570	8.3%
Isle of Wight	37,129	5.3%
Southampton	17,993	-2.7%
Gates County, NC	11,450	-6.1%
Sussex County	11,441	-5.3%
Franklin	8,355	-3.1%
Surry	6,501	-7.9%

Highlight Population Change: The Suffolk area has experienced high population growth since 2010, with projected growth anticipated to be an additional 2.8% by 2023. The rural portions of the service area, like much of Virginia and the United States, have been losing population – a trend that is projected to continue. The total of the service area population numbers over 161,000 residents, 57% concentrated in the City of Suffolk.

Unless Otherwise Stated for Specific Indicators: Source: Data provided by Claritas, updated in January 2018.
GHRConnects.org managed by Conduent Healthy Communities Institute

Population by Age

Highlight Population and Age: The service area has a higher percent of residents aged 65+ than the state as a whole, Suffolk City, Sussex and Gates Counties having the highest percent of the senior population. Suffolk has the highest percent of the very elderly, aged 85+. The service area also has a lower percent of young adults than the state, possibly reflecting the national trend for young adults to leave rural places in search of jobs. Surprisingly, Franklin has the highest percent of children under the age of 18, higher than the state at almost 26%.



Population by Race and Ethnicity

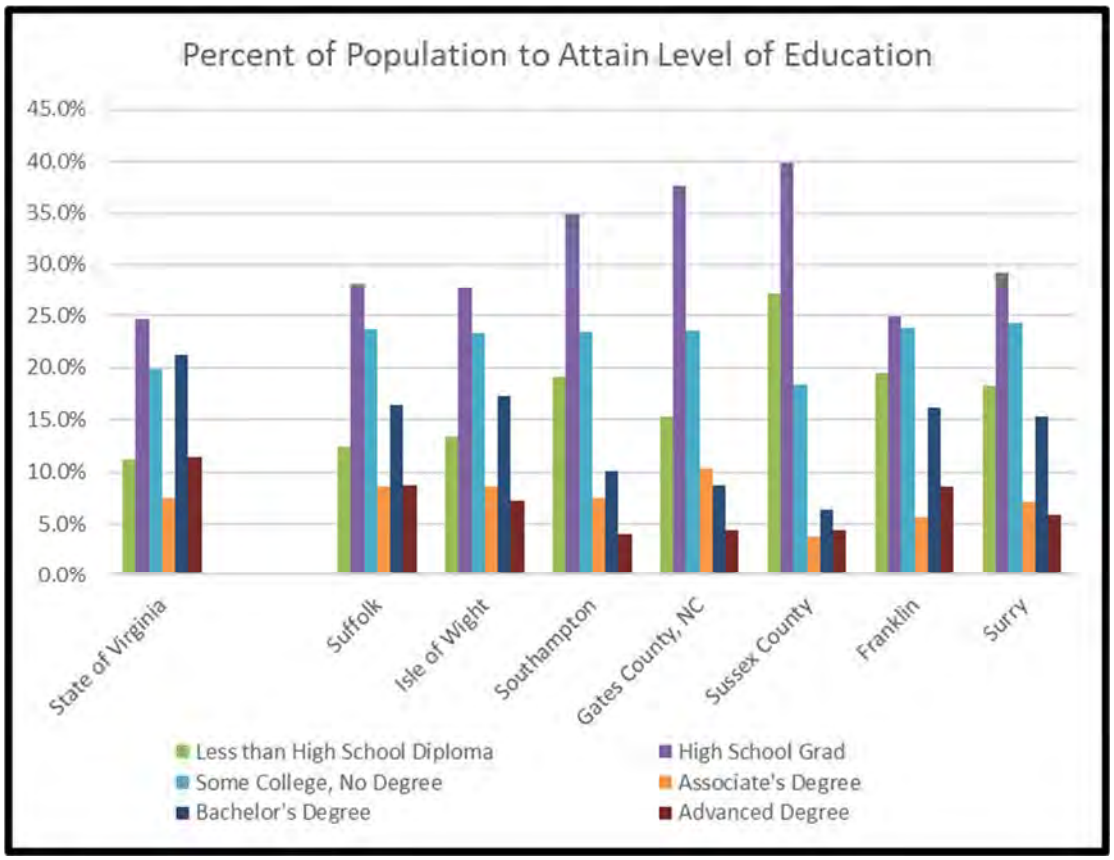
Highlight Population and Race: The population of the service area is overwhelmingly white and black, with Suffolk and Isle of Wight the most diverse communities (6.5% and 5% combined non-white or black) followed by Franklin County at 4.7%. All other localities have no more than 4% combined non-white or black population. Suffolk, Isle of Wight and Franklin Counties have very small Asian populations, but by far the largest point of diversity in the service area is the percent who identify as multiracial, still significantly lower than the state as a whole.

Highlight Population Ethnicity: The service area population as a whole has a small Hispanic population, with Suffolk home to the largest Hispanic community with 4.7% of the population followed by Isle of Wight with 3.6%. No other community in the service area has more than about 3% Hispanic population, roughly 1/3rd the percent of the state's Hispanic population at 9.6%.

Population by Race and Ethnicity											
			Race							Ethnicity	
Locality	Population	% Change 2010-2018	White	Black	American Indian /Alaskan Native	Asian	Narive Hawaiian /Pacific Islander	Some Other Race	2+ Races	Non-Hispanic /Latino	Hispanic /Latino
State of Virginia	8,492,022	6.1%	66.0%	19.4%	0.4%	6.8%	0.1%	3.8%	3.6%	90.4%	9.6%
Suffolk	91,570	8.3%	51.1%	42.4%	0.4%	2.0%	0.1%	1.2%	2.9%	95.3%	4.7%
Isle of Wight	37,129	5.3%	72.3%	22.7%	0.5%	1.1%	0.1%	0.9%	2.4%	96.4%	3.6%
Southampton	17,993	-3.1%	61.2%	35.2%	0.5%	0.4%	0.1%	0.5%	2.2%	98.3%	1.7%
Gates County, NC	11,450	-6.1%	63.8%	31.6%	0.6%	0.3%	0.2%	1.0%	2.6%	97.4%	2.6%
Sussex County	11,441	-5.3%	39.2%	56.7%	0.3%	0.6%	0.0%	1.8%	1.4%	96.8%	3.2%
Franklin	8,355	-2.7%	38.6%	56.7%	0.4%	1.0%	0.1%	0.9%	2.4%	97.8%	2.2%
Surry	6,501	-7.9%	54.1%	42.0%	0.4%	0.5%	0.1%	0.5%	2.5%	97.6%	2.4%

Population and Education

Highlight Education: Education is the basis for stable employment, and financial stability is the foundation for a sustainable household, which provides for the health needs of family members. Sussex County has the highest level of low-education population, with 27% of adults over the age of 25 not having a high school equivalent diploma compared to the state level of 11.2%. Sussex also has the highest level of population with a high school diploma only, at 39.8% compared to the state at 24.6%. None of the localities approach the state rates for bachelor's or advanced degrees. The low level of educational attainment impacts employer willingness to invest in the area and the availability of higher paying jobs.



Population by Educational Attainment						
	Less than High School Diploma	High School Grad	Some College, No Degree	Associate's Degree	Bachelor's Degree	Advanced Degree
State of Virginia	11.2%	24.6%	19.9%	7.4%	21.2%	11.4%
Suffolk	12.4%	28.1%	23.6%	8.6%	16.3%	8.7%
Isle of Wight	13.4%	27.8%	23.3%	8.6%	17.3%	7.2%
Southampton	19.1%	34.9%	23.5%	7.5%	10.1%	4.0%
Gates County, NC	15.3%	37.6%	23.6%	10.3%	8.8%	4.4%
Sussex County	27.2%	39.8%	18.4%	3.8%	6.4%	4.4%
Franklin	19.5%	24.9%	23.8%	5.6%	16.1%	8.6%
Surry	18.2%	29.2%	24.4%	7.1%	15.3%	5.9%

Income and Poverty

Highlight Income by Race: While simple poverty rates tell us something about the residents of the service area, by inserting race as a factor we see the racial disparities that constrain residents of the service area in their ability to support and sustain healthy, functioning households for themselves and their children. As with Virginia as a whole, black individuals are likely to have income that is approximately 70% of the general household income and approximately 65% of the income of white households. In Southampton and Franklin, Hispanic households earn 40% of the earnings of white households.

State of Virginia	$ 76,180	$ 49,110	$ 65,576	$ 71,167
Suffolk	$ 78,243	$ 46,290	$ 65,318	$ 65,386
Isle of Wight	$ 78,025	$ 44,954	$ 92,568	$ 69,606
Southampton	$ 66,143	$ 34,624	$ 24,737	$ 52,626
Gates County, NC	$ 59,364	$ 42,423	$ 38,879	$ 53,145
Sussex County	$ 58,398	$ 34,430	$ 24,444	$ 43,544
Franklin	$ 59,060	$ 32,934	$ 24,107	$ 40,368
Surry	$ 63,817	$ 45,929	$ 24,615	$ 58,239

Highlight Poverty Calculation: Each year the federal government calculates the income required to provide the absolute, bare necessities to sustain a household in the United States. Because each additional family member does not increase the cost of a household to the same extent (for instance, the cost of housing 4 family members is not 1.3 times higher than the cost of housing 3 family members), the government publishes the federal poverty guidelines for families with up to 8 members with a calculation for larger households. The table below presents the poverty level for up to 6 members. For more information, google "federal poverty guidelines" or visit https://aspe.hhs.gov/poverty-guidelines. **Highlight Poverty:** Poverty is perhaps the most impactful of the social determinants of health, affecting the ability to have stable housing, healthy food, the ability to maintain steady employment, and the ability to access health care when needed. The table below presents cumulative levels of poverty, in that those living below 200% of the federal poverty level are also living below 300%, etc. Sussex County and Franklin City have the highest rates of poverty, well above state levels.

2018 Federal Poverty Guidelines	
Household Size: 1	$ 12,140
Household Size: 2	$ 16,460
Household Size: 3	$ 20,780
Household Size: 4	$ 25,100
Household Size: 5	$ 29,420
Household Size: 6	$ 33,740

Source: United States Department of Health and Human Services

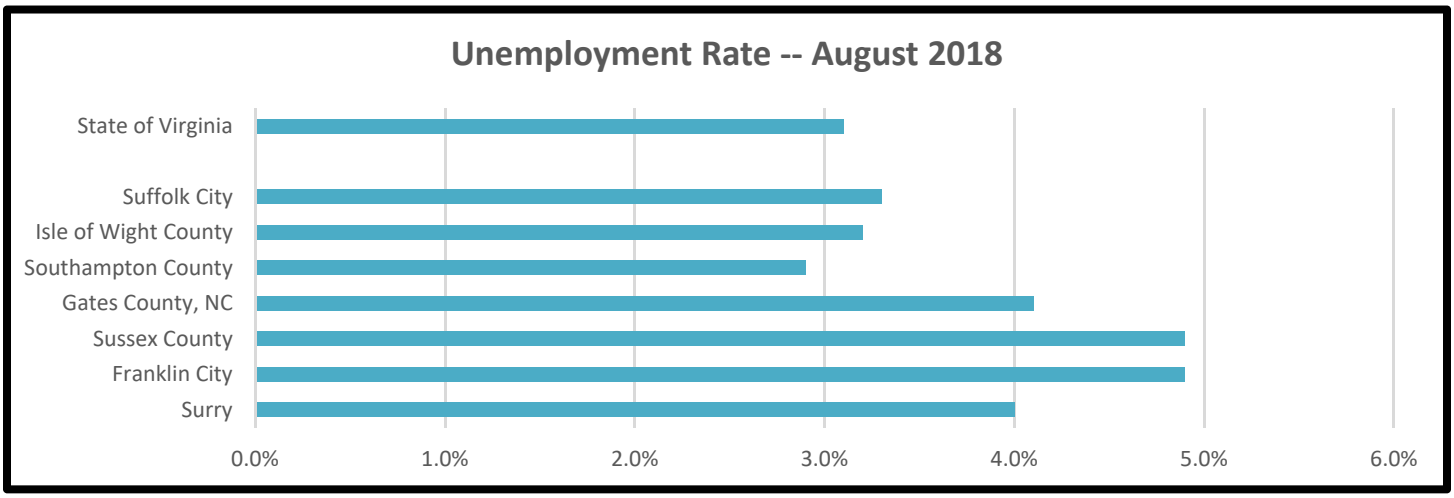
Percent of the Population Living at Specified Percent of the Federal Poverty Level

Poverty Level	100%	200%	300%	400%
State of Virginia	11.4%	26.6%	41.7%	55.0%
Suffolk	11.5%	26.3%	42.7%	57.4%
Isle of Wight	10.9%	22.9%	36.9%	53.7%
Southampton	14.7%	33.8%	51.3%	67.5%
Gates County, NC	12.0%	33.6%	51.8%	69.2%
Sussex County	18.5%	40.1%	57.7%	73.2%
Franklin	16.7%	43.8%	58.7%	72.4%
Surry	11.9%	31.7%	48.0%	60.4%

Source: US Census Bureau: American Factfinder 2017 Estimates

Employment

Highlight Employment: Central to a healthy community is an economy that supports individuals in their efforts to live well. Unemployment is a key measure of the state of the local economy and with few exceptions, the rate is higher in the SOH service area than in the state as a whole. Only Southampton has an unemployment rate lower than the state, while all the other localities have rates that are higher, Gates County, Sussex County, Franklin City and Surry County substantially so.



Source: Virginia Economic Commission, Economic Information & Analytics, Local Area Unemployment Statistics, August 2018

Highlight Employers: The largest employers (in number of employees) in the region reflect the lack of industry and commercial activity. Local governments are large employers throughout the United States, and mirror population. A mix of retail and small area businesses round out the list.

Three Largest Employers by Locality			
Suffolk	Suffolk Public Schools	City of Suffolk	Science Applications Internat'l Corp
Isle of Wight	Smithfield Fresh Meats Corporation	Isle of Wight Cty School Board	Green Mountain Coffee Roasters Inc
Southampton	Southampton County Public School Brd	Deerfield Correctional Center	County of Southampton
Gates County, NC	Gates County Board of Education	Gates County	Green Forestry LLC
Sussex County	Sussex I Correctional Center	Sussex II Correctional Center	Sussex County School Board
Franklin	Southampton Memorial Hospital	Franklin City Public Schools	Wal Mart
Surry	Dominion Virginia Power	Surry County School Board	The Atlantic Group Inc.

Source: Virginia Economic Commission, Community Profiles 2018

Health Status Indicators

Below are key health status indicators for the localities representing the **Sentara Obici Hospital (SOH)** Service Area: city of Franklin, Gates County (North Carolina), Isle of Wight County, Southampton County, city of Suffolk, Surry County, and Sussex County. Links are also included to interactive data dashboards on the Greater Hampton Roads Indicators Dashboard, also known as GHRconnects. Here indicators can be explored for a comparison to other nearby localities, change over time, race/ethnicity, and gender, where available. In addition, more indicators are often available through the link.

The key health status indicators are organized in the following data profiles:

A. Mortality Profile

B. Hospitalizations for Chronic and Other Conditions Profile

C. Risk Factor Profile

D. Cancer Profile

E. Behavioral Health Profile

F. Maternal and Infant Health Profile

G. Spotlight: Diabetes

H. Spotlight: Food Insecurity

I. Spotlight: Preventable Hospital Stays

A. Mortality Profile

Highlights: Leading causes of death in localities of the SOH service area were examined. Cancer, heart disease, and Chronic Obstructive Pulmonary Disease (COPD) were the top three causes of death in the area. In the service area, the crude death rate from all causes and each of the leading causes of death (except influenza and pneumonia) were higher than the rates for the state overall, suggesting a high mortality burden in the area. Data for Gates County were compared to death rates for North Carolina and are not captured in the total service area column.

Leading Causes of Death and Death Rates for the Sentara Obici Hospital Service Area, 2016

Leading Causes of Death	Franklin	Isle of Wight County	Southampton County	Suffolk	Surry County	Sussex County	Total VA Service Area[1]	Virginia	Gates County (NC)	North Carolina
Counts										
All Causes	147	329	187	707	81	146	1,597	63,100	119	90,498
Cancer	33	68	50	174	25	36	386	14,646	21	19,526
Heart Disease	35	67	39	157	12	29	339	13,748	23	18,276
Chronic Obstructive Pulmonary Disease (COPD)[2]	7	19	6	32	1	10	75	3,096	6	5,317
Stroke	12	12	10	31	4	4	73	3,202	3	4,941
Accidents[3]	6	13	9	30	4	10	72	3,070	6	3,950
Alzheimer's Disease	2	16	4	41	1	4	68	1,765	7	4,152
Diabetes	1	10	5	25	5	9	55	1,671	5	2,813
Kidney Disease	2	4	4	23	1	4	38	1,542	3	2,002
Blood Poisoning	4	4	3	17	--	3	31	1,336	2	1,559
Influenza and Pneumonia	--	7	3	5	2	4	21	1,490	2	1,896
Crude Death Rates per 100,000 Population										
All Causes	**1,769.8**	**899.0**	**1,035.6**	**792.0**	**1,237.8**	**1,269.1**	**937.9**	757.8	**1,036.8**	891.9
Cancer	**397.3**	**185.6**	**276.9**	**194.9**	**382.0**	**312.9**	**226.7**	175.9	**183.0**	192.4
Heart Disease	**421.4**	**183.1**	**216.0**	**175.9**	**183.4**	**252.1**	**199.1**	165.1	**200.4**	180.1
Chronic Obstructive Pulmonary Disease (COPD)[2]	**84.3**	**51.9**	**33.2**	**35.8**	**15.3**	**86.9**	**44.0**	37.2	**52.3**	52.4
Stroke	**144.5**	**32.8**	**55.4**	**34.7**	**61.1**	**34.8**	**42.9**	38.5	**26.1**	48.7
Accidents[3]	**72.2**	**35.5**	**49.8**	**33.6**	**61.1**	**86.9**	**42.3**	36.9	**52.3**	38.9
Alzheimer's Disease	**24.1**	**43.7**	**22.2**	**45.9**	**15.3**	**34.8**	**39.9**	21.2	**61.0**	40.9
Diabetes	**12.0**	**27.3**	**27.7**	**28.0**	**76.4**	**78.2**	**32.3**	20.1	**43.6**	27.7
Kidney Disease	**24.1**	**10.9**	**22.2**	**25.8**	**15.3**	**34.8**	**22.3**	18.5	**26.1**	19.7
Blood Poisoning	**48.2**	**10.9**	**16.6**	**19.0**	--	**26.1**	**18.2**	16.0	**17.4**	15.4
Influenza and Pneumonia	--	**19.1**	**16.6**	**5.6**	**30.6**	**34.8**	**12.3**	17.9	**17.4**	18.7

[1]Total Service Area with exception of Gates County in North Carolina, which represents only 5% of inpatients to SOH.

[2]Deaths for all chronic lower respiratory diseases for North Carolina

[3]Deaths for all unintentional injuries except motor vehicle accidents for North Carolina

Data Sources: Deaths - Virginia Health Department (OIM - Data Management); North Carolina State Center for Health Statistics

GREEN = Rates are better compared to State Rate **RED** = Rates are worse compared to State Rate

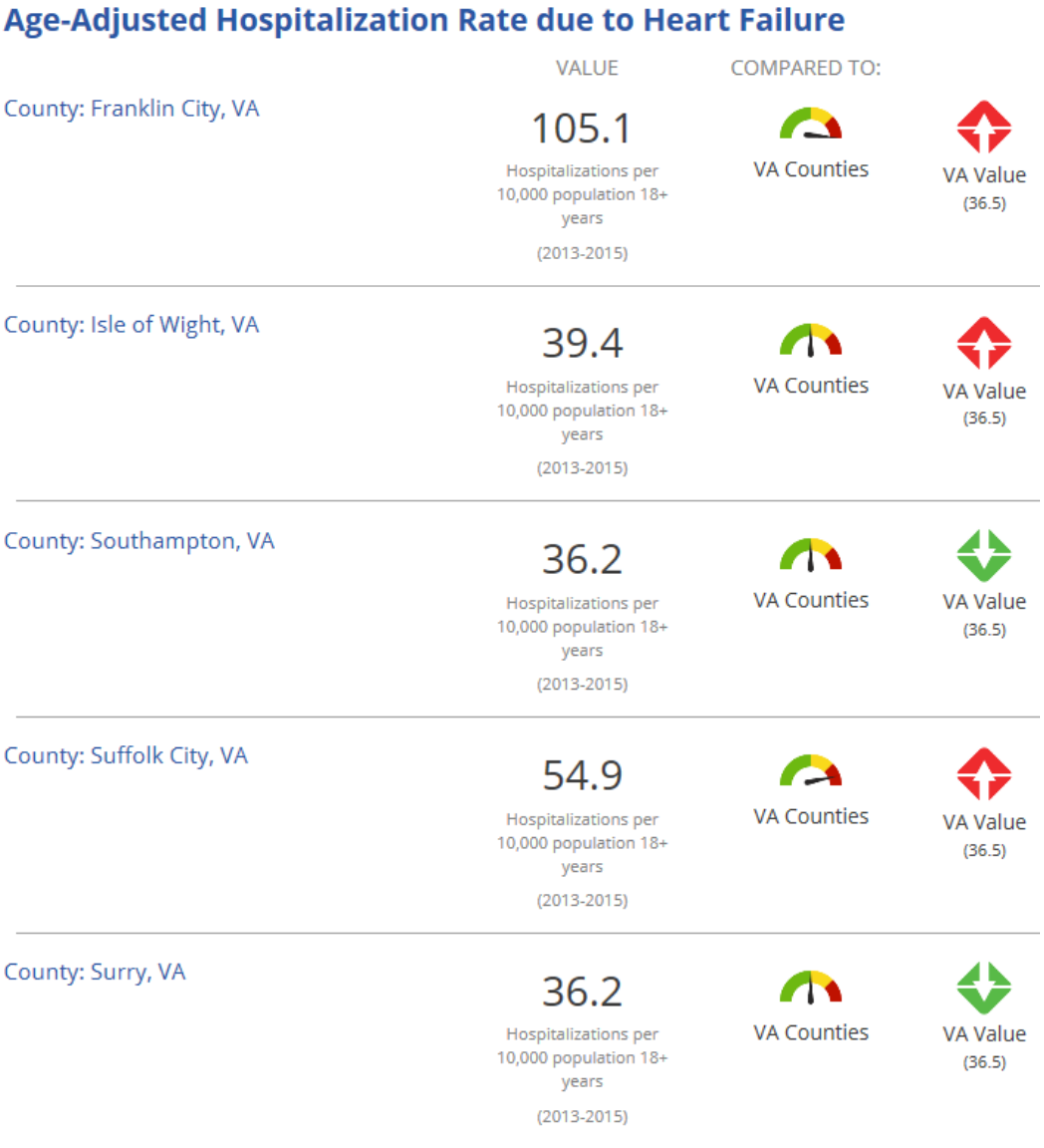
Link to interactive dashboard with age-adjusted rates: Mortality SOH

B. Hospitalizations for Chronic and Other Conditions Profile

These often could be avoided with proper outpatient care. Top conditions displayed.

Link to interactive dashboard: Hospitalizations SOH *(more conditions available)*

Highlights: Of the conditions examined, heart failure was the condition with the highest age-adjusted hospitalization rate in the SOH Service Area with the city of Franklin having the highest rate. Except for Southampton and Surry, the rates were higher than the Virginia rate. Other top conditions included community acquired pneumonia, and diabetes.



County: Sussex, VA	68.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (36.5)

Data not available for Gates County

Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia

	VALUE	COMPARED TO:	
County: Franklin City, VA	62.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)
County: Isle of Wight, VA	17.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)
County: Southampton, VA	23.9 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)
County: Suffolk City, VA	18.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)
County: Surry, VA	20.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)
County: Sussex, VA	25.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (19.6)

Data not available for Gates County

Age-Adjusted Hospitalization Rate due to Diabetes

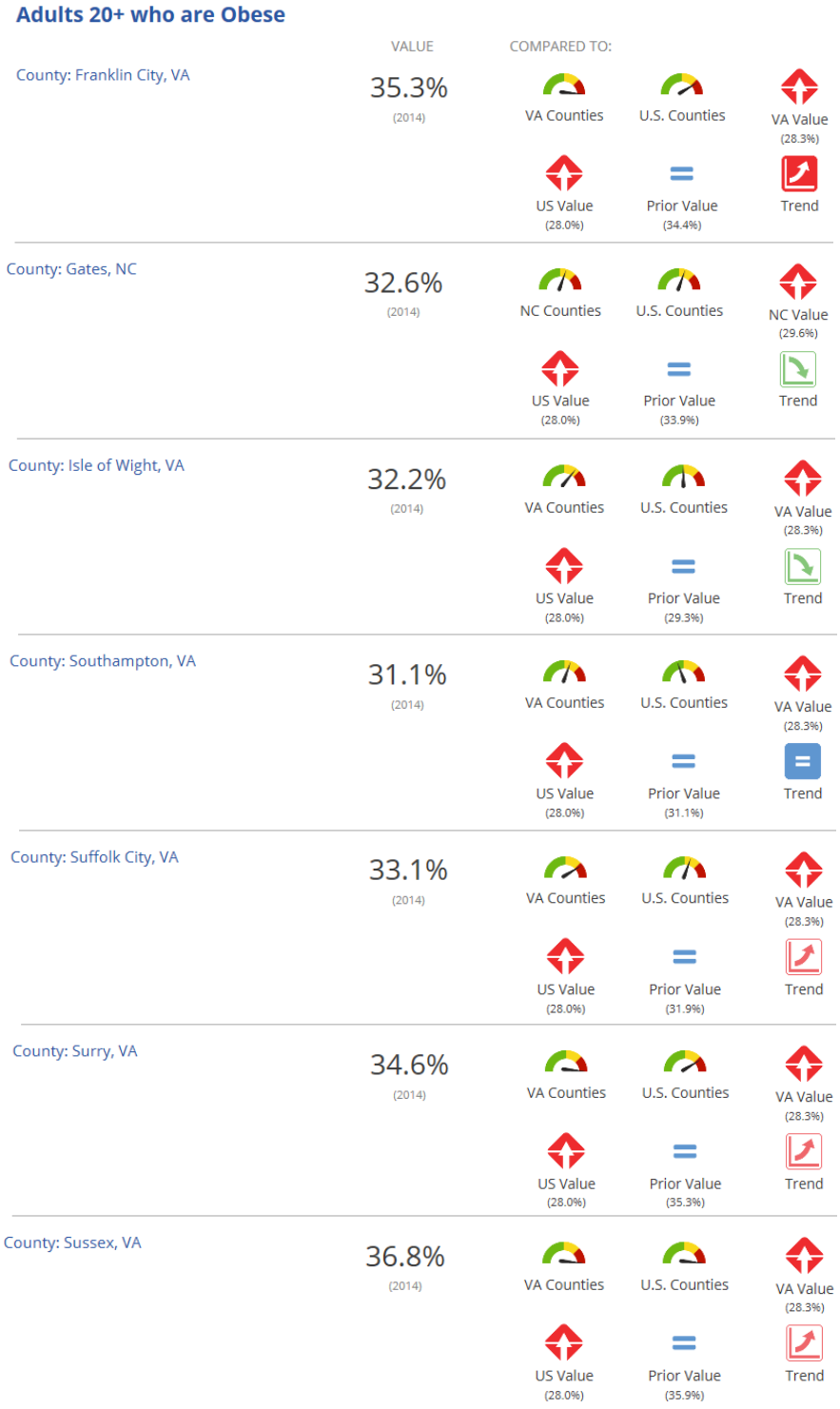
	VALUE	COMPARED TO:	
County: Franklin City, VA	51.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (18.9)
County: Isle of Wight, VA	19.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (18.9)
County: Southampton, VA	13.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (18.9)
County: Suffolk City, VA	20.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (18.9)
County: Surry, VA	24.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (18.9)
County: Sussex, VA	21.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (18.9)

Data not available for Gates County

C. Risk Factors Profile

Link to interactive dashboard: [Risk Factors SOH](#) *(more indicators available)*

Highlights: Obesity and diabetes percentages were higher for all localities in the SOH service area compared to Virginia and the United States (US) values. Notably, Franklin, Suffolk, and Surry were all in the worst quartile of localities across Virginia for obesity percentages; Franklin, Southampton, and Surry were for diabetes. Conversely, the percentage of adults who drink excessively was lower across the localities in the SOH service area compared to state and national percentages. Smoking was also examined; there were high percentages of smoking except in Isle of Wight.



Adults 20+ with Diabetes

	VALUE	COMPARED TO:		
County: Franklin City, VA	14.2% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (14.9%)	Trend
County: Gates, NC	13.3% (2014)	NC Counties	U.S. Counties	NC Value (11.1%)
		US Value (10.0%)	Prior Value (12.9%)	Trend
County: Isle of Wight, VA	12.4% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (12.6%)	Trend
County: Southampton, VA	13.7% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (12.6%)	Trend
County: Suffolk City, VA	12.0% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (10.9%)	Trend
County: Surry, VA	13.1% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (14.0%)	Trend
County: Sussex, VA	13.1% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (13.5%)	Trend

Adults who Drink Excessively

	VALUE	COMPARED TO:		
County: Franklin City, VA	13.2% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (12.6%)	HP 2020 Target (25.4%)
County: Gates, NC	16.4% (2016)	NC Counties	U.S. Counties	NC Value (16.7%)
		US Value (18.0%)	Prior Value (14.5%)	HP 2020 Target (25.4%)
County: Isle of Wight, VA	17.2% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (16.9%)	HP 2020 Target (25.4%)
County: Southampton, VA	14.9% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (14.7%)	HP 2020 Target (25.4%)
County: Suffolk City, VA	16.8% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (15.7%)	HP 2020 Target (25.4%)
County: Surry, VA	14.9% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (13.9%)	HP 2020 Target (25.4%)
County: Sussex, VA	16.0% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (15.5%)	HP 2020 Target (25.4%)

D. Cancer Profile

Highlights: Death and incidence rates for a variety of cancer types were examined. Mortality rates were highest among lung, breast and prostate cancers. Lung cancer death rates were worse than state rates for Southampton, Surry, and Sussex counties. Death rates due to breast, colorectal, and prostate cancers were consistently worse in the localities vs. the state overall (except colorectal cancer in Isle of Wight) where data for the localities were available. The city of Franklin had the highest overall death rate due to cancer followed by Sussex County. In general, breast cancer, followed by prostate and then lung cancer had the highest new or incident case rates across the localities in the SOH service area. All localities except Gates County, NC had higher all cancer incidence rates compared to state rates. Localities with the greatest all cancer incidence rates were Sussex, Franklin, Surry, and then Suffolk in order of decreasing incidence.

Age-Adjusted Cancer Death Rates by Cancer Type and City/County in the SOH Service Area, 2011-2015

Age-Adjusted Death Rate	Franklin	Isle of Wight County	Southampton County	Suffolk	Surry County	Sussex County	Virginia	Gates County	North Carolina
Breast Cancer per 100,000 females	52.3	26.4	25.8	27.0	--	--	21.8	--	21.3
Colorectal Cancer per 100,000 population	--	13.0	18.2	18.6	--	--	14.0	--	14.0
Lung Cancer per 100,000 population	39.7	38.6	44.2	43.2	57.4	76.1	44.0	46.6	49.0
Prostate Cancer per 100,000 males	--	25.2	--	37.5	--	--	20.2	--	20.7
All Cancer Sites per 100,000 population	237.5	170.5	159.5	182.3	185.6	216.0	163.8	152.5	169.3

Cancer Incidence Rates by Cancer Type and City/County in the SOH Service Area, 2011-2015

Incidence Rate	Franklin	Isle of Wight County	Southampton County	Suffolk	Surry County	Sussex County	Virginia	Gates County	North Carolina
Breast Cancer per 100,000 females	143.3	150.6	132.3	146.7	144.2	130.9	127.9	90.3	131.0
Colorectal Cancer per 100,000 population	67.7	37.4	42.1	43.6	37.7	54.5	36.0	35.9	37.5
Lung Cancer per 100,000 population	57.9	53.3	64.5	56.9	67.2	89.3	58.9	57.6	69.2
Prostate Cancer per 100,000 males	146.4	104.3	108.7	130.3	155.9	160.6	102.8	96.5	120.9
All Cancer Sites per 100,000 population	492.8	424.4	437.2	450.5	474.0	503.7	414.3	378.4	457.6

Data Source: Centers for Disease Control and Prevention National Cancer Institute. State Cancer Profiles at statecancerprofiles.cancer.gov.

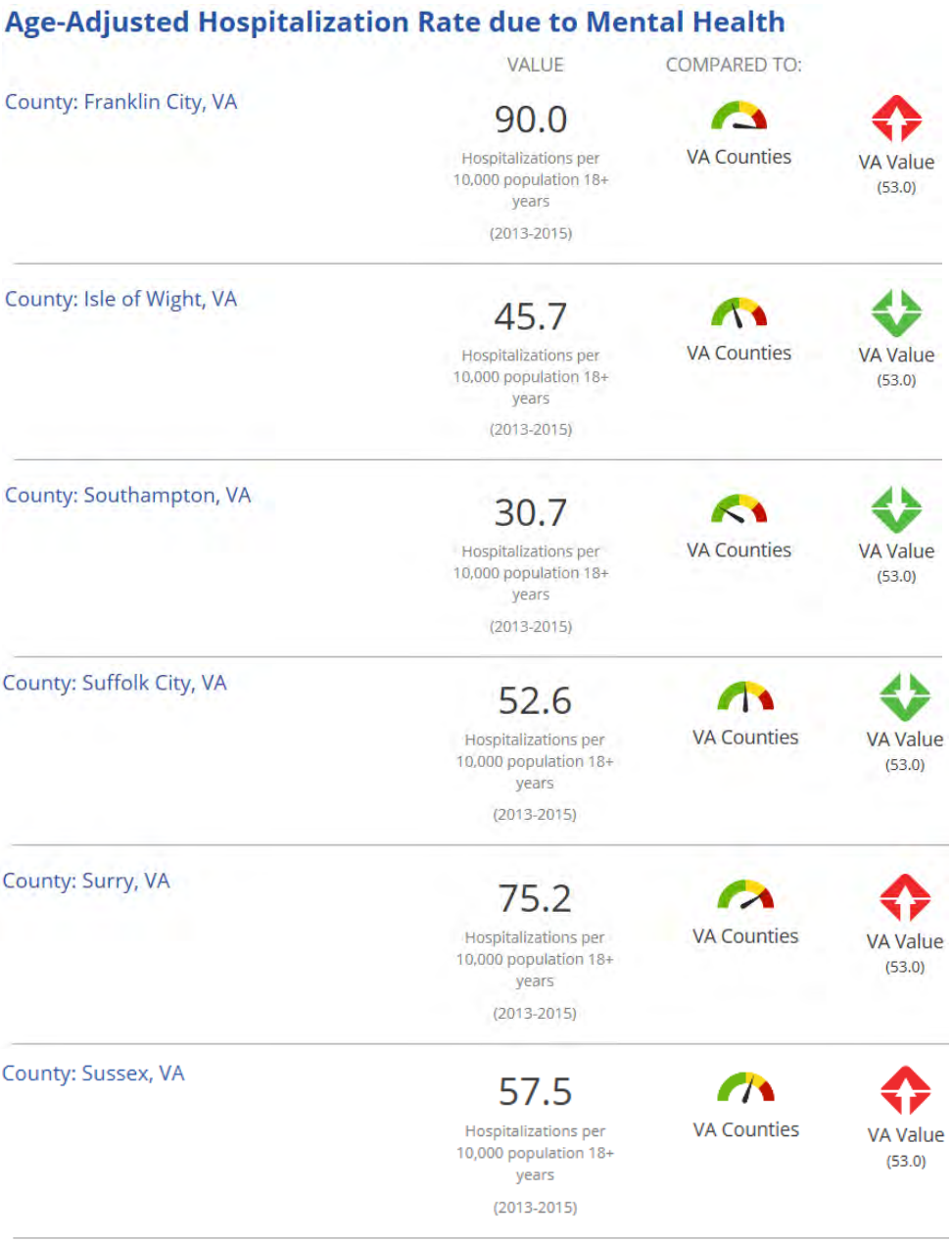
GREEN = Rates are better compared to state rate **RED** = Rates are worse compared to State rate

--Suppressed due to insufficient cases.

E. Behavioral Health Profile – Mental Health and Substance Abuse

Link to interactive dashboard: Behavioral Health SOH *(more indicators available)*

Highlights: Hospitalization rates due to mental health, suicide/self-intentional injury, and alcohol/substance abuse were examined. Franklin, Surry, and Sussex had higher hospitalization rates due to mental health compared to Virginia rates. Franklin and Surry also had higher hospitalization rates due to suicide/self-intentional injury compared to Virginia. For alcohol abuse hospitalizations, only Franklin had a rate greater than the state value. For substance abuse, Franklin and Suffolk had hospitalization rates greater than Virginia. Notably, Franklin was in the worst quartile of localities across Virginia for all four indicators.



Age-Adjusted Hospitalization Rate due to Suicide and Intentional Self-inflicted Injury

	VALUE	COMPARED TO:	
County: Franklin City, VA	49.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (28.1)
County: Isle of Wight, VA	22.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (28.1)
County: Southampton, VA	13.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (28.1)
County: Suffolk City, VA	25.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (28.1)
County: Surry, VA	30.0 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (28.1)
County: Sussex, VA	27.2 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (28.1)

Age-Adjusted Hospitalization Rate due to Alcohol Abuse

	VALUE	COMPARED TO:	
County: Franklin City, VA	21.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (12.6)
County: Isle of Wight, VA	10.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (12.6)
County: Southampton, VA	6.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	 VA Value (12.6)

County: Suffolk City, VA	10.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (12.6)
County: Sussex, VA	7.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (12.6)

Age-Adjusted Hospitalization Rate due to Substance Abuse

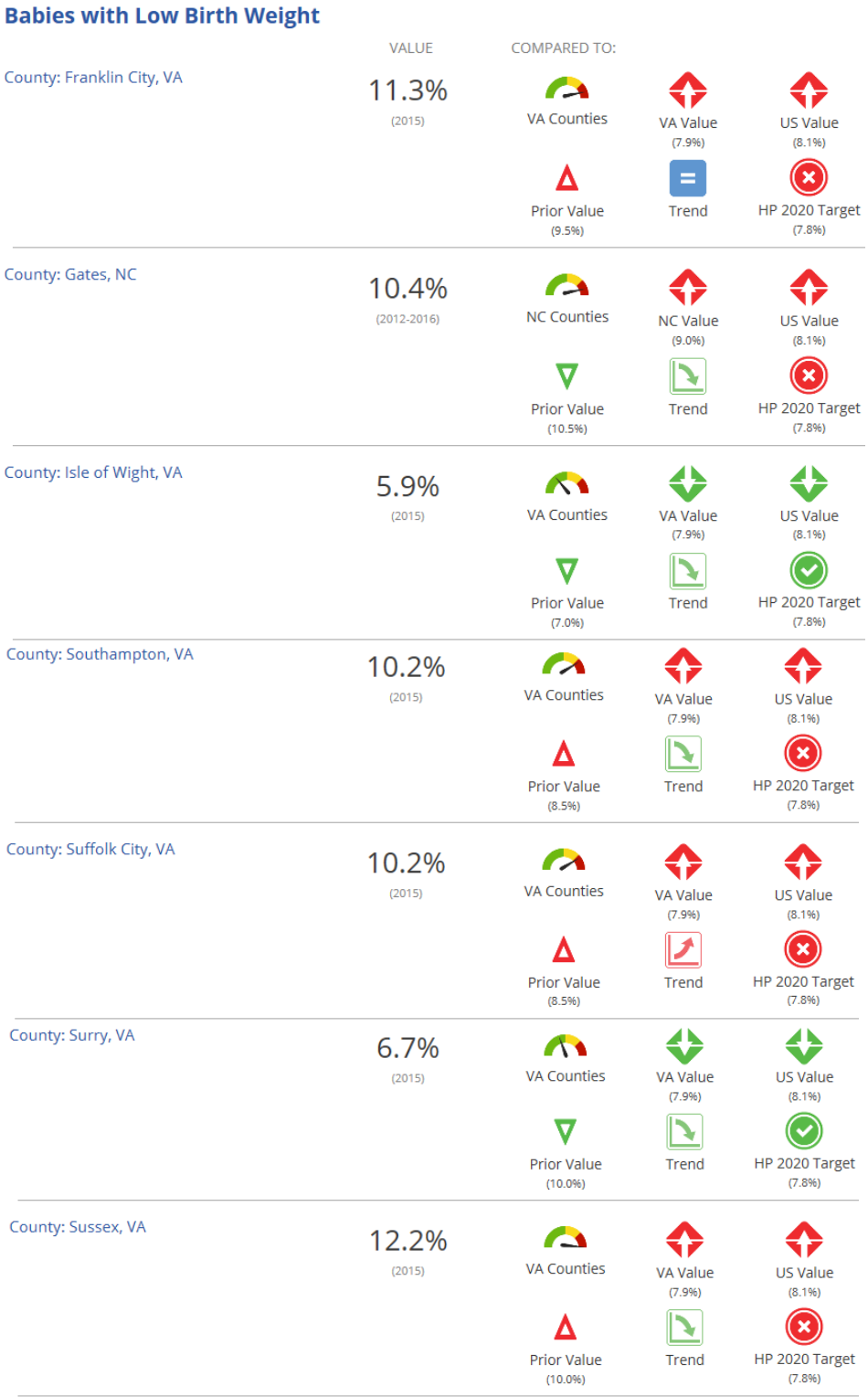
	VALUE	COMPARED TO:	
County: Franklin City, VA	16.0 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (6.2)
County: Isle of Wight, VA	5.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (6.2)
County: Southampton, VA	5.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (6.2)
County: Suffolk City, VA	6.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (6.2)
County: Sussex, VA	4.0* Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (6.2)

Data for Gates County, NC for above indicators; Franklin City not available for substance abuse hospitalizations

F. Maternal & Infant Health Profile

Link to interactive dashboard: [Maternal & Infant Death SOH](#) *(more indicators available)*

Highlights: Localities in the SOH service area except Isle of Wight and Surry had high percentages of babies born with a low birth weight compared to US and state values. The infant mortality rate was also greater in the localities compared to the US and state values except for Isle of Wight, which had a lower value. Teen pregnancy rates were also examined; only Suffolk, Sussex, and Franklin had rates higher than the state rate. Notably, Franklin was in the worst quartile of localities across Virginia.



Infant Mortality Rate

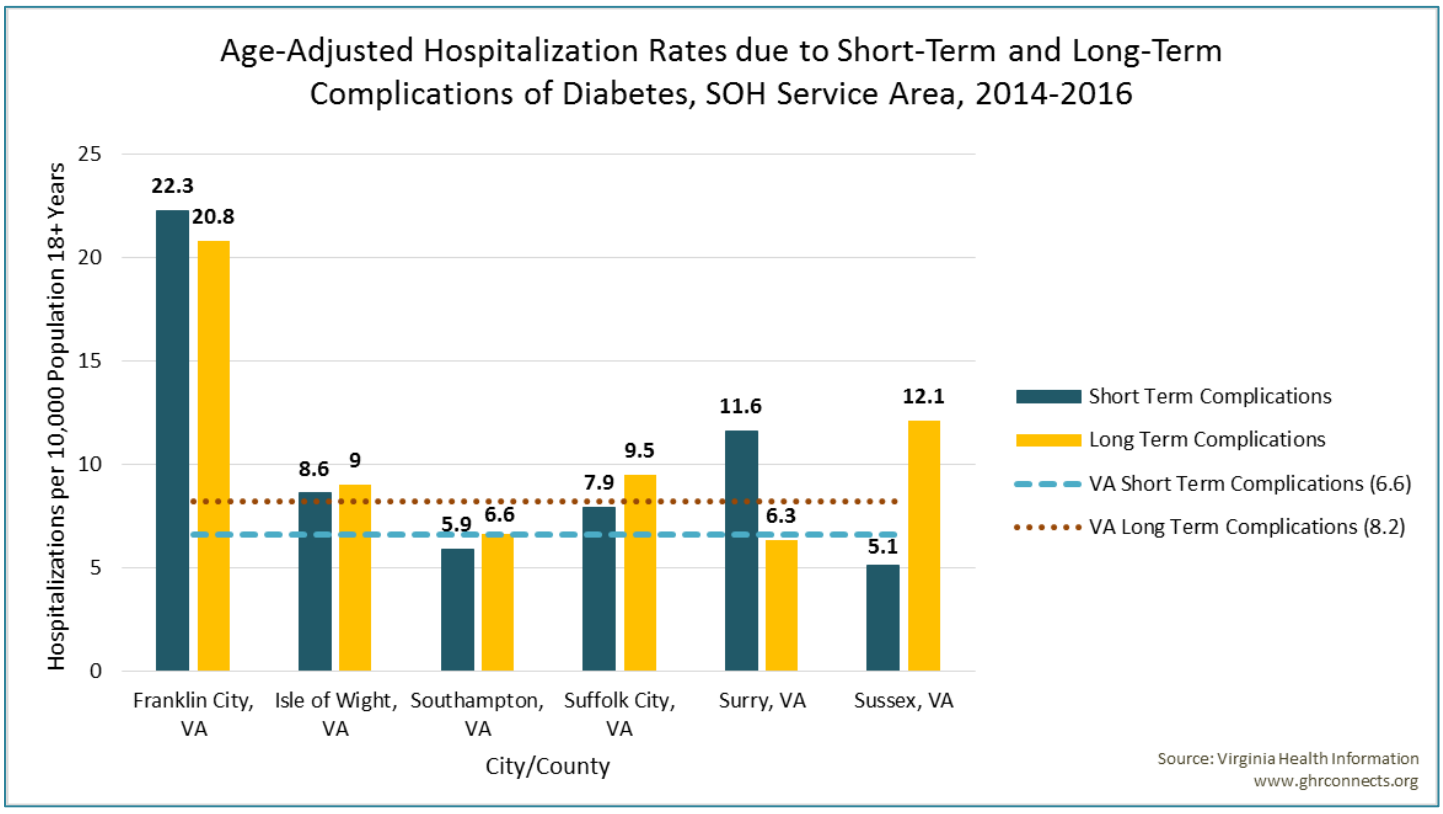
	VALUE	COMPARED TO:		
County: Franklin City, VA	15.0 Deaths per 1,000 live births (2015)	VA Counties Prior Value (19.0)	VA Value (5.9) Trend	US Value (5.9) HP 2020 Target (6.0)
County: Gates, NC	7.8 Deaths per 1,000 live births (2012-2016)	NC Counties Prior Value (7.1)	NC Value (7.2) Trend	US Value (5.9 in 2013-2015) HP 2020 Target (6.0)
County: Isle of Wight, VA	2.8 Deaths per 1,000 live births (2015)	VA Counties Prior Value (10.8)	VA Value (5.9) Trend	US Value (5.9) HP 2020 Target (6.0)
County: Southampton, VA	16.9 Deaths per 1,000 live births (2015)	VA Counties Prior Value (7.0)	VA Value (5.9) Trend	US Value (5.9) HP 2020 Target (6.0)
County: Suffolk City, VA	9.5 Deaths per 1,000 live births (2015)	VA Counties Prior Value (4.6)	VA Value (5.9) Trend	US Value (5.9) HP 2020 Target (6.0)
County: Surry, VA	15.6 Deaths per 1,000 live births (2012)	VA Counties Prior Value (0.0)	VA Value (6.3) HP 2020 Target (6.0)	US Value (6.0)
County: Sussex, VA	11.1 Deaths per 1,000 live births (2015)	VA Counties Prior Value (9.9)	VA Value (5.9) Trend	US Value (5.9) HP 2020 Target (6.0)

G. Spotlight: Diabetes

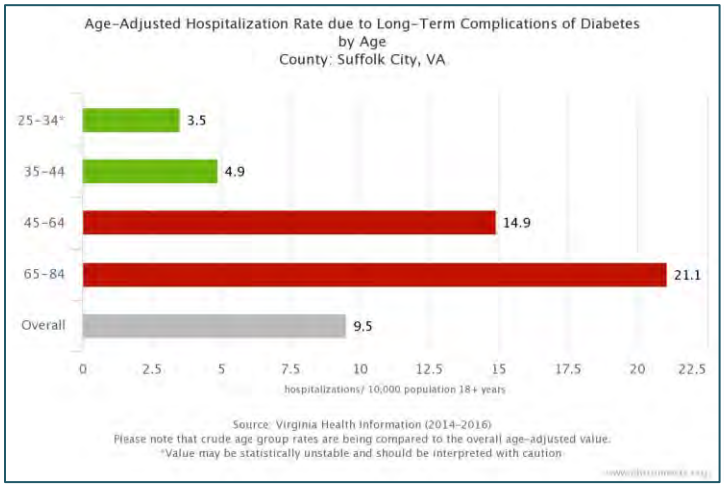
According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes increased sixfold in the second half of the 20th century. Risk factors like obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity also remain key risk factors. Earlier in this report, the death rate due to diabetes, the hospitalization rate due to uncontrolled diabetes, and the prevalence of the condition have been highlighted for the SOH service area. Diabetes is a top cause of death in the service area. Here we examine additional related indicators. SOH has helped lead the formation of the Wester Tidewater Diabetes Coalition to improve screening and follow-up services for diabetic patients throughout the area, working closely with a wide range of community partners.

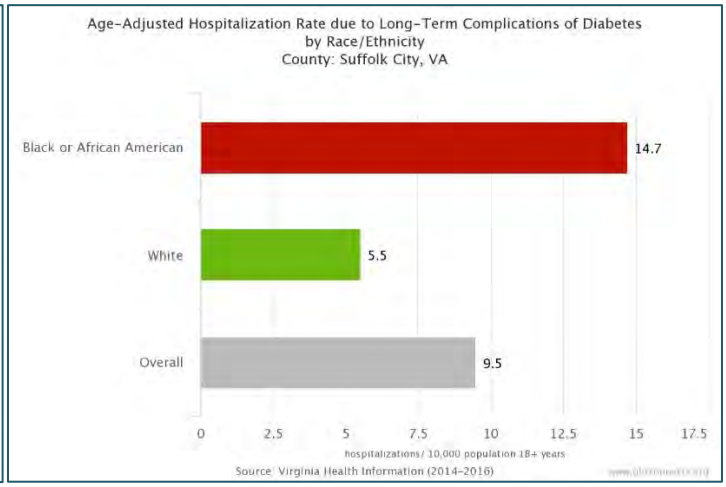
Link to interactive dashboard: SOH Hospitalization Rate due to Diabetes Complications

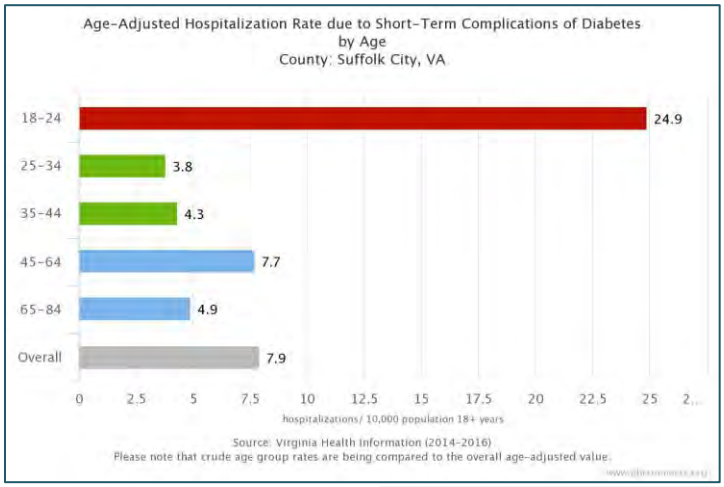
Highlights: Localities in the SOH service area except Southampton and Sussex have high hospitalization rates due complications short-term complications of diabetes (including ketoacidosis, hyperosmolarity, and coma) compared to the state rate. Localities in the SOH service area except Southampton and Surry have high hospitalization rates due complications long-term complications of diabetes (eye, renal, neurological, circulatory, or other complications). Disparities among age groups and race/ethnicity were seen for these indicators; the example for Suffolk is displayed. The data were also examined at the zip code level to identify potential areas of the service area most impacted. For hospitalizations due to long-term complications, the following zip codes in the SOH service area had the highest rates: 23315 (Carrsville in Isle of Wight), 23888 (Wakefield in Sussex), 23882 (Stony Creek in Sussex), and 23829 (Capron in Southampton).

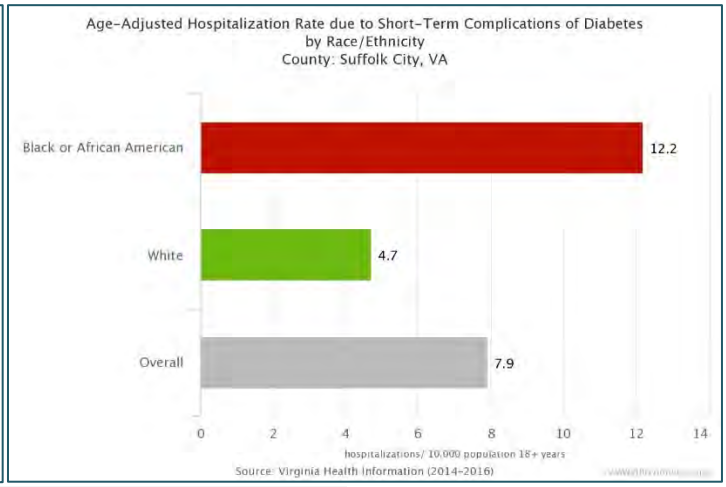


Disparities Exist due to Age and Race/Ethnicity (Suffolk Example)



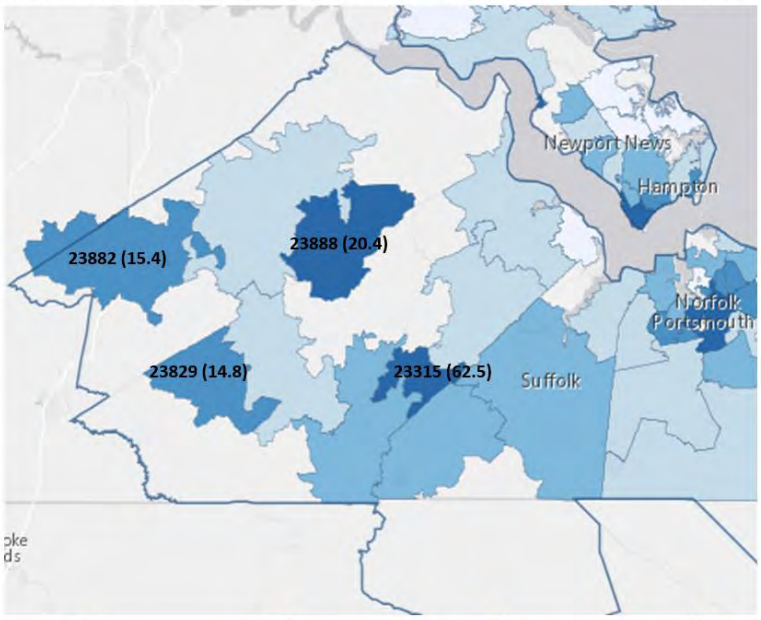






Significantly **better** than the overall value
Significantly **worse** than the overall value
Not significantly different than the overall value (or no confidence intervals available)

Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes, 2014-2016 by Zip Code



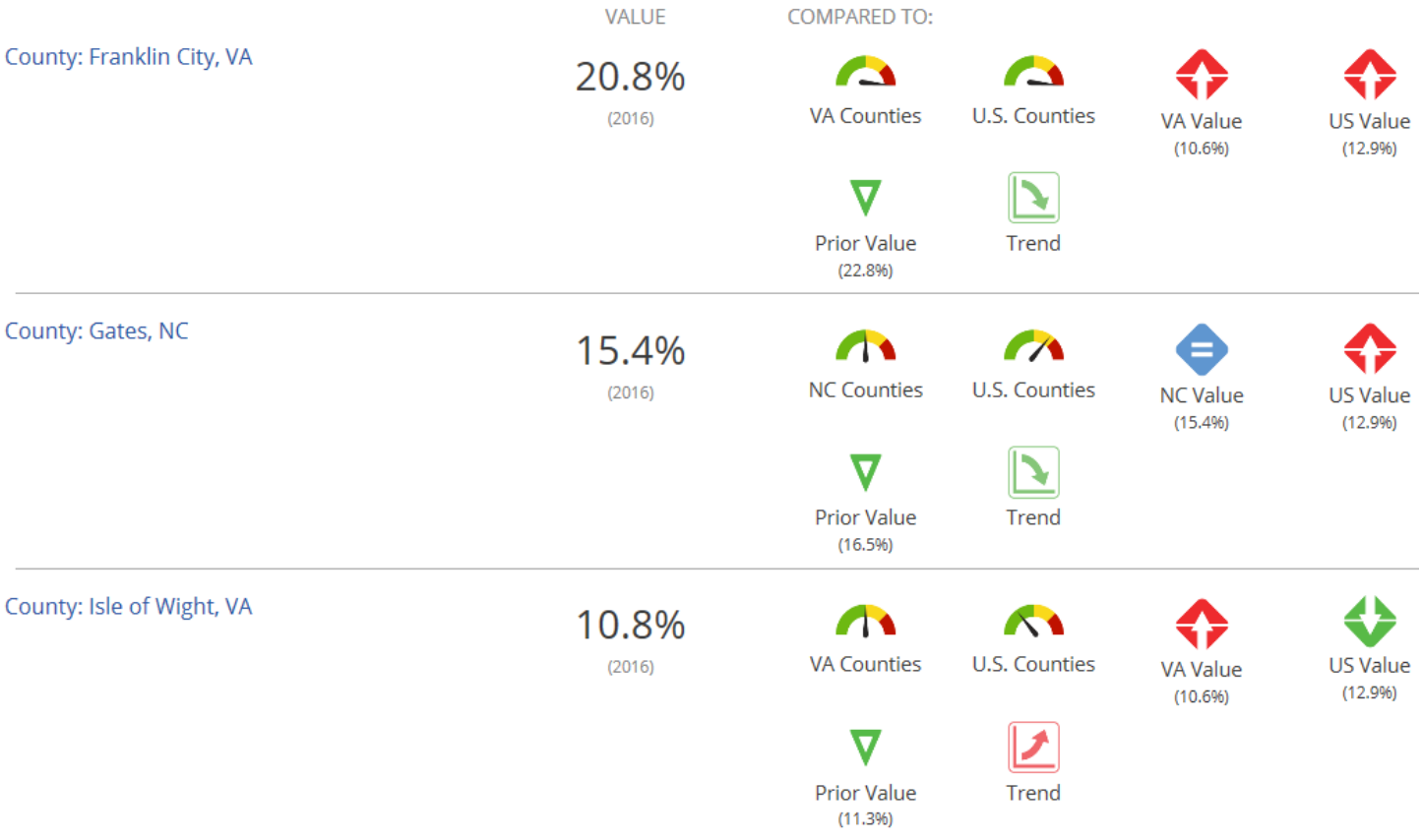
H. Spotlight: Food Insecurity

Food access is a key economic and social indicator of community health. Food insecurity, defined by the US Department of Agriculture as "the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways," inhibits individuals from consuming a balance diet, increasing the risk for chronic disease and negatively impacting health outcomes. Poor nutrition influences the onset, management, and outcome of diabetes, heart disease, stroke, obesity, certain cancers, and other health conditions.

Link to interactive dashboard: SOH Food Insecurity

Highlights: For all the Virginia localities in the SOH Service Area, the food insecurity rate is higher than the Virginia rate. Gates County in North Carolina has a rate equal to the North Carolina state rate; note that it is also much higher than the Virginia rate. Specific localities – Franklin City and Sussex County – are in the worst quartile for localities state and nationwide

Food Insecurity Rate



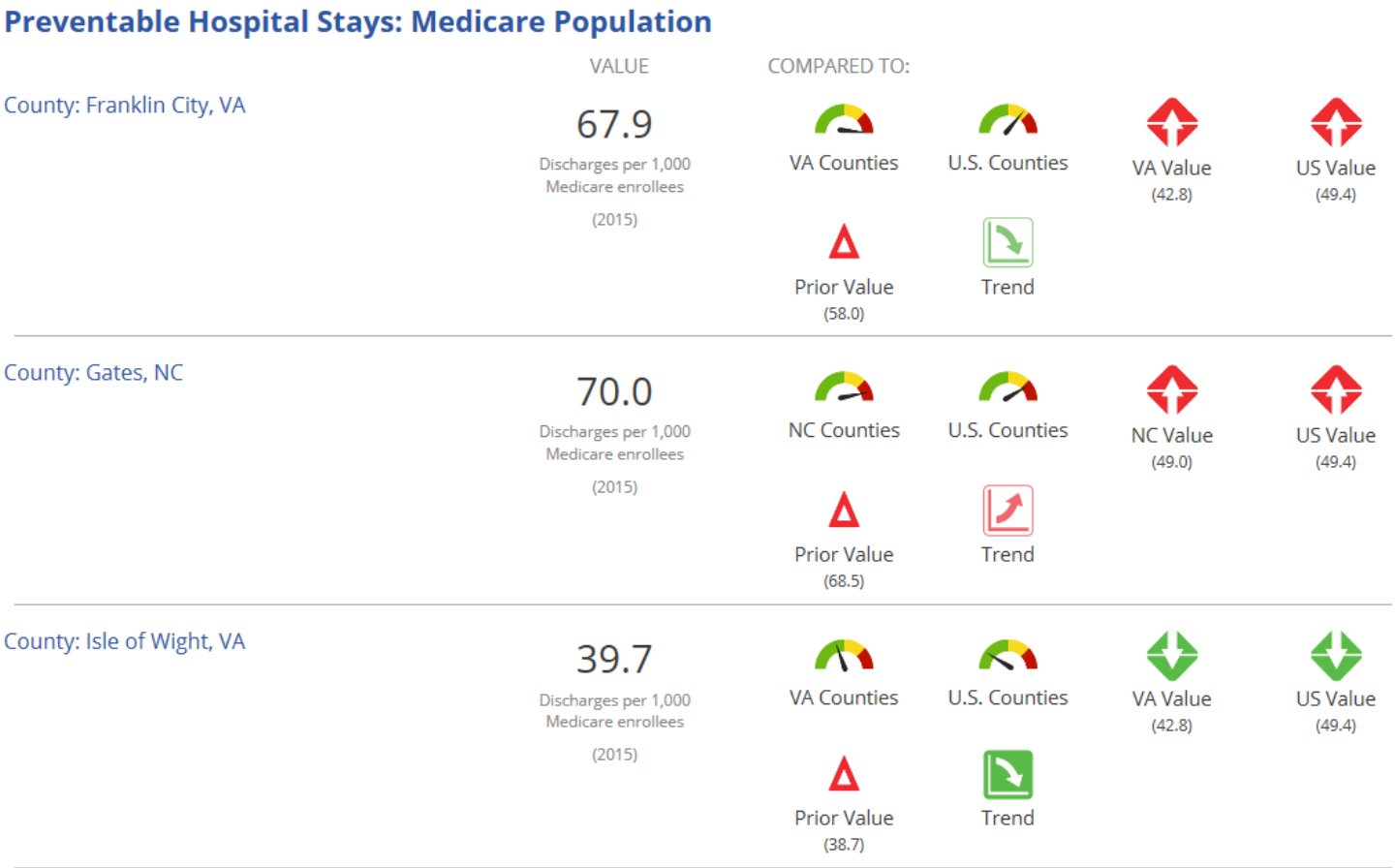
County: Southampton, VA	14.5% (2016)	VA Counties	U.S. Counties	VA Value (10.6%)	US Value (12.9%)
		Prior Value (14.9%)	Trend		
County: Suffolk City, VA	14.1% (2016)	VA Counties	U.S. Counties	VA Value (10.6%)	US Value (12.9%)
		Prior Value (14.4%)	Trend		
County: Surry, VA	14.5% (2016)	VA Counties	U.S. Counties	VA Value (10.6%)	US Value (12.9%)
		Prior Value (14.6%)	Trend		
County: Sussex, VA	19.5% (2016)	VA Counties	U.S. Counties	VA Value (10.6%)	US Value (12.9%)
		Prior Value (20.2%)	Trend		

I. Spotlight: Preventable Hospital Stays

Preventable hospitalizations illustrate the quality and accessibility of primary care and outpatient services available in a community. If outpatient care in a community is poor, then people may be more likely to overuse the hospital as their main source of care, resulting in unnecessary hospital stays. Typically, areas with higher densities of primary care have lower rates of hospitalizations for these ambulatory care sensitive conditions. Increasing access to primary care is key solution to reducing these unnecessary and costly hospital stays and improving the health of the community.

Link to interactive dashboard: [SOH Preventable Hospital Stays]

Highlights: The preventable hospitalization rates are high in all areas of the SOH Service Area except Isle of Wight and Surry. Notably, Gates County in North Carolina, the city of Franklin, and Southampton County have the three highest rates for the entire Greater Hampton Roads area.



County: Southampton, VA

60.9
Discharges per 1,000 Medicare enrollees
(2015)


VA Counties


U.S. Counties


VA Value
(42.8)


US Value
(49.4)


Prior Value
(47.2)


Trend

County: Suffolk City, VA

43.7
Discharges per 1,000 Medicare enrollees
(2015)


VA Counties


U.S. Counties


VA Value
(42.8)


US Value
(49.4)


Prior Value
(45.9)


Trend

County: Surry, VA

38.7
Discharges per 1,000 Medicare enrollees
(2015)


VA Counties


U.S. Counties


VA Value
(42.8)


US Value
(49.4)


Prior Value
(46.0)


Trend

County: Sussex, VA

47.0
Discharges per 1,000 Medicare enrollees
(2015)


VA Counties


U.S. Counties


VA Value
(42.8)


US Value
(49.4)


Prior Value
(55.1)


Trend

Sources

Profile	Data Accessed & Maintained Via	Source/Agency
Mortality Profile	Virginia Department of Health Mortality Data Portal North Carolina State Center for Health Statistics https://schs.dph.ncdhhs.gov/data/vital/lcd/2016/	Deaths – VDH (OIM – Data Management) North Carolina State Center for Health Statistics
Hospitalizations for Chronic and Other Conditions Profile	Healthy Communities Institute. Greater Hampton Roads Community Indictors Dashboard. GHRconnects. http://www.ghrconnects.org/.	Virginia Health Information (VHI)
Risk Factor Profile		County Health Rankings; Centers for Disease Control and Prevention (CDC) 500 Cities Project
Cancer Profile	State Cancer Profiles Data Tables – Incidence & Mortality Tables https://statecancerprofiles.cancer.gov/data-topics/incidence.html https://statecancerprofiles.cancer.gov/data-topics/mortality.html	National Cancer Institute
Behavioral Health Profile	Healthy Communities Institute. Greater Hampton Roads Community Indictors Dashboard. GHRconnects. http://www.ghrconnects.org/.	Virginia Health Information (VHI); County Health Rankings
Maternal and Infant Health Profile		Virginia Department of Health, Division of Health Statistics; North Carolina State Center for Health Statistics, Vital Statistics
Spotlight: Diabetes		Virginia Health Information (VHI)
Spotlight: Food Insecurity		Feeding America
Spotlight: Preventable Hospital Stays		Dartmouth Atlas of Health Care; Centers for Medicare and Medicaid Services

Community Insight

The community insight component of this CHNA consisted of two methodologies: an online Community Key Stakeholder Survey carried by the Sentara Strategy Department and a series of more in-depth Community Focus Groups carried out by the hospital.

The Key Stakeholder Survey was conducted jointly with all Sentara hospitals in Hampton Roads in conjunction Bon Secours Hampton Roads, Children's Hospital of The King's Daughters, Riverside Health System, and the Department of Health. The survey tool was similar to but expanded from the survey utilized for the 2016 CHNA.

Community Focus Group Sessions were carried out by the hospital to gain more in-depth insight from community stakeholders. The questions below were utilized. The results of the focus groups are presented after the survey results.

- What are the most serious health problems in our community?
- Who/what groups of individuals are most impacted by these problems?
- What keeps people from being healthy? In other words, what are the barriers to achieving good health?
- What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?
- What more can be done to improve health, particularly for those individuals and groups most in need?
- Considering social determinants impact health outcomes more than clinical care, which of the following resonate as a key social determinant that we should be focusing on?

Key Stakeholder Survey: The survey was conducted jointly by Bon Secours Hampton Roads, Children's Hospital of The King's Daughters, Riverside Health System, Sentara Healthcare and the Department of Health in an effort to obtain community input for the study. The *Key Stakeholder Survey* was conducted with a broad-based group of community stakeholders. The survey participants were asked to provide their viewpoints on:

- Important health concerns in the community for adults and for children;
- Significant service gaps in the community for adults and for children;
- Issues impacting the ability of individuals to access care;
- Vulnerable populations in the community;
- Community assets that need strengthening in the community;
- Additional ideas or suggestions for improving community health.

The community stakeholder list included representatives from public health, education, social services, business, local government and local civic organizations, among others. Health system and health department staff conducted outreach for community input via email and in-person and via teleconference at local events and meetings. An email survey request was sent to 922 unduplicated community stakeholders throughout Hampton Roads, and a total of 125 stakeholders in the Sentara Obici Hospital (SOH) service area submitted a response, although not every respondent answered every question. The respondents provided rich insights about community health in the study region. This report summarized the survey results for those respondents affiliated with the SOH service area.

The stakeholders responding to the survey represent 45 organizations that each have special insight into the health factors that impact the community. The stakeholders work in hospitals and physician offices, City Departments of Social Services, Health Departments and community-based non-profit service organizations working to improve life in Hampton Roads. They are Emergency medical service providers, healthcare providers, fire fighters, pastors, public school teachers and administrators, and social service providers. Some are volunteers, others are career employees in their organizations.

Survey respondents were asked to identify the type of organization that best represents their perspective on health issues through employment or other affiliation. 112 out of the 125 respondents answered this question. The table below presents the roles the respondents play in the community.

Community Roles of Survey Respondents	
Types of Organization	**% Responses**
Healthcare	60.7%
Community Nonprofit Organization (Food Bank, United Way, etc.)	17.0%
Education	5.4%
Local Government or Civic Organization	4.5%
Foundation	3.6%
Business Representative	2.7%
Faith-based Organization	1.8%
Financial Institution	0.9%
Law Enforcement / Fire Department / Emergency Medical Services (EMS)	0.0%

Additionally, respondents were asked to list a specific organization, if any, that they represent in taking the survey. Their responses are presented on the following page.

Organizations Represented in the Key Stakeholder Survey	
Access Partnership	Peninsula Health District
American Diabetes Association	Peninsula Metropolitan YMCA
Beech Grove United Methodist Church	Riverside Health System
Bon Secours/Mercy Health System	Senior Services of Southeastern Virginia
Buy Fresh Buy Local Hampton Roads	Sentara Healthcare
Catholic Charities of Eastern Virginia	Sentara Obici Hospital
Center for Child & Family Services	Southampton Department of Social Services
Champions For Children	Suffolk Department of Social Services
Children's Hospital of The King's Daughters	Summit Wellness At The Mount
City of Suffolk	The Barry Robinson Center
Compassionate Care Hospice	Urban League of Hampton Roads
Consortium for Infant and Child Health (CINCH)/EVMS	VersAbility Resources
Department of Public Health	Virginia Career Works- Greater Peninsula
Eastern Virginia Medical School	Virginia League for Planned Parenthood
Eastern Virginia Medical School Ear, Nose and Throat	Virginia Oral Health Coalition
Family & Youth Foundations Counseling Service	Virginia Peninsula Foodbank
Isle of Wight County Board of Supervisors	Western Tidewater Community Services Board
JenCare Senior Medical Center	Western Tidewater Free Clinic
Main Street United Methodist Church	Western Tidewater Health District
Obici Healthcare Foundation	Women, Infant and Children
Old Dominion University	Women, Infant and Children - Virginia Beach
Olde Towne Medical & Dental Center	YMCA of South Hampton Roads
Paul D. Camp Community College	

For both adults and, combined, children and teens, survey respondents were asked to review a list of common community health issues. The list of issues draws from the topics in *Healthy People 2020* with some refinements. The survey asked respondents to identify five challenges from the list that they view as important health concerns in the community. Respondents were also invited to identify additional issues not already defined on the list. Of the 125 respondents, 101 provided their concerns for adult challenges. The responses for children's and teen's health concerns follow on subsequent pages.

Most Frequently Chosen Health Concerns -- Adults aged 18+		
Health Concern	**% Responses**	**Rating**
Behavioral / Mental Health (Suicide, ADHD, Anxiety, Depression, etc.)	63.4%	1
Overweight / Obesity	56.4%	2
Heart Conditions (Heart Disease, Congestive Heart Failure / CHF, Heart Attacks / AMI, High Blood Pressure / Hypertension)	52.5%	3
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	50.5%	4
Diabetes	49.5%	5
Cancer	28.7%	6
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	25.7%	7
Dental / Oral Care	17.8%	8
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	16.8%	9
Alzheimer's Disease / Dementia	13.9%	10
Prenatal and Pregnancy Care	13.9%	
Hunger	12.9%	11
Accidents / Injuries (Unintentional)	11.9%	12
Chronic Pain	9.9%	13
Respiratory Diseases (Asthma, COPD, Emphysema)	9.9%	
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	9.9%	
Violence – Sexual and / or Domestic	7.9%	14
Neurological Conditions (Stroke, Seizures, Multiple Sclerosis, Traumatic Brain Injury, etc.)	5.9%	15
Intellectual / Developmental Disabilities / Autism	5.0%	16
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	4.0%	17
Physical Disabilities	3.0%	18
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	2.0%	19
Bullying (Cyber, Workplace, etc)	1.0%	20
Drowning / Water Safety	1.0%	

Emerging Themes: Throughout Hampton Roads, the most frequently chosen health concern for adults was behavioral health, followed by heart disease, alcohol and substance abuse, obesity, diabetes and cancer. This reflects a growing understanding that behavioral health is integral to overall wellness, as well as pointing to the persistent lack of services to address a health problem with a growing patient population as conditions previously undiagnosed are identified.

In addition to responding to the pre-formulated survey list, seven individuals listed additional adult health concerns. The responses offer the themes of affordable care, management of chronic conditions, public awareness of current services, and the availability of mental/behavioral health assistance. The "free response" answers draw attention to the connections between what we think of as traditional medical conditions and the non-medical factors in our everyday lives that impact health, and which are known as the "social determinants of health." In these responses, as in the other free response sections of the survey, a broader vision of health is displayed. The following table presents additional health concerns for adults.

Free Response Additional Community Health Concerns -- Adults aged 18+
I note heart conditions as that is sort of the nail in the coffin as far as functionality. But this is the result of obesity, diabetes, poverty, poor medical follow-up, smoking, substance abuse. All of these issues seem to occur singly, or more often in a combination, that results in me seeing people who are unhealthy, disabled, and unable to function in society.
balanced diet, availability of healthy, fresh foods across income levels and geographic areas
How did Womens health and health care disparities not make this list
Oral Health
Mental health is a growing populations. Yet there's limited organizations that can screen. Barriers such as appointments, transportations comes into play.
Lack of local access to primary, behavioral and oral health care Lack of choices for healthy eating and active living
Lack of understanding of community resources that are already available to patients and are under utilized

Emerging Themes: You will note that throughout the survey, where free response questions allow respondents to identify additional areas of interest we found that social and lifestyle elements were often included on the lists. Things such as transportation, affordability and the need for care coordination for health concerns and between organizations that focus on different types of assistance remind us that health is not a stand-alone experience but is instead woven into the lives we lead.

A follow-up question on the survey asks respondents to choose five healthcare services that need to be strengthened for adults in the SOH service area from a list of services that are common in communities across the country. Respondents were given the characteristics of improved access, quality of healthcare, and availability of the service as considerations to take into account when making their choices. The responses of 97 individuals are presented in the table on the next page.

Community Healthcare Services the Need to be Strengthened -- Adults aged 18+		
Healthcare Service	% Responses	Rating
Behavioral / Mental Health Services	63.9%	1
Alcohol / Substance Abuse Services	40.2%	2
Health Insurance Coverage	38.1%	3
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	33.0%	4
Aging Services	26.8%	5
Dental / Oral Health Services	26.8%	
Health Promotion and Prevention Services	26.8%	
Self-Management Services (Nutrition, Exercise, etc.)	24.7%	6
Social Services	23.7%	7
Care Coordination and Transitions of Care	22.7%	8
Primary Care	21.7%	9
Domestic Violence / Sexual Assault Services	16.5%	10
Home Health Services	15.5%	11
Public Health Services	15.5%	
Family Planning and Maternal Health Services	14.4%	12
Chronic Pain Management Services	13.4%	13
Long Term Services / Nursing Homes	11.3%	14
Cancer Services	9.3%	15
Telehealth / Telemedicine	9.3%	
Hospice and Palliative Care Services	8.3%	16
Hospital Services (Inpatient, outpatient, emergency care)	6.2%	17
Pharmacy Services	5.2%	18
Physical Rehabilitation Services	2.1%	19
Bereavement Support Services	1.0%	20

Emerging Themes: Throughout the survey, behavioral health services top the list of services most in need of strengthening. Across Hampton Roads, health insurance is the second most frequently chosen response, with substance abuse services, chronic disease management services and aging services all following. Uncertainty about health insurance coverage and affordability is part of a changing healthcare landscape and will be addressed, though probably not completely resolved, through Medicaid expansion.

Respondents were also given the opportunity to add free response suggestions of other healthcare services that need to be strengthened for adults. The additional concerns of seven respondents are listed in the table on the next page.

Free Response Additional Community Healthcare Services that Need to be Strengthened -- Adults aged 18+
Transportation is a major issue for the aging population.
Women's health
same
Health promotion and prevention is inherent in all of these categories.
transportation to physician's offices
clients are unaware of services available and not educated on the insurance availability and DSS is swamped. grants for organizational who can assist clients and give resources out there
Transportation is a critical barrier to health care for many of our patients.

Emerging Themes: Women's health, transportation and prevention efforts are seen as important additions to the list of services that need to be strengthened across Hampton Roads. Once again, it is evident that other lifestyle challenges such as housing and transportation are seen as important aspects of health related services.

Recognizing that partners in the collaboration that produced this survey may serve differing patient populations, and may have a different focus for needed information when addressing community needs, the survey repeated the two questions about adult health concerns and community services needed for children and teens from birth through age 17. Although the questions and intent are the same as the questions for adults, some of the listed health and community needs are specific to the population aged 17 and under. Of 125 respondents, 98 answered these questions. The table on the next page presents the most frequently chosen responses.

Most Frequently Chosen Health Concerns -- Children and Teens ages 0 -- 17		
Health Concern	**% Responses**	**Rating**
Behavioral / Mental Health (Suicide, ADD, Anxiety, Depression)	75.5%	1
Overweight / Obesity	63.3%	2
Violence In the Home – Child Abuse (Sexual, Physical, Emotional or Neglect) or Exposure to Domestic Violence	37.8%	3
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	36.7%	4
Bullying (Cyber, Workplace, etc)	35.7%	5
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	33.7%	6
Intellectual / Developmental Disabilities / Autism	23.5%	7
Accidents / Injuries (Unintentional)	22.5%	8
Hunger	21.4%	9
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	20.4%	10
Dental / Oral Care	19.4%	11
Teen Pregnancy	19.4%	
Respiratory Diseases (Asthma and Cystic Fibrosis)	14.3%	12
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	14.3%	
Diabetes	9.2%	13
Eating Disorders	8.2%	14
Drowning / Water Safety	7.1%	15
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	3.1%	16
Heart Conditions (Congenital Heart Defects, Fainting and Rhythm Abnormalities)	2.0%	17
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	2.0%	
Neurological Conditions (Epilepsy, Seizures, Tourette Syndrome-TICS, Sleep Disorders)	2.0%	
Physical Disabilities	2.0%	
Cancer	1.0%	18
Chronic Pain	0.0%	19

Emerging Themes: Behavioral health is the most frequently chosen health concern for children and teens, perhaps resulting from the somewhat alarming choices that follow, including obesity, violence, bullying, and substance abuse. This tracks with the increased understanding that modern children live with a great deal of stress, both mental and physical, and it impacts their health in ways we are just beginning to understand. For a more detailed discussion of these effects, follow this link to the Adverse Childhood Experiences (ACES) website: https://www.cdc.gov/violenceprevention/acestudy/index.html

Five individuals provided additional thoughts on the most important health concerns for children and teens in the community. Their additions are presented on the next page.

Free Response Additional Community Health Concerns -- Children and Teens ages 0 -- 17
Education, sex education, preventing teen pregnancy.
No access to primary care without a long wait and well check first. I'm an urgent care doc and we see this all the time on both sides of the HRBT
Many things affect children and teens with most connected to parenting skills.
Barriers for organization having to compete vs. complimenting each organizations. leaving the community without other resources out there.
Health promotion should be for children as well.

Emerging Themes: The responses reflect that children face the same challenges to access that adults do, while recognizing the effect of parenting and living conditions, often things that children have no control over.

The survey next asked respondents to choose five healthcare services for children and teens that need to be strengthened from a list of common healthcare services. Responses from 96 individuals are presented in the table on the next page.

Community Healthcare Services that Need to be Strengthened -- Children and Teens ages 0 -- 17		
Healthcare Service	**% Responses**	**Rating**
Behavioral / Mental Health Services	81.25%	1
Parent Education and Prevention Programming	51.04%	2
Child Abuse Prevention and Treatment Services	46.88%	3
Self-Management Services (Nutrition, Exercise, etc.)	39.58%	4
Social Services	32.29%	5
Care Coordination and Transitions of Care	31.25%	6
Dental / Oral Health Services	30.21%	7
Foster Care (Supporting children in the system and their host families)	30.21%	
Alcohol / Substance Use Services	29.17%	8
Health Insurance Coverage	23.96%	9
Primary Care	22.92%	10
Public Health Services	21.88%	11
Telehealth / Telemedicine	9.38%	12
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	7.29%	13
Home Health Services	7.29%	
Chronic Pain Management Services	6.25%	14
Bereavement Support Services	4.17%	15
Cancer Services	1.04%	16
Pharmacy Services	0.00%	17
Physical Rehabilitation Services	0.00%	

Emerging Themes: Continuing the focus on the behavioral health needs of children and teens, behavioral and mental health services are most cited as needing to be strengthened. Across the survey area, this choice is followed by parent education and child abuse prevention and treatment services. As we understand more about how childhood events impact adult health, the call for these support services is likely to grow stronger. For a more detailed discussion of these effects, follow this link to the Adverse Childhood Experiences (ACES) website: https://www.cdc.gov/violenceprevention/acestudy/index.html

Free response additional services to be strengthened were suggested by 10 individuals and are presented on the next page.

Free Response Community Health Services that Need to be Strengthened -- Children and Teens ages 0 -- 17
Violence prevention and gun safety educationPalliative care services
cardiac care.
Cannot emphasize more strongly the lack of adequate mental health resources for children, especially those with public insurance or no insurance.
Services can be strengthened but if parents aren't required to access services, it is of no help. Social Services is difficult to access, as is behavioral/mental health services. There is sufficient access to dental/oral health BUT parents must take minors for services.
Prevention - effective prevention strategies will work if put in place correctly and with integrity. Abuse and violence prevention is the key in reducing incidents of domestic violence and abuse.
Home visiting programs
Community safety services
Majority of what I see, parents support due to lack of support in home.
Transportation remains a barrier to health care for teens.
Water Safety/Drowning Prevention Tween/Teen Leadership Programs

Emerging Themes: Violence prevention and gun safety education is the community service most often cited as needing to be strengthened. Several other responses focused on parenting resources and prevention efforts.

Much of the information we gather on community health needs ties directly or indirectly to access to health care and other services. The table on the next page presents an incomplete list of factors that might influence an individual's access to service. Although the list is brief, it can help clarify and prioritize program design. Of 125 respondents, 98 provided their list of access concerns.

Factors Impacting Access to Care and Services		
Factors	**% Responses**	**Rating**
Costs	81.6%	1
Transportation	77.6%	2
Health Insurance	69.4%	3
Understanding the Use of Health Services	54.1%	4
Time Off From Work	48.0%	5
Childcare	42.9%	6
No / Limited Home Support Network	33.7%	7
Location of Health Services	29.6%	8
Lack of Medical Providers	27.6%	9
No / Limited Phone Access	4.1%	10
Discrimination	1.0%	11

Emerging Themes: Across Hampton Roads, the top three choices of factors impacting access to care are the same: cost, transportation and health insurance. All three are questions of affordability of care, a consistent concern across services areas and populations.

Five individuals took the opportunity to give free response suggestions for other factors that impact access to care. The suggestions are presented on the next page

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Free Response Additional Comments About Access to Healthcare
Lack of providers in Rural areas
Few providers of services are available in evenings or weekends making it difficult for working parents to take time off.
These are all important. Understanding use of health services is easily a tie for the others I chose, as is child care.....
there is no support network for families and if there is then where are they.
Language Barrier should be added

Emerging Themes: The lack of providers and the unavailability of providers to work extended hours, make access less feasible for those who work outside the home or have other scheduling constraints, and is the most often voiced barrier to care. Lack of childcare and language barriers are consistently cited across the Hampton Roads region as negative factors in accessing care.

Some aspects of access to care impact population segments differentially. Those with fewer resources, such as health insurance, sufficient income, and reliable transportation, struggle harder to access appropriate and sufficient care and other services. The survey included a question designed to identify which consumers face barriers that might be addressed through specific programming. Of 125 respondents, 97 answered the next question. The table listing those responses is on the next page.

Most Vulnerable Populations in the Community Needing Support		
Populations	**% Responses**	**Rating**
Low Income Individuals	70.1%	1
Uninsured / Underinsured Individuals	50.5%	2
Individuals Struggling with Substance Use or Abuse	46.4%	3
Individuals / Families / Children experiencing Homelessness	41.2%	4
Children (age 0-17 years)	40.2%	5
Caregivers (Examples: caring for a spouse with dementia or a child with autism)	36.1%	6
Seniors / Elderly	33.0%	7
Immigrants or community members who are not fluent in English	28.9%	8
Individuals with Intellectual or Developmental Disabilities	22.7%	9
Individuals Transitioning out of Incarceration	17.5%	10
Victims of Human Trafficking, Sexual Violence or Domestic Violence	16.5%	11
Unemployed Individuals	15.5%	12
Individuals with Physical Disabilities	12.4%	13
Individuals Struggling with Literacy	11.3%	14
Individuals Needing Hospice / End of Life Support	11.3%	
Veterans and Their Families	11.3%	
Individuals in the LBGTQ+ community	8.3%	15
Migrant Workers	7.2%	16

Emerging Themes: Respondents agreed across Hampton Roads that low-income individuals, the uninsured, families experiencing homelessness and those struggling with substance abuse are the most vulnerable people in the community, and need supportive services. These answers are consistent with the theme of life conditions creating health issues that we have seen throughout the survey.

Six respondents provided free response additional suggestions for including additional populations, which covered a broad range of community segments and included commentary on the relationships between vulnerabilities and the resulting health issues. The additional suggestions are presented in full in the table on the following page.

Additional Vulnerable Populations Needing Support and Additional Information
I would add to the "transitioning out of incarceration" to those currently incarcerated. When I see a patient who is going for trial, he states he may or may not be back for follow-up. They almost never received the medications they need while in jail, and often return to clinic after their sentence having received next to no care in the inefficacious jail clinic.
Add seniors and un or underinsured
According to data, more people are insured but our organization receives more requests for help now because although they may have coverage, they cannot afford deductibles or monthly copays. Underinsured populations with low incomes or don't understand their benefits call daily for assistance.
All of the above also have trouble accessing care for their kids - so all these fundamentally also impact access for children as a vulnerable population.
really hard to choose just five. it's a vicious circle and some are not even being address or one has more resources and funding then the other *Caregivers (Examples: caring for a spouse with dementia or a child with autism) *Individuals with Intellectual or Developmental Disabilities *Low Income Individuals *Unemployed Individuals *Victims of Human Trafficking, Sexual Violence or Domestic Violence *Veterans and Their Families ALL POINTS BACK TO MENTAL HEALTH. WE GIVE A PRESRENTATION FOR BEATING THE HOLIDAY BLUES, GRIEVING, EDUCATING STAFFS (IN SCHOOLS), FAMILIES HOW TO IDENTIFY SUICIDE IDEATIONS. AGAIN A BARRIER TO GET IN THE SYSTEM
Wow. I could have chosen several others on this list (i.e., many more than 5)!

Emerging Themes: Often forgotten, people in transitions of any description are often more vulnerable as they face new situations. Prisoners transitioning out of incarceration face many challenges, with few resources to help them. Additionally, the contradiction of more people being technically covered by insurance but unable to pay for care because of a high deductible creates a mistaken impression of the state of health care coverage.

Finally, the survey explored the many factors in addition to medical care that determine an individual's health. Collectively called the social determinants of health, these factors are becoming increasingly recognized as contributing both directly and indirectly to individual health through processes as different as the effect of household mold on respiratory disease and the effect of stress from unemployment. The effects of social determinants are sometimes subtle, sometimes only discoverable after a health problem is identified, but often important in explaining health status. Of 125 respondents, 95 addressed this question. Respondents were asked to choose five community assets to be strengthened. Their responses are presented in the table on the next page.

Community Assets that Need to be Strengthened		
Community Assets	**% Responses**	**Rating**
Transportation	57.9%	1
Healthy Food Access (Fresh Fruits & Vegetables, Community Gardens, Farmers Markets, etc.)	48.4%	2
Affordable Housing	43.2%	3
Affordable Child Care	41.1%	4
Homelessness	31.6%	5
Employment Opportunity/Workforce Development	30.5%	6
Neighborhood Safety	30.5%	
Social and Community Networks	28.4%	7
Senior Services	26.3%	8
Social Services	26.3%	
Early Childhood Education	25.3%	9
Safe Play and Recreation Spaces (Playgrounds, Parks, Sports Fields)	22.1%	10
Education – Kindergarten through High School	17.9%	11
Safety Net Food System (Food Bank, WIC, SNAP, Meals on Wheels, etc.)	16.8%	12
Walk-able and Bike-able Communities (Sidewalks, Bike/Walking Trails)	14.7%	13
Public Safety Services (Police, Fire, EMT)	8.4%	14
Education – Post High School	7.4%	15
Green Spaces	4.2%	16
Public Spaces with Increased Accessibility for those with Disabilities	3.2%	17
Environment – Air & Water Quality	2.1%	18
Housing Affordability & Stability	0.0%	19

Emerging Themes: Consistently across the survey area, the top four community assets in need of strengthening are affordable housing, transportation, access to healthy food, and affordable childcare. All of these choices share an element of cost, but also of infrastructure development and maintenance.

Respondents were also given the opportunity to increase the list by adding factors that impact health. Five individuals added factors, listed in the table on the next page.

Additional Community Assets and Additional Information
When a young family pays for child care, it cancels out a large portion of their income. Rent in a safe neighborhood is out of reach for many. Access to Healthy foods won't work if parents/individuals won't use them. Would like to see SNAP work more like WIC where only healthy foods can be purchased (currently, items like candy, soda, chips and other non-nutritional foods can be obtained with SNAP).
Community Task Forces that decide on prevention strategies for their communities...
Safe places to play and walkable/bikeable communities also rank high up there.
Public Safety is an asset, if we have the community proactive in helping. Education- after school program and have a alternative for detentions and suspensions
health safety net

In closing, survey participants were asked to share any additional thoughts that had emerged through the process of responding to the survey questions. Nine respondents shared additional ideas, presented in the table on the next page. We appreciate the time and thought that went into each survey response, and are pleased to present the results here for input into service planning throughout the communities of Hampton Roads.

Additional Comments and Additional Information
There are a lot of people I see as a specialist who are just utterly lost in the healthcare maze, and who do not know what to do without being explicitly told, multiple times, and who have no instinct or knowledge on how to advocate for themselves. I try to guide them as I can, but I wish everyone could just have a case manager to push them along. "Did you make an appointment with your PCP? Okay, make an appointment with your PCP. Did they not answer? Okay, call again."
Thank you for asking. I'd love to help from a public health standpoint if needed.
Need to identify a way to encourage or reward individuals to live a healthy lifestyle, eat nutritional foods, take responsibility for their health. We can continue to provide and strengthen services but unless an individual assumes some responsibility, it won't make a difference.
more than 5 in each area really should have been marked....
The community not only needs the mentioned resources, but needs to be empowered to access them. Often times people are turned off to assistance because someone was rude, or they were met with red tape. Self-advocacy is SO important, and unfortunately is not taught.
Thank you for the survey and for your collaboration.
All the social network is great, but if it's not being shared then we're back to where we were. We can't help our community if there's gap in our resources and social netting.
There is little vocal effective advocacy for patients ages 19-64.
Thank you for allowing me the opportunity to share my concerns

Emerging Themes: The first comment above is telling in that it represents the tension between modern healthcare and not-so-modern consumers. Several of the comments presented above reference the need to navigate, coordinate, advocate and educate the population on how to understand and access services. This is in essence the thrust of population health management, and confirms the importance of conducting community needs assessments to hear the voice of the community.

Community Focus Group Session Findings

In addition to the online surveys for community insight, Sentara Obici Hospital carried out a series of more in-depth Community Focus Groups to obtain greater insight from diverse stakeholders.

Focus groups were often drawn from existing hospital and community groups or sought from other populations in the community, including representatives of underserved communities and consumers of services. The questions below were utilized at each focus group sessions.

- What are the most serious health problems in our community?
- Who/what groups of individuals are most impacted by these problems?
- What keeps people from being healthy? In other words, what are the barriers to achieving good health?
- What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?
- What more can be done to improve health, particularly for those individuals and groups most in need?
- Considering social determinants impact health outcomes more than clinical care, which of the following resonate as a key social determinant that we should be focusing on?

3 focus group sessions were held in February (2/14) and March (3/12 and 3/14) of 2019. The number of participants ranged from 14 to 25. When possible, representatives from the health department and other local hospitals were invited to attend the sessions.

1. Focus group 1: Patient & Family Advisory Committee for Sentara Obici
2. Name of focus group 2: SNF Collaborative (reps from Skilled Nursing Facilities throughout Western Tidewater)
3. Name of focus group 3: Western Tidewater Diabetes Coalition

A brief summary of the key findings for each topic is presented below.

Topic	Key Findings
What are the most serious health problems in our community?	Substance abuse (drugs, alcohol) Mental health Obesity Cancer Diabetes Hypertension Heart disease Kidney disease Vascular disease Arthritis Vaping (especially among children and teens) Lupus Stroke Dementia & limited facilities for dementia patients COPD

	Hyperlipidemia Eye disease, visual changes secondary to other disease processes
Who/what groups of individuals are most impacted by these problems?	Those without transportation Elderly Young adults with chronic illnesses and/or injuries secondary to lifestyle (substance abuse) Low income Geographic "pockets" where health care providers are scarce Low health literacy Uninsured and underinsured Insured but high deductible Limited education, illiterate Family caretakers Those without family People living in food and health deserts Patients with dementia Patients with dual diagnoses (medical/mental health) Patients in skilled facilities under contract No home health in the community in which they live
What keeps people from being healthy? In other words, what are the barriers to achieving good health?	Lack of easily accessible education Cost of care Income Access to healthcare and food supplies Insurance issues: lack of, under insured, high deductibles Cost of medications Prioritizing & making choices (roof over head vs. the next drink/medication) Element of denial School system – food choices Lack of physicians and needed specialties Lack of computers Transportation Gangs in the community Workplace violence – correlation to mental health & social norms Inconsistent care for the youth Insurance barriers to follow up from screenings Less focus on prevention vs. treatment Knowledge of family history Food and medical deserts Insurance authorizations are more difficult to obtain Substance abuse
What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?	Genevieve Shelter Salvation Army Health fairs Western Tidewater Free Clinic YMCA Crisis Pregnancy Center

	National Night Out Recreation centers: East Suffolk, Whaleyville, Birdsong How can we use local libraries? AARP Diabetes Education Support Groups (veteran) Homeless Shelter (CAPS) For Kids program Mobile Meals Task Force on Aging (Portsmouth, Smithfield) Care Advantage Sheriff/Police/Fire Departments – wellness checks Obici's Community Health Outreach Program (CHOP) Health Department Virginia Eye Consultants Optima iRide Planet Fitness Community pharmacies
What more can be done to improve health, particularly for those individuals and groups most in need?	More regularly scheduled hospital sponsored health fairs Increased involvement in churches or other community events More health screenings Mobile health vehicles Involvement in Peanut Fest Grocery store tours Develop new partnerships (Walmart) STOP Organization Make data relatable to local communities and business leaders Education on the benefits of a healthy community Peer education for relatability Go to people in their communities Preventative Home Health Legislation to band together – health lobbyist – health policies (Chamber of Commerce? Hampton Roads Business Association?) Fire department tracking Para-medicine (paramedics) Educational forums re: long-term care vs. skilled vs. rehab Education toolkits Telemedicine
Considering social determinants impact health outcomes more than clinical care, which of the following resonate as a key social	Food Education Transportation Social support Health behaviors Housing

determinant that we should be focusing on?	

Sentara Community Health Needs Assessment Implementation Strategy

2018 Progress Report

Hospital: Sentara Obici Hospital

Quarter (please indicate): ☐First Quarter ☐Second Quarter ☐Third Quarter ☒Year End

In support of community health needs assessment and related implementation strategies, Sentara will measure the progress toward the community health needs assessment implementation strategies selected by each hospital on a quarterly basis.

To complete this quarterly progress report, the health problems and implementation strategies can be pasted into this document from the hospital's existing Three Year Implementation Strategy document. The quarterly progress should be identified in the third column below.

The quarterly report should include only key actions taken during the quarter; the report does not need to include all activities. Where possible the actions should be quantified, with outcomes measurements if available.

Reports should be emailed to Laura Armstrong-Brauer at lrarmstr@sentara.com within 15 days of the close of each quarter.

Health Problem	Three Year Implementation Strategies	Progress
All	• Ensure Western Tidewater community agencies have access to the completed community needs assessment data. o Post assessment on SOH web site o Present to community organizations as requested o Distribute assessment to agencies and individuals involved in the assessment • Continue to actively participate in community-based organizations to work collaboratively to improve health. o Participate with Healthy Suffolk Partnership at a Board or Committee level. o Participate with the Western Tidewater Free Clinic at a Board or Committee level. o Continue collaboration with Catholic Charities for Life Coach Program to assist patients in receiving needed community resources.	First Quarter Continuing representation with Western Tidewater Free Clinic and Healthy Suffolk Partnership. Continuing collaboration with Catholic Charities Life Coach program, the CHOP program, Transition Clinic and SNF Collaborative. Life Coaches provided 256 services to 107 clients. Continuing work with Western Tidewater Diabetes Coalition. Second Quarter Planning has begun for the National Night Out to be held in August. Continuing representation with Western Tidewater Free Clinic and Healthy Suffolk Partnership. Continuing collaboration with Catholic Charities Life Coach program, the CHOP program, Transition Clinic and SNF Collaborative. Continuing work with Western Tidewater Diabetes Coalition. Life Coaches provided 134 services to 72 clients.

Health Problem	Three Year Implementation Strategies	Progress
	• Participate in community-wide National Night Out. • Continue to hold free drive-through flu clinics at BelleHarbour, St. Luke's, SOH • Hold chronic disease self-management work groups in target locations. • Incorporate hospital events that are open to the community on the Healthy Suffolk web site. • Explore opportunities with the Salvation Army Health Center. • Offer community health programs and free screenings at sites throughout the hospital's service area to improve convenient access for residents. • Participate in community-wide events • Continue bereavement support group. • Collaborate with community groups to provide transportation solutions to improve access to care o Participate in Western Tidewater Transportation Collaborative • Pursue grant opportunities to develop additional programs to support community health o Pursue grant to develop shared social worker between Western Tidewater Free Clinic and the Transition Clinic • Continue Transition Clinic with broadened scope to include both heart failure and COPD, aimed at decreasing readmissions and improving self-care. • Continue the Community health disease outreach – CHOP and transition coach programs to support patients' self-care and independence. • Explore development of a parish nurse program. • Continue SNF Collaborative	Maternal/Child Programs: • CHILBIRTH CLASS 1)-Monday nights-4 weeks--usually 5-8 couples/month 2)-Saturday class--usually 10-12 couples/month 3)-Free Teen class---3-6 couples/month • MATERNITY TOUR 1st Tuesday of the month--10-13 couples/month • SIBLING CLASS Quarterly---6-10 children per quarter. • MATERNITY NURSE NAVIGATOR PROGRAM: Total: April/May/June 2018 210 Prenatal Referrals completed 210 mothers followed by Maternity Nurse Navigators 41 referrals to home visiting services 329 postnatal screenings completed 31 referred to home visiting services 226 referred to other community resources <u>Third Quarter</u> Major participant in National Night Out – an estimated 4,000 people in attendance – health screenings and information tables. Continuing representation with Western Tidewater Free Clinic and Healthy Suffolk Partnership. Continuing collaboration with Catholic Charities Life Coach program, the CHOP program, Transition Clinic and SNF Collaborative. Continuing work with Western Tidewater Diabetes Coalition. Life Coaches provided 271 services to 92 clients. Maternal/Child Programs: <u>Childbirth Class</u>: Monday nights (4 weeks) usually 5-8 couples/month Saturday class: usually 10-12 couples/month Free teen class: 3-6 couples/month <u>Maternity Tour</u> 1st Tuesday of the month: 10-13 couples/month <u>Sibling Class</u> Quarterly 6-10 children per quarter <u>Maternity Nurse Navigator Program</u>

Health Problem	Three Year Implementation Strategies	Progress
		Total: July/August/September 2018 187 Prenatal referrals completed 187 Mothers followed by Maternity Nurse Navigators 43 Referrals to home visiting services 344 Postnatal screenings completed 39 Referred to home visiting services 200 Referred to other community resources <u>Fourth Quarter</u> Continuing representation with Western Tidewater Free Clinic and Healthy Suffolk Partnership. Continuing collaboration with Catholic Charities Life Coach program, the CHOP program, Transition Clinic and SNF Collaborative. Continuing work with Western Tidewater Diabetes Coalition. Maternal/Child Programs**:** <u>Childbirth Class:</u> Monday nights (4 weeks): Oct. 6, Nov. 3, no class Dec. Saturday class: Oct. 10, Nov. 9, Dec. 14 Free Teen Class: Oct. 4, Nov. 1, Dec. 5 Total: 9 <u>Maternity Tour</u> Oct. 10, Nov. 10, Dec. 10 <u>Sibling Class:</u> Quarterly, 6 signed up and 3 showed <u>Maternity Nurse Navigator Programs:</u> Total: October/November/December 2018 143 Prenatal Referrals completed 143 Mothers followed by Maternity Nurse Navigators 32 Referrals to home visiting services 343 Postnatal screenings completed 36 Referred to home visiting services 282 Referred to other community services <u>Breastfeeding Support Group</u> Total: October/November/December 2018 3 mothers/babies attended weekly sessions each month = total of 9 individual mothers Community Health Outreach Program: Saw a total of 1,002 patients in 2018

Health Problem	Three Year Implementation Strategies	Progress
Diabetes	• Continue to hold diabetic screenings (A1C screenings). • Continue to hold a Diabetes Fair annually in November. • Continue to provide outpatient diabetes education classes. • Increase community awareness of wound care clinic services (nail trimming, hyperbaric therapy). • Continue to offer Chronic Disease Self-Management (Stanford Model) courses in various locations throughout the hospital's service area. • Provide education on reading food labels. • Develop community partnership in collaboration with Johnson & Johnson to develop solutions to improve care for diabetes.	First Quarter Work continues with Western Tidewater Diabetes Coalition. Planning November community-wide event. Second Quarter June – Diabetes Education month - 4 educational sessions & 1 Diabetes Screening (A1C and BP checks) Continue to participate in Diabetes Coalition. Third Quarter Diabetes Coalition planning community-wide screening and information event for November 3. Fourth Quarter Diabetes Coalition community-wide event held at Kings Fork High School. Approx. 100 in attendance including vendors. Throughout 2018, there were 3 Diabetes Self-Management classes – total 36 participants.
Obesity/Nutrition	• Promote healthy nutrition practices. • Participate with Healthy Suffolk initiatives. • Expand employee involvement in hospital's community garden. • Participate in the "Smithfield on the Move" Committee. • Continue to explore opportunities to offer fitness programs to employees and the community • Pursue grants to expand programs. • Promote awareness of the hospital's walking trail and the Well fitness room. • Promote walking through walking groups and walk-about programs. • Provide a strong start for children through the promotion of health programs at Growing Up at Obici Daycare. Evaluate opportunities to expand to other areas. • Support local Meals on Wheels program • Evaluate methods to promote healthy eating (i.e. nutritional information at vending machines) • Support Isle of Wight Chamber of Commerce fitness events	First Quarter Second Quarter Third Quarter Fourth Quarter

Health Problem	Three Year Implementation Strategies	Progress
Behavioral Health / Alcohol & Substance Abuse	• Collaborate with community and agencies to identify needs in psychiatric services and develop action items to close gaps. o Facilitate meeting with community providers of psychiatric services to explore opportunities for collaboration to meet community needs. o Create a resource guide of existing community resources. o Identify gaps in psychiatric services and evaluate feasibility for additional services. • Hold educational forum on depression (recognition of and treatment). • Explore opportunities for screenings. • Continue providing tele-psych consultation in the ED. • Continue providing tele-psych services through SMG offices. • Support Behavioral Health system strategic plan • Expand capacity at Obici Behavioral Health unit • Support events promoting behavioral health (i.e. Strong Will Run, Out of the Darkness)	<u>First Quarter</u> <u>Second Quarter</u> <u>Third Quarter</u> <u>Fourth Quarter</u>
Cancer	• Hold prostate cancer screenings. • Increase community awareness of cancer support groups. • Continue to provide screenings for breast cancer. Seek grant opportunities to expand mammography services to indigent patients. • Hold community education session re: breast cancer at least annually. • Start lung cancer screenings. • Evaluate colon cancer screenings. • Continue to support Navigator service to help newly diagnosed cancer patients navigate through the health care system. • Work with Community Health and Prevention to provide on-site screenings and self-learning programs. • In conjunction with Sentara Obici Auxiliary, host "Nobody Fights Alone" program. • Participate in Susan G. Komen's Race for the cure. • Hold community education programs on prostate health. • Provide 50 free screenings to patients in 2017 at BelleHarbour in conjunction with the Komen grant. • Addition of stereotactic radiosurgery (SRS) services at the Obici campus	<u>First Quarter</u> Health Fairs – 2 events, 96 attendees Support Groups – 8 meetings, 69 attendees Living Beyond Cancer Survivorship Class – 01-04-18 w 2 attnd <u>Second Quarter</u> Support Groups – 10 meetings, 56 attendees Other Misc. Outreach – 1 event, 75 attendees Relay for Life – Heroes of Hope SOH Relay for Life Team held June 15, 22 walkers from SOH Relay for Life Basket Raffle raised $2,577 Survivor Celebration – 06-26-2018 with approximately 55 in attendance. Living Beyond Cancer Survivorship Class – 04-05-18 w 4 attnd <u>Third Quarter</u> Support Groups – 8 meetings, 57 attendees National Night Out – Approx 392 actual contacts & educational info from radiology & cancer administration tables conducted. 1 Health Fair in July w/ 200 participants re Breast Cancer Education by Mammography Department Living Beyond Cancer Survivorship Class – 07-06-18 w 5 attnd

Health Problem	Three Year Implementation Strategies	Progress
		Fourth Quarter Support Groups – 8 meetings, 73 attendees Living Beyond Cancer Survivorship Class – 10-06-18 w 2 attnd Prostate/Colorectal Screening on 11/13/2018 also including lung cancer screening education – 22 male attendees Great American Smoke-Out Table in SOH atrium on 11/15/18 had 42 people learn about smoking/vaping dangers and/or agreed to stop Various Health Fairs & various community events during month of October with participation/facilitation by SOH Cancer Admin and Radiology team members. October event included breast cancer awareness and other cancer education for the tidewater community of Suffolk, Smithfield, Isle of Wight and surrounding counties with a minimum of 932 attendees Oncology Nurse Navigator reported increase of cancer patient navigation at SOH. SOH Oncology Nurse Navigator held Living Beyond Cancer Survivorship Class on 10/17/2018 w/ 5 attendees. Included talks regarding exercise & wellness, nutrition, lymphedema, and psychosocial awareness.
Heart Disease	• Continue to offer Chronic Disease Self-Management (Stanford Model) courses in various locations throughout the hospital's service area. • Work with Community Health and Prevention to provide on-site screenings and self-learning programs. • Implement the American Heart Association's Get with the Guidelines program. • Participate in the American Heart Association Run-Walk for Health. • Participate in the community-wide Heart Chase. • With partner Farm Fresh, host grocery store tours. • Continue role of inpatient CHF navigator with an expanded scope • Continue Cardiovascular support group • Participate in and support Sentara cardiovascular strategic plan. • Provide cardiac nutrition and exercise classes.	First Quarter Support Group-3 meetings, 27 attendees Second Quarter Support Group-3meetings, 26 attendees Third Quarter Support Group-3meetings, 38 attendees National Night Out Fourth Quarter Support Group-3 meetings, 25 attendees