Sentara Northern Virginia Medical Center

Lake Ridge Ambulatory Surgery Center

COMMUNITY HEALTH NEEDS ASSESSMENT 2022

We Improve Health Every Day

This joint Community Health Needs Assessment report was completed in collaboration with Sentara Northern Virginia Medical Center and Lake Ridge Ambulatory Surgery Center, which have the identical service areas of Prince William County, including Quantico, Dumfries, and Stafford County.

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EXECUTIVE SUMMARY

As an organization, we are driven to improve health every day. And while we meet that mission through the healthcare services we provide to our patients, we understand that our greater purpose must include building trust and listening to the voices of individuals in the community to better understand the specific needs of those we serve. In 2022, Sentara Northern Virginia Medical Center (SNVMC) and Lake Ridge Ambulatory Surgery Center (LRASC) began conducting the community health needs assessment of the area that we serve. The assessment, completed in 2022, 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.

> *"The power of the community to create a healthy environment and a positive future starts with us having conversations about the concerns of each other. It's why I love the CHNA process for my hometown community."*
>
> ***Helen Linton**, Director, SNVMC Community Health Needs Assessment Coordinator*

Sentara conducts comprehensive community health needs assessments for each of our inpatient hospitals and outpatient surgical centers across Virginia and Eastern North Carolina. The following comprehensive report goes into more detail about the assessment to include an introduction, social and economic factors, demographic and background information, health determinant data and incorporates extensive community survey and outreach. The community health needs assessment incorporates information from a variety of primary and secondary quantitative data sources and more importantly helps us to understand the disparities that exist in vulnerable populations.

We are grateful to the residents, faith-based organizations, businesses, clinics, nonprofits, government agencies, and others who devoted expertise and significant time helping us better understand these priorities identified and know we must be committed to working together to identify solutions. We further understand that the implementation strategies will be most successful by working with residents of the community so that we move closer to achieving health equity for all.

While there are many important community health problems, we are focusing our efforts on the key issues listed below. 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 these priority health problems in our area, all of which have been exacerbated by the COVID-19 pandemic:

Health Priorities for 2022-2025

- Behavioral Health
- Chronic Disease
- Social Determinants of Health

The geographic focus for this CHNA study includes the Prince William County (including the cities and towns within its boundaries), Stafford County, and the Lorton section of Fairfax County (defined as zip code 22079).

It is important to note that the study was conducted as a partnership between the Community Healthcare Coalition of Greater Prince William, Sentara Northern Virginia Medical Center, Lake Ridge Ambulatory Surgery Center, UVA Haymarket Medical Center, and UVA Prince William Medical Center. By working

together on this project, the partners were able to streamline the process and make the best use of available resources to learn about community health needs and possibilities for action. Community Health Solutions, a research and consulting firm, provided research and consulting support for the project.

As you read the report, please note that by design, the report does not include every possible indicator of community health. The analysis is focused on a set of community indicators that provide broad insight into community health and for which there were readily available data sources. However, nearly all of the available community health indicators are dated prior to the onset of the COVID-19 pandemic in 2020. Consequently, the numbers alone do not capture the impact of the pandemic on community health needs and capabilities across the community.

OVERVIEW

We Improve Health Every Day

Sentara celebrates more than 130 years in pursuit of its mission - "We improve health every day." Named to IBM Watson Health's "Top 15 Health Systems" in 2018 and 2021, Sentara is an integrated, not-for-profit health system of 12 hospitals in Virginia and Northeastern North Carolina, including a Level I trauma center, the Sentara Heart Hospital, the Sentara Brock Cancer Center, two orthopedic hospitals, and the Sentara Neurosciences Institute. The Sentara family also includes a medical group, Nightingale Regional Air Ambulance, home care and hospice, ambulatory outpatient campuses, advanced imaging and diagnostic centers, a clinically integrated network, the Sentara College of Health Sciences and Sentara Health Plans, comprised of Optima Health Plan and Virginia Premier Health Plan, serving 950,000 members in Virginia, and North Carolina. Sentara has more than 30,000 employees dedicated to improving health in the communities we serve and was recognized as one of "America's Best Employers" by Forbes in 2018. Sentara is strategically focused on clinical quality and safety, innovation and creating an extraordinary health care experience for our patients and members.

SENTARA AT A GLANCE

- Headquartered in Norfolk, Virginia
- 130-year not-for-profit history
- 12 hospitals
- One medical group
- 3,800+ provider medical staff
- 30,000+ team members
- Health plans (Optima Health and Virginia Premier)
- Outpatient campuses
- Urgent care centers
- Advanced Imaging Centers
- Home health and hospice
- Rehabilitation and therapy centers
- Nightingale air ambulance

INTRODUCTION

Sentara Northern Virginia Medical Center

Sentara Northern Virginia Medical Center (SNVMC) is a 183-bed not-for-profit hospital located in Woodbridge, VA. Our Trauma III designated medical center combine the resources of a major health system with the compassionate, personalized care of a community hospital.

We offer quiet, private rooms and high-quality care focused on safety and patient satisfaction. Our highly skilled physicians and clinical staff are committed to ensuring we provide the right care with the medical technology you need when you need it.

As a fully integrated healthcare system, Sentara is committed to introducing new and enhanced services and advanced technology to Northern Virginia. Recently, SNVMC completed construction on enhanced healthcare facilities. The new surgical services will allow our hospital to serve additional patients as the Northern Virginia community continues to grow. We offer a wide range of medical specialties, a highly qualified medical and clinical staff and state-of-the-art technology. Our clinical services include advanced imaging, cancer services, diabetes management, emergency care, heart and vascular care, lab services, neurosurgery, primary care, orthopedics, physical therapy, urology, weight loss surgery, wound care, women's services and more. Sentara is pleased to further its investment in patient care and optimize the healthcare environment within Prince William County.

Lake Ridge Ambulatory Surgery Center

The Lake Ridge Ambulatory Surgery Center (LRASC) is a multispecialty outpatient surgical clinic with a focus on orthopedics, spine, ENT, gynecology, plastic surgery and pain management procedures. Our mission is to deliver excellent surgical care in a convenient, comfortable, outpatient environment. Our entire team is dedicated to serving our patients in a professional, compassionate manner, and meeting your unique needs. Located in Woodbridge, VA and serving the Northern Virginia region, the Center is a joint venture with Sentara Northern Virginia Medical Center.

SENTARA CARES

Sentara cares about advancing health equity and ensuring that all members of our communities have access to the resources they need to live their healthiest and most fulfilling lives. We are guided by our understanding that our overall health is greatly influenced by where we are born and where we live, learn, work, play, worship, and age. In fact, these environmental factors account for nearly 80 percent of health outcomes, while direct healthcare accounts for only 20 percent.

Our purpose, then, calls us to address these issues on the ground every day where people live—not just when they are under our care. Only then can we help to eliminate health disparities and promote equitable access to nutritious foods, education, safe and affordable housing, and stable, rewarding job opportunities. We know such disparities cannot be solved solely in the exam room, and they cannot be solved solely by Sentara. However, through our partnerships we continue to make both immediate impact and lasting change for our communities.

> *"We approach every community and every partner with our ears and our hearts open. We're not here to provide prescriptive solutions. We're here to support and amplify the work of our partners in every way we can to improve more lives and inspire more hope for the future."*
>
> ***Sherry Norquist**, MSN, RN-ACM*
> *Director of Community Engagement & Impact*

COVID-19 RESPONSE

As we embarked on this CHNA process, the country and Virginia were focused on mitigating the COVID-19 pandemic. The impacts of COVID-19 are likely to affect community health and well-being beyond what is currently captured in available data. Sentara seeks to engage the community as directly as possible in prioritizing needs. Sentara is committed to always keeping our patients, employees, and community members safe. We have developed extensive safety protocols and guidelines to ensure you receive the care you need at any Sentara facility.

Sentara cares about improving the health and well-being of all individuals and the quality of life enjoyed by everyone in our community Sentara responds to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. We are committed to supporting, strengthening, and serving our communities.

OUR PROCESS

Sentara developed a primary statistical data profile integrating claims and encounter data to assess the population's use of emergency services, preventive services, chronic health conditions, and cultural and linguistic needs. A secondary statistical data profile was created using advanced data sources to assess population characteristics such as household statistics, age, educational level, economic measures, mortality rates, incidences rates, and racial and ethnic composition because social factors are important determinants of health. Our assessment includes a review of risk factors including obesity, smoking and health indicators such as infant mortality and preventable hospitalizations.

In this context, the community insights provided by community residents and community professionals are especially important for understanding the current Commonwealth of community health in the region. Hundreds of community stakeholders shared their insights about community health, and their ideas for how to improve health and health care in the region. The results can be helpful for understanding the scope and magnitude of health concerns within the community, especially at this moment in time when the community is recovering from the profound impacts of the pandemic.

Research components for this assessment included data from the following sources:

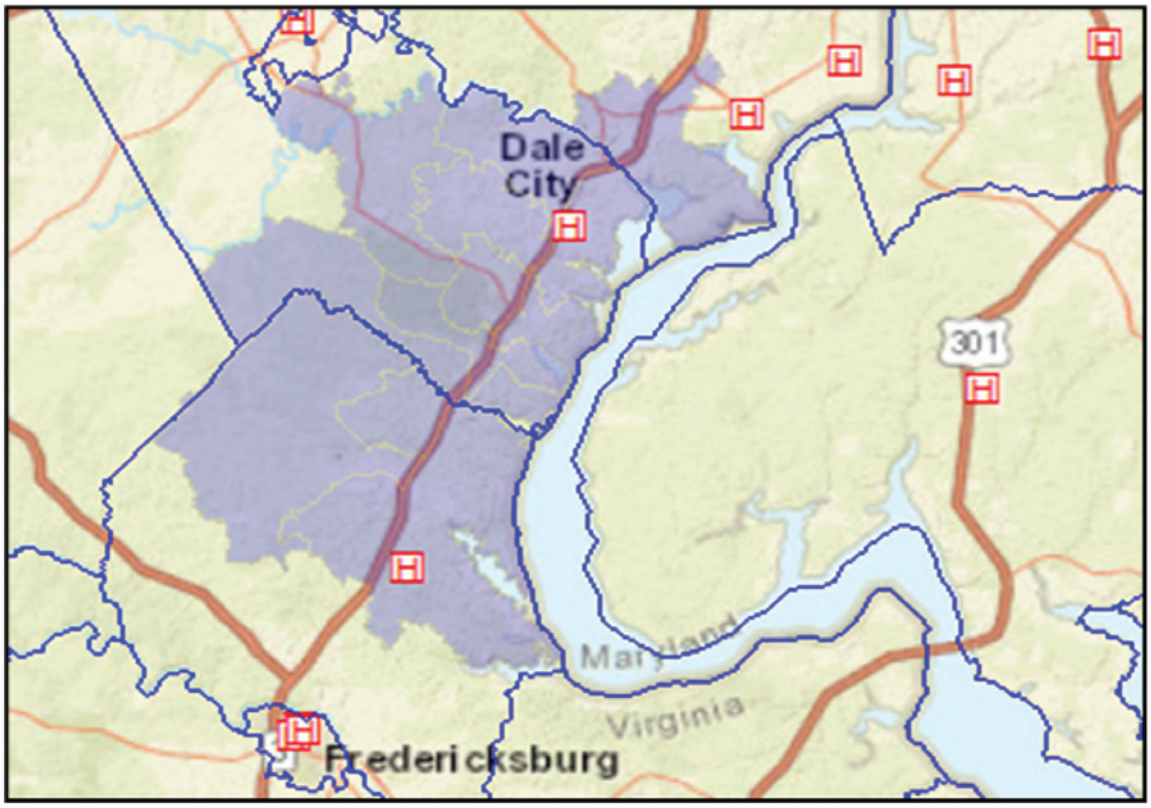
- Alzheimer's Association
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- National Cancer Institute
- United States Census Bureau
  - American Community Survey 2019: 5-Year Estimates Data Profiles
- Virginia Department of Health
- Virginia Health Information, AHRQ Quality Indicators
- Virginia Department of Medical Assistance Services
- County Health Rankings 2021
- Weldon Cooper Center for Population Studies, UVA
- Sentara Claims Data
- Community Health Needs Assessment Survey
- Community Focus Groups

The SNVMC and LRASC 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, 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. An additional survey of Prince William County residents on key health topics were included. The report also includes findings from focus groups with community members on health issues and barriers to achieving good health.

OUR NEXT STEPS

SNVMC and LRASC are part of the Community Health Coalition of Greater Prince William. The coalition's Greater Prince William Community Health Assessment 2019 report may be found on the behealthybehappyprincewilliam.com website. Additional information on available resources are available from sources including 2-1-1 Virginia, https://www.vdh.virginia.gov/prince-william/community-health-services/ and sentara.com. By using this information, 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 sentaracares.com website.



THE SENTARA NORTHERN VIRGINIA MEDICAL CENTER & LAKE RIDGE AMBULATORY SURGERY CENTER SERVICE AREA SOURCE: TRUVEN/MARKET EXPERT

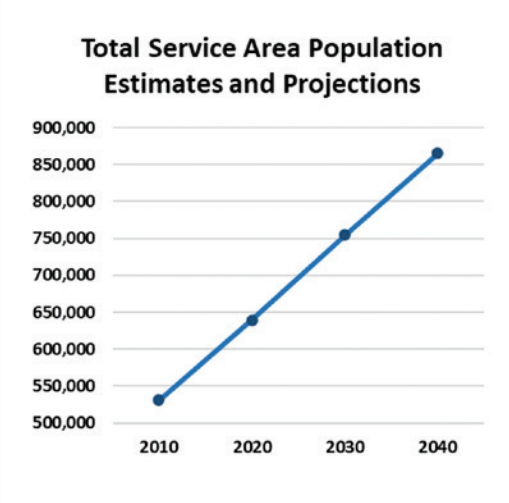
COMMUNITY DESCRIPTION

GEOGRAPHY

The service area of SNVMC and LRASC is comprised of Prince William County (including the cities and towns within its boundaries), Stafford County, and the Lorton section of Fairfax County (defined as zip code 22079).

POPULATION CHANGE

SNVMC and LRASC service area is continuing to grow. Prince William County and Stafford County are enjoying robust growth of 16.9% and 17.8% since 2010. Prince William County is projected to experience the second largest growth in the Northern Virginia region over the next 20-25 years. The service area is projected to continue growing, with a projected growth of 15.3% by 2030 and 14.6% by 2040.



Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219
Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org

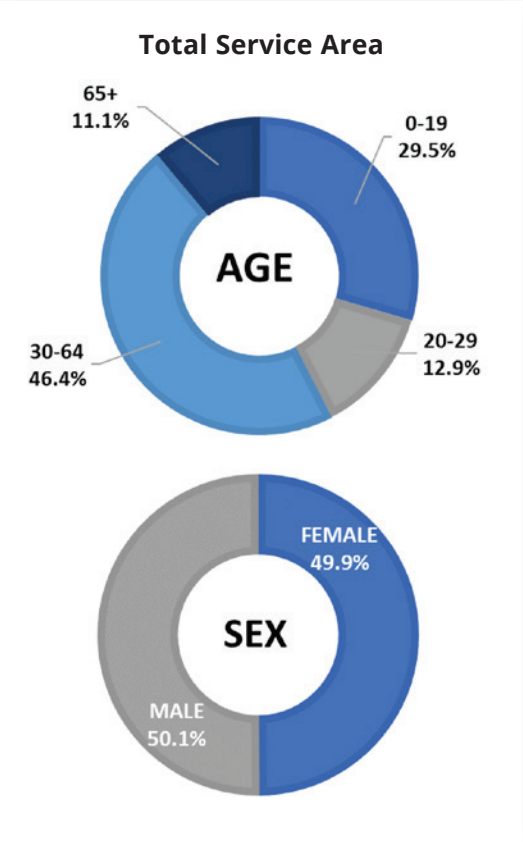
POPULATION HIGHLIGHTS

The combined population of the service area is approximately 600,000, nearly 7% of the state population. Patients coming from Prince William County is 89% of SNVMC inpatients. SNVMC and LRASC serves mostly the Prince William County (PWC) population.

Age and Sex

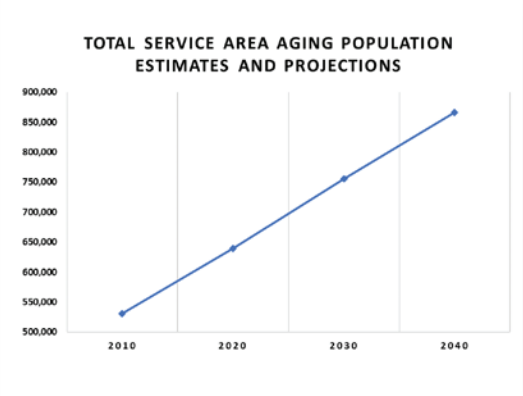
The median age of the Prince William County is younger than the Commonwealth of Virginia. Out of the 639,131 community members living in the service area, most residents are between the ages of 30-64. The service area has a lower percentage of residents aged 85+ than the state. The median age of the residents in the service area is younger than the Commonwealth of Virginia. The age cohort from 19-64 (young adults and working age adults) closely mirrors the age segmentation of Virginia. Compared to the Commonwealth of Virginia, the population has a higher percentage of children, age 17 and under, and lower percentage of individuals aged 65 and older.

Unlike the Commonwealth of Virginia, there is a slightly higher percentage of residents born as male in the service area. Prince William County shows an even number of female and male residents. Prince William County has the highest number of children. In 2019, 8,154 babies were born in the service area. Approximately 78% of the births were in Prince William County. The population segments that represent children, young adults and working age adults vary only slightly from the statewide proportions.



Aging Population

It is well understood that older individuals are likely to need more health care services, and a variety of services are targeted toward that population. Research shows that the highest utilization of medical services is among elderly populations. Within this service area, the percentage of the very elderly is highest in Prince William County. In 2020, 10.4% of the population living in the service area was age 65+, below the population of Virginia which was 15.9%. By 2030, the population of older adults in the service area is projected to be 14.4%, and 15.3% by 2040. This shows the number of older adults increasing in the next 20 years, leading to a higher number of aging adults in the service area.



Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219

Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019http://demographics.coopercenter.org

Other Demographic Features

The overall percentage of the population who are veterans is higher than either Virginia or the United States, with 9.8% of the service area's residents being veterans. The median home value for Prince William County and Stafford County are more than that of Virginia as a whole. There is a higher percentage of owner-occupied homes in the service area compared to the state. A higher percentage of the population in Prince William County, aged 65+, are without health insurance. There is a lower percentage of persons living in poverty, and higher percentage of college degrees when compared to the state.

COMMUNITY SPECIFIC DEMOGRAPHICS (APPENDIX A)

Prince William County has 482,204 residents with 4.9% of this population living in poverty and 15% uninsured. Of the population in this county, 29.9% are ages 0-19, 12.8% are ages 20-29, 46.3% are ages 30-64, 9.2% are ages 65-84, and 0.9% are aged 85 and over. 66.3% of the residents primarily speak English, while 33.7% speak another language in the home. The ethnicity breakdown for this population includes 62.4% white, 22.2% African American, 24.5% Hispanic, and 9.4% Asian.

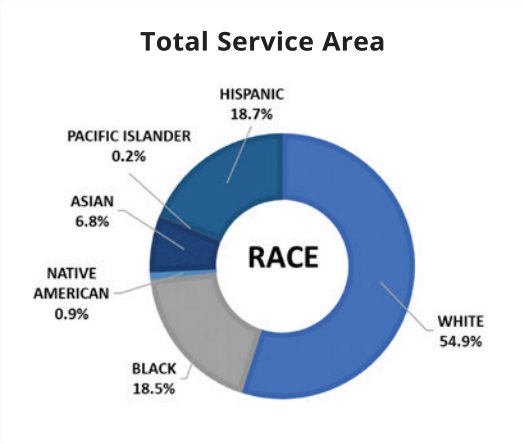
Stafford County has 156,927 residents with 5.4% of this population living in poverty and 9% uninsured. Of the population in this county, 28.7% are ages 0-19, 13.3% are ages 20-29, 46.7% are ages 30-64, 9.5% are ages 65-84, and 0.9% are aged 85 and over. 85.6% of the residents primarily speak English, while 14.4% speak another language in the home. The ethnicity breakdown for this population includes 70.9% white, 20.2% African American, 14.2% Hispanic, and 3.6% Asian.

Source: Produced by Demographics Research Group of the Weldon Cooper Center for Public Service, July 2019, http://demographics.coopercenter.org

COMMUNITY DIVERSITY PROFILE

Ethnicity

The population of Prince William County is more diverse than the Commonwealth of Virginia. Prince William County is home to approximately 118,140 Hispanic community members which is estimated to approximately 22% of the population compared to the state of Virginia at 9.8%. The service area population has a small Asian population with the majority living in Prince William County.



Preferred Language

English is the primary language spoken in the service area. As of 2020, 71% of the population being served identified as English speaking. Per the 2014 American Community Survey five-year estimates, Spanish was the second language identified in the community being served, with 42,051 community members living in the service area identifying as speaking English "less than well."

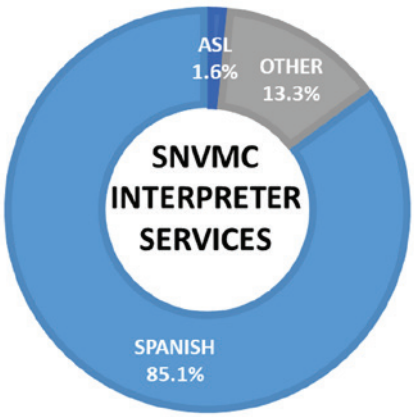
Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219

Virginia Department of Health Culturally and Linguistically Appropriate Health Care Services; US Census Bureau American Community Survey Five-Year Estimates, 2014 vintage; https://apps.vdh.virginia.gov/omhhe/clas/leppopulation/

Cultural and Linguistic Needs

It is important to note that non-English-speaking populations are vulnerable. Non-English-speaking populations are disproportionately among the lowest socioeconomic status populations, have poorer health and more disabilities, are often linguistically and culturally isolated, and live with less income and lower education than their English-speaking counterparts. The language barrier makes it difficult for this population to understand, interpret, and implement preventive recommendations.

Departments within Sentara and SNVMC continue to work closely with one another to ensure all communication to members is in the preferred language, offering interpreter services when needed. Sentara provides its patients and their families with qualified interpreters for languages other than English, as well as American Sign Language (ASL). In 2021, SNVMC had 37,017 requests for interpreter services. The highest percentage of interpreter services were for Spanish speaking individuals.



Source: SNVMC 2021 Sentara Language Line Usage Report

Health Equity

The CHNA analyzes the differences by race and ethnicity, language needs, age, gender, income, and housing. A dedicated focus on health equity allows for a better understanding of community needs. Equity continues to be an issue and is rapidly evolving in health care systems as global health crises and ongoing disparities impact local communities. Health equity work highlights awareness, education and access to care, or lack of thereof, across racial, ethnic, gender, and geographic groups, and how implicit or unconscious bias among providers affects treatment decisions and outcomes. Where people live can influence educational and occupational opportunities impacting financial stability which affects their well-being and quality of life.

Inequities *occur when barriers prevent people from reaching their full potential.*

Health disparities *are the differences in health status between groups of people.*

Health equity *provides everyone the opportunity to attain their highest level of health.*

Source: American Public Health Association (APHA), apha.org/topics-and-issues/health-equity

The Health Equity team analyzes economic status, access to health care, transportation, and other social determinants of health to identify potential causes of health inequity in our communities. Partnerships are formed with community leaders and organizations, physicians, and all Sentara facilities to achieve more equitable health care.

Priorities include measurement of disparities and factors that contribute to them, and development and implementation of an action plan to reduce disparities in care. This includes screening and diagnosis rates for chronic health issues such as hypertension and diabetes, and prevalence of prostate and breast cancers in communities of color, utilization rates for treatments and development of initiatives for communities of color, immigrants, patients who are unsheltered and other marginalized groups, including LGBTQ+ persons and individuals with disabilities.

SOCIAL DETERMINANTS OF HEALTH

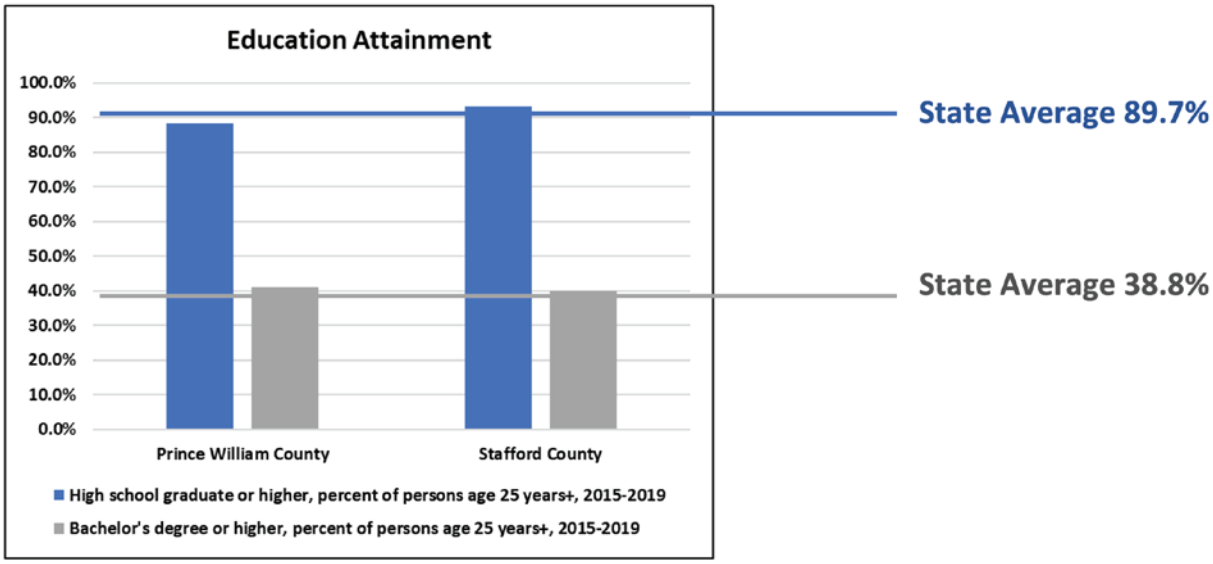
Sentara seeks to transform the lives of our neighbors by focusing on the root factors that affect our health beyond the clinical care we receive.

Sentara works to:

- Fill the unprecedented need for behavioral health practitioners in the field and ensure greater access to behavioral health services for children, families, and adults.
- Secure consistent, equitable access to nutritious food — every day and in times of emergency need.
- Support targeted training and development programs for higher-paying skilled careers.
- Develop more robust emergency and scattered housing solutions in our communities.
- Dismantle barriers to accessing health and human services in traditionally underserved populations.

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. Individuals, aged 25+ in Prince William County have less than a high school diploma at 88.5% compared to the state, however this county is above state average for advanced or professional degrees at 41.1%. Whereas, individuals, aged 25+ in Stafford County are above the state average with high school diplomas at 93.2% and advanced or professional degrees at 39.9%.



Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219

The Cycle of Poverty

Poverty continues because it reproduces existing patterns of circumstances, opportunities, and effects.

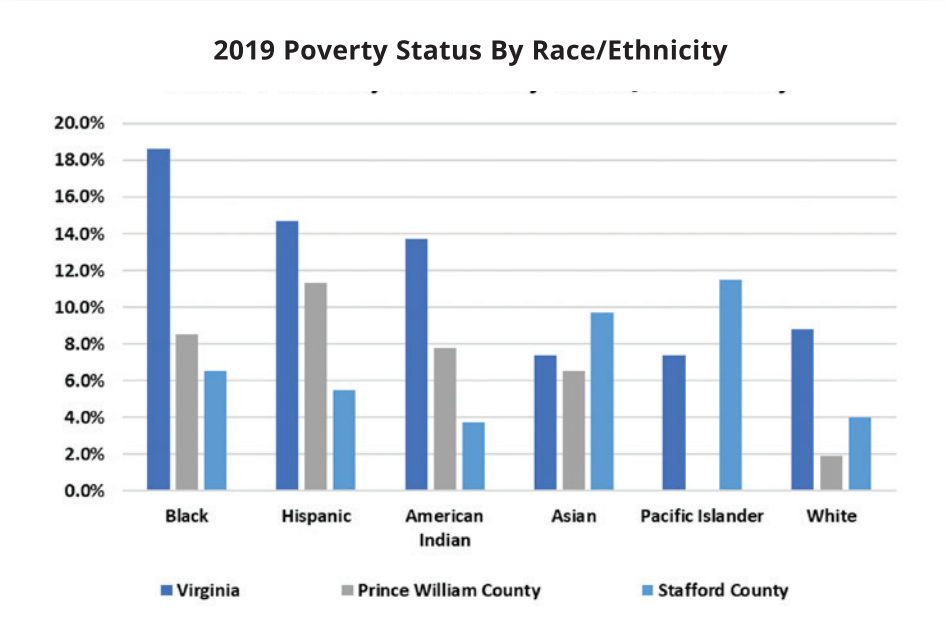
The causes of poverty lead to consequences that make it more likely that the individual – or their offspring – will experience poverty in the future.

Generational poverty is a vicious cycle in which each generation is unable to escape poverty because of a lack of resources to put toward the effort.

Rural Poverty vs Urban Poverty | Social Workers | AU Online (aurora.edu)

Poverty

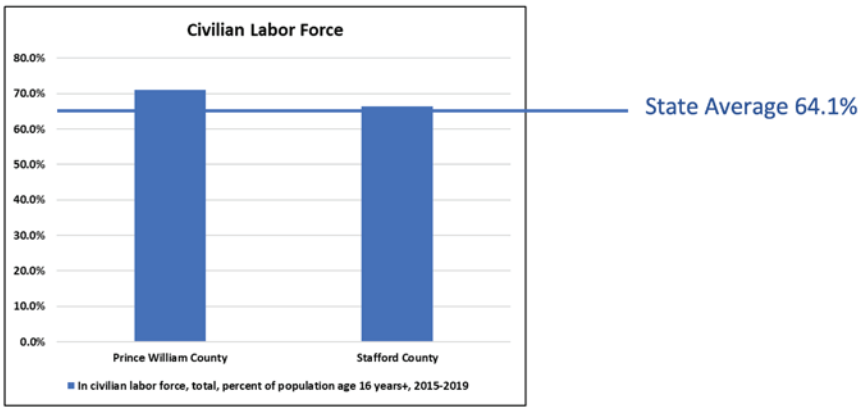
While simple poverty rates tell us something about the residents of the service area, when inserting race as a factor, we see the racial disparities that constrain residents of the service area in their ability to support and sustain healthy, functioning households for themselves and their children. As with Virginia as a whole, African Americans, Hispanics, and American Indians are more likely to live in poverty compared to white Americans.



Source: US Census Bureau QuickFacts Table 2020 https://www.census.gov/quickfacts/fact/table/VA,US/PST045219;

Employment

Central to a healthy community is an economy that supports individuals in their efforts to live well. The service area is slightly above the state average of residents in the civilian labor force. Of those in the civilian labor force, the percentage of female residents is higher than the state overall.



Medicaid & FAMIS, Medicare, Medicare & Medicaid Enrollment

Out of the 626,398 members newly enrolled in Medicaid in the Commonwealth of Virginia, 463,967 are below 100% of the federal poverty level and 162,431 are between 101-138% of the federal poverty level. The total service area has a lower percentage of members on Medicaid and FAMIS compared to Virginia overall. The number of residents living in the service area receiving Medicaid and FAMIS services continues to increase each year, with an increase of 29.3% since January 2020.

In 2019, there were 31,749 community members age 65+ living in the service area receiving Medicare and 2,413 receiving both Medicare and Medicaid. As the aging population grows in this service area, so will the need for these services.

Medicaid and FAMIS 2022/Medicare and Medicaid 65+ 2019				
	Virginia	Total Service Area	Prince William County	Stafford County
Medicaid Enrollment (Below 138% FPL)	626,398	35,836	27,175	8,661
Medicaid Percentage	7.2%	5.6%	5.6%	5.5%
FAMIS (Below 138% FPL)	1,347,010	91,409	71,458	19,951
FAMIS Percentage	15.6%	0.0%	0.0%	0.0%
Children Enrolled in Medicaid/FAMIS (Below 138% FPL)	813,229	64,157	50,411	13,746
Children Enrolled in Medicaid/FAMIS Percentage	9.4%	7.6%	**10.5%**	8.8%
65+ Medicaid (Below 138% FPL)	83,149	4,246	3,470	776
65+ Medicaid Percentage	0.9%	0.7%	0.7%	0.5%
65+ Medicare	802,949	31,749	23416	8333
65+Medicare Percentage	64.5%	54.5%	53.7%	56.7%
65+ Medicare and Medicaid	56,810	2,413	2,101	312
65+ Medicare and Medicaid Percentage	4.6%	4.1%	**4.8%**	2.1%
Persons in Poverty	9.2%	5.0%	4.9%	5.4%

Source: Virginia Medicaid Department of Medical Assistance Services; (As of January 15, 2022) https://www.dmas.virginia.gov/data; US Census Bureau QuickFacts Table 2020; (2020 Small Area Income and Poverty Estimates (SAIPE)); Source: US Census Bureau 2018 ACS 5-Year Estimates; Centers for Medicare & Medicaid Services 2019; Mapping Medicare Data;

COMMUNITY INSIGHT

Having an active, supportive, and engaged community is essential to creating the conditions that lead to improved health. The community insight component of this CHNA consisted of three methodologies: community surveys, community professional surveys, and a series of more in-depth community focus groups.

COMMUNITY RESIDENT SURVEY

Respondents

The survey of community residents was designed to capture insights about community health needs and opportunities for improvement. The survey was conducted as a partnership between the Community Healthcare Coalition of Greater Prince William, Sentara Northern Virginia Medical Center, Lake Ridge Ambulatory Surgery Center, UVA Haymarket Medical Center, and UVA Prince William Medical Center.

A guiding aim of the survey was to be as inclusive as possible by gathering insights from all demographic groups, including low-income and minority populations. To help accomplish this aim, the survey was distributed through multiple channels including online and in local settings with the help of local partners.

It should be noted that the survey was conducted using convenience sampling methods. Convenience sampling is a practical approach for obtaining insights from as many people as possible. It differs from probability sampling, which involves random selection of a smaller group of respondents that should be representative of the broader population. Consequently, the survey results are instructive for understanding the perceptions of a diverse cross-section of community members, but they are not presented as a definitive representation of the entire community population.

Demographic Profile of Survey Respondents

A total of 347 community residents submitted a survey response, although not every respondent completed every survey item. Appendix D provides a profile of survey respondents by various demographic indicators.

Compared to the overall demographic profile of the regional population, the survey respondents were more likely to reside in Prince William County, and more likely to be female. The overall distribution of survey respondents by household income was generally comparable to the region as a whole. The distribution of respondents by race and ethnicity was generally comparable for the Black/African American and Hispanic population segments. These comparisons are instructive for considering the reach of the survey, but noting again that the survey was based on convenience sampling, it is not possible to assign margins of error to the survey results.

Source: CHS analysis of community resident survey data

Survey Responses

For this CHNA report, we will focus on the below questions asked in the survey. Survey respondents were asked to review a list of common community health issues. The below tables show the answers for each section among respondents.

- Factors important for Health and Wellness
- Barriers that Make it Difficult to Access Health Services
- Personal Factors that can Influence Quality of Care
- Trusted Sources of Health Information
- COVID-19 Impacts and Vaccines
- COVID-19 Concerns
- Most Important Community Health Concerns
- Suggested Additions or Improvements to Community Services and Supports

Source: CHS analysis of community resident survey data

1. Factors Important for Health and Wellness

Community residents were asked to identify factors that can be important for health and wellness for people in their household, selecting up to five factors each for adults and for children. **Exhibit 1.1** lists the most frequently identified factors for each age group.

Exhibit 1.1 Factors Important for Health and Wellness

For Adults (18+) in Your Household	Count	%
Total Responses	333	100
Annual Checkups (Physicals, Well- Child Visits)	237	71%
Health Screenings (mammograms, colonoscopies, vision exams, cholesterol checks, etc.)	228	68%
Exercise	217	65%
Access to Fresh Food	216	65%
Healthy Eating	175	53%
Immunizations (Flu, T dap, Shingles, MMR, COVID-19, etc.)	169	51%
Awareness & Understanding of Health Issues and New Treatments	139	42%
Relationship with Primary Care Provider or Pediatrician	137	41%
Stress Relief Activities / Mindfulness	135	41%
Places of worship, Social Clubs, Athletics Groups	88	26%
Social Connections in the Community	81	24%
Parenting Support / Education	71	21%
Not Applicable	5	2%

For Children (0-17) in Your Household	Count	%
Total Responses	333	100
Annual Checkups (Physicals, Well- Child Visits)	121	36%
Access to Fresh Food	99	30%
Exercise	94	28%
Healthy Eating	90	27%
Immunizations (Flu, T dap, Shingles, MMR, COVID-19, etc.)	86	26%
Relationship with Primary Care Provider or Pediatrician	73	22%
Health Screenings (mammograms, colonoscopies, vision exams, cholesterol checks, etc.)	54	16%
Awareness & Understanding of Health Issues and New Treatments	52	16%
Places of worship, Social Clubs, Athletics Groups	48	14%
Stress Relief Activities / Mindfulness	44	13%
Social Connections in the Community	44	13%
Parenting Support / Education	40	12%
Not Applicable	26	8%

Source: CHS analysis of community resident survey data

2. Barriers that Make it Difficult to Access Health Services

Community residents were asked to identify barriers that can make it difficult for people to access health services, selecting up to five each for adults and for children. **Exhibit 1.2** lists the most frequently identified barriers for each age group.

Exhibit 1.2
Barriers that Make it Difficult for People to Access Health Services

For Adults (18+) in Your Household	Count	%
Total Responses	318	100%
Cost of care	178	56%
Appointment not available	155	49%
Health insurance	125	39%
Availability of in-person appointments	105	33%
Unable to get time off from work	98	31%
Accessing healthcare services	85	27%
Delaying care due to COVID-19	80	25%
Location of Services	68	21%
Don't know what services are available	66	21%
Coordinated care	58	18%
Childcare	56	18%
Lack of Transportation/Cost of Transportation	55	17%
Language Barrier	47	15%
Lack of understanding by providers about my culture or background	42	13%
Don't have the technology to utilize telehealth options	32	10%
Other	15	5%

For Children (0-17)) in Your Household	Count	%
Total Responses	318	100%
Cost of care	81	25%
Appointment not available	68	21%
Health insurance	58	18%
Availability of in-person appointments	50	16%
Accessing healthcare services	48	15%
Childcare	47	15%
Delaying care due to COVID-19	31	10%
Don't know what services are available	30	9%
Location of Services	28	9%
Coordinated care	25	8%
Lack of Transportation/Cost of Transportation	24	8%
Language Barrier	21	7%
Unable to get time off from work	20	6%
Lack of understanding by providers about my culture or background	16	5%
Don't have the technology to utilize telehealth options	14	4%
Other	8	3%

Source: CHS analysis of community resident survey data

3. Personal Factors that can Influence Quality of Care

Community residents were asked to identify personal factors that can influence the quality of care received by members of their household, selecting up to five factors each for adults and for children. **Exhibit 1.3** lists the most frequently identified factors for each age group.

Exhibit 1.3
Personal Factors that Can Influence Quality of Care

Factors Affecting Adults (18+) in Your Household	Counts	%
Total Responses	241	100%
Type of Health Insurance / Ways People Pay for Health Services	147	61%
Age	116	48%
Race	83	34%
Level of Education	73	30%
Language	70	29%
Ethnicity	62	26%
Physical Disabilities	62	26%
Developmental Disabilities	51	21%
Immigration Status	50	21%
Gender Identity	45	19%
Sexual Orientation	28	12%
Religious Beliefs	28	12%

Factors Affecting Children (0-17) in Your Household	Counts	%
Total Responses	241	100%
Type of Health Insurance / Ways People Pay for Health Services	56	23%
Age	50	21%
Language	43	18%
Race	42	17%
Ethnicity	37	15%
Developmental Disabilities	35	15%
Level of Education	30	12%
Immigration Status	28	12%
Physical Disabilities	22	9%
Gender Identity	18	7%
Religious Beliefs	18	7%
Sexual Orientation	14	6%

4. Trusted Sources of Health Information

Community residents were asked to identify what they consider to be trusted sources of health information. **Exhibit 1.4** lists the most frequently identified sources.

Exhibit 1.4
Trusted Sources of Health Information

Source of Health Information	Count	%
Total Responses	326	100%
Healthcare Provider (Doctor, Pediatrician, Physician Assistant, Nurse)	299	92%
Local Health System Website (Hospital, Free Clinics, etc.)	175	54%
National Government (CDC, NIH, White House, World Health Organization)	147	45%
Friends / Family	127	39%
State / Local Government (Health Department, Governor, City)	124	38%
National Healthcare Sources (Such as Web MD)	96	29%
Place of worship	38	12%
Local News/Radio Station	35	11%
Social media such as Twitter, Facebook, YouTube, Tik Tok, etc.	22	7%
Other:	17	5%

Source: CHS analysis of community resident survey data

5. COVID-19 Impacts and Vaccines

Community residents were asked to share their perspectives on the impact of COVID-19 and their perceptions of the COVID-19 vaccine. As shown in **Exhibit 1.5**, about 20 percent of respondents said someone in their household lost employment due to COVID-19, and about 3 percent said someone in their household lost housing.

Exhibit 1.5
Household Impact of COVID-19

Someone in the Household Lost Employment due to COVID-19	Count	%
Total Responses	301	100%
Yes	59	20%
No	242	80%

Someone in the Household Lost Housing due to COVID-19	Count	%
Total Responses	298	100%
Yes	9	3%
No	289	97%

6. COVID-19 Concerns

Community residents were also asked to share their concerns (if any) about the COVID-19 vaccine. The most frequently identified responses are listed in **Exhibit 1.6**.

Exhibit 1.6
Concerns About the COVID-19 Vaccine

Concerns About the COVID-19 Vaccine	Count	%
Total Responses	278	100%
I have no concerns about the vaccine	169	61%
Worried it will be harmful or have side effects	69	25%
I already had COVID-19, so I do not think it is necessary	30	11%
Other	25	9%
With multiple vaccines, I do not know which is best	20	7%
Fear of needles	15	5%
Religious Objections	15	5%
I am not concerned about COVID-19, so I do not need a shot	14	5%
Medical Condition	14	5%
I do not believe in vaccines in general	9	3%
Worried about possible costs	9	3%
Unclear how to get the shot / difficulty accessing	5	2%

Source: CHS analysis of community resident survey data

7. Most Important Community Health Concerns

Community residents were asked to identify important health concerns in their community, selecting up to five each for adults and for children. **Exhibit 1.7** lists the most frequently identified concerns for each age group.

Exhibit 1.7
Most Important Community Health Concerns

Health Concerns for Adults (18+)	Count	%
Total Responses	340	100%
Behavioral / Mental Health (Anxiety, Depression, Bullying, Psychoses, Suicide)	198	58%
Overweight/Obesity	147	43%
Cancer	140	41%
Alzheimer's and Dementia Care	125	37%
Dental/Oral Care	121	36%
Diabetes	114	34%
COVID-19	101	30%
Heart Conditions	97	29%
Substance Use (Alcohol, Drugs)	86	25%
Violence in the Community	76	22%
Violence in the Home (domestic or child abuse, including sexual, physical, emotional abuse and neglect)	57	17%
Infectious Disease	47	14%
Smoking/Tobacco use (cigarettes, vaping, e-cigarettes, chewing tobacco)	44	13%
Physical Disabilities	43	13%
Neurological Conditions	41	12%
Sexual & Reproductive Health Issues (STIs, Teen Pregnancy)	35	10%
Respiratory disease	34	10%
Developmental Disabilities	33	10%

Health Concerns for Children (0-17)	Count	%
Total Responses	340	100%
Behavioral / Mental Health (Anxiety, Depression, Bullying, Psychoses, Suicide)	132	39%
Dental/Oral Care	86	25%
Overweight/Obesity	77	23%
COVID-19	59	17%
Substance Use (Alcohol, Drugs)	53	16%
Developmental Disabilities	48	14%
Violence in the Community	47	14%
Violence in the Home (domestic or child abuse, including sexual, physical, emotional abuse and neglect)	42	12%
Sexual & Reproductive Health Issues (STIs, Teen Pregnancy)	42	12%
Smoking/Tobacco use (cigarettes, vaping, e-cigarettes, chewing tobacco)	37	11%
Cancer	33	10%
Diabetes	22	6%
Infectious Disease	19	6%
Respiratory disease	19	6%
Heart Conditions	18	5%
Physical Disabilities	12	4%
Neurological Conditions	12	4%
Alzheimer's and Dementia Care	8	2%

Source: CHS analysis of community resident survey data

8. Suggested Additions or Improvements to Community Services and Supports

Community residents were asked to identify up to five factors they would like to see added or improved in their community, to help keep themselves and their family healthy. **Exhibit 1.8** lists the most frequently identified factors.

Exhibit 1.8
Suggested Additions or Improvements to Community Services and Supports

Focus for additions or improvements...	Count	%
Total Responses	331	100%
Access to mental health providers	196	59%
Accessible communities (public/commuter transportation, roads, bike paths, parks & recreation, sidewalks, open spaces)	168	51%
Safe communities	161	49%
Healthy food access (fresh foods, community gardens, farmers' markets, EBT, WIC)	141	43%
Access to health & human services	125	38%
Affordable childcare	124	37%
Safe and affordable housing for the workforce	123	37%
Public safety services (Police, Fire, EMT)	114	34%
Environment (air & water quality)	105	32%
Employment opportunities / workforce development	101	31%
Quality of education (Pre-K - 12)	98	30%
Access to community health education (such as nutrition education, support for individuals who care for others, etc.)	95	29%
Access to internet and technology	73	22%
Access to parenting education and support programs	68	21%
Other	17	5%

COMMUNITY PROFESSIONAL SURVEY

In addition to the survey of community residents described, a second survey was conducted to obtain insights from a cross-section of community professionals with interests in community health improvement. This section describes the methods, summary results, and detailed results for each section of the survey. Also see Appendix E for additional insights from community residents and community professionals that participated in a series of 'community insight events' conducted for the study.

For this CHNA report, we will focus on the below questions asked in the survey. Survey respondents were asked to review a list of common community health issues. The below tables show the answers for each section among respondents.

- Factors important for Health and Wellness
- Barriers that Make it Difficult to Access Health Services
- Personal Factors that can Influence Quality of Care
- Most Important Community Health Concerns
- Suggested Additions or Improvements to Community Services and Supports

Source: CHS analysis of community resident survey data

Survey Methods and Respondent Perspectives

As with the survey of community residents, the survey of community professionals was designed to capture insights about community health needs and opportunities for improvement. The survey was conducted as a partnership between the Community Healthcare Coalition of Greater Prince William, Sentara Northern Virginia Medical Center, Lake Ridge Ambulatory Surgery Center, UVA Haymarket Medical Center, and UVA Prince William Medical Center. The survey was conducted via email with a pool of potential respondents identified by the project partners from their existing lists of community contacts. A total of 81 individuals submitted a survey response, although not every respondent completed every survey item.

1. Factors Important for Health and Wellness

Community professionals were asked to identify factors that can be important to the health and wellness of individuals and households, selecting up to five factors for adults and for children. **Exhibit 2.1** lists the most frequently identified factors for each age group.

Exhibit 2.1
Factors Important for Health and Wellness

For Adults (18+) in Your Community	Count	%
Total Responses	80	100
Annual Checkups (Physicals, Well-Child Visits)	46	60%
Health Screenings (mammograms, colonoscopies, vision exams, cholesterol checks, etc.)	46	60%
Access to Fresh Food	45	58%
Exercise	37	48%
Awareness & Understanding of Health Issues and New Treatments	34	44%
Immunizations (Flu, T dap, Shingles, MMR, COVID-19, etc.)	31	40%
Social Connections in the Community (Place of Worship, Social Clubs, Athletics Groups)	31	40%
Parenting Support / Education	28	36%
Relationship with Primary Care Provider or Pediatrician	28	36%
Healthy Eating	27	35%
Stress Relief Activities / Mindfulness	26	34%

For Children (0-17) in Your Community	Count	%
Total Responses	80	100
Annual Checkups (Physicals, Well-Child Visits)	47	61%
Access to Fresh Food	43	56%
Immunizations (Flu, T dap, Shingles, MMR, COVID-19, etc.)	37	48%
Exercise	36	47%
Healthy Eating	32	42%
Social Connections in the Community (Place of Worship, Social Clubs, Athletics Groups)	25	32%
Relationship with Primary Care Provider or Pediatrician	21	27%
Health Screenings (mammograms, colonoscopies, vision exams, cholesterol checks, etc.)	20	26%
Stress Relief Activities / Mindfulness	20	26%
Parenting Support / Education	17	22%
Awareness & Understanding of Health Issues and New Treatments	16	21%

Source: CHS analysis of community resident survey data

2. Barriers that Make it Difficult to Access Health Services

Community professionals were asked to identify barriers that can make it difficult for people to access health services, selecting up to five each for adults and for children. **Exhibit 2.2** lists the most frequently identified barriers for each age group.

Exhibit 2.2
Barriers that Make it Difficult for People to Access Health Services

For Adults (18+) in Your Community	Count	%
Total Responses	79	100%
Cost of care	53	67%
Health insurance	39	49%
Accessing healthcare services	33	42%
Don't know what services are available	31	39%
Lack of transportation/cost of transportation	30	38%
Appointments not available	30	38%
Language barrier	30	38%
Coordinated care	29	37%
Delaying care due to COVID-19	20	25%
Childcare	19	24%
Availability of in-person appointments	18	23%
Unable to get time off from work	14	18%
Don't have the technology to utilize telehealth options	12	15%
Location of services	9	11%
Lack of cultural and religious considerations	6	8%
Other	6	8%

For Children (0-17) in Your Community	Count	%
Total Responses	79	100%
Cost of care	43	54%
Health insurance	33	42%
Lack of transportation/cost of transportation	24	30%
Don't know what services are available	23	29%
Accessing healthcare services	21	27%
Childcare	19	24%
Unable to get time off from work	17	22%
Language barrier	16	20%
Appointments not available	15	19%
Delaying care due to COVID-19	14	18%
Don't have the technology to utilize telehealth options	13	16%
Coordinated care	12	15%
Availability of in-person appointments	8	10%
Location of services	8	10%
Lack of cultural and religious considerations	4	5%
Other	5	6%

Source: CHS analysis of community resident survey data

3. Personal Factors that can Influence Quality of Care

Community professionals were asked to identify personal factors that can influence quality of care for adults and children. **Exhibit 2.3** lists the most frequently identified factors for each age group.

Exhibit 2.3
Personal Factors that Can Influence Quality of Care

Factors Affecting Adults (18+) in Your Household	Counts	%	Factors Affecting Children (0-17) in Your Household	Counts	%
Total Responses	76	100%	Total Responses	76	100%
Type of Health Insurance / Ways People Pay for Health Services	61	80%	Type of Health Insurance / Ways People Pay for Health Services	50	66%
Language	51	67%	Immigration Status	35	46%
Immigration Status	47	62%	Language	35	46%
Level of Education	46	61%	Race	29	38%
Age	33	43%	Age	28	37%
Race	32	42%	Ethnicity	27	36%
Ethnicity	32	42%	Gender Identity	26	34%
Developmental Disabilities	29	38%	Developmental Disabilities	23	30%
Gender Identity	25	33%	Physical Disabilities	19	25%
Physical Disabilities	23	30%	Level of Education	18	24%
Sexual Orientation	20	26%	Sexual Orientation	17	22%
Religious Beliefs	12	16%	Religious Beliefs	7	9%

Source: CHS analysis of community resident survey data

4. Most Important Community Health Concerns

Community professionals were asked to identify the most important health concerns in their community, selecting up to five each for adults and for children. **Exhibit 2.4** lists the most frequently identified concerns for each age group.

Exhibit 2.4

Most Important Community Health Concerns

Health Concerns for Adults (18+)	Count	%
Total Responses	77	100%
Behavioral / Mental Health (Anxiety, Depression, Bullying, Psychoses, Suicide)	64	83%
Overweight/Obesity	44	57%
Dental/Oral Care	28	45%
Violence in the Home	21	40%
Substance Use (Alcohol, Drugs)	31	36%
Developmental Disabilities	11	34%
Smoking/Tobacco Use/Vaping	13	32%
Sexual & Reproductive Health Issues (STIs, Teen Pregnancy)	7	32%
COVID-19	23	30%
Diabetes	35	27%
Physical Disabilities	15	19%
Violence in the Community	9	17%
Respiratory Disease	6	14%
Cancer	25	12%
Infectious Disease	4	9%
Neurological Conditions	4	8%
Heart Conditions	25	5%
Alzheimer's and Dementia Care	26	5%

Health Concerns for Children (0-17)	Count	%
Total Responses	77	100%
Behavioral / Mental Health (Anxiety, Depression, Bullying, Psychoses, Suicide)	56	73%
Overweight/Obesity	37	48%
Dental/Oral Care	36	47%
Violence in the Home	30	39%
Substance Use (Alcohol, Drugs)	22	29%
Developmental Disabilities	21	27%
Smoking/Tobacco Use/Vaping	17	22%
Sexual & Reproductive Health Issues (STIs, Teen Pregnancy)	15	19%
COVID-19	13	17%
Diabetes	13	17%
Physical Disabilities	9	12%
Violence in the Community	9	12%
Respiratory Disease	5	6%
Cancer	4	5%
Infectious Disease	2	3%
Neurological Conditions	2	3%
Heart Conditions	1	1%

Source: CHS analysis of community resident survey data

5. Suggested Additions or Improvements to Community Services and Supports

Community professionals were asked to suggest additions or improvements to community services and supports. **Exhibit 2.5**, lists the most frequently suggested additions or improvements.

Exhibit 2.5

Suggested Additions or Improvements to Community Services and Supports

Focus for additions or improvements...	Count	%
Total Responses	78	100%
Access to mental health providers	63	81%
Affordable childcare	41	53%
Access to health and human services	34	44%
Access to community health Education (such as nutrition education, support for individuals who care for others, etc.)	32	41%
Access to parenting education and support Programs	29	37%
Safe and affordable housing for the workforce	28	36%
Accessible communities (public/commuter transportation, roads, bike paths, parks & recreation, sidewalks, open spaces)	26	33%
Employment opportunities / workforce development	26	33%
Access to internet and technology	25	32%
Healthy food access (fresh foods, community gardens, farmers' markets, EBT, WIC)	24	31%
Safe communities	15	19%
Quality of education (Pre K - 12)	10	13%
Public safety services (Police, Fire, EMT)	8	10%
Environment (air & water quality)	2	3%
Other	5	6%

Source: CHS analysis of community resident survey data

COMMUNITY FOCUS GROUPS

In addition to the online surveys for community insight, Sentara Northern Virginia Medical Center and Lake Ridge Ambulatory Surgery Center, in collaboration with Community Healthcare Coalition of Greater Prince William, UVA Haymarket Medical Center, and UVA Prince William Medical Center, 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 session.

- What are the most serious health problems in our community?
- When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?
- Who has health problems? 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?
- How has the COVID-19 pandemic worsened the health issues in our community?
- What more can be done to improve health, particularly for those individuals and groups most in need?

Focus Groups

1. 3/30/2022 Focus Group, virtual session, 18 participants
2. 4/21/2022 Focus Group, virtual session, 5 participants

Methodology

Due to the COVID-19 pandemic, focus groups were held virtually. Virtual 'community insight events' were held in which community members (residents and professionals) were invited to learn about preliminary results from the CHNA study and offer their insights on community health needs and opportunities for improving community health. Each focus group had a facilitator guiding discussions through the seven previously prepared questions. Additional staff took detailed notes to capture the information shared.

Results

Mental health, chronic conditions, financial instability, housing, transportation, and access concerns were brought up in every focus group. For a detailed summary of the focus group sessions see Appendix F. 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?	• I see a lot of Mental Health issues in the community and with clients • For mental health-outreach to homeless, vets, and victims of COVID • Mental Health, the range of Chronic Diseases, quality of housing which may impact health • Mental health, substance use, parenting struggles, affordable housing, returning citizens (former incarcerated individuals) • Chronic Conditions: Cancer, Heart Disease, Diabetes • Dental care • Hypertension • Individuals not seeking preventative care • Not knowing how to seek care or where to seek care • Obesity, lack of a long-term health care • Stress management
When considering Social Determinants of Health, which of the following resonate with you as a key social determinant that we should be focusing on?	• Food-eliminating sugar from diet/healthy behaviors • Health Behaviors • Housing, transportation, social support • Affordable housing. Rent and housing prices are skyrocketing • Educating and making healthy options more accessible and affordable. • Clear message on which foods are healthy and the costs of a poor diet on not only physical, but mental and emotional aspects • Education, employment affect capability to acquire housing, food and health care and play into overall health and issues around violence (x2) • Access to health care, education, transportation, access to healthy food. • Economic stability • English proficiency • Food insecurities • Health literacy • Lack of access to prevention services • Legal status is a big deterrent • Neighborhood and physical environment (especially crime impact) • Out of the last 756 people that have visited our offices, their average weekly income is $310. 86.24% of those (652) did not have any health insurance • People having illegal status don't have access to any preventive health • Social support network

TOPIC	KEY FINDINGS
Who has the health problems? **What groups of individuals are most impacted by these problems?**	• Increased depression and anxiety in adolescents. • Opioid crisis has not gone away • Kids in school, elderly, poor • Single parents, recent graduates, adults turning 26 - off of parent's insurance • Moving on to less expensive forms • City of Manassas increase in overdoses & death related to opioids during covid • Plus, increase in YOUNGER people with HIV related to intravenous drug use • Behavioral Health • Diversity within the Latino community- race, income, education • Elderly - not many affordable resources • Homeless, traditional and non-traditional • People living with cancer • People living with diabetes • People with limited access to healthy food • People with limited education • The Elderly, disabled, special needs children • Transgender • Undocumented, older and lack of access due to many barriers. • Uninsured (financial challenge to access health care services) • Working poor • Younger people with mental/behavioral health issues
What keeps people from being healthy? **What are the barriers they face with taking care of their health and accessing care?**	• Co-pays! • Cheaper and easier to access poor food choices • Opioid & HIV nationwide issue • Confusing messages regarding health of food and food preparation • Income, uninsured • Shortage of psychiatrists in the area • Transportation issue with lack of investment in local public providers. Every $1 invested by health entity in transportation gives $7 in reduced cost of care (2016 study) • Economic • Health-care system navigation • English level • Immigration status • Cultural barriers beyond language barriers • Emerging issue: immigrants with limited language supports • Financial challenges • Immigration status • Language barriers, Transportation, access to insurance • Newer immigrants without natural supports • Not intuitive

TOPIC	KEY FINDINGS
What is being done in our community to improve health and reduce barriers? **What resources exist in the community?**	• Many disparate programs working in similar space, not always working in concert with each other, not always aware of each other • County increasing financial support • OmniLink piloting "on-demand" local bus route in Manassas & Manassas Park. Pilot begins this summer, and they will expand to east side of County particularly Dumfries, Triangle areas • On-demand may enable more readily available transportation for supporting health • Community organizations can play a big role in getting healthcare to different groups • Community organizations play big role in getting health care to folks in need • Effective referral resources (people don't know who offers what services) • Finding a way to go to where individuals are • Free Clinic and Federally Qualified Health Center (FQHC) – Greater Prince William Health Center (GPWHC) • Free clinics • Government (limited) • GPW Health Center patient transportation at NO COST • House of mercy • House of Mercy for dental • Lion's club • Local health system • Local hospital • Mobile Health Units - Mammography and Family Medicine • Public transportation, free clinics, public safety • Sentara Family Health Connection, Free clinics @ Churches/Community Organizations/Businesses, free-accessible programs w/ low barrier or no barrier entry. • Simple to understand patient education • Worship centers

TOPIC	KEY FINDINGS
How has the COVID-19 pandemic worsened the health issues in our community?	• Weight gain • Took focus off existing programs • Alcohol consumption • Anxiety in youth not wanting to return to school • Inflation • overwhelming information causing confusion and apathy • PWC very proactive in getting resources out to community • Lack of appointments and delaying treatment • Primary care providers may not be aware there were ICD-10 codes created for specific billings. Important for documenting Long-COVID • More stress on families causing marital conflict • promoted funding from government for small biz • distrust in healthcare due to lack of consistent messaging (and Niyatik Dhokai agreed) • Increase in violence • Increased suicidal ideation • Increase ease of access to care and Tele-health access • Access/ comfort with technology • Even lower economic growth, lack of clear access and navigation due to all the barrier + the overload on the healthcare system created an additional barrier. • Individuals have stopped seeking care all together • Limited services due to reduce in person services • Limited Transportation access due to reduced services • Long COVID • Loss of job, and possibly housing because of life of job, so not accessing services • Paralyzed by fear • Patients avoid accessing services out of fear • Risks of self-medication • Technology barriers • Transition to Telehealth not easy for all

TOPIC	KEY FINDINGS
What more can be done to improve health, particularly for those individuals and groups most in need? **Are there specific opportunities or actions our community could take?**	• More outreach, education • popup venues in communities of need staffed with mental health workers and materials • Great Idea Danny! Pop ups where people ARE... • Decreased cost of deductibles for mental health services • more mental health officers working with police • police • More & more outdoor activities for the community. Hiking, biking. Events for the community to get together and share their experiences • Activities for the community • Local Government has the Human Services. They should know after two years - since they are first and last line for access - the excuse of “We’re Government and we don’t do that” won’t work henceforth and moving forward. • More local government funding to provide mental services for those who are not able to afford it. • The issue of Local Government being “first and last” in this area was a topic when SNVMC was developing its Strategic Plan. Particularly in relation to Mental/Behavioral Health • Community partners re-connect post COVID to reboot cooperation • Community resource site to educate people what services are available and how to access • Create a free-accessible program that would provide preventative and long-term health-care access Partner-up with businesses, organizations and churches to ensure that this program is accessible to people • Additionally, advocate the local and state legislatures to ensure that additional funding and program creation is created to remove the immigration, language and economic barriers to access healthcare • Create innovative programs to reach community in need • Expanding social programs • Partnerships- especially Partnerships with nontraditional partners • Partnerships with ‘trusted’ partners that live in community • Provide free consultation. If not free, lower cost. Making it available for all. Also care for those individuals and groups

In addition to the focus groups, Sentara Northern Virginia Medical Center and Lake Ridge Ambulatory Surgery Center, in collaboration with Community Healthcare Coalition of Greater Prince William, UVA Haymarket Medical Center, and UVA Prince William Medical Center carried out a series of more in-depth community sessions to obtain greater insight from diverse stakeholders.

The additional forums were 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 session.

- Are there any additional community issues or concerns that should be included in the CHNA study? List up to three issues or concerns.
- Where should our community focus its efforts for improving community health? List up to three focus areas.
- What are some creative ways that community organizations might work together to help address community issues and concerns? List up to three ideas.

1. 3/29/2022 Community Insight Event, virtual session, 35 participants
2. 3/31/2022 Community Insight Event, virtual session, 8 participants

Demographics

The 43 participants ranged in age from 18 to over 60. Altogether, the focus group participants were comprised of 32.5% Caucasian, 13.9% African American, 9.3% Hispanic, 6.9% Asian, 4.6% biracial and 32.5% that preferred not to answer. The groups were 81.4% female and 18.6% male.

Methodology

Due to the COVID-19 pandemic, focus groups were held virtually. Virtual 'community insight events' were held in which community members (residents and professionals) were invited to learn about preliminary results from the CHNA study and offer their insights on community health needs and opportunities for improving community health. Each focus group had a facilitator guiding discussions through the seven previously prepared questions. Additional staff took detailed notes to capture the information shared.

Results

Mental health, chronic conditions, financial instability, housing, transportation and access concerns were brought up in every focus group. For a detailed summary of the focus group sessions see Appendix F. A brief summary of the key findings for each topic is presented below..

TOPIC	KEY FINDINGS
Are there any additional community issues or concerns that should be included in the CHNA study? **List up to three issues or concerns.**	• Affordable medical and dental care • Collaboration between community providers to support continuity of care • Financial viability/sustainability of health care organizations to continue to provide or expand health care services in the community • Impact of recent refugee resettlement and immigration; lack of affordable housing (Social determinants of health); in PWC, development issues/Impact on environment/climate (e.g. data centers • Transportation for underserved communities and Medicaid/Medicare members • An expansion of the access to care provided for both outpatient and inpatient services in the community • Need for wraparound care across multidisciplinary systems of care working with youth and adolescents • Pedestrian safety • Returning citizens (recently incarcerated peoples) and juveniles engaged in the court system • Substance use services for youth • The need for trauma informed care to be a standard of practice across all health and behavioral health disciplines across the county • Veterans' services (housing)
Where should our community focus its efforts for improving community health? **List up to three focus areas.**	• Availability of comprehensive mental health services across the population; expansion of public health services, including dental care; affordable housing • Behavior/Mental Health Services • Mental health for children- particularly low-income households • Building relationships / networks with non-healthcare organizations and groups to address transportation and housing • Collaboration for connecting services and resources, medical and non-medical • Educate community that Alzheimer's Disease & Related Dementias (ADRD) is NOT behavioral or mental health. • PACE (program of all-inclusive care for the elderly) program for adult day care -- no choices for Medicare covered services • Pooling resources for affordable health care (including dental and mental health) services and ensuring that these services are advertised in multiple languages and is accessible for all to understand ` *Continued>*

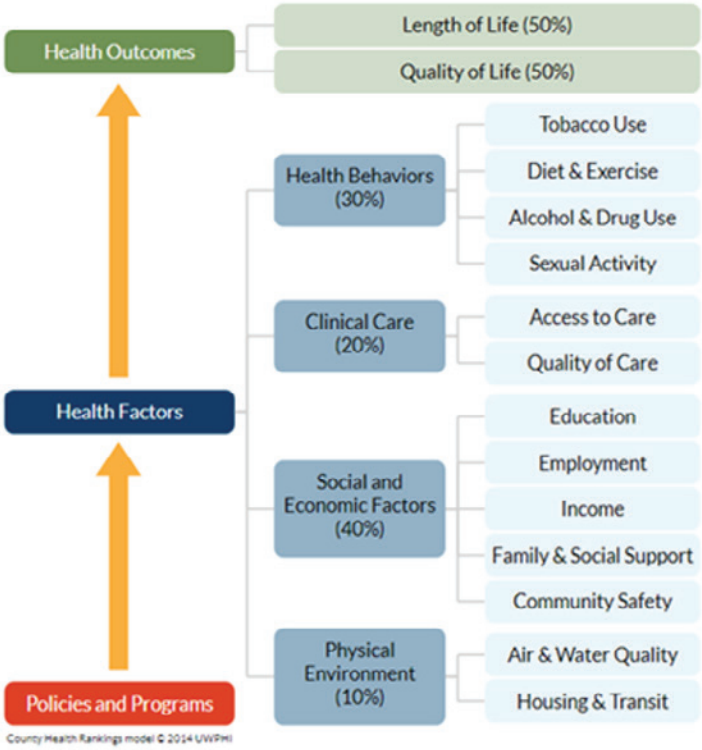
TOPIC	KEY FINDINGS
Where should our community focus its efforts for improving community health? **List up to three focus areas.** *(Continued)*	• Having a resource sheet or person where someone can who does not know how or to get the healthcare, support services for behavioral health, drug and alcohol abuse, teen pregnancy etc. • Health education • Integrate mental health and wellness into Primary Care • Involving community advisory boards into governance and planning • LGBTQ services • Making sure all resources are accessible --easy to understand, available in multiple languages, for all residents to participate
What are some creative ways that community organizations might work together to help address community issues and concerns? List up to three ideas.	• More outreach, education • popup venues in communities of need staffed with mental health workers and materials • Great Idea Danny! Pop ups where people ARE... • Decreased cost of deductibles for mental health services • more mental health officers working with police • police • More & more outdoor activities for the community. Hiking, biking. Events for the community to get together and share their experiences • Activities for the community • Local Government has the Human Services. They should know after two years - since they are first and last line for access - the excuse of "We're Government and we don't do that" won't work henceforth and moving forward. • More local government funding to provide mental services for those who are not able to afford it. • The issue of Local Government being "first and last" in this area was a topic when SNVMC was developing its Strategic Plan. Particularly in relation to Mental/Behavioral Health • Community partners re-connect post COVID to reboot cooperation • Community resource site to educate people what services are available and how to access • Create a free-accessible program that would provide preventative and long-term health-care access Partner-up with businesses, organizations and churches to ensure that this program is accessible to people • Additionally, advocate the local and state legislatures to ensure that additional funding and program creation is created to remove the immigration, language and economic barriers to access healthcare • Create innovative programs to reach community in need • Expanding social programs • Partnerships- especially Partnerships with nontraditional partners • Partnerships with 'trusted' partners that live in community • Provide free consultation. If not free, lower cost. Making it available for all. Also care for those individuals and groups

HEALTH STATUS INDICATORS

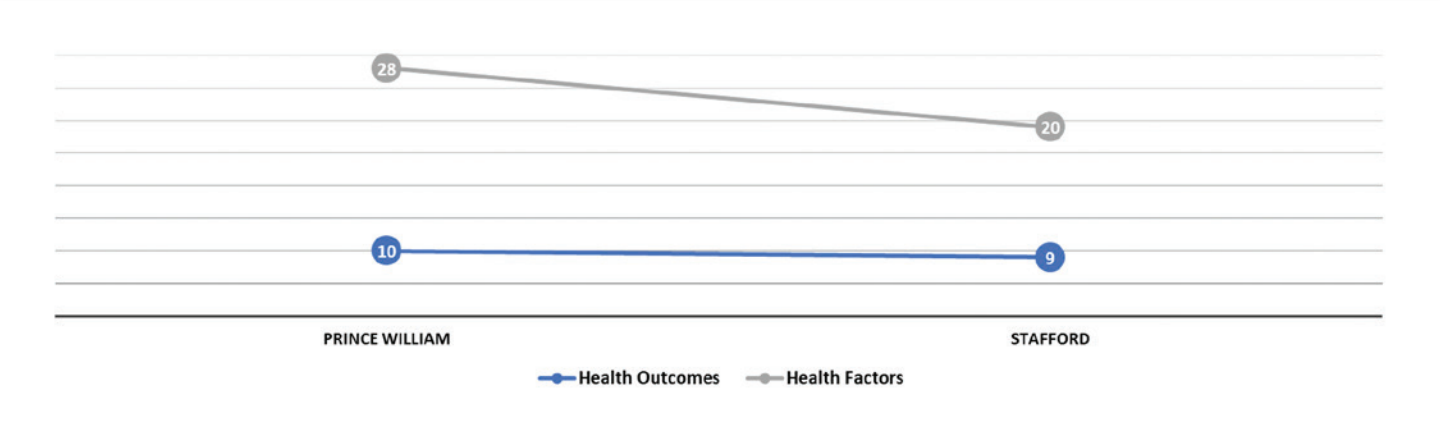
County Health Rankings

Health Indicators were viewed on County Health Rankings. The County Health Rankings are based on a model of community health that emphasizes the many factors that influence how long and how well we live. The rankings use more than 30 measures that help communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors). Explore the model to learn more about these measures and how they fit together to provide a profile of community health.

- There are many factors that influence how well and how long people live.
- The County Health Rankings model (right) is a population health model that uses data from different sources to help identify areas of concerns and strengths to help communities achieve health and wellness.
- The Rankings provides county-level data on health behavior, clinical care, social and economic and physical environment factors.



The graph below shows the Health Outcomes Rank and Health Factors for the communities in the service area of Prince William and Stafford Counties (Appendix B).



Source: County Health Rankings 2021, Rankings and Documentation;

Health Status Indicators

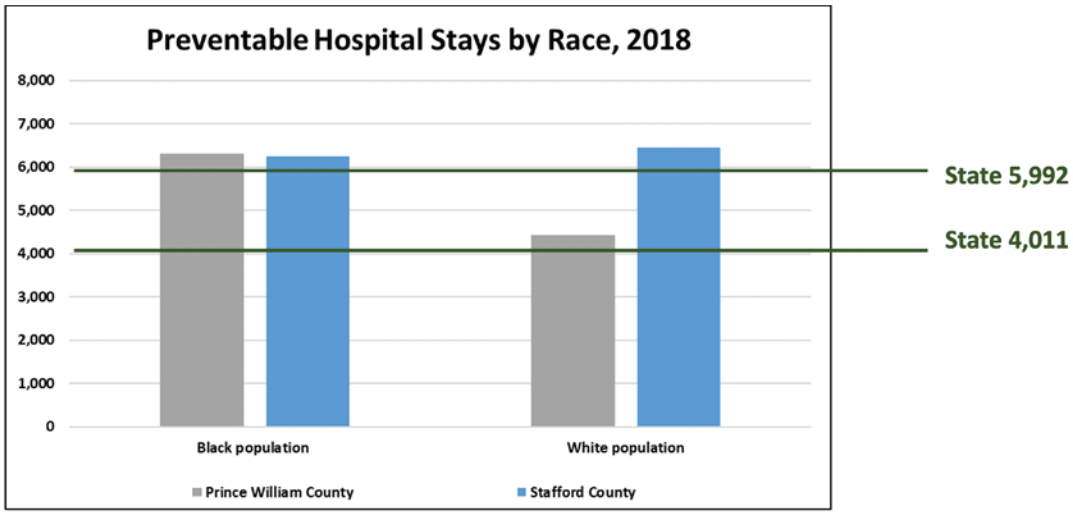
Below are key health status indicators for the zip codes representing the Prince William County area that SNVMC and LRASC serve. Links are also included to the interactive Be Healthy Be Happy Greater Prince William Area Community Dashboard. There, you can compare indicators like change over time, race/ethnicity, and gender where available, among nearby localities. In addition, more indicators are often available through the link.

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

A. Access to Health Services Profile
B. Mortality Profile
C. Hospitalizations for Chronic and Other Conditions Profile
D. Risk Factor Profile
E. COVID-19 Profile
F. Maternal and Infant Health Profile
G. Older and Aging Adults Profile
H. Cancer Profile
I. Diabetes Profile
J. Surgical Site Infections Profile
K. Behavioral Health Profile
L. Community Violence and Gun Violence Profile

ACCESS TO HEALTH SERVICES PROFILE

Access to quality and affordable health care is important to an individual's health. Health insurance and local care resources can ensure access to care. 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 sensitive ambulatory care conditions. Increasing access to primary care is key solution to reducing unnecessary and costly hospital stays and improving the health of the community.

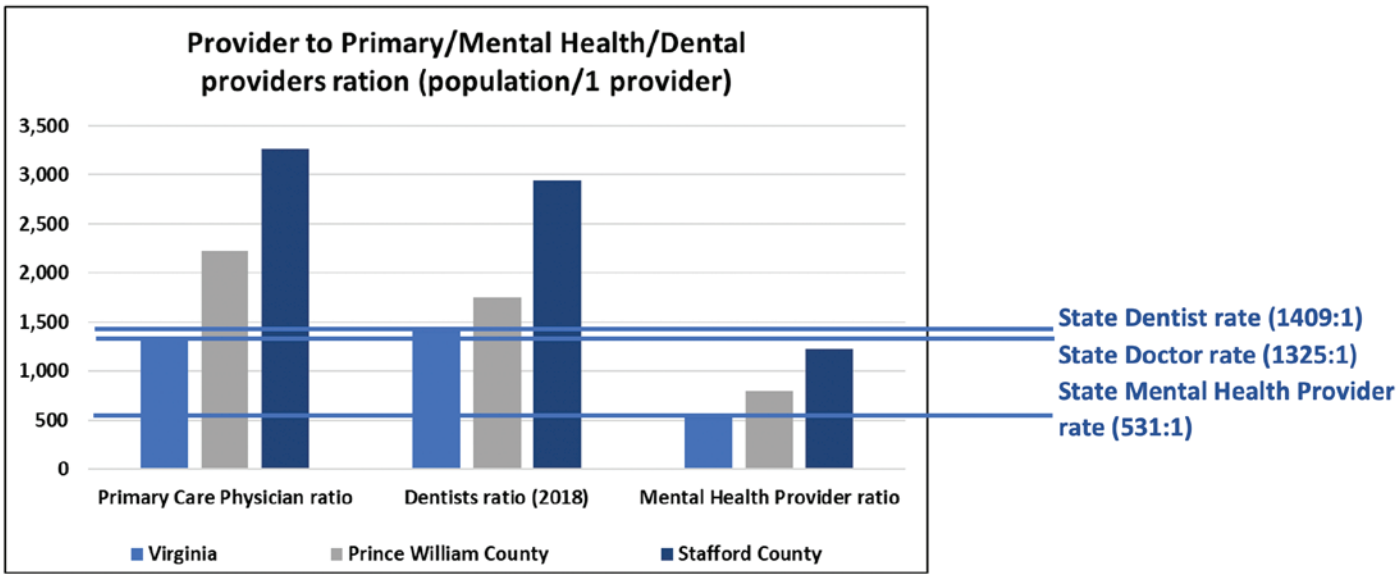


*Source: County Health Rankings 2021, Rankings and Documentation; *Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees*

Provider Ratio

The rate of primary care and dental care providers was examined in the service area. The ratios for population to primary care providers were higher in the service area than the state overall (1325:1), Stafford County (3260:1) and Prince William County (2229:1). The population ratio for dental care providers were also higher than the state (1409:1) in the service area, Stafford County (2940:1) and Prince William County (1748:1) (Appendix B). Fewer providers suggests concerns with access to health care, including oral health, throughout the service area.

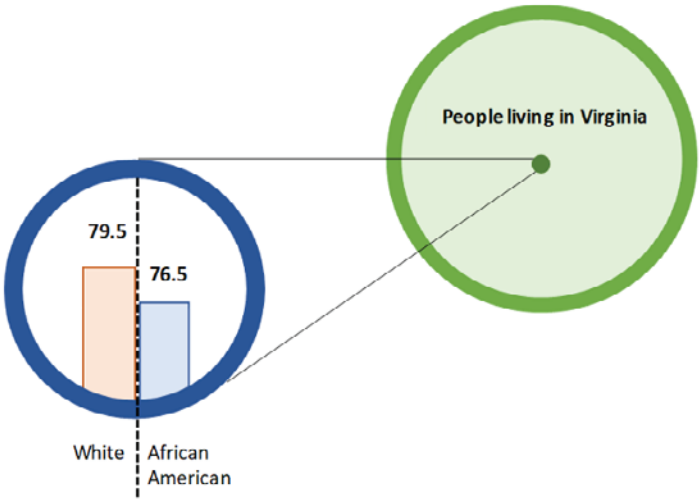
The percentage of people with health insurance was in line with the state percentage except in Prince William County, which had a higher percentage of uninsured. The preventable hospital stay rate among Medicare beneficiaries was higher than the state overall in the service area which suggest that there may be challenges with access to primary and outpatient care. Data also shows a disparity among African American beneficiaries.



Source: County Health Rankings 2021, Rankings and Documentation;

MORTALITY PROFILE

The life expectancy for a person living in the Commonwealth of Virginia is 79.5. Prince William County and Stafford County have a slightly higher life expectancy than the state (82.4, 80.1). It is important to note there is a racial/ethnic disparity related to life expectancy among African American populations. Life expectancy among African Americans is one to four years shorter than white Americans in the service area (Appendix B).



Leading causes of death in localities of the service area were examined. In 2019, cancer, heart disease, and accidents were the top three causes of death in the service area and the state. In the service area, the crude death rate from all causes was lower than the rate in the state overall.

Leading Causes of Death Per 100,000, Age-adjusted per 100,000 Population

	Crude Death Rate	All Causes	Cancer	Heart Disease	Respiratory Diseases	Accidents	Stroke	Alzheimer's Disease	Diabetes	Suicide	Chronic Liver Disease	Hypertension and Renal Disease
Prince William County	Prevalence Rate	434.6	99.3	83.3	23.8	26.2	23.0	11.3	17.6	8.3	7.7	6.8
	Numerator (count)	2,044	467	392	112	123	108	53	83	39	36	32
Stafford County	Prevalence Rate	562.5	122.3	116.4	28.1	35.3	24.9	37.9	9.8	7.8	5.2	5.9
	Numerator (count)	860	187	178	43	54	38	58	15	12	8	9
Virginia	Prevalence Rate	823	176	176.1	42.9	46.8	44.7	30.8	27.5	13.3	12.1	9.6
	Numerator (count)	70,242	15,024	15,035	3,662	3,993	3,819	2,626	2,351	1,135	1,037	816

Prevalence Rate

200 0

Data Source: Virginia Department of Health, Division of Health Statistics, Virginia statistics 2019, received 1-13-2019

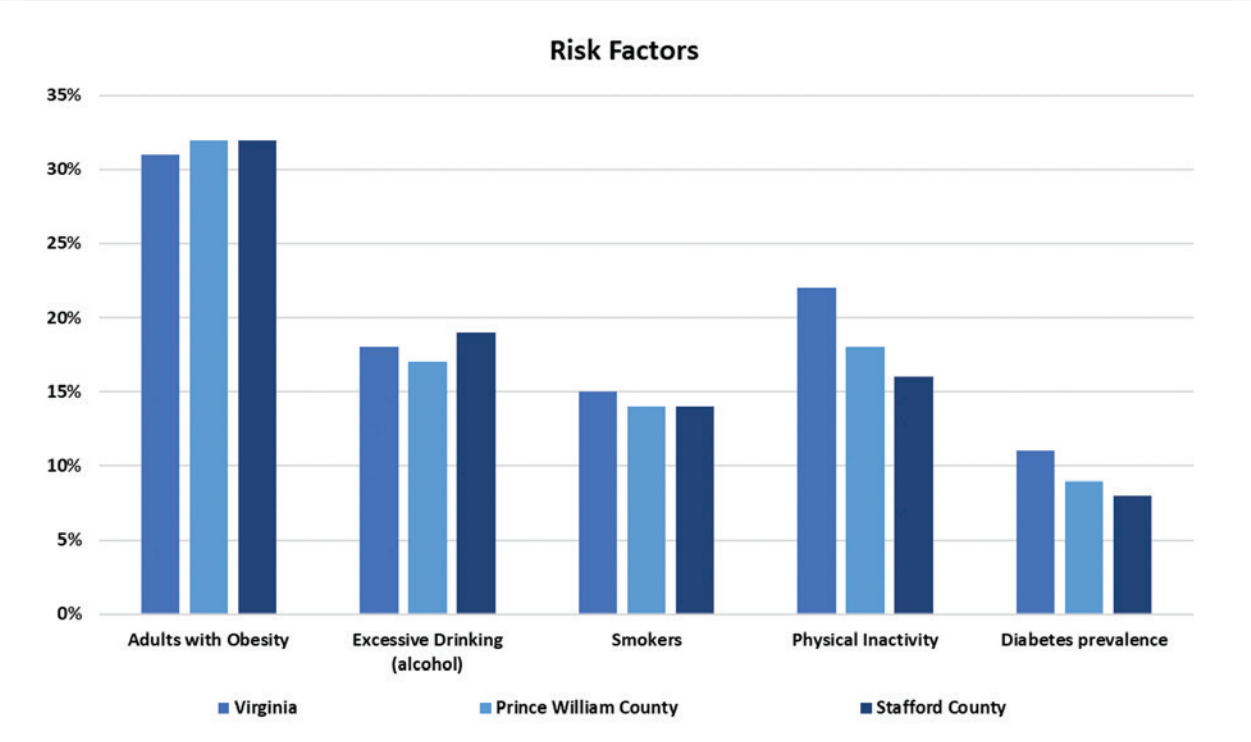
HOSPITALIZATIONS FOR CHRONIC AND OTHER CONDITIONS PROFILE

SNVMC and LRASC examined the age-adjusted hospitalization rates for Prince William County. For the top conditions seen in this medical center, heart conditions, diabetes and substance use were the highest rated in Prince William County. Rates for influenza and pneumonia and adult asthma rated above the state (Appendix B).

RISK FACTOR PROFILE

Overall, community members living in the service area are fairly healthy. Smoking rates were lower for the service area compared to Virginia overall. Conversely, the percentage of adults who drink excessively was higher in Stafford County compared to that of the Commonwealth of Virginia, but slightly lower in Prince William County.

Diabetes was lower in the service area compared to the state overall. Food insecurity rates are also lower in the service area when compared to the state overall (Appendix B). Obesity percentages were higher for the service area compared to Virginia overall. Access to exercise opportunities was higher than the state, especially in Prince William County. Obesity is a concern because it increases the risk of diabetes, heart disease, stroke, and some cancers. It is also associated with poor mental health outcomes and reduced quality of life.

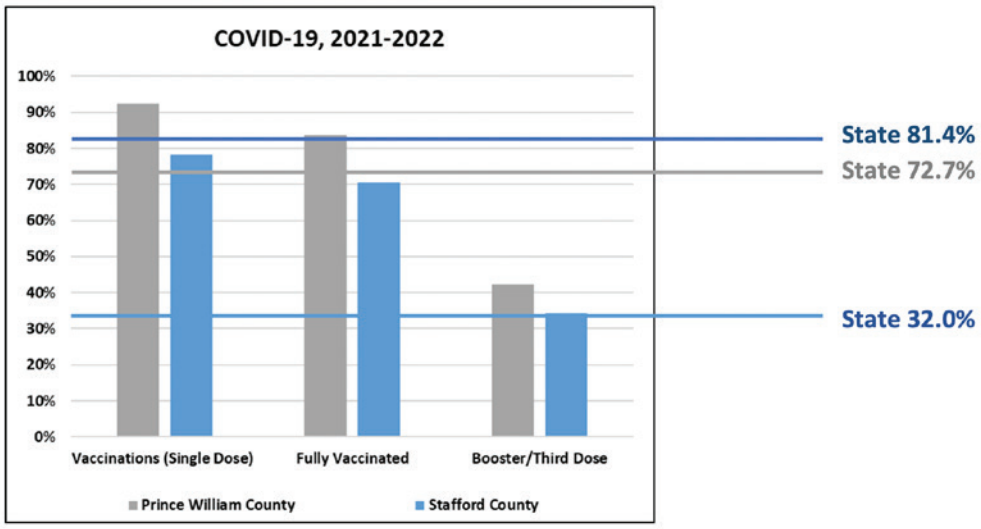


Source: County Health Rankings 2021, Rankings and Documentation Be Healthy Be Happy Prince William Indicator Dashboard4

COVID-19 PROFILE

In 2020, the nation faced the COVID-19 pandemic. This contagious disease impacted the health of the communities. People infected with the virus may experience mild to moderate respiratory illness and recover without medical treatment. However, some people will become seriously ill, requiring medical attention and possible hospitalization. People with underlying medical conditions are at a higher risk for developing serious illness while infected with COVID-19, and are at a higher risk for death (World Health Organization, 2022).

Between August 27, 2020 and April 1, 2022, the Commonwealth of Virginia had 1,669,750 COVID-19 cases with 19,714 deaths. Between March 2021 and April 2022, Prince William County had the highest rate of cases at 51,817 per 100,000 residents in the service area. Stafford County had the highest rate of deaths at 65.7 per 100,000 residents in the service area. As of April 2022, Prince William County has the highest percentage of residents that have received a single dose and two doses of the vaccine, higher than the state percentage of 81.4%.



MATERNAL AND INFANT HEALTH PROFILE

Unsupported and under-supported young families face many negative health outcomes and predict many long-term health challenges as time goes on, so looking at the way families begin can help us understand the current and future health of the community. Compared to the Commonwealth of Virginia, residents of the service area had lower percentages of babies born with a low and very low birthweight compared to Virginia values. The infant mortality rate was slightly greater in Stafford County compared to Virginia overall (Appendix B). While teen births are a community concern, the low numbers do not permit meaningful standardization for comparison to state rates. The non-marital birth rate for the service area is slightly lower than the Virginia rate at 30.7%. While this does not carry the stigma that it once did, it may indicate the degree of support for both the mother and the infant.

Source: World Health Organization, Coronavirus disease (COVID-19); Virginia Department of Health, COVID-19 Data in Virginia, Dashboard; Virginia Department of Health Division of Health statistics

OLDER AND AGING ADULTS PROFILE

In many communities, older adults is growing are the fastest growing segment of the population. Challenges come with an aging population, including health-related factors and other factors that ultimately impact health. Preventable hospital stays among the Medicare population in the service area were lower than for the state overall. However, there may be opportunities to improve primary and outpatient care to this population.

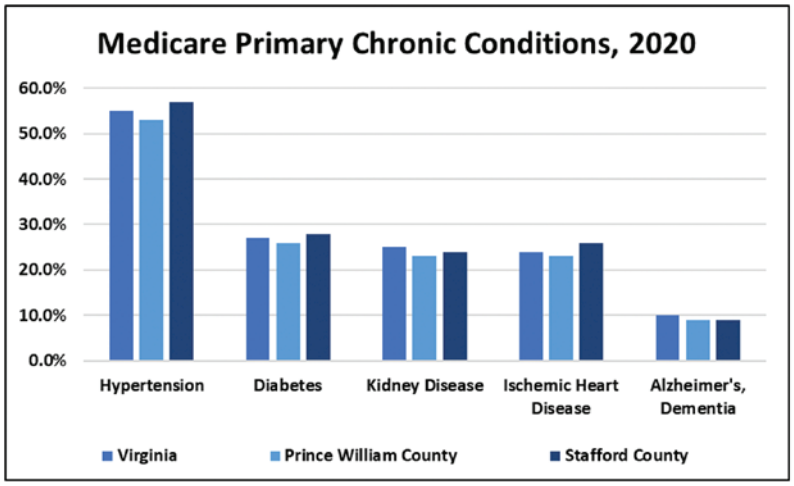
The Medicare population was seen for multiple conditions during 2020. Hypertension and diabetes were the top conditions seen in the services area having higher percentages than the state. Kidney disease and heart conditions also showed high percentages for the Medicare population utilizing hospital services.

The percentage of Alzheimer's disease and dementia diagnosis for persons under age 65 living in the service area is higher than the state. The percentage of Medicare beneficiaries treated for Alzheimer's disease or dementia was slightly higher in the service area compared to Virginia (Appendix B). Per the Alzheimer's Association, there is a projected increase of 26.7% in prevalence of the number of people age 65+ receiving an Alzheimer's disease diagnosis in the Commonwealth of Virginia by 2025. This is important to note as it will impact the aging populations health, quality of life, health care demands and costs.

1 in 3 seniors dies with Alzheimer's or another dementia. It kills more than breast cancer and prostate cancer combined.

Source: Alzheimer's Association, 2022

Advance Care Plans are for adults to specify their medical wishes and/or designate someone as their legal medical decision maker in the event they cannot communicate and advocate for themselves. While many team members working within the healthcare industry understand the importance and value of Advance Care Plans, it is evident within the acute care setting that our community members may not have that same understanding until it is too late. Currently, within the Commonwealth of Virginia, there are 41,380 active registrants with Advanced Care Plans filed within the USLWR (US Living Will Registry). Sentara has 70,236 active registrants with Advanced Care Plans on file within the USLWR with 34 of those completed for residents of the service area.



Source: Centers for Medicare & Medicaid Services, Data.cms.gov
Alzheimer's Association, 2022 Alzheimer's Disease Facts and Figures, Virginia Alzheimer's Statistics; Virginia Alzheimer's Commission, AlzPossible Initiative; United States Living Will Registry

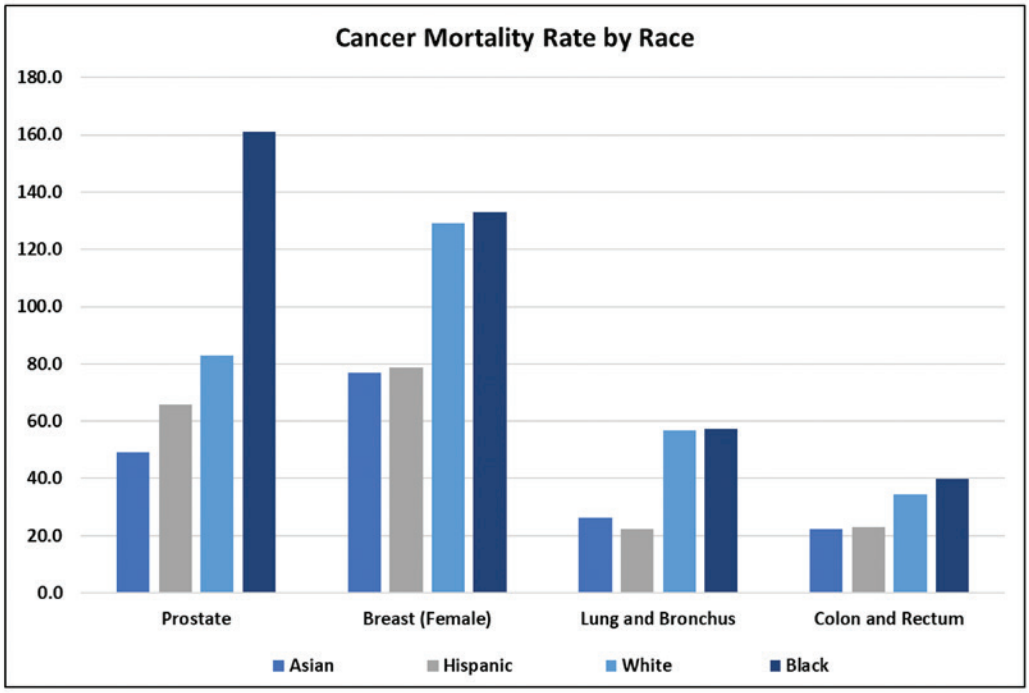
CANCER PROFILE

Death and incidence rates for a variety of cancer types were examined since cancer is the leading cause of death in the service area. Compared to the previous 5-year collective rates for both incidence and mortality from the leading types of cancer, the service area is trending down, with fewer cases and lower rates of death. However, the cancer incidences rate in Stafford County were mostly higher than the state and the lung and bronchus and colon cancer death rate in Stafford County was above the state rate. It is important to note the rates are rising for the African American population living in the Commonwealth of Virginia.

Breast cancer is the most common cancer diagnosed among U.S. women and is the second leading cause of death among women after lung cancer.

Source: American Cancer Society

Mortality rates were highest among lung, breast, prostate, and colon cancers, though these are not the only ones Sentara will focus efforts on. The trend for these cancers is falling compared to the previous 5-year period. Mortality rates for African Americans diagnosed with breast cancer is rising compared to previous years (Appendix B). Prostate cancer and breast cancer are the leading cause of cancer death for African Americans living in Virginia. See the below graph showing the mortality disparities among races. The community outreach programs which educate and provide cancer screenings, as well as medical developments, are having an impact, however, efforts will need to focus on populations at higher risk of this disease.



Data Source: NIH National Cancer Institute, 2014-2018 Incident Rate Report for Virginia

DIABETES PROFILE

According to the Centers for Disease Control and Prevention, the prevalence of type 2 diabetes continues to increase in the United States and is the 7th leading cause of death (CDC, 2021). Risk factors such as obesity and physical inactivity have played a significant role in this increase, but age and race/ethnicity also remain key risk factors. Diabetes is a top cause of death in the service area. Here, we examine additional related indicators.

The percentage of adults with diabetes living in Prince William County (9.1%) is higher than the state percentage of 8.5%. The death rate due to diabetes in Prince William County is lower than the state overall. SNVMC and LRASC examined hospitalization rates due to diabetes and found the age-adjusted hospitalization rates due to diabetes, hospitalization rates due to short-term complications of diabetes and hospitalizations due to long-term complications were lower in Prince William County than the state rate. It is also important to note that the percentage of the Medicare population living in the service area and diagnosed with diabetes is lower than the state overall.

Diabetes is also associated with increased risk of certain types of cancer, such as liver, pancreas, uterine, colon, breast, and bladder cancer.

Source: CDC, 2019

SURGICAL SITE INFECTIONS PROFILE

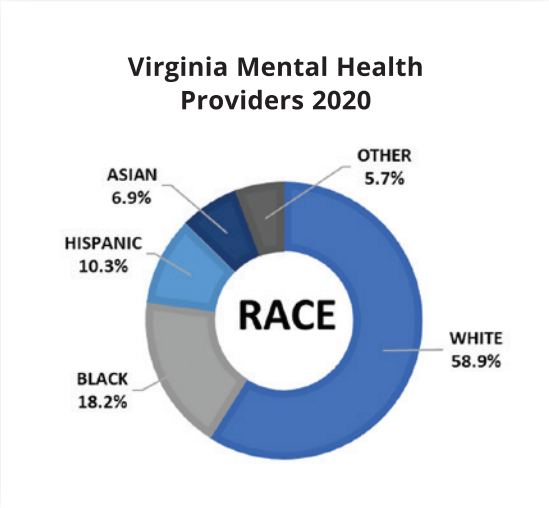
LRASC examined surgical site infections (SSIs). SSIs occur after surgery and in the part of the body where the surgery took place. SSIs can occur within days of the surgery, or even months after surgery to develop. Some patients may be at higher risk for developing an SSI due to their age and underlying medical conditions, such as diabetes and COVID-19. SNVMC and LRASC will continue to work together to educate patients on the risk factors for SSIs to decrease infection rates.

"Data from AHRQ's Partnership for Patients initiative indicates that the national rate of SSI decreased by 16% between 2010 and 2015, translating into significant benefits for patients (including many lives saved), as well as significant cost savings" (Agency for Healthcare Research and Quality, 2019). Advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, yet SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death in the inpatient setting (National Healthcare Safety Network, OPC-SSI, 2022).

Data Source: Centers for Disease Control and Prevention, Diabetes; Diabetes Report Card, 2019; Be Healthy Be Happy Greater Prince William Area Indicators Dashboard; Agency for Healthcare Research and Quality, Surgical Site Infections;

BEHAVIORAL HEALTH PROFILE

Hospitalization rates due to alcohol, substance use and mental health were examined for the service area. Prince William County had a lower hospitalization rate due to substance use compared to Virginia rates between 2018 and 2020.



Mental health is becoming an increasing health concern for both adolescents and adults. Sentara examined emergency department visits for 2021 to gain a better understanding of the mental health crisis communities have been facing during the COVID-19 pandemic. In 2021, SNVMC emergency department saw a patient frequency of 1,607 for people, aged 18+, with a behavioral health diagnosis. Of the 1,607 visits, 26.5% presented with suicidal ideations and 8.7% with major depressive disorder.

"In early 2021, emergency department visits in the United States for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019" (Office of Surgeon General, 2021). SNVMC saw 457 youth patients, age 0-17, present with a behavioral health diagnosis. Of the 457 visits, 40.2% presented with suicidal ideations and 12.6% with major depressive disorder.

The COVID-19 pandemic has worsened mental health among youth and adults with increasing anxiety, depression, and stress. Loss off freedoms due to social distancing, masking, and isolating negatively impacted the most vulnerable, increasing emergency department visits due to a lack of mental health providers to assist with therapy and development of coping skills. Most of the service area has fewer mental health providers per person compared to the state (531:1), Prince William County (800:1) and Stafford County (1,223:1) (Appendix B). It is also important to note that the mental health workforce is nearing retirement age which will negatively impact provider capacity. There is also a need for a more racially and ethnically diverse mental health workforce to provide racially concordant care (Appendix B).

Source: County Health Rankings 2021, Rankings and Documentation; Virginia Health Care Foundation; Be Healthy Be Happy Prince William Indicator Dashboard

COMMUNITY VIOLENCE AND GUN VIOLENCE PROFILE

Violent crimes such as gun violence, robbery, or aggravated assault have socio-emotional impact. Physical and emotional symptoms such as sleep disturbances increase in feelings of distress, anger, depression, inability to trust, and significant problems with family, friends, or coworkers can occur. Violent crimes can hinder the pursuit of healthy behaviors such as outdoor physical activities. Chronic stress has been associated with violent crimes and increases the prevalence of certain illnesses such as upper respiratory illness and asthma. This can have a life-long impact on one's health.

> ***"Firearm injury is a leading cause of death for youth in the United States."***
>
> *Source: Andrews AL, et al. Pediatrics. Feb. 28, 2022*

The violent crime rate in the service area is lower compared to the state rate of 207 violent crime offenses per 100,000 population (Appendix B). Gun violence is a top contributor to premature deaths. Deaths due to firearms are considered largely preventable; as a result, gun violence has been identified as a key public health issue by national agencies. A study published by American Academy of Pediatrics (2022) showed an increase in pediatric deaths due to firearms. The study also showed a disparity among African American youth who are "14 times more likely to die of firearm injury compared with their white peers" (Andrews AL, et al. Pediatrics. Feb. 28, 2022).

When deaths were examined by locality within the service area, the rate was only slightly lower than the state rate for firearm fatalities per 100,000 population.

Source: County Health Rankings 2021, Rankings and Documentation

2019 IMPLEMENTATION STRATEGY PROGRESS REPORT

The previous community health needs assessment identified several health issues. The SNVMC and LRASC implementation strategy progress report was developed to identify activities to address health needs identified in the 2019 CHNA report through primary and secondary data sources. This section of the CHNA report describes these activities and collaborative efforts.

SNVMC and LRASC are monitoring and evaluating progress to date on its 2019 implementation strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Please note that the 2019 community health needs assessment implementation strategy process was disrupted by COVID-19, which has impacted all of our communities.

Sentara Northern Virginia Medical Center

For reference, the list below includes the 2019 CHNA health needs that were prioritized to be addressed by SNVMC in the 2019 implementation strategy.

- Chronic Disease and Conditions
- Access to Healthcare
- Behavioral Health / Substance Use (including Opioid Addiction)
- Social Determinants of Health: Nutrition/Physical Activity (including Obesity)

STRATEGY PROGRESS

Chronic Disease and Conditions

SNVMC continued to work to improve chronic conditions such as cancer, diabetes, and congestive heart failure. SNVMC continues to provide health education and information on these conditions for the community in waiting rooms and community events. SNVMC was also able to continue support programs during the COVID-19 pandemic and provided information for support groups throughout the medical center and at the Cancer Resource Center which opened in the Century Building. Support groups were either in person or virtual depending on CDC guidelines. Support groups included:

Cancer Support Groups

- Healing with Meditation series
- Cancer Conversations
- Yoga for Cancer and Gentle Yoga
- Breast Cancer Support Group
- Cancer & Caregiver Support Group
- Nueva Vida Cancer Support Group
- Living Beyond Cancer Classes

Diabetes Support Groups

- Diabetes Support Group
- Healthy Habits Support Group

Congestive Heart Failure

- Stroke Recovery Group
- Stroke Support Group

SNVMC promoted free community health screenings and wellness events. A1c and Cholesterol screenings were offered during American Red Cross blood drives. SNVMC promoted free community health screenings for Four Seasons 55+ adult community and Potomac Place Assisted Living. A Congestive Heart Failure (CHF) Patient Navigator worked with the Area Agency on Aging's CHF program. A video series on heart & vascular topics and heart disease was offered. A video series on breast cancer, colon cancer, prostate cancer, general cancer topics was also offered.

Access to Health Care

With access to health care being a focus, SNVMC continues to assist the community. Sentara Family Health Connection started telehealth to provide health care to uninsured clients and expanded to a 300% charity Care Program. During the start of the COVID-19 pandemic in 2020, free COVID-19 testing and test kits were provided. SNVMC personnel assisted with processing the tests for the community until VDH took over free screenings in the service area. After VDH took over screening logistics, Sentara Healthcare continued to collaborate with VDH.

Prior to the pandemic, Sentara provided a Mobile Mammography Van regularly for screening throughout the community. During the pandemic and with CDC guidelines and restrictions in place, the Sentara Mobile Mammography Van and the Sentara Family Health Connection van could only go into the community when restrictions allowed. SNVMC continues to support events and provide screenings through the Sentara Mobile Mammography Van and the Sentara Family Health Connection Mobile Clinic.

SNVMC continues to provide health education to parents in the community and was able to provide the following classes virtually to support new parents.

Childbirth and Parenting Classes

- Infant and Child/Safety (English only)
- Pregnancy (English and Spanish)
- Childbirth (English and Spanish)
- You and Your Newborn (English and Spanish)
- Breastfeeding (English and Spanish)
- Postpartum Health and Baby (English only)
- Grandparenting (English only)
- Multiples (English only)
- Fatherhood (English only)
- All in One (English only)
- Cesarean Birth (English only)

Behavioral Health / Substance Use (including Opioid Addiction)

SNVMC continues to support the implementation of the Sentara Behavioral Health Strategic Plan. Sentara continues to improve access to behavioral health resources. In 2021, a Behavioral Health Care Center opened to provide follow-up care within seven days of being discharged as a behavioral health patient from the emergency department or an inpatient behavioral health unit. This clinic started as an Inpatient Behavioral Health Unit for behavioral health patients discharged from Sentara Virginia Beach General Hospital, Sentara Independence and Sentara Princess Anne Hospital Emergency Departments. The Behavioral Health Care Center has expanded its services to include other individuals in the community that need behavioral health care. As of March 2022, the Behavioral Health Care Center has seen a total of 1,215 patients.

In 2022, the Hampton Roads Behavioral Health Consortium convened as a regional coalition of private

and public partners in mental health to address the escalating mental health crisis. The Behavioral Health Consortium will develop a strategic action plan to address prevention, intervention, treatment, workforce, resources, access, education, recovery and eliminating the stigma associated with behavioral health.

Sentara has expanded, and will continue to expand, Telepsychiatry within the EDs and working on expanding Intensive Outpatient Programs and Partial Hospitalization Programs in Hampton Roads.

Sentara will continue to partner with community mental health programs to identify placement options outside of the emergency department for patients with behavioral health needs.

A Behavioral Health Safety Workgroup is focusing on improving the emergency department's staff and patient safety.

A Behavioral Health Tactical Operations Committee (BHTOC) Clinical Patient Management Workgroup is addressing:

- rapid treatment of agitation.
- active treatment of psychiatric illness.
- timely evaluation of medical comorbidities.
- improved coordination and communication around dispositions; and
- improved guidance on the ECO process.

The BHTOC Clinical Patient Management workgroup will continue to improve processes and work toward:

- management of patients with behavioral health needs who are placed on regular medical units.
- provide active treatment for substance intoxication or withdrawal/overdose.

A BHTOC Safety workgroup:

- Working on leader trainings.
- Behavioral Health Consultant and Behavioral Health Safety Workgroup completed priority I & II Emergency Departments site visits and BH Risk Assessments in March 2022.
- Priority III Emergency Departments site visits and Risk Assessments will be completed by the Behavioral Health Consultant and BH Safety Workgroup team by May 2022

SNVMC collaborates with Prince William County Police and the Community Healthcare Coalition of Greater Prince William County to offer semi-annual DEA Drug Take-back activities. SNVMC is exploring and developing relationships with key community partners in the area of mental health/emotional wellbeing for collective impact. SNVMC is increasing opportunities to decrease preventable emotional distress through wellness programs. SNVMC supports the community by offering support groups and Optima EAP services to Sentara employees to improve mental health.

Social Determinants of Health: Nutrition/Physical Activity (including Obesity)

SNVMC continues obesity-related outreach efforts (seminars, support groups, and education) and collaborates with local community stakeholders in efforts to improve healthy lifestyle behaviors with a focus on nutrition and physical activity. SNVMC provided healthy alternatives for patients post weight loss surgery and held monthly weight loss management classes. Diabetic and gestational diabetic education was held virtually during the pandemic.

Lake Ridge Ambulatory Surgery Center

For reference, the list below includes the 2019 CHNA health needs that were prioritized to be addressed by LRASC in the 2019 implementation strategy.

- Chronic Disease and conditions
- Access to Healthcare
- Behavioral Health / Substance Use (including Opioid Addiction)
- Social Determinants of Health: Nutrition/Physical Activity (including Obesity)

STRATEGY PROGRESS

Chronic Disease and conditions

LRASC refers patients with elevated Blood Pressure (BP), diabetes and history of sleep apnea. Information is provided free and located in the waiting room. Patients that are identified with these conditions are referred to their primary care physicians, including Sentara Medical Group Primary Care Physicians, for further evaluation. LRASC provides relevant resource and referral material, including the Sentara Diabetes Management Program, smoking cessation tools, logs, diet and exercise logs, and information on high BP. Materials contain websites and points of contact for further information. LRASC also continues to work with Sentara Community Outreach programs.

Access to Healthcare

LRASC continues to work with families and patients offering both free health care and/or at greatly discounted health care to patients in the Prince William community following the Sentara financial assistance policy. In 2021, we provided free surgical services to 26 patients in our community. In 2021, LRASC developed a new referral pathway with the Sentara Family Connection Van and Mother of Mercy Free Clinic to meet the specialty needs of their patients. LRASC has recently been credentialed with multiple Medicaid products, increasing our access to patients. We continue to assist our underinsured or uninsured patients with free, durable medical equipment and pre-op testing.

Behavioral Health / Substance Use (including Opioid Addiction)

LRASC continues to collaborate with the community and agencies to identify needs in behavioral health and substance abuse prevention. LRASC also continues to provide psychiatric services and referrals in our patient population and provides referral resources as appropriate. Prior to COVID-19, LRASC held educational forums on behavioral health issues and substance use cessation. LRASC utilizes Early Recovery After Surgery (ERAS) to reduce opioid utilization for its surgical patients. LRASC also promotes and participates in DEA drug take back events at our location.

Social Determinants of Health: Nutrition/Physical Activity (including Obesity)

LRASC provides take-home 'Family Nutrition Program Lesson Logs' and free meal planning logs for both adults and children. We also have information on pediatric immunizations (back to school requirements), take-home booklet/flyers. LRASC also offers free "Your Health" magazines. LRASC promoted Potomac Mills Walking Club, prior to the COVID-19 pandemic. LRASC promotes community events, including new Facebook live events as an answer to COVID-19 restrictions.

Sentara

GRANTMAKING AND COMMUNITY BENEFIT

In the 2019 Implementation Strategy process, Sentara and hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grant making, in-kind resources, collaborations, and partnerships.

Sentara is focused on supporting organizations and projects that address prominent social determinants of health factors and that promote health equity by eliminating traditional barriers to health and human services. Sentara strongly encourages grant proposals that align with one or more of the following priorities:

- Housing
- Skilled Careers
- Food Security
- Behavioral Health
- Community Engagement

Sentara is aware of the significant impact that our organization has on the economic vitality of our communities. In 2020, Sentara invested nearly $256 million in our communities. Sentara invested $20 million in health and prevention programs, $45 million in teaching and training of healthcare professionals, $11 million in philanthropic giving and $180 million in uncompensated patient care. In 2021, Sentara invested $245 million in the communities; $16 million in community giving, $23 million in health and prevention programs, $45 million in teaching and training of healthcare professionals and $167 million in uncompensated patient care.

Clearly, the definition of community health is broader than simply medical care. As more is known about the role of social determinants of health, more opportunities will arise to influence population health through engaging in community building approaches to care. Beyond the scope of SNVMC and LRASC alone, these opportunities will require active partnerships among community organizations and individuals to create lasting impact. Sentara, SNVMC and LRASC are committed to finding innovative, responsive, and successful strategies to address these challenges in order to fulfill our mission to improve health every day.

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Alzheimer's Association, Virginia Alzheimer's facts

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World Health Organization, Coronavirus disease (COVID-19)

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