Sentara Port Warwick Ambulatory Surgery Center

Community Health Needs Assessment 2019

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Sentara Port Warwick Ambulatory Surgery Center

Community Health Needs Assessment (CHNA)

2019

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Introduction

Sentara Port Warwick Ambulatory Surgery Center has conducted a community health needs assessment in collaboration with Sentara CarePlex Hospital. The assessment provides us with a picture of the health status of the residents in our communities and provides us with information about health and health-related problems that impact health status.

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

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

- **Access to Health Care for Low Income and/or Underinsured**
- **Health Literacy and Community Outreach, including Eye Health and Cancer**
- **Community Drug Use**
- **Access to Healthy, Affordable Food**

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

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

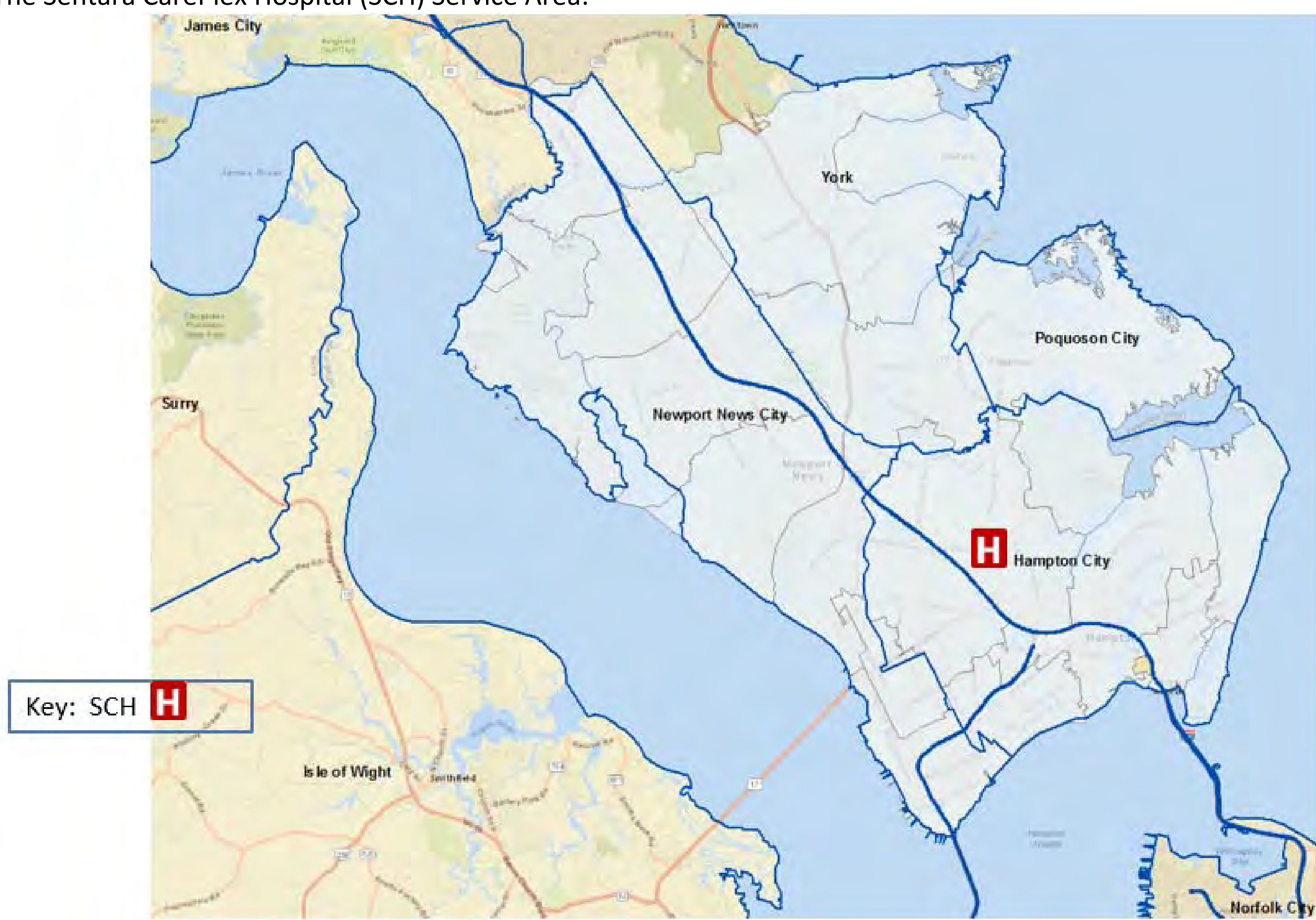
Your input is important to us so that we can incorporate your feedback into our assessments. You may use our online feedback form available on the Sentara.com website. Thanks!

Demographic Information

Population

Highlight Population: The combined population of the Sentara CarePlex Hospital (SCH) service area numbers almost 400,000, approximately 5% of the State population. The service area of SCH is comprised of 4 localities: the Cities of Newport News, Hampton, and Poquoson, and the County of York. Newport News is the most populous locality in the service region, followed by Hampton and York County. Those four localities make up the lower peninsula, with SCH located near the center of Hampton.

The Sentara CarePlex Hospital (SCH) Service Area:



Source: Truven/Market Expert

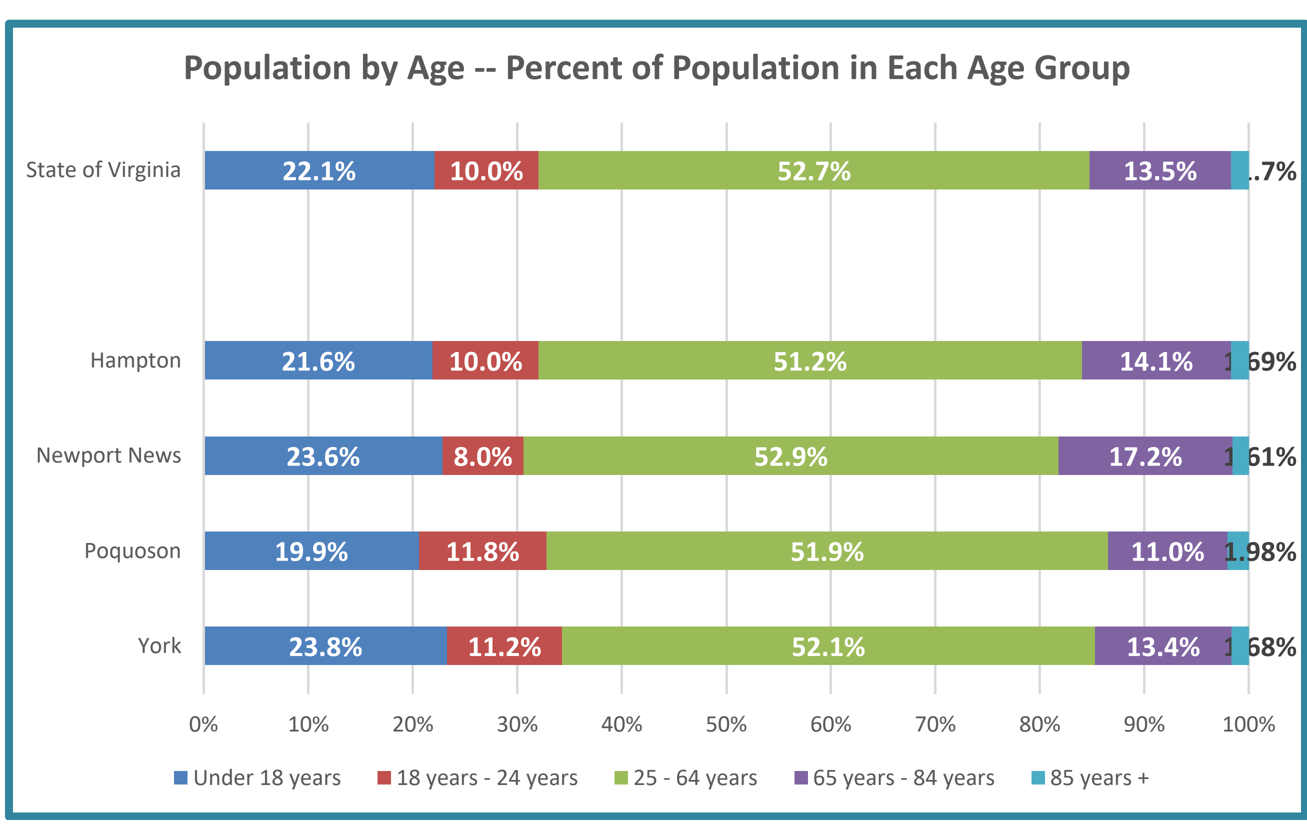
Population Change 2010 - 2018		
Locality	**Population**	**% Change 2010-2018**
State of Virginia	8,492,022	6.1%
Hampton	135,544	-1.4%
Newport News	182,626	1.1%
Poquoson	12,099	-0.4%
York	68,734	5.0%

Highlight Population Change: The service area population as a whole is stable, with both Hampton and Poquoson losing residents and Newport News experiencing a counterbalancing modest population growth. York County, however, has experienced 5% growth, approaching the state's 6.1%.

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

Population by Age

Highlight Population and Age: The service area has a lower percent of residents aged 85+ than the state as a whole, with the exception of Poquoson, although it is also home to a higher percent of population aged 65-84 years. The population segments that represent children, young adults and working age adults vary only slightly from the statewide proportions.



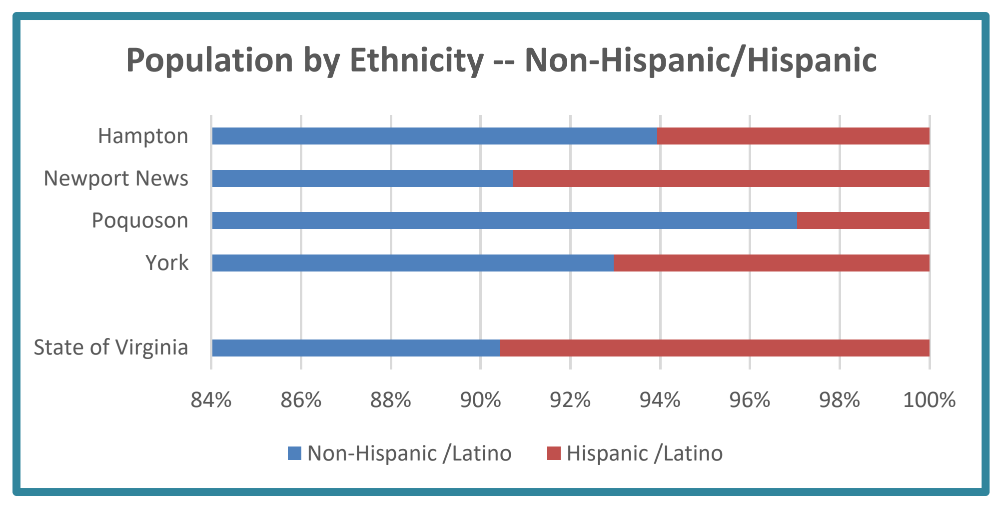
Population by Race and Ethnicity

Highlight Population and Race: The population of the service area is overwhelmingly white and black, with York and Newport News the most diverse communities, each reporting 12% of the population not solely either white or black, followed by Hampton, at 9.4%. The area has small Asian populations, but no other racial groups are represented in the area in any significant number.

Highlight Population Ethnicity: The service area as a whole is home to a small Hispanic population, with only Newport News approaching the state's level of Hispanic population at 9.3% (compared to 9.6% statewide).

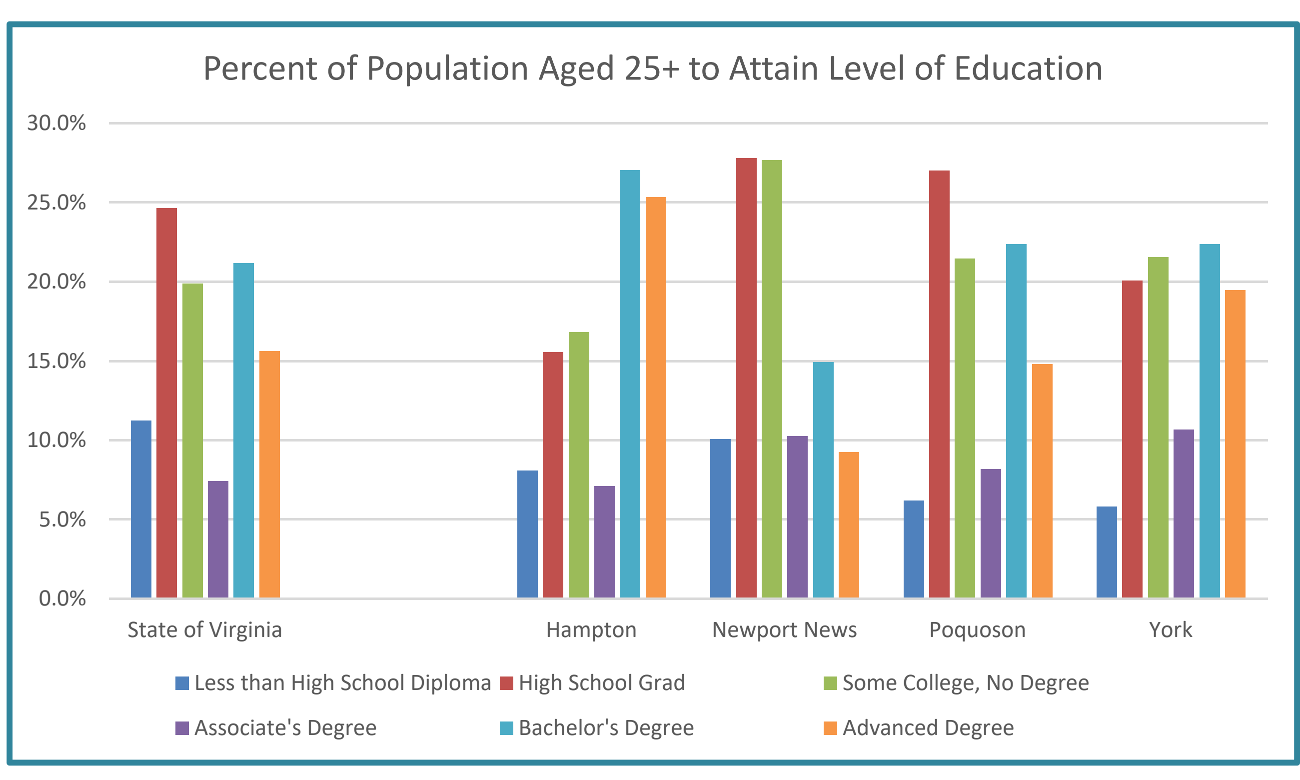
Population by Race -- Percent of Population in Each Racial Group

	State of Virginia		Hampton	Newport News	Poquoson	York
2+ Races	3.6%		4.7%	4.7%	2.3%	4.2%
Some Other Race	3.8%		1.7%	3.3%	0.5%	2.0%
Native Hawaiian/Pacific Islander	0.1%		0.2%	0.2%	0.1%	0.3%
Asian	6.8%		2.4%	3.3%	2.4%	5.7%
American Indian /Alaskan Native	0.4%		0.4%	0.5%	0.4%	0.4%
Black	19.4%		49.2%	40.4%	1.6%	13.4%
White	66.0%		41.3%	47.6%	92.8%	74.1%



Population and Education

Highlight Education: Education is the basis for stable employment, and financial stability is the foundation for a sustainable household, which provides for the health needs of family members. Collectively, the 4 localities have a lower proportion of the adult population (aged 25 and over) who have not achieved a high school diploma than the state as a whole, although Newport News's rate of 10.1% is the highest in the service area. Hampton, Poquoson and York County all have higher levels of advanced degrees than Virginia as a whole. Newport News lags significantly at both bachelor's degree and advanced degree level.



Educational Attainment -- Percent of Population to Achieve Specified Level of Education						
	Less than High School Diploma	High School Grad	Some College, No Degree	Associate's Degree	Bachelor's Degree	Advanced Degree
State of Virginia	11.2%	24.6%	19.9%	7.4%	21.2%	15.6%
Hampton	8.1%	15.57%	16.83%	7.12%	27.04%	25.4%
Newport News	10.1%	27.81%	27.68%	10.25%	14.95%	9.2%
Poquoson	6.2%	27.02%	21.44%	8.17%	22.36%	14.8%
York	5.8%	20.08%	21.56%	10.69%	22.38%	19.5%

Income and Poverty

Highlight Income by Race: While simple poverty rates tell us something about the residents of the service area, by inserting race as a factor we see the racial disparities that constrain residents of the service area in their ability to support and sustain healthy, functioning households for themselves and their children. As with Virginia as a whole, black individuals are likely to have income that is approximately 77% of the general household income and approximately 70% of the income of white households. The exception is Poquoson, with an unexpectedly high income – 50% higher -- for black households.

Highlight Income by Ethnicity: Similar to the disparity in income by race, income for Hispanic residents of the service area is substantially lower than for the service area as a whole, even lower compared to the income for white residents, but is still higher than the income of black residents.

Median Household Income by Race/Ethnicity				
Locality	**White**	**Black**	**Hispanic**	**All Races**
State of Virginia	$ 76,180	$ 49,110	$ 65,576	$ 71,167
Hampton	$ 62,547	$ 43,982	$ 54,988	$ 52,996
Newport News	$ 65,360	$ 41,180	$ 46,746	$ 52,925
Poquoson	$ 87,770	$ 132,292	$ 68,490	$ 87,464
York	$ 94,504	$ 68,311	$ 66,914	$ 90,352

Highlight Poverty Calculation: Each year the federal government calculates the income required to provide the absolute, necessities to sustain a household in the United States. Because each additional family member does not increase the cost of a household to the same extent (for instance, the cost of housing 4 family members is not 1.3 times higher than the cost of housing 3 family members), the government publishes the federal poverty guidelines (FPG) for families with up to 8 members with a calculation for larger households. The table below presents the poverty level for up to 6 members. For more information, google "federal poverty guidelines" or visit https://aspe.hhs.gov/poverty-guidelines. **Highlight Poverty:** Poverty is perhaps the most impactful of the social determinants of health, affecting the ability to have stable housing, healthy food, the ability to maintain steady employment, and the ability to access health care when needed. The table below presents the percent of individuals residing in the 4 localities who live in acute (100% FPG) or less acute, but equally debilitating over the long term poverty (200% and 300%). Individuals living over 400% of the FPG are generally considered to have sufficient income and are not considered eligible for government services.

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

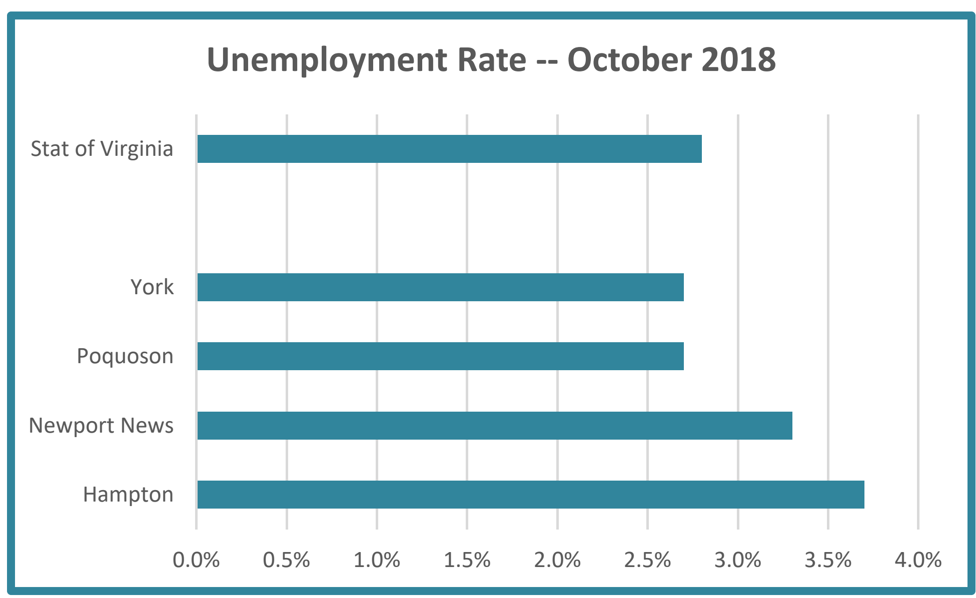
Source: US Department of Health and Human Services

Percent of the Population Living at Specified Percent of the Federal Poverty Level				
Poverty Level	100%	200%	300%	400%
State of Virginia	11.4%	26.6%	41.7%	55.0%
Hampton	15.6%	35.2%	53.9%	69.2%
Newport News	7.9%	36.2%	55.7%	69.7%
Poquoson	7.6%	12.8%	23.8%	39.7%
York	6.2%	15.8%	30.2%	45.3%

Source: US Census Bureau: American Factfinder 2017 Estimates

Employment

Highlight Employment: Central to a healthy community is an economy that supports individuals in their efforts to live well. Unemployment is a key measure of the state of the local economy and the rate for the service area as a whole is slightly higher than that of the state due to the larger populations of Hampton and Newport News, which also have the highest unemployment rates. Please note the scale of the chart below. The measurements are in .5 percent increments.



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

Highlight Employers: The largest employers (in number of employees) in the region reflect the military presence of several military bases in the service area. Local governments are large employers throughout the United States, and mirror population as a higher number of students requires a higher number of teachers, for example. Healthcare and commerce round out the list of largest employers.

Three Largest Employers by Locality	
Hampton	Hampton City School Board, City of Hampton, U.S. Department of Defense
Newport News	Huntington Ingalls Industries, Riverside Regional Medical Center, Newport News Public Schools
Poquoson	Poquoson City Public Schools, City of Poquoson, Farm Fresh
York	York County School Board, County of York, Wal Mart

Source: Virginia Economic Commission, Community Profiles 2018

Health Status Indicators

Below are key health status indicators for the localities representing the **Sentara CarePlex Hospital (SCH)** Service Area: the cities of Hampton, Newport News, and Poquoson, and York County. Links are also included to interactive data dashboards on the Greater Hampton Roads Indicators Dashboard, also known as GHRconnects. Here indicators can be explored for a comparison to other nearby localities, change over time, race/ethnicity, and gender, where available. In addition, more indicators are often available through the link.

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

A. Mortality Profile

B. Hospitalizations for Chronic and Other Conditions Profile

C. Risk Factor Profile

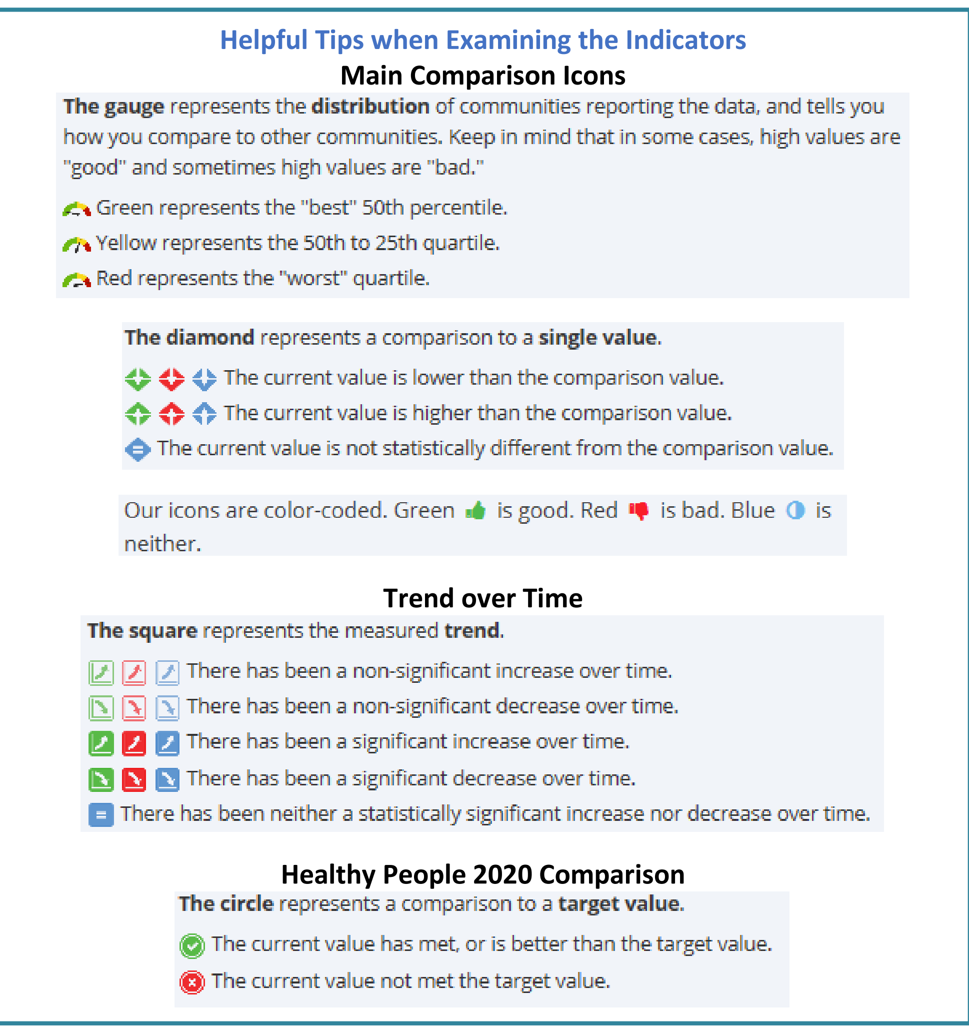
D. Cancer Profile

E. Behavioral Health Profile

F. Maternal and Infant Health Profile

G. Spotlight: Opioid Epidemic

H. Spotlight: Food Access



A. Mortality Profile

Highlights: Leading causes of death in localities of the SCH service area were examined. Cancer, heart disease, and COPD were the top three causes of death in the area. The top three causes of death in Virginia were cancer, heart disease, followed by stroke; stroke was the fifth leading cause of death in the SCH service area. In the service area, the crude death rate from all causes and most of the leading causes of death were higher than the rates for the state overall, suggesting a high mortality burden in the area. The exceptions were stroke, blood poisoning, and influenza and pneumonia, which all had lower rates compared to Virginia.

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

Leading Causes of Death	Hampton	Newport News	Poquoson	York County	Total Service Area	Virginia
Counts						
All Causes	1,236	1,572	128	415	3,351	63,100
Cancer	256	334	30	103	723	14,646
Heart Disease	269	310	25	73	677	13,748
Chronic Obstructive Pulmonary Disease (COPD)	56	88	9	30	183	3,096
Accidents	65	80	5	20	170	3,070
Stroke	62	67	4	20	153	3,202
Diabetes	52	74	7	17	150	1,671
Alzheimer's Disease	48	62	8	28	146	1,765
Kidney Disease	32	40	2	9	83	1,542
Blood Poisoning	26	28	1	6	61	1,336
Influenza and Pneumonia	12	15	2	3	32	1,490
Crude Death Rates per 100,000 Population						
All Causes	**912.8**	**864.6**	**1,065.2**	**610.5**	**843.6**	757.8
Cancer	**189.1**	**183.7**	**249.6**	**151.5**	**182.0**	175.9
Heart Disease	**198.7**	**170.5**	**208.0**	**107.4**	**170.4**	165.1
Chronic Obstructive Pulmonary Disease (COPD)	**41.4**	**48.4**	**74.9**	**44.1**	**46.1**	37.2
Accidents	**48.0**	**44.0**	**41.6**	**29.4**	**42.8**	36.9
Stroke	**45.8**	**36.8**	**33.3**	**29.4**	**38.5**	38.5
Diabetes	**38.4**	**40.7**	**58.3**	**25.0**	**37.8**	20.1
Alzheimer's Disease	**35.4**	**34.1**	**66.6**	**41.2**	**36.8**	21.2
Kidney Disease	**23.6**	**22.0**	**16.6**	**13.2**	**20.9**	18.5
Blood Poisoning	**19.2**	**15.4**	**8.3**	**8.8**	**15.4**	16.0
Influenza and Pneumonia	**8.9**	**8.2**	**16.6**	**4.4**	**8.1**	17.9

Data Source: Deaths - VDH (OIM - Data Management)

GREEN = Rates are better compared to Virginia, **RED** = Rates are worse compared to Virginia

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

B. Hospitalizations for Chronic and Other Conditions Profile

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

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

Highlights: Of the conditions examined, heart failure was the condition with the highest age-adjusted hospitalization rate in the SCH Service Area with the city of Newport News followed closely by Hampton having the highest rates. Both localities had rates higher than the state values. Other top conditions included diabetes and community acquired pneumonia. Hampton and Newport News had greater rates of hospitalizations due to diabetes than the overall rate for Virginia.

Age-Adjusted Hospitalization Rate due to Heart Failure

	VALUE	COMPARED TO:	
County: Hampton City, VA	49.2 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)
County: Newport News City, VA	49.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)
County: Poquoson City, VA	28.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)
County: York, VA	24.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (36.5)

Age-Adjusted Hospitalization Rate due to Diabetes

	VALUE	COMPARED TO:	
County: Hampton City, VA	25.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (18.9)
County: Newport News City, VA	23.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (18.9)
County: Poquoson City, VA	8.2 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (18.9)
County: York, VA	8.2 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (18.9)

Age-Adjusted Hospitalization Rate due to Community Acquired Pneumonia

	VALUE	COMPARED TO:	
County: Hampton City, VA	16.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (19.6)
County: Newport News City, VA	18.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (19.6)
County: Poquoson City, VA	15.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (19.6)
County: York, VA	11.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (19.6)

C. Risk Factors Profile

Link to interactive dashboard: Risk Factors SCH *(more indicators available)*

Highlights: Obesity percentages were higher for in Hampton and Newport News in compared to Virginia and the United States (US) values, but lower in Poquoson and York County. Notably, Hampton was in the worst quartile of localities across Virginia. Diabetes percentages were higher than Virginia and US values in all parts of the SCH service area except York County. The percentage of adults who drink excessively was higher in the localities except for Newport News compared to the state value. Smoking was also examined; there were high percentages of smoking in Hampton and Newport News, although the percentage declined from the prior value.

Adults 20+ who are Obese

	VALUE	COMPARED TO:		
County: Hampton City, VA	37.3% (2014)	VA Counties	U.S. Counties	VA Value (28.3%)
		US Value (28.0%)	Prior Value (34.8%)	Trend
County: Newport News City, VA	31.5% (2014)	VA Counties	U.S. Counties	VA Value (28.3%)
		US Value (28.0%)	Prior Value (32.3%)	Trend
County: Poquoson City, VA	26.5% (2014)	VA Counties	U.S. Counties	VA Value (28.3%)
		US Value (28.0%)	Prior Value (24.7%)	Trend
County: York, VA	26.8% (2014)	VA Counties	U.S. Counties	VA Value (28.3%)
		US Value (28.0%)	Prior Value (26.1%)	Trend

Adults 20+ with Diabetes

	VALUE	COMPARED TO:		
County: Hampton City, VA	12.8% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (12.4%)	Trend
County: Newport News City, VA	12.3% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (12.7%)	Trend
County: Poquoson City, VA	11.2% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (11.5%)	Trend
County: York, VA	9.5% (2014)	VA Counties	U.S. Counties	VA Value (9.7%)
		US Value (10.0%)	Prior Value (9.5%)	Trend

Adults who Drink Excessively

	VALUE	COMPARED TO:		
County: Hampton City, VA	17.7% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (16.7%)	HP 2020 Target (25.4%)
County: Newport News City, VA	16.3% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (16.1%)	HP 2020 Target (25.4%)
County: Poquoson City, VA	19.5% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (18.9%)	HP 2020 Target (25.4%)
County: York, VA	17.8% (2016)	VA Counties	U.S. Counties	VA Value (17.4%)
		US Value (18.0%)	Prior Value (18.0%)	HP 2020 Target (25.4%)

D. Cancer Profile

Link to interactive dashboard: Cancer SCH *(more indicators available)*

Highlights: Death and incidence rates for a variety of cancer types were examined. Mortality rates were highest among lung, prostate, and breast cancers. These rates were consistently worse in Hampton and Newport News vs. the state overall, but better in York County. In general, breast cancer, followed by prostate and then lung cancer had the highest new or incident case rates across the localities in the SCH service area. Among the localities, Hampton had the greatest all cancer incidence rate, but the trend was improving over time. All of the localities had higher all cancer incidence compared to the overall Virginia rate.

Age-Adjusted Cancer Death Rates by Cancer Type and City/County in the SCH Service Area, 2010-2014

Age-Adjusted Death Rate	Hampton	Newport News	Poquoson	York County	Virginia
Breast Cancer per 100,000 females	23.0	24.9	--	14.0	21.9
Colorectal Cancer per 100,000 population	14.5	14.9	25.9	9.7	14.2
Lung Cancer per 100,000 population	54.9	57.0	37.6	35.0	45.5
Prostate Cancer per 100,000 males	30.6	27.9	--	14.0	21.1

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

Incidence Rate	Hampton	Newport News	Poquoson	York County	Virginia
Breast Cancer per 100,000 females	139.7	141.6	153.1	135.5	127.9
Colorectal Cancer per 100,000 population	35.7	39.5	31.3	32.0	36.0
Lung Cancer per 100,000 population	76.1	71.2	66.1	53.9	58.9
Prostate Cancer per 100,000 males	141.8	124.2	93.8	116.0	102.8

Data Source: Healthy Communities Institute. Greater Hampton Roads Community Indictors Dashboard. GHRconnects. From National Cancer Institute.

GREEN = Rates are better compared to Virginia, **RED** = Rates are worse compared to Virginia

All Cancer Incidence Rate

VALUE | COMPARED TO:

County: Hampton City, VA

473.4
Cases per 100,000 population
(2011-2015)

VA Counties

U.S. Counties

VA Value
(414.3)

US Value
(441.2)

Prior Value
(473.8)

Trend

County: Newport News City, VA

454.6
Cases per 100,000 population
(2011-2015)

VA Counties

U.S. Counties

VA Value
(414.3)

US Value
(441.2)

Prior Value
(459.0)

Trend

County: Poquoson City, VA

454.8
Cases per 100,000 population
(2011-2015)

VA Counties

U.S. Counties

VA Value
(414.3)

US Value
(441.2)

Prior Value
(450.0)

Trend

County: York, VA

416.2
Cases per 100,000 population
(2011-2015)

VA Counties

U.S. Counties

VA Value
(414.3)

US Value
(441.2)

Prior Value
(378.3)

Trend

E. Behavioral Health Profile – Mental Health and Substance Abuse

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

Highlights: Hospitalization rates due to mental health, suicide/self-intentional injury, and alcohol/substance abuse were examined. Hampton and Newport News had higher hospitalization rates due to mental health compared to Virginia rates; the other localities in the service area had lower rates. For the other categories of hospitalizations, all the localities had rates lower than the state values.

Age-Adjusted Hospitalization Rate due to Mental Health

	VALUE	COMPARED TO:	
County: Hampton City, VA	58.9 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (53.0)
County: Newport News City, VA	67.7 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (53.0)
County: Poquoson City, VA	41.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (53.0)
County: York, VA	23.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (53.0)

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

	VALUE	COMPARED TO:	
County: Hampton City, VA	10.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (28.1)
County: Newport News City, VA	12.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (28.1)
County: Poquoson City, VA	10.3 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (28.1)
County: York, VA	5.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (28.1)

Age-Adjusted Hospitalization Rate due to Alcohol Abuse

	VALUE	COMPARED TO:	
County: Hampton City, VA	7.6 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	 VA Value (12.6)
County: Newport News City, VA	11.1 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	 VA Value (12.6)
County: Poquoson City, VA	11.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (12.6)
County: York, VA	5.4 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (12.6)

Age-Adjusted Hospitalization Rate due to Substance Abuse

	VALUE	COMPARED TO:	
County: Hampton City, VA	4.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	 VA Counties	VA Value (6.2)
County: Newport News City, VA	4.5 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	 VA Value (6.2)
County: Poquoson City, VA	5.1 Hospitalizations per 10,000 population 18+ years (2012-2014)	VA Counties	VA Value (5.6)
County: York, VA	3.8 Hospitalizations per 10,000 population 18+ years (2013-2015)	VA Counties	VA Value (6.2)

F. Maternal & Infant Health Profile

Link to interactive dashboard: Maternal & Infant Health SCH *(more indicators available)*

Highlights: Of the localities in the SCH service area, Hampton and Newport News had high percentages of babies born with a low birth weight and high infant mortality rates compared to US and Virginia values. Newport News had the higher low birth weight percentage of the two cities, while Hampton had the higher infant mortality rate. Teen pregnancy rates were also examined; Hampton, Newport News, and Poquoson had rates higher than the state rate.

Babies with Low Birth Weight

	VALUE	COMPARED TO:		
County: Hampton City, VA	8.6% (2015)	VA Counties	VA Value (7.9%)	US Value (8.1%)
		Prior Value (10.2%)	Trend	HP 2020 Target (7.8%)
County: Newport News City, VA	9.5% (2015)	VA Counties	VA Value (7.9%)	US Value (8.1%)
		Prior Value (8.9%)	Trend	HP 2020 Target (7.8%)
County: Poquoson City, VA	2.1% (2015)	VA Counties	VA Value (7.9%)	US Value (8.1%)
		Prior Value (4.1%)	Trend	HP 2020 Target (7.8%)
County: York, VA	6.5% (2015)	VA Counties	VA Value (7.9%)	US Value (8.1%)
		Prior Value (7.1%)	Trend	HP 2020 Target (7.8%)

Infant Mortality Rate

VALUE | COMPARED TO:

County: Hampton City, VA

9.2
Deaths per 1,000 live births
(2015)

VA Counties

VA Value
(5.9)

US Value
(5.9)

Prior Value
(9.1)

Trend

HP 2020 Target
(6.0)

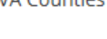
County: Newport News City, VA

7.1
Deaths per 1,000 live births
(2015)

VA Counties

VA Value
(5.9)

US Value
(5.9)


Prior Value
(7.8)

Trend

HP 2020 Target
(6.0)

County: Poquoson City, VA

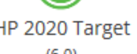
0.0
Deaths per 1,000 live births
(2012)

VA Counties

VA Value
(6.3)

US Value
(6.0)

Prior Value
(11.6)


HP 2020 Target
(6.0)

County: York, VA

1.6
Deaths per 1,000 live births
(2015)

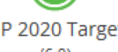
VA Counties

VA Value
(5.9)

US Value
(5.9)

Prior Value
(5.7)

Trend



HP 2020 Target
(6.0)

G. Spotlight: Opioid Epidemic

In late 2016, the Virginia Health Commissioner declared the opioid crisis a public health emergency due to the growing number of opioid overdoses in Virginia. The declaration has helped to spur communities throughout the state to begin taking action across several areas to combat the epidemic: prevention (legal and illegal), harm reduction (such as naloxone/Narcan strategies), treatment, and culture change.

Link to interactive dashboard: [Opioid Epidemic SCH] *(more indicators available)*

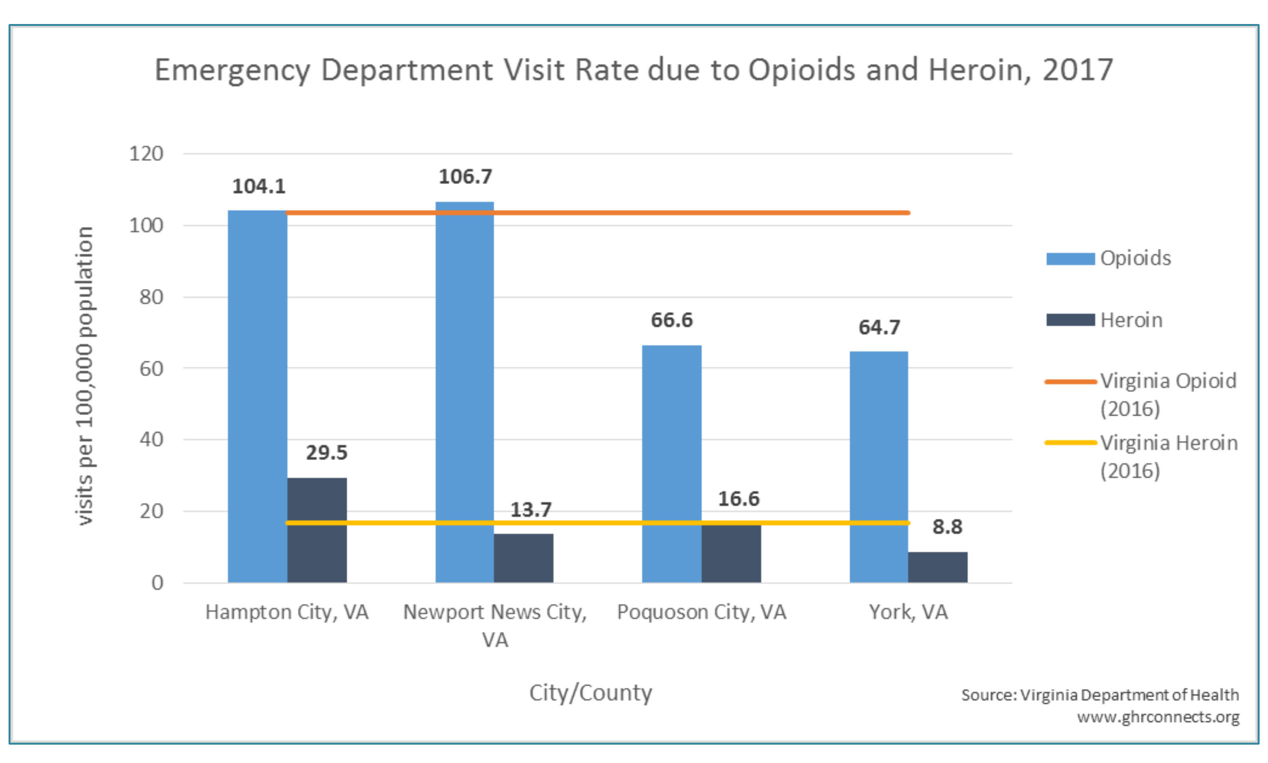
Highlights: Based on 2017 data, the death rate due to fentanyl/heroin overdose for all localities in the SCH service area except Poquoson was worse than the state comparison value. The trend over time was increasing (2013 to 2017). The death rate due to opioid overdose was lower than the state value in all of the localities. In Chesapeake, the death rate due to fentanyl/heroin overdose was higher than the state rate. Emergency department visits in 2017 due to opioids and heroin were also examined. Hampton residents had high rates of visits for both, although visits in 2017 were lower than peak rates in 2016. Newport News residents also had a high rate of emergency department visits due to opioids, but they also decreased from 2016. Narcan administration by emergency medical service providers was also examined. Rates were increasing throughout the service area; this, in part, reflects greater access and training to the rescue saving drug that can rapidly reverse overdoses to combat the epidemic.

Death Rate due to Fentanyl and/or Heroin Overdose

County	VALUE	COMPARED TO: VA Counties	VA Value	Prior Value	Trend
County: Hampton City, VA	11.1 Deaths per 100,000 population (2017)	VA Counties	VA Value (11.0)	Prior Value (14.8)	Trend
County: Newport News City, VA	13.7 Deaths per 100,000 population (2017)	VA Counties	VA Value (11.0)	Prior Value (13.2)	Trend
County: Poquoson City, VA	0.0 Deaths per 100,000 population (2017)	VA Counties	VA Value (11.0)	Prior Value (25.0)	Trend
County: York, VA	11.8 Deaths per 100,000 population (2017)	VA Counties	VA Value (11.0)	Prior Value (8.8)	Trend

Death Rate due to Prescription Opioid Overdose

	VALUE	COMPARED TO:			
County: Hampton City, VA	5.2 Deaths per 100,000 population (2017)	VA Counties	VA Value (5.9)	Prior Value (6.6)	Trend
County: Newport News City, VA	4.9 Deaths per 100,000 population (2017)	VA Counties	VA Value (5.9)	Prior Value (11.0)	Trend
County: Poquoson City, VA	0.0 Deaths per 100,000 population (2017)	VA Counties	VA Value (5.9)	Prior Value (8.3)	Trend
County: York, VA	2.9 Deaths per 100,000 population (2017)	VA Counties	VA Value (5.9)	Prior Value (1.5)	Trend



H. Spotlight: Food Access

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

Link to interactive dashboard: SCH Food Access

Highlights: The food insecurity rate for Hampton and Newport News was higher than state and national comparison values. Both cities were in the worst quartile for localities state and nationwide. Similarly, the child food insecurity rate was higher than Virginia for the two cities. People with low access to a grocery store defined as the percentage of individuals living more than 1 mile from a supermarket or large grocery store in urban areas or more than 10 miles in rural area was also examined. Percentages were high for all localities in the service area suggesting poor access to grocery stores; values across the localities were also higher than the year prior except for Poquoson, which stayed the same. These percentages are likely to be even higher today, since several large stores left the area in 2018. When this measure was examined for people aged 65+, percentages were in the lowest quartile across localities in the state and US for Poquoson and York County. The density of farmers markets was also poor across the service area, less than US comparison values. Farmers markets are one way to improve access to fresh, nutritious foods in the community.

Food Insecurity Rate

	VALUE	COMPARED TO:					
		VA Counties	U.S. Counties	VA Value	US Value	Prior Value	Trend
County: Hampton City, VA	17.8% (2016)			(10.6%)	(12.9%)	(18.0%)	
County: Newport News City, VA	16.7% (2016)			(10.6%)	(12.9%)	(16.9%)	
County: Poquoson City, VA	5.2% (2016)			(10.6%)	(12.9%)	(5.7%)	
County: York, VA	7.8% (2016)			(10.6%)	(12.9%)	(8.4%)	

People with Low Access to a Grocery Store

	VALUE	COMPARED TO:		
County: Hampton City, VA	30.0% (2015)	VA Counties	U.S. Counties	Prior Value (23.4%)
County: Newport News City, VA	22.6% (2015)	VA Counties	U.S. Counties	Prior Value (18.7%)
County: Poquoson City, VA	42.9% (2015)	VA Counties	U.S. Counties	Prior Value (42.9%)
County: York, VA	31.7% (2015)	VA Counties	U.S. Counties	Prior Value (29.5%)

People 65+ with Low Access to a Grocery Store

	VALUE	COMPARED TO:		
County: Hampton City, VA	3.5% (2015)	VA Counties	U.S. Counties	Prior Value (2.8%)
County: Newport News City, VA	2.2% (2015)	VA Counties	U.S. Counties	Prior Value (2.3%)
County: Poquoson City, VA	6.0% (2015)	VA Counties	U.S. Counties	Prior Value (6.0%)
County: York, VA	5.3% (2015)	VA Counties	U.S. Counties	Prior Value (4.6%)

Farmers Market Density in the SCH Service Area, 2016

Farmers Markets provide opportunities for members of the community to buy fresh and affordable agricultural products that emphasize good nutrition.

	Hampton	Newport News	Poquoson	York County	United States
Farmers Market Density	**0.01**	**0.02**	**0.00**	**0.01**	0.03

Sources

Profile	Data Accessed & Maintained Via	Source/Agency
Mortality Profile	Virginia Department of Health Mortality Data Portal	Deaths – VDH (OIM – Data Management)
Hospitalizations for Chronic and Other Conditions Profile	Healthy Communities Institute. Greater Hampton Roads Community Indictors Dashboard. GHRconnects. http://www.ghrconnects.org/.	Virginia Health Information (VHI)
Risk Factor Profile		County Health Rankings; Centers for Disease Control and Prevention (CDC) 500 Cities Project
Cancer Profile		National Cancer Institute
Behavioral Health Profile		Virginia Health Information (VHI); County Health Rankings
Maternal and Infant Health Profile		Virginia Department of Health, Division of Health Statistics
Spotlight: Opioid Epidemic		Virginia Department of Health
Spotlight: Food Access		United States Department of Agriculture – Food Environment Access; Feeding America

Community Insight

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

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

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

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

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

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

The community stakeholder list included representatives from public health, education, social services, business, local government and local civic organizations, among others. Health system and health department staff conducted outreach for community input via email and in-person and via teleconference at local events and meetings. An email survey request was sent to 922 unduplicated community stakeholders throughout Hampton Roads, and a total of 190 stakeholders in the Sentara CarePlex Hospital (SCH) service area submitted a response (although not every respondent answered every question). The respondents provided rich insights about community health in the study region. This report summarized the survey results for those respondents affiliated with the SCH service area.

The stakeholders responding to the survey represent 64 organizations that each have special insight into the health factors that impact the community. The stakeholders work in hospitals and physician offices, City Departments of Social Services, Health Departments and community-based non-profit service organizations to improve life in Hampton Roads. They are Emergency medical service providers, healthcare providers, fire fighters, pastors, public school teachers and administrators, and social service providers. Some are volunteers; others are career employees in their organizations.

Survey respondents were asked to identify the type of organization that best represents their perspective on health issues through employment or other affiliation. 170 out of the 190 respondents answered this question. The table below presents the roles the respondents play in the community.

Community Roles of Survey Respondents	
Type of Organization	**% Responses**
Healthcare	61.2%
Community Nonprofit Organization (Food Bank, United Way, etc.)	14.1%
Local Government or Civic Organization	6.5%
Education	3.6%
Foundation	3.5%
Law Enforcement / Fire Department / Emergency Medical Services (EMS)	3.5%
Other (Please specify below)	3.5%
Faith-based Organization	2.4%
Business Representative	1.8%
Financial Institution	0.6%

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

Organizations Represented in the Key stakeholder Survey		
Access Partnership	Hampton Division of Fire and Rescue	Riverside Health System
American Diabetes Association	Hampton Health Department	Riverside Rehabilitation Hospital
Bon Secours Mercy Health Mary Immaculate Hospital	Hampton Newport News Community Services Board	Riverside Lifelong Health and Aging
Buy Fresh Buy Local Hampton Roads	Hampton Public Library	Riverside Medical Group -- infectious diseases
Catholic Charities of Eastern Virginia	Hampton Roads Ecumenical Lodgings & Provisions, Inc. (including HELP Clinic)	Sentara Healthcare
Center for Child & Family Services	Hampton Social Services	Sentara Hospital Williamsburg, Va.
Champions For Children	JenCare Senior Medical Center	Summit Wellness At The Mount
Child Development Resources	Lackey Clinic	The Barry Robinson Center
Children's Hospital of The King's Daughters	Literacy for Life	United Way of the Virginia Peninsula
Citizens' Unity Commission	Newport News Department of Human Services	Urban League of Hampton Roads
City of Newport News Department of Human Services	Newport News Fire Dept.	VersAbility Resources
City of Williamsburg Fire Department	Newport News Public Schools	Virginia Career Works- Greater Peninsula
Colonial Behavioral Health	Newport News Redevelopment and Housing Authority	Virginia Oral Health Coalition
Community Emergency Response Team	Olde Towne Medical & Dental Center	Virginia Peninsula Foodbank
Community Services Coalition (Historic Triangle Comm. Center)	Peninsula Agency in Aging	Williamsburg Health Foundation
Compassionate Care Hospice	Peninsula Health Center	Women, Infant and Children - Virginia Beach
Consortium for Infant and Child Health at EVMS	Peninsula Health Department	York County Fire & Life Safety
Eastern Virginia Medical School	Peninsula Metropolitan YMCA	York Juvenile Services
Family & Youth Foundations Counseling Service	PHC	York Poquoson Social Services
Freedom Life Church	Respite of Williamsburg United Methodist Church	Zaremba Center for Estate Planning and Elder Law
Hampton Clean City Commission		

For both adults and, combined, children and teens, survey respondents were asked to review a list of common community health issues. The list of issues draws from the topics in *Healthy People 2020* with some refinements. The survey asked respondents to identify five challenges from the list that they view as important health concerns in the community. Respondents were also invited to identify additional issues not already defined on the list. Of the 190 respondents, 161 provided their concerns for adult challenges. The responses for children's and teen's health concerns follow on subsequent pages.

Most Frequently Chosen Health Concerns -- Adults aged 18+		
Health Concern	**% Responses**	**Rating**
Behavioral / Mental Health (Suicide, ADHD, Anxiety, Depression, etc.)	63.4%	1
Heart Conditions (Heart Disease, Congestive Heart Failure / CHF, Heart Attacks / AMI, High Blood Pressure / Hypertension)	51.6%	2
Overweight / Obesity	51.6%	
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	50.3%	3
Diabetes	45.3%	4
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	29.8%	5
Cancer	24.2%	6
Dental / Oral Care	19.9%	7
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	18.6%	8
Alzheimer's Disease / Dementia	16.8%	9
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	16.8%	
Hunger	14.3%	10
Prenatal and Pregnancy Care	12.4%	11
Accidents / Injuries (Unintentional)	9.9%	12
Neurological Conditions (Stroke, Seizures, Multiple Sclerosis, Traumatic Brain Injury, etc.)	9.9%	
Respiratory Diseases (Asthma, COPD, Emphysema)	9.9%	
Violence – Sexual and / or Domestic	9.9%	
Chronic Pain	8.7%	13
Intellectual / Developmental Disabilities / Autism	6.8%	14
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	5.6%	15
Physical Disabilities	4.4%	16
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	3.7%	17
Bullying (Cyber, Workplace, etc.)	1.9%	18
Drowning / Water Safety	0.6%	19

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

In addition to responding to the pre-formulated survey list, 17 individuals listed additional adult health concerns. The responses offer the themes of affordable care, management of chronic conditions, public awareness of current services, and the availability of mental/behavioral health assistance. The "free response" answers draw attention to the connections between what we think of as traditional medical conditions and the non-medical factors in our everyday lives that impact health, and which are known as the "social determinants of health." In these responses, as in the other free response sections of the survey, a broader vision of health is displayed. The following table presents additional health concerns for adults.

Free Response Additional Community Health Concerns -- Adults Ages 18+
Women's health
Health promotion and prevention is inherent in all of these categories
Housing and care communities for adults on the autism spectrum
Better quality of services in the social services department. Need to do anonymous testing of customer service at DSS and health department to promote better problem solving and actual assistance
Accessing services, hard for some to know service availability, especially if they have no insurance
Transportation
Hospice and palliative care also important, but there are many gaps in services and in education of providers and the public
Transportation to physicians' offices
People need to feel comfortable and not be penalized for reporting another adult with behavioral or mental health concern. Also, these services need to be widely available and affordable.
Clients are unaware of services available and not educated on the insurance availability and DSS is swamped. Grants for organizations that can assist clients and give resources out there
Transportation is a critical barrier to health care for many of our patients
Also would select HEALTH INSURANCE coverage and health promotion and prevention services
Transport up to medical appointments impossible to get affordable transporting if you are crossing some jurisdictions, i.e., treatments in Richmond or Norfolk
Behavioral health – need doctors and clinicians who go to the person's home due to transportation or health reasons. Under care coordination, need someone to go into the home to help take medication daily. This would greatly improve mental and physical health.

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

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

Community Healthcare Services that Need to be Strengthened -- Adults ages 18+		
Healthcare Service	% responses	Rating
Behavioral / Mental Health Services	64.1%	1
Health Insurance Coverage	46.8%	2
Alcohol / Substance Abuse Services	35.9%	3
Health Promotion and Prevention Services	34.0%	4
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	32.7%	5
Dental / Oral Health Services	30.1%	6
Aging Services	26.3%	7
Public Health Services	21.8%	8
Care Coordination and Transitions of Care	21.2%	9
Self-Management Services (Nutrition, Exercise, etc.)	20.5%	10
Social Services	19.2%	11
Family Planning and Maternal Health Services	18.0%	12
Long Term Services / Nursing Homes	15.4%	13
Primary Care	15.4%	
Domestic Violence / Sexual Assault Services	12.8%	14
Home Health Services	12.8%	
Chronic Pain Management Services	12.2%	15
Telehealth / Telemedicine	10.3%	16
Cancer Services	9.6%	17
Hospice and Palliative Care Services	8.3%	18
Hospital Services (Inpatient, outpatient, emergency care)	6.4%	19
Pharmacy Services	5.1%	20
Bereavement Support Services	3.2%	21
Physical Rehabilitation Services	1.9%	22

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

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

Free Response Community Healthcare Services that Need to be Strengthened -- Adults Ages 18+
Women's health
Health promotion and prevention is inherent in all of these categories
Housing and care communities for adults on the autism spectrum
Better quality of services in the social services department. Need to do anonymous testing of customer service at DSS and health department to promote better problem solving and actual assistance
Accessing services, hard for some to know service availability, especially if they have no insurance
Transportation
Hospice and palliative care also important, but there are many gaps in services and in education of providers and the public
Transportation to physicians' offices
People need to feel comfortable and not be penalized for reporting another adult with behavioral or mental health concern. Also, these services need to be widely available and affordable.
Clients are unaware of services available and not educated on the insurance availability and DSS is swamped. Grants for organizations that can assist clients and give resources out there
Transportation is a critical barrier to health care for many of our patients
Also would select HEALTH INSURANCE coverage and health promotion and prevention services
Transport up to medical appointments impossible to get affordable transporting if you are crossing some jurisdictions, i.e., treatments in Richmond or Norfolk
Behavioral health – need doctors and clinicians who go to the person's home due to transportation or health reasons. Under care coordination, need someone to go into the home to help take medication daily. This would greatly improve mental and physical health.

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

Recognizing that partners in the collaboration that produced this survey may serve differing patient populations, and may have a different focus for needed information when addressing community needs, the survey repeated the two questions about adult health concerns and needed community services for children and teens from birth through age 17. Although the questions and intent are the same as the questions for adults, some of the listed health and community need choices are specific to the population aged 17 and under. Of 190 respondents, 156 answered these questions. The table on the next page presents the most frequently chosen responses.

Most Frequently Chosen Health Concerns -- Children and Teens ages 0 -- 17		
Health Concern	**% Responses**	**Rating**
Behavioral / Mental Health (Suicide, ADD, Anxiety, Depression)	72.4%	1
Overweight / Obesity	61.5%	2
Violence in the Community (Gun injuries, Gangs, Human Trafficking, etc.)	41.7%	3
Violence In the Home – Child Abuse (Sexual, Physical, Emotional or Neglect) or Exposure to Domestic Violence	37.8%	4
Alcohol/ Substance Use (Prescription or Illegal Drugs including Opioids)	37.2%	5
Bullying (Cyber, Workplace, etc.)	36.5%	6
Smoking / Tobacco Use (Cigarettes, Chewing Tobacco, Vaping or E-Cigarettes)	25.6%	7
Intellectual / Developmental Disabilities / Autism	21.8%	8
Hunger	21.2%	9
Teen Pregnancy	20.5%	10
Dental / Oral Care	19.9%	11
Accidents / Injuries (Unintentional)	19.2%	12
Sexually Transmitted Infections (HPV, HIV/AIDS, Chlamydia, Gonorrhea, Herpes, etc.)	15.4%	13
Diabetes	10.3%	14
Eating Disorders	10.3%	
Respiratory Diseases (Asthma and Cystic Fibrosis)	10.3%	
Environmental Health (Water Quality, Pollution, Mosquito Control, etc.)	5.1%	15
Drowning / Water Safety	4.5%	16
Neurological Conditions (Epilepsy, Seizures, Tourette Syndrome-TICS, Sleep Disorders)	3.2%	17
Cancer	1.9%	18
Infectious Diseases (Hepatitis, TB, MRSA, etc.)	1.9%	
Physical Disabilities	1.9%	
Heart Conditions (Congenital Heart Defects, Fainting and Rhythm Abnormalities)	0.6%	19
Chronic Pain	0.0%	20

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

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

Free Response Additional Community Health Concerns -- Children and Teens (Ages 0 - 17)
No access to primary care without a long wait and well check first. I'm an urgent care doc and we see this all the time on both sides of the HRBT
Affordable quality healthcare
Many things affect children and teens with most connected to parenting skills
Poverty
Housing impacts health
Barriers for organizations having to compete vs. complementing other organizations, leaving the community without other resources out there
Health promotion should be for children as well

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

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

Community Healthcare Services that Need to be Strengthened -- Children and Teens ages 0 -- 17		
Healthcare Service	**% Responses**	**Rating**
Behavioral / Mental Health Services	83.7%	1
Parent Education and Prevention Programming	57.5%	2
Child Abuse Prevention and Treatment Services	45.1%	3
Alcohol / Substance Use Services	36.6%	4
Self-Management Services (Nutrition, Exercise, etc.)	36.0%	5
Health Insurance Coverage	34.6%	6
Social Services	32.7%	7
Foster Care (Supporting children in the system and their host families)	31.4%	8
Dental / Oral Health Services	27.5%	9
Care Coordination and Transitions of Care	21.6%	10
Primary Care	20.9%	11
Public Health Services	19.0%	12
Chronic Disease Services (Diabetes, High Blood Pressure/ Hypertension)	9.2%	13
Telehealth / Telemedicine	8.5%	14
Home Health Services	6.5%	15
Chronic Pain Management Services	3.9%	16
Bereavement Support Services	3.3%	17
Cancer Services	1.3%	18
Pharmacy Services	1.3%	
Physical Rehabilitation Services	0.0%	19

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

Free response additional services to be strengthened were suggested by 12 individuals and are presented on the next page.

Free Response Community Health Services that Need to be Strengthened -- Children and Teens Ages 0 - 17
Violence prevention and gun safety education and palliative care services
Cardiac care
Cannot emphasize more strongly the lack of adequate mental health resources for children, especially those with public insurance or no insurance
Safe affordable quality child care
Services can be strengthened but if parents aren't required to access services it is of no help. Social services is difficult to access, as is behavioral health/mental health services. There is sufficient access to dental/oral health service but parents must take minors for services.
Transportation
Prevention – effective prevention strategies will work if put in place correctly and with integrity. Abuse and violence prevention is the key in reducing incidents of domestic violence and abuse.
Home visiting programs
Majority of what I see, parents support due to lack of support at home
Transportation remains a barrier to health care for teens
Water safety/drowning prevention tween/teen leadership programs
Need more services for autistic children and their families

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

Much of the information we gather on community health needs ties directly or indirectly to access to health care and other services. The table on the next page presents an incomplete list of factors that might influence an individual's access to service. Although the list is brief, it can help clarify and prioritize program design. Of 190 respondents, 154 provided their list of access concerns, presented on the next page.

Factors Impacting Access to Care and Services		
Factors	**% Responses**	**Rating**
Costs	84.4%	1
Transportation	77.3%	2
Health Insurance	67.5%	3
Time Off From Work	62.3%	4
Understanding the Use of Health Services	52.6%	5
Childcare	39.0%	6
No / Limited Home Support Network	38.3%	7
Lack of Medical Providers	26.0%	8
Location of Health Services	24.0%	9
Discrimination	3.3%	10
No / Limited Phone Access	3.3%	

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

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

Free Response Additional Comments About Access to Healthcare
Lack of providers in rural areas
Few providers of services are available in evenings or weekends making it difficult for working parents to take time off
Lack of Medicaid providers and that will only become more serious as additional people enroll in the program. Also understanding the use of health services
Lack of providers that accept insurance of certain types, including but not limited to Medicaid and/or Medicare
These are all important. Understanding use of health services is easily a tie for the others I chose, as is child care.
Perception of issues confronting the community
Child care costs can be equivalent to costs per month for rent or mortgage. If there are multiple children, it's even higher. Many parents cannot afford to work because of the costs of healthcare. They become reliant on welfare system as a result. This is one reason you have generations of families on welfare. Additionally, the Hampton Roads area has a serious lack of public transportation, particularly on the peninsula (Yorktown, James City, Williamsburg). You can't work if you can't get to work.
There is no support network for families and if there is then where are they
Language barriers should be added to the list.

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

Some aspects of access to care impact population segments differentially. Those with fewer resources, such as health insurance, sufficient income, a stable home, and reliable transportation, struggle harder to access appropriate and sufficient care and other services. The survey included a question designed to identify which consumers face barriers that might be addressed through specific programming. Of 190 respondents, 150 answered the next question. The table expressing the responses is on the next page.

Most Vulnerable Populations in the Community Needing Support		
Populations	**% Responses**	**Rating**
Low Income Individuals	61.3%	1
Uninsured / Underinsured Individuals	56.7%	2
Individuals / Families / Children experiencing Homelessness	49.3%	3
Individuals Struggling with Substance Use or Abuse	44.7%	4
Seniors / Elderly	38.7%	5
Caregivers (Examples: caring for a spouse with dementia or a child with autism)	38.0%	6
Children (age 0-17 years)	34.7%	7
Immigrants or community members who are not fluent in English	26.7%	8
Individuals Transitioning out of Incarceration	22.7%	9
Individuals with Intellectual or Developmental Disabilities	22.0%	10
Individuals Struggling with Literacy	18.7%	11
Unemployed Individuals	17.3%	12
Victims of Human Trafficking, Sexual Violence or Domestic Violence	16.0%	13
Individuals Needing Hospice / End of Life Support	11.3%	14
Individuals with Physical Disabilities	10.0%	15
Veterans and Their Families	8.7%	16
Individuals in the LBGTQ+ community	6.7%	17
Migrant Workers	5.3%	18

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

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

Additional Vulnerable Populations and Additional Information
I would add to the "transitioning out of incarceration" to those currently incarcerated. When I see a patient who is going for trial, he states that he may or may not be back for follow-up. They almost never received the medications they need while in jail, and often return to clinic after their sentence having received next to no care in the inefficacious jail clinic.
Add seniors and un or underinsured
Affordable quality child care
According to data, more people are insured but our organization receives more requests for help now because although they may have coverage, they cannot afford deductibles or monthly copays. Underinsured populations with low incomes or don't understand their benefits call daily for assistance.
Socially isolated individuals and individuals or families impacted by behavioral health/mental health issues. Tried to select more inclusive categories that would affect the specific demographic groups
All of the above also have trouble accessing care for their kids – so all these fundamentally also impact access for children as a vulnerable population
Taxpayers spend a lot of money caring for and trying to rehabilitate prisoners, yet when they are released, many are homeless, without a job, and without any means to get what they need so they turn to drugs or crime and end up back in jail. This area needs better transitional services for those being released from jail. Also, employment services are hard to access due to distance (30+ minutes to Hampton office) and public transportation is limited.
Really hard to choose just five. It's a vicious circle and some are not even being addressed or one has more resources and funding than the other caregivers (example: caring for a spouse with dementia or a child with autism). Individuals with intellectual or developmental disabilities, low income individuals, unemployed individuals, victims of human trafficking, sexual violence or domestic violence, veterans and their families ALL POINTS BACK TO MENTAL HEALTH. WE GIVE A PRESENTATION FOR BEATING THE HOLIDAY BLUES, GRIEVING, EDUCATING STAFF (IN SCHOOLS) FAMILIES HOW TO IDENTIFY SUICIDE IDEATIONS. AGAIN A BARRIER TO GET IN THE SYSTEM.
Wow. I could have chosen several others on this list (i.e., many more than 5!)

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

Finally, the survey explored the many factors in addition to medical care that determine an individual's health. Collectively called the social determinants of health, these factors are becoming increasingly recognized as contributing both directly and indirectly to individual health through processes as different as the effect of household mold on respiratory disease and the effect of stress from unemployment. The effects of social determinants are sometimes subtle, sometimes only discoverable after a health problem is identified, but often important in explaining health status. Of 190 respondents, 149 addressed this question. Respondents were asked to choose five community assets to be strengthened. Their responses are presented in the table below.

Community Assets that Need to be Strengthened		
Community Assets	**% Responses**	**Rating**
Affordable Housing	51.7%	1
Transportation	49.7%	2
Healthy Food Access (Fresh Fruits & Vegetables, Community Gardens, Farmers Markets, etc.)	47.0%	3
Affordable Child Care	43.6%	4
Homelessness	36.9%	5
Employment Opportunity/Workforce Development	31.5%	6
Senior Services	30.9%	7
Neighborhood Safety	28.9%	8
Social Services	28.9%	
Early Childhood Education	22.2%	9
Social and Community Networks	20.8%	10
Safety Net Food System (Food Bank, WIC, SNAP, Meals on Wheels, etc.)	18.1%	11
Education – Kindergarten through High School	16.1%	12
Safe Play and Recreation Spaces (Playgrounds, Parks, Sports Fields)	16.1%	
Walk-able and Bike-able Communities (Sidewalks, Bike/Walking Trails)	16.1%	
Public Safety Services (Police, Fire, EMT)	10.7%	13
Education – Post High School	6.0%	14
Green Spaces	6.0%	
Environment – Air & Water Quality	2.7%	15
Public Spaces with Increased Accessibility for those with Disabilities	2.7%	
Housing Affordability & Stability	0.0%	16

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

Respondents were also given the opportunity to increase the list by adding factors that impact health. Nine individuals added factors, listed in the table below.

Additional Community Assets and Additional Information
HRT services are awful. Maybe the powers to be can look into improving those services. Take a week and observe what would be improvements to these services
Dental services which aren't always a part of insurance
When a young family pays for child care, it cancels out a large portion of their income. Rent in a safe neighborhood is out of reach for many. Access to healthy foods won't work if parents/individuals won't use them. Would like to see SNAP work more like WIC where only healthy foods can be purchased (currently items like candy, soda, chips and other non-nutritious foods can be obtained with SNAP).
Community task forces that decide on prevention strategies for their communities
Checked one education box, but all are necessary. This question is very hard to deal with, since most are needed.
Safe places to play and walkable/bikeable communities also rank high up there
Public safety is an asset, If we have the community proactive in helping. Education – after school program and have an alternative for detentions and suspensions
Safety net food system should be oriented to healthy food access
Health safety net

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

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

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

Community Focus Group Session Findings

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

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

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

3 focus group sessions were held in during February-March, 2019. The number of participants ranged from 10 to 29. When possible, representatives from the health department and other local hospitals were invited to attend the sessions.

List of the focus groups/stakeholders in order they were carried out:

1. Newport News Rotary group (business leaders from the Upper and Lower Peninsula)
2. Sentara CarePlex Volunteer/Auxiliary Board members (retired citizens of the Upper and Lower Peninsula)
3. United Way of the Virginia Peninsula Community Investment committee (business leaders/non-profit executives from the Upper and Lower Peninsula)

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?	Surprisingly, there was a fair amount of consensus among all three groups. Not necessarily ranked in any particular order, surveyed members mentioned diabetes/obesity, Heart Failure, Kidney Failure, multiple areas of cancer and treatment, and access to health care for the poor and/or underinsured as key problems. Lack of available care givers for post-acute care was also identified on survey. Two groups mentioned the opioid crisis as an area requiring much more resources and attention as it potentially trickles down and affect all community members.

Who/what groups of individuals are most impacted by these problems?	Mentioned in the surveyed group were the homeless, "working poor" families, i.e. working families just barely living paycheck to paycheck (ALICE), elderly without convenient access to health care services, and people living in food deserts without access to healthy, affordable foods.
What keeps people from being healthy? In other words, what are the barriers to achieving good health?	Television/marketing messaging was seen as a major contributor to the promotion of non-healthy lifestyles. Ready availability of affordable fast food was mentioned as the beginning of the decline of a healthy lifestyle. Convenient exercise/outdoor parks seen by one group as a barrier to achieving a healthy lifestyle. Lack of healthy food options for seniors in restaurants noted by one group. Overall, there appeared to be a 'just in time' attitude towards good health in that the perception exists that one really does not have to take responsibility for his/her health because when needed, one could easily access the ED for their PCP for treatment and care only to again repeat the behavior which led to the issue in the first place. All groups felt they did not need to travel outside of the Peninsula to receive high quality health care.
What is being done in our community to improve health and to reduce the barriers? What resources exist in the community?	Most groups had some knowledge of at least one community outreach education/screening/health fair in their neighborhood. All expressed the need for even more 'education' to help not just with specific diseases but perhaps how to gain access into the health care continuum, from insurance to acute care to post-acute care options. Not surprisingly, all expressed the notion to decrease the cost of healthcare, most found it to be too high and a definite contributor to their financial well-being. Everyone should have access to their own primary care doctor. One group mentioned transportation barriers to access health care of their choosing as a significant barrier. A greater number and frequency of bus lines seen as barrier. Hospitals need to stop competing with each other and work collectively to improve the overall health of the same community they jointly serve.
What more can be done to improve health, particularly for those individuals and groups most in need?	A greater number of education offerings at appropriate comprehension levels for general community members seen by all three groups. Make 'things more affordable' mentioned by two of the groups. Efforts should be made to link up each member with a PCP before they have a health care issue (i.e. preventative, proactive approach). Healthier food offering in restaurants also mentioned as factor to improve health.
Considering social determinants impact health	Crime/gang issue in Lower Peninsula has to be addressed. Medication costs at times prevent ready availability and consistent

outcomes more than clinical care, which of the following resonate as a key social determinant that we should be focusing on?	usage ("can go to Canada and get the same medications for ¼ of the cost"). Linking up uninsured/underinsured with 'lifestyle coach' seen as possible strategy to improve health outcomes. Opioid crisis seen as taking community resources which could be directed to creating a healthier community. Affordable housing mentioned as contributor. Lack of 'green space' for overall enjoyment mentioned by one group. Affordable transportation again mentioned as determinant.

Sentara Community Health Needs Assessment Implementation Strategy

2018 Progress Report

Hospital: Sentara Port Warwick ASC

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

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

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

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

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

Health Problem	Three Year Implementation Strategies	Progress
All		
Problem #1: Uninsured/ Underinsured	• Implement association with Community Health Clinics to provide after-procedure medical follow-up care resource option • Partner with Local Churches, Community Centers, and Civic Leagues to sponsor a series of medical screening in collaboration with SPW Cares-a "Lot" campaign • Partner with SPW to support the Drive Thru Flu Shot Program	• Continue to partner with SEVHSA to provide on-site navigator assistance on Campus to establish medical homes for un/underinsured patients visiting Center • Continue with community outreach activates/educational series/screening activities focusing on breast health, diabetes education, and early cancer identification • Peninsula Group agreed to support collaborative effort centered on Healthy Lifestyle with concentration on access to healthy food. Representative from Peninsula Food Bank brought in to outline current service offering and propose new model which collaborates with current but expands to health-

Health Problem	Three Year Implementation Strategies	Progress
		system centric. Secured corporate funding level at $50K to help kick start initiative. Steering Committee continues to meet with goals: 1.) identification of target patient population, 2.) Entrance Site into program, 3.) outcome metrics. Diabetic Educators selected from each institution for their expertise in program development and participant selection. • Program to be initiated at SCH and SWRMC June, 2018. • Partner with Lackey Clinic to provide direct linkage for uninsured/Underinsured patients who present to PW ED. Establish medical home for this patient population. Program referral stream/protocols finalized, to be initiated June, 2018. To date, 9 patients have found medical home at the Lackey Clinic. • October update: 23 patients without primary care coverage now linked with Lackey Clinic • December update: additional 29 patients now linked to either Lackey Clinic or SEVHSA
Problem #2: Obesity-Adult	• Promote offering of surgical options for treatment of morbidly obese adults by partnering with nearby medical-surgical weight loss Center • Partner with SCH to set up Educational Resource Stand to provide pamphlets on weight loss/healthy choices	• Healthy Food Initiative Plan scheduled to go live for both PW and SCH Campuses June, 2018. Update per June Kick-off: 48 patients screened, 10 +ve, 38 –ve, with 8 patients choosing to participate in the program. October update: 65 patients screened, 19 patients currently in the program December update: program reviewed with goal of increasing patient participation for duration of

Health Problem	Three Year Implementation Strategies	Progress
		program. Appears patients successfully screened, interviewed, and given initial food box only to have unsuccessful continuation with program. Program redesign under discussion.
Problem #3: Cancer	• Continue collaboration with the Hampton Roads Prostate Cancer Health Forum providing education and screening to the community, especially the un- and underinsured • Work with Community Health and Prevention to provide on-site screenings and self-learning programs • Continue to partner with the DGH Center and VDH to provide breast cancer screening and early treatment options • Continue providing annual community education sessions re: breast cancer	• Tobacco Cessation classes held 2/5,2/12, 2/19, 2/26,2/27,2/28 for total of 19 participants • Tobacco Cessation classes held 4/16 and 4/23 for total of 5 participants. • Clinical Trial session held for patients at high risk for breast cancer 2/27. 30 patients admitted into the program. • Lung Cancer/Awareness, Skin Cancer Awareness and Education, and Colon Cancer educational seminars held on CNU campus 3/7 for 325 participants • Colorectal Cancer Screening and Surgical Management of Colorectal Cancer held by Dr. Fitzharris in Williamsburg for 136 participants. • “Don’t Sit on Colon Cancer” banner displayed throughout March along with CRC educational materials • 28th Annual Health & Cancer Screening Held 4/21 at SEVHS 48th Street Clinic for 119 participants. 2018 Annual Community Health and Cancer Screening held at SEVHS for a total of 119 participants. • 7/30 Optima/Mission Health presentation on Cancer presented via WEBEX to 200 participants • 8/28 Skin Cancer and Awareness at the Colonial Courthouse in Gloucester to 17 participants • 8/31 First Friday Event at PW, 100 participants, General Health Fair Information

Health Problem	Three Year Implementation Strategies	Progress
		• 8/07/2018 Coliseum Central Neighborhood Night out Health & Safety Fair, 200 participants • 7/27 DGHCBC, NN Komen Grant Mammogram Screening, 26 uninsured/underinsured participants • 9/15 SVHS Stonybrook, Prostate Cancer Early Detection Program, 33 participant • 10/25, Funtober Fall Festival, Va Living Museum, 110 Medical Staff members participated • Continued throughout the year with the Cancer Resource Mobile Cart which provided cancer education and community resources • 10/6 How to get Screened for Colon Cancer, Antioch Baptist Church, Hampton, 55 participants • 10/6 Breast Cancer Awareness Event, Boo Williams Sports Center, education event for 100 participants • 10/16 Breast Cancer Awareness event, Zion Prospect Church, Yorktown, 45 participants • 10/20, Breast Cancer Awareness event, Denbigh Community Center, 30 participants • 10/23 Therapeutic Massage and Lymphedema Management for Breast Cancer patients, Support group with 25 participants 10/6 Women in Unity, Newport News, Cancer Awareness education for 50 participants Continue with Cancer Education Mobile Resource Cart which outlines community resources for those families struggling with this disease
Problem #4: Diabetes	• Evaluate Partnership with local podiatrist to offer a Foot Clinic • Partner with SCH to help educate patients on resources available to	• Continue to offer Comprehensive Wound Care to patients with diabetic foot disease (59% growth noted in 2017).

Health Problem	Three Year Implementation Strategies	Progress
	include: weekly Free Diabetes Classes and monthly Diabetes Support Groups	• 7% growth noted in Diabetic wound care visits from Jan-June, 2017 vs 2018. • October update: 24% growth noted in Wound Care patients. 8% of patient population without insurance treated in Center. • Continue to partner with Diabetes Educator to offer education/training to patients without access to healthy food options. Engage Diabetes Educator in Health Food Offering program running through EDs of SCH and SPW. • December update: 41% increase growth noted in wound care visits year to date.